Proposed Unfair Claims Regulations

William W. Palmer

Follow this and additional works at: http://digitalcommons.law.scu.edu/lawreview

Part of the Law Commons

Recommended Citation
Available at: http://digitalcommons.law.scu.edu/lawreview/vol36/iss3/1

This Article is brought to you for free and open access by the Journals at Santa Clara Law Digital Commons. It has been accepted for inclusion in Santa Clara Law Review by an authorized administrator of Santa Clara Law Digital Commons. For more information, please contact sculawlibrarian@gmail.com.
ARTICLES

PROPOSED UNFAIR CLAIMS REGULATIONS

William W. Palmer*

I. INTRODUCTION

In January 1993, after a lengthy administrative review, the Unfair Claims Settlement Practices Regulations [hereinafter Regulations or current Regulations] became law in California.\(^1\) The Regulations are based on section 790.03(h) of the California Insurance Code, which enumerates sixteen claims practices that are deemed unfair if they are knowingly committed on a single occasion, or if they are performed with such frequency as to indicate a general business practice.\(^2\)

\* Deputy Commissioner and General Counsel for the California Department of Insurance; B.A. 1985, University of California, Los Angeles; J.D. 1989, University of Pacific, McGeorge School of Law. This article would not have been possible without the hard work and dedication of Kristin Joyce, a third year law student at Santa Clara University School of Law.


2. CAL. INS. CODE § 790.03(h) (West 1993). The practices include "[m]isrepresenting to claimants pertinent facts or insurance policy provisions," id. § 790.03(h)(1); "[f]ailing to acknowledge and act reasonably promptly" upon receipt of communications about claims, id. § 790.03(h)(2); "[f]ailing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured," id. § 790.03(h)(4); "[i]not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear," id. § 790.03(h)(5); and "[f]ailing to provide promptly a reasonable explanation of the basis relied on in the insurance policy . . . for the denial of a claim or for the offer of a compromise settlement," id. § 790.03(h)(13).

Section 790.03(h) is part of a broader statutory base commonly referred to as the "Unfair Claims Practices Act." Quackenbush & Palmer, supra note 1, at 1. The Act is enforced by the Department of Insurance (DOI) under an administrative scheme that allows the DOI to issue penalties and cease and desist orders. \textit{Id.}
The Regulations guide all insurance claims in California. They are extensive in scope and prescribe affirmative standards of conduct for both insurers and other licensees of the Insurance Commissioner. They were established to set minimum standards for settling unfair claims practices; promote the good faith, efficient, and equitable settlement of claims on a cost-effective basis; discourage and monitor the presentation to insurers of false or fraudulent claims; and encourage prompt and thorough reporting and investigation of suspected fraudulent claims.

Although the Regulations' objectives are straightforward, implementing them over the past two years has proven troublesome. For instance, certain terminology in the Regulations is undefined and/or creates conflict with existing California legislation and case law. Other terms create subjective standards for enforcement, which may result in some members of the public obtaining increased benefits over others. Additionally, the Regulations create penalties for certain violations, but there is no infractions schedule that correlates to a fine structure. Thus, in practice, the language of the Regulations undermines the goal of efficient and cost-effective claims settlement.

In response to concerns expressed by several California businesses and insurance companies, Insurance Commis-
sioner Charles "Chuck" Quackenbush and his department have proposed new unfair claims regulations [hereinafter new regulations or proposed regulations]. The proposed regulations contain seven principal changes designed to make the Regulations easier to follow, and clearer for insurance companies, claims adjusters, and claimants.\footnote{14}{See generally infra part IV.}

This article begins with an overview of the affected provisions of the current Regulations.\footnote{15}{See infra part II.} Next, it discusses how the current Regulations have impacted or may continue to impact the insurance industry and insurance claims in California.\footnote{16}{See infra part III.} This article then presents the proposed changes to the Regulations and a discussion of the basis for each change.\footnote{17}{See infra part IV.} Finally, this article concludes with a discussion of how the new regulations, if adopted, may impact insurance claims in California.\footnote{18}{See infra part V.}

II. AFFECTED PROVISIONS OF THE REGULATIONS

The purpose of the Regulations is to set minimum standards for settling insurance claims, promote the good faith settlement of claims, and discourage false and fraudulent claims.\footnote{19}{CAL. CODE REGS. tit. 10, § 2695.1(a) (1995).} The Regulations apply to licensees\footnote{20}{Under the Regulations, the term licensee means "any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in . . . California or with California residents . . . ." Id. § 2695.2(n).} or insurance companies and their employees, agents, and brokers, and independent adjusters, when resolving insurance claims with claimants or consumers.\footnote{21}{Quackenbush & Palmer, supra note 1, at 2-3.} This section discusses the affected provisions of the Regulations.

A. Section 2695.2: Definition of Claimant and Designation

Section 2695.2(c) of the Regulations defines claimant as a first or third party claimant . . . , any person who asserts a right of recovery under a surety bond, or any of the following persons who have been properly designated by the claimant: attorney, insurance adjuster, public adjuster,
beneficiary, guardian, guardian ad litem, conservator where the claimant is incapable of representing his/her own interests, and where the claimant is an individual, a member of the claimant's family.22

This section also contains a designation requirement for claimants who wish to have someone else handle their claims.23 Designations must be "in writing, signed and dated by the claimant, [and must] clearly indicate that the designated person is authorized to handle the claim..."24 They must be transmitted to the insurer, and they are valid for one year from the date of execution.25 Currently, attorneys must submit designation forms to insurers indicating that they are authorized to represent their client with respect to a given claim.26 The California Trial Lawyers Association recently initiated an action in Los Angeles County Superior Court to have this requirement removed.27 Although they were able to obtain declaratory relief on this issue, the judgment was binding only in Los Angeles County.28

B. Section 2695.5: Communications

Section 2695.5 of the Regulations is titled "Failure to Acknowledge Communications." This section contains provisions regarding communications between claimants, insurance agents, and insurers. It deals mainly with time deadlines for replying to a notice of claim, based on whether or not the notice is complete.

1. Notice of Claim

A "notice of claim" is a communication by a claimant to an insurer or its claims agent, that "reasonably apprises" the insurer of certain information.29 Notice of claim can be either written or oral.30 The notice must include the date, time, and place of loss; the name and address of the claimant and any

23. Id.
24. Id.
25. Id.
26. Id.
28. Id.
30. Id. § 2695.2(o)(1).
other person(s) known by the claimant to be involved in the loss; the name and address of the insured under the insurance policy in question; and the insurance policy number, if known by the claimant.

Notice of the claim is deemed to be complete as to the insurer when the required information has been provided to the insurer by the claimant, "or has been independently determined by the insurer, or when the claimant has advised the insurer that all information in [his or her] possession has been provided to the insurer."31

2. **Claimant-Insurance Agent Communications**

Section 2695.5, subsection (a), establishes standards for communications between claimants and insurance or claims agents. It provides:

Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen . . . calendar days later acknowledge receipt of such notice to the claimant unless payment is made within that period of time except where extraordinary circumstances preclude the insurer from complying with this section or where the insurer receives notice of legal action. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer if the insurer has knowledge of prior failure(s) to promptly transmit notice by the insurance agent or claims agent and has failed to take remedial measures . . . 32

3. **Insurance Agent-Insurer Communications**

Subsection (b) governs communications between insurance or claims agents and insurers. Upon receipt of notice of claim, every insurance agent or claims agent shall immediately transmit notice of claim to the insurer. Failure . . . to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation of California Insurance Code Section 790.03(h)(3) and this subsection,
where the insurer has provided the appointed insurance agent or claims agent with written instructions as to the proper handling of a notice of claim . . . .

4. Claimant-Insurer Communications

Communications between insurers and claimants are discussed in subsections (g) and (h). Insurers must reply "as soon as practicable but in no event more than fifteen . . . calendar days after receipt, to any communication from a claimant regarding a claim that reasonably suggests that a response is expected." Additionally, upon receiving notice of claim, "every insurer shall immediately, but in no event more than fifteen . . . calendar days later with respect to [personal, commercial, and title policies,] and twenty-one . . . calendar days with respect to bonds, provide necessary claim forms, instructions, and reasonable assistance" to claimants.

C. Section 2695.6: Standards for Prompt Investigation of Claims

Section 2695.6 sets forth standards for investigating claims, including establishing training for agents and certification of that training. Specifically, insurers must "begin any necessary investigation of the claim immediately [upon receiving notice of claim,] but in no event more than fifteen . . . calendar days later, except in [extraordinary] cases . . . or where the notice of claim the insurer receives is a notice of legal action." Additionally, all insurers must adopt and communicate to their insurance and claims agents "written standards for the prompt investigation and processing of claims . . . ."

Under subsection (c), all licensees are required to provide "thorough and adequate training regarding the [unfair claims] regulations . . . to all of their employees who have any involvement in claims handling and require certification of

33. Id. § 2695.5(b).
34. Id. § 2695.5(g).
35. Id. § 2695.5(h).
36. Id. § 2695.6.
37. Id. § 2695.6(a).
38. Id. § 2695.6(b). Insurers were required to adopt and communicate these standards to their agents within 90 days after the effective date of the Regulations. Id. If the insurer failed to meet this deadline, "delay in investigating or processing claims [would] be imputed to the insurer." Id.
training regarding these regulations . . . ."39 The Regulations establish different methods of demonstrating compliance with section 2695.6 for licensees who are individuals and licensees who are entities,40 but the basic requirement is the same: the licensee must certify in writing on an annual basis, under penalty of perjury, that he or she has read and understands the Regulations, or that a copy of the Regulations and clear written instructions regarding the procedures to be followed are contained in the claims adjusting manual or are provided to all employees who are involved in handling claims.41

D. Section 2695.7: Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

1. General Prohibitions

As its title suggests, section 2695.7 addresses the main goal of the Unfair Claims Regulations, namely to provide prompt, fair, and equitable settlement of insurance claims. This section prohibits insurers from doing any of the following: discriminating in claims settlement practices based upon the claimant’s race, gender, income, language, religion, national origin, sexual orientation, or physical disability;42 persisting in seeking information not reasonably required for or material to the resolution of a claim;43 attempting to settle a claim by making an unreasonably low settlement offer;44 requesting or requiring that an insured submit to a polygraph examination;45 or denying a claim based upon information obtained in a telephone conversation or personal interview with any source unless the “interaction” is documented in the claim file.46

2. Claims and Liability

Additionally, section 2695.7 provides that upon “receiving proof of claim, every insurer . . . shall immediately, but in

39. Id. § 2695.6(c).
40. Id. § 2695.6(c)(1), (2).
41. Id.
42. Id. § 2695.7(a).
43. Id. § 2695.7(d).
44. Id. § 2695.7(g).
45. Id. § 2695.7(j).
46. Id. § 2695.7(l).
no event more than forty . . . calendar days later, accept or deny the claim, in whole or in part, and affirm or deny liability.” Denial or rejection of a first party claim in whole or in part must be in writing, and such writing must provide a factual basis for the denial or rejection. If a claimant believes that his or her claim has been wrongfully denied or rejected, the claimant may have such claim reviewed by the California Department of Insurance.

3. Payment of Claims

Insurers are required to render payment immediately upon, but in no event more than thirty . . . calendar days after, the insurer’s affirmation of coverage with respect to first party claimants and the insurer’s affirmation of coverage and liability with respect to third party claimants, of the amount of the claim which has been determined and is not in dispute . . .

If settlement of the claim has been negotiated, then the insurer must “tender payment of the negotiated amount immediately upon, but in no event more than thirty . . . calendar days after receipt by the insurer of a properly executed release.”

E. Section 2695.9: Policies with Replacement Cost Coverage

Section 2695.9 covers fire and extended coverage type policies that include replacement cost coverage. Under this section, when a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy, must be included in the loss. The insured is only re-

47. Id. § 2695.7(b). If the insurer needs more time than given by statute, the insurer must provide the claimant with written notice of the need for such additional time. Id. § 2695.7(c)(1). The insurer must continue to provide the claimant with this written notice every 30 days until a determination is made.

48. Id. § 2695.7(b)(1). Insurers are not required to “disclose any information that could reasonably be expected to alert a claimant that the subject claim is being investigated as a suspected fraudulent claim.” Id. § 2695.7(b)(2).

49. Id. § 2695.7(b)(3).

50. Id. § 2695.7(h).

51. Id.

52. Id. § 2695.9.

53. Id. § 2695.9(a)(1).
sponsible for paying the applicable deductible, not depreciation of the item or part or any other cost.54

Subsection (a)(2) establishes what is known as the "line of vision" test.55 It reads:

When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area and that area which encompasses a clear line of vision from the damaged area so as to conform to a reasonably uniform appearance. This applies to interior and exterior losses.56

This "test" has generated considerable controversy, insofar as it is highly subjective, and it may result in different recoveries for identically situated members of the general public.57

Finally, if the insured property has nominal or no economic value, the insurer must provide a full written explanation of the reason for limiting the amount of recovery, along with the amount payable under the policy.58 Thus, this section is substantially the same as section 2695.7(g)(1), insofar as it mandates that denials of claims be in writing.59

F. Section 2695.11: Standards Applicable to Title Insurers

Section 2695.11 enumerates additional standards applicable to handling claims under a title insurance policy.60 Essentially, this section duplicates other provisions of the Regulations.61 Subsection (a) provides that

[i]f a notification of a claim against the policy of title insurance is given to an underwritten title company which participated in the issuance of that policy of title insurance, then the insurer which issued that policy shall be under the duty to ensure that such underwritten title company immediately forward such claim to the insurer responsible for the issued policy. The underwriting agreement between the insurer and underwritten title company shall provide for the duty of the underwritten title company to immediately forward such claim to the insurer.62

54. Id.
55. Id. § 2695.9(a)(2).
56. Id. (emphasis added).
57. See infra part III.C.
59. Compare id. § 2695.7 with id. § 2695.10.
60. Id. § 2695.11.
62. Id. § 2695.11(a).
Subsection (b) requires that the insurer fully cooperate with the insured upon receipt of proper notice of any claim arising under a policy of title insurance based upon another person's assertion.63 "However, such cooperation by the insurer shall not be construed to create any additional rights of the other person."64

G. Section 2695.13: Workers' Compensation Insurance

Section 2695.13 delineates procedures to be followed when a person is awarded a final award of workers' compensation benefits pursuant to the Workers' Compensation Appeals Board [hereinafter WCAB], and the insurer has failed to pay such a final award within thirty days, as mandated by law.65 The section provides definitions relevant to the workers' compensation context,66 and it contains procedures for obtaining payment of an award from the Insurance Commissioner if an insurer has not paid all or any part of a final WCAB award within ten days after the award became final.67

H. Violations of Regulations and Penalties

Two of the most important provisions of the Regulations relate to what constitutes a violation of the Regulations, and what penalties may be imposed.

1. Violations

Section 2695.14 enumerates examples of when a licensee has knowingly committed an act or acts in noncompliance with the Unfair Claims Regulations.68 The list is illustrative, not exhaustive.69 A licensee violates the Regulations when he or she promulgates express policies or procedures that are in noncompliance with the Regulations, or when an employee or claims agent of a licensee commits an act that receives prior approval, and later ratification, from a licensee.70

In considering whether a licensee has not complied with the Regulations, the Insurance Commissioner is directed to

63. Id. § 2695.11(b).
64. Id.
65. Id. § 2695.13.
66. Id. § 2695.13(a).
67. Id. § 2695.13(b).
68. Id. § 2695.14(a).
69. Id.
70. Id. § 2695.14(a)(2).
Consider any admissible evidence offered regarding the existence of extraordinary circumstances;\(^\text{71}\) whether the licensee has a good faith and reasonable belief that the claims are fraudulent;\(^\text{72}\) the complexity of the claims involved;\(^\text{73}\) and substantial mischaracterization or "suspiciousness"\(^\text{74}\) of the facts and circumstances surrounding the claim or loss.\(^\text{75}\)

2. Penalties

Section 2695.15 provides penalties for a licensee who violates any of the Regulations. Any violator is "subject to all applicable monetary penalties or other administrative actions within the jurisdiction of the Commissioner including, but not limited to, suspension or revocation of an insurer's certificate of authority or license or revocation or suspension of an agent's license."\(^\text{76}\)

In determining the appropriate fine, penalty, or other administrative action to be taken against a violator, the Insurance Commissioner may consider the frequency of occurrence and/or severity of the detriment to the public caused by the particular violation.\(^\text{77}\) Section 2695.15 then sets forth two separate lists of factors which may be considered in determining penalties to be imposed.

First, for determining "any penalty for noncompliance" with the regulations, the Commissioner shall consider "any admissible evidence offered" regarding:

(A) the relative number of claims where the noncomplying act(s) are found to exist, as contrasted to the total number of claims handled by the licensee during the relevant time period;

(B) whether the licensee has taken remedial measures with respect to the noncomplying act(s);

(C) the existence or nonexistence of previous violations by the licensee;

(D) the degree of harm occasioned by the noncompliance; and

\(^{71}\) See id. § 2695.14(b)(1).

\(^{72}\) Id. § 2695.14(b)(2).

\(^{73}\) Id. § 2695.14(b)(3).

\(^{74}\) See id. § 2695.14(b)(4)(A), (C) (gross exaggeration of value of property or severity of injury); see also id. § 2695.14(b)(5)(A), (C) (gross exaggeration of the amount of damages incurred).

\(^{75}\) Id. § 2695.14(b)(4)(B), (5)(B).

\(^{76}\) Id. § 2695.15(a).

\(^{77}\) Id. § 2695.15(b).
(E) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the regulations. 78

Then, for determining "the penalty for any noncompliance with the deadlines imposed by [the regulations]" the Insurance Commissioner may consider whether any of certain acts have been committed in connection with the claim(s). 79

With respect to claims arising under an insurance policy, the acts include:

(1) gross exaggeration of the value of the property or severity of the injury;
(2) substantial mischaracterization of the facts and circumstances surrounding the loss;
(3) secreting property which has been claimed as lost or destroyed;
(4) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent . . . ; and/or,
(5) establishment or variation of claim settlement practices or standards of scrutiny or review, upon claimant's race, gender, income, religion, language, sexual orientation, ancestry, national origin, physical disability or upon the territory of the property or person insured . . . . 80

For claims arising under a surety bond, the Insurance Commissioner shall consider whether the following acts have been committed in connection with the claim(s):

(1) gross exaggeration of the amount of damages incurred;
(2) substantial mischaracterization of the facts and circumstances surrounding the alleged default of the principal; and/or
(3) presentation of a claim where the facts and circumstances surrounding the claim are so similar to a previously presented claim that the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of the law, or the claimant is otherwise engaged in activity consistent with fraudulent activity . . . . 81

78. Id. § 2695.15(b)(1).
79. Id. § 2695.15(b)(2).
80. Id. § 2695.15(b)(2)(A).
81. Id. § 2695.15(b)(2)(B).
In both situations, however, the Insurance Commissioner shall not consider "reasonable mistakes or opinions as to valuation of property, losses or damages when determining any penalty for noncompliance . . ." 82

Sections 2695.14 and 2695.15 direct the Insurance Commissioner to consider virtually the same set of factors in determining both noncompliance and penalties. Significantly, there is no schedule of penalties that corresponds to certain infractions.

III. HOW THE REGULATIONS IMPACT THE INSURANCE INDUSTRY

This section highlights some of the issues that have been encountered under the current Regulations. It also questions whether the Regulations have made any meaningful progress toward achieving the stated goals of good faith, prompt, efficient, and equitable claims settlement.

A. Claimants

The term "claimant" has "several different uses within the context of an insurance relationship." 83 Members of the general public who purchase insurance have certain privacy rights that are protected. 84 However, these privacy rights differ depending on whether the person is a first or third party claimant. 85

A first party claimant is a member of the public who makes a claim under his or her own insurance policy. 86 A first party claimant may freely inquire about virtually any aspect of his or her policy because the relationship between the member of the public and the insurer is an open one. 87

A third party claimant is an injured or an allegedly injured individual. 88 Third party claimants may not freely inquire about another person's insurance information. 89 "In

82. Id. § 2695.15.
83. Letter from Chuck Quackenbush to John Garamendi, supra note 9, at 2.
84. Id. at 9.
85. Id.
86. Id. at 2.
87. Id.
88. Id. The Regulations define third party claimant as "any person asserting a claim against any person or the interests insured under an insurance policy." Cal. Code Regs. tit. 10, § 2695.2(z) (1995).
view of the increasingly litigious nature of our society, to allow any member of the public to freely access the insurance information of another member of the public would create an invitation to litigate against those individuals who most seek to protect themselves through insurance.\textsuperscript{90}

The current Regulations do not adequately define the term “claimant” or specify consumer privacy protections.\textsuperscript{91} Instead, they create a situation in which insurance companies appear to be obligated to supply third party claimants with privileged information about their own insured(s).\textsuperscript{92}

B. Notice of Claim

Another ambiguous term is “notice of claim,” receipt of which triggers the time deadlines under the Regulations.\textsuperscript{93} Under the current Regulations, notice of claim is essentially the first notice an insurer, business, broker, or agent receives to inform them about a possible claim.\textsuperscript{94} However, the definition does not take into account the different natures of the businesses it purports to regulate.\textsuperscript{95}

For instance, health care insurers are vastly different from automobile insurers, business insurers, and transportation insurers, in the manner in which they do business.\textsuperscript{96} A health care insurer usually does not receive direct communications from its clients. Instead, the first “notice of claim” typically comes in the form of bills from a doctor or hospital.\textsuperscript{97} On an average hospital visit, the health care insurer might receive a dozen or more separate billings for various hospital services, including doctors’ visits, x-rays, and prescriptions.\textsuperscript{98}

Application of the notice of claim provision thus becomes onerous when a single bill constitutes a notice of claim.\textsuperscript{99} An insurer would be required to respond with a communication to its insured(s) for each notice of claim — or bill — it re-

\textsuperscript{90.} \textit{Id.}
\textsuperscript{91.} \textit{Id.}
\textsuperscript{92.} \textit{Id.}
\textsuperscript{93.} \textit{Id.}
\textsuperscript{94.} \textit{Id.}
\textsuperscript{95.} \textit{Id.}
\textsuperscript{96.} \textit{Id.}
\textsuperscript{97.} \textit{Id.}
\textsuperscript{98.} Letter from Chuck Quackenbush to John Garamendi, \textit{supra} note 9, at 2-3.
\textsuperscript{99.} \textit{Id.} at 3.
ceives. "An insurer might work with 600 to 1000 injured insured[s] per week, in Northern California alone, while responding to each 'Notice of Claim' in the costly manner set forth in the regulations."

C. Line of Vision Replacement Test

One especially troublesome provision of the current Regulations is the line of vision test for insurance policies with replacement cost coverage:

When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area and that area which encompass a clear line of vision from the damaged area so as to conform to a reasonably uniform appearance.

As the section reads, insurers are obligated to replace damaged, as well as undamaged, property in order to bring the aesthetics of the repaired property into conformity with the undamaged, unrepaired portion of the property. "This appears to obligate an insurer to replace an entire brick wall, or roof, where the repaired bricks or shingles do not match the color of the remaining undamaged wall or roof."

The line of vision test creates a subjective standard for replacing damaged (and undamaged) property. In some instances, identically situated members of the public will be treated differently. For example, one member of the public may demand and receive a new roof or brick wall, while another, less vocal person may receive replacement of only the damaged portion. The line of vision test creates an open invitation for conflict and litigation between the claimant, the insured, and the insurer, which the Regulations seek to avoid.

100. Id.
101. Id.
103. Letter from Chuck Quackenbush to John Garamendi, supra note 9, at 3.
104. Quackenbush & Palmer, supra note 1, at 11.
105. Id.
106. Id.
107. Id.
108. Id.
D. Market Conduct Examinations

For insurers, perhaps one of the Regulations' biggest impacts has been upon market conduct examinations. In market conduct exams, insurers are audited for compliance and accreditation by the Department of Insurance. Prior to January 14, 1993, market conduct exams were subjectively performed by the Department of Insurance. The investigator conducting the exam would make decisions based on his or her own notions of what activities constituted unfair or deceptive insurance practices.

Now, however, the Market Conduct Bureau is responsible for conducting on-site examinations of insurance companies to ensure that companies are treating their policyholders and claimants fairly and equitably, and in accordance with California's insurance laws and regulations. In order to help reduce the frequency and severity of unfair insurance practices, the Market Conduct Bureau has implemented a program to detect unfair claims practices.

1. Section 790 Unfair Claims Regulation Enforcement Examinations

These examinations relate directly to the Unfair Claims Regulations. Pursuant to the Regulations, the Department of Insurance has developed an enforcement strategy to ensure effective implementation of the Regulations. Various levels of discipline may be imposed upon an insurance company depending on the frequency and severity of the unfair claim practice discovered. One element of this enforcement strategy includes conducting focused market conduct exams of companies that have been previously identified as having failed to comply with the Regulations.

Under the current Regulations, conduct exams typically focus on a sampling of the insurer's files within the lines of insurance subject to the Regulations. The examinations

109. Id. at 13.
110. Id.
111. Id.
112. CAL. INS. CODE § 790.04 (West 1993).
113. Id.
114. Id.
115. Id.
116. Id.
UNFAIR CLAIMS REGULATIONS emphasize compliance with the various time deadlines under the Regulations. For example, the examiner counts the number of calendar days the insurer took to complete each step in the claims process. Failure to comply with the deadlines is a per se violation, which subjects the licensee to a $5000 fine, absent a remedial measure by the licensee.

Conduct exams also focus on the reporting of fraudulent claims to the Department of Insurance's Fraud Bureau. Notations in a claim file which indicate suspicious or intentionally fraudulent activity must be accompanied by materials indicating that the claim was reported to either the insurer's Special Investigation Unit or the Fraud Bureau, or that the adjuster further investigated and concluded that there was no fraudulent activity on the part of the insured or the injured third party.

Finally, when the Market Conduct Bureau investigates insurers, it looks for the date on which settlement was reached with the insured, and the date final payment was made. Partial settlements within an overall claim may give an insurer more time to investigate a claim.

Virtually all examinations result in some additional payments for insureds and/or claimants. In those instances where procedural deficiencies or errors are detected, total recoveries can be substantial.

E. Do the Current Regulations Achieve Their Goals?

1. Number of Complaints

There is no way to accurately measure any increase in the volume of consumer complaints that are directly attributable to the current Regulations. However, they do provide

118. Id.
119. Id.
120. Id.
121. Id.
122. For instance, an adjuster's handwritten notes or a letter from an attorney might indicate suspicious or intentionally fraudulent activity. Id.
123. Id.
124. Id.
125. Id.
126. Id.
127. Id.
a more specific measure by which to identify non-compliant claims handling activity.¹²⁹

More efficient claims tracking regulations enabled the Market Conduct Bureau to implement an alternative resolution program in 1994.¹³⁰ Now, Market Conduct Supervisors, rather than staff legal counsel, negotiate penalties with insurers and prepare the necessary documents to impose discipline for "[n]on-compliant activity, acts or violations of the Unfair Claims Settlement Practices Regulations [and n]on-compliant activity, acts or violations of the California Insurance Code."¹³¹

The number of actual complaint files opened each year since 1990 is as follows:

- 1990 - 16,100 claims
- 1991 - 19,305
- 1992 - 18,303
- 1993 - 17,618 [Regulations in effect 4/14/93]
- 1994 - 17,992
- 1995 (through June) - 8146¹³²

Assuming the volume of written premiums is constant, these figures tend to suggest that the number of post-regulations claims-related complaints has diminished only slightly.¹³³ The Regulations might have let insurance companies know what conduct is expected of them and thus might have kept complaints from increasing despite large-scale disasters like the Northridge earthquake and the Malibu fires.¹³⁴ The constant number might also be due to increased monitoring of nonadmitted carriers.¹³⁵

2. Amount of Recoveries

Figures from the Consumer Services Division show that total recoveries on behalf of consumers have increased:

- 1990 - $19,651,000
- 1991 - $23,304,000
- 1992 - $38,452,000
- 1993 - $43,928,000

¹²⁹ Id.
¹³⁰ Id.
¹³¹ Id.
¹³² Id.
¹³³ Id.
¹³⁴ Id.
¹³⁵ Id.
If this trend continues, consumers will experience record increases in recoveries in 1995.

Although the current Regulations may be positively impacting the insurance industry, ambiguity over certain terms and "tests" has generated enough concern for the Department of Insurance to have promulgated new regulations.

IV. THE PROPOSED REGULATIONS

In response to the concerns expressed by insurance companies and businesses, and in an attempt to better achieve the goals of good faith, prompt, efficient, and equitable claims settlement, the California Department of Insurance has promulgated proposed regulations. The Insurance Commissioner determined that it is necessary to modify the current Regulations in the following ways:

1. Eliminate portions of the regulations that are burdensome and costly once implemented.
2. Create exemptions for certain classes of insurance that are not amenable to the regulations.
3. Clarify subsections that are susceptible to more than one interpretation.
4. Reorganize the regulations so that they are more readily understandable and easier to use.
5. Eliminate those portions of the regulations that are unnecessary in that other laws provide an adequate remedy.

Although they make many changes in terms of semantics and structure, the proposed regulations attempt to retain the basic framework and goals of the current Regulations. This section presents the primary changes to the Regulations, and it continues earlier discussions of the rationales behind the changes.

A. Section 2695.2(c): "Claimant"

"Claimant" now means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a

136. Id.
surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.\textsuperscript{138}

The proposed definition of claimant eliminates the requirement that an attorney submit a designation form indicating that he or she is authorized to represent his or her client with respect to a claim.\textsuperscript{139} Other persons who need not comply with the designation requirement are those who have some independent legal authority to represent the claimant, including beneficiaries, guardians, and conservators.\textsuperscript{140} These persons are now categorized as “any person authorized by the operation of law.”\textsuperscript{141}

Family members, insurance adjusters, and public adjusters still must comply with the designation requirement.\textsuperscript{142} The actual designation requirement is found in section 2695.5(c).\textsuperscript{143} It remains essentially unchanged, except that a designation is now valid from the date of execution until the claim is settled or the designation is revoked.\textsuperscript{144}

B. \textit{Section 2695.5: Duties Upon Receipt of Communications}

Section 2695.5 was previously titled “Failure to Acknowledge Communications.”\textsuperscript{145} This entire section has been re-
vised and more logically organized. It now deals only with the licensee's duties regarding acknowledgment of communications.\textsuperscript{146} The section's new title reflects the content and reorganization.\textsuperscript{147}

Subsection (a) (formerly subsection 2695.5(f)) establishes the licensee's obligation to respond upon receiving a communication from the Department of Insurance.\textsuperscript{148} It provides:

Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one . . . calendar days [after] receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section [is] not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.\textsuperscript{149}

These amendments address problems that the Department of Insurance has encountered in attempting to obtain "timely and complete answers to its inquiries regarding claims handling."\textsuperscript{150}

Subsection (b) (formerly subsection 2695.5(g)) sets forth the licensee's obligations to respond upon receipt of an inquiry from a claimant.\textsuperscript{151} It has been amended to clarify that licensees are "not required to communicate with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant."\textsuperscript{152} Subsection (b) states:

Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen . . . calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication

\begin{itemize}
\item \textsuperscript{146} \textit{Cal. Dep't of Ins., supra} note 137, at 8-10.
\item \textsuperscript{147} \textit{Id.}
\item \textsuperscript{148} \textit{Cal. Code Regs. tit. 10, § 2695.5(a)} (proposed Nov. 16, 1995).
\item \textsuperscript{149} \textit{Id.} (proposed Nov. 16, 1995).
\item \textsuperscript{150} \textit{Cal. Dep't of Ins., supra} note 137, at 9.
\item \textsuperscript{151} \textit{Cal. Code Regs. tit. 10, § 2695.5(b)} (proposed Nov. 16, 1995).
\item \textsuperscript{152} \textit{Cal. Dep't of Ins., supra} note 137, at 9.
\end{itemize}
with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.\footnote{153}{Id.}

Finally, subsection (c) provides the actual requirements for an effective designation by a claimant.\footnote{154}{See supra note 143 and accompanying text.} Written designation by a claimant is now valid until the claim is settled, or until the designation is revoked.\footnote{155}{CAL. DEP'T OF INS., supra note 137, at 9.} Requiring that the written designation be submitted to the insurer on an annual basis proved to be too burdensome.\footnote{156}{Id. at 8-10.}

Almost all other subsections formerly in section 2695.5 dealing with notice of claim issues have been moved to section 2695.7.\footnote{157}{Id.} Former subsection 2695.5(h), which provided more time for furnishing claim forms to commercial insurance policy insurers, has been deleted as irrelevant, since the proposed regulations no longer use commercial-personal classifications to distinguish between lines of insurance.\footnote{158}{See CAL. CODE REGS. tit. 10, § 2695.6 (proposed Nov. 16, 1995).}

C. Section 2695.6: Training and Certification

Section 2695.6 was previously titled “Standards for Prompt Investigation of Claims.”\footnote{159}{See CAL. CODE REGS. tit. 10, § 2695.6 (1995).} This section has been further logically organized and shortened for clarity.\footnote{160}{CAL. DEP'T OF INS., supra note 137, at 10.} It now deals only with training and certification issues.\footnote{161}{Id.} This section’s new organization enables licensees to look to one provision in order to understand all relevant training and certification issues.\footnote{162}{Id. at 8-10.}

Proposed section 2695.6 reads as follows:

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety . . . days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding these regulations to all claims agents. Licensees shall certify that their claims agents have been
trained regarding these regulations and any revisions thereto.\textsuperscript{163}

Previously, subsection (b) was susceptible to more than one interpretation.\textsuperscript{164} Some licensees interpreted this subsection as requiring that they provide training regarding the Regulations only to their employees who were involved in claims handling.\textsuperscript{165} Other licensees believed that they were required to train both their employees and independent contractors with whom they contracted to perform claims handling functions.\textsuperscript{166}

Licensees must demonstrate compliance with the training and certification requirements in the following manner:

(1) [W]here the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands these regulations . . . ;

(2) where the licensee is an entity, the annual written certifications shall be executed, under penalty of perjury, by a principal of the entity as follows:

\begin{itemize}
  \item[(A)] that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,
  \item[(B)] that clear written instructions regarding the procedures to be followed to effect proper compliance with the subchapter were provided to all its claims agents;
\end{itemize}

(3) where the licensee retains independent adjusters, the licensee must provide training to the independent adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the independent adjuster may annually certify in writing, under penalty of perjury, on an annual basis, that he or she has read and understands these regulations . . . or has successfully completed a training seminar which explains these regulations;

(4) a copy of the [required] certification . . . shall be maintained at all times at the principal place of business of the

\textsuperscript{163} Cal. Code Regs. tit. 10, § 2695.6(a), (b) (proposed Nov. 16, 1995).

\textsuperscript{164} Cal. Dep't of Ins., supra note 137, at 10.

\textsuperscript{165} Id.

\textsuperscript{166} Id.
licensee, to be provided to the Commissioner only upon request. . . . 167

Proposed section 2695.6 now provides a uniform deadline for certification: it must occur annually on or before September 1. 168 The licensee's duty to train and certify remains unchanged. 169

D. Section 2695.7: Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

Section 2695.7 has been substantially reorganized. All subsections found in the former 2695.5 and 2695.6 dealing with the insurer's obligations upon receipt of notice or proof of claim are now found in this section. 170

1. Transmitting Notice of Claim

The new subsection (b) provides that upon receipt of notice of claim,

every insurance agent or claims agent shall immediately transmit notice of claim to the insurer. Failure of the insurance agent or claims agent to immediately transmit notice of claim to the insurer shall constitute a separate and distinct violation of California Insurance Code Section 790.03(h)(3) and this subsection, where the insurer has provided the appointed insurance agent or claims agent with written instructions as to the proper handling of a notice of claim. Transmission of the notice of claim by the insurance agent or claims agent of the insurer in conformity with the written instructions received from the insurer shall satisfy the insurance agent's or claims agent's duty under this section to promptly transmit the notice of claim to the insurer. 171

---

167. Cal. Code Regs. tit. 10, § 2695.6(b) (proposed Nov. 16, 1995) (emphasis added). The Department has received "numerous inquiries from licensees who are unsure as to whether they are required to file their annual written certifications with the Department." Cal. Dep't of Ins., supra note 137, at 10. The amendment clarifies that certification shall be provided to the Insurance Commissioner only upon request. Id.


169. Id. § 2695.6(a)-(b) (proposed Nov. 16, 1995).

170. Id. (proposed Nov. 16, 1995).

171. Id. § 2695.7(b) (proposed Nov. 16, 1995).
2. **Time Deadlines**

   a. **Initial Response**

   This section contains the same time deadlines for acting upon receipt of notice and proof of claim.\(^{172}\) It incorporates the deadlines for acting from former sections 2695.5 and 2695.6.\(^{173}\) Subsection (c) thus provides:

   Upon receiving notice of claim, every insurer . . . shall immediately, but in no event more than fifteen . . . calendar days later, do the following unless the notice of claim received is a notice of legal action:

   1. acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgment is not in writing, a notation of acknowledgment shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program[;]

   2. provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

   3. begin any necessary investigation of the claim.\(^{174}\)

   b. **Liability**

   Subsection (g) states that upon receiving proof of claim, every insurer\(^{175}\) must "immediately, but in no event more than forty . . . calendar days later, accept or deny the claim, in whole or in part."\(^{176}\) If an insurer denies or rejects a first party claim or a bond claim in whole or in part, it must do so in writing, and it must provide to the claimant a statement of

---

172. Id. § 2695.7(b), (c), (d), (g) (proposed Nov. 16, 1995).
173. Id. (proposed Nov. 16, 1995).
174. Id. § 2695.7(c)(1)-(3) (proposed Nov. 16, 1995). This section does not apply to "claims arising from policies of disability insurance [under] Section 10123.13 or life insurance subject to Section 10172.5 of the Insurance Code." Id. § 2695.7(c)(4) (proposed Nov. 16, 1995).
175. An exception is specified in § 2695.7(g)(4). It states that the 40 day time frame in (g) does not apply to claims arising from policies of disability, life, or mortgage guaranty insurance, and it does not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance. Id. § 2695.7(g)(4) (proposed Nov. 16, 1995).
176. Id. § 2695.7(g) (proposed Nov. 16, 1995).
the factual basis for the denial or rejection which is then within the insurer's knowledge.\textsuperscript{177} Furthermore, if the denial or rejection of a first party claim or bond claim is based upon a specific policy provision or document (in the case of a bond claim), the written denial must "include reference to the provision and provide an explanation of the application of the provision to the claim."\textsuperscript{178}

c. Payment

The provision for payment has been revised for easier understanding. Appearing in subsection (m), it now states that upon "acceptance of the claim and, when necessary, upon receipt of a properly executed release, every insurer, . . . shall immediately, but in no event more than thirty . . . calendar days later, . . . tender payment of the amount of the claim which has been determined and is not disputed by the insurer."\textsuperscript{179}

Subsection (m) does not apply to claims arising under policies of disability, life, mortgage guaranty, or fire insurance.\textsuperscript{180} It is also inapplicable to automobile repair bills arising from policies of automobile collision and comprehensive insurance.\textsuperscript{181}

3. Duty to Investigate

A new subsection specifically sets forth an affirmative duty to investigate claims: "After commencing the investigation of a claim, every insurer shall continue to investigate until the claim is accepted or denied."\textsuperscript{182}

4. Claimant Protection

Another new subsection serves a claimant/consumer protection function. It provides that "[n]o insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter com-

\textsuperscript{177} Id. § 2695.7(g)(1) (proposed Nov. 16, 1995). Third party claims which are rejected or denied must also be in writing. Id. (proposed Nov. 16, 1995).
\textsuperscript{178} Id. (proposed Nov. 16, 1995).
\textsuperscript{179} Id. § 2695.7(m) (proposed Nov. 16, 1995).
\textsuperscript{180} Id. § 2695.7(m)(1) (proposed Nov. 16, 1995).
\textsuperscript{181} Id. (proposed Nov. 16, 1995).
\textsuperscript{182} Id. § 2695.7(f) (proposed Nov. 16, 1995).
plained of as a condition precedent to the settlement of any claim." 183

E. Section 2695.9: Additional Standards Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage

The title of this section has been changed to reflect that its standards are additional to those imposed by section 2695.7. 184 Additionally, it helps provide a more uniform, consistent, and concise set of titles so that regulated persons or entities can more easily locate applicable sections and understand and apply the regulations. 185

The most important change in this section is that it eliminates the line of vision replacement test. 186 An insurer's obligation is now limited to replacing "all items in the damaged area so as to conform to a reasonably uniform appearance." 187

The old requirement, that an insurer replace all items in the damaged area "and that area which encompasses a clear line of vision from the damaged area," often led to unjust enrichment for certain claimants, since a "clear line of vision" is a subjective and difficult standard to determine. 188 It was often difficult for insurers and claimants to interpret and apply the section in a meaningful manner. 189

Additionally, the proposed regulations eliminate the former section 2695.9(b) requirement of written explanation of the basis for limiting the amount of recovery on a claim with little or no economic value. 190 Since section 2695.7(g)(1) already requires that denials be in writing, the proposed regulations eliminate this duplication. 191
F. Section 2695.10: Additional Standards Applicable to Surety Insurance

Former subsections (a) through (g) have been deleted because they duplicated obligations imposed upon all insurers by other sections.\(^{192}\) The Commissioner is considering whether the Department should draft new regulations applicable to surety insurers in addition to other duties imposed in the Unfair Claims Regulations.\(^{193}\)

G. Former Section 2695.11: Additional Standards Applicable to Title Insurance

This entire section has been deleted because it was duplicative of other provisions in the Unfair Claims Regulations.\(^{194}\) The subsection (a) requirements are duplicative because an underwritten title company is now included within the definition of "insurance agent."\(^{195}\) Subsection (b) was deleted because it duplicated other general provisions of the Regulations that apply to all insurers.\(^{196}\)

H. Former Section 2695.13: Standards Applicable to Workers' Compensation Insurance

The proposed regulations have deleted this entire section.\(^{197}\) Workers' Compensation Appeals Board statutes and rules already establish remedies for late payment of claims.\(^{198}\) Thus, the section did not add to, was duplicative of, and may have even been in conflict with regulations promulgated by the Department of Workers' Compensation Appeals Board.\(^{199}\)

\(^{192}\) Cal. Dep't of Ins., supra note 137, at 17-19.
\(^{193}\) Id.
\(^{194}\) Id. at 18-19.
\(^{195}\) Id. The definitions section provides that "insurance agent" includes "an underwritten title company." Cal. Code Regs. tit. 10, § 2695.2(h)(4) (proposed Nov. 16, 1995).
\(^{196}\) Cal. Dep't of Ins., supra note 137, at 20.
\(^{197}\) Id.
\(^{198}\) Id.
\(^{199}\) Id. at 21.
I. Section 2695.12: Noncompliance and Penalties

The factors used under the regulations to determine noncompliance and penalties were virtually the same. The proposed regulations therefore combine these sections for convenience and simplicity.

Subsection (b) has been amended to provide that in determining noncompliance with appropriate penalties under the Unfair Claims Regulations, the Insurance Commissioner shall consider admissible evidence regarding:

1. the existence of extraordinary circumstances;
2. whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law . . . ;
3. the complexity of the claims involved;
4. gross exaggeration of the value of the property or severity of the injury or amount of damages incurred;
5. substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;
6. secreting of property which has been claimed as lost or destroyed;
7. the relative number of claims where the noncomplying act(s) are found to exist, as contrasted to the total number of claims handled by the licensee during the relevant time period;
8. whether the licensee has taken remedial measures with respect to the noncomplying act(s);
9. the existence or nonexistence of previous violations by the licensee;
10. the degree of harm occasioned by the noncompliance; and
11. whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter.
12. Frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter.

This section still states that the Insurance Commissioner shall not consider "reasonable mistakes or opinions as to valuation of property, losses or damages when determining the

201. Id. § 2695.12(b) (proposed Nov. 16, 1995).
licensee's noncompliance with this subchapter or penalties to be assessed."\(^{202}\)

V. CONCLUSION: THE IMPACT OF THE NEW REGULATIONS

Clarifying and improving the current Regulations, and enforcing the new regulations, is a high priority of the Department of Insurance.\(^{203}\) Having held public hearings during December 1995, it is hoped that the proposed regulations will go into effect in early 1996.

With the new regulations, the Department of Insurance eliminates ambiguities in terms and concepts, so that the regulations will be easier for insurers, insureds, and claimants to use. It streamlines provisions so that same or similar subject matters are covered in a single section. The Department of Insurance also eliminates subjective standards of enforcement, to achieve the goals of fair and equitable claims settlement.

There is a regulatory balance that the Commissioner and the Department seek among the many competing interests within the State when revising regulations. The Commissioner's regulatory mission is to insure the financial solvency of the insurance companies in the State of California, to promote the affordability and availability of insurance to our citizens, and to assure that policyholders and claimants are treated fairly by the insurance entities licensed by the Department, in order to provide a healthy environment in which insurance companies may compete. These goals are not mutually exclusive. There is a careful balance which must be struck, for ultimately the public pays the price for a Department that is either lackadaisical or overzealous in these responsibilities.

\(^{202}\) Id. § 2695.12(c) (proposed Nov. 16, 1995).

\(^{203}\) CAL. DEP'T OF INS., supra note 137 at 1.