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Joint Oversight Hearing

Senate Committee on Insurance
and
Senate Budget Subcommittee No. 4 on State Administration and General Government

Richard D. Roth, Chair

Subject: Legislation, Regulation, and Litigation: Enforcement of the Unfair Practices Act

April 27, 2016

1:30 p.m. - State Capitol Room 112

I. Introduction and Welcoming Remarks
Senator Richard Roth, Chair

II. California Department of Insurance
Dave Jones, Insurance Commissioner

III. Public Comment

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The Unfair Practices Act establishes a basic code conduct for insurers to ensure that policyholders and claimants are treated fairly. Over the last decade or so, the insurance industry and the Department of Insurance have engaged in several legal skirmishes over regulations adopted pursuant to UPA. Some of the recent decisions and rulings have raised concerns about the enforceability of those regulations, as well as costs. One case is pending in front of the Supreme Court and may fundamentally alter the way the Commissioner uses that rulemaking authority. This hearing will examine that history and status of these cases and potential legislative solutions.

I. THE POWERS OF THE INSURANCE COMMISSIONER

Insurance plays a critical role in nearly every aspect of our lives. We have insurance on our cars, homes, business, wages, and lives. California consumers spend about $259 billion on insurance premiums annually. CDI, led by the Insurance Commissioner ("Commissioner"), enforces California's insurance laws and is charged with the task of making sure an insurer can keep its promises and treats consumers fairly. The Insurance Commissioner, a statewide elected official, has extensive authority on a variety of matters and executes enacted statutes, sets rules

by adopting regulations (as authorized by those statutes), and adjudicates administrative disputes. As a statutory position, the Insurance Commissioner may only exercise those powers granted by statute.

Due process demands a careful balancing of administrative efficiency and separation of powers. The roles played by a state agency become critical elements in the due process analysis. Some agencies serve as either prosecutor or judge and pose little to no risk of an unconstitutional consolidation of power. In agencies like CDI, where the Commissioner serves as rulemaker, prosecutor and judge, the risks of potential due process violations increase significantly, such as those involving improper ex parte contact or pro-agency bias by the decision-maker or hearing officer.

In order to protect due process rights, agencies must internally separate the executive, quasi-judicial, and quasi-legislative functions. The Administrative Procedure Act (APA) provides some critical process protections when an agency adopts rules and when the agency enforces them.

Most regulations must be properly adopted pursuant to the APA which requires a public hearing and approval by the Office of Administrative Law (OAL). Regulations remain subject to court review.

When CDI commences an enforcement action against a licensee, the APA is intended to provide for a fair hearing. Usually these hearings must be presided over by an administrative law judge (ALJ) employed by the Office of Administrative Hearings (OAH). The ALJ will take the evidence, rule on motions, and propose a decision to the Commissioner, who may accept or reject it. The Commissioner has the ultimate authority to adopt or reject proposed decisions and may adopt a final decision of his or her own (even when CDI's own regulations are challenged or respondent alleges misconduct). Because the Commissioner also oversees the unit that prosecutes these cases, the ALJ plays a critical role in making sure that due process is respected.

II. THE UNFAIR PRACTICES ACT

The Unfair Practices Acts (UPA), sometimes known as the Unfair Insurance Practices Act, prohibits practices that generally involve blatantly unfair or deceptive conduct, or breaches of an insurer's obligation of good faith and fair dealing. UPA recognizes two types of unfair acts or practices; those listed and defined in Insurance Code Section 790.03 and those determined to be wrongful under a special process established in Section 790.06 (the "omnibus" provision).[1]

These two procedures may be read to establish an "either/or" situation. The Commissioner may proceed directly to disciplinary proceedings against an insurer for committing a defined act listed in Section 790.03. But whenever the Commissioner believes the insurer is engaging in an undefined unfair practice, he may proceed under Section 790.06. The Legislature also added Section 790.10 granting the Commissioner rulemaking authority, but the scope of that authority is the subject of much litigation.

[1] All subsequent references are to the Insurance Code unless otherwise noted.

A. Defined and Determined Unfair Practices

Section 790.03 lists prohibited practices divided into two categories. "Unfair trade practices" include practices such as issuing false or misleading statements, colluding to restrain competition, and unfairly discriminating against individual of the same life insurance class. "Unfair claims settlement practices" are found only in subdivision (h) and include practices such as misrepresenting pertinent facts or policy provisions relative to a claim, lowballing a claim value, failing to confirm or deny coverage within a reasonable time, and advising a claimant not to hire an attorney. An individual act itself does not constitute a practice; these acts are not penalized unless the insurer is "knowingly committing or performing with such frequency as to indicate a general business practice[.]"

If, after an evidentiary hearing, the Commissioner finds that a licensee has violated Section 790.03, the Commissioner may issue a cease and desist order with a civil penalty, pursuant to Section 790.035, up to $5,000 for unintentional conduct or up to $10,000 for "willful" conduct.[2]

Whenever the Commissioner believes that a licensee is engaging in an unfair practice not listed under Section 790.03, he or she may issue an order to show cause (OSC) and hold a hearing to determine if the act is unfair or deceptive. The Commissioner will issue a report if insurer is found to be acting unfairly. If the insurer continues to act in that way, the Commissioner may seek an injunction in the Superior Court. Only if the insurer violates an injunction may the Commissioner order a civil penalty under Section 790.07.

B. Regulations

Section 790.10 requires the Commissioner to "promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article. But Govt. Code Section 11342.2 invalidates any regulation in conflict or inconsistent with the underlying statute. Those who view Sections 790.03 and 790.06 as a complete system in dealing with all unfair practices, see no room for regulations to add new unfair practices. Others view Section 790.10 as an additional means of adopting new unfair practices.

In 1993, CDI adopted a new set of regulations known as the Fair Claims Settlement Practice Regulations (FCSPR). Those regulations are a subset of UPA regulation tied specifically to the unfair claims settlement practices listed Section 790.03(h). The FCSPR specify time deadlines within which insurers must acknowledge, evaluate, and pay claims; restrict the information that can be demanded from a claimant; require a denial of a claim to be in writing; and require notice to the claimant that if the claimant believes the claim to have been wrongfully denied, the matter may be reviewed by CDI. The FCSPR also include sections dedicated to classes of insurance imposing special duties based on the type of insurance.

[2] The default penalties violations of the Insurance Code are provided Section 704 and 704.7. Section 704 gives the Commissioner the authority to suspend an insurer's certificate of authority; Section 704.7 gives the Commissioner the ability to offer a fine not to exceed $55,000 in lieu of suspension.

III. LEGISLATIVE HISTORY

The Legislature enacted UPA in 1959 based on the Unfair Trade Practices Model Act adopted by the National Association of Insurance Commissioners (NAIC). The model act took inspiration from omnibus provision from federal law governing the Federal Trade Commission (FTC), although the federal act has no equivalent to Section 790.03. Neither the original California statute nor the model act contained rulemaking provisions.

In the 1970s, the NAIC examined the model and considered several changes. Stakeholders and commissioners alike viewed the omnibus provision as too burdensome and removed it. At the same time, the NAIC added a rulemaking provision. California, however, kept the omnibus and enacted AB 1353 (Fenton), Chapter 975, Statutes of 1971, which codified the Commissioner's rulemaking authority in Section 790.10.

While the Legislature was considering AB 1353, the NAIC was also examining proposals for adding rulemaking authority under UPA. In June 1971, the NAIC Industry Advisory Committee presented its report on a New Hampshire bill that "would give the Commissioner the power to define unfair trade practices by rule or regulation." The committee objected to that part of the bill because it felt that only the Legislature should define the scope of acts constituting unfair trade practices due to the serious and penal nature of a violation. Instead the committee recommended authority to issue regulations that identify specific acts but not extend or enlarge the statute.

AB 1353 passed out of both houses on the consent calendar and CDI adopted its first set of regulations under Section 790.10 the following year.

IV. REGULATIONS AND LITIGATION

UPA regulations remained unchallenged until the early 2000s. Since then, the legal challenges have grown in frequency and intensity. Several of these challenges hinge on the view that Section 790.03 establishes an exclusive list of defined practices and preclude additions through rulemaking. Another theory holds that UPA is written broadly and not intended to serve as an exclusive list of prohibited practices.

This dispute gives rise to two basic questions that surface throughout the several cases. A legal question of whether the Commissioner may establish new unfair practices outside of Section 790.06 and factual a question of whether a regulation simply makes an existing regulation more specific.

Several cases involve direct attacks against the validity of UPA regulations. These challenges originate in court and must show that the regulation is invalid on its face. In *ACIC v. Jones*, the Superior Court declared one section related to replacement estimates for residential properties to be invalid and Court of Appeal agreed. CDI appealed the case and it is currently pending in the Supreme Court (all references to the "Supreme Court" are to the California Supreme Court). In *PIFC v. Garamendi,* the court enjoined CDI from enforcing several

provisions covering multiple subjects related to property insurance. *ACLHIC v. Poizner,* the court declared invalid two regulations related to post-claims underwriting in disability policies.

Three more cases arise out of disciplinary actions where insurers attacked the validity of regulations in their own defense. In *Western General* and *Torchmark Matters*, the ALJ determined that he could not enforce CDI's regulations as pleaded because, in part, they exceeded the scope of the statute and ordered CDI to amend the pleading. Neither matter has received an evidentiary hearing.[3] In the *PacifiCare Matter*, a hearing was held and the Commissioner found many UPA violations. The insurer requested review by the court which, in the first of three phases of the review, declared invalid three FCSPR provisions.

ACIC v. Jones and the *PacifiCare Matter* are the two most significant cases because they significantly impact the Commissioner's rulemaking authority. These two cases are addressed in detail, but summaries of all of the above-mentioned cases are provided as an appendix.

A. ACIC v. Jones: CDI's "Interpretative" Authority

Insurance Code Section 790.03(a) generally prohibits licensees from making misleading statements. CDI adopted a regulation that requires insurers to provide estimated replacement values of residential properties in a very specific manner. (Accurate estimates are essential in measuring the amount of insurance needed to replace a home after a total loss.) Any estimate provided that does not follow the formula prescribed by the regulation and include specified "ingredients," would be deemed "misleading" under Section 790.03. The regulation also requires the estimate to be provided in writing and itemized, and that certain assumptions be explained, although the regulation does not treat a failure to follow those rules as inherently misleading.

Insurers sought declaratory relief seeking to invalidate the regulations. CDI defends the regulation on the theory that it is merely interpretative of the concepts of false, misleading, or deceptive practices and that it establishes a uniform definition of the term "estimate of replacement costs." In effect, the regulation only makes an existing unlawful act more specific. The insurers respond that because the regulation might capture lawful conduct, such as an accurate estimate that does not follow the regulation's formula, it actually adds new acts and enlarges the scope of the statute.[4]

CDI relies heavily on *Ford Dealers Association. v. Department of Motor Vehicles* that held that the Department of Motor Vehicles (DMV) has the discretion to decide what statements are inherently misleading based on supporting evidence. In that case, DMV issued a regulation requiring auto dealers to disclose the fact that a vehicle had previously served as a rental car and

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[3] A second ALJ has recently been assigned in the *Torchmark Matter*. All reference to the ALJ in the Torchmark Matter are to the original ALJ that granted the Motion to Strike with Leave to Amend unless otherwise noted.

[4] Although not pointed out in court, PIFC submitted comments during the rulemaking process that manufactured homes are not reconstructed but replaced following a total loss and that the reconstruction value estimation process is significantly different than site-built homes. Those values do not include those required under the regulation including cost of foundation, architects' plans and engineering reports, whether the structure is located on a slope, the type of frame, or nonstandard wall heights.

requiring dealers to strike itemized charges on invoices if those charges were to be paid by a franchisor. The dealers argued, in part, that the rules also captured innocent conduct. The *Ford* Court explained further that "the statute affords protection against the probability of likelihood as well as the actuality of deception."

CDI lost at the Superior Court and appealed. A unanimous Court of Appeal agreed with lower court's decision and rejected the Commissioner's authority for "filling in the details" of the statutory scheme viewing Section 790.06 as the exclusive means to penalize unfair acts not defined in Section 790.03. The Court stated "We infer that these omissions were deliberate, and that under the guise of 'filling in the details,' the Commissioner therefor could not do what the Legislature has chosen not to do." That court distinguished *Ford* because the underlying statute in *Ford* has no equivalent to Section 790.06.

CDI petitioned for review and depublication. The Supreme Court granted review and the case is currently pending.

B. PacifiCare: Burden of Production

PacifiCare is the first UPA case litigated to a decision. As a result of market conduct exams that occurred in 2006 and 2007, CDI alleged numerous violations of UPA related to the merger of UnitedHealth Group and PacifiCare Life and Health Insurance Company. The Commissioner issued an OSC in January 2012. In August 2013, after about 237 days of hearing, the ALJ issued a decision recommending a $11.5 million fine (the largest ever recommended under that statute). Commissioner Dave Jones rejected the proposed decision and issued his own 220 page decision in June 2014. He found about 900,000 incidents of unfair practices and assessed a $173.6 million fine. In that decision, the Commissioner articulates and affirms the validity of his own regulations. He then designated the decision as precedential, meaning that ALJs would be bound by the decision. The insurer filed for review by the Superior Court.

In September of 2015, the court issued an order granting a Motion for Judgment on the Pleadings, declaring three provisions of the FCSPR invalid including two provisions related to CDI's burden to produce evidence when alleging unfair claims settlement practices.

<u>The Single Incident Trigger</u>. Unlike an unfair trade practice, as addressed in *ACIC v. Jones*, unfair claims settlement practices involve a separate evidentiary requirement. Section 790.03(h) prohibits an insurer from "[k]nowingly committing or performing with such frequency as to indicate a general business practice" a list of specified claims settlement practices.

The Preamble to the FCSPR, adopted in the early 1990s, declares that the insurer commits an unfair claims settlement practice "when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice" engages in the practices listed in Section 790.03. This interpretation is often referred to as the "single trigger." In his adopted decision in the *PacifiCare Matter*, the Commissioner argues the following:

> The ordinary and proper meaning of the word "or" is well-settled. It has a disjunctive meaning. That is, the function of "or" is to mark an alternative such

as "either this or that." As such, there can be no ambiguity that the Legislature intends to punish single acts knowingly committed *or* acts performed with such frequency that they demonstrated a general business practice.

On review of the *PacifiCare* decision, the Superior Court ruled otherwise consistent with similar conclusions in *PIFC v. Garamendi*, *Western General*, *Torchmark* and *ACLHIC v. Poizner*.

"Knowingly" UPA does not define "knowingly committed," but the FCSPR defines it as "performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law." According to the Commissioner, "knowingly committed" does not require actual knowledge even of the underlying facts. In his decision in the *PacifiCare Matter*, he cites California Civil Code Section 19 that states "every person who has actual notice of circumstances sufficient to put a prudent man upon inquiry as to a particular fact, has constructive notice of the fact itself in all cases in which, by prosecuting such inquiry, he might have learned such fact." He also argues that facts "known to one part of a corporation place those facts within the constructive knowledge of the corporation as a whole."

But some commentators have suggested that the FCSPR definition is so broad that it potentially creates a strict liability standard. The ALJ in Torchmark explains that under that definition, an "actionable violation of section 790.03 subdivision (h) can occur through a single act of inadvertence due to the exceedingly broad constructive and applied knowledge definition of 'knowingly committed.'"

The reviewing court in *PacifiCare* declared CDI's definition of "knowingly committed" to be invalid.

C. *Torchmark* and *ALHIC v. Poizner*: Defining New Acts through Rulemaking

In his decision in the *PacifiCare Matter*, the Commissioner rejects that position, at least for unfair claims practices, and argues 790.03(h) was "written broadly and is not intended to serve as the exclusive definition of all unfair claims settlement practices." Section 2695.1(a)(1) of the FCSPR Preamble declares that violating a provision of those regulations shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h).

The ALJ in *Torchmark* disagrees and refer to Section 2695.1 as a "bridging mechanism" and in regards to CDI's practice of pleading violations of the FCSPR regulations without explaining how that provision fit within the statute. The ALJ in *Torchmark Matter* ruled that several provisions were not supported by the statute, but rather by the bridging mechanism found. (See the Commissioner's comments in *PacifiCare* that 790.03(h) was "written broadly and is not intended to serve as the exclusive definition of all unfair claims settlement practices.") The ALJ ruled that regulations that rely on the bridging mechanism "as a bridge between alleged violations of the newly engrafted duties, requirements, and responsibilities of insurers … constitutes an impermissible extension of the Department's authority" and fails as a matter of law.

A similar issue arises when CDI cites an unrelated statute as authority for adopting regulations under UPA. This permits CDI to lend Section 790.10 to other statutes and applies UPA's more severe penalties. However, courts have recognized boundaries drawn by Section 790.03 and 790.06. The court in *ACLHIC v. Poizner* invalidated two regulatory provisions relating to post-claims underwriting (canceling a policy for a reason discovered after the insured files a claim). The court explained that the Commissioner lacked authority to adopt regulations related to post-claims underwriting since post-claims underwriting is regulated under a different section that does not grant any rulemaking authority.

For examples of instances where the Legislature expressly links UPA with other code sections, see Insurance Code Sections 394, 676.10, 758.5, 10089.16, 10112.27(e), and others.

D. *PIFC v. Garamendi*: Regulations that Alter Contractual Obligations

Because insurance contract law and regulatory law are closely intermingled, a provision that purports to regulate insurers may impermissibly impact the civil obligations of a contract. In 2003, an insurance trade association applied for a preliminary injunction to restrain the Commissioner from enforcing regulations that would have established standards for the adjustment and settlement of property claims, and more specifically, would have prohibited insurers from depreciating the expense of labor necessary to repair or replace the damaged property. That year, the court granted an injunction while the matter was pending. The court ruled that the regulations mandated coverage benefits without statutory authorization; imposed duties and dictated valuation methodologies inconsistent with California law; and imposed standards on insurers that are unreasonably burdensome without a showing of substantial evidence that the regulations are necessary. For example, the regulations would have required insurers to pay all the reasonable vehicle towing and storage charges incurred by the insured and would have required insurers that did not cover those costs to alter the policy language. The court also found that a regulation unlawfully held insurers to a strict liability standard when using information derived from third-party software to value an insured's claim, but the statute applies a "good faith" standard. The court found that these and other regulations amounted to improper legislation of policy benefits. Pending review, the insurers and CDI resolved all of the issues by settlement but one. The case was finally resolved in 2006 when the court ruled in favor of CDI because the regulation addressing labor depreciation was consistent with the Supreme Court's reading of the insurer's contractual duties.

V. LITIGATION EXPENSES

The following chart provides a cumulative estimate of CDI's expenses related to the discussed cases. These estimates do not include costs to insurers which are likely much higher. For example, CDI will typically use its own attorneys or those employed by the California Department of Justice (DOJ). The DOJ currently charges $170 an hour for attorney services. Insurers will likely pay four or five times that depending on the experience of the attorney.

	CDI Attorney*	DOJ Attorney	Appointed Counsel	OAH Hearing	Estimated Total Cost
Western General	$81,796				**$81,796**
ACLHIC	$49,787	$71,456			**$121,243**
Torchmark	$265,843	$7,438		$48,195	**$321,476**
ACIC	$146,071	$416,455			**$562,526**
PacifiCare	$980,376	$63,942	$9,589,829	$358,829	**$10,992,718**

Additionally, CDI submitted estimates for prior and current efforts to amend the anti-steering and the labor rate survey regulations discussed below.

VI. PROPOSED REGULATIONS

CDI recently began formal rulemaking proceedings for two sets of amendments to the FCSPR. The first set would amend the "anti-steering regulations" that prohibit an insurer from coercing insureds to use a particular body shop. The second set of proposed amendments amend the regulations related to "labor rate surveys" used by insurers to establish a basis for calculating how much they will pay a body shop for labor.

A. Anti-Steering Regulations

Auto insurers establish contracts with some auto body shops to perform repairs covered under the policy as part of a "direct repair program" (DRP). Participating DRP shops agree to certain conditions in return for being placed on a referral list. Typical conditions include a negotiated labor rate (usually below what the shop normally charges) and a promise to guarantee the work performed.

Insurance Code Section 758.5 prohibits insurers from requiring claimants to use a specific body shop. It also restricts the insurer from suggesting a body shop unless the claimant requests the referral or the claimant is informed in writing of his or her right to choose a shop. But Section 785.5 also permits insurers to provide claimants with specific truthful information regarding the services and benefits available for using DRP shops, including information about the repair warranties offered, the type of replacement parts to be used, the anticipated time to repair the damaged vehicle, and the quality of the workmanship available to the claimant. This section also expressly grants the Commissioner UPA enforcement powers.

Existing regulations restate the statutory prohibitions, as well as prohibiting insurers from requiring a claimant to travel an unreasonable distance to have a vehicle inspected or obtain a repair estimate. CDI's proposed amendments would make the following changes.

- Deem "misleading" any statement that a body shop chosen by the claimant has a poor record of service or other negative allegation solely on the basis of the shop's participation or nonparticipation in a labor rate survey or without having clear documentation to support the claim.

- Prohibit insurers from requiring a claimant to wait an unreasonable period of time for the insurer to inspect a replacement automobile or conduct an inspection of the claimant's auto. Reasonable periods of time include six weeks to inspect, three days to request an estimate of repairs from the claimant in lieu of physical inspection, and six business days following receipt of the estimate to inspect after receiving an estimate of repairs.

- Sets the maximum number of miles an insurer may require a claimant to travel from where the vehicle is located to have a vehicle inspected or obtain a repair estimate. Insurer would not be able to require a claimant to travel more than 10 miles in urban areas with population of 100,000 or more than 25 miles anywhere else in the state.

- Prohibit insurers from having the vehicle inspected by a DRP shop, or any other shop, once the claimant has chosen an automobile repair shop.

CDI previously considered similar anti-steering regulations, but those regulations were preempted by AB 1200 (Hyashi, 2009), Chapter 387, Statutes of 2009, that explicitly granted the insurer the ability to provide truthful information about the use of the DRP**.** Concerns have been expressed that the new regulations may be inconsistent with that statute and may pose an unconstitutional restriction on commercial free speech if it inhibits truthful information.

Additionally, by declaring it unreasonable to require an insured to travel more than 10 or 25 miles to have a vehicle inspected or obtain an estimate, CDI's regulation would establish a standard dissimilar to Insurance Code Section 11580.17 which prohibits an insurer from requiring an applicant to travel more than 20 miles to have a vehicle inspected for the purpose of issuing collision and comprehensive coverage.

A public hearing on these propose amendments was held on April 22, 2016. CDI projects total costs to adopt the 2016 amendments at $38,374. CDI did not provide an estimate of the costs related to the 2009 proposed amendments.

B. Labor Rate Survey Regulations

An insurer must return a covered vehicle to its pre-loss condition up to the limit of the policy. Insurers use labor rate surveys to establish what they consider to be a reasonable rate to pay for auto body repairs.

Insurance Code Section 758(c) requires any insurer that conducts a labor rate survey to submit it to CDI so that CDI may make it available upon request. That section states that the survey information shall include the names and addresses of the auto body repair shops and the total number of shops surveyed.

Existing regulations provide definitions, outline what basic information should be included in surveys conducted by insurers, and provides a procedure for submitting the surveys to CDI. In addition to the statutory reporting requirements, the regulation requires the insurer to report a description of the formula and method used to calculate the geographic area excluding any confidential information.

The proposed amendments would make two significant changes to the current process. First, they would establish an optional method for preparing a labor rate survey called a "standardized labor rate survey" recommended by Commissioner. The use of a standardized survey would establish a rebuttable presumption that the insurer has attempted in good faith to establish the labor rate component of a claim or to adjust the labor rate component of a non-DRP shop. CDI projects $1.15 million in benefits will be passed on to auto body shops and policy holders (households).

Secondly, the proposed amendments would alter the requirements for all surveys by requiring insurers to submit survey data in a standard electronic form, upon CDI's request, for publication on the CDI website; and requiring insurers to submit data not intended for public consumption, including a copy of the survey questionnaire, the name of any shops excluded from the survey, and any information that an insurer obtains indicating that the shop does not meet applicable standards. The new rules would also require the insurer to give CDI access to the underlying data of the survey even if provided by a third party.

In 2007, OAL disapproved a set similar of amendments on the grounds that the administrative record did not support the use of Section 790.03 as an authority because, in part, UPA contains no provisions related to labor rate surveys or to automobile insurance claims.[5] The OAL decision notes "Here the Department has taken [Ins. Code § 758] saying little more than 'if an insurer does a survey, it must report the results to the Department and produced an extensive and prescriptive set of requirements for what is permitted and what is required in a survey." Commissioner Poizner did not contest OAL's decision.

While the 2007 proposed regulations cited the UPA as authority, the new set does not. However, the proposed regulations are placed within the FCSPR which the Preamble explains is purposed to indicate what acts "shall constitute an unfair claims settlement practice" under Section 790.03. The Commissioner anticipates OAL approval this time because the new package will include additional documentation to including a study by the California State University, Sacramento; documented complaints of labor rate violations; class action lawsuits; enforcement actions; and an economic impact statement. CDI also intends to add greater details as to why each provision is reasonably necessary to effectuate the purpose of the statute. Additionally, the 2007 regulations would have established mandatory standards for labor rate surveys, the current regulations only recommend a standard form.

A public hearing on these amendments was held on April 21, 2016. CDI projects total costs to adopt the 2016 amendments at $332,501, the costs to propose the 2006 proposed at $112,656, and the costs to adopt the 2002 amendments at less than $100,000.

VII. CONCLUSION

Except perhaps the Governor, the Insurance Commissioner holds significant quasi-legislative and quasi-judicial authority, as well as prosecutorial discretion, and yet is subject to

[5] In contrast, Section 4.N of the NAIC's Unfair Claims Settlement Practices Model Act considers it an unfair practice for an insurer to fail to "adopt and implement reasonable standards that the repairs of a vehicle owned by or required to be used by the insurer are performed in a workmanlike manner."

few formal checks and balances. Unlike a board or commission, the position vests all authority in one person not subject to appointment and confirmation. The Commissioner directs attorneys, sworn police officers, and administrative law judges; adjudicates administrative matters; and adopts and amends an extensive set of rules and regulations. The only substantive oversight comes from Legislature and the courts.

Typically, the Legislature avoids involvement in ongoing litigation. However, the costs and scope of the litigation (with little end in sight), the drafting problems in UPA, and other factors, may persuade the Legislature to act sooner rather than later. To the extent that confusion about UPA undermines the predictability and enforceability of the law, clarifying UPA could provide clear rules for the regulator and the regulated.

For example, the Legislature could eliminate the omnibus provision in Section 790.06. Research indicates that the procedure has only been used twice and has never been used to establish a new unfair practice. At the same time, the Legislature might clarify whether it wishes to reserve for itself the authority to adopt new unfair practices or give the Commissioner authority to do so via rulemaking. Compare, for example, language granting the FTC explicit authority to adopt "rules which define with specificity acts or practices which are unfair or deceptive acts or practices in or affecting commerce."

Regarding the FCSPR, the *PacifiCare* ruling places a high burden on the Commissioner to prove unfair claims practices. The regulations almost impose a contrary, strict liability standard. The Legislature may wish to consider NAIC model language that recognizes an unfair claims settlement practice when an act is committed (1) flagrantly and in conscious disregard of the law or (2) with such frequency as to indicate a general business practice acts. Additionally, the NAIC model only places "knowingly" in front of one defined act, misrepresenting relevant facts or policy provisions relating to coverage issues.

On the other hand, the Legislature may wish to wait. The Supreme Court should decide *ACIC* in the coming months and that decision may determine whether legislation is needed at all.

SUMMARY OF THE CASES

PIFC v. Garamendi. In 2003, an insurer trade association applied for a preliminary injunction to restrain the Commissioner from enforcing regulations that would have established standards for the adjustment and settlement of property claims, including a regulation that prohibits insurers from depreciating the expense of labor necessary to repair or replace the damaged property. The court granted an injunction while the matter was pending finding that the petitioners were likely to succeed on the merits because the challenged regulations amounted to improper legislation of policy benefits. Pending review, the insurers and CDI resolved all of the issues but one. The case was finally resolved in 2006 when it ruled in favor of CDI because the regulation addressing labor depreciation was consistent with the California Supreme Court's reading of the insurer's contractual duties.

ACLHIC v. Poizner. In 2010, the court declared two regulatory provisions invalid relating to post-claims underwriting. The court ruled that Commissioner lacked authority to adopt regulations since Section 790.10 grants authority to administer UPA, but post-claims underwriting is regulated under a different section. The court upheld one provision which clarified the term "reasonably promptly" or "reasonable time" by setting precise timelines by which an insurer must conduct a cancelation investigation because UPA already imposes on an insurer the duty to investigate and process claims reasonably and promptly in communicating with insured regarding the investigation of a claim.

In the Matter of Western General Ins. In 2010, an ALJ made a tentative ruling granting a motion to strike most of CDI's allegations, with leave to amend its pleading to charge a violation of the statute rather than the regulation. That case did not proceed and settled for a penalty of $85,000. That case was the first time CDI had trouble enforcing the regulations since historically these matters were settled beforehand.

In the Matters of Globe Life et al ("Torchmark"). (This matter is referred to as "Torchmark" because the several companies involved belong to the Torchmark holding company.) As a result of a market conduct examination that started in 2005, CDI issued an OSC in 2011 alleging numerous unfair or deceptive acts or practices. In 2012, before taking any evidence in that case, the ALJ granted a motion to strike most of the allegations, with leave to amend, on the grounds that many of CDI's regulations were unenforceable. The ALJ intended to treat the regulations as guidance for best practices. Relying, in part, on the *ACLHIC v. Poizner* and the *Western General Matter*, he issued a 51 page order explaining how the regulations rewrote the statute, diluted CDI's burden of proof, and added unfair practices without regard to Section 790.06. The ALJ reasoned that CDI could only plead a violation of the regulation and not the statute, and therefore was adding to the list of unfair practices by circumventing Section 790.06. Two years later, in 2014, the Commissioner issued a decision in the *PacifiCare Matter* affirming the validity of his own regulations and deemed that decision precedential. CDI filed an amended OSC re-alleging the stricken motions and claiming that the precedential *PacifiCare* decision applied. The insurers filed two writ petitions in Superior Court. The first contended that the ALJs decision was final by operation of law (a state agency has 100 days to adopt or reject proposed decisions). The other made a facial challenge against the FCPRS, (that action has not proceeded). The court ruled that an ALJs interim order would not be reviewed before a final decision has been issued. The case was remanded back to OAH and a new ALJ was

assigned. During a hearing with the second ALJ, CDI admitted that it purposefully delayed reinitiating the *Torchmark Matter* until after the *PacifiCare* decision was issued. CDI attempted to reassert the original OSC based on the *PacifiCare* ruling. The ALJ determined that *PacifiCare* did not excuse CDI from amending its OSC to comply with the 2012 order. Her January 8, 2016 order required CDI to file an amended OSC or risk a motion to dismiss the entire proceeding. In February 2016, two years after the ALJ's order, CDI filed an amended OSC.

In the Matter of PacifiCare. As a result of market conduct exam that occurred in 2006 and 2007 that alleged a large number of claims-handling violations resulting from the merger between UnitedHealth Group and PacifiCare Life and Health Insurance Company, the Commissioner issued an OSC in January 2012. In August 2013, after about 237 days of hearing, the ALJ proposed a decision recommending an $11.5 million fine (the largest ever recommended for that statute) which the Commissioner refused to adopt. (This is the first UPA case litigated to a decision.) In June 2014, the Commissioner issued a 220 page decision against UnitdHealth finding 900,000 incidents of unfair claims settlement practices prohibited by UPA and the FCSP regulations and assessed a $173.6 million fine. In his decision, the Commissioner articulates and affirms the validity of his own regulations and designated the decision as precedential. The insurer filed for review by the Superior Court. In September of 2015, the court issued an order granting a Motion for Judgment on the Pleadings, declaring three subdivisions of the FCSPR invalid relating to whether CDI must prove a pattern of unfair claims settlement practices, as well as the definitions of the term "knowingly" and "willfully." Other issues were reserved for later phases of the case. The court has not yet applied the facts in the record to the final decision. A status conference is scheduled for June 22, 2016. If the court's order becomes the judgment, the court will order that the Commissioner's Decision be vacated and remand the case to the Commissioner for reconsideration consistent with the ruling.

ACIC v. Jones. Insurance Code Section 790.03(a) generally prohibits licensees from making misleading statements. CDI adopted a regulation that requires insurers to provide estimated replacement values for residential property used to determine insurance coverage maximum levels. The regulations deem "misleading" any estimate provided that does not follow the form and formula, including specific "ingredients" that CDI claims is essential when preparing an estimate to replace a home after a total loss. The regulation also requires the estimate to be provided in writing and itemized, and that certain assumptions be explained, although the regulation does not treat a failure to follow those rules as inherently misleading. (It is not clear as to what authority CDI relies to adopt those portions of the regulations.)

Insurers sought declaratory relief that the regulation is invalid. The Court of Appeal rejected the Commissioner's authority of "filling in the details" of the statutory scheme viewing Section 790.06 as the exclusive means to penalize unfair acts not defined in Section 790.03.

The California Supreme Court granted review. Responses to amicus briefs are due on May 11, 2016.