Can The Fair Claims Settlement Practices Regulations Help Your Third-Party Personal Injury Claim?

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Many of us associate the Fair Claims Settlement Practices Regulations with first claims. That makes sense, since there is no private right of action for violating the Unfair Claims Practice Act. See *Moradi-Shalal v. Fireman's Fund Ins. Companies* (1988) 46 Cal.3d 287. However, that does not mean the regulations are irrelevant in third-party contexts. In fact, they can be a valuable tool in prosecuting third-party personal injury claims.

The Fair Claims Settlement Practices Regulations are found in the California Code of Regulations (Cal. Code Regs., tit. 10, §§ 2695.1 to 2695.14). The regulations establish minimum standards for handling insurance claims. See Cal. Code Regs., tit. 10, § 2695.1(a)(1) (regulations "delineate certain minimum standards for the settlement of claims"). The regulations apply to all types of insurance, subject to a few exceptions. See Cal. Code Regs., tit. 10, § 2695.1(b) ("regulations are applicable to the handling or settlement of all claims").

Insurers' duties are owed to "claimants," who are defined as either first-party or third-party claimants. See Cal. Code Regs., tit. 10, § 2695.2(c). First and third-party claimants are further defined in subsections (f) and (x) of section 2695.2.

The specific duties imposed on insurers apply equally in the third-party context. Some of those duties include:

- *15-day response rule:* "Any" communication from a "claimant" that reasonably suggests a response "must" be answered within 15 days. This duty ends when a lawsuit is filed. See Cal. Code Regs., tit. 10, § 2695.5(b).
- *15-day acknowledgement rule:* The insurer "must" acknowledge receipt and begin investigation within 15 days of notice of a claim. See Cal. Code Regs., tit. 10, § 2695.5(e).
- *40-day acceptance or denial rule:* After receiving proof of a claim, the insurer has 40 days to accept or deny the claim. If it can't do that, then it must send written notice explaining why. And every insurer that denies or rejects a third-party claim or disputes liability, "shall do so in writing." See Cal. Code Regs., tit. 10, § 2695.7(b)(1) and (c)(1).
- *Fair and objective rule:* Every insurer "shall" conduct a "thorough, fair and objective investigation" and not insist on seeking unreasonable or irrelevant information. See Cal. Code Regs., tit. 10, § 2695.7(d).

Continued on page 33

Insurance Law continued from page 11

- *No lowball offers:* No insurer "shall attempt to settle a claim by making a settlement offer that is unreasonably low." See Cal. Code Regs., tit. 10, § 2695.7(g). Factors used to determine whether an offer is "unreasonably low" include the extent to which the insurer considered evidence submitted, legal authority, advice of its claims adjuster, and advice of its counsel. *Id*.
- *30-day payment rule:* Once the insurer settles the claim, it must tender payment within 30 days. See Cal. Code Regs., tit. 10, § 2695.7(h).
- *Good faith requirement for IME (DME):* An insurer can only request a medical examination when it has a good faith belief that one is "reasonably necessary." See Cal. Code Regs., tit. 10, § 2695.7(n).

Although there is no third-party bad faith in California, these regulatory duties still provide meaningful strategic advantages in third-party personal injury claims.

First, use the regulations to enforce discipline and accountability in the claims process. Because you represent a "claimant," those required deadlines apply to any communication you send the insurer. Add the relevant deadline to your letterhead when you're writing to the insurer. Every time the insurer fails to follow that deadline, memorialize it in another letter to the insurer. Calendar that 40-day period when you send your settlement package. Although you can't "enforce" the insurer's failure against following the deadlines, you can put pressure on the insurer to timely move your claim forward. If the insurer denies your claim or disputes liability or damages (which insurer *doesn't* do that?), make sure the insurer's decision and explanation is in writing. See Cal. Code Regs., tit. 10, § 2695.7(b)(1) and (c)(1). And if you settle, consider adding to the release that the insurer must tender payment within 30 days under Cal. Code Regs., tit. 10, § 2695.7(h).

Second, confirm the insurer is conducting a "thorough, fair and objective investigation" and not insisting on seeking unreasonable or irrelevant information. See Cal. Code Regs., tit. 10, § 2695.7(d). Always ask them in writing to explain their investigation into liability, causation, and damages. Did they consider *these* medical records, *this* witness statement, *those* photographs? What did the insurer investigate? How was the investigation "thorough, fair, and objective" if the insurer denied liability after only talking to the insured, and didn't consider either the police report or your client's version of the facts? As for unreasonable or irrelevant information, how many times have insurers asked our clients to sign unlimited and overbroad medical authorizations? Push back against that abuse by citing the regulation and narrowing the scope of what is truly relevant. There's no enforcement mechanism, but at least the regulations provide authority for you to question the insurer's handling of the claim.

Third, build leverage through documentation. Not every claim of "bad faith" is actually *bad faith*. And insurers know this. But a clear and credible threat of bad faith can create leverage and settlement pressure. Documented trails of neglect (blown deadlines, biased investigations, lowballed offers) can undermine any subsequent "genuine dispute" defense raised by the insurer.

Fourth, scrutinize defense medical examination requests. Demand in writing that the insurer explain its "good faith belief" that your client's DME is "reasonably necessary." See Cal. Code Regs., tit. 10, § 2695.7(n). The defense has the right to a medical exam under CCP § 2032.220, if limited to a person's physical or mental condition in controversy. But how many DMEs are a far cry from being "reasonably necessary"? Consider adding this regulation to your response under CCP § 2032.230.

Fifth and final, if you get an assignment of rights from the insured, then the regulatory violations can become evidence of bad faith. Did you document or can otherwise demonstrate stonewalling or institutional apathy when the insurer handled your claims against the insured? Documented violations of the regulations can serve as objective evidence that the insurer's rejection of your settlement offer was unreasonable. With an assignment of rights from the insured, the violations you documented while your client was a third-party become the core evidence used to prove the insurer breached the covenant of good faith and fair dealing owed to the insured. **TBN**