FROM:	Director, Worldwide Markets	EXTN:	6863
DATE:	18 January 2005	REF:	Y3484
SUBJECT:	**California Fair Claims Settlement Practices Regulations - amendments**		
SUBJECT AREA(S):	California insurance claims		
ATTACHMENTS:	Annexe – Memorandum from LeBoeuf, Lamb, Greene & MacRae LLP		

ACTION POINTS:	**Underwriters and Lloyd's brokers dealing with insurance from California to take note and inform third parties as necessary.**
DEADLINE(S):	**Immediate**

1. Purpose of the bulletin

To inform the market of amendments to the California Fair Claims Settlement Practices Regulations.

This bulletin will be of interest to all those involved in the settlement of claims for policyholders in California.

2. Amendments to the Regulations

Compliance with the amended regulations was required from 5 January 2005. The amended regulations can be found at: http://www.insurance.ca.gov/LGL/Regulations/Fair-Claims-Amendments.pdf

LeBoeuf, Lamb, Green & MacRae, LLP ("LLGM") has provided a summary of the changes – see the annexe to this bulletin.

Every insurer is required to "…adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims…" (s. 2695.6(a)). To help the market comply with this requirement LLGM have prepared a manual, copies of which are available from LLGM's London and Los Angeles offices. Contact details are as follows

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725 South Figueroa Street
31st Floor
Los Angeles
CA 90017-5404

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LLGM intends to hold annual claims handling certification seminars in May. When arrangements are finalised, the Market will be notified of these sessions accordingly.

3. Further information

If you have any queries about this bulletin please contact either LLGM as above, or:

Lloyd's Worldwide Market Services
Gallery 1, Box 190b
Tel: 020 7327 6677
Email: market.services@lloyds.com

This bulletin has been sent to active underwriters and the compliance officers of managing agents and Lloyd's brokers.

Julian James
Director
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TO: The Market

FROM: LeBoeuf, Lamb, Greene & MacRae, L.L.P.

DATE: December 23, 2004

RE: Amendments to California's Fair Claims Settlement Practices Regulations

Amendments to California's Fair Claims Settlement Practices Regulations (the "Regulations") became effective October 4, 2004. The purpose of the amendments, as explained by California Insurance Commissioner John Garamendi in a March 14, 2003 press release, was to "make the [Regulations] applicable to all types of insurers and strengthen[] control of how claims are handled." The press release also states that the amendments "require that insurers be held responsible for the accuracy of the information they use to evaluate insurance claims[,] enhance restrictions on certain clauses in policies that result in unfair claims practices, prohibit unfair penalties against motorists who use non-preferred provider auto repair shops, and broaden language that defines what constitutes non-compliance by insurers." Following is a more detailed analysis of the amendments.

Within ninety days of the amendment to the Regulations (i.e., by January 2, 2005), the market is required to "adopt and communicate to all its claims agents, written standards for the prompt investigation and processing of claims …" In order to assist the market, LeBoeuf have prepared a manual that explains the comprehensive claims handling standards imposed by the Regulations, including but not limited to, record keeping requirements, procedures for claim settlement, and a discussion of additional procedures that are applicable with respect to handling automobile insurance, fire and extended coverage, surety, and life and disability insurance claims. A copy of this manual is available without cost by contacting Dean Hansell at LeBoeuf. A copy of the amendments is attached. The amendments left most of the Regulations intact, but did make noteworthy changes that we outline below.

Section 2695.1. Preamble

- The Regulations now apply to home repair contracts and companies writing home repair contracts. Section 2695.1(d).

- Any policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the Regulations. Section 2695.1(f). We recommend the market review policies issued to California residents (or that cover risks located in California) to ensure that the policies comply with the Regulations.

Section 2695.2. Definitions

- The definition of the term "Insurer" is expanded to include the California Earthquake Authority and companies writing home repair contracts. Section 2695.2(i).

- The definition of the term "Insurance policy" now includes home repair contracts, and certificates or contracts of insurance issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR plan.

- The definition of the term "Investigation" has been modified. The term is now defined as follows: "'Investigation' means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damages for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond."

Section 2695.5. Duties Upon Receipt of Communications

- The failure of a licensee or claims agent to immediately transmit a notice of claim to the insurer no longer constitutes a separate and distinct violation of California's Unfair Claims Settlement Practices Act. Section 2695.5(d). Nonetheless, a licensee or claims agent could still be subject to regulatory sanctions under California's Unfair Claims Settlement Practices Act for failing to immediately transmit a notice of claim to the insurer.

- Former Section 2695.5(c)(4) and references to that section have been eliminated. Pursuant to that change, disability and life insurance claims are not subject to the prompt claims handling and investigation requirements set forth in Section 2695.7, though they are subject to the requirements set forth in Section 2695.11.

Section 2695.7. Standards for Prompt, Fair and Equitable Settlements

- Age has been added as a basis upon which insurers may not discriminate in their settlement practices. Section 2695.7(a).

- The amounts of the claim that are accepted or denied by the insurer must be documented by the insurer unless the claim has been denied in its entirety. Section 2695.7(b).

- Section 2695.7(b)(3) was amended to clarify that insurers must notify a claimant in writing that the claimant can seek to have the decision reviewed by the Department of Insurance when they deny a claim in whole or in part.

- Section 2695.7(b)(4) was revised, so that the 40 day time frame for accepting or denying claims that is set forth in Section 2695.7(b) does not apply to disability insurance claims, but does not apply to life insurance claims.

- The following language was added to Section 2695.7(d): "Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation …" The fair investigation requirements previously existed under the Regulations, and the amendment is simply intended to emphasize the need for insurers to comply with this requirement.

- Section 2695.7(h) now requires the completion of total or partial payment of a claim, or of whatever action is necessary to perform the claim obligation, within thirty days of either total or partial acceptance of a claim (except where the policy provides for a waiting period after acceptance of a claim and before payment of benefits). Previously, Section 2695.7(h) did not specifically require partial payment to be made within thirty days of partial acceptance of a claim.

- Section 2695.7(h)(1) provides that the thirty day time frame for payment of claims does not apply to disability insurance claims, disability insurance income claims, mortgage guaranty insurance claims, or automobile repair bills. The thirty day time frame does now apply to life insurance claims and fire insurance claims.

- The Regulations add Section 2695.7(p), which requires every insurer to provide written notification to a first party claimant whether the insurer intends to pursue subrogation of the claim, and also requires written notice if the insurer discontinues pursuit of subrogation. No notice is required where the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the deductible, or there is no applicable deductible or no legal basis for subrogation.

- The Regulations add Section 2695.7(p) which requires every insurer that makes a subrogation demand to include in every demand the first party claimant's deductible. Every insurer is required to share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. Insurers may not deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. Section 2695.7(p) does not apply to disability and health insurance, and also does not apply when multiple policies have been issued to the insured covering the same loss and the language of those policies prescribes alternative subrogation rights.

Section 2695.8. Additional Standards Applicable to Automobile Insurance

- Section 2695.8(b) concerns adjusting and settling first party automobile total losses. The cash settlement amount must include all applicable taxes, one-time fees incident to transfer of evidence of ownership of a comparable automobile, license fees, and other annual fees to be computed based upon the remaining term of the loss vehicle current registration, regarding of whether a replacement automobile is purchased. Section 2695.8(b)(1).

- If the insured chooses to retain the loss vehicle, the case settlement amount must include the sales tax associated with the costs of a comparable vehicle discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount must also include all fees incident to transfer of the claimant's vehicle to salvage status. The salvage value may be deducted from the settlement amount and must be the amount which a salvage dealer would pay for the salvage. If requested by the claimant, the insurer must identify the salvage dealer who will purchase the salvage. The insurer must disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle's value. The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles. Section 2695.8(b)(1)(A).

- Section 2695.8(b)(2) sets forth more detailed standards for what is considered a "comparable automobile." In short, a comparable automobile is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of the same model type, of a similar body type, with options and mileage similar to the insured vehicle. Further guidelines on what is a "comparable automobile" are set forth in Section 2695(b)(2). The burden is on the insurer to justify all deductions it makes from the cost of a "comparable automobile."

- Section 2695.8(b)(3) obligates the insurer to take reasonable steps to verify that the cost of a comparable vehicle is accurate and representative of the market value

of a comparable vehicle in the local market area within the past ninety days. The insurer must provide all information used to determine the market value to the Department of Insurance upon being requested to do so.

- Section 2695.8(c) requires the insurer, in first party automobile total loss claims, to provide notice to the insured, within thirty-five days of the settlement payment or final settlement offer, that the insurer will reopen its claims file if the insured cannot purchase a comparable automobile for the gross settlement amount.

- Section 2695.8(f) requires the insurer to provide the insured with a copy of the written estimate used to settle partial losses. If the insured subsequently contends that the necessary repairs will exceed the amount of the estimate, the insurer must: (1) pay the difference between the estimate and the claimant's higher estimate; (2) provide the claimant with the name of a repair shop that will make the repairs for the amount of the insurer's written estimate; or (3) reasonably adjust any written estimates prepared by the repair shop of the claimant's choice and provide a copy of the adjusted estimate to the claimant.

- Per Section 2695.8(g)(4), insurers must disclose the use of non-original equipment manufacturer replacement parts in the repair of the insured's automobile.

Section 2695.85. Auto Body Repair Consumer Bill of Rights

- The amendments to the Regulations add an entirely new section entitled the "Auto Body Consumer Bill of Rights". It requires every insurer issuing commercial, private passenger, or motorcycle automobile liability or collision insurance to provide the named insured (including named insureds added at renewal) with an Auto Body Repair Consumer Bill of Rights either at the time of application for an automobile insurance policy, at the time a policy is issued, or following an accident or less that is reported to the insurer. The Auto Body Repair Consumer Bill of Rights must contain the exact same language as developed by the Department of Insurance. The text of the Auto Body Repair Consumer Bill of Rights follows:

AUTO BODY REPAIR CONSUMER BILL OF RIGHTS

A CONSUMER IS ENTITLED TO:

1. SELECT THE AUTO BODY REPAIR SHOP TO REPAIR AUTO BODY DAMAGE COVERED BY THE INSURANCE COMPANY. AN INSURANCE COMPANY SHALL NOT REQUIRE THE REPAIRS TO BE DONE AT A SPECIFIC AUTO BODY REPAIR SHOP.

2. AN ITEMIZED WRITTEN ESTIMATE FOR AUTO BODY REPAIRS AND, UPON COMPLETION OF REPAIRS, A DETAILED INVOICE. THE ESTIMATE

AND THE INVOICE MUST INCLUDE AN ITEMIZED LIST OF PARTS AND LABOR ALONG WITH THE TOTAL PRICE FOR THE WORK PERFORMED. THE ESTIMATE AND INVOICE MUST ALSO IDENTIFY ALL PARTS AS NEW, USED, AFTERMARKET, RECONDITIONED, OR REBUILT.

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES.

4. BE INFORMED ABOUT THE EXTENT OF COVERAGE, IF ANY, FOR A REPLACEMENT RENTAL VEHICLE WHILE A DAMAGED VEHICLE IS BEING REPAIRED.

5. BE INFORMED OF WHERE TO REPORT SUSPECTED FRAUD OR OTHER COMPLAINTS AND CONCERNS ABOUT AUTO BODY REPAIRS.

COMPLAINTS WITHIN THE JURISDICTION OF THE BUREAU OF AUTOMOTIVE REPAIR

Complaints concerning the repair of a vehicle by an auto body repair shop should be directed to:

Toll Free (800) 952-5210
California Department of Consumer Affairs
Bureau of Automotive Repair
10240 Systems Parkway
Sacramento, CA 95827

The Bureau of Automotive Repair can also accept complaints over its web site at:
www.autorepair.ca.gov

COMPLAINTS WITHIN THE JURISDICTION OF THE CALIFORNIA INSURANCE COMMISSIONER

Any concerns regarding how an auto insurance claim is being handled should be submitted to the California Department of Insurance at:

(800) 927-HELP or (213) 897-8921

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013

The California Department of Insurance can also accept complaints over its web site at:
www.insurance.ca.gov

Section 2695.9. Additional Standards Applicable to First Party Residential and Commercial Property Insurance

- Section 2695.9(b) states that no insurer shall require an insured to have its residential or commercial property repaired by a specific individual or entity.

- Section 2695.9(c) states that insurers may not suggest or recommend that an insured use a particular person or entity to perform repairs to a property unless: (1) the insured requests the recommendation; or (2) the insurer informs the claimant in writing that the insured may select a contractor who will restore the property to its condition before the loss at no additional cost to the insured.

- Section 2695.9(d) requires insurers to provide copies of all documents upon which an estimate is based, and to take steps that the estimate is reasonable and accurate for the local market. If the amount of an estimate is disputed by an insured, the insurer must either pay the difference between its estimate and the insured's, provide the claimant with the name of a person who will perform the repairs for the amount of the insurer's estimate, or reasonably adjust the insurer's written estimate.

- Per Section 2695.9(e), once the appraisal provision of an insurance policy is invoked, the appraisal process must comply with the terms of California's Standard Form Fire Insurance Policy. A copy of the Standard Form Fire Insurance Policy is set forth in Section 2071 of the Insurance Code. Under the Standard Form Fire Insurance Policy, in case the insured and the insurer are unable to agree as to the actual cash value or the amount of the loss, the parties are require to participate in informal appraisal proceedings. Losses must be paid by insurers within sixty days after proof of loss.

Section 2695.11. Additional Standards Applicable to Life and Disability Claims

- Section 2695.11(a) provides that no insurer may seek reimbursement of an overpayment on a life or disability claim absent clear evidence of all of the following: (1) the overpayment was erroneous under the terms of the policy; (2) the error which resulted in the payment is not a mistake of law; (3) the insurer notifies the insured within six months of the error unless the error was prompted by the representations of the claimant or third parties; and (4) the notice states the cause of the error and the amount of the overpayment.

- An insurer that contests a disability claim must affirm or deny the claim within thirty days of the claim notice. If the insurer requires additional time to affirm or deny the claim, it must notify the claimant in writing, providing the reasons for its

inability to make a determination. This notice must be given within thirty days of the notice that the claim is being contested and every thirty days thereafter. Section 2995.11(d).

- If a policy requires preauthorization of non-emergency medical services, such preauthorization or denial must be communicated or confirmed in writing no more than five days after the request, and must contain particular explanations. Section 2695.11(e).

- Insurers are prohibited from requiring preauthorization of emergency medical services. Section 2695.11(f).

- Insurers must reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer. Section 2695.11(g).

Section 2695.12. Penalties

- The penalty provisions of the Regulations continue to be directed at persons and entities licensed by the Department of Insurance, though it is possible the Commissioner could attempt to impose penalties against non-admitted insurers indirectly (by directing surplus lines brokers not to place business with the non-admitted insurer or otherwise ostracizing the non-admitted insurer from the California market).

- The Regulations add two new factors which the Commissioner should consider in determining noncompliance with the Regulations: (1) whether the licensee's management was aware of the wrongful acts and failed to take any remedial measures, and (2) the licensee's reasonable mistakes or opinions as to the valuation of property, losses, or damages. Section 2695.12(13),(14).

Please contact Dean Hansell at (213) 955-7331 or dhansell@llgm.com with any questions.