

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA  
FOURTH APPELLATE DISTRICT, DIVISION THREE

**PACIFICARE LIFE AND HEALTH  
INSURANCE COMPANY,**

Petitioner-Plaintiff and Respondent,

v.

**DAVE JONES, IN HIS CAPACITY AS  
INSURANCE COMMISSIONER OF THE  
STATE OF CALIFORNIA,**

Respondent-Defendant and Appellant.

Case No. G053914

(Super Ct. No. 30-2014-  
00733375-CU-WM-CXC)

Orange County Superior Court  
Case No. 30-2014-00733375-CU-WM-CXC (Dept. CX 104)  
The Honorable Kim G. Dunning, Judge

**APPELLANT'S OPENING BRIEF**

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FOURTH APPELLATE DISTRICT, DIVISION 3**

Case: *PacifiCare Life and Health Insurance* Court of Appeal No.:  
 Name: *Company v. Dave Jones, in his capacity as Insurance Commissioner of the State of California* G053914

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## INTRODUCTION

When faced with a disruptive or catastrophic loss—a car accident or a medical emergency—insurance consumers often have little leverage in claim settlement and are particularly vulnerable to sharp practices. They necessarily rely on their insurers for quick and fair settlement of claims so they may get on with their lives. To protect consumers, the process of insurance-claims settlement in California is subject to the requirements and prohibitions of the Unfair Insurance Practices Act, Insurance Code sections 790 through 790.15, and the regulations that implement it. Among other things, the Act ensures that Californians receive their full insurance benefits without undue delay or burden. The Act’s claim-settlement provision, Insurance Code section 790.03, subdivision (h), prohibits a list of harmful activities relating to the administration and processing of insurance claims.<sup>1</sup> It requires insurers to communicate with consumers promptly and honestly, to require only reasonable documentation from claimants to process a claim, and to settle the claim fairly.

The Insurance Code relies on an active Insurance Commissioner to achieve its objectives. In addition to various enforcement powers, the Legislature expressly granted the Commissioner rulemaking authority, providing that he “shall” promulgate rules and regulations “as necessary to administer” the Unfair Insurance Practices Act. (§ 790.10.) The Commissioner determined that the industry required additional guidance so that the Legislature’s consumer-protection purposes in enacting section 790.03(h) would be fully realized in practice. In 1992, after extensive public review and deliberation, the Commissioner adopted the Fair Claims

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<sup>1</sup> Subsequent statutory citations are to the Insurance Code unless otherwise noted. For convenience, subdivision (h) of section 790.03 is referred to as “section 790.03(h).”

Settlement Practices regulations, which implement the Unfair Insurance Practices Act with respect to claims settlement practices. (Cal. Code Regs., tit. 10 (Regs.) §§ 2695.1-2695.14.)<sup>2</sup> These regulations set minimum standards for claims settlement and encourage the prompt and fair processing of claims.

At issue in this appeal are three of those regulations, all of which the trial court struck down on their face. The first regulation states that under section 790.03(h), a violation occurs when the enumerated practices are “either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice.” (Reg. § 2695.1(a).) The other two regulations define key words used in the statute in ways that are consistent with common legal understanding and authorities, and the purpose of the Unfair Insurance Practices Act. Specifically, one regulation provides that “knowingly” is not limited to actual knowledge, but includes implied and constructive knowledge. (Reg. § 2695.2(l).) The other states that, for purposes of assessing penalties, a “willful” violation does not require any intent to harm or violate the law. (Reg. § 2695.2(y).)

These regulations are eminently reasonable, flow naturally from the text of the statute, are consistent with the Legislature’s intent, and fall squarely within the Commissioner’s broad charge to engage in rulemaking as necessary to protect California’s insurance consumers. For nearly 25 years, Insurance Commissioners have enforced these regulations, the insurance industry has structured its practices around them, and the public has relied on them to ensure fair treatment. There is no basis in law to disrupt this settled and successful regulatory structure.

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<sup>2</sup> Individual sections of the regulations are cited here as “Reg.” followed by the section number, with or without a subsection, as appropriate (e.g., “Reg. 2695.2(y)”).

This Court should reverse the trial court's order, dissolve the injunction, and uphold the challenged regulations.

## LEGAL BACKGROUND

### I. THE INSURANCE CODE AND THE UNFAIR INSURANCE PRACTICES ACT

The Commissioner administers and implements the Insurance Code, “regulating the business of insurance” and enforcing the law. (§ 12921, *subd. (a)*.) This includes the code's general provisions and statutes addressing various classes of insurance, including disability and health insurance (§§ 10110-11535), which Respondent PacifiCare Life and Health Insurance Company (PacifiCare) is licensed to issue.

Among the Commissioner's duties is the responsibility to ensure that the purposes of the Unfair Insurance Practices Act (Act) are carried out. (See §§ 790.04, 790.05, 790.06, 790.10.)<sup>3</sup> Enacted in 1959 and amended several times since, the Act prohibits unfair trade practices in the business of insurance. Section 790.03 describes certain prohibited acts that have been identified by the Legislature as “as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.” (§ 790.03.) These include, for example, misrepresenting the terms of a policy (*id. (a)*); making untrue, deceptive, or misleading statements to the public (*id. (b)*); and engaging in unfair claims settlement practices (*id. (h)*). Added in 1972 and amended thereafter, section 790.03(h) prohibits an insurer from “knowingly committing or performing with such frequency as to indicate a general business practice” sixteen enumerated unfair claims settlement practices. Among those prohibited practices are making misrepresentations to claimants, failing to communicate with claimants and

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<sup>3</sup> The Unfair Insurance Practices Act resembles, but does not wholly track, the Uniform Fair Trade Practices Model Act developed by the National Association of Insurance Commissioners.

policy holders, failing to adopt fair claims processing standards, and failing to attempt good faith claim settlements.

The Act provides the Commissioner with a range of tools to carry out his responsibilities. For example, section 790.04 empowers the Commissioner to examine and investigate the business affairs of any person to determine compliance with the Act. The Commissioner may bring enforcement actions under section 790.05 against any person alleged to have engaged in a prohibited act or practice defined in section 790.03. Over the years, the Legislature has expanded the Commissioner’s enforcement options in the event of a violation, as discussed below.

In addition, in 1971, the Legislature expanded the Commissioner’s authority by enacting section 790.10, which vests the Commissioner with broad rulemaking authority. It provides that “[t]he commissioner shall, from time to time as conditions warrant, after notice and public hearing, promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article.”

## **II. IN 1988, THE SUPREME COURT HELD IN *MORADI-SHALAL* THAT THE UNFAIR INSURANCE PRACTICES ACT COULD NOT BE ENFORCED BY PRIVATE ACTION**

In 1979, in *Royal Globe Insurance Co. v. Superior Court* (1979) 23 Cal.3d 880, the California Supreme Court held that a private right of action exists for an individual—either an insured or a third party—to sue an insurer who has violated any of the unfair claims settlement practices listed in section 790.03(h). Given that private claims often center on a particular transaction involving a single injured party or insurance consumer, *Royal Globe* held that a single act may violate section 790.03; private claimants did not need to prove a pattern of unfair settlement practices. (*Id.* at pp. 890-891.) At this time, the Commissioner’s remedies against an insurer that violated section 790.03 were limited to prospective relief. (See

§§ 790.05 (Stats. 1959, ch. 1737, § 1, p. 4189), 790.07 (Stats. 1959, ch. 1737, § 1, p. 4190, amended by Stats. 1987, ch. 953, § 1).

Allowing private enforcement of unfair claims settlement practices produced unanticipated adverse social and economic consequences. Accordingly, in 1988, the Supreme Court reconsidered and reversed *Royal Globe* in *Moradi-Shalal v. Fireman's Fund Ins. Co.* (1988) 46 Cal.3d 287, 299. It held that in enacting section 790.03(h), the Legislature contemplated only administrative enforcement by the Commissioner, not private parties. (*Id.* at p. 300.) Recognizing that *Royal Globe's* interpretation of subdivision (h) to allow liability based on single acts, rather than a course of conduct, was in part due to the difficulties individuals would have in proving a pattern of wrongful practices, the *Moradi-Shalal* Court deferred to the Legislature and declined to revisit the interpretation of section 790.03(h): “resolution of these issues regarding the application of *Royal Globe* involves a difficult weighing of competing policies . . . [that] is more properly made by the Legislature.” (*Id.* at pp. 303-304.) In addition, the Court directly “urged” the Commissioner to continue to enforce the Unfair Insurance Practices Act and the unfair claims practices it prohibits. (*Id.* at p. 304.)

### **III. THE LEGISLATURE RESPONDED TO *MORADI-SHALAL* BY STRENGTHENING THE COMMISSIONER'S ADMINISTRATIVE ENFORCEMENT POWERS**

The Legislature responded to *Moradi-Shalal's* invitation for stronger administrative enforcement of the Unfair Insurance Practices Act. In 1989, the Legislature added section 790.035, which authorized the Commissioner to impose civil penalties of up to \$5,000 for each act in violation of section 790.03, or \$10,000 for each willful act, and authorized such penalties without the need for the Commissioner to first issue any prior cease-and-desist order. Section 790.035 was intended to provide the Commissioner

with an additional tool to induce compliance and to deter insurers from engaging in unfair and deceptive claims-handling acts or practices. ([Stats. 1989, c. 725 \(S.B. 1363\) § 1](#), Ex. A to Commissioner’s Motion for Judicial Notice (“RJN”).) The Legislature, in enacting section 790.035, recognized that the remedies available to the Commissioner at the time were insufficient to deter unfair practices. (Sen. Insurance, Claims and Corporations Com., Rep. on Sen. Bill No. 1363 (1989-1990 Reg. Sess.), pp. 2-3, Ex. B to RJN.) It stated that section 790.035 was intended to be “consistent with the spirit of *Moradi-Shalal* by giving adequate power to the Commissioner to dissuade insurers from unfair practices, and by providing an incentive to the insurance industry to refrain from such practices.” (*Id.* at p. 3.)

One year later, in 1990, the Legislature enacted section 12921.1, directing the Commissioner to establish a program to receive and investigate consumer complaints, including complaints of insurers’ claims-handling practices, and to take enforcement action based on those complaints consistent with existing laws, including the Unfair Insurance Practices Act. ([§ 12921.1, subd. \(a\)\(6\)](#).) In so doing, the Legislature stated that “the Department of Insurance should . . . focus[] increased energies on bringing actions against those insurers who are found through the complaint handling process to be in violation of insurance laws and regulations” and “develop sufficient procedures to investigate complaints and to pursue appropriate disciplinary action . . . .” ([Stats. 1990, ch. 1375 \(S.B. 2569\), § 1](#), Ex. C to RJN.)

#### **IV. IN RESPONSE TO THE NEW ENACTMENTS, THE COMMISSIONER ADOPTED THE FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS**

Between 1985 and 1989, the Department of Insurance significantly increased its staff and budget for handling complaints relating to claims



handling, yet consumer complaints were not materially decreasing. (Initial Statement of Reasons, p. 2, Ex. D to RJN.) The Commissioner determined that part of the problem was that some of the language of section 790.03(h) was broad and open-ended, leading to ambiguity about the prohibited conduct. The Department and insurers “frequently disagree[d] on how to apply the provisions of the Act in specific cases....” (*Ibid.*) The Commissioner concluded that “[i]f the guidelines were more specific, the ambiguity that fosters disputes would be eliminated and the need for department intervention to mediate those disputes would be reduced.” (*Ibid.*)

The Commissioner further recognized that *Moradi-Shalal*’s elimination of private enforcement heightened the need for administrative enforcement. In the past, a civil suit by an individual policyholder or claimant was a powerful deterrent against any delay in an insurer’s claims settlement practices. *Moradi-Shalal* eliminated that deterrent, and instead the Court “invited the Department of Insurance to step into the breach and become the guardian of the rights of insurance consumers.” (Initial Statement of Reasons, p. 3, Ex. D to RJN; see *Moradi-Shalal, supra*, 46 Cal.3d at p. 304.)

These considerations led the Commissioner to propose claims settlement regulations “appropriate for the California insurance environment.” (Initial Statement of Reasons, p. 3, Ex. D to RJN.) The express purpose of these regulations was to “delineate certain minimum standards for the settlement of claims, which when violated ... shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h).” ([Reg. 2695.1\(a\)\(1\)](#).) The regulations would define statutory terms and set definitive standards for claims processing. The Commissioner studied various model regulations, but determined that “they did not address the particular needs of the California

insurance consumer or the varied and complex insurance industry in a comprehensive manner.” (Initial Statement of Reasons, p. 3, Ex. D to RJN.) Therefore, the Commissioner convened a task force consisting of industry groups, consumer groups, members of the legal community and other public interest groups to advise him on “appropriate unfair claims settlement practice regulations that would meet California’s needs.” (*Ibid.*)

On October 22, 1991, after considering the task force’s recommendations and determining the regulations’ objectives, the Commissioner proposed to promulgate the Fair Claims Settlement Practices Regulations to implement, interpret and make specific the provisions of section 790.03(h). (Notice of Proposed Action, Ex. E to RJN; Initial Statement of Reasons, p. 1, Ex. D to RJN.) The Commissioner held a public hearing, received and responded to extensive written public comments, and made various amendments to the proposed regulations based on input received from stakeholders, including consumer groups and the industry. He further applied his knowledge of “the particular needs of the California insurance consumer” and his expertise in the “varied and complex insurance industry” to ensure that the regulations addressed the crucial issues necessary to effectively administer and further the purposes of the Unfair Insurance Practices Act. (Initial Statement of Reasons, pp. 3-4, Ex. D to RJN.)

On October 22, 1992, the Commissioner issued his Final Statement of Reasons for the Fair Claims Settlement Practices Regulations. He explained that while numerous alternatives were suggested during the rulemaking process, he determined that “none of the alternatives to the proposed regulation would be as effective and less burdensome [on consumers] than the proposed regulation.” (Final Statement of Reasons, p. 4, Ex. F to RJN.) The Office of Administrative Law approved the

regulations pursuant to Government Code section 11349.3 and the regulations took effect on January 14, 1993.

The Legislature has twice amended section 790.03(h) since the regulations were adopted in 1992. ([Stats. 2001, ch. 253 \(A.B. 1193\)](#), § 2, Ex. G to RJN; [Stats. 2011, ch. 426 \(S.B. 712\)](#), § 1, Ex. H to RJN.) In addition, in 1991, while the regulations were under consideration, the Legislature enacted section 790.034 to require that the regulations “take into consideration settlement practices by classes of insurers.” ([§ 790.034, subd. \(a\)](#).) That statute was amended in 2001—almost a decade after the Commissioner first adopted the regulations—to require that insurers, upon receipt of a claim, provide the claimant with a written notice stating that “[i]n addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state,” and explain to the insured how to obtain a copy of the regulations. ([§ 790.034, subd. \(b\)\(1\)](#).)

## STATEMENT OF THE CASE

### **I. THE COMMISSIONER ISSUED A DECISION AND ORDER FINDING PACIFICARE ENGAGED IN UNFAIR CLAIMS SETTLEMENT PRACTICES**

The administrative enforcement proceeding underlying this facial challenge arose in the aftermath of the acquisition of PacifiCare by UnitedHealth. (AA 84-85.)<sup>4</sup> In 2005, after announcing it intended to acquire PacifiCare, UnitedHealth sought approval of the acquisition from the Insurance Commissioner. UnitedHealth assured then-Commissioner John Garamendi that, although it had previously been the subject of a

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<sup>4</sup> The Commissioner provides this enforcement history for the Court’s reference, but notes that the appeal currently before this Court involves only Phase 1, which resulted in the trial court’s facial invalidation of certain regulations. (See discussion at pp. 22, below.)

multi-state enforcement action, it would not repeat its prior problems and it would not undermine PacifiCare, an insurer that until then had a good record of regulatory compliance and customer service. The Commissioner agreed to the acquisition, subject to certain commitments, and the acquisition closed on December 20, 2005. (*Ibid.*)

Significant deterioration in claims handling immediately followed the acquisition. (AA 85-90.) PacifiCare implemented cost-cutting measures, laid off employees, and transferred several key functions to outside vendors with no knowledge of PacifiCare's business. The transition to UnitedHealth systems was beset by problems. (See generally *ibid.*) These difficulties led to multiple problems at every level of claims handling. (*Ibid.*)

Within one year of the acquisition, the Department received increasing complaints from consumers and providers about PacifiCare's claims-handling practices, including from the California Medical Association and the University of California Medical Centers. (AA 90-91.) The large volume of complaints triggered an investigation which uncovered regulatory compliance issues. This prompted the Department to undertake a targeted Market Conduct Examination in May 2007, and in November 2007 it transmitted to PacifiCare its written findings. In December 2007, PacifiCare issued its responses, admitting to approximately 130,000 violations of law, and disputing other findings. (AA 91.)

In 2008, based on the complaints, investigation and market conduct examination, the California Department of Insurance filed an administrative enforcement action against PacifiCare for violating claims handling practices under the Unfair Insurance Practices Act and other provisions of the Insurance Code. Following an evidentiary hearing that proceeded over three years, the Commissioner issued a 220-page Decision and Order on June 9, 2014, finding over 900,000 acts and practices in violation of the

Insurance Code. The Department recommended an aggregate penalty of \$325 million. The Commissioner imposed penalties of \$173,603,750. (AA 90-92.)

## **II. PACIFICARE CHALLENGED THE COMMISSIONER’S DECISION**

On July 10, 2014, PacifiCare filed a writ petition challenging almost all of the Commissioner’s factual findings and legal conclusions in the administrative hearing. (AA 13.) PacifiCare further sought declaratory and injunctive relief as to the validity of the three provisions of the Fair Claims Settlement Practices Regulations, which the Commissioner relied on in his decision:

1. [Regulation 2695.1\(a\)](#), provides (among other matters) that claims settlement violations occur “when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice.”

2. [Regulation 2695.2\(l\)](#), defines “knowingly committed,” as “performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.”

3. [Regulation 2695.2\(y\)](#), defines “willful” and “willfully,” for the purpose of imposing fines under section 790.035, as “simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage.”

## **III. THE TRIAL COURT IN PHASE 1 INVALIDATED THE REGULATIONS ON THEIR FACE**

The trial court bifurcated the proceedings into two phases: the declaratory relief/injunction action (Phase 1) and review of the Commissioner’s factual findings and legal determinations in the Decision (Phase 2).

On September 8, 2015, the trial court issued its order in Phase 1, and invalidated the three regulations. (AA 1194.) The court held that Regulation 2695.1(a) improperly interpreted section 790.03(h) by finding that a violation can be based upon a single act of any of the enumerated 16 practices. It held that section 790.03(h) does not prohibit these practices when they are “knowingly committed on a *single occasion*.” (AA 1196, italics in original.) It determined that the regulation “is inconsistent and in conflict with the statute” and, based on “legislative history” and the court’s interpretation of case law, was “promulgated in excess of the Commissioner’s jurisdiction.” (*Ibid.*) The court also invalidated Regulation 2695.2(l)’s definition of “knowingly committed,” holding that the inclusion of “implied or constructive knowledge ... enlarges, alters, and amends the scope of section 790.03(h)” as the “commonly understood meaning” of knowingly “applies to facts, not legal concepts.” (*Ibid.*) And it invalidated Regulation 2695.2(y)’s definition of “willful” or “willfully,” holding that the definition is “inconsistent with the two-tier penalty scheme in section 790.035, which fixes a lower maximum penalty for non-willful acts than for willful acts,” that it “blurs the distinction between willful and non-willful” and that it is “impermissibly broad.” (*Ibid.*)

On August 18, 2016, the trial court issued an injunction based on its September 8 order, enjoining the Commissioner from enforcing those portions of the regulations that the court had declared invalid. (AA 1134.)

On August 19, 2016, the Commissioner timely appealed. On September 6, 2016, the Commissioner filed a motion to confirm that the injunction was mandatory. (AA 1363.) The Commissioner also requested, alternatively, that the trial court exercise its discretion to stay the injunction if the Court considered the injunction to be prohibitory. (AA 1364.) Further, because most of PacifiCare’s extensive factual and legal challenges

to the Commissioner's order will be mooted if the injunction is overturned on appeal, the Commissioner moved to stay the writ proceeding. (*Ibid.*)

On September 28, 2016, the trial court denied the Commissioner's motion in its entirety. (AA 1514.) On November 3, 2016, this Court granted the Commissioner's petition for writ of supersedeas in part and denied it in part, suspending the injunction pending resolution of the appeal. The Court explained "To preserve the status quo and to prevent irreparable harm, the injunction is SUSPENDED pending the resolution of this appeal, which involves 'substantial' issues of law." (November 3, 2016 Order.) It continued, "However, the petition is DENIED to the extent it requests trial court proceedings to be stayed pending the resolution of this appeal." (*Ibid.*)

Oral proceedings on Phase 2 were held over six days in January and February 2017. The trial court has not yet issued a final decision.

## STANDARD OF REVIEW

### **I. REGULATIONS ARE PRESUMED VALID AND CAN BE SET ASIDE ONLY ON A SHOWING THAT THE AGENCY CLEARLY OVERSTEPPED ITS STATUTORY AUTHORITY**

Regulations "come[] to the court with a presumption of validity." (*Association of California Insurance Companies v. Jones* (2017) 2 Cal.5th 376, 389 ("ACIC").) The burden of demonstrating invalidity is squarely on the challenger. (*Credit Ins. General Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 657.)

Where, as in this case, the Legislature has conferred on a state agency or officer the power to adopt regulations to carry out a statute, the question before a reviewing court is whether a challenged regulation is "consistent and not in conflict with the statute" and whether it is "reasonably necessary to effectuate the purpose of the statute." (*Gov. Code*, § 11342.2; see also *ACIC, supra*, 2 Cal.5th at p. 396 [citing *Gov. Code*, § 11342.2].) Applying this standard, "courts recognize that the Legislature

must be permitted to rely on the peculiar ability of an administrative agency to achieve continuous, flexible, and expert regulation ....” (*Ralph’s Grocery v. Reimel* (1968) 69 Cal.2d 172, 176.) A contrary view—where agencies are prevented from exercising their discretion and expertise to address emerging problems—would “suggest that the Legislature had little need for agencies in the first place.” (*ACIC, supra*, 2 Cal.5th at p. 398, citing *Ralph’s Grocery, supra*, 69 Cal.2d 172.)

The nature of a regulation may affect how a court undertakes its review. “Quasi-legislative rules represent ‘an authentic form of substantive lawmaking’ in which the Legislature has delegated to the agency a portion of its lawmaking power.” (*ACIC, supra*, 2 Cal.5th at p. 396, quoting *Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 10.) “Because [quasi-legislative] rules ‘have the dignity of statutes,’ a court’s review of their validity is narrow: ‘If satisfied that the rule in question lay within the lawmaking authority delegated by the Legislature, and that it is reasonably necessary to implement the purpose of the statute, judicial review is at an end.’” (*ACIC, supra*, 2 Cal.5th at p. 397, quoting *Yamaha, supra*, 19 Cal.4th at pp. 10–11.)

In contrast, a court may have a somewhat more active role in reviewing a rule that is purely interpretive and “devoid of any quasi-legislative authority.” (*ACIC, supra*, 2 Cal.5th at p. 397.) In that circumstance, the court must determine “whether the administrative interpretation is a proper construction of the statute[.]” (*Ibid.*) But a court does not approach even this question on a legal blank slate. While the court takes “ultimate responsibility” for construing the statute, it “‘accords great weight and respect’ to the administrative construction.” (*Ibid.*, quoting *Yamaha, supra*, 19 Cal.4th at p. 12.) Even in reviewing a purely interpretive rule, the agency’s view “matters a great deal ....” (*Ibid.*)



In practice, agency rules often “defy easy categorization.” (See *ACIC, supra*, 2 Cal.5th at p. 397; see also *Ramirez v. Yosemite Water Co.* (1999) 20 Cal.4th 785, 799.) As the California Supreme Court recently explained: “It may be helpful instead to imagine ‘quasi-legislative’ and ‘interpretive’ as the outer boundaries of a continuum measuring the breadth of the authority delegated by the Legislature.” (*ACIC, supra*, 2 Cal.5th at p. 397.) “Thus, in certain circumstances, a regulation may have both quasi-legislative and interpretive characteristics—‘as when an administrative agency exercises a legislatively delegated power to interpret key statutory terms.’” (*Ibid.*, quoting *Ramirez, supra*, 20 Cal.4th at p. 799.) Where a rule’s category is not outcome determinative, a court may choose to apply the standard for purely interpretive rules, asking only whether the agency “has reasonably and properly interpreted the statutory mandate.” (*Ibid.*) A rule that meets this standard must be upheld, no matter its category.

In the end, whatever the nature of the rule, the question is whether the agency has acted within the scope of the authority delegated to it by the Legislature. And where “the Legislature has delegated to an administrative agency the responsibility to implement a statutory scheme through rules and regulations, the courts will interfere only where the agency has clearly overstepped its statutory authority ....” (*Ford Dealers Assn. v. Department of Motor Vehicles* (1982) 32 Cal.3d 347, 356.)

## **II. IN THIS FACIAL CHALLENGE, PACIFICARE MUST ESTABLISH THAT THE REGULATIONS CANNOT BE APPLIED CONSISTENT WITH THE RELEVANT STATUTES**

PacifiCare does not challenge the three Fair Claims Settlement Practices Regulations as applied to its own case; rather, it contends that the regulations are invalid on their face because they are in conflict with the Insurance Code. A facial challenge based on an asserted inconsistency with a statute “considers only the text” of the challenged measure as compared

to the statute, “not its application to ... particular circumstances of an individual.” (*Brown v. Superior Court* (2011) 199 Cal.App.4th 971, 990 [facial challenge to furlough program based on statute; ellipses in original], quoting *Tobe v. City of Santa Ana* (1995) 9 Cal.4th 1069, 1084 [constitutional facial challenge].) The challenger must show that the challenged regulation poses “a present total and fatal conflict’ with applicable prohibitions.” (*T.H. v. San Diego Unified School Dist.* (2004) 122 Cal.App.4th 1267, 1281 [facial challenge to school district regulations based on constitution and statute], quoting *Tobe, supra*, 9 Cal.4th at p. 1084.) This standard is “exacting.” (*Today’s Fresh Start, Inc. v. Los Angeles County Office of Ed.* (2013) 57 Cal.4th 197, 218 [constitutional facial challenge].) Courts have required the challenger to establish that any conflict be inevitable, or be present in at least “the generality” or “vast majority” of cases. (*Ibid.* [quotations and citations omitted].) In the constitutional context, the California Supreme Court routinely has declined to “settle the precise formulation” because facial challenges typically fail under any version of the standard. (*Ibid.*)

## SUMMARY OF ARGUMENT

The three regulations at issue in this case are an exercise of the Commissioner’s broad rulemaking authority under section 790.10, which provides that the “Commissioner shall, from time to time as conditions warrant, after notice and public hearing, promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer [the Unfair Insurance Practices Act].” By statute, the Commissioner has the “power to ‘flesh out the statutory public policy’ of the [Act].” (*ACIC, supra*, 2 Cal.5th at p. 391, quoting *Spray, Gould & Bowers v. Associated Int’l Ins. Co.* (1999) 71 Cal.App.4th 1260, 1269.) This includes “interpreting or elaborating on the statutory text[,]”

particularly where “the Legislature uses open-ended language that implicates policy choices of the sort the agency is empowered to make ....” (*Id.* at p. 393.) The regulations embody the Commissioner’s considered policy choices about how best to ensure that the Legislature’s consumer protection objectives are realized in practice, and thus are quasi-legislative in nature. Accordingly, this court’s inquiry could end with a determination that the rules are within the Commissioner’s broad delegated lawmaking authority (see p. 14 and discussion at pp. 24-25, above) and are reasonably necessary to implement the Unfair Insurance Practices Act’s consumer protection purposes (see p. 13, above).

Even assuming the regulations mostly or wholly interpretive, however, they must be upheld. Here, all relevant contextual factors tip toward affording the Commissioner’s interpretations the greatest weight. (See *ACIC, supra*, 2 Cal. 5th at p. 390.) The Commissioner has particular “technical knowledge and expertise” (see *ibid.*; see also pp. 17-19, above) given his long history of overseeing, providing guidance to, investigating, and enforcing against the insurance industry, and of receiving and responding to consumer complaints. And the regulations at issue were promulgated with great “care” (see *ACIC, supra*, 2 Cal. 5th at p. 390)—after study and a lengthy public process and in compliance with the APA—in response to identified compliance issues. (See p. 18, above.) As discussed below, giving proper respect to the Commissioner’s construction of the Unfair Insurance Practices Act, and in light of the relevant text, legislative history, and statutory purpose, the Commissioner “reasonably and properly interpreted the statutory mandate.” (See *ACIC, supra*, 2 Cal.5th at p. 397.)

## ARGUMENT

### **I. REGULATION 2695.1(A), CLARIFYING THAT THE UNFAIR INSURANCE PRACTICES ACT PROHIBITS UNFAIR CLAIMS SETTLEMENT PRACTICES KNOWINGLY COMMITTED ON A SINGLE OCCASION, IS VALID**

The trial court held that the Commissioner, in enacting Regulation 2695.1(a), improperly expanded the scope of the statute by reading the words “knowingly committing” as a separate clause from “performing with such frequency as to indicate a general business practice.” The trial court judged the Commissioner’s interpretation against its own independent statutory construction, as if it were approaching a question of statutory interpretation on a blank slate. This was error. At the very least, a reviewing court must give the Commissioner’s approach great weight. Through that lens, and in light of the statute’s open-ended text and the consumer protection purpose of the Unfair Insurance Practices Act, the regulation must be upheld. It was well within the Commissioner’s authority to determine that single knowing acts in violation of the unfair claim settlement provisions are subject to administrative enforcement, and that the statute does not give insurers a free pass to harm individual consumers.

#### **A. The Single Knowing Act Regulation Is Consistent with the Text and Purpose of Section 790.03(h)**

Section 790.03 prohibits “knowingly committing or performing with such frequency as to indicate a general business practice” any one of sixteen types of claims settlement practices. (§ 790.03, subd. (h).) The Commissioner interpreted the statute as parsing the prohibited behavior into two categories: either the insurer knowingly commits the prohibited practice, or it performs it with such frequency that it is a general business practice. This is a reasonable interpretation. The word “or” between the

two phrases—“knowingly committing” and “performing with such frequency as to indicate a general business practice”—allows for the reading that they are alternatives, because the ordinary meaning of “or” is disjunctive. “[T]he function of the word ‘or’ is to mark an alternative such as ‘either this or that.’” (*In re Jesusa V.* (2004) 32 Cal.4th 588, 622.) If the word “or” is not read as a disjunctive between two alternative bases for liability, then it is functionally read as “and,” so that the statute would read “knowingly committing and performing.” This interpretation treats the words “committing” and “performing” as synonyms, rendering one surplusage. (See *Tuolumne Jobs & Small Business Alliance v. Superior Court* (2014) 59 Cal.4th 1029, 1037 [statutory interpretation that renders words surplusage is to be avoided].)

In addition to reasonably interpreting the statutory language, the Commissioner’s interpretation makes practical sense and reflects his industry expertise. The statute ensures that an insurer is not penalized for a single unwitting mistake. It also ensures that an insurer does not get a free pass to commit one violation to the detriment of the public. Certainly, even one instance of “[f]ailing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies” (§ 790.03, subd. (h)(3)), for example, if committed knowingly, should be subject to enforcement.

Section 790.03(h)’s phrase “unfair claims settlement practices” does not support an argument against single-act liability. In fact, in numerous contexts “practice” has been defined to include single acts. (See, e.g., *Walnut Creek Manor v. Fair Employment & Housing Com.* (1991) 54 Cal.3d 245, 269 [under plain-meaning analysis, a single act may be an “unlawful practice”]; *People v. Ring* (1937) 26 Cal.App.2d Supp. 768, 773 [a single act may constitute the illegal practice of law], acknowledged on this point but disapproved on others by *Birbrower, Montalbano, Condon &*

*Frank v. Superior Court* (1998) 17 Cal.4th 119, 128.) And subdivision (h) itself identifies, among the 16 categories, violations phrased in the singular. (See § 790.03, subds. (h)(7) [“Attempting to settle *a* claim by *an* insured for less than the amount to which a reasonable person would have believed he or she was entitled”], (h)(13) [“failing to provide promptly a reasonable explanation ... for the denial of *a* claim”], (h)(14) [“directly advising *a* claimant”], (h)(15) [“misleading *a* claimant”], (h)(16) [“delaying ... after the insurer has received *a* claim”], italics added to each subdivision.)

A more narrow interpretation of section 790.03(h), to prohibit only knowing acts performed with such frequency as to indicate a general business practice, would not serve the purposes of that provision. It would provide very little incentive or deterrence for the insurance industry to ensure that each claim is processed promptly and correctly. During the rulemaking process, the Commissioner rejected a “one free bite” rule—requiring multiple acts of misconduct before liability attached—as “unacceptable from a consumer protection standpoint” and “bad public policy in view of the protective intent of the law and, most especially, the lack of a private right of action under the [Unfair Insurance Practices Act] since *Moradi Shalal*.” (Response to Public Comments at p. 76, Ex. I to RJN.) Such a construction would mean “that consumers in many cases would have no remedy for single acts of willful misconduct in claim-handling.” (*Ibid.*)

For the past 25 years, “single act” regulations—together with the entire set of unfair claim settlement practices regulations—have worked to protect consumers from unfair claims handling practices. The Department annually receives thousands of complaints related to insurers’ claims handling and annually identifies approximately 10,000 acts in violation of section 790.03(h) and the regulations. (AA 1387.) In the past six years, consumers have recovered over \$240 million from individual complaints

related to claims handling and through the Department’s discovery of such individual violations in market conduct examinations. (AA 1388.) The ability to pursue administrative enforcement of even single, knowing violations is consistent with section 790.03(h) and reasonably necessary to the purpose of protecting the public from unfair acts or practices.

**B. The Supreme Court’s Holding in *Moradi-Shalal* Eliminating Private Enforcement Does Not Preclude the Commissioner’s Interpretation of His Administrative Enforcement Authority**

The trial court held that Regulation 2695.1(a) contradicts the Supreme Court’s 1988 decision in *Moradi-Shalal*. This was error. *Moradi-Shalal* did not address whether the Commissioner had administrative enforcement authority to take action against the knowing commission of single acts of unfair claim settlement. That question was not before the Court.

*Moradi-Shalal* addressed the authorization of a private right of action against insurers under section 790.03(h) for damages asserted by insureds and third parties. The Court had initially authorized private damage claims in *Royal Globe*, and in that context had held that private parties could sue over single-act violations. (*Moradi-Shalal, supra*, 46 Cal.3d at p. 294.) But the practical difficulties and disruption that arose from allowing private claims soon became clear.

The Court in *Moradi-Shalal* therefore revisited its previous decision and determined that enforcement of section 790.03(h) was limited to *administrative* enforcement. (*Moradi-Shalal, supra*, 46 Cal.3d at p. 303.) The Court in *Moradi-Shalal* noted that in allowing for private claims, the *Royal Globe* Court was forced to interpret section 790(h), and in that instance held that there must be liability for single-act violations, because “the plaintiffs in these cases (whether insureds or third party claimants) seldom have the ability to prove any widespread pattern of wrongful

settlement practices on the part of the insurer.” (*Id.* at p. 303.) The *Moradi-Shalal* Court, in contrast, was not required to interpret the statute. Instead, the Court avoided the question altogether by holding that the Unfair Insurance Practices Act did *not* allow for a private right of action:

Yet the interpretive difficulties and complex public policy choices arising under *Royal Globe* result solely from its conclusion that the Legislature intended to confer a private right of action for violation of section 790.03. Reconsideration of that decision seems a far better alternative than allowing ourselves to be swept deeper into the developing interpretive whirlpool it has created.

(*Id.* at p. 304.)

Because *Moradi-Shalal* did not interpret section 790.03(h), it did not limit the Commissioner’s interpretation. As the United States Supreme Court stated in an analogous case under federal law, “[a] court's prior judicial construction of a statute trumps an agency construction otherwise entitled to Chevron deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion.” (*Nat'l Cable & Telecommunications Ass'n v. Brand X Internet Services* (2005) 545 U.S. 967, 982.)

The California Supreme Court did not adopt a new contrary construction, that a single knowing violation of an unfair claim settlement practice cannot be the basis of an enforcement action by the Commissioner. To the contrary, the Supreme Court cautioned that its “decision is not an invitation to the insurance industry to commit the unfair practices proscribed by the Insurance Code” and “urge[d] the Insurance Commissioner and the courts to continue to enforce the laws forbidding such practices to the full extent consistent with our opinion.” (*Moradi-Shalal, supra*, 46 Cal.3d at p. 304.)

Neither do the policy considerations underlying *Moradi-Shalal* suggest that the Commissioner should be prevented from enforcing against



single knowing acts. The Court’s rejection of private rights of action arose in part from the practical problems resulting from allowing *individuals* to pursue claims for damages related to claims settlement: it fosters a multiplicity of lawsuits; individual claims are unpredictable; claims can lead to excessive jury awards; transaction and legal expenses are markedly increased; and such claims place insurers in conflict between insureds and third parties. (*Id.* at pp. 301-302.) The Commissioner, however, is in an entirely different position from a private party, as he acts with the perspective and discretion of a regulator, not a party with interests in an individual transaction. It is reasonable to require insurers to be responsible, even for individual acts, to one entity that is charged with regulating a complex industry to protect consumers as a whole from unfair practices. (See *ACIC, supra*, 2 Cal.5th at p. 394 [regulatory action “offers the agency an opportunity to research and develop all relevant arguments from the affected stakeholders and address a problem in a comprehensive way that treats regulated entities in a like manner.”].)

The Commissioner reasonably determined that the ability to hold insurers accountable for even single violations serves the statute’s purposes. Nothing in *Moradi-Shalal* prevents the Commissioner from carrying out his responsibilities as charged by the Legislature by allowing for enforcement against single, knowing instances of an unfair claim settlement practice.

**C. The Single Knowing Act Regulation Is Consistent with Legislative Intent, as Confirmed by Other Statutory Enactments**

In direct response to *Moradi-Shalal*—because private parties could no longer enforce Unfair Insurance Practices Act violations—the Legislature significantly broadened the scope of the Commissioner’s enforcement authority. It also strengthened support for the Commissioner to enforce single acts that violate section 790.03(h). Section 790.035, which authorizes the Commissioner to penalize *each act*, and section 12921.1, which directs the Commissioner to increase enforcement based on individual consumer complaints, confirm the Legislature’s intent to give the Commissioner authority to enforce the Unfair Insurance Practices Act’s unfair claim settlement practice prohibitions against individual acts. As the courts have declared repeatedly, “we do not construe statutes in isolation, but rather read every statute ‘with reference to the entire scheme of law of which it is part so that the whole may be harmonized and retain effectiveness.’” (*Horwich v. Superior Court* (1999) 21 Cal.4th 272, 276; *Glassman v. McNab* (2003) 112 Cal.App.4th 1593, 1600 [“the various parts of a statutory enactment must be harmonized by considering the particular clause or section in the context of the statutory framework as a whole”].)

**1. Section 790.035 Authorizes the Commissioner to Assess Penalties for Single Acts**

Regulation 2695.1 was promulgated after the enactment of section 790.035 in 1989. Section 790.035 addresses penalties for violations of section 790.03 and makes express reference to the words “any act” (singular) six times:

Any person who engages in *any* unfair method of competition or *any* unfair or deceptive *act* or practice defined in Section 790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars (\$5,000)

for *each act*, or, if *the act* or practice was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for *each act*. The commissioner shall have the discretion to establish what constitutes *an act*. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a *single act* for the purpose of this section.

(§ 790.035, subd. (a) (*italics added*)).) A plain reading of this statute indicates that the Legislature contemplated that the Commissioner might impose penalties based on singular acts, and clarifies that single acts may constitute a violation of the Unfair Insurance Practices Act. Since this statute makes no exception for section 790.03(h), the plain reading illustrates that a single, knowing commission of a prohibited claims settlement practice can constitute a violation.

The legislative history of section 790.035 confirms the intent to broaden and strengthen the statutory enforcement scheme and to afford the Commissioner the power to more vigorously and flexibly enforce the prohibitions of the Act. The then-existing enforcement scheme—which the Legislature specifically noted had no analogy in any of the various codes governing regulation of business—became particularly troubling after the Supreme Court overruled *Royal Globe* and eliminated the private right of action.<sup>5</sup> The Legislature stated that “[t]his measure will allow the Commissioner to impose charges for the initial acts which prompt regulator action.” (Assem. Com. on Finance and Insurance Rep. on Sen. Bill 1363 (1989-1990 Reg. Sess.) as amended July 6, 1989, p. 2, Ex. J to the RJN.) It noted that under the then-existing law, “insurance companies committing unfair and deceptive practices cannot be fined unless they continue the practice after the Insurance Commissioner issues a cease-and-desist order,”

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<sup>5</sup> See Sen. Rules Com. Senate Floor Analyses of Sen. Bill 1363 (1989-1990 Reg. Sess.) as amended Sept. 11, 1989, p. 3, Ex. L to the RJN.

but that “[t]his bill will make insurance companies liable for the *initial act*.” (Assem. Com. On Finance & Insurance Rep. on Sen. Bill No. 1363 (1989-1990 Reg. Sess.) as amended June 23, 1989, p. 1, italics added, Ex. K to RJN). The statute’s words and the express legislative intent make it clear that committing the individual acts enumerated in subdivisions (h)(1) through (h)(16) may be penalized as unfair claims settlement practices, as reflected in Regulation 2695.1(a).

## **2. Section 12921.1, the Consumer Complaint Provision, Directs the Commissioner to Take Action Even Against Single Acts**

In 1990, the Legislature enacted section 12921.1, directing the Commissioner to set up a program for consumers to file complaints about insurance practices, and for the Department to investigate those complaints and to bring appropriate enforcement actions against insurers. (§ 12921.1, subd. (a)(6); § 12921.3; Stats. 1990, ch. 1375 (S.B. 2569), Senate Third Reading, Digest, p. 2, attached as Ex. C to RJN.)<sup>6</sup>

The Legislature’s directive for the Commissioner to investigate an individual consumer complaint about insurance claims handling, and, if appropriate, bring an enforcement action based on that consumer complaint, is in harmony with the Commissioner’s interpretation in Regulation 2695.1(a) that section 790.03(h) prohibits both single acts and acts performed “with such frequency as to indicate a general business practice.” (§ 2695.1(a). )

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<sup>6</sup> In subsequent amendments to section 12921.1, the Legislature expressly recognized that investigation and enforcement of complaints under section 12921.1 apply to claims-handling practices prohibited by section 790.03(h). (See Senate Rules Com. Bill Analysis of Sen. Bill 708 (2001-2002 Reg. Sess.) as amended September 5, 2011, Ex. M to RJN.)

The trial court’s view, on the other hand, that section 790.03(h) requires evidence of a general business practice, would mean that the Department could not take appropriate enforcement action based on a consumer complaint of a single act—even in an egregious case—despite a legislative mandate to do so. It would do little to deter or discourage the insurance industry against unfair claims practices for the Department to receive a complaint alleging prohibited conduct that led to severe harm, to investigate the claim and find it justified, and then tell that consumer that it can do nothing until many more people suffer the same harm. As noted by the Court of Appeal in *Spray, Gould & Bowers v. Associated Int’l Ins. Co.*, *supra*, 71 Cal.App.4th at p. 1271, “[i]t would be a perverse irony for government to take down an insured’s valid complaint, and duly note the insured’s evidence, with an eye only toward the next victim.” The Commissioner’s view—that single knowing acts can be the subject of enforcement—is consistent with the Legislature’s desire for an active, responsive Commissioner and within the Commissioner’s experienced exercise of discretion.

**II. REGULATION 2695.2(L), WHICH DEFINES THE PHRASE “KNOWINGLY COMMITTING” IN SECTION 790.03(H), IS VALID**

In section 790.03(h), the Legislature prohibited insurers from “[k]nowingly committing” listed acts and practices relating to claims settlement. The term “knowingly” is not further defined; accordingly, exercising his broad rulemaking authority under section 790.10, the Commissioner was empowered to define it. Contrary to the trial court’s decision, the Commissioner did not enlarge, alter, or amend the scope of the statute by including in the definition both implied and constructive knowledge. Rather, the Commissioner simply confirmed generally applicable principles governing what constitutes knowledge by an entity. By including “implied” knowledge, the regulation makes clear that well-

established imputation-of-knowledge principles that apply in principal-agent and corporate contexts apply to the claim settlement prohibitions. Further, by including constructive knowledge—consistent with the common legal understanding of knowledge—the regulation creates proper incentives to keep required files and to conduct reasonable investigations. Indeed, any interpretation that would limit knowledge to *actual* knowledge would improperly restrict the scope of regulatory authority and fail to serve the consumer protection purposes of the statute.

**A. Defining Knowledge to Include Implied Knowledge is Consistent with Well-Established Legal Principles**

By including a reference to “implied” knowledge in the regulation, the Commissioner simply confirmed that accepted legal principles serving to impute knowledge in certain circumstances also apply to prohibited insurance claims settlement practices.

In enforcing the Unfair Insurance Practices Act, the Commissioner is often concerned with what businesses, corporations, and principals “know.” Necessarily, a corporation can only act and acquire knowledge through its employees and agents. Therefore, by operation of law, the knowledge of an officer, employee, and agent of a corporation “is the knowledge of the corporation.” (*Sanfran Co. v. Rees Blow Pipe Mfg. Co.* (1959) 168 Cal.App.2d 191, 205 [corporate knowledge includes knowledge of its agent]; *Meyer v. Glenmoor Homes, Inc.* (1966) 246 Cal.App.2d 242, 264 [“Generally, the knowledge of a corporate officer within the scope of his employment is the knowledge of the corporation.”].)<sup>7</sup> Further, a

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<sup>7</sup> As the Commissioner noted in response to comments: “In the context of unfair claim practices, the insurer as a corporation, always possess[es] ‘implied’ or ‘constructive’ knowledge of the acts of its employees in the handling of claims when that conduct is ratified by corporate officers.” (Response to Public Comment at p. 42, Ex. I to RJN.)

corporation has knowledge of the state of its own records and the information they contain. (*McConnell v. Imperial Water Co. No. 1* (1912) 20 Cal.App. 8, 10.) Even when the requisite information is dispersed among several employees, a corporation is charged with knowledge of the sum of the facts known by each. (*People v. Forest E. Olson, Inc.* (1982) 137 Cal.App.3d 137, 139-140 [where three different employees had information collectively sufficient to establish falsity of advertisement, “this knowledge is imputed to the corporate defendant itself,” making the company liable for false and misleading advertisements].)

It is similarly well established that the acts of an agent may be imputed to the principal. An agent has a duty to disclose material matters to the principal, and actual knowledge of the agent is imputed to the principal. (*O’Riordan v. Federal Kemper Life Assur.* (2005) 36 Cal.4th 281, 288; see also *Civ. Code*, § 2332 [“both principal and agent are deemed to have notice of whatever either has notice of, and ought, in good faith and the exercise of ordinary care and diligence, to communicate to the other”].)

At least one other California agency has also seen fit to be clear in its regulations that these principles apply in the insurance context. The Labor Code prohibits the unreasonable delay or refusal of payment of workers’ compensation insurance benefits, and imposes penalties for violations that are both knowing and frequent. (*Lab. Code*, §§ 5814, 5814.6.) In its implementing regulations defining “knowingly,” the Department of Industrial Relations explained that:

a corporation has knowledge of the facts an employee receives while acting within the scope of his or her authority. A corporation has knowledge of information contained in its records and of the actions of its employees performed in the scope and course of employment. An employer or insurer has knowledge of information contained in the records of its third-party administrator and of the actions of the employees

of the third-party administrator performed in the scope and course of employment.

(Cal. Code Regs., tit. 8, § 10112.1.) It was reasonable for the Commissioner, similarly, to remove any ambiguity that might impede industry compliance to the detriment of consumers.

By including a reference to “implied” knowledge in the regulation, the Commissioner simply confirmed that accepted legal principles serving to impute knowledge in certain circumstances also apply to prohibited insurance claims settlement practices. This rulemaking action is consistent with section 790.03(h) and reasonably necessary to the purpose of ensuring the application of the regulations to the regulated industry.

**B. Defining Knowledge to Include Constructive Knowledge is Consistent with the Term’s Common Legal Understanding and Serves the Statute’s Consumer Protection Purposes**

The Commissioner’s interpretation of the word “knowingly” to include constructive knowledge—what a reasonable entity or person would have known in a given circumstance—is consistent with the common legal understanding of that term. Knowledge generally encompasses both actual and constructive knowledge. Civil Code section 18, for instance, expressly recognizes that “notice” of a fact may be either “actual” or “constructive.” Similarly, Black’s Law Dictionary includes within its definition of “knowledge,” not only a definition for “actual knowledge,” but also one for “constructive knowledge.” (Black’s Law Dict. (10th ed. 2014); see also Assem. Com. com. to Civ. Code, § 683.2, subd. (b) [clarifying that “knowledge” means “both actual and constructive knowledge”].)

The general rule is that constructive knowledge—that “which is imputed by law” (Civ. Code, § 18)—is charged to any person who has



sufficient actual knowledge of certain facts for the law to impute to him or her constructive knowledge of another fact:

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.

(Civ. Code, § 19.) Regulation 2695.2(l) simply mirrors this formulation from the Civil Code, by defining “knowingly committed” to mean “performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.”

In many circumstances, courts have recognized that “the means of knowledge is equivalent to knowledge[.]” (*DuBeck v. California Physicians’ Service* (2015) 234 Cal.App.4th 1254, 1267 [citing cases]; see also *Kaiser Foundation Hospitals v. Workers Comp. Appeals Bd.* (1985) 39 Cal.3d 57, 60 n.1 [employer who gains “[k]nowledge of an [employee’s work-related] injury,” from “any source,” is deemed to be on notice of the injury, citing Lab. Code, § 5402, subd. (a).) Interpreting “knowingly” to include constructive knowledge is particularly appropriate where a statute serves a public protection purpose, preventing “what has become known as the ‘ostrich’ type situation where an individual has ‘buried his head in the sand’ and failed to make simple inquiries ....” (*San Francisco Unified School District ex rel. Contreras v. First Student, Inc.* (2014) 224 Cal.App.4th 627, 646 [internal citation omitted].)

The Commissioner reasonably rejected a definition of “knowingly” that would be restricted to actual knowledge as it would not serve the statute’s purposes. (Response to Public Comments at pp. 42-43, 65, Ex. J to RJN.) In the insurance claims settlement context, it is important to create proper incentives to make all proper inquiries and to exercise diligence. Further, as the Commissioner noted, a requirement of actual knowledge would “fail to take into account that in a claims setting many

people handle a claim, and an unfair practice can be committed by cumulative acts, not simply the intentional act of one person.” (*Id.* at pp. 42-43, 65.) A narrower and more restrictive interpretation would offer little protection to insurance consumers and would not effectuate the Legislature’s purpose in enacting unfair claim settlement practices prohibitions. (*Id.* at p. 43.) Indeed, a construction of the term “knowingly” limited to actual knowledge is almost certainly barred by statute. (*Western Oil and Gas Assn. v. Monterey Bay Unified Air Pollution Control Dist.* (1989) 49 Cal.3d 408, 425 [“A court should not adopt a statutory construction that will lead to results contrary to the Legislature's apparent purpose.”].)

If section 790.03(h) recognized only actual knowledge, it would offer little protection to insurance consumers and it would not effectuate the Legislature’s purpose in enacting the Unfair Insurance Practices Act. (Response to Public Comment, p. 43, Ex. J to RJN.) An actual knowledge requirement would impose an element of proof that would significantly impair enforcement of the Act given the inherent difficulty of establishing a defendant’s state of mind, particularly that of a corporate defendant. Such a limiting rule would be “fraught with danger and would open up avenues of fraud which would lead to incalculable hazards. It would permit a corporation, by not letting its right hand know what is in its left hand, to mislead and deceive those who are dealing with it in perfectly good faith.” (*Sanders v. Magill* (1937) 9 Cal.2d 145, 154; see also *People v. Forest E. Olson, Inc.*, *supra*, 137 Cal.App.3d at p. 140.)

Regulation 2695.2(l) reflects the common legal understanding of “knowledge.” The trial court’s rejection of Regulation 2695.2(l) not only failed to give weight to the Commissioner’s interpretation, but affirmatively undermines the purposes of the Unfair Insurance Practices Act. It must be reversed.

### **III. REGULATION 2695.2(Y), WHICH REASONABLY CLARIFIES “WILLFUL” AS USED IN THE CIVIL PENALTY PROVISION, SECTION 790.035, IS VALID**

Regulation 2695.2(y) provides that “willful” or “willfully” “means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter [of the regulations]. It does not require any intent to violate law, or to injure another, or to acquire any advantage.” The regulation provides particular guidance in the application of section 790.035, which provides that the Commissioner may assess penalties against insurers for violations of the Unfair Insurance Practices Act. Under section 790.035, each act or practice in violation of the Act is subject to a penalty of up to \$5,000 per act, but, if the “act or practice was willful,” the maximum penalty increases to \$10,000 per act. Section 790.035 does not specifically define “willful.”

The regulation carries out the intent of the Act, and the Insurance Code more generally, and reflects a common understanding of “willful” in a variety of contexts to mean only that the act was deliberate. This is a reasonable exercise of the Commissioner’s discretion. Both of the trial court’s grounds for striking down this regulation on its face—that it is inconsistent with the two-tier penalty scheme in section 790.035, and that it attempts to override other definitions of “willful” or “willfully” in the Insurance Code—are without merit and fail to give great weight and respect to the Commissioner’s interpretation.

#### **A. A Definition of “Willful” that Requires Deliberate Action, but Not Bad Intent, Is Consistent with the Insurance Code’s Consumer Protection Purposes**

As a threshold matter, the term “willful,” standing alone, is open-ended, and must be “construed according to context.” (*Goodhew v. Industrial Acc. Com.* (1958) 157 Cal.App.2d 252, 256.) The Legislature can, of course, choose to specially define “willful” to require a bad intent.

But where the Legislature has elected not to so limit the term, it has often been understood to require merely deliberate action—particularly where the harm of any violation falls on persons who are in some way vulnerable, or on the public. (See, e.g., [Penal Code, § 7](#) [discussed below]; [Heritage Residential Care, Inc. v. Division of Labor Standards Enforcement](#) (2011) 192 Cal.App.4th 75, 84 [willful failure of employer to provide itemized wage statements]; [Patarak v. Williams](#) (2001) 91 Cal.App.4th 826, 829-830 [willful violation of Mobilehome Residency Law]; [Apollo Estates, Inc. v. Department of Real Estate](#) (1985) 174 Cal.App.3d 625, 639 [willful violation of regulations governing licensed real estate brokers]; [People v. Clem](#) (1974) 39 Cal.App.3d 539, 542 [willfully selling unqualified securities]; [Goodhew, supra](#), 157 Cal.App.2d at p. 257 [willful failure of employer to secure workers’ compensation insurance].)

Because the Legislature used “willful” in 790.035 but did not specifically define it, the Commissioner was empowered under section 790.10, and arguably had an affirmative obligation, to define the term. The Commissioner modeled the clarifying regulation on the definition in Black’s Law Dictionary, which defines willful as “as ‘deliberate, intentional or purposeful, not accidental or involuntary’” and Penal Code section 7, which provides in relevant part:

The word “willfully,” when applied to the intent with which an act is done or omitted, implies simply a purpose or willingness to commit the act, or make the omission referred to. It does not require any intent to violate law, or to injure another, or to acquire any advantage.

(Response to Public Comments, p. 79, Ex. J to RJN.) These definitions require deliberate action, but do not require bad intent.

The Commissioner considered other possible definitions, such as the definition of “willful” that applies to workers’ compensation insurance

rating organizations (§ 11750.1, subd. (d), requiring intent to commit the violation)) and the definition that applies only to title insurance (§ 12340.9, similar)). (Response to Public Comments, p. 79, Ex. J to RJN [discussing review of sections 11750.1 and 12340.9; see also § 1858.07 [penalties related to rates and rating].) Those more limited definitions make sense in their particular, highly technical, contexts, which do not involve direct communications and interactions with the public and policyholders. But there is no suggestion that the Legislature intended that these more limited definitions should govern the interpretation of “willful” in other parts of the Insurance Code, particularly where those formulations of the term would work counter to the purposes of the Unfair Insurance Practices Act. The Commissioner’s decision was within his considered expertise.

The trial court relied on *Kwan v. Mercedes-Benz of North America* to jettison the regulation, but that case does not call the Commissioner’s use of Penal Code section 7 into question. In *Kwan*, a car buyer sued the dealer for violation of the refund-or-replace provision of the Song-Beverly Consumer Warranty Act (Civ. Code, §§ 1790, 1793.2, subd. (d)(2)). (*Kwan v. Mercedes-Benz of North America, Inc.* (1994) 23 Cal.App.4th 174, 177.) That act provides for an additional award of civil penalties if the violation is “willful.” (Civ. Code, § 1794, subd. (c).) The case was tried to a jury and, over the dealer’s objections, the only instruction the jury was given on “willful” was modeled on Penal Code 7. (*Id.* at pp. 180-181.) The court held that under the circumstances of the case, providing only this instruction was prejudicial, because the jury should have been allowed to consider whether the dealer’s actions were “the result of a good faith and reasonable belief the facts imposing the statutory obligation [to refund] were not present.” (*Id.* at p. 185.)

Here, in contrast, there are no private party claims and no jury trials. Rather, alleged violations are considered by the Commissioner, who has

expertise in the California insurance market and a deep understanding of the practical application of the Unfair Insurance Practices Act. Importantly, the regulation’s definition of “willful” does not in any way inhibit the Commissioner’s discretion as a fact finder. The Commissioner is fully capable of considering any additional nuances in the concept of “willful” that are relevant to a particular violation. (See, e.g., [Regulation 2695.12, subd. \(a\)\(2\), \(8\), \(11\)](#), providing that Commissioner will consider insurer’s good faith attempt at compliance and remedial measures taken by insurer to address noncompliance.) Construing “willful” where it is otherwise undefined in the Insurance Code to require deliberate action, but not bad intent, encourages insurers to be informed and careful in their actions, particularly towards consumers, who trust insurers and rely on their expertise. Indeed, an insurer is a fiduciary with a heightened duty to the policyholder. (See, e.g., *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 818-819 [“For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it again must give at least as much consideration to the latter’s interests as it does to its own.”].) And an implied covenant of good faith and fair dealing exists in every insurance contract. (*Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 658.) As the Commissioner reasonably determined, the regulation here creates the proper incentives for insurers to know the law in this area and to assiduously comply with it.

**B. The Regulation’s Definition of “Willful” Is Consistent with the Two-Tier Penalty Structure of Section 709.035**

The trial court stated summarily that “[t]he regulation is inconsistent with the two-tier penalty scheme in Insurance Code section 790.035, which fixes a lower maximum penalty for non-willful acts than for willful acts” because it “blurs the distinction between willful and non-willful.” (Order, p. 4, citing *Kwan, supra*, 23 Cal.App.4th at pp. 184-185.) This is error.

The trial court failed to apply the standard for a facial challenge, which presents a high hurdle. There is no suggestion that applying the regulation will, in the generality of the vast majority of cases, lead to all violations of section 790.03 being categorized as willful as subject to increased penalties under section 790.035, and PacifiCare did not even attempt to make that showing. This result precludes striking down the regulation on its face, and this Court could end its analysis here.

In any event, the regulation does not require that all violations of subdivision (h) be categorized as willful. This is plainly true if subdivision (h) is read in the disjunctive, and the adjective “knowingly” applies only to single act violations (see pp. 28-37, above). In that case, where a prohibited claims settlement practice is performed with such frequency to indicate a general business practice, there may be a violation that is neither knowingly committed nor willful, and that violation would be subject to the lower-tier penalty under section 790.035.

And it is also true for violations of section 790.03(h) that are committed knowingly. Knowing violations are not necessarily willful, because Regulation 2695.2(l) and Regulation 2695.2 (y) do not define “knowingly” and “willful” as synonyms. For example, the Commissioner could find that an insurance company violated the Act by failing to properly train its claims agents on the Fair Claims Settlement Practices Regulations, as required by Regulation 2695.6(b). Under the circumstances of the case, the company could be held to have constructive knowledge that it did not have adequate training, establishing a knowing violation. Proper training is foundational to proper claims processing, so this violation is clearly serious. Improper training can result in denied or delayed medical treatment, providers taking insureds to collection for nonpayment, insureds being unaware of their appeal rights, and many other harms. Yet, depending on the circumstances, the Commissioner might find that the failure falls short

of being willful. The failure to conduct the training could be the result of oversight or neglect in failing to carry out the company's clear plan to institute training, and therefore, the Commissioner could determine that it was not a willful violation.<sup>8</sup>

The view that knowingly is not synonymous with willful is also reflected in the Penal Code. Penal Code section 7, which is the basis for the regulation's definition of "willfully," also includes a separate definition for "knowingly." The Penal Code states that "[t]he word 'knowingly' imports only a knowledge that the facts exist which bring the act or omission within the provisions of this code. It does not require any knowledge of the unlawfulness of such act or omission." ([Penal Code, § 7, subd. \(5\).](#)) Willfully is "a purpose or willingness to commit" the act that constitutes the violation, without necessarily an intent to violate the law. ([Pen. Code, § 7, subd. \(1\).](#)) In the Penal Code and in the Commissioner's regulations, "knowingly" relates to knowledge of the facts that constitute the violation, while "willful" or "willfully" describes the mental state that accompanies the undertaking of the activity.

In the context of the Unfair Insurance Practices Act, the Commissioner makes an individual determination whether a knowing, single-act violation is also willful, based on the facts involved and the exercise of his regulatory discretion. Those individual determinations are not before the Court in this facial challenge, and PacifiCare cannot show that the regulation's definition of "willful" poses a "a present total and fatal conflict" with the penalty structure of section 709.035. (*T.H. v. San Diego Unified School Dist.* (2004) 122 Cal.App.4th 1267, 1281.)

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<sup>8</sup> Indeed, the Commissioner's decision here found 8 categories of single knowing act violations willful while 11 categories were not. (AA 84.)



**C. The Regulation’s Definition of “Willful” Does Not Override Any Specific Legislative Definition of “Willful” Set Out in the Insurance Code**

The trial court’s final basis for invalidating Regulation 2695.2(y) on its face may be quickly rejected. The court stated that “the scope of the regulation is impermissibly broad because it purports to encompass any acts or omissions referenced in the entire California Insurance Code, even where ‘willful’ and ‘willfully’ have already been defined.” (AA 1197.)

The Commissioner acknowledges that other parts of the Insurance Code, outside the Unfair Insurance Practices Act, have different definitions of willfulness. (See §§ 11750.1 and 12340.9, discussed above, defining willful in the context of workers compensation and title insurance.) PacifiCare has made no showing that the Commissioner has ever contended that Regulation 2695.2(y) overrides a different legislative definition in another context, nor has PacifiCare suggested that the Commissioner has ever applied it to parts of the code where the term is already specifically defined. Nor did the trial court make such a finding. In fact, any such instance would form the basis for an as-applied challenge. In this facial challenge, however, the Court is not called to consider the application of the regulation to other areas of the Insurance Code, and the Commissioner’s decision to define “willful” in the context of the Fair Claims Settlement Practices Regulations is consistent with the Act.

Where the Legislature has chosen to leave the term open-ended—as it has in the Unfair Insurance Practices Act—it has thereby invited the Commissioner to “fill up the details[.]” (See *ACIC, supra*, 2 Cal.5th at p. 391, quoting *Ford Dealers Assn. v. Department of Motor Vehicles* (1982) 32 Cal.3d 347, 362-363.)

Whether viewed as quasi-legislative, purely interpretive, or something in between, the Commissioner’s reasonable and considered

interpretation of “willful” as set out in Regulation 2695.2(y) should be upheld.

#### **IV. THE LEGISLATURE HAS RATIFIED THE COMMISSIONER’S LONGSTANDING FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS**

The three challenged regulations are a reasonable exercise of the Commissioner’s informed discretion. They are within the Commissioner’s broad rulemaking authority and represent his considered determination, after a careful process and in harmony with the language of the Unfair Insurance Practices Act, of how to best protect California’s insurance consumers. The Court should reverse the trial court’s ruling on the grounds discussed above. But as an additional ground, the Legislature has recognized and ratified the regulations since they were promulgated.

For over 25 years, the Commissioner has enforced the Fair Claims Settlement Practices Regulations, including the three regulations challenged in this case. Such longstanding construction indicates that the administrative interpretations are consistent with the Legislature’s intent to prohibit insurers from knowingly committing on a single occasion any act that violates the unfair claims settlement practices, to recognize that knowledge includes implied and constructive knowledge, and to define willfully as acts that are purposeful even if not intended to violate the Act. (*El Dorado Oil Works v. McColgan* (1950) 34 Cal.3d 731, 739; see *Moore v. California State Bd. of Accountancy* (1992) 2 Cal.4th 999, 1017-1018 [Legislature is presumed to be aware of administrative construction of longstanding duration].)

Here, there is even stronger evidence that the regulations are consistent with legislative intent. The Legislature closely followed the rulemaking process when the Fair Claims Settlement Practices Regulations were under consideration, and it was well aware of their contents. In fact,

in 1991, while the rulemaking was in process, the Legislature enacted section 790.034 to require the Commissioner to “take into consideration settlement practices by classes of insurers” when adopting the regulations—but elected not to further direct the content of the regulations. (§ 790.034, subd. (a).)

And in 2001, almost a decade after the regulations were promulgated and had been in effect, the Legislature amended section 790.034 to require insurers upon receipt of a claim, to provide insureds with a written notice stating that “*In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state.*” (*Id.*, subd. (b)(1), italics added.) That statute also required insurers to explain to the insureds how to obtain a copy of the regulations. (*Ibid.*) Thus, the Legislature not only specifically acknowledged the regulations but cited them with approval noting that they “govern” and required insureds to be made aware of them. Section 790.034 was originally drafted to sunset in 2017, but in 2015, the Legislature passed Assembly Bill 1515, which made section 790.034 permanent.

As *Yeoman v. Dept. of Motor Vehicles* (1969) 273 Cal.App.2d 71 explained, the Legislature may ratify and approve a regulation by specifically referencing it in a subsequent legislative act. (*Id.* at p. 80.) *Yeoman* considered a State Board of Education regulation addressing school bus driver certificates. Although those regulations exceeded the scope of the agency’s rulemaking authority at the time because the Board did not have authority over the Department of Motor Vehicles, the Legislature’s subsequent enactment of laws that referred to “the regulations of the State Board of Education for school bus drivers” was sufficient to ratify the regulations. (*Id.* at pp. 81 [quoting statutes], 83; see also *Professional Engineers in Cal. Government v. Schwarzenegger* (2010) 50 Cal.4th 989, 1000, 1051 [concluding that even if the Governor had no

authority to impose furlough on represented state employees, the Legislature's subsequent passage of budget acts which included the savings equal to the Governor's furlough program "operated to ratify" the furlough].)

Thus, to the extent there is any question that the Fair Claims Settlement Practices Regulations were fully authorized at the time of their enactment by section the broad language of section 709.10, the Legislature effectively ratified the regulations when it referred to them expressly in section 790.034, required them to be made available to consumers, and stated that they govern claims processing.

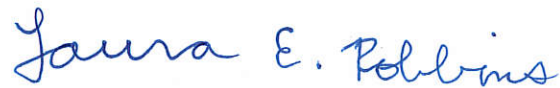
### **CONCLUSION**

Regulations 2695.1(a), 2695.2(I), and 2695.2(y) are well within the Commissioner's broad rulemaking authority under section 790.10 and reasonably necessary to ensure that the consumer protection purposes of section 790.03(h) are met. The regulations can and should be upheld on these grounds alone, as expressions of the Commissioner's quasi-legislative rulemaking authority. But even if the regulations are viewed as purely interpretive, they are entitled to great weight and must be upheld as consistent with the Unfair Insurance Practices Act's text, legislative history, and statutory purpose. Further, PacifiCare has made no showing that the regulations cannot be applied consistent with the Act, as is required to prevail on a facial challenge. The Commissioner did not clearly overstep his rulemaking authority and therefore respectfully requests that this Court reverse the trial court's order invalidating the regulations and dissolve the injunction.

Dated: April 7, 2017

Respectfully submitted,

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LA2016602083

**CERTIFICATE OF COMPLIANCE**

I certify that the attached APPELLANT'S OPENING BRIEF uses a 13 point Times New Roman font and contains 13,474 words.

Dated: April 7, 2017

XAVIER BECERRA  
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official capacity as the Insurance  
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**DECLARATION OF ELECTRONIC SERVICE AND SERVICE BY U.S. MAIL**

Case Name: **Pacificare v. Jones, Ins. Commissioner (DOI)**

Case No.: **G053914**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the Office of the Attorney General for collecting and processing electronic and physical correspondence. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service with postage thereon fully prepaid that same day in the ordinary course of business. Correspondence that is submitted electronically is transmitted using the TrueFiling electronic filing system. Participants who are registered with TrueFiling will be served electronically. Participants in this case who are not registered with TrueFiling will receive hard copies of said correspondence through the mail via the United States Postal Service or a commercial carrier.

On April 7, 2017, I electronically served the attached **APPELLANT'S OPENING BRIEF** by transmitting a true copy via this Court's TrueFiling system. Because one or more of the participants in this case have not registered with the Court's TrueFiling system or are unable to receive electronic correspondence, on April 7, 2017, I placed a true copy thereof enclosed in a sealed envelope in the internal mail collection system at the Office of the Attorney General at 300 South Spring Street, Suite 1702, Los Angeles, CA 90013, addressed as follows:

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On April 7, 2017, I caused one electronic copy of the **APPELLANT'S OPENING BRIEF** in this case to be served on the California Supreme Court by submitting a copy through the Court of Appeals' electronic filing system (TrueFiling), pursuant to Rule 8.212 (c)

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on April 7, 2017, at Los Angeles, California.

Angela Artiga  
Declarant

  
Signature