DEPARTMENT OF INSURANCE

Commissioner: Dave Jones ♦ Toll-Free Consumer Hotline: (800) 927–4357 ♦ Licensing Hotline: (800) 967–9331 ♦ Internet: www.insurance.ca.gov

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. Following a June 5, 2018 primary election, the candidates for Commissioner are Steve Poizner, a former Republican Insurance Commissioner who is running as an independent in 2018, and Senator Ricardo Lara, a member of the Senate Committee on Insurance, Banking, and Financial Institutions. Lara defeated Asif Mahmood and Nathalie Hrizi in the June primary election. *[23:2 CRLR 207]*

MAJOR PROJECTS

Commissioner and Legislature Respond to Deadly 2018 Wildfires

During the summer of 2018, California suffered another devastating wildfire season, with the Mendocino Complex fire (the largest wildfire in state history to date) and the Carr fire (the seventh largest wildfire in state history, which featured a rare "fire tornado" and was not finally

contained until September 19, 2018) together burning over 688,000 acres of land. On September 6, 2018, Commissioner Dave Jones reported that more than 10,000 claims had been filed, totaling $845 million in insured losses from those two fires alone. By that date, the Mendocino fires had killed one firefighter, and the Carr fire killed 8 people. Together, the two fires damaged or destroyed more than 8,800 homes, 329 businesses, and more than 800 private autos, commercials vehicles, and other types of property. During July 2018 alone, the California Department of Forestry and Fire Protection (CAL FIRE) estimated that 12,000 firefighters were battling 17 fires in addition to the Carr and Mendocino fires. However, Jones added that fire experts speculate "the worst fires for 2018 may still be ahead of us."

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. In an August 1 press release, Jones explained that DOI's "first action is a notice requesting insurers expedite claims handling procedures for wildfire damage claims," including flexibility with deadlines and documentation requirements to assist policyholders affected. The irony often lies in the fact that the very documents insurers demand are missing or have been destroyed in fires. In addition, Jones issued a declaration of an emergency, which allows insurers to respond more quickly by using qualified out-of-state adjusters who work under a California insurance company's license. Beyond procedural and formal methods of helping victims, Jones also visited burn areas, met with residents and DOI staff, and worked with legislators on multiple bills.

In September 2018, the Commissioner and UC Berkeley School of Law's Center for Law, Energy & Environment released a report which examines the challenges and opportunities associated with climate risk, climate change, and insurance. In the report, DOI urged the market

to adapt, explaining that "catastrophic events often drive public solutions," because the historical pattern has been a withdrawal from the market. Simply put, "climate change threatens the basic functioning of insurance markets," as evidenced by the private market withdrawal from mudslide, debris flow, and soil subsidence policies. The report is not only doom and gloom; it offers substantial insight into emerging strategies and best practices that insurance regulators should consider: (1) refining insurance pricing and contract design to more precisely reflect climate risks and incentivize mitigation efforts; (2) fortifying consumer protections and resilience efforts to ensure insurance availability, adequacy, and affordability; (3) continuing to champion and improve climate risk disclosure; (4) supporting innovation in loss modeling, data science, and stress testing; (5) identifying and mitigating barriers to green insurance and risk reduction; (6) participating in climate mitigation and adaption research and inter-agency initiatives; (7) enhancing market awareness of disparate risks and insurance responses; and (8) increasing engagement in broader public policy discussions. While "history continues to present significantly unanticipated outcomes in terms of the scale and nature of weather- and climate-related catastrophes, as well as slower-moving and spatially distributed change[,] … innovative insurance products and services can serve as new sources of revenue for the industry while aligning the insurance process with broader technological and economic pathways[.]" To overcome California's "trial by fire," consumers, insurers, governments, NGOs, and academia must all play proactive and essential roles.

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].

Proposition 103 Legal Opinion

On August 10, 2018, DOI General Counsel and Deputy Commissioner Kenneth B. Schnoll issued a legal opinion concluding that Insurance Code section 1861.07 requires underwriting rules provided to the Commissioner in connection with an application for approval of property and casualty rates must be available for public inspection regardless of whether such rules are marked as "confidential," "proprietary," or "trade secret."

Proposition 103 was passed by California voters in 1988 to—among many other things—lower insurance rates and encourage the public to participate in the ratesetting process. Article 10 of the Insurance Code, added by the initiative, both opens the ratesetting process to public scrutiny and—according to the opinion—"provides the Commissioner with broad authority over insurance rates and expressly provides that no subject rate shall be approved or remain in effect that is 'excessive, inadequate, unfairly discriminatory or otherwise in violation of' Chapter 9 of the Insurance Code." Insurance Code section 1861.05(b), added by the initiative, requires insurance companies seeking a rate increase or decrease to submit public rate applications to the Commissioner; additionally, section 1861.05(c) requires the Commissioner to provide notice to the public of any application by an insurer for a rate change, and allows a consumer to request a public hearing within 45 days of the notice. Finally, section 1861.07 provides that "all information provided to the commissioner pursuant to this article shall be available for public inspection."

For purposes of this legal opinion, General Counsel Schnoll defined the term "underwriting rule" to mean "any rule or factor used by an insurer in the process of examining, accepting, or rejecting insurance risks, and classifying those risks selected in order to charge the proper premium for each. 'Underwriting rules' shall also include, but not be limited to, the 'eligibility guidelines' insurers must maintain pursuant to 10 CCR section 2360.2"—defined as "specific, objective

factors, or categories of specific, objective factors, which are selected and/or defined by an insurer, and which have a substantial relationship to an insured's loss exposure." Schnoll concluded that

> if an insurer fails to submit its underwriting rules with each rate application or denominates its underwriting rules as confidential and not subject to public disclosure, such rate application would not include and make available for public inspection all information required by the Commissioner … under such circumstances, the public would be improperly denied the full statutorily guaranteed forty-five day public-notice period to analyze a complete rate application and determine whether to request a hearing with respect to the application….Accordingly, a rate application that does not include underwriting rules or denominates such underwriting rules as confidential or not subject to public inspection is incomplete under Insurance Code section 1861.05(b) and insufficient to trigger public notice of the rate application pursuant to Insurance Code section 1861.05(c).

"Consumers and insurers alike benefit from transparency," said Insurance Commissioner Dave Jones. "Consumers are able to better understand how insurance companies decide who to insure and who to renew."

Rulemaking

The following is a status update on several rulemaking proceedings recently initiated by the Department:

♦ ***Methodology for Determining Average Contracted Rate.*** On August 3, 2018, DOI published notice of its intent to adopt sections 2238.10, 2238.11, and 2238.12, Title 10 of the CCR. According to the initial statement of reasons, the proposed regulations implement AB 72 (Bonta) (Chapter 492, Statutes of 2016), which was enacted 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 noncontracting provider. *[23:2 CRLR 213]*

AB 72 created, 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), defined as the average of the contracted commercial rates paid by the health insurer for the same or similar services in the geographic region. Thereafter, AB 72 (specifically, Insurance Code section 10112.82(a)(3)(A)) directed DOI—by January 1, 2019, and in consultation with the Department of Managed Health Care (DMHC) and other stakeholders—to

> specify a methodology that insurers shall use to determine the average contracted rates for services most frequently subject to [Insurance Code] Section 10112.8. This methodology shall take into account, at a minimum, information from the independent dispute resolution process [established by AB 72], the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the insurer includes the highest and lowest contracted rates.

The proposed regulations would govern the methodology for calculating the ACR for purposes of determining the reimbursement of individual noncontracting health professionals who provide covered services to insureds at contracting health facilities.

Specifically, proposed section 2238.10 would define various terms in the regulation, including "average contracted rate." Section 2238.11 sets forth the methodology for calculating the ACR for health care services most frequently subject to Insurance Code section 10112.8; insurers are directed to divide the total payment for a service code by the total number of paid service units for that service code in each geographic regions across all commercial policies regulated by DOI during the baseline year, then adjusted to the date the service was rendered using the inflation adjustment method described in Insurance Code section 10112.82(a)(2)(B). Section 2238.12 fleshes out the reporting requirements and data that insurers must provide to DOI established in Insurance Code section 10112.82(a)(4).

DOI held a public hearing on these purposed regulations on September 17, 2018. At this writing, DOI staff is reviewing the comments received at the hearing and preparing modified text of the proposed regulations.

♦ ***Standard Prescription Drug Formulary Template***. On April 23, 2018, DOI held a public hearing on its proposal 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 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 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.

Section 2218.80 establishes the scope of new Article 1.4, and section 2218.81 defines key terms utilized throughout the regulations. Section 2218.82 establishes 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 of prescription drugs. Section 2218.82 describes the exact and detailed contents of each of these five components. Finally, section 2218.83 requires 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.

On May 25, 2018, DOI issued revised text of the regulation; it did not revise two of the proposed sections, and made minor revisions to the other provisions. On August 1, 2018, the Office

of Administrative Law approved new Article 1.4; the changes became effective on October 1, 2018.

DOI Enforcement Activity

Following is a status update on recent DOI enforcement actions:

♦ ***DOI Issues Cease and Desist Order Against NRA***. On September 11, 2018, DOI issued a formal cease and desist order to the National Rifle Association of America (NRA), alleging that the NRA marketed an insurance product in California without being licensed to do so. The NRA sponsors the "Carry Guard Personal Firearms Liability Including Self-Defense Insurance Policy," which covers legal damages from bodily injury or property damage arising out of use of a firearm, air gun, bow and arrow, or trapping equipment while engaged in the following activities: an "act of self-defense"; hunting, trapping, or shooting at competitions or for recreation; and accidental discharges. The policy provides four levels of coverage ranging from $250,000 to $1.5 million in civil defense benefits, and $50,000 to $250,000 in criminal defense benefits.

In its order, DOI alleges that on June 1, 2017, the NRA sent an email to subscribers of its mailing list featuring NRA spokesperson Dana Loesch explaining why the recipient should buy the policy. Another email on October 16, 2017 from NRA CEO Wayne LaPierre asked recipients to "sign up for NRA Carry Guard today!" Insurance Code section 1631 prohibits a person from soliciting or negotiating insurance policies in California without a valid license, which the NRA has never held.

♦ ***DOI Serves Order to Show Cause and Accusation against Accordia***. On June 12, 2018, DOI released a press release announcing its action against Accordia Life and Annuity Company and Athene Annuity and Life Company, in which the Department alleges that Accordia and Athene failed to service over 50,000 policies issued to California consumers and withheld benefits to

which they were entitled. In the order, DOI charged respondents with (1) restricting the policies, causing them to be frozen in time; (2) failing to provide timely annual reports to policyholders; and (3) failing to administer the policies in good faith. DOI alleges that respondents at best failed to carry out their life insurance contracts in good faith and engaged in fraudulent business practices, seeking suspension of respondents' certificate of authority for one year.

♦ ***DOI's Pending Accusation Against Wells Fargo***. At this writing, DOI and Wells Fargo Bank, N.A. and Wells Fargo Insurance are in settlement negotiations concerning DOI's December 2017 accusation in which the Department seeks to revoke or suspend their 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. *[23:2 CRLR 215; 23:1 CRLR 242–43]* Following an investigation ordered by the Commissioner in August 2017, 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.

♦ ***DOI Sues AbbVie for Alleged Insurance Fraud and Illegal Kickbacks***. On September 18, 2018, DOI filed suit against AbbVie Inc., in which DOI alleges illegal kickbacks to health care providers for prescribing HUMIRA, seeking injunctive and equitable relief to end the kickbacks, an assessment of treble the amount of each claim for compensation, civil penalties, and attorneys' fees and costs. Following reports from a whistleblower, DOI alleges in its *qui tam* action that AbbVie used both classic and sophisticated methods of providing kickbacks to physicians to induce and reward HUMIRA prescriptions—including but not limited to cash, meals, drinks, gifts, trips, patient referrals, free and valuable professional goods and services such as insurance

processing and prior authorizations, gifts of medical practice management hardware and software, and marketing assistance.

CVS Acquisition of Aetna

On June 19, 2018, the Department held a public hearing on the proposed acquisition by CVS Health, which operates a nationwide chain of pharmacies and retail clinics, of Aetna, Inc.—one of the nation's largest health insurers. *[23:2 CRLR 211]* After opening remarks by Commissioner Jones, DOI heard testimony from industry, academic, medical provider, and consumer witnesses. The Department videotaped the hearing and posted it on its website; it also posted written testimony of all witnesses who provided it on its website.

Following the public hearing and an in-depth review and analysis of the testimony, studies, and written comments, Commissioner Jones—on August 1, 2018—released a detailed 15-page letter finding that the proposed merger of CVS and Aetna would have significant anticompetitive impacts on American consumers and health care and health insurance markets; Jones recommended that DOJ sue to block the merger. In particular, Commissioner Jones found that the proposed merger poses competitive concerns in the Medicare Part D market, where both companies currently compete

Nevertheless, on October 10, 2018, the U.S. Department of Justice approved the acquisition conditioned upon the divestment of Aetna's Medicare Part D prescription drug plan business for individuals. DOJ's approval must be reviewed and approved by a federal judge.

Update on Federal Government's Actions Concerning Health Care Coverage

The following is a status update on several Trump administration actions that have the effect of undermining the Affordable Care Act (ACA), covered previously in Volume 23, No. 2 (Spring 2018) of the *California Regulatory Law Reporter*:

♦ ***"Skimpy" Health Care Coverage***. On August 3, 2018, the U.S. Department of Health and Human Services and two other federal agencies published the final rule permitting the sale of short-term, limited duration health policies in response to President Trump's Executive Order 13813. *[23:2 CRLR 209]* The rule, which will lengthen the maximum duration of short-term, limited-duration insurance policies, was scheduled to become effective on October 2, 2018. The final rule: (1) allows short-term plans to be sold with initial terms of up to 364 days; (2) allows short-term plans to be renewed as long as the total duration of the plan does not exceed 36 months; and (3) requires short-term plan information to include a disclosure to help people understand how short-term plans differ from individual health insurance.

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. Under the previous rule, short-term insurance could not last for more than three months, as it was meant to be a stopgap. 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. Additionally, while "skimpy" coverage may be cheaper than coverage that complies with the ACA, such policies need not cover the ten essential health benefits required by the ACA.

The Trump administration adopted the final rule over the objection of Commissioner Jones. On the day that the administration proposed the rule, 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." *[23:2 CRLR 209]*

The short-term policies are subject to state regulation. Governor Brown recently signed SB 910 (Hernandez) (Chapter 687, Statutes of 2018), which prohibits the sale of these short-term, limited duration plans in California [see LEGISLATION]. Also, a coalition of patient advocates and health care groups filed a federal court lawsuit challenging the federal rule on September 14, 2018, in Washington, D.C., and succeeded in securing a preliminary injunction to postpone the effective date of the rule [see LITIGATION].

♦ ***Association Health Plans***. Effective August 20, 2018, the U.S. Department of Labor (DOL)—pursuant to President Trump's Executive Order 13813—issued a final rule allowing 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. *[23:2 CRLR 210]* According to DOL's press release, the use of AHPs will "expand affordable health coverage options for America's small businesses. … AHPs are about more choice, more access, and more coverage."

Critics of the Trump Administration's efforts to undermine the ACA—including Commissioner Jones—disagree. Although lower in cost than ACA-compliant policies, AHPs 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. In a June 19, 2018 statement, Commissioner Jones stated that, while the administration's regulation recognizes continued state regulation of AHPs, "outside California, the Trump Administration's final rule threatens the continued existence of comprehensive health insurance coverage, as those who are sick may no longer be provided coverage that meets their health care needs or may obtain coverage through an arrangement that may later fail when needed most." In fact, California Governor Jerry Brown recently signed SB 1375 (Hernandez) (Chapter 700, Statutes of 2018), which prohibits sole proprietors from joining AHPs [see LEGISLATION].

On July 26, 2018, a group of twelve state attorneys general filed a federal challenge to the rule, arguing that it is an arbitrary and capricious attempt to undermine the market structure underpinning the ACA [see LITIGATION].

LEGISLATION

Wildfire / Property Insurance Legislation

SB 894 (Dodd), as amended August 24, 2018, is DOI-sponsored legislation that amends Insurance Code section 675.1, which 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 requires 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 also amends section 2051.5, which currently provides (in part) the definition for the measure of indemnity for a loss under a property insurance policy and specifies time limits under which an insured must collect the full replacement cost of the loss; prohibits insurers from

limiting or denying payment of replacement costs of property in the event the insured decides to rebuild or replace the property at a location other than the insured premises; and provides a 24-month coverage period for additional living expenses incurred due to a covered loss relating to a state of emergency. SB 894 requires an insurer to grant an extension for additional living expenses of 12 additional months if the insured is acting in good faith and with reasonable diligence when they encounter delay in the reconstruction process that is a result of circumstances beyond the control of the insured.

Finally, the bill adds section 10103.7 to the Insurance Code, which provides that—in the event of a covered loss relating to a state of emergency—an insured under a residential property insurance policy shall be permitted to combine payments for claims for losses up to the policy limits for the primary dwelling and other structures, for any of the covered expenses reasonably necessary to rebuild or replace the damaged or destroyed dwelling, if the policy limits for coverage to rebuild or replace the primary dwelling are insufficient. Any claims payments for such losses for which replacement cost coverage is applicable shall be for the full replacement value of the loss without requiring actual replacement of the other structures or contents. Claims payments for other structures in excess of the amount applied towards the necessary cost to rebuild or replace the damaged or destroyed dwelling shall be paid according to the terms of the policy.

Governor Brown signed SB 894 on September 21, 2018 (Chapter 618, Statutes of 2018).

AB 1875 (Wood), as amended August 24, 2018, also sponsored by the Commissioner, adds sections 10095.7 and 10103.2 to the Insurance Code. New section 10095.7 requires DOI to establish the California Home Insurance Finder to assist homeowners in connecting with an insurance agent or broker offering residential property insurance. The bill spells out requirements, including the use of social media, to promote finders in multiple languages, and—on and after July

1, 2020—requires insurers to provide to an applicant who is denied coverage, or to a policyholder whose policy is canceled or not renewed, information regarding DOI's California Home Insurance Finder.

New section 10103.2 requires insurers—on and after July 1, 2020—upon an offer of a policy of residential property insurance, to provide to the applicant a disclosure that states policies offering extended replacement cost coverage of at least 50% may be available for that property and that includes the Internet website address of DOI's Homeowners Coverage Comparison Tool, pursuant to the following conditions: (1) if an insurer does not offer at least 50% above the residential dwelling coverage limit to the applicant, the insurer shall provide the disclosure; (2) if an insurer, utilizing an agent or broker, does not offer an applicant at least 50% above the residential dwelling coverage limit to the applicant, the insurer, agent, or broker shall provide the disclosure; and (3) if an agent or broker provides quotes to a consumer from multiple insurers, but none of the offers include coverage at least 50% above the residential dwelling coverage limit, the agent or broker shall provide the disclosure.

Governor Brown signed this bill on September 21, 2018 (Chapter 629, Statutes of 2018).

AB 1772 (Aguiar-Curry and Wood), as amended August 24, 2018, is DOI-sponsored legislation that amends section 2051.5 of the Insurance Code to extend—in cases of a loss relating to a declared disaster—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. The bill also allows a six-month extension (on top of the 36-month period) to policyholders for "good cause," as defined by the bill. 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 receive full replacement cost benefits under their policy."

AB 1772 was an urgency bill, the changes took effect immediately upon Governor Brown's September 21, 2018 approval (Chapter 627, Statutes of 2018).

AB 1800 (Levine), as amended August 24, 2018, is a DOI-sponsored bill that amends section 2051.5 of the Insurance Code 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."

AB 1800 was an urgency bill, the changes took effect immediately upon Governor Brown's September 21, 2018 approval (Chapter 628, Statutes of 2018).

AB 2594 (Friedman), as amended August 6, 2018, is DOI-sponsored legislation that amends section 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.

AB 2594 was an urgency bill, the changes took effect immediately upon Governor Brown's September 21, 2018 approval (Chapter 627, Statutes of 2018).

AB 1797 (Levine), as amended June 19, 2018, adds section 10103.4 to the Insurance Code, to require an insurer that provides replacement cost coverage to provide, on and after July 1, 2019 and on an every other year basis, at the time an offer to renew a policy of residential property

insurance is made to the policyholder, an estimate of the cost necessary to rebuild or replace the insured structure that complies with specified existing DOI regulations. The bill exempts an insurer from this requirement if either the policyholder has requested, within the two years prior to the offer to renew the policy, and the insurer has provided, coverage limits greater than the previous limits that the policyholder had selected, or if the insurer has made specified offers to the policyholder.

Governor Brown signed this bill on August 27, 2018 (Chapter 205, Statutes of 2018).

AB 2229 (Wood), as amended April 12, 2018, amends 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.

Governor Brown signed AB 2229 on July 9, 2018 (Chapter 75, Statutes of 2018).

AB 1799 (Levine), as amended April 12, 2018, amends 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.

Governor Brown signed this bill on July 9, 2018 (Chapter 69, Statutes of 2018).

SB 917 (Jackson), as amended August 23, 2018, adds section 530.5 to the Insurance Code, concerning landslides, mudslides, mudflow, or debris flow. The new section provides that if a loss or damage results from a combination of perils, one of which is a landslide, mudslide, mudflow, or debris flow, coverage shall be provided if an insured peril is the efficient proximate cause of the

loss or damage and coverage would otherwise be provided for the insured peril. Coverage shall be provided under the same terms and conditions as would be provided for the insured peril.

Governor Brown signed SB 917 on September 21, 2018 (Chapter 620, Statutes of 2018).

SB 824 (Lara), as amended August 24, 2018, makes legislative findings that insurance losses due to wildfires are on the rise in California; the risk of catastrophic wildfires is increasing due to global climate change; and in order to ensure a vibrant and robust insurer marketplace relating to fire risk, it is necessary for the Insurance Commissioner to collect data on fire loss experience from insurers writing residential property insurance and to issue a report summarizing findings from that data collection. In this regard, the bill adds new Article 10.4 (commencing with section 929) to the Insurance Code, which requires insurers with written California premiums totaling $10 million to submit a report with specified fire risk information on its residential property policies to the Commissioner on or before April 1, 2020, and every two years thereafter. The bill requires the Commissioner to post a report on wildfire risk compiled from the submitted data to DOI's Internet website every two years. The bill authorizes the Commissioner to specify the manner of submission and the format of the report submitted by the insurer, authorizes the Commissioner to grant a submission extension to an insurer, and subjects an admitted insurer that fails to submit a report to a civil penalty.

SB 824 also amends Insurance Code section 675.1 of the Insurance Code to prohibit—subject to specified exemptions—insurers from canceling or refusing to renew a policy of residential property insurance based solely on the location of the property and its proximity to a wildfire or fire perimeter for one year after the declaration of a state of emergency.

Governor Brown signed this bill on September 21, 2018 (Chapter 616, Statutes of 2018).

SB 30 (Lara), as amended June 21, 2018, adds section 12922.5 to the Insurance Code, which requires the Insurance Commissioner to convene a working group to identify, assess, and recommend risk transfer market mechanisms that promote investment in natural infrastructure to reduce the risks of climate change related to catastrophic events, create incentives for investment in natural infrastructure to reduce risks to communities, and provide mitigation incentives for private investment in natural lands to lessen exposure and reduce climate risks to public safety, property, utilities, and infrastructure.

Governor Brown signed SB 30 on September 21, 2018 (Chapter 614, Statutes of 2018).

Health/Disability Legislation

SB 910 (Hernandez), as amended August 20, 2018, adds section 10123.61 to the Insurance Code (and makes conforming changes to several other Insurance Code provisions) to prohibit health insurers, as of January 1, 2019, from issuing, amending, selling, renewing, or offering "short-term limited duration health insurance," which is defined as health insurance provided pursuant to a policy that has an expiration date that is less than 12 months after the original effective date of coverage, including renewals. These so-called "skimpy" plans do not provide comprehensive coverage nor do they cover the ten 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 August 3, 2018 adoption of regulations permitting the sale of "skimpy" health insurance that will be cheaper than ACA-compliant insurance [see MAJOR PROJECTS].

Governor Brown signed SB 910 on September 22, 2018 (Chapter 687, Statutes of 2018).

SB 1375 (Hernandez), as amended August 23, 2018, amends sections 10700, 10753, 10753.05, and 10755 and adds section 10965.02 to the Insurance Code, relating to health insurance. The bill prohibits sole proprietors from joining association health plans [see MAJOR

PROJECTS]. New section 10965.02 prohibits small employer group health benefit plans from being issued, marketed, or sold to a sole proprietorship or partnership without employees; it further specifies that "only individual health benefit plans shall be sold to any entity without employees." The amendments to sections 10700, 10753, and 10755 of the Insurance Code revise the definition of "eligible employee" for purposes of small employer health insurance policies to exclude sole proprietors, partners of a partnership, and the spouses of sole proprietors and partners.

Governor Brown signed SB 1375 on September 22, 2018 (Chapter 700, Statutes of 2018).

SB 1021 (Wiener), as amended August 23, 2018, adds section 10123.1932 to the Insurance Code, which prohibits a health insurer from maintaining a prescription drug formulary with more than four tiers, and extends—until January 1, 2024—a requirement that puts a cap on the cost sharing of a covered outpatient prescription drug at $250 or $500 per 30-day supply, as specified. The bill also adds new section 10123.1931 to the Insurance Code, which provides that—for combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV—a health insurer shall not have utilization management policies or procedures, including a standard of care, which rely on a multitablet drug regimen instead of a single-tablet drug regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and equally or more likely to result in adherence to a drug regimen. Finally, SB 1021 makes conforming amendments to Insurance Code section 10123.193.

Governor Brown signed SB 1021 on September 26, 2018 (Chapter 787, Statutes of 2018).

AB 2863 (Nazarian), as amended, August 13, 2018, adds section 10123.65 to the Insurance Code, which limits the amount a health insurer may require an insured to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the

retail price. The bill prohibits a health insurer from requiring a pharmacist or pharmacy to charge or collect from an insured a cost-sharing amount that exceeds the total retail price for the prescription drug. Finally, the new section provides that the payment rendered shall constitute the applicable cost-sharing and shall apply to the deductible and/or the maximum out-of-pocket limit in the same manner as if the insured had purchased the prescription drug by paying the cost-sharing amount.

Governor Brown signed AB 2863 on September 26, 2018 (Chapter 770, Statutes of 2018).

AB 2499 (Arambula), as amended August 9, 2018, amends section 10112.25 of the Insurance Code, which sets minimum medical loss ratios (MLRs) that guarantee that at least 80% or 85% of premiums go towards actual medical care and quality improvement activities, and requires health insurers to provide an annual rebate to insureds if the MLR does not meet established standards. AB 2499 deletes the requirements that MLRs be implemented to the extent required by, in compliance with, and not to exceed federal law, and instead requires MLRs to be implemented as described in federal law and any rules or regulations issued as in effect on January 1, 2017. This bill exempts specialized health insurance policies that provide only dental or vision services from the annual rebate requirement; changes the date from August 1 of the following calendar year, to September 30, that a health insurer that does not meet the MLR must pay an insured a rebate; and repeals section 10112.25's authorization to the Commissioner to implement it by way of emergency regulations, and its requirement that DOI consult with DMHC in adopting regulations.

Governor Brown signed AB 2499 on September 22, 2018 (Chapter 678, Statutes of 2018).

SB 1008 (Skinner), as amended August 23, 2018, amends section 10112.26 and adds section 10603.04 to the Insurance Code regarding health insurers that cover dental services. New

section 10603.04 requires such a health insurer—for policy years on and after January 1, 2021, or 12 months after DOI adopts regulations, whichever occurs later (as described below)—to utilize a uniform benefits and coverage (UBC) disclosure matrix, with specified contents. The new section requires insurers to utilize the UBC matrix to make available, at minimum, all of the following information relating to covered dental services, together with the corresponding copayments or coinsurance and limitations: (1) the annual overall policy deductible; (2) the annual benefit limit; (3) coverage for the following categories: preventive and diagnostic services, basic services, major services, and orthodontia services; (4) dental policy reimbursement levels and estimated insured cost share for services; (5) waiting periods; and (6) examples to illustrate coverage and estimated insured costs of commonly used benefits. The new section requires DOI to adopt emergency regulations to implement it, and DOI must do so in consultation with DMHC.

Amended section 10112.26 requires health insurers that offer dental coverage to file an MLR report with DOI by July 31 of each year. The MLR report shall be organized by market and product type and shall contain the same information required in the 2013 federal MLR Annual Reporting Form. DOI must post a health insurer's annual MLR report on its Internet website within 45 days after receiving the report. Finally, the bill authorizes DOI to issue guidance to health insurers of specialized health insurance policies subject to this section regarding compliance with these provisions until regulations are adopted.

Governor Brown signed SB 1008 on September 29, 2018 (Chapter 933, Statutes of 2018).

AB 2193 (Maienschein), as amended August 17, 2018, adds section 10123.867 to the Insurance Code, which requires health insurers, by July 1, 2019, to develop a maternal mental health program designed to promote quality and cost-effective outcomes. "Maternal mental health"

is defined to mean a mental health condition that occurs during pregnancy or during the postpartum period that includes, but is not limited to, postpartum depression.

Governor Brown signed AB 2193 on September 26, 2018 (Chapter 755, Statutes of 2018).

AB 1860 (Limón and Cervantes), as amended August 20, 2018, amends section 10123.206 of the Insurance Code to increase the $200 copayment and coinsurance limit to $250 for an individual 30-day prescription of orally administered anticancer medication used to kill or slow the growth of cancerous cells, and extends the sunset date in that provision from January 1, 2019 to January 1, 2024. Section 10123.206 allows the $250 prescription limit to be increased only once an insured's deductible in a high deductible health policy has been satisfied.

Governor Brown signed AB 1860 on September 17, 2018 (Chapter 427, Statutes of 2018).

AB 2941 (Berman), as amended August 18, 2018, adds section 10112.95 to the Insurance Code, requiring health insurers to provide insureds who have been evacuated by a state of emergency access to medically necessary health care services. Section 10112.95 requires a health insurer, within 48 hours of the declaration of emergency that displaces or could displace insureds, to file a notice with DOI containing specified information regarding how the insurer is addressing the needs of its insureds during the state of emergency. The health insurer may be required to take actions including, but not limited to, the possibility of relaxed time limits for prior authorization, precertification, or referrals; extended filing deadlines for claims; suspension of prescription refill limitations; allowing insureds to refill prescriptions at an out-of-network pharmacy; replacement of medical equipment or supplies; access to an out-of-network provider should an 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.

Governor Brown signed AB 2941 on August 24, 2018 (Chapter 196, Statutes of 2018).

SB 1156 (Leyva), as amended August 24, 2018, would have added section 10176.11 to the Insurance Code, which would have required health insurers to accept premium payments from specified third-party entities. On September 30, 2018, Governor Brown vetoed SB 1156, stating that "this bill goes too far as it would permit health plans and insurers to refuse premium assistance payments and to choose which patients they will cover. I encourage all stakeholders to continue to work together to find a more narrowly tailored solution that ensures patients' access to coverage."

SB 399 (Portantino), as amended August 23, 2018, would have amended section 10144.51 of the Insurance Code, which requires health insurance policies to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Among other things, the bill would have changed the eligibility requirements needed to become a "qualified autism service professional" and a "qualified autism service paraprofessional."

On September 29, Governor Brown vetoed SB 399, stating that "this bill would revise qualification standards for providers of behavioral health treatment for individuals with autism. Standards for autism providers were updated last year. I'm not inclined to revise them again."

AB 2384 (Arambula), as amended August 23, 2018, would have added section 10123.204 to the Insurance Code regarding medication-assisted treatment (MAT). The new section would have required health insurers that provide prescription drug benefits to cover, at minimum, at least one version of MAT, relapse prevention, and overdose reversal prescription drugs for opioid use disorder, regardless of whether a drug is self-administered or administered by a health care provider.

On September 23, 2018, Governor Brown vetoed AB 2384, stating that "this bill requires health plans to cover at least one version of each drug used in medication-assisted treatment for opioid disorders and restricts health plans' ability to manage the utilization of these drugs. While

the drugs specified in this bill are useful to treat opioid addiction, I am not willing to eliminate requirements that may be in interest of patients."

AB 2342 (Burke and Waldron), as amended August 17, 2018, would have added section 10123.815 to the Insurance Code, which would have required every policy of disability insurance that provides coverage for hospital, medical, or surgical expenses, and which is issued or renewed on or after January 1, 2019, to provide coverage for breast and ovarian cancer susceptibility screening as recommended by the United States Preventive Services Task Force.

On September 27, 2018, Governor Brown vetoed AB 2342 and several other insurance-related bills, stating that they require "significant, ongoing general fund commitments. As such, I believe they should be considered as part of the budget process."

Legislative Bills that Died

The following bills reported in Volume 23, No. 2 (Spring 2018) died in committee or otherwise failed to be enacted during 2017: SB 437 (Atkins), which would have required an existing senior level DOI/DMHC working group to review and examine timely access to care, network adequacy, and state implementation of federal health care reforms as part of its duties; AB 2895 (Arambula), which would have required a health insurer to annually report to DOI the percentage of expenses the health insurer allocated to primary care; SB 538 (Monning), which would have prohibited contracts between a hospital and a health insurer from containing certain provisions; SB 1285 (Stone), which would have required a health insurance policy to cover services provided by an advanced practice pharmacist; AB 2643 (Irwin), which would have required health insurance policies to cover general anesthesia required for dental procedures; SB 1023 (Hernandez), relating to the provision of family planning benefits via telehealth under the Medi-Cal program; AB 3087 (Kalra), which would have created a commission to impose limits

on health care costs; and SB 562 (Lara and Atkins), which would have enacted "The Healthy California Act," a comprehensive universal single-payer health care coverage system for all Californians. SB 897 (McGuire and Dodd), relating to claims for additional living expenses being covered by residential property insurance; AB 1679 (Burke), relating to auto body repair labor rates; and SB 898 (Hertzberg), relating to bail bonds.

Other Insurance-Related Legislation

AB 2634 (Chau), as amended August 20, 2018, is DOI-sponsored legislation that adds section 10113.70 to the Insurance Code, which—effective July 1, 2019—requires life insurers to provide 90 days' notice to owners of a variable premium life insurance policy of an increase in the cost of insurance or administrative charges. The insurer is required to provide a summary notice and, if the policy is designated as one that uses illustrations, an inforce illustration of current and future benefits and values. The illustration shall be based on the insurer's illustrated scale after the effective date of the adverse change in the current scale of elements.

Governor Brown signed AB 2634 on September 19, 2018 (Chapter 545, Statutes of 2018).

AB 1373 (Daly), as amended July 3, 2018, amends sections 10202, 10202.5, and 10202.8 of the Insurance Code, to include former employees (including retired employees) within the definition of "employee" for purposes of specified group life insurance policies.

Governor Brown signed AB 1373 on September 17, 2018 (Chapter 425, Statutes of 2018).

AB 2142 (Bigelow), as amended August 17, 2018, amends Insurance Code section 12752 relating to insurance provided by home protection companies. 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 authorizes the Commissioner to extend the period between examinations up to two additional years if the Commissioner determines that conditions warrant the extension. In making that determination, the Commissioner may consider the company's reserves, net worth, and any other factors the Commissioner considers relevant.

Governor Brown signed AB 2142 on September 17, 2018 (Chapter 431, Statutes of 2018).

AB 2045 (Committee on Insurance), as amended July 3, 2018, is DOI's omnibus bill that makes technical and noncontroversial changes to numerous provisions of the Insurance Code. Of note, the bill amends 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).

Governor Brown signed AB 2045 on August 28, 2018 (Chapter 231, Statutes of 2018).

AB 1817 (Committee on Budget), as amended June 11, 2018, amends Insurance Code section 12905 to require the Commissioner to keep offices in Sacramento, Los Angeles, San Diego, and the San Francisco Bay area.

Governor Brown signed this bill on June 27, 2018 (Chapter 37, Statutes of 2018).

AB 2844 (Cooley), as amended August 24, 2018, adds section 769.1 to the Insurance Code, which requires that any commission payable to a broker-agent be paid pursuant to the terms agreed upon in writing between the insurer and the broker-agent. The bill establishes a rebuttable presumption that a commission is lawful if it complies with Insurance Code sections 769 and 1861.16 and if it is paid in accordance with the written agreement.

Governor Brown signed AB 2844 on September 28, 2018 (Chapter 879, Statutes of 2018).

SB 10 (Hertzberg), as amended August 20, 2018, the California Money Bail Reform Act, eliminates—effective October 1, 2019—the so-called "money bail" system (which has been

widely criticized as unfair to low-income people) and instead establishes a risk-based preventive detention system designed to assess the risk level of persons charged with the commission of a crime, which will be used to determine whether and when a charged person will be released from custody. In addition to vastly changing the bail system, the bill likely eliminates a DOI licensure category—bail agents. Unhappy with its fate, the bail bond industry immediately commenced a referendum drive to put an initiative on the ballot to overturn SB 10; the industry needs to obtain the signatures of almost 366,000 voters within 90 days of Governor Brown's August 28, 2018 signature on the bill (Chapter 244, Statutes of 2018).

LITIGATION

PacifiCare Life & Health Insurance Company v. Jones. On September 20, 2018 in *PacifiCare Life & Health Insurance Company v. Jones*, 27 Cal. App. 5th 391 (2018), a three-justice panel of the Fourth District Court of Appeal upheld the Insurance Commissioner's 1992 adoption of regulations implementing Insurance Code section 790 et seq., the Unfair Insurance Practices Act (UIPA). These so-called "unfair claims settlement practices regulations" were developed by DOI in conjunction with the Department's Consumer Complaints and Unfair Practices Task Force appointed by then-Commissioner John Garamendi in May 1991 *[11:3 CRLR 126]* and were intended to clearly define with detailed specificity the full range of unfair acts or types of conduct by insurers that are prohibited under Insurance Code section 790.03(h). *[13:1 CRLR 83; 12:4 CRLR 146; 12:2&3 CRLR 171; 12:1 CRLR 117]*

In 2008, after a lengthy investigation, DOI filed an administrative enforcement action against PacifiCare, alleging that the company had engaged in over 900,000 acts and practices in violation of Insurance Code section 790.03(h) and the three regulations specifically at issue (sections 2695.1(a), 2695.2(l), and 2695.2(y), Title 10 of the CCR). Following a lengthy

administrative hearing, the Commissioner imposed fines against PacifiCare in excess of $173 million. In July 2014, PacifiCare filed a petition for writ of mandate challenging the Commissioner's decision and order. The trial court ruled for PacifiCare and enjoined the Commissioner from enforcing the three regulations adopted in 1992 under the UIPA.

On appeal, the Fourth District unanimously reversed the trial court's order as to all three regulations and determined in a legally and factually detailed decision that they are consistent with 39 years of California Supreme Court precedent and the legislature's clear intention to give the Commissioner authority to protect consumers and to fine insurers for Insurance Code section 790.03(h) violations where consumers have no private right of action to redress them. PacifiCare argued that insurers are immune from fines for committing unfair acts unless the Commissioner is able to show that the insurer knew it had committed the acts frequently enough to constitute a "general business practice." The Fourth District rejected this argument as being a false interpretation of 790.03(h) and also rejected PacifiCare's argument that the Commissioner must prove an insurer had "actual knowledge" of its illegal conduct. Finally, the appellate court upheld the Commissioner's interpretation that an insurer's "willful" violation of the UIPA may be established by showing a purpose or willingness to commit the act, and agreed that penalties for willful violations do not require a showing that the insurer intended to violation the law or injure someone. The court held: "As the Commissioner points out, he engaged in an extensive, formal rulemaking process in the course of promulgating these regulations. That careful consideration, combined with the Commissioner's expertise in the area, weighs in favor of according significant deference to the Commissioner's interpretation of the terms, and we do so." At this writing, PacifiCare is seeking review of the Fourth District's decision by the California Supreme Court.

Liberty Surplus Ins. Corp. v. Ledesma & Meyer Construction Co., Inc. On June 4, 2018, the California Supreme Court—answering a question of law posed by the U.S. Ninth Circuit Court of Appeals—held in *Liberty Surplus Insurance Corporation v. Ledesma & Meyer Construction Company, Inc.*, 5 Cal. 5th 216 (2018), that the negligent hiring, retention, and supervision of an employee who intentionally injures a third party may constitute an "occurrence" triggering coverage under the employer's commercial general liability policy, even where the policy defines "occurrence" as "an accident."

In 2010, a 13-year-old student sued L&M Construction for its negligent hiring, retention, and supervision of an employee who sexually assaulted her at one of L&M's job sites. L&M tendered the defense to its insurer, Liberty Surplus Insurance Corporation, and Liberty sought declaratory relief in federal district court, contending that it had no obligation to defend L&M because the commercial general liability policy only covered "bodily injury caused by an occurrence" (which was defined as "an accident"). The district court granted summary judgment to Liberty. On appeal, L&M argued that the district court misapplied California law. The Ninth Circuit requested a legal opinion from the California Supreme Court, and that court agreed with L&M that claims of negligence that harm a third party can be considered "accidents" and, as such, covered as "occurrences" under liability insurance. Writing for a near-unanimous Court, Justice Carol Corrigan wrote that "'[u]nder California law, the word "accident" in the coverage clause of a liability policy refers to the conduct of *the insured* for which liability is sought to be imposed on the insured.' ... Accordingly, a policy providing a defense and indemnification for bodily injury caused by 'an accident' promises coverage for liability resulting from the *insured's* negligent acts" (emphasis original; internal citations omitted).

Ass'n for Cmty. Affiliated Plans, et al. v. United States Dep't of Treasury, et al. On September 14, 2018, seven patient advocate and health care groups filed a complaint in the U.S. District Court for the District of Columbia against the Departments of Labor, Treasury, and Health and Human Services ("the departments") in *Association for Community Affiliated Plans, et al. v. United States Department of Treasury, et al.,* Civil Action No. 18-2133, requesting that the departments' short-term, limited duration insurance rule ("STLDI Rule") be set aside under the Administrative Procedure Act because it cannot be reconciled with the text, structure, or purpose of the Affordable Care Act. The STLDI Rule converts the narrow exemption for "short-term, limited duration insurance" into a loophole that permits the creation of a parallel individual insurance market consisting of plans that are not subject to the ACA's consumer protection standards [see MAJOR PROJECTS]. According to the complaint, STLDI plans may omit essential health benefits and engage in business practices that are otherwise forbidden to ACA-compliant individual health insurance plans. The complaint also alleges that the STLDI Rule is arbitrary and capricious for multiple reasons, and that the departments failed to provide the public with reasonable notice of important aspects of the rule in their notice of proposed rulemaking. In particular, plaintiffs allege that the departments failed to disclose that they intended to permit STLDI plans to be renewable at all, or for a period of up to 36 months. Plaintiffs are seven organizations that participated in the 2018 rulemaking proceeding and/or believe strongly that the STLDI Rule is incompatible with their shared purpose of ensuring access to adequate, affordable health care for all Americans. The plaintiffs are the Association for Community Affiliated Plans, National Alliance on Mental Illness, Mental Health America, American Psychiatric Association, AIDS United, National Partnership for Women and Families, and Little Lobbyists.

On September 28, 2018, plaintiffs filed a motion for preliminary injunction blocking enforcement of the rule. On October 2, 2018, the court granted that motion and ordered departments to file their response no later than October 22, 2018. The court also ordered a preliminary injunction hearing for October 26, 2018.

State of New York, et al. v. U.S. Dep't of Labor. On July 26, 2018, twelve state attorneys general filed *State of New York, et al. v. U.S. Department of Labor*, Civ. Action No. 18-1747-JDB, in the U.S. District Court for the District of Columbia. This complaint challenges the Trump administration's regulation issued this year that makes it easier for individuals and small employers to band together to purchase health care coverage through association health plans (AHPs) that do not meet ACA standards [see MAJOR PROJECTS]. Plaintiffs argue that the administration is violating the ACA's purpose of establishing minimum insurance protections. Defendants argue the loosening of health plans allows for more affordable health care, and more covered Americans. On August 23, 2018, plaintiffs filed a motion for summary judgment; at this writing, all parties and numerous *amici curiae* are briefing the case; no hearing has yet been held.

Pharm. Research & Mfg. of Am. v. Brown. On August 30, 2018, in *Pharmaceutical Research and Manufacturers of America v. Brown,* No. 2:17-cv-02573-MCE-KJN, U.S. District Judge Morrison C. England of the Eastern District of California ruled on PhRMA's December 2017 challenge to the constitutionality of SB 17 (Hernandez) (Chapter 603, Statutes of 2017). SB 17 attempts to provide transparency in regard to prescription drug pricing, including requiring drug manufacturers to provide advance information on and a justification for prescription drug price increases. In addition, SB 17 requires health insurers to annually report to DOI information regarding the 25 most frequently prescribed drugs, costliest drugs, and highest year-over-year

increase in total annual spending. Starting January 1, 2019, DOI must compile the information into a report which it must submit to the legislature and post on its website. *[23:1 CRLR 249–50]*

In his August 30 ruling, Judge England dismissed the complaint in its entirety, but granted PhRMA leave to file an amended complaint within thirty (30) days following August 30, 2018. Judge England dismissed the Governor as a party to the action because he is immune from suit and the complaint failed to allege facts sufficient to apply an exception. The court also dismissed PhRMA's complaint in its entirety for lack of standing.

On September 28, 2018, PhRMA submitted its first amended complaint. PhRMA alleges that SB 17 is unconstitutional in that it compels them to speak about potential price increases when they would prefer not to communicate that information at all (thus violating these corporations' asserted first amendment rights); additionally, plaintiff alleges that the bill interferes with interstate commerce. In its prayer for relief, PhRMA seeks an injunction to prevent California from implementing and enforcing SB 17, and a declaration that the statute is unconstitutional. At this writing, a hearing on Defendant Robert P. David's motion to dismiss the case is set for December 13, 2018; David is the Director of the California Office of Statewide Health Planning and Development.

State Farm General Ins. Co. v. Jones. At this writing, San Diego County Superior Court Judge Katherine Bacal still has yet to issue a final judgment in *State Farm General Insurance Company v. Jones*, No. 37-2016-00041469-CU-MC-CTL. On March 23, 2018, 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. Rather than considering the investment income of State Farm General in making his rate decision, Commissioner Jones also considered the investment income of the two affiliates, which Judge Bacal ruled was an error because "there was only one applicant/insurer/insurance company that sought a rate change: State Farm." *[23:2 CRLR 235]*

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. 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 intervenor compensation for its work, intervened in this litigation and has indicated its intent to appeal once a final judgment is issued.