

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.

On May 16, 2017, Commissioner Jones [appointed](#) Ken Schnoll as DOI General Counsel. According to the Commissioner, "Schnoll brings more than 30 years' experience to his new role, including work in regulatory and transactional matters with health insurers and property-casualty insurers." Most recently, Schnoll was a partner at Dentons US LLP, where he focused on insurance regulation and health care practices.

On October 5, 2017, Commissioner Jones [announced](#) his promotion of Amorette Yang, then chief of DOI's Community Programs and Policy Initiatives branch, to the position of deputy commissioner of the same branch. Yang replaces Chris Shultz, who left DOI to become chief deputy director of the Department of Consumer Affairs. Yang joined DOI after serving as capacity building manager for the New York City Department of Youth and Community Development.

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; he has announced plans to run for California Attorney General. Several individuals have announced their intent to run for Insurance Commissioner, including Senator Ricardo Lara, a Democrat who is a member of the Senate Committee on Insurance, Banking, and Financial Institutions. Other Democrats who have expressed interest in the position are former Assemblymember Henry Perea, who resigned from his Assembly seat in December 2015 to take a job lobbying for the pharmaceutical industry; and Asif Mahmood, a pulmonologist from Los Angeles. Running as a Republican is Peter Kuo, an insurance agent from Santa Clara. Steve Poizner, who served as Insurance Commissioner as a Republican from 2007–2011, is running as an Independent for the post; Poizner is a businessman and technology entrepreneur.

MAJOR PROJECTS

Commissioner Commences Investigation of Wells Fargo

On August 8, 2017, Commissioner Jones [directed](#) DOI to investigate allegations that Wells Fargo and National General Insurance improperly charged consumers for “force-placed” or “lender-placed” automobile insurance for consumers who had auto loans with Well Fargo. “Force-placed” insurance refers to insurance that a lender requires a borrower to purchase by signing up the borrower for the insurance to cover the vehicle in case the borrower fails to get his/her own insurance or allows auto insurance to lapse.

The Commissioner's order regarding Wells Fargo follows several troubling events, including (1) Wells Fargo's recent admission that between May 2011 and July 2015, thousands of its employees opened over two million unauthorized deposit and credit card accounts incurring approximately \$2.4 million in fees for bank customers (for which the bank was fined over \$100 million in September 2016 by the federal Consumer Financial Protection Bureau); and (2) DOI's December 2016 [announcement](#) that it would investigate allegations made by former employees of Prudential Insurance Company that Wells Fargo employees signed up consumers for life insurance without the consumers' authorization.

The Commissioner's directive also follows Wells Fargo's July 27, 2017 [news release](#) acknowledging that it failed to properly manage the auto insurance program; stating that approximately 570,000 customers may have been impacted; and announcing that it would issue refunds and compensation to the tune of almost \$80 million, and would additionally assist impacted consumers in correcting their credit reports.

At this writing, DOI's investigation into the auto insurance allegations is ongoing.

State Farm Issuing \$13 Million in Refunds to Overcharged Californians

On May 11, 2017, Commissioner Jones [announced](#) that State Farm has issued over \$13 million in refunds to over 240,000 Californians who have been overcharged for homeowners' and renters' rates—but only after losing twice in court.

In late 2014, State Farm requested permission to raise its homeowners', renters', and condominium rates by an average of 6.9%. On November 7, 2016, Commissioner Jones not only [rejected](#) the company's proposed rate increase, but also ordered State Farm

to reduce its rates (effective December 8, 2016) by 7% overall after lengthy public hearings in which the Commissioner found that State Farm's rates were excessive; additionally, Commissioner Jones ordered State Farm to refund more than \$100 million in excessive rates collected since July 15, 2015. State Farm responded by [suing](#) the Commissioner in San Diego County Superior Court on November 23, 2016, seeking a stay while it challenges the Commissioner's reduction order (which could take years). The court denied State Farm's request and ordered the rate reductions to go into effect immediately. After the company refused to comply with that order, DOI filed a [notice of noncompliance](#) and threatened enforcement action; State Farm again sought court intervention, which was denied.

As a result, the company began to issue refunds (with interest) to customers who were overcharged from December 8, 2016 through mid-February 2017. At this writing, State Farm's lawsuit challenging DOI's rate reduction order is still pending in San Diego County Superior Court.

Reinsurance Oversight Regulations

On June 16, 2017, the Department published [notice of its intent](#) to amend sections 2303–2023.22 (nonconsecutive), and to adopt new sections 2303.23–.28, Title 10 of the CCR; this proposal amends DOI's reinsurance oversight regulations to clarify the principal requirements of substance and procedure in accounting for reinsurance on insurer financial statements, the general requirements applicable to reinsurance agreements, and related sanctions and oversight.

Reinsurance is an arrangement wherein an insurer, or cedent, transfers some or all of the risk that it has assumed under a policy or group of policies to a reinsurer. In this contractual relationship between the insurer and the reinsurer, the reinsurer agrees to indemnify the cedent for a portion of the premium as consideration for the risk assumed. As a contract of indemnity, the reinsurer's obligation is to reimburse the cedent for the agreed-upon percentage of assumed risk, meaning the reinsurer does not owe the cedent anything unless and until the specific contractual requirements have been met. The reinsurer does not have any contractual liability to the policyholder as there is no privity of contract between the reinsurer and the insured. Insurance Code section 900 *et seq.* requires every insurer in the state to file annual financial statements prepared by a certified public accountant. The determination of the provision of credit for reinsurance on a cedent's financial statement is based on statutory accounting principles and regulatory requirements; these rules and laws determine when credit will be allowed to the cedent for reinsurance ceded as either an asset or a deduction from liability. Insurance Code sections 922.1–.8 provide when credit for reinsurance will be allowed to a domestic ceding insurer as an asset or a deduction from liability on account of reinsurance ceded when specific requirements are met.

Many of the Department's proposed amendments to its reinsurance oversight regulations—which were originally adopted in 2006—are technical in nature; however, several proposed changes are substantive and come in response to changes in federal and state law.

The 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act included, as a separate subtitle, the Nonadmitted and Reinsurance Reform Act (NRRA). Under the

NRRA, no state may deny financial statement credit for reinsurance if the credit is recognized by the ceding insurer's state of domicile; further, it provides that the laws of nondomestic states, except those with respect to taxes and assessments on insurance companies, are preempted to the extent they apply to reinsurance agreements. The NRRA further provides that for a defined category of insurers principally engaged in the business of reinsurance ("Professional Reinsurers"), the state of domicile shall be solely responsible for regulating solvency. Finally, nondomestic states are specifically prohibited from requiring Professional Reinsurers to provide financial information other than the financial information required by their domiciliary state. In 2011, the Commissioner implemented some of the requirements of the NRRA through his adoption of [Bulletin No. 2011-2](#), but others must be made by way of formal rulemaking. The instant rulemaking amends sections 2303.14, 2303.15, and 2303.21 to bring them into compliance with Bulletin No. 2011-2 and the NRRA.

The Department also proposes revisions to its reinsurance oversight regulations in response to changes in state law. Specifically, [SB 1216 \(Lowenthal\) \(Chapter 227, Statutes of 2012\)](#) made significant changes to the credit for reinsurance statutes found in Insurance Code section 922.1 through 922.8. SB 1216 amended Insurance Code section 922.6, which had previously authorized the Commissioner to impose specific credit for reinsurance accounting requirements on foreign insurers, to provide that the Commissioner could no longer deny financial statement credit to a foreign ceding insurer to the extent that credit is recognized by the cedent's domestic state if that state is accredited by the National Association of Insurance Commissioners (NAIC) or has financial solvency requirements

substantially similar to the requirements necessary for NAIC accreditation. The instant rulemaking further amends sections 2303.14 and 2303.15 to comply with SB 1216.

New sections 2303.23 through 2303.28 adopt [NAIC's Model Regulation #787](#), also known as the Term and Universal Life Insurance Reserve Financing Model Regulation, which addresses when credit for reinsurance will be provided to California domiciled life insurers for reinsurance treaties that cede liabilities pertaining to non-grandfathered life insurance policies with guaranteed non-level gross premiums and/or guaranteed non-level benefits. NAIC's Model Regulation #787 is expected to become an accreditation standard as early as January 1, 2020.

Following a July 31, 2017 public hearing on these proposed amendments, Department staff prepared modified text of some of the changes in response to comments, and released that [modified text](#) on August 28, 2017 (and subsequently clarified them in a [revised notice](#) issued on August 31, 2017). The Department sought public comments on the modified provisions until September 15, 2017. Having received no comments, staff is finalizing the language of the amendments and preparing the rulemaking file for submission to the Office of Administrative Law.

LEGISLATION

Health/Disability Legislation

[SB 223 \(Atkins\)](#), as amended September 5, 2017, amends section 10133.8 and adds section 10133.11 to the Insurance Code regarding language assistance services and qualifications for interpreters provided by health insurers to insureds with limited English proficiency (LEP).

Amended section 10133.8 requires health insurers to provide written notice in specified documents of the availability of interpretation services in the top fifteen languages spoken by LEP individuals in California, identified annually as determined by the Department of Health Care Services. The amendments to section 10133.8 require interpreters to have demonstrated proficiency in English and the target language, and knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems. Additionally, an interpreter must adhere to generally accepted interpreter ethics and principles, including client confidentiality. The amendments also prohibit an insured from being required to provide his/her own interpreter, rely on an adult or minor child for interpretation services, or rely on a staff member who does not meet the new requirements for interpreters.

New section 10133.11 requires health insurers to notify insureds and members of the public of all of the following information: (1) the availability of language assistance services, including oral interpretation and translated written materials, and how to access these services free of charge and in a timely manner; (2) the availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats; (3) the health insurer does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identify, sexual orientation, age, or disability; (4) the availability of a grievance procedure, how to file a grievance, and how to submit the grievance to DOI after completing the grievance process or participating in it for at least 30 days; and (5) how to file a discrimination complaint with the U.S. Department of Health and Human Services' Office of Civil Rights. The new section requires health insurers to provide this information to an

insured within individual coverage upon initial enrollment and annually thereafter. The section also requires that the information be provided in a conspicuously visible location in the evidence of coverage; in or with materials that are routinely disseminated to the insurer's insureds at least annually; and on the insurer's Internet website in a manner that allows insureds, prospective insureds, and members of the public to easily locate the information. Governor Brown [signed](#) SB 223 on October 13, 2017 (Chapter 771, Statutes on 2017).

[SB 17 \(Hernandez\)](#), as amended on September 5, 2017, amends Insurance Code section 10181.45 and adds new section 10123.205 to the Insurance Code to promote transparency in prescription drug pricing, to enable measurement of the impact of prescription drug costs on the overall health insurance premium, and to provide information on prescription drug price increases to patients, state programs, employers, and other payers.

Beginning October 1, 2018, new section 10123.205 requires health insurers that report rate information to DOI through the existing small and large group rate review process to also report annually to DOI the following information on all covered prescription drugs: (1) the 25 most frequently prescribed drugs; (2) the 25 most costly drugs by total annual spending; and (3) the 25 drugs with the highest year-over-year increase in total annual spending. The new section also requires DOI to compile this information into a report for the public and legislators, and—beginning January 1, 2019—to post that report on its website.

The amendments to section 10181.45 require health insurers to annually report to DOI the following information on specified prescription drugs: (1) the percentage of the

premium attributable to prescription drug costs for the prior year for each category of prescription drugs; (2) the year-over-year increase, as a percentage, in per-insured, per-month total health insurer spending for each category of prescription drugs; (3) the year-over-year increase in per-insured, per-month costs for drug prices compared to other components of the health care premium; (4) the specialty tier formulary list; (5) the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available; and (6) information on the insurer's use of a pharmacy benefit manager (PBM), if any, including its name and which components of the prescription drug coverage are managed by the PBM.

SB 17 also adds new Chapter 9 (commencing with section 127675) to the Health and Safety Code, which requires manufacturers of certain prescription drugs that are purchased by state-regulated programs (including licensed health insurers) to notify the state at least 90 days in advance of the planned effective date of an increase in the wholesale acquisition cost of those drugs under specified circumstances. Governor Brown [signed](#) SB 17 on October 9, 2017 (Chapter 603, Statutes on 2017).

[SB 374 \(Newman\)](#), as amended June 12, 2017, adds section 10144.4 to the Insurance Code. The new section requires large group, small group, and individual health insurance policies to provide all covered mental health and substance use disorder benefits in compliance with the federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all rules, regulations, and guidance issued pursuant to MHPAEA. Governor Brown [signed](#) SB 374 on July 31, 2017 (Chapter 162, Statutes of 2017).

[AB 1048 \(Arambula\)](#), as amended September 8, 2017, adds section 4052.10 to the Business and Professions Code to permit pharmacists—beginning July 1, 2018—to dispense a Schedule II controlled substance as a partial fill (defined as a part of a prescription filled that is of a quantity less than the entire prescription). Additionally, the bill adds section 10123.203 to the Insurance Code, which requires health insurers—commencing July 1, 2019—to prorate an insured’s cost sharing for a partial fill of a prescription dispensed pursuant to Business and Professions Code section 4052.10. Section 10123.203 applies only to oral, solid dosage forms of prescription drugs. AB 1048 is intended to prevent the overprescription of opioids and minimize the number of pills available for unintentional or intentional diversion. Governor Brown [signed](#) AB 1048 on October 9, 2017 (Chapter 615, Statutes of 2017).

[SB 133 \(Hernandez\)](#), as amended September 12, 2017, and as it relates to DOI, amends section 10133.56 of the Insurance Code to require a health insurer, at the request of a newly covered insured under an individual health insurance contract, to arrange for the completion of covered services as set forth in existing law by a nonparticipating provider if the newly covered insured’s prior coverage was terminated under certain circumstances (including when a health benefit plan is withdrawn from any portion of a market). The bill also requires health insurers to provide notice as to the process by which an insured may request completion of covered services at the time the insurer sends a notice of termination of coverage notice to the insured. SB 133 is intended to ensure continuity of care to insureds suffering from a serious chronic condition and whose health insurer withdraws from a particular market while the insured is undergoing treatment. Governor Brown [signed](#) SB 133 on October 4, 2017 (Chapter 481, Statutes of 2017).

[AB 1074 \(Maienschein\)](#), as amended August 24, 2017, amends Insurance Code section 10144.51, which requires health insurers to provide coverage for behavioral health treatment (BHT) for pervasive developmental disorder or autism provided by a qualified autism service professional supervised and employed by a qualified autism service provider. AB 1074 revises those provisions to require a qualified autism service professional or a qualified autism service paraprofessional to be supervised by a qualified autism service provider for purposes of providing BHT. The bill requires a qualified autism service professional and a qualified autism service paraprofessional to be employed by a qualified autism service provider or an entity or group that employs qualified autism service providers. The bill additionally authorizes a qualified autism service professional to supervise a qualified autism service paraprofessional. The bill also revises the definition of a “qualified autism service professional” to, among other things, specify that the BHT provided by the qualified autism service professional may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider. According to the author, the bill is intended to update existing law relating to providers of BHT for children with autism to reflect existing practices and changes in the field, and remove unnecessary barriers and increase access to care. Governor Brown [signed](#) AB 1074 on September 30, 2017 (Chapter 385, Statutes of 2017).

[SB 562 \(Lara and Atkins\)](#), as amended May 26, 2017, is far-reaching and controversial legislation that would create the “Healthy California” program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state, regardless of their immigration status. Although the Senate passed the bill on June 1, Assembly Speaker Anthony Rendon

[held](#) the bill primarily because it does not identify how the program would be funded. [A. Desk]

Reinsurance Legislation

[AB 938 \(Cooley\)](#), as amended April 25, 2017, is an urgency bill that amends Insurance Code sections 922.4 and 922.5 to authorize the Commissioner to adopt regulations applicable to reinsurance arrangements relating to the valuation of assets or reserve credits, the amount or value of securities, and the extent to which credit will be reduced or eliminated for life insurance policies, long-term care insurance policies, and annuities. The bill also amends section 922.85 to limit the new rulemaking authority to reinsurance agreements covering the following insurance products: (a) life insurance policies with guaranteed non-level gross premiums or guaranteed non-level benefits; (b) universal life insurance policies with a secondary guarantee period; (c) variable annuities with guaranteed death or living benefits; (d) long-term care insurance policies; and (e) other life and health insurance and annuity products as to which NAIC adopts model regulatory requirements with respect to credit for reinsurance. The bill also specifies that any regulations adopted by the Commissioner pursuant to this new authority be based upon, and be consistent with, the current version of the NAIC model regulations to the extent they do not conflict with California law. Governor Brown [signed](#) AB 938 on September 1, 2017 (Chapter 202, Statutes of 2017) and it took effect on that date.

[SB 430 \(Committee on Insurance\)](#), as amended April 17, 2017, amends Insurance Code section 1063.2 to authorize the California Insurance Guarantee Association (CIGA)—an association of insurers created by legislation in 1969 that makes payments to

policyholders of property/casualty, workers' compensation and "miscellaneous" insurers when a member insurance company becomes insolvent—with the express approval of the Insurance Commissioner, to reinsure with, or transfer liabilities to, a California admitted and authorized reinsurer or other reinsurer approved by the Commissioner to limit or eliminate adverse development, to stabilize or limit the need for assessments, or to reduce its potential ultimate liability for covered claims, provided CIGA retains the ultimate responsibility to the policyholder or beneficiary for payment of claims covered by the reinsurance agreement. Any reinsurance agreement or transfer of liabilities shall be paid for using CIGA's available funds from one of its accounts and shall not be charged to administrative expense or allocated to any liquidation estate. The payment and discharge of covered claims shall be undertaken by the Association, either directly or through an authorized third-party administrator. Any recoveries from a reinsurance agreement or transfer of liabilities shall solely be the property of CIGA, shall not inure to the benefit of any liquidation estate, and shall be paid to CIGA's account from which the payment for the reinsurance or transfer of liabilities was made. SB 430 was [signed](#) by the Governor on September 23, 2017 (Chapter 268, Statutes of 2017).

Other Insurance-Related Legislation

[AB 1460 \(Dababneh\)](#), as amended June 12, 2017, amends Insurance Code sections 1734 and 1734.5 to allow an insurance agent and broker to hold fiduciary funds in a federally chartered bank or financial institution in any state. According to an Assembly analysis, 47 states already allow this practice. Governor Brown [signed](#) this bill on July 17, 2017 (Chapter 69, Statutes of 2017).

[AB 1641 \(Daly\)](#), as amended July 3, 2017, amends Insurance Code provisions relating to surplus line brokers. A surplus line broker is a DOI-licensed broker who—when a risk cannot be placed with an admitted insurer—is authorized (after the surplus line broker has conducted a “diligent search” among admitted insurers) to place the risk with an insurer that is not fully licensed in California, subject to specific rules and financial requirements. Existing Insurance Code section 1763.1 authorizes the Commissioner to allow placement of any type of insurance coverage or risk with a surplus line broker when he/she finds, after a public hearing, that there is not a reasonable or adequate market among admitted insurers; the Commissioner is required to maintain an “export list” of coverages so designated. AB 1641 amends section 1763.1 to additionally authorize the Commissioner to also add coverage (after holding a public hearing) for new, innovative products for which a reasonable or adequate market among admitted insurers has not had time to develop to the export list, allowing surplus line brokers to sell policies from a non-admitted insurer without fulfilling a diligent search requirement among admitted insurers.

Existing Insurance Code section 1780.50 *et seq.* creates a surplus line advisory (SLA) organization to assist the Commissioner in the regulation of surplus line brokers; all licensed surplus line brokers are members of the SLA. AB 1641 amends Insurance Code section 1780.52 to declare that any member of the National Association of Registered Agents and Brokers (NARAB), licensed as a surplus line broker in his, her, or its home state of residence or business and paying the applicable California license fee, is deemed to be a member of the SLA. This subdivision is not effective unless and until the SLA recognizes in writing the NARAB is incorporated and operating under its board-adopted

bylaws. Governor Brown [signed](#) AB 1641 on October 4, 2017 (Chapter 477, Statutes of 2017).

[AB 1699 \(Committee on Insurance\)](#), as amended September 7, 2017, amends numerous provisions of the Insurance Code to update the statutory fees in the Code to reflect the actual fees charged by DOI; the bill also requires the Department to notify the insurance committees of both houses of the legislature when it increases or decreases fees. Governor Brown [signed](#) AB 1699 on October 6, 2017 (Chapter 534, Statutes of 2017).

[AB 1398 \(Kalra\)](#), as amended June 20, 2017, is a Department-sponsored bill that adds section 10168.45 to the Insurance Code, which protects annuity owners from losing investment value if insurers delay processing annuity surrenders. AB 1398 requires insurers—for individual annuity contracts issued on and after January 1, 2019—to value the surrender of a fixed annuity on the date the insurer receives the surrender request from the consumer and then to process the surrender as expeditiously as possible, but no later than 45 days from the date the surrender request is received. Governor Brown [signed](#) AB 1398 on September 11, 2017 (Chapter 228, Statutes of 2017).

[AB 1696 \(Committee on Insurance\)](#), as amended September 7, 2017, is an omnibus bill that makes numerous technical nonsubstantive changes to the Insurance Code. Some of the more important changes include: (1) an amendment to section 1063.7 to clarify notice requirements when an insurer is liquidating; (2) an amendment to section 1622 to expand the categories of DOI licensees subject to a bond requirement; (3) an amendment to section 1682 to limit the number of times a licensure candidate may take examinations in a certain category; and (4) an amendment to Unemployment Insurance Code section 1095 to authorize the Employment Development Department to share information with

DOI peace officer investigators who are investigating life insurance and annuity fraud, property and casualty insurance fraud, organized automobile insurance fraud, and health or disability insurance fraud. Governor Brown [signed](#) AB 1696 on October 2, 2017 (Chapter 417, Statutes of 2017).

[SB 569 \(Monning\)](#), as amended August 28, 2017, adds new section 2085 to the Insurance Code. The new provision requires the Insurance Commissioner, in the case of a disaster declaration by the President or the Governor and at the request of a property owner or the property owner's legal representative that is unable to identify the insurer for a property located in the disaster area, to electronically provide the property owner's name, property location, and contact information to insurers who issue homeowners' insurance policies in the state. Governor Brown [signed](#) this bill on September 28, 2017 (Chapter 361, Statutes of 2017).

[SB 788 \(Lara\)](#), as amended August 31, 2017, amends Insurance Code section 1666.5 to permit an individual applying for, or a licensee renewing, certain types of insurance licenses to submit an individual taxpayer identification number in lieu of a social security number. This bill also restricts the sharing of sensitive information collected during the application process. Governor Brown [signed](#) SB 788 on October 4, 2017 (Chapter 487, Statutes of 2017).

LITIGATION

On May 10, 2017, the California Supreme Court [denied](#) Mercury Casualty Company's petition to review the Third District Court of Appeal's decision in *Mercury Casualty Company v. Jones*, 8 Cal. App. 5th 561 (Feb. 10, 2017), in which the Third

District rejected the insurance industry’s challenge to the Commissioner’s authority to preapprove homeowners’ insurance rates and to apply DOI regulations that exclude certain expenses from the regulatory calculations resulting in those rates.

The Third District’s decision and the Supreme Court’s refusal to review it represent the latest judicial responses to the insurance industry’s decades-long attempts to undermine Proposition 103, which was passed by California voters in 1988. Among many other things, Proposition 103 creates a “prior approval” system for rate setting in many lines of insurance (notably excluding health insurance), and required many insurers to roll back their 1988 rates and make refunds to policyholders. Since 1988, the industry has tried to undermine Proposition 103 by way of subsequent legislation (which is barred unless the legislation is passed by a two-thirds vote in each house and “furthers [Proposition 103’s] purposes”), litigation challenging almost every aspect of the initiative (including its constitutionality and—as in this matter—the validity of regulations adopted by the Commissioner to implement it)—most of which has been rejected, and even subsequent initiatives (which have been defeated).

In 2009, Mercury filed an application to increase its rates for three kinds of homeowners’ insurance policies by 6.9%–8.8%. After a public hearing in which consumer group Consumer Watchdog intervened, the Commissioner rejected Mercury’s request for a rate increase and in fact ordered Mercury to decrease its overall homeowners’ rates by 5.4% on two grounds. First, the Commissioner held that section 2644.10(f), Title 10 of the CCR, bars Mercury from including “institutional advertising expenses” (defined as “advertising not aimed at obtaining business for a specific insurer and not providing consumers with information pertinent to the decision whether to buy the insurer’s product”)

for ratemaking purposes because the Commissioner found that “Mercury General Corporation is the parent company for Mercury Casualty and 21 other entities.... Mercury General and all its affiliates advertise under the name ‘Mercury Insurance Group,’” and “Mercury does not allocate advertising expenditures to specific insurance affiliates nor does the advertising department distinguish between insurance entities when generating advertising campaigns.” As such, the Commissioner determined that Mercury’s entire advertising budget must be excluded from the rate application. Second, the Commissioner concluded that Mercury does not qualify for the constitutional variance available under section 2644.27(f)(9), Title 10 of the CCR, which permits an insurer to seek a variance from otherwise applicable ratesetting provisions if “the maximum permitted earned premium would be confiscatory as applied,” because “Mercury failed to demonstrate that the rate decrease results in deep financial hardship.” Mercury appealed the Commissioner’s decision to the Sacramento County Superior Court, which denied Mercury’s petition. Thereafter, Mercury (accompanied by several insurance company trade associations) appealed to the Third District Court of Appeal.

In a lengthy and detailed decision, the Third District rejected all of the arguments asserted by Mercury and the insurance industry (which the court captioned as “The Trades”), characterizing some of them as “little more than hocus pocus” and “smoke and mirrors.” The Third District first analyzed the “institutional advertising expenses” exclusion in section 2644.10(f), Title 10 of the CCR. On this issue, the superior court had ruled that “if Mercury wished to include its advertising expenses in the ratemaking calculation, it was required to show that (1) its advertising was aimed at obtaining business for a specific insurer *and* (2) provided consumers with information pertinent to the decision

whether to buy the insurer’s product” (italics original). On appeal, Mercury contended that it is entitled to include its advertising costs in the ratemaking calculation if it can show that either of the criteria in section 2644.10(f) are met. The appellate court disagreed, finding that the regulation “does not set forth two criteria that are to be separately analyzed and applied. Instead, the regulation sets forth a singular, unified definition of what constitutes ‘[i]nstitutional advertising’ . . . aimed at obtaining business for a specific insurer.” The court agreed with the Commissioner’s finding that Mercury General and all its affiliates advertise under the name “Mercury Insurance Group,” which is not a legal entity in any state and not a licensed insurer in California; as such, Mercury’s advertising is not aimed at obtaining business for a specific insurer, contrary to the requirement in section 2644.10(f). The appellate court rejected a phalanx of industry arguments in support of its contention that the Commissioner’s regulation and his interpretation of that regulation are invalid, and also rejected a First Amendment challenge to the constitutionality of section 2644.10(f), finding that the regulation survives the “strict scrutiny” test because it is narrowly tailored and promotes a compelling government interest (that is, prohibiting excessive insurance rates and ensuring that insurers like Mercury pass on to consumers through their insurance premiums only expenses for advertising that directly benefits them by providing them with information pertinent to consumers’ decision whether to buy a specific insurer’s product).

Second, the Third District briefly entertained the industry’s contention that Mercury should be afforded a “constitutional variance” under section 2644.27(f)(9); that regulation provides for a variance from the regulatory formula for fixing rates if “the maximum permitted earned premium would be confiscatory as applied,” as articulated in *20th Century v. Garamendi*, 8 Cal. 4th 216 (1994) (which case citation is expressly

incorporated into the regulation). Again confronted with a myriad of challenges to the Commissioner's and the superior court's conclusions on this issue, the Third District held "Mercury contends the commissioner and the superior court erred in rejecting the 'fair rate of return' standard of confiscation in favor of the 'deep financial hardship' standard, but we find no such error." On October 10, 2017, Mercury filed a petition for certiorari with the U.S. Supreme Court.

On May 26 in *California FAIR Plan Association v. Garnes*, 11 Cal. App. 5th 1276 (2017), the First District Court of Appeal [reversed](#) a lower court decision and ordered FAIR to pay a homeowner whose house had been seriously damaged by a fire the amount that it would cost to repair her home minus depreciation (\$320,549) instead of the fair market value of the house at the time of the fire (\$75,000).

Marlene Garnes's home was seriously damaged—but not destroyed—by a kitchen fire in 2011. She had purchased fire insurance for the property, with a policy limit of \$425,000, from California FAIR Plan Association, California's insurer of last resort. Her policy was an "open policy" (meaning one in which the value of the subject matter is not agreed upon, but is left to be ascertained in cases of loss) and also an "actual cash value" (ACV) policy. She contended that—for a "partial loss to the structure"—Insurance Code section 2051 required FAIR to pay her "the amount it would cost the insured to repair, rebuild, or replace the thing lost or injured less a fair and reasonable deduction for physical depreciation" or "the policy limit, whichever is less." FAIR contended that Garnes's loss was total because the cost to repair exceeded the home's fair market value, and that Garnes was entitled only to the fair market value under section 2051.

The First District analyzed in great detail the plain meaning of the language used in Insurance Code sections 2051, 2070, and 2071; their relevant legislative history (including 2004 amendments to section 2051 clarifying the definition of “actual cash value”); and the Insurance Commissioner’s interpretation of the statutes (Commissioner Jones had submitted an *amicus curiae* brief in support of Garnes’s position), and concluded that Garnes’s interpretation of the statutes is correct.

In particular, the court noted that FAIR relied heavily on a 1970 California Supreme Court decision for its definition of the term “actual cash value” (which, at that time, was synonymous with “fair market value”), whereas the legislature amended section 2051 in 2004 as part of the “Homeowners’ Bill of Rights.” According to the First District, the 2004 amendments provide that

[f]or a total loss, the Legislature determined ‘actual cash value’ means the *lesser* of fair market value of the structure *or* the policy limit. For a partial loss to the structure or loss to its contents, it means the *lesser* of the cost to repair or replace the thing lost or injured minus a reasonable deduction for physical depreciation *or* the policy limit (italics original).

Additionally, the court noted that in 2006, the Insurance Commissioner amended section 2695.9, Title 10 of the CCR, to provide that

under a policy, subject to California Insurance Code Section 2071, where the insurer is required to pay the expense of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality, the measure of recovery is determined by the actual cash value of the damaged or destroyed property, as set forth in California Insurance Code Section 2051.

The First District noted that “[t]he Commissioner maintains this interpretation in his *amicus curiae* brief, and it deserves significant deference.”

On August 9, 2017, the California Supreme Court denied FAIR's petition for review of the First District's decision.