Insurance Law Committee Annual Report On Developments in California Insurance Law – 2010

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This article reviews significant developments in three areas of California insurance law: legislation, published case law, and insurance regulations.

Legislation

The following are a few significant insurance related bills that were signed into law during 2010 and went into effect January 1, 2011 (unless otherwise specified in the law or in this article).

Health

AB 1602 (Perez)

California Health Benefit Exchange Chapter 655

In conjunction with SB 900 (Alquist), this bill enacts the California Patient Protection and Affordable Care Act and creates the California Health Benefit Exchange. This legislation requires the board governing the Exchange to begin to facilitate the purchase of health plans through the Exchange by January 1, 2014. The bill also requires the board to determine the minimum requirements that a carrier must meet to be considered for participation in the Exchange.

AB 2244 (Feuer)

Children's Guarantee Issuance Chapter 656

In response to the provision under the federal Patient Protection and Affordable Care Act (PPACA), which prohibits a health insurer from denying coverage because of preexisting conditions for children, this bill establishes an initial open enrollment period for the guaranteed issuance of coverage for children under 19 beginning January 1, 2011 and ending 60 days after. The bill also establishes an annual open enrollment period each year tied to the month of a child's birthday. During the enrollment periods or for late enrollees, health insurers will not be able to rate for any child due to health status more than two times the standard risk rate. If a child who is not a late enrollee fails to maintain coverage with any health plan or health insurer for the 90-day period prior to the date of the child's application, then they will receive a 20-percent surcharge above the highest allowable rate. The surcharge will only apply for the 12-month period following the effective date of the child's coverage. Finally, a health insurer will be prohibited from offering new individual plan contracts or policies in California for 5 years if it does not, or ceases to, write new plan contracts or policies for children.

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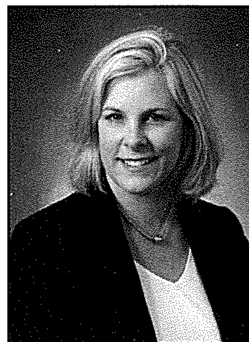

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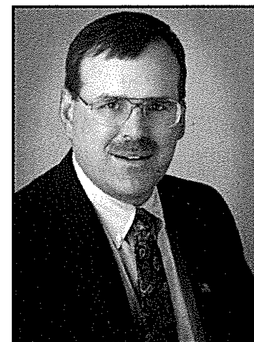
Kimberley Dellinger Dunn serves as General Counsel for the Personal Insurance Federation of California (PIFC), a nonprofit insurance trade association whose members are insurers specializing in personal lines of insurance. She represents those companies before the Legislature and the Department of Insurance on legislative and regulatory issues, and manages general legal matters for the association.



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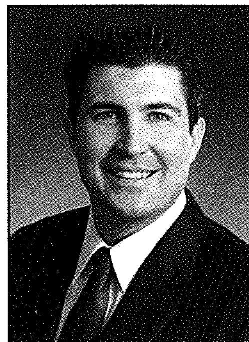

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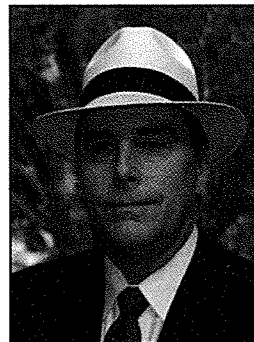

William L. Gausewitz
William Gausewitz is a partner in the Sacramento office of Michelman & Robinson, LLP. He is a member of the firm's Regulatory and Administrative Department. He has previously served as Counsel to the Commissioner in the California Department of Insurance, and as Director of the California Office of Administrative Law.

AB 2470 (De La Torre)

Cancellation and Rescissions of Individual Policies Chapter 658

Prohibits a health insurer or health plan from rescinding a policy or contract once an insured is covered unless the insurer or plan can demonstrate that the insured has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy or contract. Requires an insurer or plan to send a notice to the subscriber or enrollee, or insured or policyholder, at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the insured or policyholder of his or her right to appeal that decision to the California Department of Insurance (CDI) or Department of Managed Health Care (DMHC). The bill also requires insurers or plans to continue to provide coverage under the policy or plan during any appeal.

SB 227 (Alquist)

Temporary High Risk Pool Chapter 31

In conjunction with AB 1887 (Villines), requires the Managed Risk Medical Insurance Board (MRMIB) to enter into an agreement with the federal Department of Health and Human Services to administer a temporary high risk pool to provide health coverage until January 1, 2014 to individuals that have preexisting conditions, consistent with the federal Patient Protection and Affordable Care Act (PPACA). **Urgency Statute, Effective: June 29, 2010.**

SB 900 (Alquist)

California Health Benefit Exchange Chapter 659

In conjunction with AB 1602 (Perez), establishes the California Health Benefit Exchange (the Exchange). Requires the Exchange to be governed by an executive board consisting of five members who are residents of California. Of the members of the board, two will be appointed by the Governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee will serve as a voting, ex officio member of the board.

SB 1088 (Price)

Dependent Coverage Chapter 660

Prohibits the limiting age for dependent children covered by individual and group health insurance policies from being less than 26 years of age with respect to policy years beginning on or after September 23, 2010.

SB 1163 (Leno)

Health Care Premium Rate Review Chapter 661

Requires health insurers in the individual and small group markets to file all required rate information with the Department of Insurance sixty days prior to implementing a rate change. For large group health insurance policies, only rate information for "unreasonable" rate increases need to be filed at least sixty days prior to implementing any rate change. Also requires information submitted to the Department to be certified by an independent actuary as actuarially sound and to determine if the rate increase is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies.

Property/Casualty

AB 41 (Solorio)

Insurance: Community Development Investments Chapter 340

Amends existing law that requires insurers to provide information to the Commissioner of Insurance on all community development and community infrastructure investments and requires the Commissioner to provide certain information on such investments to the public. Provides final filing and public reporting dates. States certain insurers could meet the filing requirements through a single specified filing. Requires the biannual filing of a policy statement on insurer's community investments.

AB 953 (Eng)

Motor Vehicles: Records: Confidentiality Chapter 353

Amends existing law that requires the residence address in a record of the Department of Motor Vehicles to be kept confidential, with an exception that applies when an insurance company requests information for obtaining the address of another motorist or vehicle owner involved in an accident with the company's insured. Expands that exception to include an authorized contractor acting on behalf of the insurance company. This legislation would require an insurance company to be responsible for any misuse of the information by the contractor and would also subject the contractor to, among other things, the requirement that the information obtained from the department be destroyed once the contractor has used the information for the authorized purpose.

AB 1011 (Jones)

Insurance: Green Investments Chapter 418

Includes green investments as community development investments for insurers. Requires the Insurance Commissioner, on the department's website, to biannually identify those insurers that

make investments that qualify as green investments and the aggregate amount of identified insurer investments in green investments.

AB 1597 (Jones)

Assigned Risk Plans: Low-Cost Automobile Insurance Chapter 234

Amends existing law that provides for the Low-Cost Automobile insurance program. Requires a certain public notice regarding the approval and issuance of the plan. Modifies the notice and the effective dates of coverage under the plan. Extends the program expiration date to January 2016. Revises the plan reporting requirements and extends the no-financial responsibility requirement in specified cities and counties.

AB 1708 (Villines)

Insurance: Surplus Line Brokers Chapter 362

Requires the total capital and surplus requirement of a surplus line broker, as well as the amount of assets to be used in calculating capital and surplus that consists of cash and those other specified types of securities, to be at least specified amounts. Provides capital and reserve requirements for nonadmitted insurers. This legislation relates to the determining factors for financial stability of insurance exchanges.

AB 1837 (Gaines)

Insurance Transaction: Nonadmitted Insurers Chapter 581

Amends existing law that limits the ability of a surplus lines broker to place any coverage with a nonadmitted insurer. Authorizes an insurer domiciled in the state to have common directors with an affiliated nonadmitted insurer provided those directors do not constitute a majority of the voting authority and do not perform any management functions for the insurer in this state. Authorizes an insurer domiciled in the state to perform specified administrative, claims adjusting, and investment services.

AB 1871 (Jones)

Motor Vehicle Insurance Coverage: Vehicle Sharing Chapter 454

Prohibits a private passenger motor vehicle from being classified for insurance purposes as a commercial, for-hire, or permissive use vehicle, or livery solely on the basis of it being used for personal vehicle sharing program if it meets certain conditions. Requires the personal vehicle sharing program to provide insurance coverage and limits insurance liability.

AB 2022 (Gaines)

Property Insurance: Residential Disclosure Chapter 589

Revises the mandatory language of the State Residential Property Insurance Disclosure to simplify and rearrange the description of types of coverage and to include additional information concerning insurance limits. Revises and simplifies the Residential Property Insurance Bill of Rights. **Effective: July 1, 2011**

AB 2404 (Hill)

Insurance Chapter 387

Requires that any insurance policy that includes a provision to refund a premium other than on a pro rata basis, including the assessment of cancellation fees, disclose that fact. Disclosure would include the actual or maximum fees or penalties applied, which is permitted in the form of percentages of the premium. This bill provides that such disclosure is not required under certain conditions. Relates to the postponing of a market conduct examination by the Insurance Commissioner. The bill applies to policies issued or renewed on or after January 2012. **Effective: January 1, 2012, with the exception of Section 1, which relates to the disclosure requirements that would apply prospectively and only to policies issued or renewed on or after January 1, 2012.**

AB 2486 (Feuer)

Social Host Liability Chapter 154

Amends existing law under which a social host who furnishes alcoholic beverages to any person may not be held legally accountable for damages suffered by that person, or for injury, death, or property damage resulting from their consumption. Provides that these provisions do not preclude a claim against a parent, guardian, or another adult who knowingly furnishes alcoholic beverages at his or her residence to a minor person when it may be found to be the proximate cause of resulting injuries or death. **Section(s) Affected: An act to amend Section 1714 of the Civil Code, relating to social host liability.**

AB 2717 (Skinner)

Insurance: Agents/Brokers: Senior Designation: Use Chapter 606

Amends existing law that provides that an insurance broker or agent may not use a senior designation unless he or she has met certain conditions. Requires that the Insurance Commissioner approve such designation only if the organization that issues the designation satisfies specified requirements including accreditation standards, education and examination requirements, and has minimum standards and procedures regarding disciplining the organization's designees for improper or unethical conduct.

SB 156 (Wright)

Insurance: Fraud Prevention and Detection Chapter 305

Amends existing law that provides for the prevention, detection, and investigation of insurance fraud to include work-

ers' compensation and requires insurers to disclose such insurance fraud incidents. Authorizes the Department of Insurance to convene meetings with insurance companies to discuss information concerning suspected, anticipated, or completed acts of fraud. Protects a person sharing information pursuant to the authorization from civil liability for libel, slander, or other cause of action.

Case Review

California Supreme Court

In 2010, the California Supreme Court published the following four insurance law decisions:

Ameron International v. Insurance Company of Pennsylvania, 50 Cal. 4th 1370 (2010).

In *Foster-Gardner, Inc. v. National Union Fire Insurance Company*, 18 Cal. 4th 857, 887 (1998), the California Supreme Court held that the term "suit" in the coverage clause of a comprehensive general liability (CGL) policy meant "court proceedings initiated by the filing of a complaint." Based on this definition, the insurer in *Foster-Gardner* had no duty to defend its insured against an environmental agency's pollution abatement order and no obligation to indemnify the insured against the cost of the ordered environmental cleanup.

In *Ameron*, the court of appeal held that the *Foster-Gardner* rule excused CGL insurers from defending their insured in administrative law proceedings before the U.S. Department of Interior Board of Contract Appeals. The Supreme Court reversed the court of appeal's decision. Observing that the proceedings before the administrative law judge were initiated by a complaint and involved "22 days of trial, numerous witnesses, and substantial evidence," the supreme court unanimously held that this "quasi-judicial adjudicative proceeding, employed to resolve government demands against insured parties, is a 'suit' as a reasonable insured would understand that term" and therefore that a CGL policy covering "suits" provides coverage for proceedings before the Interior Department's Board of Contract Appeals.

Village Northridge Homeowners Association v. State Farm Fire and Casualty Company, 50 Cal. 4th 913 (2010).

Village Northridge Homeowners Association sought benefits for damages caused by the Northridge earthquake. State Farm paid more than $2 million under a policy with limits of $5 million, but disputed whether all of the claimed damage was caused by the earthquake. Village Northridge disputed State Farm's interpretation of the policy limits. The parties settled with State Farm paying an additional $1.5 million and Village Northridge releasing all of its known and unknown claims against State Farm.

Village Northridge then sued State Farm for fraudulently inducing the settlement agreement by misrepresenting the policy limits, but at the same time sought to affirm the settlement agreement and keep the $1.5 million State Farm paid under that agreement. The trial court sustained State Farm's demurrer without leave to amend. The court of appeal reversed, holding that rules requiring rescission of a settlement and release as a prerequisite to suing for fraudulent inducement did not apply in the insurance context.

The Supreme Court granted review. Reversing the court of appeal, the Supreme Court held that an " 'affirm and sue' " strategy is barred by both precedent and Civil Code section 1691 when the settlement agreement at issue includes a waiver of all known and unknown claims. Instead, the insured must proceed under the rules for rescission and restore the benefit received under the contract before suing for fraud in the inducement. However, the insured may seek to delay restoration until judgment under Civil Code section 1693 if restoration is impossible because the insured has already spent the settlement funds and the defendant cannot establish substantial prejudice.

Clark v. Superior Court, 50 Cal. 4th 605 (2010).

A group of senior citizens sued an insurance company under California's unfair competition law (Cal. Bus. & Prof. Code § 17200 et seq.), alleging deceptive sales of high-commission annuities with large " 'early surrender' " penalties, and seeking restitution to the plaintiffs' class of money spent to purchase the annuities. Plaintiffs also sought trebling of the restitution award under Civil Code section 3345, which allows the trier of fact to award senior citizens and disabled persons up to three times an amount imposed by statute as a "fine, or a civil penalty or other penalty, or any other remedy the purpose or effect of which is to punish or deter." The court of appeal held that the plaintiffs were entitled to seek a trebling of the restitution award under section 3345 because that award had a deterrent effect.

The supreme court reversed, holding that: "[b]ecause restitution in a private action brought under the unfair competition law is measured by what was taken from the plaintiff, that remedy is not a penalty and hence does not fall within the trebled recovery provision of Civil Code section 3345, subdivision (b)." *Id.* at 614-15.

Minkler v. Safeco Insurance Company of America, 49 Cal. 4th 315 (2010).

In *Minkler*, the California Supreme Court unanimously held that the severability provision of a homeowners policy (stat-

ing that " '[t]his insurance applies separately to each insured'") should be construed to mean that the policy's exclusion for " 'bodily . . . injury expected or intended by an insured' " applies separately to each insured who allegedly contributed to the plaintiff's bodily injury. *Id.* at 320. Accordingly, the court held the exclusion did not bar coverage for a mother who was sued for negligently allowing her adult son to sexually molest a minor, even though the exclusion barred coverage for the son's intentional misconduct.

The court left open the possibility that the result may be different when the plaintiff alleges that the insured is merely vicariously or derivatively liable for a co-insured's intentional acts, rather than alleging that the insured's own acts or omissions contributed to the bodily injury. Thus, even after *Minkler*, when a single tortious act causes the injury and that injury was intended, the intentional acts exclusion may bar coverage for all insureds notwithstanding the severability provision.

California Court of Appeal

The California court of appeal published numerous insurance law decisions in 2010; the following of which are among the most significant:

Levine v. Blue Shield of California, 189 Cal. App. 4th 1117 (2010) (Health insurers have no duty to inform their insureds how to best structure health coverage to minimize premiums.)

MacKay v. Superior Court (21st Century Ins. Co.), 188 Cal. App. 4th 1427 (2010) (Insureds may not challenge a CDI-approved insurance rate in a civil action; rather, their exclusive remedy is to petition the superior court for writ of mandate to compel the CDI to hold an administrative hearing regarding the challenged rate.)

Chicago Title Insurance Company v. AMZ Insurance Services, Inc., 188 Cal. App. 4th 401 (2010) ("Evidence of Property Insurance" document is an insurance binder when issued by an agent with actual or ostensible authority to bind insurance, and therefore enforceable as a policy of insurance.)

Colony Insurance Company v. Crusader Insurance Company, 188 Cal. App. 4th 743 (2010) (Evidence that an insurer failed to follow internal underwriting guidelines does not waive or estop the insurer from denying coverage based on insured's misrepresentations in the insurance application, even if the misrepresentations would have been discovered had the guidelines been followed.)

Howard v. American National Fire Insurance Co., 187 Cal. App. 4th 498 (2010) (Where a settlement demand, although in excess of an individual insurer's policy limit, is within the aggregate policy limits of the multiple primary insurers on the risk and is reasonable in light of the ultimate judgment, the demand triggered each primary insurer's obligation to tender its policy limit toward that settlement. The failure to do so constitutes a bad faith failure to settle.)

Essex Insurance Company v. Heck, 186 Cal. App. 4th 1513 (2010) (Insurer who pays a single lump sum to settle a plaintiff's causes of action for personal injury as well as bad faith, breach of contract, fraud, and misrepresentation, without allocating the settlement funds between those claims, waives its right to pursue a subrogation claim against another tortfeasor whose liability is limited to the plaintiff's personal injury claim.)

Blankenship v. Allstate Insurance Company, 186 Cal. App. 4th 87 (2010) (Plaintiff's status as a minor does not excuse his failure to comply with the two-year limitations period under Insurance Code section 11580.2, subdivision (i) for bringing suit against an insurer to recover uninsured motorist benefits.)

Legacy Vulcan Corporation v. Superior Court (Transport Ins. Co.), 185 Cal. App. 4th 677 (2010) (Umbrella policy insurer owes primary duty to defend insured against potentially covered claims regardless of whether the underlying primary insurance or the self-insured retention has been exhausted.)

Wallace v. GEICO General Insurance Company, 183 Cal. App. 4th 1390 (2010) (Insured has standing to pursue unfair competition law (UCL) class allegations against insurer for failing to pay for all body shop repair costs regardless of insurer's subsequent offer to fully compensate the insured for those costs.)

Risely v. Interinsurance Exchange of the Automobile Club, 183 Cal. App. 4th 196 (2010) (The mere fact that insurer defended insured under one policy did not necessarily insulate it from liability for allegedly breaching its duty to defend and settle under a second policy, where this failure potentially increased the insured's exposure to personal liability.)

United Enterprises, Inc. v. Superior Court of San Diego County, 183 Cal. App. 4th 1004 (2010) (A stay must be issued when an insurer seeks declaratory relief that it has no duty to defend an insured in underlying lawsuit, and the insured would be required to marshal evidence that established liability in the underlying actions.)

Gray v. Begley, 182 Cal. App. 4th 1509 (2010) (When an insurer provides an insured a defense under a reservation of rights, and the insured subsequently reaches a private settlement with the third party claimant without the insurer's participation, the insurer may intervene in the underlying action brought by

the claimant to protect its own interests—including the right to seek a set-off of the judgment against the insured based on the claimant's prior settlement with a former co-defendant in the case.)

Nieto v. Blue Shield of California Life & Health Insurance Company, 181 Cal. App. 4th 60 (2010) (Insurer is entitled to rescission as a matter of law where insured failed to disclose material information about her medical condition and treatment on her application. The evidence that insured lacked any intent to defraud failed to create a triable issue of material fact.)

Superior Dispatch, Inc. v. Insurance Corporation of New York, 181 Cal. App. 4th 175 (2010) (Insurer must notify its insured claimant of the contractual limitations provisions that may apply to the claim, regardless of whether the insured is represented by counsel.)

Insurance Regulations

A. Homeowners Insurance

On December 29, 2010, the Office of Administrative Law (OAL) approved regulations by the California Department of Insurance (CDI) entitled "Standards and Training for Estimating Replacement Value on Homeowners Insurance." Many of the regulations in this package are fairly noncontroversial, dealing with training standards for insurance agents and appraisers regarding calculation of replacement value when applying for a homeowners' insurance policy. One provision, however, has generated a great deal of concern among insurers writing homeowners insurance. Cal. Code Regs. tit. 10, § 2695.183. This section dictates specific factors that must be considered and procedures that must be followed if any insurer or agent/broker calculates an estimated replacement cost for purposes of homeowners insurance. Insurers and agents contend that this provision exceeds the scope of authority that is granted by statute to the Department. Since the regulation has been approved, litigation is the only remaining process for challenging its legality. This regulation will take effect on June 27, 2011.

B. Noncompliance Hearings

On December 30, 2010, OAL approved CDI regulations governing noncompliance hearings held pursuant to Insurance Code section 1858.1. The new rule provides that prepared direct testimony is required only for witnesses who at the time the testimony is offered are employees, agents, officers, directors, or independent contractors of the party offering the testimony or experts retained by the party offering the testimony. The previous rule required prepared written testimony to be submitted for all witnesses including adverse witnesses. Insurers objected to this rule, arguing that it would allow the CDI to demonstrate alleged noncompliance through the testimony of insurance company employees and contractors. Since the regulation has been approved, litigation is the only remaining process for challenging its legality. A successful court challenge seems unlikely since the new rule appears to be entirely within the CDI's statutory authority. The new rule takes effect on January 29, 2011.

C. Iran Investments Initiative

On October 11, 2010, OAL issued its determination that the actions by CDI to regulate insurer investments in businesses associated with Iran were illegal underground regulations. CDI has since filed litigation pursuant to Cal. Gov't Code § 11340.5 seeking a judicial ruling that OAL's determination is invalid. The suit names both OAL and the five insurance trade associations which sought the OAL determination as defendants. Commissioner Dave Jones has made no public statement regarding whether he intends to pursue this initiative, which was instituted by his predecessor.

D. Title Insurance

On October 4, 2010, OAL disapproved CDI regulations establishing a limit of $5,000 for a retained liability clause in any contract between a title insurance underwriter and an underwritten title company acting as an agent for that insurer. The regulations were disapproved because OAL felt that CDI had not adequately demonstrated the necessity for the rule. OAL specifically reserved the right to rule later on the question of whether the rule was within CDI's statutory authority. CDI has until February 8, 2011 to resubmit a corrected version of the regulation to OAL for re-evaluation. Commissioner Dave Jones has made no public statement regarding whether he will pursue this regulation which originated during the tenure of Commissioner Poizner. ■