

DEPARTMENT OF INSURANCE

Commissioner: Ricardo Lara ♦ 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 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 annually receives and processes tens of thousands of referrals regarding suspected fraud against insurers, 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 consumer protection 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 reviews and approves/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;

(3) it establishes rates and rules for workers' compensation insurance;

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

(5) 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 (CSD) is a member of the Consumer Services and Market Conduct Branch within DOI. CSD maintains four separate bureaus: Consumer Communications Bureau, Claims Services Bureau, Health Claims Bureau, and Rating and Underwriting Services Bureau. CSD operates the Department's toll-free complaint line. Through

its bureaus, CSD 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 CSD 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.

On November 6, 2018, Californians elected a new Insurance Commissioner, Ricardo Lara. Raised in East Los Angeles by immigrant parents, Commissioner Ricardo Lara made history in 2018 by becoming the first openly gay person elected to statewide office in California's history. Commissioner Lara previously served in the California Legislature.

On January 7, 2019, Commissioner Lara swore in new members of the Department of Insurance Executive Team including Chief Deputy Catalina Hayes Bautista, Deputy Commissioner and Legislative Director Michael Martinez, Deputy Commissioner for Climate and Sustainability Michael Peterson, Director of Community Outreach Julia Juarez, Special Assistant David Green, and Deputy Commissioner for Communications and Press Relations Michael Soller. In the Commissioner's announcement, he stated "[o]ur team will embrace innovation, with the first in the nation executive-level position engaging the insurance industry in the fight against climate change. Protecting California's consumers' demands we confront the growing threats from

wildfires, fraud, and the rising cost of health care in partnership with the Governor and Legislature.”

MAJOR PROJECTS

Methodology for Determining Average Contracted Rate

On December 31, 2018, DOI issued a [press release](#) announcing the adoption of sections 2238.10, 2238.11, and 2238.12, Title 10 of the CCR. [\[24:1 CRLR 202\]](#) [\[23:2 CRLR 213\]](#) Then Insurance Commissioner Dave Jones, commented that “[t]hese regulations were carefully crafted to provide a fair way of calculating the average contracted rate for medical services in a given geographic region in those circumstances in which a patient inadvertently receives care from an out-of-network provider. Insurers are required to maintain an adequate provider network to ensure timely access to care for their policyholders and when patients are forced to go out-of-network at an in-network facility, the patient should not have to pay more for their care and the providers should be reimbursed fairly.” Pursuant to the press release, the Office of Administrative Law (OAL) approved the regulations and the [final text](#) went into effect on January 1, 2019.

Commissioner Denies Petition for Rulemaking Regarding Proposition 103

On February 21, 2019, organizations including Consumer Watchdog, United Policyholders, and Public Advocates Inc. filed a [Petition for Rulemaking](#) to amend Prop 103. The Petition sets forth that insurance companies in California are improperly utilizing a person’s occupation and education to set auto insurance premiums, and further, the use of these unauthorized rating factors increases the cost of insurance for lower wage, less educated and blue-

collar California motorists. The Petition concludes that these practices are a direct violation of Proposition 103. The Petitioners requested Commissioner Lara to amend Prop 103 Automobile Rating Factors starting in section 2632, Title 10 of the CCR. Petitioners also cited to a recent national study conducted by the Consumer Federation of America which states, “some major auto insurers charge higher rates to drivers with less education and lower-status jobs.” Auto insurers are discriminating on the basis of income and race, including in California. Petitioners cite California’s Administrative Procedure Act as giving them the authority to file the Petition.

On March 25, 2019, Commissioner Lara [denied](#) the Petition, but stated his intent to “call for a public hearing into the rating practices alleged in the Petition to identify and evaluate whether and to what extent insurers are engaged in rating practices with respect to group insurance plans that are inconsistent with California law, including but not limited to, the provisions of Proposition 103 and the Unruh Civil Rights Act (Cal. Civ. Code § 51).”

Special Investigative Unit Pre-Notice Draft Regulations

On February 26, 2019, DOI issued an [invitation](#) to a pre-notice public discussion on special investigative unit regulations. The pre-hearing will be regarding contemplated changes to sections 2698.30, 2698.33, 2698.34, 2698.35, 2698.36, 2698.37, 2698.38, 2698.39, 2698.40, and 2698.41, Title 10 of the CCR. The draft [text](#) of these sections were written by the DOI and the Insurance Fraud Advisory Board. The main purpose of these amendments is to, “improve fraud detection, investigation, and referrals.” The purpose of these discussions is “to provide interested and affected persons an opportunity to present statements or comments regarding the regulation changes.”

Most of the changes to the sections are incidental, but there would be a major change in accordance with section 2698.40 regarding the Special Investigation Unit’s annual report. The

amendments give precise detail to what is to be included in the annual report, and the proposed regulations appear to ask for more information to be publicly available and a better approach to fraud detection in insurance companies. The pre-notice public discussion was set for March 20, 2019.

Commissioner and Legislature Respond to Deadly Wildfires

During the fall and winter of 2018, California suffered another record-breaking and devastating fire season, with the Camp and Woolsey fires. On November 8, 2018, in accordance with section 14022.5(a) of the Insurance Code, Governor Newsom and Commissioner Lara [declared 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 to help ease the burden of the large volume of claims resulting from these two fires.

On January 28, 2019, Commissioner Lara [reported](#) the Camp and Woolsey fires as “the most devastating wildfires in the last 100 years, destroying nearly an entire town and leaving 89 people dead and thousands homeless.” Lara reported that more than 46,000 claims had been filed, of which more than 13,000 insured homes and businesses suffered a total loss, totaling more than \$11.4 billion in insured losses from the November fires alone. DOI provided onsite assistance in all affected areas and at local assistance and disaster recovery centers throughout California by providing expertise and counsel to wildfire survivors. DOI deployed its law enforcement personnel to impacted communities following the fires to deter fraudulent activity. Additionally, DOI escorted homeowners and claim adjusters through blocked roads and hazard areas for more than 1,200 properties to help expedite claims.

On February 12, 2019, Commissioner Lara [announced](#) in a press release his support of Governor Newsom’s call for a comprehensive plan within 60 days to bring justice to wildfire survivors and protection for Californians from the risks of wildfire. Lara further explained his plan to engage the insurance industry in creative approaches, including offering new products and models of insurance that will reduce financial risk to our communities. He noted that California must become more resilient to climate-driven disasters through the availability and affordability of insurance.

On March 5, 2019, DOI [published](#) a photo press release while encouraging survivors of wildfires to call DOI Consumer Hotlines for assistance throughout their recovery. Commissioner Lara explained that DOI is available for wildfire survivors who are still recovering from the devastating fires in 2018. He acknowledged the long and emotional process of recovery and associated insurance claim resolution.

DOI and legislators whose constituents were affected by these natural disasters have also teamed up to draft [SB 290 \(Dodd\)](#), a bill designed to strengthen consumer protections for wildfire survivors making insurance claims. *[see LEGISLATION]*

DOI Releases 2017 Prescription Drug Cost Transparency Report

Despite undecided legal challenges to the constitutionality of the 2017 legislation *[see LITIGATION]*, on December 31, 2018, DOI released its prescription drug cost transparency [report](#). [SB 17 \(Hernandez\) \(Chapter 603, Statutes of 2017\)](#), as codified in Insurance Code section 10123.205(b), requires health plans to annually report to DOI specific information related to the costs of covered prescription drugs. The purpose of the report is to look at the impact of the cost of prescription drugs on commercial health insurance policies.

DOI received filings from nine insurers. The filings include the 25 most frequently prescribed drugs, the 25 most costly drugs by total annual prescription drug spending, and the 25 drugs with the highest year over-year increase in total annual prescription drug spending in each of the three drug categories: generic, brand name and specialty. The tables in the report reflect aggregated data across all insurers and do not reveal information specific to individual health insurers.

DOI Enforcement Activity: Cease and Desist Order

On February 14, 2019, DOI issued a formal [cease and desist order](#) to two companies, NexGen Insurance Services, Inc. and Riverstone Capital, LLC and their owner/operators. Investigations revealed that NexGen and Riverstone had been operating as an unauthorized “Multiple Employer Welfare Association.” This type of employer offers or provides health and welfare benefits to employers and their employees. NexGen and Riverstone were accused of marketing, soliciting, and selling purported “self-insured” health plan arrangements to employers. In a February 15, 2019 [press release](#), Commissioner Lara stated these companies and their owners “misrepresented their ability to pay medical claims, putting employers and their employees in immediate danger.” DOI took action to stop the illegal practices and ensure the safety of workers and employers.

On December 19, 2018, former California Insurance Commissioner Dave Jones issued a [decision](#) and [order](#) imposing a \$4.3 million penalty on American Labor Alliance and CompOne USA for selling workers’ compensation and liability policies to employers of farmworkers without being properly licensed with DOI. Previously, in December of 2016, the Commissioner issued a Cease and Desist Order alleging that respondents unlawfully acted in a capacity that required a license, which they did not possess. On November 10, 2017, the Commissioner issued a decision

finding that the respondents did act in a capacity that required this licensing, in violation of section 700 of the Insurance Code.

The respondents, ALA and CompOne USA, were then ordered to pay a section 12921.8 penalty. Respondents argued that section 12921.8's penalty provisions are unconstitutional. ALA was found liable in the December 19, 2018 Order and was held to pay the monetary penalty of over \$4 million dollars. This amount represents the constitutional holding of \$5,000 per penalty for each of the 869 days that ALA acted in the capacity for which a certificate of authority was required but not possessed.

Protection of consumers was Commissioner Jones's top priority. In a [press release](#) regarding the decision and order, he stated, "[i]nsurance companies not properly licensed to transact insurance in California place policyholders at risk because the insurers have not met the standards required under state law. In this case the health and wellbeing of the farmworkers was put at risk by the unlicensed insurers who sold workers' compensation insurance illegally to the employers of farmworkers."

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 24, No. 1 (Fall 2018) of the *California Regulatory Law Reporter*.

◆ ***Texas Rules ACA Unconstitutional.*** On December 14, 2018, U.S. District Judge Reed O'Connor's [decision](#) in Texas ruled that the individual mandate of the ACA was unconstitutional after Congress' elimination of the tax penalty for failure to comply with the mandate. When the ACA first took effect in 2014, Americans had to pay a penalty known as the individual mandate if

they did not have insurance coverage. The Court issued its [Final Judgment](#) on December 30, 2018. In January 2019, several states filed a [notice of appeal](#) with the Fifth Circuit Court of Appeals. As of this writing, the lawsuit is awaiting review from the Court of Appeals and the ACA remains the law of the land.

When the decision came out, then-California Insurance Commissioner Dave Jones issued the following statement in response: “This ruling threatens access to health care for tens of millions of Americans who gained health coverage thanks to the Affordable Care Act and means that more than 100 million Americans with pre-existing conditions are now at risk when it comes to buying their own health insurance coverage. The lawsuit brought by Republican Attorneys General to deprive Americans of life-saving health care has also successfully placed in jeopardy the protections for those with pre-existing conditions.” [see LITIGATION]

◆ ***Gavin Newsom’s Proposed Health Care Plan.*** On January 7, 2019, California Governor Gavin Newsom was sworn into office and shortly after released an [executive order](#) outlining a proposed health care plan: California’s version of the ACA, which would reinstate the individual mandate and penalties for not having coverage. Governor Newsom’s plan would give the state new powers to negotiate drug prices. Newsom’s proposed plan would help keep California’s health care system stable and encourage people to enroll in coverage. Other states including Massachusetts, New Jersey, and Vermont already have their own individual mandates in place. Newsom’s health care plan would also extend the age limit of children living in California illegally to be able to receive Medi-Cal benefits until age 26.

◆ ***Commissioner Lara Fights Back.*** In a February 19, 2019 [letter](#), Commissioner Lara urged the Trump Administration to withdraw proposed changes to the federal regulations referred to as the Notice of Benefit and Payment Parameters, which relate to the ACA. According to the

DOI's [press release](#), the proposed regulations would threaten “Silver Loading,” auto re-enrollment, and would require insurers selling through the Exchange to sell products that exclude abortion coverage. “Silver Loading” is a practice that California and many other states have used since the federal government stopped making the cost-sharing reduction payments (CSRs); it keeps the cost of insurance coverage and the out-of-pocket costs affordable. Auto re-enrollment has been the practice since 2014 and, according to the Commissioner, the danger of it being taken away would cause “confusion and will cause some people to lose coverage.”

LEGISLATION

[SB 290 \(Dodd\)](#), as introduced February 14, 2019, would add section 8566.5 to, the Government Code to authorize the Governor to purchase insurance, reinsurance, insurance-linked securities, or other related alternative risk-transfer products for the state to help mitigate against costs incurred by the state in response to natural disasters, including earthquakes, wildfires, or floods. The bill is in response to the last two wildfire seasons, which caused insurance losses totaling more than \$25 billion, and have caused the state to spend over \$450 million more than budgeted in wildland protection and firefighting costs. This bill is the outgrowth of [SB 30 \(Lara\) \(Chapter 614, Statutes of 2018\)](#), which required 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 risks of climate change. [*S. Appr*]

[AB 1535 \(Carrillo\)](#), as amended April 11, 2019, would add section 12880.6 to the Insurance Code to require an insurer to include a written disclosure about DOI at the time a pet insurance policy is issued or delivered to a new policyholder. The bill would also specify the format in which the disclosure would need to be printed and the contents it must include—12-point boldface type and contact information for DOI and the agent or broker of record. According

to the author, the bill is intended to ensure that consumers have the proper information to be able to contact the insurance company if issues arise, and encourage policyholders to attempt to resolve issues directly with the company or its agent before seeking the assistance of DOI. *[A. Ins]*

[AB 1591 \(Cooley\)](#), as introduced February 22, 2019, would add section 12964 to the Insurance Code to require the Insurance Commissioner to provide a specified presentation on the National Association of Insurance Commissioners (NAIC) accreditation process to the committees of the Senate and the Assembly having jurisdiction over insurance. The bill would also require DOI to include the information presented in a written report provided to relevant legislative committees and posted to the DOI website; would authorize DOI to coordinate with NAIC to have NAIC make a presentation at its national meeting in lieu of the commissioner's presentation if certain criteria are met, including that DOI coordinates with the legislature to allow specified committee members to attend the NAIC national meeting; and would require DOI to coordinate with the legislature to allow the chairs and ranking members specified committees to become members in the National Council of Insurance Legislators (NCOIL) and attend NCOIL meetings. According to the author, AB 1591 allows the legislature to play a more active role in oversight of the creation of model insurance policy developed by interstate regulatory insurance organizations and implemented in California. *[A. Ins]*

[AB 1813 \(Committee on Insurance\)](#), as amended April, 11, 2019, would amend sections 677, 678, 922.41, 1215.8, 10103.2, 12968, and 12969, add section 900.3, and repeal and then add section 1726 of the Insurance Code related to the business of insurance in the state. Specifically, sections 677 and 678 would require, on or after July 1, 2020, a notification that if a policy holder believes the policy has been wrongfully canceled, the policyholder can contact DOI at its listed mail or website address, or its toll-free telephone number. Section 900.3 would add a new "internal

audit function” to the responsibilities insurers must satisfy as part of their efforts to ensure the regulation tools used by the DOI and insurers satisfy the NAIC. Section 1726 would update the rules governing advertising that were adopted for written advertising to more clearly apply to internet-based advertising. *[A. Ins]*

[AB 1611 \(Chiu\)](#), as introduced February 22, 2019, would add sections 10112.91, 10112.92, and 10181.35 to the Insurance Code, to prohibit a hospital from charging insured individuals more than the in-network cost-sharing amount for emergency and post-stabilization care. According to the author, this bill seeks to end “surprise billing” for such care. California law states that if the consumer reasonably believed they were having an emergency and got emergency care, a health plan is required to cover that care whether it is an in-network hospital or out of network. This bill ensures that patients who need to seek emergency services are not caught in disputes between insurers and hospitals, nor forced to pay the difference between hospital charges and insurer payments. Enrollees in health care service plans regulated by the Department of Managed Health Care are already protected from balance billing based on case law. *[A. Health]*

[AB 731 \(Kalra\)](#), as amended March 20, 2019, would amend sections 10181, 10181.2, 10181.3, 10181.7 of the Insurance Code, relating to health care coverage rate review transparency. This bill would expand existing law, which requires a health service plan or health insurer offering a contract or policy in the individual or small group market to file specified information 120 days before implementing a rate change. This bill would extend this requirement to large health care service plan contracts and policies. Section 10181 would provide new definitions to rate requirements. Section 10181.2 would be amended to apply these articles to individual or group markets in California, just not specialized health insurance policies. Section 10181.3 defines all of the information that needs to be submitted at least 120 days prior to implementing a rate change,

including annual rate, average rate of increase, product type, and total earned premiums in each policy form. Section 10181.7 would be amended to allow all information submitted under this article be made public except for confidential information. *[A. Appr]*

[SB 343 \(Pan\)](#), as introduced February 19, 2019, would amend section 10181.45 of the Insurance Code, relating to healthcare. This section currently requires large health insurance policies and insurers to file with DOI the weighted average rate increase for all large group benefit designs during a 12-month period. SB 343 would eliminate alternative reporting requirements for plans or insurers that have no more than 2 medical groups or a health facility that receives the majority of its revenue from prepayment health care service plans. This bill would result in all health care service plans reporting the same information and being held to the same standards as large health insurance plans. *[S. Appr]*

[SB 534 \(Bradford\)](#), as amended March 28, 2019, would add Article 10.2 (commencing with section 927) to the Insurance Code, to authorize and expand the Supplier Diversity Survey to require insurers to report on its minority, women, LGBT, veteran, and disabled veteran-owned business procurement efforts. This bill would require reports to be submitted by July 1, 2020, and then biennially thereafter. The Commissioner would also be required by section 927.4 to establish and appoint an Insurance Diversity Task Force.

On April 11, 2019, DOI published a [press release](#) regarding the bill. According to Senator Bradford, “California is a diverse state and becomes more diverse with each day. Ignoring that fact also ignores the proven value diverse businesses have and the importance of making our economy more inclusive. Insurance spending on diverse businesses increased 93% over the few years the supplier survey was administered. I think that difference speaks to the enormous impact this measure will have.” *[S. Jud]*

[SB 36 \(Hertzberg\)](#), as amended March 13, 2019, would add Chapter 1.7 (commencing with section 1320.35) to the Penal Code to require each pretrial service agency that uses a pretrial risk assessment tool to validate the tool on a regular basis and to make “[l]ine items, scoring, and weighting as well as details on how each line item is scored, for each pretrial risk assessment tool that the agency uses,” publicly available. According to the author, the bill’s purpose would be to help the legislature better understand how the tool is used by agencies that assess risk, and reduce bias based on race, ethnicity, gender, economic circumstances, and behavioral or developmental disabilities in pretrial release decision making. *[S. Appr]*

LITIGATION

Lat v. Farmers New World Life Ins. Co., Case No. B282008 (Cal. Ct. App.). On October 16, 2018, in *Lat v. Farmers New World Life Ins. Co.*, the California Court of Appeals [reversed](#) the trial court’s grant of summary judgment in an action that showed the power of California’s notice prejudice rule. Marty and Mikel Lat brought this case against Farmers Insurance because they were denied benefits from their insured disabled mother’s death. Farmers claimed that since the insured did not give proper notice of her disability and stopped making payments on the policy, the coverage lapsed and no benefits could be reaped.

The Judge in this case brought up the important California notice prejudice rule, in which “an insurance company may not deny an insured’s claim under an occurrence policy based on lack of timely notice or proof of claim unless it can show actual prejudice from the delay,” *Id.* at 6. It was undisputed that the insured mother was totally disabled due to cancer and Farmers had shown no evidence of prejudice in its motion for summary judgment.

This ruling extends the notice prejudice rule to the notice of disability requirement in health insurance cases. The Court ruled that the insured was entitled to the deduction waiver benefit given

to disabled insured members and the Lats were entitled to the benefits from the policy. The California Supreme Court denied the Petition for Review on January 16, 2019.

Texas, et al. v. United States of America, et al., Case No. 4:18-cv-00167-O (N.D. Tex.).

On December 14, 2018, U.S. District Judge Reed O'Connor's [decision](#) in Texas ruled that the individual mandate of the ACA was unconstitutional after Congress' elimination of the tax penalty for failure to comply with the mandate. Plaintiffs argue that since the individual mandate will be reduced to \$0 starting in 2019, due to the Trump Administrations tax cuts in 2017, it will no longer create income for the federal government, and thus, cease to be a tax. The district court judge held that without the individual mandate, the entirety of the ACA is unconstitutional.

The Court issued its [Final Judgment](#) on December 30, 2018. In January 2019, several states filed a [notice of appeal](#) with the Fifth Circuit Court of Appeals. As of this writing, the lawsuit is awaiting review from the Court of Appeals. The ACA had originally been upheld by the U.S. Supreme Court back in 2012 in *National Federation of Independent Businesses (NFIB) v. Sebelius*, 567 U.S. 519 (2012). The lawsuit was filed on February 26, 2018 by a Republican state attorney general and governors from 20 other states.

Smith v. United Healthcare Insurance Co. & United Behavioral Health, Case No. 4:18-cv-06336-DMR (N.D. Cal.). On October 16, 2018, in *Smith v. United Healthcare Insurance Co. and United Behavioral Health*, plaintiff Smith [sued](#) United Healthcare Insurance Co. (UHC) in federal district court claiming that the company wrongfully limited coverage for psychotherapy services provided through employee health care plans. Smith received psychotherapy for her post-traumatic stress disorder, then found out that UHC only covered \$61.86 of her \$120 therapy sessions. Smith claims that this was due to UHC's discriminatory reimbursement penalty. In the class action lawsuit, the plaintiff seeks an order directing UHC to pay for all denied claims as well

as court costs and attorney fees. On December 18, 2018, defendants filed a motion to dismiss the complaint. The motion was briefed and heard on March 21, 2019. District Court Judge Haywood S. Gilliam, Jr. took the motion under submission at the hearing. At the time of this writing the Court has not issued its decision.

***Liberty Surplus Ins. Corp. v. Ledesma & Meyer Constr. Co., Inc.*, Case No. 14-56120 (9th Cir.)**. The following is an update on *Liberty Surplus Insurance Corp. v. Ledesma & Meyer Construction Co., Inc.*, that was covered previously in Volume 24, No. 1 (Fall 2018) of the *California Regulatory Law Reporter*. [[24:1 CRLR 227](#)]

On October 19, 2018, the United States Court of Appeals for the Ninth Circuit [reversed and remanded](#) the district court’s finding that L&M’s negligent hiring, retention, and supervision of a worker was too attenuated from the injury-causing conduct to constitute an “occurrence” under Liberty’s commercial general liability policy. The general policy covered “bodily injury” “caused by an occurrence.” Occurrence was later defined as an “accident.” The appellate judge went to general tort principles and stated that, “as long as a defendant’s conduct is a ‘substantial factor’ in bringing about a plaintiff’s injury, causation is established.” The judge called for the reversal of the district court’s summary judgment ruling in favor of Liberty and the case was remanded back to district court to decide the impending issue of whether or not the school district was an additional insured under the insurance policy.

***New York v. United States Dep’t of Labor*, Case No. 18-747 (JDB) (D.D.C.)** The following is an update on *New York v. United States Dep’t of Labor*, which was covered previously in Volume 24, No. 1 (Fall 2018) of the *California Regulatory Law Reporter*. [[24 CRLR 229](#)]

On March 28, 2019, the court [found](#) that the U.S. Department of Labor’s AHP rule, interpreting the definition of “employer” more broadly, is unlawful under the Employee

Retirement Income Security Act of 1974. The rule would have allowed small businesses and individuals to band together to create group health plans. In his ruling, the judge stated that “[t]he final rule is clearly an end-run around the ACA. The final rule was designed to expand access to AHPs in order to avoid the most stringent requirements of the ACA.” The court vacated the rule and remanded it to the Department of Labor for reconsideration.

Shonetta Crain, et al. v. Accredited Surety & Casualty Co., et al., Case No. RG19004509 (Super. Ct., Alameda County). On January 29, 2019 in *Shonetta Crain and Kira Serna v. Accredited Surety and Casualty Company et al.*, plaintiffs filed a class action [complaint](#) in superior court against various sureties, bail agencies, bail agent associations, and individuals alleging that defendants have engaged in acts to restrain trade and commerce, and price fixing of commercial bail bond premiums sold to plaintiffs and members of the class in violation of the Cartwright Act. Plaintiffs further allege that defendants’ actions to restrain trade and fix prices in the market for commercial bail bonds constitute unfair competition and unlawful, unfair, and fraudulent business acts and practices in violation of California Business and Professions Code sections 17200 *et seq.* Defendants Seaview Insurance Company and Two Jinn, Inc. filed a notice of removal to the Northern District of California on March 8, 2019 (Case No. 4:19-cv-1265). A case management hearing was set for April 24, 2019, before Judge Jon S. Tigar.

The legislation, [SB 10 \(Hertzberg\) \(Chapter 244, Statutes of 2018\)](#), was signed by Gov. Jerry Brown in August 2018. It would make California the first state to eliminate the requirement that a defendant post monetary bail, in an amount based on the seriousness of the charges, to be freed while awaiting trial. After the legislation was signed, a coalition of bail bond industry groups attempted to block California’s historic overhaul of the bail system by submitting enough

signatures for a statewide referendum on the law in 2020.¹ [[24:1 CRLR 224-225](#)] Subsequently SB 36 (Hertzberg) was introduced on December 3, 2018. [*see* LEGISLATION]

Pharmaceutical Research & Manufacturers of America v. Brown, Case No. 2:17-cv-02573-MCE-KJN (E.D. Cal.). On October 26, 2018, on the Court's own motion and pursuant to Local Rule 230(g), U.S. District Judge Morrison C. England, Jr. of the Eastern District of California [vacated](#) the December 13, 2018, hearing on Defendant's Motion to Dismiss without appearance and argument, in *Pharmaceutical Research and Manufacturers of America v. Brown*. (This case involves the constitutionality of [SB 17 \(Hernandez\) \(Chapter 603, Statutes of 2017\)](#), a bill challenged by Petitioner PhRMA in this lawsuit, which 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.). The order also provided that the opposition or statement of non-opposition and reply shall be filed in accordance with the original motion hearing date and, if the court determines that oral argument is needed, it will be scheduled at a later date. To date, oral argument has not been scheduled. At this writing, motions and responses have been submitted by both parties and are pending.

As reported previously, on September 28, 2018, Petitioner 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 (thus violating these corporation's asserted first amendment rights); additionally, PhRMA alleges that the bill interferes with interstate commerce. In its prayer for relief, PhRMA seeks an injunction to

¹ See Jazmine Ulloa, [Bail Bond Industry Moves to Block Sweeping California Law, Submitting Signatures for a 2020 Ballot Referendum](#), SAN DIEGO UNION-TRIBUNE: NEWS (Nov. 20, 2018 4:05 PM).

prevent California from implementing and enforcing SB 17, and a declaration that the statute is unconstitutional. [[24:1 CRLR 229–231](#)]

Other pharmaceutical companies have followed PhRMA’s lead and filed lawsuits to prevent the enforcement of SB 17. On December 11, 2018, Petitioner Amgen Inc., filed a Petition for Writ of Mandate and declaratory and injunctive relief in superior court to prevent disclosure of its confidential, proprietary, and trade secret drug pricing information that it was required to provide to the California Correctional Health Care Services (CCHCS) in *Amgen Inc. v. The California Correctional Health Care Services*, No. 18-step-03147 (Super. Ct. Los Angeles). According to the petition, in November and December 2018, CCHCS, informed Amgen that it had received Californian Public Records Act (CPRA) requests for the potential price changes that Amgen had provided to the agency. According to Amgen’s petition, SB 17 does not require drug manufacturers to publicly disclose potential increases in drug prices, nor does it modify the CPRA in any way.

On February 1, 2019, after consideration of the parties’ briefs and argument, in an eight-page order (the “PI Order”), the court granted Amgen’s preliminary injunction motion and ordered that Amgen’s SB 17 notice should not be disclosed pursuant to a Public Records Act request until Petitioner effectuates a price increase for the medications in the notice. At this writing, Defendant CCHCS’s appeal is pending.

A similar ruling was also [granted](#) in *Ipsen Biopharmaceuticals, Inc. v. California Public Employees’ Retirement System, et al.*, No. CPF-18-516445 (Super. Ct. San Francisco). On December 13, 2018, the superior court judge granted Ipsen Biopharmaceuticals, Inc.’s order to show cause and temporary restraining order against defendants The California Public Employees’ Retirement System (CalPERS), and the CCHCS. CalPERS and CCHCS are ordered to show cause

why a preliminary injunction should not be ordered, pending trial in this action, restraining and enjoining defendants from disclosing the content of any Ipsen confidential pricing information submitted in accordance with the section 127677 of the Health and Safety Code, as responsive to the California Public Records Act request received or to be received requesting such information.

On February 27, 2019, the court issued an [order](#) on joint stipulation regarding stay of proceedings in this action. The court stated that there is “substantial overlap between the claims, issues, and parties involved in this case and the Los Angeles litigation (*Amgen Inc. v. The California Correctional Health Care Services*); and therefore, the outcome of proceedings relating to the preliminary injunction motion in the Los Angeles case will affect the scope and conduct of this case. According to the order, the parties stipulate and agree that all proceedings in this litigation shall be stayed while the preliminary injunction in the Los Angeles litigation remains in effect and the stay will automatically expire if the preliminary injunction in the Los Angeles litigation is terminated. The order also stipulates, in the event that an order issued terminates the preliminary injunction in the Los Angeles litigation, CalPERS and CCHCS shall continue to withhold Ipsen’s allegedly confidential and proprietary information for a period of 21 days from the issuance of the order. If Ipsen moves for a preliminary injunction during that 21-day period, CalPERS and CCHCS shall continue to withhold Ipsen’s allegedly confidential and proprietary information until a ruling on that motion is issued.

Not all parties requesting preliminary injunctions against agencies are being granted so quickly. On October 26, 2018, the Plaintiffs’ motion for preliminary injunction was heard and taken under advisement in *Association for Community Affiliated Plans, et al. v. United States Department of Treasury, et al.*, Case No. 1:18-cv-02133-RJL (D.D.C.). The court [stated](#) that it

would not be possible to complete an opinion in this case within a few weeks because it's too complicated, too large, and too consequential, and then the court went into recess.

On November 12, 2018, upon consideration of Plaintiffs' notice of withdrawal of motion for a preliminary injunction and motion for expedited briefing schedule, and defendants' response, the court ordered a hearing on the parties' cross-motions for summary judgment to be held on February 19, 2019. However, on December 31, 2018, Judge Richard J. Leon granted the Defendants' motion to stay proceedings in light of a lapse of appropriations to the Department of Justice. On March 1, 2019, Judge Leon ordered that the stay in this case be lifted and Defendants' motion to modify the briefing schedule be granted. At this writing, all parties and numerous *amici curiae* are briefing the case; no further arguments have been held.

State Farm General Insurance Company v. Jones, No. 37-2016-00041469-CU-MC-CTL (Super. Ct. San Diego). On February 5, 2019, in *State Farm General Insurance Company v. Jones*, the judge in the superior court action entered [judgment](#) for State Farm and awarded State Farm its statutorily permitted costs of the proceeding. The judge further ordered that a peremptory writ of mandate be issued to remand the matter to the Commissioner and command the Commissioner to set aside the Department's November 7, 2016 Order Adopting Revised Proposed Decision in the Matter of the Rate Application of State Farm General Insurance Company, File No.: PA-2015-00004 ("November 7, 2016 Order"), insofar as the November 7, 2016 Order is inconsistent with the March 23, 2018 Order. The court retained jurisdiction until the Commissioner's required actions are accepted by the court. 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: its primary argument was rather than considering the investment income of State Farm General in making his rate decision, Commissioner Jones also considered the investment income of 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 235–236](#); [24:1 CRLR 230–231](#)]

On February 5, 2019 State Farm filed its notice to appeal the judgment. On February 25, 2019, both Consumer Watchdog and Commissioner Lara filed their respective notices of cross-appeals.

***State Farm General Ins. Co., et al. v. Pacific Gas & Electric Co.*, 34-2018-00247024-CU-MT-GDS (Super. Ct. Sacramento).** On December 21, 2018, in *State Farm General Insurance Company v. Pacific Gas and Electric Company*, plaintiffs filed their [complaint](#) in superior court alleging that defendant PG&E failed to reasonably inspect, maintain and monitor power lines, and keep power lines “in a safe condition at all times to prevent fires.” Plaintiff alleges these failures ultimately causing the Camp Fire in Northern California. In its complaint, plaintiff also acknowledged the other cases that plaintiff brought against PG&E regarding the same and similar issues. On February 13, 2019, plaintiff State Farm General Insurance, filed a notice of stay due to PG&E’s petition for bankruptcy. (*See, e.g., State Farm General Ins. Co. v. Pacific Gas & Electric Co.*, Case No. 19CV000203 (Super. Ct. Monterey), filed Jan. 14, 2019. This case was stayed as of February 19, 2019 following PG&E’s notice of bankruptcy.)

Additionally, Attorney General Becerra outlined a variety of scenarios under which the embattled utility (PG&E) could face criminal charges in the Camp fire or other deadly blazes since 2017 in his [amicus brief](#) submitted to a federal judge overseeing the criminal case following PG&E’s fatal 2010 pipeline explosion in San Bruno at the court’s request.

In re Wells Fargo, Case No. LA201600665-AP (Insurance Commission). On January 2, 2019, DOI [published](#) a press release announcing a \$10 million penalty as part of a [settlement agreement](#) in *In re Wells Fargo*, pending before the insurance commissioner. The accusation resulted from Insurance Commissioner Dave Jones' investigation from 2008 to 2016, which found that Wells Fargo customers were issued approximately 1,500 insurance policies without their knowledge or permission. [[23:1 CRLR 206](#); [23:2 CRLR 215](#); [24:1 CRLR 206](#)] As part of the settlement, Wells Fargo agreed to leave the personal insurance business. \$5 million of the penalty is due immediately, and the remaining \$5 million is required only if Wells Fargo returns to the California insurance marketplace.

State of California v. AbbVie Inc., Case No. RG18893169 (Super. Ct. Alameda). On September 18, 2018, DOI initially [filed](#) suit in superior court against AbbVie Inc. alleging 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. [[24:1 CRLR 206](#)] On October 19, 2018, AbbVie [removed](#) the case to the United States District Court for the Northern District of California. Defendant AbbVie filed its motion to dismiss on October 26, 2018 for which the court set a hearing on December 4, 2018 then took off calendar on October 29, 2018. On November 2, 2018, Defendant AbbVie declined magistrate judge jurisdiction and the case was reassigned to District Judge James Donato on November 5, 2018. On November 19, 2018, plaintiffs filed a joint motion to remand. On February 7, 2019, the court ordered the case stayed. At this writing, the case remains stayed.

State of California v. Azar, Case No. 18-15144 (9th Cir.). On December 13, 2018, in *State of California v. Azar*, a three-justice panel of the Ninth Circuit [upheld](#) an injunction preventing the

Trump administration from broadly excusing nonprofits and others from having to provide contraceptive coverage to workers but limited the order to California and four other states. Thus, effectively in California, nonprofit agencies cannot deny contraceptive coverage for their employees.

By way of background, the decision outlines how the ACA and its implementing regulations require group health plans to cover contraceptive care without cost sharing. The defendant federal agencies issued two interim final rules (IFRs) exempting employers with religious and moral objections from this requirement. California, Delaware, Maryland, New York, and Virginia sued to enjoin the enforcement of the interim final rules, and the district court issued a nationwide preliminary injunction based on the states' likelihood of success on their Administrative Procedures Act (APA) claim. *State of California v. Azar*, 911 F.3d 558, 566 (9th Cir. 2018). Plaintiff states alleged that the IFRs were procedurally invalid.

On appeal, the Ninth Circuit panel held that the five states, including California, had standing to sue on their procedural APA claims, and had shown that the threat to their economic interests was reasonably probable, since women denied contraceptive care through their employers would access state funds or programs to obtain contraceptives. *Id.* at 571. However, the Ninth Circuit panel's affirmation of the preliminary injunction went only as far as the plaintiff states, and they vacated the portion of the injunction barring enforcement in other states as overbroad. *Id.* at 575–76.