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REGULATORY DEFICIENCIES IN THIRD-PARTY LIABILITY INSURANCE: THEIR IMPACT ON COMPENSATION, JUDICIAL EFFICIENCY, AND FINANCIAL SECURITY

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Abstract

Third-party liability insurance serves both a private contractual function and a broader compensatory function. Particularly in automobile liability systems, insurance is a principal mechanism through which states seek to ensure that persons injured by legally responsible motorists have access to a financially reliable source of compensation. Yet the legal relationship among the liability insurer, insured tortfeasor, and injured third-party claimant remains fragmented across state insurance, contract, tort, and procedural law. This Article identifies four recurring regulatory deficiencies: (1) compensation may depend upon conduct an innocent third party cannot control; (2) substantive coverage defenses are not always sufficiently distinguished from technical post-loss policy-condition defenses; (3) information necessary to evaluate a coverage denial may be concentrated within the insurer-insured relationship; and (4) unresolved insurance issues may generate sequential or secondary litigation after underlying liability has already been determined. A comparative examination of California, New York, Florida, Texas, and Washington demonstrates that states already recognize different aspects of these problems but address them through materially different regulatory mechanisms. The Article proposes a coherent analytical framework centered on four principles: classification of defenses, material prejudice, meaningful disclosure, and earlier identification of insurance disputes. The proposal does not seek nationwide statutory uniformity or federalization of insurance law. Rather, it offers a transferable methodology capable of practical development in California and adaptation within other state liability-insurance systems. Greater regulatory coherence has the potential to improve compensation security, reduce avoidable procedural disputes, preserve legitimate insurer protections, and strengthen the financial-security function of third-party liability insurance.

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I. INTRODUCTION

Liability insurance serves a dual function. It protects an insured against personal financial exposure, but it also provides a mechanism through which legally established liabilities may be satisfied without depending solely upon the personal assets of the tortfeasor.

This function is particularly important in automobile liability insurance, where state financial-responsibility systems require or strongly compel motorists to maintain liability protection.^1 The resulting system is therefore not solely a private contractual arrangement. It also serves a public compensatory and financial-security function.

The economic importance of that function is substantial. The National Highway Traffic Safety Administration estimated that motor vehicle crashes occurring in 2019 imposed approximately $340 billion in economic costs in the United States, including medical expenses, lost productivity, property damage, legal and court costs, emergency services, congestion costs, and insurance-administration expenses.^2

The central regulatory question is therefore not simply whether liability insurance exists.

It is whether the rules governing the relationship among the insurer, insured tortfeasor, and injured third party operate coherently enough to allow liability insurance to fulfill its compensatory purpose while preserving legitimate insurer protections.

Four recurring problems deserve particular attention:

1. an injured third party may bear the consequences of conduct entirely outside the claimant's control;
2. technical post-loss policy violations may be treated similarly to genuine absence of coverage;
3. information necessary to evaluate an insurer's defense may be unavailable to the affected claimant; and
4. insurance disputes may remain unresolved until after underlying tort liability has already been litigated.

These deficiencies affect not merely individual claims. They implicate compensation security, litigation efficiency, insurance administration, and the distribution of accident-related financial loss.

II. COMPENSATION SHOULD NOT TURN AUTOMATICALLY ON CONDUCT THE CLAIMANT CANNOT CONTROL

A third-party claimant ordinarily does not choose the tortfeasor's insurer, negotiate the liability policy, draft its conditions, or control the insured's performance after a loss.

Yet the claimant's ability to recover may be affected by whether the insured:

- reports the accident;
- responds to insurer communications;
- provides a statement;
- forwards legal papers;
- participates in discovery;
- attends proceedings; or
- otherwise complies with a cooperation clause.

This creates a basic structural imbalance:

The insured controls compliance, but the innocent third party may ultimately bear the financial consequence of noncompliance.

Cooperation clauses serve legitimate purposes. Insurers must be able to investigate liability, preserve evidence, detect fraud, evaluate damages, consider settlement, and defend insureds effectively.

But the existence of a valid contractual obligation does not answer the separate question of what consequence should follow from its breach.

California law has long recognized this distinction.

In *Campbell v. Allstate Insurance Co.*, the California Supreme Court held that breach of a cooperation clause does not automatically relieve an insurer from liability; the insurer must demonstrate substantial prejudice.^3

The California Supreme Court reaffirmed that principle in *Billington v. Interinsurance Exchange of Southern California*, placing the burden upon the insurer to establish substantial prejudice caused by the insured's violation of the cooperation clause.^4

The principle is significant because it separates two questions that

should not be conflated:

Was the policy condition breached?

And

Did that breach materially impair the insurer?

A regulatory system that treats those questions as identical risks imposing complete forfeiture where no meaningful insurer harm occurred.

III. TRUE COVERAGE DEFENSES SHOULD BE DISTINGUISHED FROM TECHNICAL POLICY-CONDITION DEFENSES

A coherent third-party liability system should expressly distinguish between two categories of insurer defenses.

A. True Coverage Defenses

True coverage defenses concern whether the insurer assumed the relevant risk in the first place.

Examples include:

- no policy existed on the date of loss;
- the policy had been validly cancelled;
- the relevant person or vehicle was not insured;
- a substantive exclusion applies;
- fraud or collusion exists;
- the occurrence falls outside the coverage grant; or
- the claimed amount exceeds the applicable policy limit.

These defenses concern the scope of the insurance contract itself.

An injured third party should not acquire coverage that never existed merely because the claimant is innocent.

B. Technical or Procedural Policy-Condition Defenses

A different category involves post-loss compliance, including:

- delayed notice;
- failure to forward suit papers;
- failure to produce requested documentation;
- failure to provide a statement;
- failure to attend litigation proceedings; or
- noncooperation.

These conditions principally protect the insurer's ability to investigate and defend.

Their consequence therefore should bear a rational relationship to the actual harm resulting from the breach.

If noncooperation causes the loss of material evidence, prevents meaningful investigation, destroys an available defense, or materially compromises litigation, substantial prejudice may exist.

But where the insurer already possessed relevant evidence and retained a reasonable opportunity to investigate, a technical violation presents a materially different problem.

The distinction may be stated simply:

Coverage asks whether the insurer assumed the risk. A policy-condition defense asks whether post-loss conduct materially impaired the insurer's ability to manage that risk.

Those questions should not automatically produce the same consequence.

IV. COMPARATIVE STATE APPROACHES

The fragmented nature of third-party liability regulation becomes clear when several state systems are compared.

A. California: Judgment-Creditor Rights and Substantial Prejudice

California Insurance Code section 11580(b)(2) requires qualifying liability policies to permit a judgment creditor, after obtaining judgment against the insured, to bring an action against the insurer on the policy, subject to its terms and limitations.^5

California therefore expressly recognizes that liability insurance has consequences beyond the contractual relationship between insurer and insured.

At the same time, California preserves legitimate policy defenses.

The significance of *Campbell* and *Billington* is that a cooperation-clause violation is not automatically sufficient. The insurer must demonstrate substantial prejudice.^6

California thus provides an important doctrinal foundation for a structured prejudice-based framework.

The remaining problem is one of coherence: the principles governing cooperation, notice, investigation, third-party rights, and post-

judgment enforcement are spread across contract doctrine, statutes, case law, and administrative regulation rather than integrated into a single analytical methodology.

B. New York: Express Statutory Treatment of Noncooperation and Prejudice

New York Insurance Law section 3420 expressly addresses the rights of injured persons and judgment creditors under liability policies.^7

Of particular significance, where an insurer relies upon the insured's failure or refusal to cooperate in an action governed by the statute, the insurer bears the burden of proving the noncooperation.^8

New York also incorporates a statutory prejudice standard into specified notice disputes. The statute provides that prejudice exists where delayed notice materially impairs the insurer's ability to investigate or defend the claim.^9

New York therefore demonstrates that contractual obligations may be preserved without treating technical breach as automatic forfeiture.

The law asks not only whether noncompliance occurred but also whether the insurer's legitimate interests were materially affected.

C. Florida: Sequential Litigation Through Nonjoinder

Florida follows a materially different procedural structure.

Under Florida Statutes section 627.4136, a person who is not an insured generally must first obtain a settlement or verdict against the insured before maintaining an action against the liability insurer.^10

This rule serves legitimate purposes by separating questions of tort liability from insurance coverage.

But the structure can also produce sequential proceedings:

first, liability and damages;

then, insurance coverage or enforcement.

That sequence may be necessary where the second proceeding concerns a genuine substantive coverage dispute.

The efficiency concern is greater where the secondary proceeding concerns only a technical policy condition that caused no material impairment of the insurer.

Florida therefore illustrates how procedural design can influence the number and timing of proceedings required to obtain compensation.

D. Texas: Regulation Without Equivalent Third-Party Private Enforcement

Texas provides another model.

Texas Insurance Code section 541.060 regulates specified unfair settlement practices but expressly limits the ability of third parties asserting claims against insured tortfeasors to maintain certain statutory causes of action.^11

This distinction shows that **regulatory standards and private enforcement rights are not always coextensive**.

A state may impose obligations upon insurers while determining that third-party claimants should not directly enforce every regulatory duty.

That policy may reduce satellite litigation.

But where direct private enforcement is limited, the importance of other mechanisms increases, including:

- clear claims standards;
- meaningful explanations of coverage positions;
- regulatory oversight;
- predictable judicial doctrine; and
- efficient judgment-enforcement procedures.

E. Washington: Explicit Recognition of Third-Party Claimants

Washington expressly recognizes third-party claimants in its insurance claims regulations.^12

Washington's unfair claims settlement rules require insurers to attempt in good faith to achieve prompt, fair, and equitable settlements where liability has become reasonably clear.^13

The regulation specifically addresses prompt payment of property-damage claims to innocent third parties in clear-liability situations.^14

This approach is significant because it recognizes that the third-party claimant is a legitimate participant in the regulated claims process even though the claimant is not the contracting insured.

Washington therefore provides an example of administrative regulation designed not merely around the insurer-insured relationship, but around the functioning of the claims process as a whole.

V. WHAT THE STATE COMPARISON REVEALS

The comparative analysis does not establish that one state has developed a universally superior model.

It establishes something more important:

States regulate the same fundamental three-party relationship through materially different mechanisms.

California combines statutory judgment-creditor rights with judicial substantial-prejudice doctrine.

New York expressly allocates the burden of proving noncooperation and incorporates statutory prejudice rules.

Florida emphasizes procedural separation through nonjoinder.

Texas regulates insurance conduct while limiting specified third-party remedies.

Washington expressly recognizes third-party claimants within administrative claims regulation.

The central deficiency therefore is not absence of regulation.

It is fragmentation and insufficient coordination among rules governing the same compensation process.

VI. INFORMATION ASYMMETRY CAN PREVENT EARLY RESOLUTION

Coverage disputes frequently depend upon facts possessed primarily by the insurer.

The insurer may control:

- policy language;
- endorsements;
- correspondence with the insured;
- cooperation requests;
- claim notes;
- investigative records;
- reservation-of-rights communications; and
- the factual basis for a coverage decision.

The injured claimant may know only that the insurer has denied payment.

This is particularly problematic where the defense arises exclusively from conduct between the insurer and insured.

A statement that the insured "failed to cooperate" does not establish:

- what cooperation was requested;
- whether requests were reasonable;
- what information remained independently available;
- what investigation the insurer actually conducted;
- what evidence became unavailable; or
- how the insurer was prejudiced.

Without sufficient information, meaningful pre-litigation evaluation becomes difficult.

A more coherent framework should therefore require a technical-denial analysis to identify, subject to legitimate privilege and confidentiality protections:

1. the policy condition involved;
2. the conduct constituting breach;
3. the information or opportunity allegedly lost;
4. the causal relationship between the breach and that loss; and
5. the material prejudice resulting from the loss.

Washington's regulations provide one example of a system requiring insurers to give reasonable explanations of the policy and factual basis for claim denials.^15

This type of transparency does not eliminate insurer defenses.

It makes them capable of earlier evaluation.

VII. PROCEDURAL FRAGMENTATION CAN CREATE AVOIDABLE LITIGATION

A single accident may generate disputes involving:

1. liability;
2. comparative fault;
3. damages;
4. existence of insurance coverage;
5. exclusions;
6. notice;
7. cooperation;

8. material prejudice;
9. judgment enforcement; and
10. collection.

Some disputes are unavoidable.

The problem arises when issues capable of being identified and narrowed during the claims process remain unresolved until after the underlying tort dispute has already been adjudicated.

The resulting sequence is straightforward:

regulatory ambiguity → inconsistent claims positions → reduced settlement predictability → secondary litigation → additional transaction and judicial costs.

This Article does not claim that third-party liability disputes alone account for a particular percentage of court congestion.

The available evidence would not justify such a conclusion.

The narrower proposition is well supported: when an otherwise resolvable insurance issue survives into an additional proceeding, private parties and courts incur additional costs.

NHTSA expressly includes legal, court, and insurance-administration expenses among the economic costs associated with motor vehicle crashes.^16

Accordingly, improving the timing and clarity of insurance dispute resolution has potential value not merely to individual claimants but also to the administration of civil justice.

VIII. REGULATORY DEFICIENCIES CAN PRODUCE FINANCIAL LOSS-SHIFTING

When an insurer does not satisfy an otherwise covered liability, the underlying economic loss does not disappear.

Depending upon the circumstances, it may remain with or be shifted to:

- the injured person;
- the person's family;
- health insurers;
- collision insurers;
- employers;
- healthcare providers;

- public benefit systems; or
- other economic actors.

This loss-shifting dimension is important because automobile financial-responsibility systems exist precisely to reduce the risk that accident-related liabilities remain entirely with individual victims or financially incapable tortfeasors.

The continuing regulatory concern surrounding uninsured motorists reflects that broader financial-security objective.^17

The same principle is relevant where liability coverage formally exists but payment is defeated by a technical condition unrelated to the claimant and unconnected to meaningful insurer prejudice.

Again, the proposition is not that every denied claim is improper.

Where no coverage exists, a valid exclusion applies, fraud occurred, or the insurer actually suffered substantial prejudice, denial may be fully justified.

The regulatory concern is narrower:

> Should an otherwise covered liability be entirely forfeited because of a technical post-loss breach where the injured claimant did not cause the breach and the insurer cannot demonstrate material impairment?

IX. A COHERENT ANALYTICAL FRAMEWORK

The solution does not require nationwide uniform legislation.

Nor does it require federalization of insurance regulation.

A more realistic approach is a transferable analytical methodology adaptable to different state systems.

Four principles should guide that framework.

A. Classify the Defense

The first question should be whether the insurer asserts:

a true absence of coverage

or

a technical post-loss condition defense.

This distinction should precede analysis of breach.

B. Require Material Prejudice for Technical Breaches

For technical conditions, the decisionmaker should determine what the breach actually caused.

Relevant questions include:

- When did the insurer receive notice?
- What information did it already possess?
- What investigation did it conduct?
- What investigation remained reasonably available?
- What evidence became unavailable?
- What defense was impaired?
- What settlement opportunity was lost?
- Was the impairment caused by the insured's breach?

The inquiry therefore moves from:

formal noncompliance to demonstrable material consequence.

C. Require Meaningful Explanation

Where an insurer relies on a technical condition, the denial should clearly identify the causal chain:

policy condition → breach → lost information or opportunity → material prejudice.

A conclusory statement of "noncooperation" should not substitute for substantive analysis.

D. Identify Dispositive Insurance Issues Earlier

Potentially dispositive insurance issues should, where practicable, be identified before completion of underlying litigation.

This does not require an insurer to become a party to every tort action.

It requires only that the parties understand as early as reasonably possible:

- whether coverage is disputed;
- what precise defense is asserted;
- whether the defense is substantive or technical; and
- what factual issue prevents resolution.

Earlier identification improves the possibility of settlement and reduces the risk of avoidable post-judgment litigation.

X. A PRACTICAL THIRTEEN-QUESTION TEST

The framework may be reduced to thirteen questions:

1. Did basic coverage exist?
2. Does a substantive exclusion apply?
3. Is the asserted defense substantive or technical?
4. What exact policy obligation was allegedly breached?
5. Who controlled compliance with that obligation?
6. When did the insurer obtain notice?
7. What evidence did the insurer possess?
8. What investigation was reasonably available?
9. What information or opportunity was actually lost?
10. Did that loss materially prejudice the insurer?
11. Was the prejudice actually caused by the breach?
12. Did the third-party claimant participate in fraud, collusion, concealment, or obstruction?
13. Is complete forfeiture proportionate to the demonstrated prejudice?

The framework does not dictate an outcome.

It requires a logical connection among:

the obligation, the breach, the resulting harm, and the remedy.

XI. CALIFORNIA AS THE PRINCIPAL AREA OF APPLICATION

The proposed methodology need not be implemented simultaneously throughout the United States.

California provides a practical jurisdiction for its initial development and application.

California already recognizes:

- statutory judgment-creditor rights under Insurance Code section 11580;
- substantial-prejudice principles governing cooperation-clause defenses;
- an insurer burden to establish substantial prejudice; and

- extensive insurance claims-handling regulation.^18

The framework can therefore be developed through California legal research, practitioner collaboration, claims analysis, litigation, scholarship, and regulatory study.

The multi-state analysis serves a separate purpose.

It demonstrates that the underlying questions are not uniquely Californian.

Issues involving:

- insured noncooperation;
- late notice;
- prejudice;
- third-party rights;
- information access;
- coverage enforcement; and
- sequential litigation

also arise elsewhere.

The proposed methodology is therefore California-centered in practical development but transferable in analytical structure.

Its broader contribution does not depend upon enactment of identical legislation across all states.

XII. POTENTIAL SYSTEMIC EFFECTS

A more coherent framework could produce three principal benefits.

A. Compensation Security

Clearer classification and prejudice analysis could reduce circumstances in which otherwise available compensation is defeated solely because of conduct an innocent claimant could neither cause nor prevent.

B. Judicial Efficiency

Earlier identification of genuine insurance disputes could narrow litigation, improve settlement predictability, and reduce secondary proceedings attributable primarily to unresolved technical questions.

C. Financial Security

More predictable administration of covered liability claims could reduce unnecessary shifting of accident-related losses to injured

individuals, families, other insurers, healthcare providers, employers, and public programs.

These effects are interconnected:

regulatory clarity promotes predictability; predictability promotes settlement; settlement reduces avoidable litigation; efficient claim resolution strengthens the financial-responsibility function of liability insurance.

XIII. CONCLUSION

Third-party liability insurance is extensively regulated in the United States.

The principal problem is therefore not lack of regulation.

It is lack of sufficient coherence among the laws governing the insurer, insured tortfeasor, and injured third party.

The problem becomes especially visible when an innocent claimant's compensation depends upon a technical policy violation committed by an insured whom the claimant cannot control.

A balanced regulatory system must preserve insurer rights.

Insurers must remain able to:

- deny genuinely uncovered claims;
- enforce substantive exclusions;
- investigate liability;
- obtain material evidence;
- prevent fraud and collusion;
- enforce policy limits; and
- require reasonable cooperation from insureds.

But those interests do not require treating every technical policy violation as automatically equivalent to absence of coverage.

California's substantial-prejudice doctrine demonstrates that cooperation obligations can remain enforceable while requiring proof that a breach actually harmed the insurer.^19 New York similarly demonstrates that noncooperation and notice defenses can coexist with meaningful burdens of proof and prejudice standards.^20 Washington demonstrates that third-party claimants can be expressly recognized within claims regulation.^21 Florida and Texas illustrate different

procedural and enforcement choices, confirming the fragmented character of state approaches.^22

The appropriate objective is therefore neither unrestricted claimant recovery nor erosion of legitimate insurer protections.

It is **regulatory coherence and proportionality**.

A technical breach should be evaluated according to:

what obligation was breached;
who controlled compliance;
what information the insurer possessed;
what investigative opportunity was lost;
what material prejudice resulted;
and whether the legal consequence is proportionate to that prejudice.

A structured methodology built upon those questions can be developed principally through California law and practice while remaining capable of adaptation within other state systems.

Greater regulatory coherence can improve compensation security.

It can reduce avoidable procedural disputes.

And it can strengthen the financial-security function that third-party liability insurance is intended to perform.

REFERENCES

1. See Nat'l Ass'n of Ins. Comm'rs, *Auto Insurance* (discussing automobile liability and financial-responsibility requirements).

2. Nat'l Highway Traffic Safety Admin., *Traffic Crashes Cost America $340 Billion in 2019* (Jan. 10, 2023) (reporting approximately $340 billion in economic costs associated with crashes occurring in 2019).

3. *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 305–07, 384 P.2d 155, 156–58 (1963).

4. *Billington v. Interinsurance Exch. of S. Cal.*, 71 Cal. 2d 728, 737, 456 P.2d 982, 987 (1969).

5. Cal. Ins. Code § 11580(b)(2) (West 2026). The statute provides a post-judgment pathway by which a qualifying judgment creditor may proceed against the liability insurer, subject to policy terms and limitations.

6. See *Campbell*, 60 Cal. 2d at 305–07; *Billington*, 71 Cal. 2d at 737.

7. N.Y. Ins. Law § 3420(a)–(b) (McKinney 2026).

8. *Id.* § 3420(c)(1).

9. *Id.* § 3420(c)(2).

10. Fla. Stat. § 627.4136 (2025).

11. Tex. Ins. Code Ann. § 541.060 (West 2026).

12. Wash. Admin. Code § 284-30-320 (2026). See generally Wash. Admin. Code ch. 284-30, which contains Washington's unfair claims settlement regulations.

13. Wash. Admin. Code § 284-30-330(6) (2026).

14. *Id.*

15. See Wash. Admin. Code § 284-30-330(13) (requiring a reasonable explanation of the insurance-policy, factual, or legal basis for a denial or compromise offer).

16. Nat'l Highway Traffic Safety Admin., supra note 2.

17. See Nat'l Ass'n of Ins. Comm'rs, *Uninsured Motorists*.

18. See Cal. Ins. Code § 11580(b)(2); *Campbell*, 60 Cal. 2d at 305–07; *Billington*, 71 Cal. 2d at 737.

19. See *Campbell*, 60 Cal. 2d at 305–07; *Billington*, 71 Cal. 2d at 737.

20. See N.Y. Ins. Law § 3420(c)(1)–(2) (McKinney 2026).

21. See Wash. Admin. Code §§ 284-30-320, -330 (2026).

22. See Fla. Stat. § 627.4136 (2025); Tex. Ins. Code Ann. § 541.060 (West 2026).