Insurance is the only interstate business wholly regulated by the several states rather than the federal government. In California, this responsibility rests with the Department of Insurance (DOI), organized in 1868 and headed (as of 1988) by an elected Insurance Commissioner. Insurance Code sections 12900 through 12938 set forth the Commissioner’s powers and duties. Authorization for DOI is found in section 12906 of the 1,000-page Insurance Code; the Department’s regulations are codified in Chapter 5, Title 10 of the California Code of Regulations (CCR).

The Department’s designated purpose is to regulate the insurance industry in order to protect policyholders. Such regulation includes the licensing of agents and brokers, and the admission of companies to sell insurance products in the state. Nearly 1,400 employees work at DOI to oversee more than 1,300 insurance companies and license more than 410,000 agents, brokers, adjusters, and business entities. In the normal course of business, DOI annually processes more than 8,000 rate applications, issues approximately 190,000 licenses (new and renewals), and performs hundreds of financial reviews and examinations of insurers doing business in California. DOI annually receives more than 170,000 consumer assistance calls, investigates more than 37,000 consumer complaints and, as a result, recovers more than $84 million a year for consumers. DOI also annually receives and processes tens of thousands of referrals regarding suspected fraud against insurers and others, and conducts criminal investigations resulting in thousands of arrests every year.
In addition to its licensing function, DOI is the principal agency involved in the collection of annual taxes paid by the insurance industry. The Department also collects more than 175 different fees levied against insurance producers and companies.

The Department also performs the following functions:

(1) it regulates insurance companies for solvency by tri-annually auditing all domestic insurance companies and by selectively participating in the auditing of other companies licensed in California but organized in another state or foreign country;

(2) it grants or denies security permits and other types of formal authorizations to applying insurance and title companies;

(3) it reviews formally and approves or disapproves tens of thousands of insurance policies and related forms annually as required by statute, principally related to accident and health, workers’ compensation, and group life insurance;

(4) it establishes rates and rules for workers’ compensation insurance;

(5) it preapproves rates in certain lines of insurance under Proposition 103, and regulates compliance with the general rating law in others; and

(6) it becomes the receiver of an insurance company in financial or other significant difficulties.

The Insurance Code empowers the Commissioner to hold hearings to determine whether brokers or carriers are complying with state law, and to order an insurer to stop doing business within the state. However, the Commissioner may not force an insurer to pay a claim; that power is reserved to the courts.
DOI’s Consumer Services Division operates the Department’s toll-free complaint line. Through its bureaus, the Division responds to requests for general information; receives, investigates, and resolves individual consumer complaints against insurance companies, agents, and brokers that involve violations of statute, regulations, or contractual provisions; and tracks trends in code violations and cooperates with law enforcement to bring deterrent compliance actions. Cases which cannot be resolved by the Consumer Services Division are transferred to DOI’s Legal Division, which is authorized to file formal charges against a licensee and take disciplinary action as appropriate, including cease and desist orders, fines, and license revocation.

The Department’s Fraud Division was established in 1979 to protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud. The Fraud Division is currently composed of four separate fraud programs: automobile; workers’ compensation; property, life, and casualty; and disability and health care.

Californians will elect a new Insurance Commissioner on November 6, 2018. Commissioner Dave Jones will have served for two full terms and is thus ineligible to run again. On the ballot for the June 5, 2018 primary election are Steve Poizner, who served as Insurance Commissioner as a Republican from 2007–2011, but who is running as an Independent in 2018; Democratic Senator Ricardo Lara, who is a member of the Senate Committee on Insurance, Banking, and Financial Institutions; Asif Mahmood, a pulmonologist from Los Angeles; and Peace and Freedom Party candidate Nathalie Hrizi.
MAJOR PROJECTS
Commissioner and Legislature Respond to Deadly Wildfires and Mudslides

From October 2017 through January 2018, California suffered the most destructive and deadliest wildfires in state history. Throughout the disasters, Commissioner Dave Jones collected information from insurers on the devastating losses of property and life. On January 31, 2018, Jones reported that insurers had received nearly 45,000 insurance claims totaling almost $12 billion from fires that burned in fourteen counties across California in October and December 2017. The fires killed 45 people across the state, burned more than 1.2 million acres of land, and destroyed or damaged more than 32,000 homes, 4,300 businesses, and more than 8,200 vehicles, watercraft, farm vehicles, and other equipment. To make matters worse, January 2018’s heavy rains in Santa Barbara County caused fire-ravaged hillsides and vegetation to give way, resulting in mudslides that—according to an April 2, 2018 DOI press release—killed 21 people, destroyed or damaged more than 400 homes and businesses, and caused an additional $421 million in losses.

DOI and other state and federal agencies (including the Contractors’ State License Board) dispatched their consumer services team to every local assistance center to meet with consumers and help them begin the claims process and answer questions about DOI resources (see also report on CSLB). In mid-October, Commissioner Jones issued a notice to insurers asking them to expedite claims by cutting through red tape and helping policyholders who have little or no documentation that insurers normally require. In particular, he asked insurers to waive the requirement for policyholders to submit a detailed home inventory and pay up to 100% of contents coverage to spare survivors the task of trying to recreate lists of every item they lost in the fires.
Beginning in December 2017, DOI staff participated in numerous local insurance claims workshops to assist survivors in navigating the claims process.

DOI and legislators whose constituents were affected by these natural disasters have also teamed up to draft multiple bills designed to strengthen consumer protections for wildfire survivors making insurance claims (see LEGISLATION for a description of these bills).

**Trump Administration Actions Roil Health Insurance Markets**

On October 12, 2017, President Trump—having been defeated in two earlier attempts to repeal or significantly undermine the Affordable Care Act (ACA)—issued Executive Order 13813, which encourages the expansion and use of “short-term limited duration” individual health insurance policies. Originally designed to fill temporary gaps in health coverage, these so-called “skimpy” policies are typically purchased by healthy consumers who have few preexisting health conditions. According to experts, these policies will be cheaper because they will provide fewer benefits, and insurers do not have to cover preexisting conditions. Health care advocates across the country have voiced concern that these limited health plans will entice younger, healthier consumers to opt for short-term health plans, driving up the cost for those (usually older and sicker consumers) insured through the ACA health care exchanges or existing health care plans in the individual market.

On February 20, 2018, the U.S. Department of Health and Human Services proposed federal regulatory changes to permit the sale of “skimpy” health insurance policies. On the same day, Commissioner Jones issued a press release condemning the proposal, stating that “the Trump Administration admits that their plan will degrade the risk pool for ACA plans, raise premiums in
state exchanges, and increase costs to the federal government. I oppose the Trump Administration proposal to offer consumers health plans that cannot be relied upon to cover essential health services when people need them most and will result in higher premiums for people who maintain their ACA coverage.” Senator Ed Hernandez has already introduced legislation to ban the sale of these policies in California (see LEGISLATION).

The President’s executive order additionally allows for the use of association health plans (AHPs), which allow small businesses or self-employed individuals to band together by geography or industry and buy coverage as if they were a single large employer. Although lower in cost than ACA-compliant policies, they have been poorly managed and are not obligated to provide the ten “essential health benefits” that ACA-compliant policies must provide and that have been incorporated into California law and DOI regulations. On January 4, 2018, the U.S. Department of Labor announced proposed regulatory changes to expand the opportunity to offer employment-based health insurance to small businesses through AHPs. On March 6, 2018, Commissioner Jones submitted public comments on the proposal, stating that “the AHPs proposed by this rule will harm consumers by degrading the individual and small group health insurance markets through adverse selection, and will impinge upon states’ rights while opening the door to fraud, insolvency and abuse.”

On December 22, 2017, Congress passed the “Tax Cuts and Jobs Act,” Trump administration legislation that provides massive tax cuts to the wealthy, slashes the federal corporate income tax rate from 35% to 21%, and dramatically changes the health care landscape. Effective in 2019, this bill eliminates the ACA’s so-called “individual mandate” that all Americans have some form of health insurance or be required to pay a penalty. The nonpartisan Congressional
Budget Office has estimated that the repeal of the individual mandate will cause 13 million fewer Americans to be insured by 2027. Healthier and wealthier people may choose to forego coverage, and even poorer, medically needy people may not sign up for insurance because they do not know which options are available and there may not be the same sense of urgency to enroll without the mandate.

On March 16, 2018, Commissioner Jones issued a notice regarding the federal tax bill to all property and casualty insurers subject to Proposition 103. In the notice, the Commissioner stated that “the federal corporate income tax rate directly impacts the calculation of property and casualty insurance rates.” The Commissioner reminded these companies that, in California, Proposition 103’s prior approval process that applies to property and casualty insurance rates limits insurer profits and rates. Under Insurance Code section 1861.05, excessive property and casualty insurance rates shall not remain in effect. The Commissioner noted that he had already directed his staff to “commence a regulatory review of these insurers' rates given the major tax windfall under the new federal tax rules. I have also directed staff to consider and identify possible actions in other lines of business where insurers will benefit from the tax cut to see if we can enable their policyholders to also benefit from the lower corporate taxes paid by their insurers.”

CVS Seeks to Acquire Aetna

On December 3, 2017, CVS Health announced its intention to purchase Aetna, Inc. If approved by the U.S. Department of Justice, the $69 billion acquisition would merge one of the nation’s largest health insurers into CVS, which operates a nationwide chain of pharmacies and retail clinics. The deal, which could allow Aetna to provide care to its insureds through CVS clinics
but could also concentrate what used to be separate health care-related silos to reduce choice for consumers, illustrates the various initiatives of businesses in the field to adapt to the volatile terrain of the health care industry. On March 13, 2018, CVS and Aetna shareholders approved the merger.

DOI is scheduled to hold a public hearing to discuss the merger of the two companies on June 19, 2018 in San Francisco. Similarly, the Department of Managed Health Care (DMHC) is scheduled to hold an open forum on the proposal on May 2, 2018 in Sacramento.

**Standard Prescription Drug Formulary Template**

On March 9, 2018, DOI published notice of its intent to adopt new Article 1.4 (sections 2218.80–.83), Title 10 of the CCR, to implement SB 1052 (Torres) (Chapter 575, Statutes of 2014), which amended Insurance Code section 10123.199 and added new section 10123.192 to the Insurance Code. The latter provision requires DOI to collaborate with DMHC to develop—by January 1, 2017—a standard formulary template to be utilized by health plans and health insurers that provide prescription drug benefits and maintain one or more drug formularies.

Under new section 10123.192, such health insurers (and health plans subject to DMHC jurisdiction) must do all of the following: (1) post the formulary or formularies for each product offered by the insurer on the insurer’s Internet website in a manner that is accessible and searchable by potential insureds, insureds, and providers; (2) update the formularies on a monthly basis; and (3) no later than six months after the date that a standard formulary template is developed by DMHC and DOI, an insurer must use that template to display the formulary or formularies for each product offered by the insurer.

Proposed section 2218.80 would establish the scope of new Article 1.4, and section 2218.81 would define key terms utilized throughout the regulations. Proposed section 2218.82
would establish the structure and content of the template. The formulary must include (1) a title page, (2) a table of contents, (3) an informational section, (4) a categorical list of prescription drugs, and (5) an alphabetical index or prescription drugs. Proposed section 2218.82 describes the exact and detailed contents of each of these five components. Finally, proposed section 2218.83 would require a health insurer—no later than six months after new Article 1.4 is approved—to submit all prescription drug formularies to the Commissioner for review for compliance with Article 1.4.

DOI is scheduled to hold a public hearing on proposed Article 1.4 on April 23, 2018 in Sacramento. At this writing, DMHC has not yet published proposed regulations to implement SB 1052.

**Reinsurance Oversight Regulations**

On November 27, 2017, the Office of Administrative Law (OAL) approved DOI’s amendments to sections 2303–2303.22 (nonconsecutive), and its adoption of new sections 2303.23–.28, Title 10 of the CCR. These changes clarify DOI’s reinsurance oversight regulations to clarify the principal requirements of substance and procedure in accounting for reinsurance on insurer financial statements, the general requirements applicable to reinsurance agreements, and related sanctions and oversight. [23:1 CRLR 244] These regulatory changes became effective on January 1, 2018.

**Implementation of AB 72 (Bonta)**

On November 15, 2017, DOI held a pre-notice public discussion of draft regulations to implement AB 72 (Bonta) (Chapter 492, Statutes of 2016), which is intended to protect consumers from surprise medical bills when they go to in-network facilities, such as hospitals, labs, or imaging
centers, and receive non-emergency services from a noncontracted provider. The bill imposed identical requirements on DOI and on DMHC, which proposed regulations to implement the statute on February 2, 2018 (see report on DMHC).

Among other things, AB 72 added new section 10112.81 to the Insurance Code, which required the Commissioner—by September 1, 2017—to establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health insurer and a noncontracting individual health professional for services subject to Insurance Code section 10112.8. The Commissioner complied with that requirement.

AB 72 also imposed—effective July 1, 2017—a default reimbursement rate for noncontracting providers, which is the greater of 125% of the Medicare rate or the “average contracted rate” (ACR) for health care services subject to Insurance Code section 10112.8. Thereafter, section 10112.82 requires the Commissioner—by January 1, 2019—to develop a standardized methodology for calculating the ACR paid to noncontracting providers for services most frequently subject to section 10112.8. This methodology must take into account, at minimum (1) information from the independent dispute resolution process created in AB 72, at Insurance Code section 10112.81, (2) the specialty of the individual health professional, (3) the geographic region in which the services are rendered, and (4) the highest and lowest contracted rates for those services.

At this writing, DOI has not yet published proposed regulations to implement AB 72 (Bonta).

**DOI Enforcement Activity**

Following is a status update on recent DOI enforcement actions:
DOI Files Accusation Against Wells Fargo. On December 6, 2017, DOI filed a formal accusation against Wells Fargo Bank, N.A. and Wells Fargo Insurance, in which the Department seeks to revoke or suspend its licenses for alleged improper insurance sales practices related to the company’s online insurance referral program, which resulted in insurance products being purchased and paid for by consumers without their knowledge. Following an investigation ordered by the Commissioner in August 2017 [23:1 CRLR 242–243], DOI alleges that Wells Fargo caused a total of 1,469 unauthorized policies to be issued to California consumers due to improper sales practices between 2008 and 2016. Additionally, DOI alleges that Wells Fargo entered into an agreement with American Modern Insurance Group (AMIG), which resulted in the issuance of 1,258 unauthorized AMIG renters’ insurance policies to bank customers.

Wells Fargo released a statement saying that it disbanded the online referral program in late 2016 and had undertaken an internal review of the matter. The bank added that it has cooperated with DOI for about a year. “We are sorry for any harm this caused our customers and we are making things right for them as part of an ongoing remediation,” the bank statement said. The accusation matter remains pending.

DOI Orders Access Insurance Company to Cease and Desist. On March 6, 2018, DOI issued a cease and desist order against Access Insurance Company which requires the company to immediately stop transacting any insurance business in California. The order follows DOI’s filing of an accusation, two orders to show cause, and notice of noncompliance against the company in July 2017. DOI took the action because it found that Access’s policyholder surplus was negative $27.6 million as of December 31, 2017 and negative $29 million as of January 31, 2018, indicating that the company failed to maintain the capital required by law.
DOI and DMHC Investigating Aetna. On February 12, 2018, both DOI and DMHC announced that they are investigating Aetna’s coverage decisions after CNN reported that one of the company’s medical directors had testified in a deposition that he did not examine patients’ records before deciding whether to approve or deny care; instead, he relied on the opinion of nurses who had reviewed the records. Commissioner Jones directed his staff to look into Aetna’s practices in denying claims and requests for prior authorization for care, and its utilization review process. “If a health insurer is making decision to deny coverage without a physician every reviewing medical records that is a significant concern and could be a violation of the law,” according to Jones.

LEGISLATION

Fire/Property Insurance Legislation

SB 894 (Dodd and McGuire), as amended March 8, 2018, would amend Insurance Code section 675.1. That section currently provides (in part) that in a case involving total loss to the primary insured structure under a residential policy subject to section 675, an insurer is required to offer to renew the homeowners’ insurance policy at least once if the total loss was caused by a disaster and was not due to the negligence of the homeowner; SB 894 would require the insurer to offer to renew the policy for at least the next two annual renewal periods or 24 months, whichever is greater. The bill would also add section 10103.7 to the Code, which would provide that, in the event of a covered loss relating to a state of emergency as defined in Section 8558 of the Government Code, an insured under a residential property insurance policy shall be permitted to combine the policy limits for the primary dwelling, other structures, contents, and additional living expenses. If the insured chooses this option, the insured may use these combined limits for any of
the covered expenses reasonably necessary to rebuild or replace the damaged or destroyed dwelling, other structures, or contents, or for additional living expenses. [S. Ins]

**SB 897 (McGuire and Dodd)**, as amended February 28, 2018, would amend Insurance Code section 2060, which pertains to losses under a residential property insurance property for which the insured has made a claim for “additional living expenses” (ALE). The bill would amend section 2060 to provide that ALE coverage under a residential property insurance policy shall include reimbursement for all reasonable additional expenses incurred by the insured in order to maintain a comparable standard of living following a covered loss. These additional costs shall include, but not be limited to, housing, furniture rental, food, transportation, storage, and boarding of pets and livestock. Additionally, the insured may, at his/her option and in lieu of itemized expenses, choose to collect the monthly fair rental value of the dwelling for the duration of the time it is not inhabitable due to the covered loss, up to the limits of the policy.

The bill would also add section 2061 to the Insurance Code, which would require the following to apply in the case of a total loss that is the result of a state of emergency: (a) upon request of the insured, the insurer must provide an advance payment of no less than four months of ALE or fair rental value, with additional payments upon proper proof following the advance period; (b) insurers must adopt a standard four-month or fair rental payment amount; (c) insurers must make an initial advance payment of no less than 25% of the policy limit for a claim for contents related to a total loss of a primary residence without completion of an inventory, and make additional payments upon request with proper proof; (d) in the case of a claim for contents, insurers are prohibited from requiring the use of a company-specific inventory form if the insured can provide an inventory using a form that contains substantially the same information, and the
insurer must accept an inventory that includes grouping of categories, as specified; and (e) insurers are required to offer no less than 80% of the policy limits if an insured has made a claim for contents without requiring the insured to file an itemized claim, and the insurer must notify the insured that they retain the option to recover additional benefits if the insured subsequently completes a full inventory.

Finally, the bill would add section 2062 to the Code, which would require insurers, in the event of a state of emergency, to grant a 30-day grace period for payment of premiums for all homeowners’ policies covering properties within the affected area, and prohibits the cancellation of policies for non-payment of premium or assessing of late fees during that period. [S. Ins]

**AB 1875 (Wood)**, as introduced January 16, 2018, would add section 10103.6 to the Insurance Code to provide that a policy of residential property insurance shall not be issued or renewed in California on or after January 1, 2019, unless the applicant or insured is offered extended replacement cost coverage in an amount of no less than 50% of coverage above the policy limits for the primary dwelling, other structures, contents, and additional living expenses. The offer shall be accompanied by a disclosure of the premium cost for each additional coverage amount. [A. Ins]

**AB 1797 (Levine)**, as introduced January 9, 2018, would add section 10103.4 to the Insurance Code, to require an insurer to provide an estimate of replacement value for the insured property for every policy of residential property insurance that is newly issued or renewed in this state on and after January 1, 2019, and would impose liability on an insured that fails to do so in the amount of the actual cost to replace the insured property, minus the amount of the policy coverage. The term “replacement value” is defined in sections 2695.180 to 2695.183, Title 10 of
the CCR. The bill would also prohibit an insurer that provided an estimate of replacement value from being liable to the insured if the policy limit is not sufficient to replace the insured property. 

[A. Ins]

**AB 2229 (Wood)**, as amended April 12, 2018, would amend Insurance Code section 10102 to require a residential property insurer—effective January 1, 2020 and upon the renewal of a homeowner’s policy—to disclose any fire safety discounts it offers. [A. Ins]

**AB 1772 (Aguiar-Curry and Wood)**, as amended April 11, 2018, is a DOI-sponsored bill that would amend section 2015.5 of the Insurance Code to extend from 24 months to 36 months the period of time within which a policyholder is entitled to collect full replacement benefits under a replacement cost fire insurance policy. According to the author, “the goal of this bill is to ensure that homeowners, who face delays in permitting, finding contractors who have an adequate labor force, and other structural impediments after a wildfire disaster, have adequate time to rebuild their homes and still received full replacement cost benefits under their policy.” [A. Ins]

**AB 1800 (Levine)**, as amended April 12, 2018, would also amend Insurance Code section 2015.5 to clarify that a policyholder who chooses to relocate to a different location to rebuild or replace a total loss of the insured home is entitled to receive the benefits of extended replacement and building upgrade coverages. According to DOI, “some insurers have maintained that ‘extended replacement cost’ and ‘building code upgrade’ coverages do not transfer to a new location. The bill is intended to make it clear that, if the policyholder bought these coverages, they transfer if the policyholder decides to rebuild or replace at a new location.” [A. Ins]

**AB 1799 (Levine)**, as amended April 12, 2018, would amend Insurance Code section 2084 to require an insurer, upon a request by a policyholder after a covered loss, to provide a complete
copy of the fire insurance policy that was in effect at the time of the loss, including any endorsements and the declarations page, within 30 days. The bill also provides that, in the case of a declared state of emergency, a policyholder may request the complete policy documents to be provided via email, even if the policyholder has not opted-in to electronic transactions pursuant to statutory requirements. [A. Ins]

**AB 2594 (Friedman)**, as amended April 11, 2018, would amend Insurance Code sections 2071 and 6010 to extend the existing statute of limitations for a homeowner to sue their insurer from 12 to 24 months if the loss is related to a declared state of emergency. [A. Ins]

**SB 917 (Jackson)**, as introduced January 22, 2018, would add section 530.5 to the Insurance Code, concerning mudslides. The bill would provide that, notwithstanding Insurance Code section 532, and in the absence of an endorsement or additional policy provision specifically covering the peril of landslide, a policy that does not cover the peril of landslide shall not exclude coverage for any loss or damage attributable to a landslide if the landslide resulting in the loss or damage was proximately caused by another covered peril. This subdivision applies regardless of whether the loss or damage attributable to the landslide directly or indirectly resulted from, or was contributed to by, concurrently or in any sequence, any other proximate or remote cause, whether or not that cause was covered by the policy. [S. Ins]

**SB 824 (Lara)**, as introduced January 3, 2018, would amend Insurance Code section 675.1, which pertains to cases involving a total loss to the primary insured structure under a residential policy subject to section 675 and which specifies that an insurer may not cancel coverage while a primary insured structure is being rebuilt after a total loss, except for specified reasons (including non-payment of premium, fraud or negligent acts) to provide that it applies to, but is not limited
to, all insured properties located within a county for which a state of emergency has been declared by the President or the Governor, or for which a local emergency has been declared by the executive officer or governing body of a city, county, or city and county.

The bill would also add section 758.8 to the Code, to require an insurer that intends to materially reduce the number of policies covering properties within a particular geographic region to submit to the Commissioner, at least 30 days prior to implementing that action, or 60 days prior to implementing that action if the policies include homeowners’ insurance policies, a plan for the orderly reduction of the volume of policies that addresses specified issues. [S. Ins]

Health/Disability Legislation

SB 910 (Hernandez), as amended March 5, 2018, would add section 10123.61 to the Insurance Code to prohibit health insurers—as of January 1, 2019—from offering “short-term limited duration health insurance,” defined as health insurance coverage provided pursuant to a health insurance policy that has an expiration date that is less than 12 months after the original effective date of the coverage, including renewals. These so-called “skimpy” plans do not provide comprehensive coverage nor do they cover the “essential health benefits” required under the Affordable Care Act. This bill is a response to the Trump administration’s repeated attempts to repeal the ACA and its February 20, 2018 announcement of proposed federal regulations permitting the sale of “skimpy” health insurance that will be cheaper than ACA-compliant insurance (see MAJOR PROJECTS). [S. Appr]

SB 437 (Atkins), as amended April 6, 2017, would amend section 12923.5 of the Insurance Code, which requires DOI and DMHC to maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the
regulations of these departments. The bill would amend section 12923.5 to also require the joint working group to review and examine timely access to care and network adequacy as part of its review of the grievance and consumer complaint processes, and to review and examine the state implementation of federal health care reforms, including any changes in federal law, rules, regulations, or guidance issued under federal law. [A. Health]

**SB 1021 (Wiener),** as introduced February 7, 2018, would amend section 10123.193 of the Insurance Code to prohibit health insurers from maintaining a prescription drug formulary that has more than four tiers, and require a health insurer’s prescription drug benefit to prohibit an insured from being required to pay more than the retail price if the pharmacy’s retail price for a prescription drug is less than the applicable copayment or coinsurance amount. [S. Health]

**AB 2863 (Nazarian),** as amended April 11, 2018, would add section 10123.65 to the Insurance Code, to limit the amount a health insurer may require an insured to pay at the point of sale for a covered prescription to the lesser of the applicable cost-sharing amount or the retail price. The bill would prohibit a health insurer from requiring a pharmacy to charge or collect a copayment from an insured that exceeds the total submitted charges by the network pharmacy. The bill would require the amount paid for a prescription to be applied to the insured’s deductible and out-of-pocket maximum if the insured pays the retail price. [A. Health]

**AB 2895 (Arambula),** as amended April 11, 2018, the “Primary Care Spending Transparency Act,” would add section 10110.8 to the Insurance Code to require a health insurer that reports rate information to DOI to annually report the percentage of expenses the health plan allocated to primary care. Beginning January 1, DMHC and DOI must annually compile and post a report with that information on their websites. The bill would also require DMHC and DOI to
convene a Primary Care Payment Reform Collaborative to propose revisions to the types of primary care data collected from health plans and health insurers.

The bill would also add section 10181.35 to the Insurance Code, to require health insurers—beginning October 1, 2019—to report to DOI the following information no later than October 1 of each year: (1) for medical benefits, a separation of primary care and specialty services; (2) the percentage of expenses the health insurer allocated to primary care, compared to the health insurer’s overall expenditures; and (3) the methods the health insurer used to financially support the delivery of primary care services. DOI must compile this information into a public report that demonstrates health insurers’ spending on primary care services, and must post the report on its website. [A. Health]

**SB 1156 (Levyva),** as amended March 22, 2018, would add section 10176.11 to the Insurance Code, which would require health insurers that provide coverage for hospital, medical, or surgical expenses to accept premium and cost-sharing payments from specified third-party entities (including an Indian tribe or a local, state, or federal government program). The bill would also require an entity, other than those specified entities, that is making third-party premium and cost-sharing payments, to provide that assistance in a specified manner and to perform other related duties, including annually providing a statement to the health insurer and to DOI from the recipient of the financial assistance confirming that the recipient has completed and submitted an application for Covered California or Medi-Cal and is not eligible for financial help from either program, and requiring the entity to disclose to DOI the name of the insured for each policy on whose behalf a third-party premium or cost-sharing payment, or both, will be made.
According to the author, “health insurance rates in California are driven up every year when providers seek profit by exploiting loopholes created by the Affordable Care Act. Financially-interested providers who steer patients away from Medicare and Medi-Cal by directly or indirectly paying their commercial insurance premiums raise prices for Californians who purchase their own insurance, businesses purchasing insurance on behalf of their employees, and state/local governments purchasing insurance on behalf of their employees. Financially-interested providers steering patients onto commercial insurance plans can also expose patients to unnecessary coverage disruptions, higher out-of-pocket costs, and other harms. . . . SB 1156 will require financially-interested providers or provider-funded entities to disclose that relationship to regulators and comply with disclosure requirements, including showing that patients are not otherwise eligible for Medicare or Medi-Cal.” [S. Health]

**SB 538 (Monning)**, as amended May 26, 2017, would add section 10133.57 to the Insurance Code regarding contracts between a hospital and a health insurer. To mitigate anticompetitive contract provisions commonly used in these contracts, new section 10133.57 would provide that a contract between a hospital and a health insurer may not, directly or indirectly, do any of the following: set payment rates or other terms for nonparticipating affiliates of the hospital; require the health insurer to contract with any of the hospital’s affiliates; require payors to confirm in writing that the payor is bound by the terms of the contract between the hospital and the health insurer; require the health insurer, as a condition of entering into or continuing the contract with the hospital, to submit to arbitration or any other alternative dispute resolution program any claims or causes of action that arise under state or federal antitrust laws; require the health insurer to impose the same cost-sharing obligations on beneficiaries when the hospital is in-
network but at a different cost-sharing tier than any other in-network hospital; or require the health insurer to keep the contract’s payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments. Any contract provision that includes any of these conditions is void.

According to the author, “[h]igh hospital prices are driving up health care spending by employers, consumers and taxpayers. Increasing consolidation of hospitals into mega-chains has decreased competition and that market power is a major driver of price increase and health care spending. Empirical studies demonstrate that dominant providers in California are using their market power to engage in unfair contracting practices that result in higher-than-competitive prices. This bill seeks to prohibit anti-competitive contract provisions that dominant hospital systems impose to maintain market power and to inflate prices charged to consumers, workers and employers.” [A. Health]

AB 2499 (Arambula), as introduced February 14, 2018, would amend section 10112.25 of the Insurance Code to increase the minimum medical loss ratio percentages applicable to health insurers from 85% to 90% for a health insurer in the large group market, and from 80% to 85% for a health insurer in the individual market. The bill would also delete language in section 10112.25 relating to DOI’s authority to adopt emergency regulations and its duty to consult with DMHC in adopting regulations. [A. Health]

SB 1008 (Skinner), as amended April 10, 2018, would amend section 10112.25 of the Insurance Code to establish medical loss ratios for dental health insurers of 75% for large group products and 70% for small and individual market products. The bill would also add new section 10603.04, which would require a health insurer that provides dental services to implement a
uniform benefit disclosure form that includes the annual deductible; the annual benefit limit; coverage for preventive and diagnostic services; dental policy reimbursement levels; estimated annual out-of-pocket expenses; the applicable medical loss ratio; and limitations, exceptions and waiting periods. SB 1008 would also amend section 10112.26, which requires health insurers that issue health insurance contracts covering dental services to file an annual report with DOI, to additionally require those insurers to report their medical loss ratios and to file those reports by July 1 instead of September 30; additionally, DOI must post the information on its website within 45 days of receiving it.

Finally, SB 1008 would add new section 10112.255, which would require a health insurer that covers dental services and provides out-of-network dental services as a covered benefit to provide a billing and treating provider, on behalf of the insured, all of the following: (a) the health insurer’s criteria for determining eligibility for payment for coverage of dental care; (b) the dental treatment and procedures covered; and (c) the actual percentages or amounts payable as a benefit toward dental care or treatment on behalf of the insured for dental treatment rendered by the billing provider. [S. Health]

**SB 1375 (Hernandez),** as amended March 22, 2018, would amend sections 10700, 10753, and 10755 of the Insurance Code to revise the definition of “eligible employee” for purposes of all small employer health insurance policies to exclude sole proprietors. [S. Health]

**AB 2384 (Arambula),** as introduced February 14, 2018, would add section 10123.204 to the Insurance Code regarding medication-assisted treatment (MAT). New section 10123.204 would require health insurers that provide prescription drug benefits and maintain one or more drug formularies to include, at a minimum, five specified MAT prescription drugs for substance
abuse disorders. The new sections require health insurers to presume that MAT is medically necessary and not subject to prior authorization; an annual or lifetime dollar limit; a requirement that an insured receives coverage at a facility that exceeds allowable time and distance standards for network adequacy, a specific number of visits, days of coverage, scope or duration of treatment, or other similar limitations; financial limitations different than those for other illnesses covered under the health insurance policy; and step therapy, fail first policies, or other similar drug utilization strategies. [A. Health]

**SB 1285 (Stone)**, as introduced February 16, 2018, would add section 10123.204 to the Insurance Code to require a health insurance policy issued or renewed after January 1, 2019 to cover services provided by an advanced practice pharmacist (as defined in Business and Professions Code section 4016.5) to include comprehensive medication management. The term “comprehensive medication management” means the process of care that ensures each beneficiary’s medications, whether they are prescription drugs and biologics, over-the-counter medication, or nutritional supplements, are individually assessed to determine that each medication is appropriate for the beneficiary, effective for the medical condition, and safe given the comorbidities and other medications being taken, and that all medications are able to be taken by the patient as intended. [S. Health]

**AB 2342 (Burke and Waldron)**, as introduced February 13, 2018, would add section 10123.815 to the Insurance Code to require health insurance policies issued or renewed after January 1, 2019 to cover screening, genetic counseling, and testing for breast cancer susceptibility (BRCA) gene mutations in women who have not been diagnosed or who do not show symptoms but may have increased risk of breast cancer based on familial history. [A. Health]
AB 2193 (Maienschein), as introduced February 12, 2018, would add section 10123.867 to the Insurance Code, to require health insurers, by July 1, 2019, to develop a case management program that is available for an insured when her treating provider determines that she may have a maternal mental health (MMH) condition. The case management program must offer all of the following: (a) provide the provider and insured direct support in accessing treatment and, if available, managing care in accordance with the provider’s treatment plan; (b) provide direct access to a clinician assigned to both the provider and the patient; (c) support the provider and insured in accessing care in a timely manner, pursuant to existing timely access standards, to provide direct access for the insured to a therapist trained in MMH and direct access for both the provider and insured to a provider-to-provider psychiatric consultation with a psychiatrist familiar with the latest research in MMH; and (d) require, when a treatment plan is available, clinical case managers in the program to extend the capacity of the insured’s provider by following the insured’s treatment access, symptoms, and symptom severity and by recommending potential changes to the treatment plan when clinically indicated. Commencing July 1, 2019 and annually thereafter, health insurers must notify providers in writing of the availability of the MMH case management program and the process by which a provider can access that program. [A. Health]

AB 1860 (Limón and Cervantes), as introduced January 10, 2018, would amend section 10123.206 of the Insurance Code to delete the January 1, 2019 sunset date and to extend permanently that section’s prohibition on an individual or group health insurance policy that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells from requiring an insured to pay, notwithstanding any deductible, a
total amount of copayments and coinsurance that exceeds $200 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication. [A. Appr]

**AB 2643 (Irwin),** as introduced February 15, 2018, would amend section 10119.9 of the Insurance Code to require health insurance policies covering hospital, surgical, or medical expenses to cover general anesthesia and associated facility charges for dental procedures when the clinical status or underlying medical condition of the insured requires dental procedures that ordinarily would not require general anesthesia. [A. Health]

**AB 2941 (Berman),** as introduced February 16, 2018, would add section 10112.95 to the Insurance Code to require health insurers to provide insureds who have been displaced due to a state of emergency access to medically necessary health care services, including possible relaxed time limits for prior authorization, precertification, or referrals; extended filing deadlines for claims; suspension of prescription refill limitations; prescription refills from an out-of-network pharmacy; replacement of medical equipment or supplies; access to an out-of-network provider should their in-network provider become unavailable due to the state of emergency; and a toll-free number an insured may access for inquiries related to health care. [A. Appr]

**SB 1023 (Hernandez),** as amended March 12, 2018, would amend section 10123.85 of the Insurance Code to clarify that health insurers are permitted to cover sexual and reproductive health services that are provided appropriately through telehealth according to clinical guidelines; and to require services provided by a Family PACT provider through direct video and telephonic communications with a provider, or direct or asynchronous care provided through a smart phone application, that are appropriate to be delivered remotely based on current clinical guidelines, to
be covered services under the Family PACT Program (which is administered by the Department of Health Care Services). [S. Appr]

SB 399 (Portantino), as amended January 22, 2018, would amend section 10144.51 of the Insurance Code, which requires health insurers that offer hospital, surgical, and medical coverage to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. This bill would broaden the eligibility criteria to become a “qualified autism service professional” and a “qualified autism service paraprofessional” by allowing specified education, work experience, and training qualifications to meet the requirements of a qualified autism service professional or paraprofessional. [A. Health]

AB 3087 (Kalra), as amended April 9, 2018, would add Title 23 (commencing with section 100600) to the Government Code, which would create the nine-member California Health Care Cost, Quality, and Equity Commission, described as an independent state agency with the purpose of imposing a limit on California health care costs. Under section 100603, the purposes of the Commission are to (1) set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other health care providers; (2) determine methods for state government to reduce the cost of prescription drugs and medical devices paid for by private purchasers in the commercial market; (3) control in-state health care costs in a manner intended to improve health care quality, improve health outcomes, and reduce health disparities for all Californians; (4) reduce price discrimination by health care providers among health care purchasers and the variation in prices paid to providers by private purchasers in the commercial market; (5) ensure payments to health care providers will permit them to provide medically necessary, effective, and efficient health care services in a manner that improves health outcomes, reduces health disparities, ensures
there are an adequate number of providers to provide timely access to health care services for all Californians with commercial health coverage, and ensures a fair and reasonable return on investment to providers; and (6) measure and reduce total health care expenditures per capita in the state.

The bill would prohibit the Commission from being regulated by DMHC or DOI. However, section 100612 would require funding for the implementation of the Commission to come—in part—from the Managed Care Fund (managed by DMHC) and the Insurance Fund (managed by DOI). [A. Health]

**SB 562 (Lara and Atkins),** as amended May 26, 2017, would add Title 22.2 to the Government Code to enact “The Healthy California Act.” The Healthy California Act would require a comprehensive universal single-payer health care coverage system for all Californians. The bill is not to become effective until the Secretary of Health and Human Services establishes funding for the implementation of the bill.

SB 562 would require Healthy California to be governed by an unpaid executive board comprised of nine members appointed by the Governor and legislature. It would also require the executive board members to have demonstrated knowledge, evident expertise in health care, and would require four members from a nurse labor organization, the general public, a labor organization, and the medical provider community. The bill would permit all Californians residents to be eligible and entitled to enroll. “Resident” is defined as an individual whose primary dwelling is in the state without regard to that individual’s immigration status. Enrollees of Healthy California would not be required to pay any premium, co-payments, co-insurance, deductible and any other form of cost-sharing for all covered benefits.
SB 562 would require all medical care determined to be medically appropriate by the member’s health care provider. This would include all services provided by Medi-Cal, essential health benefits (from the Affordable Care Act), and all health plan- or insurance-mandated benefits. Benefits shall include: chiropractic, vision, dental, ancillary health or social services (previously covered by a regional center), skilled nursing facility care, and therapies shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective. [A. Desk]

Other Insurance-Related Legislation

SB 898 (Hertzberg), as amended March 21, 2018, would make a number of legislative findings about the criminal justice system and the current commercial bail system (bail bonds are sold by DOI licensees), calling it “a global anomaly, used only in the Philippines and the United States.” According to the findings, “commercial money bail requires people to pay nonrefundable deposits to private companies in order to secure release from jail, often leaving working Californians at risk of losing their jobs, their housing, and even their children. The commercial money bail system does not improve rates of appearance in court or enhance public safety. It has a coercive effect on people unable to make bail, who are more likely to plead guilty to crimes that they may not have committed in order to get out of jail.”

SB 898 would add section 1820.5 to the Insurance Code, to require each bail licensee to post the terms and conditions of its bail contracts online. Each bail licensee shall translate the terms and conditions of each bail contract issued into not fewer than three and not more than five of the most common non-English languages spoken in the county in which the contract is issued. The bill would also add section 1824 to the Code, to require DOI to conduct a study and, no later than
July 1, 2019, make recommendations regarding insurers who provide coverage to bail licensees. Specifically, the report shall provide an analysis of both of the following: (1) the relationship between risk to insurers and rates charged; and (2) a comparison of the risk and rates analyzed pursuant to paragraph (1) and the risk and rates of automobile insurers in California. [S. Ins]

**AB 2844 (Cooley)**, as amended March 22, 2018, would add section 769.1 to the Insurance Code to require that any commission payable to a broker-agent be at the rate and in accordance with the terms agreed to in writing between the insurer and the broker-agent. The bill would declare that a commission that is paid in accordance with Insurance Code sections 769 and 1861.16, relating to the termination of an insurance contract and minimum commission amounts, is conclusively presumed to be lawful. [A. Ins]

**AB 2634 (Chau)**, as introduced February 15, 2018, would add section 10113.70 to the Insurance Code to require life insurers to provide 120 days’ notice to policyholders whenever a flexible premium life insurance policy is subject to an increase in the cost of insurance charge or administrative expense charge. [A. Ins]

**AB 1373 (Daly)**, as amended March 22, 2017, would amend Insurance Code section 10905.915 to require an insurance agent soliciting the purchase of an annuity to provide the consumer with a buyer’s guide produced by the National Association of Insurance Commissioners. [A. Ins]

**AB 2142 (Bigelow)**, as amended March 19, 2018, would amend Insurance Code section 12752 relating to insurance provided by home protection companies. Home protection contracts are short-term, low-cost products typically provided in connection with the purchase of residential real estate, designed to give home purchasers peace of mind that appliances which fail due to
normal wear and tear during the contract period will be repaired or replaced. Existing law requires companies that sell home protection contracts to file an annual financial statement with the Commissioner and to maintain a specified amount in reserve for unearned premiums, and requires the Commissioner to perform a financial examination on these companies before licensure and at other times as appears necessary. This bill would exempt a home protection company from financial examination if it meets specified heightened financial standards. [A. Ins]

AB 2276 (Burke), as introduced February 13, 2018, would amend section 758 and add section 758.1 to the Insurance Code, relating to auto body repair. The bill would amend section 758 to repeal a subsection that governs insurers’ duty to file auto body repair labor rate surveys with DOI, and replaces it with section 758.1, a more detailed statutory methodology that complements existing DOI regulations for insurers to use in surveying auto body repair shops to determine the prevailing auto body repair labor rate in a particular geographic area. [A. Ins]

AB 2045 (Committee on Insurance), as amended March 20, 2018, is DOI’s omnibus bill that makes technical and noncontroversial changes to numerous provisions of the Insurance Code. Of note, the bill would amend Insurance Code section 1668 to permit the Commissioner to deny or revoke a license when a licensee enters a no-contest plea (instead of requiring a final conviction based on a no-contest plea). [A. Appr]

LITIGATION

On February 20, 2018, the U.S. Supreme Court declined to review the Third District Court of Appeal’s decision in *Mercury Casualty Company v. Jones*, 8 Cal. App. 5th 561 (2017), in which the appellate court rejected the insurance industry’s challenge to the Commissioner’s authority to preapprove homeowners’ insurance rates and to apply DOI regulations that exclude
certain expenses from the regulatory calculations resulting in those rates. The California Supreme Court had similarly declined to review the Third District’s decision on May 10, 2017. In its ruling, the Third District rejected all of the arguments asserted by Mercury and the insurance industry—which have been trying to repeal or undermine Proposition 103 for 30 years—as “little more than hocus pocus” and “smoke and mirrors.” [23:1 CRLR 257–261]

On March 23, 2018 in State Farm General Insurance Company v. Jones, No. 37-2016-00041469-CU-MC-CTL, San Diego Superior Court Judge Katherine Bacal ruled against Commissioner Jones in State Farm’s challenge to Jones’s 2016 order that the company reduce its homeowners’ insurance rates by 7%.

In this matter, State Farm sought a 6.9% increase in its homeowners’ rates in 2014 (a rate request later amended to 6.4%); after lengthy public hearings in 2016, the Commissioner not only denied State Farm’s request for an increase but ordered a 7% rate reduction retroactive to July 15, 2015. State Farm sued the Commissioner in San Diego County Superior Court on several bases, but its principal argument, according to Judge Bacal, is that “the Commissioner erred in attributing income from two affiliates—State Farm Mutual Automobile Insurance Company (‘SF Mutual’) and State Farm Fire and Casualty Company (‘SF Fire’). State Farm is a wholly owned subsidiary of SF Mutual, which is a holding company for the State Farm Group of affiliates.” State Farm General operates only in California, while SF Fire operates in 47 other states.

Insurance Code section 1861.05(b) directs the Commissioner, when considering a rate change request, to consider the investment income of the insurance company making the application. Relying on section 2644.20, Title 10 of the CCR (which governs how “projected yield” should be calculated and directs the Commissioner to use “the insurer’s most recently
consolidated statutory annual statement’’), and a National Association of Insurance Commissioners’ interpretation of the word “company” to mean “company and its affiliates,” the Commissioner considered the investment income of State Farm and its affiliates. In this respect, Judge Bacal ruled that he erred because “there was only one applicant/insurer/insurance company that sought a rate change: State Farm.”

Because she ruled that the Commissioner improperly calculated State Farm’s investment income, Judge Bacal found it unnecessary to consider State Farm’s alternative argument that the Commissioner is not permitted to retroactively order refunds once a rate has been approved. Judge Bacal remanded the matter to the Department. At this writing, Judge Bacal has not yet signed the final judgment and it is unclear whether DOI will appeal her ruling. Consumer Watchdog, which participated in the original administrative hearing and was awarded intervener compensation for its work, intervened in this litigation and has indicated its intent to appeal.