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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

ASSOCIATION OF CALIFORNIA INSURANCE COMPANIES and PERSONAL INSURANCE FEDERATION OF CALIFORNIA, Plaintiffs, v. DAVE JONES in his capacity as Commissioner of the California Department of Insurance, Defendant.	CASE NO. BC463124 **PLAINTIFFS' REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF DECLARATORY JUDGMENT** **DEPT.: 36** **ACTION FILED: JUNE 8, 2011** **TRIAL DATE: JANUARY 30, 2013**

Plaintiffs Association of California Insurance Companies and Personal Insurance Federation of California request judicial notice of the following documents pursuant to California Evidence Code section 452, subdivisions (b) and (c), and section 453; California Rules of Court, Rule 3.1306(b); and Los Angeles County Superior Court Local Rule 3.8, subdivision (b):

A. Title 10 of the California Code of Regulations, section 2695.183. A copy of the text is attached as Exhibit A.

B. The ruling issued on December 30, 2010, in *Association of California Life & Health Insurance Companies v. California Department of Insurance*, Sacramento County Superior Court Case No. 34-2010-8000637, by the Honorable Michael Kenny. A certified copy of the ruling is attached as Exhibit B for filing with this request.

C. The Order on Demurrer and Motions to Strike and Dismiss issued on August 15, 2012, in the Matter of the Order to Show Cause; Accusation; Notice of Non-Compliance and Hearing; and Demand Issued to: *Globe Life and Accident Insurance Company, et al.* by Administrative Law Judge Stephen J. Smith, Office of Administrative Hearings, before the Insurance Commissioner, Department of Insurance, Case No. UPA-2008-00017. An endorsed-filed copy of the Order is attached as Exhibit C for filing with this request.

DATED: December 14, 2012

GREENBERG TRAURIG, LLP

By: _____
GENE LIVINGSTON
Attorneys for Plaintiffs Association of California Insurance Companies and Personal Insurance Federation of California

EXHIBIT A

10 CA ADC § 2695.183

§ 2695.183. Standards for Estimates of Replacement Value.

Term

10 CCR § 2695.183

Cal. Admin. Code tit. 10, § 2695.183

Barclays Official California Code of Regulations Currentness
Title 10. Investment
Chapter 5. Insurance Commissioner
Subchapter 7.5. Unfair or Deceptive Acts or Practices in the Business of Insurance
Article 1.3. Valuation of Homes (Refs & Annos)
§ 2695.183. Standards for Estimates of Replacement Value.

No licensee shall communicate an estimate of replacement cost to an applicant or insured in connection with an application for or renewal of a homeowners' insurance policy that provides coverage on a replacement cost basis, unless the requirements and standards set forth in subdivisions (a) through (e) below are met:

(a) The estimate of replacement cost shall include the expenses that would reasonably be incurred to rebuild the insured structure(s) in its entirety, including at least the following:

(1) Cost of labor, building materials and supplies;

(2) Overhead and profit;

(3) Cost of demolition and debris removal;

(4) Cost of permits and architect's plans; and

(5) Consideration of components and features of the insured structure, including at least the following:

(A) Type of foundation;

(B) Type of frame;

(C) Roofing materials and type of roof;

(D) Siding materials and type of siding;

(E) Whether the structure is located on a slope;

(F) The square footage of the living space;

(G) Geographic location of property;

(H) Number of stories and any nonstandard wall heights;

(I) Materials used in, and generic types of, interior features and finishes, such as, where applicable, the type of heating and air conditioning system, walls, flooring, ceiling, fireplaces, kitchen, and bath (s);

(J) Age of the structure or the year it was built; and

(K) Size and type of attached garage.

(b) The estimate of replacement cost shall be based on an estimate of the cost to rebuild or replace the structure taking into account the cost to reconstruct the single property being evaluated, as compared to the cost to build multiple, or tract, dwellings.

(c) The estimate of replacement cost shall not be based upon the resale value of the land, or upon the amount or outstanding balance of any loan.

(d) The estimate of replacement cost shall not include a deduction for physical depreciation.

(e) The licensee shall no less frequently than annually take reasonable steps to verify that the sources and methods used to generate the estimate of replacement cost are kept current to reflect changes in the costs of reconstruction and rebuilding, including changes in labor, building materials, and supplies, based upon the geographic location of the insured structure. The estimate of replacement cost shall be created using such reasonably current sources and methods.

(f) Except as provided in subdivision (k) of this Section 2695.183, the provisions of this article are binding upon licensees, notwithstanding the fact that information, data or statistical methods used or relied upon by a licensee to estimate replacement cost may be obtained through a third party source. Any and all information received by the Department pursuant to this article shall be accorded the degree of confidential treatment required by section 735.5 of the Insurance Code or Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code, commencing at section 11180.

(g)(1) If a licensee communicates an estimate of replacement cost to an applicant or insured in connection with an application for or renewal of a homeowners' insurance policy that provides coverage on a replacement cost basis, the licensee must provide a copy of the estimate of replacement cost to the applicant or insured at the time the estimate is communicated. However, in the event the estimate of replacement cost is communicated by a licensee to an applicant to whom the licensee determines an insurance policy shall not be issued, then the licensee is not required pursuant to the preceding sentence to provide a copy of the estimate of replacement cost. In the event the estimate of replacement cost is communicated by telephone to an insured, the copy of the estimate shall be mailed to the insured no later than three business days after the time of the telephone conversation. In the event the estimate of replacement cost is communicated by telephone to an applicant, the copy of the estimate shall be mailed to the applicant no later than three business days after the applicant agrees to purchase the coverage.

(2) An estimate of replacement cost provided in connection with an application for or renewal of a homeowners' insurance policy that provides coverage on a replacement cost basis must itemize the projected cost for each element specified in paragraphs (a)(1) through (a)(4), and shall identify the assumptions made for each of the components and features listed in paragraph (a)(5), of this Section 2695.183.

(h) If an estimate of replacement cost is updated or revised by, or on behalf of, the licensee and the revised estimate of replacement cost is communicated to the applicant or insured in connection with an application for or renewal of a homeowners' insurance policy that provides coverage on a replacement cost basis, the licensee shall provide a copy of the revised or updated estimate of replacement cost to the applicant as provided in paragraph (g)(1) of this Section 2695.183, or to the insured simultaneously with the renewal offer, as the case may be. This subdivision (h) shall not apply when the update or revision to the estimate of replacement cost or the policy limit results solely from the application of an inflationary provision in a policy or an inflation factor. This subdivision (h) shall not obligate a licensee to recalculate an estimate of replacement cost on an annual basis.

(i) Licensees shall maintain (1) a record of the information supplied by the applicant or insured that is used by the licensee to generate the estimate of replacement cost, and (2) a copy of any estimate of replacement cost supplied to the applicant or insured pursuant to paragraph (g)(1), or subdivision (h), of

this Section 2695.183. If a policy is issued, these records and copies shall be maintained for the entire term of the insurance policy or the duration of coverage, whichever terminates later in time, and for five years thereafter. However, if the estimate of replacement cost is provided to an applicant to whom an insurance policy is never issued, the records and copies referred to in the first sentence of this subdivision (i) shall be maintained for the period of time the licensee ordinarily maintains applicant files in the normal course of business, provided that such period of time shall be at least sufficient to ensure that the licensee is able to comply with the provisions of this subdivision in the event the policy is issued to the applicant.

(j) To communicate an estimate of replacement value not comporting with subdivisions (a) through (e) of this Section 2695.183 to an applicant or insured in connection with an application for or renewal of a homeowners' insurance policy that provides coverage on a replacement cost basis constitutes making a statement with respect to the business of insurance which is misleading and which by the exercise of reasonable care should be known to be misleading, pursuant to Insurance Code section 790.03.

(k) When an insurer identifies one or more specific sources or tools that a broker-agent must use to create an estimate of replacement cost,

(1) the insurer shall prescribe complete written procedures to be followed by broker-agents when they use the sources or tools,

(2) the insurer shall provide the broker-agent with the training and written training materials necessary to properly utilize the sources or tools according to the insurer's prescribed procedures, and

(3) the insurer, and not the broker-agent, shall be responsible for any noncompliance with this Section 2695.183 that results from the failure of the estimate to satisfy the requirements of subdivisions (a) through (e), unless that noncompliance results from failure by the broker-agent to follow the insurer's prescribed written procedures when using the source or tool.

(l) This Section 2695.183 applies to all communications by a licensee, verbal or written, with the sole exception of internal communications within an insurer, or confidential communications between an insurer and its contractor, that concern the insurer's underwriting decisions and that never come to the attention of an applicant or insured.

(m) No provision of this article shall be construed as requiring a licensee to estimate replacement cost or to set or recommend a policy limit to an applicant or insured. No provision of this article shall be construed as requiring a licensee to advise the applicant or insured as to the sufficiency of an estimate of replacement cost.

(n) No provision of this article shall limit or preclude a licensee from providing and explaining the California Residential Property Insurance Disclosure, as cited in Insurance Code section 10102, explaining the various forms of replacement cost coverage available to an applicant or insured, or explaining how replacement cost basis policies operate to pay claims.

(o) No provision of this article shall limit or preclude an applicant or insured from obtaining his or her own estimate of replacement cost from an entity permitted to make such an estimate by Insurance Code section 1749.85.

(p) For purposes of this subdivision (p), "minimum amount of insurance" shall mean the lowest amount of insurance that an insurer requires to be purchased in order for the insurer to underwrite the coverage on a particular property, based upon an insurer's eligibility guidelines, underwriting practices and/or actuarial analysis. An insurer may communicate to an applicant or insured that an applicant or insured must purchase a minimum amount of insurance that does not comport with subdivisions (a) through (e) of this Section 2695.183; however, if the minimum amount of insurance that is communicated is based in whole or in part on an estimate of replacement value, the estimate of replacement value shall also be provided to the applicant or insured and shall comply with all applicable provisions of this article. Nothing in this article shall limit or preclude an insurer from agreeing to provide coverage for a policy limit that is greater than or less than an estimate of replacement cost provided pursuant to this article.

(q) This article shall apply only to estimates of replacement value that are prepared, communicated or used by a licensee on or after June 27, 2011.

Note: Authority cited: Sections 730, 790.03, 790.04, 790.10, 1749.7, 1749.85, 1861.05 and 2051.5,

Insurance Code. Reference: Sections 730, 790.03, 790.04, 735.5 and 1749.85, Insurance Code.

HISTORY

1. New section filed 12-29-2010; operative 6-27-2011 pursuant to Government Code section 11343.4(b) (Register 2010, No. 53).

10 CCR § 2695.183, **10 CA ADC § 2695.183**

This database is current through 11/30/12 Register 2012, No. 48

END OF DOCUMENT

Term

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EXHIBIT B

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

ASSOCIATION OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANIES, a California not-for-profit corporation,

Petitioner and Plaintiff,

v.

CALIFORNIA DEPARTMENT OF INSURANCE, a public entity; STEVE POIZNER, in his official capacity as Commissioner of California Department of Insurance; and DOES 1-10,

Respondents and Defendants.

Case No. 34-2010-80000637-CU-WM-GDS

RULING ON SUBMITTED MATTER: GRANTING IN PART AND DENYING IN PART PETITIONER ASSOCIATION OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANIES' PETITION FOR WRIT OF MANDATE AND/OR DECLARATORY RELIEF

On August 16, 2010, Petitioner and Plaintiff Association of California Life & Health Insurance Companies filed a Petition for Writ of Mandate and/or Declaratory Relief ("Petition") alleging the Department abused its discretion in adopting various regulations related to postclaims underwriting. Petitioner seeks a peremptory writ of mandate pursuant to Civil Procedure Code § 1085 compelling Respondents and Defendants California Department of Insurance and Steve Poizner, Commissioner, to withdraw the regulations.[1]

Pursuant to the Court's December 9, 2010 Tentative Ruling, the parties appeared before

[1] Petitioner also asks the Court to declare the regulations void and invalid and seeks a permanent injunction precluding the Department from issuing and enforcing the regulations – claims that are essentially duplicative of its Petition

the Court on December 10, 2010, to address the merits of the Petition. The Court subsequently took the matter under submission. The Court, having heard oral argument, read and considered the written argument of all parties, and read and considered the documents and pleadings in the above-entitled action, now rules on the matter as follows:

I. FACTUAL AND PROCEDURAL BACKGROUND

On or about June 5, 2009, Respondent and Defendant California Department of Insurance (the "Department") initiated a rulemaking proceeding, Regulation File REG-2007-00054, intended to address proposed regulations adding a new article 11 to title 10, subchapter 2 of the California Code of Regulations, entitled "Standard for Health History Questionnaires in Health Insurance Applications, Pre-Issuance Medical Underwriting and Rescission of Health Insurance Policies," sections 2274.70-2274.78. (Petition at ¶ 20; Answer at ¶ 20.) The Department invited submission of written comments by July 20, 2009. (Petition at ¶ 22; Answer at ¶ 22.)

Petitioner is a California not-for-profit corporation comprised of 37 member life and health insurance companies in California. (Petition at ¶ 15.) Petitioner represents its constituent members with respect to legislative and regulatory issues affecting the health care and health insurance industries. It brings this action on behalf of its members. (Petition at ¶ 15.) Petitioner submitted written comments regarding the proposed regulations to the Department by the July 20, 2009 deadline. The comments generally asserted that many of the proposed regulations conflicted with the Insurance Code and existing case law. (Petition at ¶ 23; Answer at ¶ 23) The Department responded to the comment letters and issued the Amended Text of Regulation on April 19, 2010. (Petition at ¶¶ 24, 25; Answer at ¶¶ 24, 25.)

On May 2, 2010, Petitioner submitted additional written comments regarding the Department's proposed regulations. (Petition at ¶ 26; Answer at ¶ 26.) The Department responded to Petitioner's comments without altering the proposed regulations (Petition at ¶ 27; Answer at ¶ 27.)

On July 19, 2010, the Office of Administrative Law approved the regulations and the regulations took effect on August 18, 2010. (Petition at ¶ 28; Answer at ¶ 28.)

Petitioner presents a number of challenges to Sections 2274.74, 2274.77, and 2274.78(c),

(d), (g), and (h) of Title 10 of the Code of Regulations ("CCR"). However, from the Court's review of the challenged regulations and the parties' written and oral arguments, it has become clear that the key issue is whether the Department has authority – either express or implied – to promulgate the challenged regulations.

II. DISCUSSION

A. Petitioner has standing to pursue its claims.

The Department contends that Petitioner lacks standing to pursue its claims on two grounds. First, Petitioner, as an association of insurers, does not have standing to pursue its Government Code § 11350 declaratory relief claim because only its members (not Petitioner itself) are subject to the challenged regulations. (Opposition at 9:22-1012.) Second, Petitioner lacks the necessary beneficial interest to seek a petition for writ of mandate pursuant to Civil Procedure Code § 1085. (Opposition at 10:13-25.)

Petitioner has standing to pursue its declaratory relief claim. Government Code § 11350 provides in pertinent part: "Any interested person may obtain a judicial declaration as to the validity of any regulation or order of repeal by bringing an action for declaratory relief in the superior court in accordance with the Code of Civil Procedure." (Gov't Code § 11350(a).)

The Department relies on the First Appellate District's decision in *Associated Boat Industries v. Marshall*, (1951) 104 Cal.App.2d 21, for the proposition that "an incorporated trade association lacks standing to challenge the regulations where only the members of the association, and not the association itself, are subject to the regulations." (Opposition at 10.2-5.) The Department goes on to note that "[s]ome courts have retreated from a strict application of *Marshall*" (Opposition at 10:6), but fails to note that the First Appellate District is one of those courts. In *Environmental Protection Information Center v Department of Forestry and Fire Protection*, (1996) 43 Cal.App.4th 1011, the First Appellate District stated:

> Upon reflection, we agree with the *Residents* court and disapprove of our 1951 decision in *Marshall*. In our view it simply no longer makes good sense to draw a hard and fast line between an organization, particularly a nonprofit one, and its members for purposes of analyzing whether that organization is an "interested party" for purposes of Government Code section 11350. Accordingly, we now hold, consistent with the *Residents* court, that a party may be an "interested" person for purposes of Government Code section 11350 if either it or its members

is or may well be impacted by a challenged regulation.

(*Environmental Protection Information Center, supra*, 43 Cal.App.4th at 1017-18.)

The Department's reliance on *Pacific Legal Foundation v Unemployment Insurance Appeals Board*, (1997) 74 Cal.App.3d 150, is misplaced. There, the Third Appellate District distinguished the *Associated Boat Industries* decision, stating that the First Appellate District addressed the issue of whether an "incorporated trade association, whose members are subject to the regulations attacked but which itself is not subject to those regulations," was an interested person. (*Pac. Legal Found*, *supra*, 74 Cal.App.3d at 156.) The Third Appellate District, however, addressed plaintiff Pacific Legal Foundation, an employer that "is or could be [itself] subject to" the regulation at issue. (*Ibid.*)

Petitioner also possesses the beneficial interest necessary to pursue its Civil Procedure Code § 1085 claim. Civil Procedure Code § 1086 requires a party seeking a peremptory writ of mandate to have a "beneficial interest" in the outcome of the writ proceeding "A beneficial interest means the petitioner has a special interest over and above the interest of the public at large." (*Cal. Ass'n of Health Servs at Home v State Dep't of Health Servs* (2007) 148 Cal.App.4th 696, 706 (citation omitted).) "'[A]n association has standing to bring suit on behalf of its members when: (a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.'" (*Driving School Ass'n of Cal v San Mateo High School Dist* (1992) 11 Cal.App.4th 1513, 1517 (citation omitted).))

The Department does not contend that Petitioner's constituent members do not have standing to sue in their own right. (See Opposition at 10:1-5.) Based on Petitioner's allegations, the Court finds that Petitioner's members indeed have standing to sue in their own right. The Court concludes that the remaining requirements for associational standing are met. Accordingly, Petitioner has standing to pursue its Civil Procedure Code § 1085 claim.

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B. Standard of Review.

Government Code § 11342.2 provides: "Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute."

The traditional two-pronged analysis governing a court's review of an administrative regulation is well known. "First, the court asks whether the [agency] exercised [its] quasi-legislative authority within the bounds of the statutory mandate." (*Mineral Ass'ns Coalition v State Mining and Geology Board* (2006) 138 Cal.App.4th 574, 582 (internal quotations and citation omitted).) Under this first prong, the Court "independently reviews the administrative regulation for consistency with controlling law." (*Communities for a Better Environment v Cal Res Agency* (2002) 103 Cal.App.4th 98, 109 (citation omitted); *State Farm Mutual Auto Ins Co v Garamendi* (2004) 32 Cal.4th 1029, 1040 (citation omitted).) Regulations that alter or amend the governing statute or case law or enlarges or impairs its scope are void. (*Communities*, *supra*, 103 Cal.App.4th at 108 (citation omitted); *Mineral Ass'ns Coalition*, *supra*, 138 Cal App.4th at 582 (citation omitted).)

"[T]he second prong of this standard, reasonable necessity, generally does implicate the agency's expertise; therefore, it receives a much more deferential standard of review. The question [here] is whether the agency's action was arbitrary, capricious, or without reasonable or rationale basis." (*Communities*, *supra*, 103 Cal.App.4th at 109 (citation omitted))

Here, however, resolution of most of the issues before the Court rests on a more fundamental question, assumed in the express language of Government Code § 11342.2: Does the Department have the authority, either express or implied, to adopt the regulations at issue?

"'It is well settled in this state that [administrative] officials may exercise such additional powers as are necessary for the due and efficient administration of powers expressly granted by

statute, or as *may fairly be implied* from the statute granting the powers."[2] (*CalFarm Ins Co*, *supra*, 48 Cal.3d at 824-25 (internal quotations and citation omitted); *In re J G.* (2008) 159 Cal.App.4th 1056, 1066 ("To be valid, administrative action must be within the scope of authority conferred by the enabling statutes") (citation omitted).) "[C]ourts usually give great weight to the interpretation of an enabling statute by officials charged with its administration, including their interpretation of the authority vested in them to implement and carry out its provisions. [Citation.] But regardless of the force of administrative construction, final responsibility for interpretation of the law rests with courts. If the court determines that a challenged administrative action was not authorized by or is inconsistent with acts of the Legislature, that action is void." (*In re J G*, *supra*, at 1066-67 (citation omitted).) The Court must therefore utilize its independent judgment to evaluate the claimed source of the Department's rulemaking authority in order to determine whether the Department in fact has the power to adopt the challenged regulations. (See *County of Santa Cruz v State Bd of Forestry* (1998) 64 Cal. App 4th 826, 834 (citation omitted))

Whether the Legislature expressly delegated quasi-legislative powers to an administrative agency should be readily apparent from the language of a statute. Whether an administrative agency has the implied power to engage in rulemaking involves a more complicated analysis The doctrine of implied powers "'is not without limitations. It cannot be invoked where the grant of express powers clearly precludes the exercise of others, or where the claimed power is incompatible with, or outside the scope of, the express power. For a power to be justified under the doctrine, it must be essential to the declared objects and purposes of the enabling act-not simply convenient, but indispensable. Any reasonable doubt concerning the existence of the power is to be resolved against the agency.'" (*Addison v Dept of Motor Vehicles* (1977) 69 Cal.App.3d 486, 498 (citing 1 Cal.Jur.3d, Administrative Law, § 39, pp. 257-58).)

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[2] Courts have repeatedly held that the commissioner "has broad discretion to adopt rules and regulations as necessary to promote the public welfare " (*Id* at 824, *State Farm, supra*, 32 Cal 4th at 1040 (citation omitted)) However, the commissioner's discretion to adopt necessary rules and regulations must still stem from the Legislature's delegation – either express or implied – of quasi-legislative power to engage in administrative rulemaking.

C. The Petition is granted in part and denied in part.

1. Section 2274.74 is invalid.

Petitioner contends the Department exceeded its authority in promulgating Section 2274.74, "Standard for Avoiding Prohibited Postclaims Underwriting." Section 2274(a) provides:

> In order to complete medical underwriting prior to issuing a policy, the insurer shall obtain the necessary information to evaluate eligibility for coverage in accordance with the insurer's medical underwriting guidelines and determine the appropriate rate for the policy offered. The insurer shall obtain health history information about an applicant necessary to complete medical underwriting from at lease one source of such information, if available, other than self-reported information provided by the applicant. The insurer must engage in the activities specified in Paragraphs (1) through (7) of this Subdivision (a) to the degree necessary to assure that it has obtained the health history information in the detail needed for complete and consistent application of its medical underwriting guidelines and rating plan.

Section 2274.74(a) then goes on to define "medical underwriting" as including, but not limited to, seven enumerated activities. "In order to resolve all reasonable questions arising from written information submitted on an application prior to issuing a policy, the insurer shall obtain and use any necessary additional information external to the health insurance application to resolve inconsistencies or conflicts in the application" (10 CCR § 2274(b).) Section 2274.74(b) then outlines the activities that must be conducted in order to resolve all reasonable questions. (10 CCR § 2274.74(b).)

If an insurer fails to fully comply with the above-outlined provisions, "the insurer is prohibited from rescinding, canceling, limiting a policy or certificate, or increasing the rate charged, subsequent to receiving: (1) a request for authorization of service or verification of eligibility for benefits; (2) notice of a claim; (3) a claim or a request for a change in coverage; or (4) any other communication that puts the insurer on notice of a claim." (10 CCR § 2274.74(c).)

The Department fails to address the authority for the promulgation of Section 2274.74 in its Opposition. During oral argument, however, the Department contended that Insurance Code §§ 790.10 and 12921 authorized the Department to adopt Section 2274.74.[3] The Court disagrees.

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3 Section 2274 74 also identifies the following authorities in support of its adoption Insurance Code §§ 10291 5 and 12926; *CalFarm Ins Co v Deukmejian* (1989) 48 Cal.3d 805, and *20th Century Ins Co v Garamendi* (1994) 8 Cal 4th 216 In support of its adoption of Section 2274 74 The Department failed to address these purported authorities in either its Opposition or during oral argument The Department's failure to rebut Petitioner's arguments constitutes a waiver of any argument the Department may have that these authorities authorize it to adopt the

The Department's argument regarding Insurance Code § 790.10 fails for several reasons. First, Insurance Code § 790.10, which is contained in Article 6.5 of Chapter 1 of Part 2 of Division 1 of the Insurance Code expressly authorizes the commissioner to, "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.***" (Emphasis added.) Postclaims underwriting, however, is governed by a separate article outside the reach of Insurance Code § 790.10 – Article 6 of Chapter 4 of Part 2 of Division 2 of the Insurance Code

Second, Insurance Code § 790.03 defines "unfair methods of competition and unfair and deceptive acts or practices in the business of insurance" to include nine categories of actions, none of which include postclaims underwriting and rescission based thereon. (Ins. Code § 790.03(a)-(i).) "Few cases have provided a more appropriate occasion to apply the maxim *expressio unius exclusio alterius est*, under which the enumeration of things to which a statute applies is presumed to exclude things not mentioned." (*O'Grady v Super Ct* (2006) 139 Cal App. 4th 1423, 1443; *In re J W.* (2002) 29 Cal. 4th 200, 209 ("The other principle, commonly known under the Latin name of *expressio unius est exclusio alterius*, is that the expression of one thing in a statute ordinarily implies the exclusion of other things").)

Nothing in the language or structure of Insurance Code § 790.03 indicates that the list of actions is anything but exclusive. The statute does not contain language commonly found in other statutes setting forth a list of included or excluded items, such as "including, but not limited to " The Legislature could have easily included postclaims underwriting within the definition of unfair methods of competition or unfair or deceptive acts or practices had it intended Insurance Code § 790.03 to cover this practice. (See *O'Grady, supra*, 139 Cal.App.4th at 1444 (citation omitted).)

Most importantly, however, is the fact that the Legislative intent articulated in Article 6 5 supports the conclusion that the Legislature reserved for itself, and only itself, the right to categorically define unfair methods of competition and unfair and deceptive acts or practices [4]

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challenged regulations (*Cal Dept of Corrections v State Personnel Bd* (2004) 121 Cal App 4th 1601, 1619 (citation omitted))

[4] Insurance Code § 790 06 outlines the procedures to be followed "whenever the commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or

Article 6.5 applies to all persons engaged in the business of insurance (Ins. Code § 790.01) and prohibits such persons from engaging in "any trade practice ***which is defined in this article as, or determined pursuant to this article to be***, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." (Ins. Code § 790.02 (emphasis added).) The express purpose of Article 6.5 "is to regulate trade practices in the business of insurance . . . ***by defining, or providing for the determination of,*** all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." (Ins. Code § 790 (emphasis added).)

During oral argument, the Department argued that postclaims underwriting resulting in rescission constitutes an unfair settlement practice, which is defined by Insurance Code § 790.03(h). Insurance Code § 790.03(h) expressly defines an "unfair claims settlement practice" as including 16 specific types of actions.[5] (Ins. Code § 790.03(h)(1)-(16).) Again, the

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in any act or practice in the conduct of the business that is not defined in Section 790.03 " The Department does not cite to Insurance Code § 790 06 as the authority for promulgating Section 2274 74 and did not address this provision in either its Opposition or during oral argument Upon independent review of Insurance Code § 790 06, the Court is unconvinced that it provides authority for the Department to promulgate the challenged regulation In contrast to Insurance Code § 790 03, which generally precludes broad categories of unfair practices, Insurance Code § 790 06 allows the commissioner to identify a specific unfair practice committed by an identifiable insurer, in which case the commissioner may serve that insurer with an order to show cause and notice of hearing to address the alleged unfair practice. It also is undisputed that the outlined procedure has not been followed in this instance

[5] These include (1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverage at issue; (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies, (3) Failing to adopt and implement reasonable standard for the prompt investigation and processing of claims arising under insurance policies, (4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured, (5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear, (6) Compelling insureds to initiate litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered, (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 by reference to written or printed advertising material accompanying or made part of an application, (8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker, (9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made, (10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (11) Delaying the investigation or payment of claims by requiring an insured claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information, (12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage, (13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement, (14) Directly advising a claimant not to obtain the services of an

Legislature could have easily defined unfair settlement practices to include postclaims underwriting had it intended Insurance Code § 790.03(h) to cover this practice.

Moreover, the language of Section 2274.74 indicates the Department's clear intent to prohibit outright the rescission, cancellation, or limiting of a policy or the increasing of rates if an insurer fails to complete medical underwriting and answer all reasonable questions. (10 CCR § 2274.74(c).) An insurer, therefore, is in violation of Section 2274.74 if it engages in postclaims underwriting one time, even if that is the one and only time an insurer engages in such conduct. This scheme is incompatible with Insurance Code § 790.03(h), which provides that an insurer engages in an unfair settlement practice when that insurer knowingly commits or performs various activities "with such frequency as to indicate a general business practice" of engaging in unfair settlement practices.

The Department also contended that Insurance Code § 12921(a) provided the Department with implied authority to adopt Section 2274.74. [6] Insurance Code § 12921(a) requires the commissioner to "perform all duties imposed upon him or her by the provisions of this code and other laws regulating the business of insurance in this state, and shall enforce the execution of those provisions and laws." The Court is unconvinced that this particular provision impliedly authorize the Department's adoption of Section 2274.74. Insurance Code § 12921(a) has consistently been recognized by courts as requiring the commissioner to enforce existing laws regulating the insurance industry, which include duly enacted statutes and duly promulgated administrative regulations. (See *Employees Serv Ass'n v. Grady* (1966) 243 Cal.App 2d 817, 823; *Franklin Life Ins Co. v. State Bd Of Equal.* (1965) 63 Cal.2d 222, 228-29.) The Department has not cited, and the Court has been unable to locate, any authorities supporting the Department's authority to promulgate regulations pursuant to this statute.

That the Department does not have broad-based authority to enact regulations pursuant to

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attorney; (15) Misleading a claimant as to the applicable statute of limitations; and (16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurance has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted coverage

6 The Department did not argue that Insurance Code § 12921(b), which relates to the commissioner's powers in an administrative enforcement action, authorized the adoption of Section 2274 74

Insurance Code §12921(a) is supported by the specific delegation of quasi-legislative power that exists throughout the Insurance Code – a delegation absent from Insurance Code § 12921(a). As discussed in detail above, Insurance Code §790.10 expressly authorizes the commissioner to promulgate regulations governing unfair insurance practices. Most important here, however, is the language of Insurance Code § 12921(c), which specifically provides authority for the promulgation of regulations for document filing:

> Notwithstanding any other provision of law, the commissioner may accept documents submitted for filing or approval, process transactions, and maintain records in electronic form or as paper documents, and may adopt regulations to further this subdivision.

This stands in stark contrast to the absence of such language in Insurance Code § 12921(a). The express delegation of quasi-legislative power by the Legislature to the commissioner in Insurance Code § 12921(c) is clear, rendering the absence of such a delegation in Insurance Code §12921(a) both conspicuous and meaningful.

The Department also cites Insurance Code § 10384 as an authority for the adoption of Section 2274.74. Although not specifically addressed by the Department in its Opposition, the Court addresses this purported authority in light of the parties' significant discussion of this particular statute in both their pleadings and during oral argument.

Insurance Code § 10384 provides: "No insurer issuing or providing any policy of disability insurance covering hospital, medical, or surgical expenses shall engage in the practice of postclaims underwriting. For purposes of this section, "postclaims underwriting" means the rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate " It is clear from the language of Insurance Code § 10384 that the Legislature did not expressly delegate to the Department the authority to promulgate regulations related to postclaims underwriting.

It is also evident that Insurance Code § 10384 fails to provide the Department with the implied authority to adopt regulations related to postclaims underwriting. Nothing in the language of Insurance Code § 10384 relates to the Department. Insurance Code § 10384 is a clear

prohibition on the ability of an insurer to engage in postclaims underwriting. Any argument by the Department that it has implied authority pursuant to Insurance Code § 10384 to adopt Section 2274.74 is negated by the passage of Assembly Bill 658, which was chaptered on September 20, 2010. Effective January 1, 2011, Insurance Code § 10273 7 allows the commissioner, on or before July 1, 2011, to "issue guidance regarding compliance with this section and Sections 10713, 10273.4, 10273.6, 10384.17, and 10384, or any regulations promulgated under those provisions. The guidance shall not be subject to the Administrative Procedure Act. The guidance shall only be effective through December 31, 2013, or until the commissioner adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first." (Ins Code § 10273.7(g).)

Thus, while the Department will arguably have the authority to promulgate regulations related to postclaims underwriting and rescission based thereon as of January 1, 2011, it is evident that the Department did not have this authority at the time Section 2274.74 was adopted.

2. Section 2274.77 is invalid.

Petitioner also challenges Section 2274.77, as being promulgated in excess of the Department's jurisdiction and authority. Section 2274.77 requires an insurer, at the time of issuance and delivery of a policy, to return a complete copy of the application attached to the policy to the insurer for review. (Section 2274.77(a).) An insurer is precluded from using the information on an application "as the basis for rescission or cancellation of the policy unless the application was attached to or endorsed on the policy at the time the policy was delivered to the insured." (Section 2274.77(c).) "Attached to or endorsed on the policy" is defined as requiring "that a complete copy of the applicant's application for health insurance coverage was included in the same mailing, or other delivery mechanism used, at the same time that the health insurance policy was delivered." (Section 2274.74(d).)

For the same reasons articulated by the Court with regard to Section 2274.74, the Court finds that Section 2274.77 is also invalid.

3. Section 2274.78 is valid.

Petitioner also contends that the Department lacked the authority to adopt various timing

requirements encapsulated in Section 2274.78(c), (d), (g), and (h). Section 2274.78 is the only regulation for which the Department addresses the authority for the regulation's adoption in its Opposition. (Opposition at Section VII.) The Department contends that "Insurance Code section 790.03, which proscribes unfair claims investigations, and section 790.10, which grants broad rulemaking authority to implement section 790.03", support the adoption of the challenged portions of Section 2274.78 The Court agrees

Section 2274.78, "Post-Contract Issuance Rescission or Cancellation Investigations," "applies only to claims investigations intended to produce facts or other information that could be used as the basis for an evaluation by the insurer of whether to rescind of cancel the policy where the insurer has either received a claim from a claimant . . . or a notice of a claim . . . ." (10 CCR § 2274.78(a).) Section 2274.78 goes on to impose various timelines related to an insurer's claims investigation where "an insurer receives medical or health history information about an insured after having issued health insurance coverage to the insured and such information reasonably raises a question of whether the insured misrepresented or omitted material information prior to the issuance of the policy . . . ." (10 CCR § 2274.78(c)) For example, an insurer must commence any review or investigation within 15 calendar days of receipt of such information (10 CCR § 2274.78(c)); notify the insured of the investigation or review within seven days after the decision to investigate or review is made (10 CCR § 2274.78(d)); complete the investigation or review within 90 calendar days after delivery of written notice (10 CCR § 2274.78(g)); and notify the insured of the results of its investigation within seven calendar days of the conclusion of its investigation (10 CCR § 2274.78(h)).

Insurance Code § 790.10 expressly authorizes the commissioner to "promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article." Section 2274.78 falls squarely within the Department's power to regulate unfair practices, including those defined by Insurance Code §§ 790.03(g)(2), (3), (4), and/or (5).

> (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
>
> (3) Failing to adopt and implement reasonable standard for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

These statutory subsections all require an insurer to act "reasonably promptly" or within a "reasonable time" within receipt of a claim. Section 2274.78 in no way conflicts with Insurance Code § 790.03 by defining the precise timeframes within which an insurer must act with respect to a cancellation investigation conducted after receipt of a claim by an insurer In outlining precise timeframes within which an insurer must conduct a cancellation investigation, the Department in no way alters or amends the scope of Insurance Code §§ 790.03(g)(2), (3), (4), and/or (5), which all require an insurer to act "reasonably promptly" or within a "reasonable time" in communicating with insureds regarding claims, investigating and processing claims, and effectuating settlements of claims.

In contrast to Section 2274.74 and 2274.78, Section 2274.78 does not purport to define a new unfair practice. Instead, Section 2274.78 establishes reasonable timeframes within which an insurer must conduct a cancellation investigation after submission of a claim. The Court cannot conclude that the Department acted arbitrarily, capriciously, or without reasonable or rationale basis in adopting Section 2274.78.

III. DISPOSITION

The petition for a peremptory writ of administrative mandamus is GRANTED in part and DENIED in part.[7] A judgment shall issue in favor of Petitioner, and against Respondents, granting the petition for writ of mandamus. A peremptory writ shall issue from this Court to Respondents, commanding Respondents to withdraw Sections 2274.74 and 2274.77 in accordance with the Court's ruling and to take any other action enjoined on them by law. The writ shall further command Respondents to make and file a return within 60 days after issuance of the writ, setting forth what it has done to comply with the writ. The Court reserves jurisdiction in

[7] Respondents' Request for Judicial Notice is DENIED on the basis the attached documents are irrelevant (*Gbur v Cohen* (1979) 93 Cal App 3d 296, 301)

this action until there has been full compliance with the writ.

In accordance with Local Rule 9.16, Petitioner is directed to prepare a formal order and judgment, incorporating this Court's ruling as an exhibit, and a peremptory writ of mandamus; submit them to opposing counsel for approval as to form in accordance with Rule of Court 3.1312(a); and thereafter submit them to the Court for signature and entry of judgment in accordance with Rule of Court 3 1312(b).

DATED: December 30, 2010

Judge MICHAEL P. KENNY
Superior Court of California,
County of Sacramento

CERTIFICATE OF SERVICE BY MAILING
(C.C.P. Sec. 1013a(4))

I, the undersigned deputy clerk of the Superior Court of California, County of Sacramento, do declare under penalty of perjury that I did this date place a copy of the above-entitled **RULING ON SUBMITTED MATTER** in envelopes addressed to each of the parties, or their counsel of record as stated below, with sufficient postage affixed thereto and deposited the same in the United States Post Office at 720 9th Street, Sacramento, California.

Gregory N. Pimstone
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Sacramento, CA 94244-2550

Superior Court of California,
County of Sacramento

Dated: December 30, 2010

By: S. Shay
Deputy Clerk

EXHIBIT C

BEFORE THE
INSURANCE COMMISSIONER
DEPARTMENT OF INSURANCE
STATE OF CALIFORNIA

In the Matters of the Order to Show Cause; Accusation; Notice of Noncompliance and Hearing; and Demand Issued to:

GLOBE LIFE AND ACCIDENT INSURANCE COMPANY;

And

AMERICAN INCOME LIFE INSURANCE COMPANY;

And

LIBERTY NATIONAL LIFE INSURANCE COMPANY;

And

UNITED AMERICAN INSURANCE COMPANY;

And

UNITED INVESTORS LIFE INSURANCE COMPANY,

Respondents.

Case No. UPA-2008-00017

OAH No. 2011090887

ORDER ON DEMURRERS AND MOTIONS TO STRIKE AND DISMISS

Administrative Law Judge Stephen J. Smith, Office of Administrative Hearings, State of California heard this matter on May 25, 2012, in Oakland, California.

Mary Ann Schulman, Insurance Counsel, represented the Insurance Commissioner and the Department of Insurance (Department) of the State of California.

Robert W. Hogeboom, and Suh H. Choi, Attorneys at Law, of Barger and Wolen, LLP, Attorneys, represented all respondents.

FACTUAL FINDINGS

1. Counsel for the Department, acting on behalf of the Department in an official capacity only, made the charges and allegations contained in the Order to Show Cause, the Accusation, the Notice of Noncompliance (Notice) and Demand, which was signed on August 11, 2011, filed on September 23, 2011, and was timely served on all respondents.

2. The Order to Show Cause was filed pursuant to the authority of Insurance Code sections 790.03, 790.05 and 790.06, and the Department's Fair Settlement Practices Regulations, California Code of Regulations, (CCR), title 10, sections 2695, et. seq.

3. The Accusation was filed pursuant to the authority of Insurance Code sections 704, 790.02, 790.03, 790.05, 790.06, 1879.2, 10111.2, subdivision (c), 10172.5, 10198.7, subdivision (a), 10232.92, 10232.95, and CCR, title 10, sections 2695, et. seq.

4. The Notice of Noncompliance was filed pursuant to the authority of Insurance Code sections 704, 790.02, 790.03, 790.05, 790.06, 1879.2, 10111.2, subdivision (c), 10172.5, 10198.7, subdivision (a), 10232.92, 10232.95, and CCR, title 10, sections 2695, et. seq.

5. The Demand was filed pursuant to Insurance Code sections 704, 790.035, 790.08, 10234.2, 10234.3, 10234.4, and 12976.

6. The Order to Show Cause, the Accusation, the Notice of Noncompliance and the Demand were consolidated into a single pleading document. Hereafter, this consolidated pleading will be referred to collectively as the consolidated OSC, unless otherwise specified.

NOTICE OF DEFENSE

7. Counsel for all respondents timely filed a Notice of Defense. In that Notice of Defense, counsel for respondents filed a general denial, and raised specific challenges to the consolidated OSC, consistent with the requirements of Government Code section 11506. The Notice of Defense, 26 pages in all, attacks the pleadings comprehensively, as well as the charging allegations contained in Paragraphs 50 through 73, specifically. The specific challenges included the following:

a. The consolidated OSC fails to state a cause of action or claim against LIBERTY NATIONAL LIFE INSURANCE COMPANY (LIBERTY);

b. The consolidated OSC fails to state a legally cognizable claim against any respondent, in that the Department's Fair Claims Settlement Practices Regulations,[1] that form the basis of many of the allegations contained in the consolidated OSC, are invalid as applied to respondents;

c. The consolidated OSC and its sub parts are materially deficient and fail to set forth the charges and allegations in ordinary and concise language, such that the acts or omissions of which the respondents are charged may be reasonably ascertained;

d. The consolidated OSC fails to state a cause of action against any respondent pursuant to the authority of Insurance Code section 790.03, subdivision (h), in that the consolidated OSC fails to state a cause of action alleging any specific unfair or deceptive claims practice described by subdivision (h) and its 16 subdivisions, and specifically that the consolidated OSC seeks to sanction respondents for a pattern of unfair settlement practices without pleading and proving what those practices are;

e. The consolidated OSC fails to state a cause of action against respondents pursuant to Insurance Code section 704, subdivision (b); and

f. The consolidated OSC fails to state a cause of action pursuant to the authority of Insurance Code section 10234.3.

g. Specific defenses were enumerated and identified with respect to each and every one of the specific allegations, attacking those allegations individually made in Paragraphs 50 through 73, inclusive, in the consolidated OSC that were based upon the Department's Fair Claims Settlement Practices Regulations. Those defenses include:

h. The consolidated OSC is procedurally defective as it alleges acts and omissions of unfair and deceptive claims and settlement practices as violations of the Fair Claims Settlement Practices Regulations, warranting imposition of civil penalties pursuant to Insurance Code sections 790.03 and 790.035, without first following the process for such action required by Insurance Code section 790.06, which is a prerequisite to an action based on section 790.03;

i. The Department's interpretation of law reflected in the consolidated OSC violates respondents' rights to due process of law;

j. The proposed Cease and Desist Orders sought by the consolidated OSC are overbroad;

k. The consolidated OSC reflects and pleads an inflated number of "acts"; and

[1] California Code of Regulations (CCR), title 10, sections 2695.1-.17.

1. The consolidated OSC and its attachments fail to provide any pleading or factual foundation for allegations that any respondent, or all of them, engaged in willful violations of any statute or regulation alleged to have been violated in the consolidated OSC.

DEMURRERS AND MOTION TO STRIKE

8. Counsel for respondents filed on January 13, 2002, a First General and Specific Demurrer and Motion to Strike, pursuant to the authority of Government Code section 11506. This specific challenge to the consolidated OSC filed by respondents is actually a Motion to Strike, in that in order to resolve the challenges made by this pleading, reference by both parties to evidence and materials extrinsic to the four corners of the consolidated OSC was required. Both parties referred to and incorporated such extrinsic materials, and argued both in support and opposition to the challenges made to the consolidated OSC using such extrinsic information. Thus, the collective challenges by the respondents to the legal and factual efficacy of the consolidated OSC is hereinafter referred to as the Motion to Strike.

9. The Motion to Strike consists of 48 pages with 10 attachments. The Motion to Strike actually is a much more detailed and fully supported reflection of the challenges to the consolidated OSC set forth in the Notice of Defense enumerated above, enhanced, elaborated with reference to the attachments and exhibits, and augmented with points and authorities supporting the numerous specific challenges. Counsel for respondents sought a briefing schedule for responses and replies to the Motion to Strike, as well as an opportunity to make oral argument, and sought specific rulings on respondents' numerous legal challenges to the consolidated OSC and its allegations.

10. Counsel for the Department filed an Opposition to the Motion to Strike, with an attached memorandum of points and authorities (Opposition), on April 25, 2012. The Opposition consists of 45 pages, augmented with and incorporating by reference numerous attachments and exhibits, including one submitted under seal ("Exhibit E").

11. One of the attachments to the Opposition, Exhibit G, a lengthy letter dated August 8, 2008, from Vice President and Associate Counsel for one of the respondents, United American Insurance Company, purports to be written on behalf of all respondents. This document is an offer in compromise and an effort to engage in settlement negotiation, violative of the general prohibition contained in Evidence Code section 1152, and not conforming to the exception provided in section 1152, subdivision (b). Thus Exhibit G is not appropriate as an attachment to the Opposition, and is excluded. Exhibit G was not considered for any purpose in making this ruling.

12. Counsel for respondents filed a Reply to the Opposition on May 8, 2012.

13. Oral argument on the Motion to Strike, Opposition and Reply took place before the undersigned on May 25, 2012 in Oakland, California. Ms. Schulmann appeared

for the Department and Mr. Hogeboom for all respondents. The matter was submitted on May 25, 2012.

14. During the oral argument, the parties agreed that the Prehearing and Settlement Conferences, scheduled for July 25, 2012, should be vacated, to be rescheduled if or when needed.

ISSUES RAISED BY MOTION TO STRIKE

15. The Motion to Strike raised eight specific groups of challenges to the consolidated OSC issues, further refining and defining the challenges set forth in the Notice of Defense. The specific issues are as follows:

a. Whether the Department exceeded its authority in the consolidated OSC by seeking to impose monetary penalties, pursuant to the authority of Insurance Code section 790.035, or to issue a Cease and Desist Order, per the authority of Insurance Code section 790.05, for acts or omissions not specifically identified and listed in Insurance Code section 790.03;

b. Whether the Department exceeded its authority in the consolidated OSC by seeking to impose monetary penalties or issuing a Cease and Desist Order for violations of the Department's Fair Claims Settlement Practices not identified within any of the provisions of Insurance Code section 790.03, or in any of its subdivisions;

c. Whether the Department exceeded its authority in the consolidated OSC by seeking to impose monetary penalties or by issuing a Cease and Desist Order, pursuant to the authority of Insurance Code section 790.05, for violations of other Insurance Code provisions not identified as unfair or deceptive claims settlement practices in Insurance Code section 790.03; in other words, seeking to transform violations of other Insurance Code provisions and into additional violations of Insurance Code section 790.03;

d. Whether allegations contained in Paragraphs 56, 64, 66, 67 and 73, alleging violations of Insurance Code section 790.03, subdivision (h) (3), are legally insufficient and therefore fail as a matter of law;

e. Whether joinder to these consolidated actions of an action brought pursuant to Insurance Code section 790.06 is legally impermissible and must be severed or dismissed;

f. Whether the Accusation, containing allegations seeking to suspend or revoke respondents' Certificates of Authority pursuant to Insurance Code section 704, subdivision (b), are insufficient as a matter of law, or, alternatively, are improperly joined to the other claims in this consolidated action; and

g. Whether allegations seeking mandatory penalties under the long-term care (LTC) provisions of Insurance Code section 10234.3, alleging violations of the Fair

Settlement Practices Regulations (Paragraphs 53 and 55) and Insurance Code sections 10232.92 and 10232.95 (Paragraphs 56d and 66) are legally insufficient as a matter of law.

16. Issue letter e. just above was removed as a disputed issue during the course of the oral argument in this matter, when counsel for the Department moved to dismiss the allegations of the consolidated OSC that are based on Insurance Code section 704.06. That Motion to Dismiss was not opposed, and was granted, and is incorporated in this Order.

LEGAL AUTHORITY FOR THE PRIMARY ACTION

17. Section 790.05 provides, in pertinent part, as follows:

> Whenever the Commissioner shall have reason to believe that a person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in section 790.03, and that a proceeding by the Commissioner, and in respect thereto would be to the interest of the public, he or she shall issue and serve upon that person an order to show cause containing a statement of the charges in that respect, a statement of that person's potential liability under section 790.035, and a notice of hearing thereon to be held at the time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the Commissioner should issue an order to that person to pay the penalty imposed by section 790.035, and to cease and desist those methods, acts, or practices, or any of them.
>
> [¶] ... [¶]
>
> The hearing shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing at section 11500, of Part One of Division Three of Title Two of the Government Code.
>
> [¶] ... [¶]

18. Insurance Code section 790.03 provides, in pertinent part, as follows:

> The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.
>
> [¶] ... [¶] [Omit definitive subdivisions (a) through (g)]
>
> (h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

[¶] ... [¶] [Omit 16 specific enumerated unfair claims settlement practices]

19. Insurance Code section 790.035 provides as follows:

(a) 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 Department, not to exceed five thousand dollars ($5000) 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 Department 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 are a single act for the purpose of this section.

(b) The penalty imposed by this section shall be imposed by and determined by the Department as provided by section 790.05. The penalty imposed by this section is appealable by means of any remedy provided by section 12940 or by Chapter 5 (commencing with section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SYNOPSIS OF RULINGS

20. The ALJ has the authority to hear and consider the Motion to Strike and to grant the relief sought by the Motion to Strike, including, but not limited to, dismissing all or any portion of the consolidated OSC, as a matter of law and with prejudice, or without prejudice and with leave to amend, and determining whether the Department has exceeded its legislatively granted mandate of authority in attempting to apply its Fair Settlement Practices Regulations in the manner that it has in this consolidated OSC.

21. The portion of the consolidated OSC based upon Insurance Code section 790.06 is severed and dismissed from this action, granting the motion of counsel for the Department for severance and dismissal of this portion of the action.

22. The consolidated OSC is dismissed against respondents LIBERTY NATIONAL LIFE INSURANCE COMPANY and UNITED INVESTORS LIFE INSURANCE COMPANY.

23. The Accusation portion of the consolidated OSC alleging violations of Insurance Code section 704, subdivision (b), based upon violations of the long-term care statutes, Insurance Code sections 10123.92 and 10123.95, is severed, as improperly joined to this action, and dismissed from this action.

24. The portion of the consolidated OSC alleging that violations of Insurance Code provisions other than section 790.03, alleging that those other violations constitute

additional unfair methods of competition and unfair and deceptive acts or practices in the business of insurance actionable pursuant to Insurance Code section 790.03, are dismissed, for attempting to add to and create additional species of deceptive and unlawful settlement practices not enumerated in section 790.03 and its numerous subdivisions, without first successfully completing the process set forth in Insurance Code section 790.06. In addition, these allegations are overbroad and vague and fail to state claims upon which relief can be granted.

25. The Paragraphs of the consolidated OSC alleging violations of Insurance Code sections 10234.2, et seq., and 12976 are severed from the action as improperly joined, and are dismissed from this action.

26. All allegations seeking civil penalties pursuant to the authority of Insurance Code sections 790.03, subdivision (h) and 790.035, based exclusively upon alleged violations of the Fair Settlement Practices Regulations (CCR, title 10, sections 2695.1-17) are dismissed with prejudice. These allegations are found in Paragraphs 50-68 (with a few exceptions), all of which are individually enumerated below. These charging Paragraphs of the consolidated OSC depend upon the link between the Fair Settlement Practices Regulations as the basis for action, via a definitional, trigger Regulation, section 2695.1, subdivision (a). Section 2695.1, subdivision (a) seeks in this consolidated OSC to add all the acts, omissions and practices set forth in the Fair Settlement Practices Regulations to the 16 actionable unlawful settlement practices detailed by the Legislature in Insurance Code section 790.03, subdivision (h), without following the exclusive process for doing so set forth in Insurance Code section 790.06. As applied to these specific respondents in these specific Paragraphs of this consolidated OSC, the Fair Settlement Practices Regulations impermissibly seek to establish new standards and duties constituting unfair methods of competition and unfair and deceptive acts or practices in the business of insurance within the meaning of Insurance Code section 790.03, subdivision (h), and then seek to penalize respondents for failure to meet the standards, all in derogation of the precedent process required by Insurance Code section 790.06. Thus, under the specific circumstances extant in the manner in which the Fair Settlement Practices Regulations are sought to be applied by the Department in this consolidated OSC, the Regulations are unenforceable.

27. The Motion to Strike shall be granted in part and overruled in part. The Demand is dismissed as superfluous as a result of these rulings.

28. The currently scheduled evidentiary hearing dates on the consolidated OSC, October 28, 2012 through February 19, 2013 (60 trial days) are, as a result of these rulings, vacated.

AUTHORITY TO DECIDE THE ISSUES RAISED IN THE MOTION TO STRIKE

29. Counsel for the Department challenged the authority of the ALJ to grant the relief sought in the Motion to Strike and, in particular, the authority to find all or a portion of the Fair Claims Settlement Practices Regulations invalid or unenforceable as applied in the

particular consolidated OSC allegations challenged by the Motion to Strike, Paragraphs 50-68, with a few noteworthy exceptions. The contention lacks any persuasive legal support, in fact, the great weight of authority, included with long settled Supreme Court precedent, is directly contrary.

30. Government Code section 11512, subdivision (b) provides, in pertinent part, as follows:

> [¶] ... [¶]
>
> (b) ... When the administrative law judge alone hears a case, he or she shall exercise all powers relating to the conduct of the hearing. A ruling of the administrative law judge admitting or excluding evidence is subject to review in the same manner and to the same extent as the administrative law judge's proposed decision in the preceding.

31. Government Code section 11511.5 provides the administrative law judge assigned to a pending APA formal adjudication matter pursuant to Government Code section 11500, et. seq., broad authority during pretrial proceedings to hear and rule upon, among other things:

> [¶] ... [¶]
>
> (b)(12) Any other matters as shall permit the orderly and prompt conduct of the hearing.

AUTHORITY TO RULE ON CHALLENGES TO THE VALIDITY AND ENFORCEABILITY OF REGULATIONS-PROPER FORUM

32. The Supreme Court of the State of California more than three decades ago confirmed that an administrative hearing is an appropriate venue to raise and adjudicate the enforceability and/or the validity of a challenged regulation, and that an administrative law judge has the authority, and indeed, the duty, to rule upon such challenges properly raised, as they are here, and grant relief from an invalid or inappropriate application of an regulation in the appropriate circumstances.[2]

> Petitioner contends that because an administrative agency is compelled to enforce its own regulations, an attack on the validity of those regulations in a statutory "fair hearing" necessarily encourages a "useless act." But, on principle, an invalid regulation should be vulnerable to attack at the administrative level. This is consistent both with precedent and common sense. The legislative acceptance of this principle is clear. Government Code section 11342.2 declares: 'Whenever by the express or implied terms of any statute a state agency has authority to

[2] *Woods v. Superior Court of California, County of Butte* (1981) 28 Cal.3d 668, 680.

adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.' Repeatedly, we have held that administrative regulations which exceed the scope of the enabling statute are invalid and have no force or life.[3]

[¶] ... [¶]

The practical effect of prohibiting an administrator from nullifying an invalid regulation of his own making would be to require the invocation of a judicial remedy in all such cases. Such conceptual rigidity is ill-advised. The general principle that courts should not be burdened with matters which can be adequately resolved in administrative fori, frequently expressed in the rule requiring exhaustion of administrative remedies, is founded at least in part on the wisdom of the efficient use of governmental resources. Such use serves the twin goals of avoiding delay and unnecessary expense in vindication of legal rights. Permitting administrators an opportunity to construe challenged regulations in a manner to avoid their invalidation is preferable to requiring a court challenge. Moreover, in those cases in which the validity of such a regulation must be judicially resolved, the task of a reviewing court is simplified by a narrowing and clarification of the issues in an administrative hearing.[4]

AUTHORITY TO RULE ON CHALLENGES TO THE VALIDITY AND ENFORCEABILITY OF REGULATIONS-SUBSTANTIVE MATTERS

STATUTES GOVERNING LAWFUL SCOPE OF REGULATIONS

33. Government Code section 11342.1 provides:

Except as provided in Section 11342.4, nothing in this chapter confers authority upon or augments the authority of any state agency to adopt, administer, or enforce any regulation. Each regulation adopted, to be effective, shall be within the scope of authority conferred and in accordance with standards prescribed by other provisions of law.

34. Government Code section 11342.2 provides:

Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the

[3] *Woods, supra,* citing *Bright v. Los Angeles Unified School District.* (1976) 18 Cal.3d 450, 459-464, *Cooper v. Swoap* (1974) 11 Cal.3d 856, 864-865, *California Welfare Rights Organization v. Brian* (1974) 11 Cal.3d 237, 239, 242-243, *In re Jordan* (1972) 7 Cal.3d 930, 939, and *Mooney v. Pickett, supra,* 4 Cal.3d 669, 675-676, 681.
[4] *Id.*

statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute.

35. Government Code section 11350 provides, in relevant part:

[¶] ... [¶]

(b) In addition to any other ground that may exist, a regulation or order of repeal may be declared invalid if either of the following exists:

(1) The agency's determination that the regulation is reasonably necessary to effectuate the purpose of the statute, court decision, or other provision of law that is being implemented, interpreted, or made specific by the regulation is not supported by substantial evidence.

[¶] ... [¶]

CASE AUTHORITY GOVERNING LAWFUL SCOPE OF REGULATIONS (IN ADDITION TO THE SUPREME COURT'S DECISION IN *WOODS*, ABOVE)

36. A regulation is invalid if it alters or amends the governing statutes or enlarges or restricts the agency statutory power.[5] Regulations that alter or amend the statute or enlarge or impair its scope are void, and no protestation that they are merely an exercise of administrative discretion can sanctify them.[6]

> As we recently summarized ... Government Code section 11342.2 [states 'no] regulation adopted is valid or effective unless [1] consistent and not in conflict with the statute and [2] reasonably necessary to effectuate the purpose of the statute.'
>
> [First,] the judiciary independently reviews the administrative regulation for consistency with controlling law. The question is whether the regulation alters or amends the governing statute or case law, or enlarges or impairs its scope.... This is a question particularly suited for the judiciary as the final arbiter of the law, and does not invade the technical expertise of the agency.[7] For a power [quasi-legislative via adoption of regulations] to be justified, it must be essential to the declared objects and purposes of the enabling act-not simply convenient, but

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[5] *Woods, supra*, p. 680-1, *Webb v. Swoap* (1974) 40 Cal. App.3d 191, 196

[6] *Id., Henning v. Division of Occupational Health and Safety* (1990) 219 Cal.App.3d 747, 757-58, *Credit Insurance General Agents Association v. Payne* (1976) 16 Cal.3d 651, 657, *Communities for a Better Environment v. California Resources Agency* (2002) 103 Cal.App.4th 98, 108–109.

[7] *Sheyko v. Saenz* (2003) 112 Cal.App.4th 675, 687-88

indispensable. Any reasonable doubt concerning the existence of the power is to be resolved against the agency.[8]

37. Review of the validity of a challenged regulation takes place as a matter of law and the agency is not entitled to any particular deference in such a review.[9] We do not defer to the Department about whether its regulations lie within the scope of authority delegated by statute.[10]

38. Therefore, the Department's contention that the administrative law judge lacks authority in these proceedings to entertain the Motion to Strike and/or grant the remedies and relief sought in the Motion to Strike, is rejected as in conflict with the well-settled authority in this State; that an administrative law judge assigned to hear a case pursuant to the provisions of the APA, Government Code section 11500, et. seq., has the authority, and in fact, the duty, to rule upon such appropriately raised claims for relief and seeking remedies that are raised in the instant Motion to Strike, and has the authority to grant the relief and remedies sought in the Motion to Strike, including, but not limited to, finding a regulation invalid or unenforceable in the context raised in this matter.

GENESIS-THE MARKET CONDUCT EXAMINATION REPORT; ITS TWO VERSIONS AND CITATIONS, LEADING TO VIOLATIONS IN THE CONSOLIDATED OSC, AND EXHIBIT E, THE THIRD FORM OF THE MARKET CONDUCT EXAMINATION REPORT

39. The genesis of this action is the Department's Market Conduct Examination Report of 2008, attached as an Exhibit and incorporated by reference to the consolidated OSC. The Market Conduct Examination Report is the final result of a September 2006 Department Field Claims Bureau examination of the claims handling practices of the various respondents, covering the period July 16, 2005 through July 15, 2006. The examination covered individual and group life insurance, annuities, individual and group disability insurance, Medicare supplements, cancer and long-term care (LTC) claims and policies. The Department's field examiners selected what they believed to be representative portions of claims processed by the various respondents during the one year period of examination, and when they found what they considered to be a noncompliant, the examiner submitted a "referral" to the representatives of the respondent insurer that handled the claim. The respondent insurer's representatives handling the referral submitted responses to the referrals, and the process went back and forth in an effort to explain, clarify, supplement missing facts or take corrective measures, or reached an impasse that no agreement and resolution was forthcoming over a specific claims file or practice.

40. Counsel for the Department explained during oral argument and in her reply brief this "back and forth process" of the claims files examination conducted by the Department's Field Representatives. The referrals process resulted in the Department's Field

[8] *Addison v. Department of Motor Vehicles* (1977) 69 Cal.App.3d 486. 498.

[9] Unlike the discretion afforded agency interpretation set forth in *Nish Norian Farms v. Agricultural Labor Relations Board* (1984) 35 Cal.3d 726, 745, or in the seminal case on this point, *Chevron U.S.A. v. Natural Resources Defense Council* (1984) 467 U.S. 203, 316. *Id.*, Government Code section 11350.

[10] *Sheyko, supra*, citing *Yamaha Corp. of America v. State Board of Equalization* (1998) 19 Cal.4th 1, 11, fn. 4.

Examiners issuing Citations for what they believed to be alleged violations, after having given the respondents an opportunity to reply and explain. These Citations for violations ultimately found their way into the 2008 Market Conduct Examination Report if the respondent's representatives and the Field Examiners could not agree on any disputed point. Most, but not all (for example regarding respondent LIBERTY NATIONAL LIFE INSURANCE COMPANY, where one Citation resulted in no allegations in the consolidated OSC) of these Citations resulted in allegations being made of violations that found their way into the consolidated OSC.

41. There are two copies of the 2008 Market Conduct Examination Report, one for public dissemination (the Public Report) and one that is for the Department's internal use (the Department's Report). The Public Report contains no more information regarding the allegations, transactions alleged to have constituted violations or the identity of the respondents alleged to be responsible for those violations than does the consolidated OSC. The Department's Report contains a bit more detail, but is still rather vague regarding the details of specific transactions alleged to have constituted violations.

42. The primary difference between the Public Report that was appended to and incorporated by reference in the consolidated OSC, and the Department's Report, which was not, is that referrals, and any responses by the respondent insurers' representatives, are contained in the Department's Report copy of the Market Conduct Examination Report, but not in the Public Report version. The Department's Report version was appended to counsel's reply brief, and was first disclosed several months after the filing and service of the consolidated OSC, but not appended to or incorporated by reference in the consolidated OSC. The Department's Report also contains a more detailed discussion and breakout of the development of the violations and Citations than contained in the Public Report version, and describes to some extent the back and forth process of negotiating over the referrals. Counsel offered the Department Report version of the Market Conduct Examination Report in an effort to respond to and attempt to cure the attacks made in the Motion to Strike on the lack of clarity defects of overbreadth, vagueness and imprecision of the allegations contained in the consolidated OSC.

43. Exhibit E, entitled "The Table of Specific Findings," (the Specific Findings), submitted under seal, made its first appearance just before the evidentiary hearing on the Motion to Strike. It did not appear that the contents of Exhibit E had been disclosed to the respondents before the service of the Department's reply and appended Exhibits on April 25, 2012. Exhibit E contains yet a third version of the Market Conduct Examination Report; this copy contains an augmented and detailed version listing individual claims numbers and insureds of each policy examined as part of the process leading to the Market Conduct Examination Reports being written and published, as well as specific and individual allegations of violations for each individual claim. From examination of the contents of Exhibit E and the version of the Market Conduct Examination Report contained in the exhibit and submitted under seal, it is evident that at the time of the drafting and service of the consolidated OSC, the Department's representatives were aware of the details of the identities of individual insureds, claims numbers, details of individual claims alleged to have

constituted violations, including dates of claims and dates of acts or failures to act by involved insurers, and the identities of the insurers who allegedly committed the individual violations.

NUMERICAL ANALYSIS OF THE ALLEGATIONS OF VIOLATIONS IN THE CONSOLIDATED OSC AND MARKET CONDUCT EXAMINATION REPORT-PUBLIC COPY

44. Analysis of the number and distribution of the allegations in the consolidated OSC with respect to the five named respondents and the allegations of misconduct reflected in the Public Copy of the Market Conduct Examination Report incorporated by reference into the consolidated OSC, is material to the resolution of some of the claims made in the Motion to Strike.

45. Paragraph 49 of the consolidated OSC makes the following allegation, while referring to the Public Copy of the appended Market Conduct Examination Report:

> 49. Based on the examination (the Market Conduct Examination Report), the Department alleged that GLOBE, AMERICAN INCOME, LIBERTY, UNITED AMERICAN, and UNITED INVESTORS engaged in the following six hundred ninety seven (697) unfair or deceptive acts or practices, in violation of California Insurance Code section 790.03, and/or the Fair Claims Settlement Practices Regulations, as more fully described in the Market Conduct Reports as of July 15, 2006 (Exhibits one and two).

46. Paragraph 49 removes the numbers from the context in which the numbers were actually reported in the Market Conduct Examination Report. Paragraph 49 also suggests, ipso facto, that numeric correlation equals violation causation. Numerators are meaningless without denominators.

47. The Market Conduct Examination Report discloses that the total examination involved the selection of 486,724 claims files, of which 684 were more carefully reviewed and 697 were determined by the Department's Field Examiners to contain what the examiners believed were violations described and alleged in Paragraph 49 above. Therefore, .00143 per cent of all claims files selected were found by the examiners to have contained at least one alleged violation. In a number of instances, one claim file was found to have two or more alleged violations, further reducing the already rather tiny percentage of claims files containing at least one alleged violation.

48. The following table below, breaking out the number of claims files selected, reviewed and found to have violations with respect to each respondent, and the number of violations attributed by the Department's Field Examiners to each respondent, puts these numbers into more of a context. This table reports only the number of alleged violations the Field Examiners believed constituted violations within the evaluation of the 486,724 claims files, and not whether these violations actually exist, or that whether those claimed violations could actually be proved within the applicable legal and evidentiary standards that govern

this matter. Respondents disputed many of the claims of violations the Field Examiners believed they had determined, some quite vehemently. Nevertheless, the raw number of claims and number of violations determined by the Field Examiners with respect to each individual respondent are as follows:

INSURER	# CLAIMS SEL.	# CLAIMS REV.	VIOLATIONS
1. GLOBE	2,762	51	16
2. AMER. INC.	6,195	300	212
3. UNITED INV.	135	22	2
4. UNITED AM.	477,439	297	271
5. LIBERTY	173	4	0
6. TORCHMARK[11]	0	0	0

RESPONDENTS LIBERTY AND UNITED INVESTORS

49. Some of the claimed violations from the Market Conduct Examination report were not alleged as violations in the consolidated OSC. For example, there were zero citations issued by the Market Conduct examiners against RESPONDENT LIBERTY NATIONAL LIFE INSURANCE COMPANY (LIBERTY), and, as a result, there are zero allegations against LIBERTY contained in any of the consolidated OSC's charging allegations.

50. There were only two citations noted in the Market Conduct Examination Report against UNITED INVESTORS LIFE INSURANCE COMPANY (UNITEDINVESTORS). There are only two Paragraphs of the consolidated OSC that address UNITED INVESTORS, Paragraphs 51, subpart (d), (failure to provide an explanation of benefits with clear explanation of the computation of benefits in one (1) instance, in violation of Regulation section 2695.11, subdivision (b), and Paragraph 69, subdivision (b), where it is alleged that UNITED INVESTORS failed in eight instances to pay interest on life insurance benefits due, allegedly violating Insurance Code section 790.03, subdivision (h) (5).

51. As set forth in detail below, Insurance Code section 790.03, subdivision (h) requires, as a threshold matter, for proof of a violation of any of its 16 subparts, proof that any named respondent knowingly engaged in unlawful or deceptive settlement practices as a part of a "general business practice." The Market Conduct Examination Report and the

[11] Torchmark is the holding company for the five other respondents. Torchmark did not have any of its own claims files examined by the Field Examiners.

associated and correlated allegations in the consolidated OSC that reflect those findings, reveal that there are no allegations of any violations contained in the consolidated OSC against respondent LIBERTY, and only two, a relatively tiny amount relative to the number of total claims files examined, against respondent UNITED INVESTORS LIFE INSURANCE COMPANY.

52. One of the few places that the parties agree is that there is almost no legal guidance regarding how many or what percentage of claims must be proved to be unlawful in order to reveal "a general business practice," within the meaning of section 790.03, subdivision (h). What is evident is that zero or two claimed unlawful claims practices violations in nearly a half-million claims files selected for further review cannot, as a matter of law, meet that standard. Reading the contents of the Market Conduct Examination Reports in any of its iterations yields no facts from which it may be reasonably ascertained that the defect with the OSC claims against either of these respondents could be corrected with leave to amend the allegations. As there is no possible way that the allegations of the consolidated OSC can be amended based upon the contents of the Market Conduct Examination Report, in any of its iterations, to allege a sufficient number of allegedly unlawful practices as to constitute even a reasonably arguable general business practice within the meaning of section 790.03, subdivision (h), the allegations against these two respondent insurers, LIBERTY and UNITED INVESTORS.

PLEADING AND JOINDER- CONSOLIDATED ACTIONS

53. Government Code section 11507.3 provides as follows:

> (a) When proceedings that involve a common question of law or fact are pending, the administrative law judge on the judge's own motion or on motion of a party may order a joint hearing of any or all of the matters at issue in the proceedings. The administrative law judge may order all the proceedings consolidated and may make orders concerning the procedure that may tend to avoid unnecessary costs or delay.
>
> (b) The administrative law judge on the judge's own motion or upon motion of a party, in furtherance of convenience or to avoid prejudice or when separate hearings will be conducive to expedition and economy, may order a separate hearing of any issue, including any issue raised in the notice of defense, or of any number of issues.

54. Section 11507.3 encourages liberal joinder of actions where the basis of joinder is the presence of common questions of law or fact, including common legal standards for assessment of evidence and burdens of proof. By the same token, actions where common questions of law or fact do not predominate, or have significantly different burdens of proof and evidentiary standards are not appropriate for joinder. The effort to keep significantly dissimilar, non-like kind actions requiring different standards and burdens of

evidentiary production and proof is neither economical nor conducive to expedition, and oftentimes results in prejudice to one or more parties.

55. The consolidated OSC joins together a number of different species of non-like-kind, dissimilar actions, such as the primary action here, the section 790.05/790.03 Order to Show Cause enforcement action, with the dissimilar section 704, subdivision (b) Accusation, and the section 790.06 action to these other actions, when the 790.06 action requires, as a matter of law, procedural precedence (the section 790.06 action must be tried separately and before the 790.05/790.03 action for alleged violations not already listed in section 790.03, subdivision (h), as set forth below in detail), all contained in the one consolidated OSC. Several of these different species of actions are improperly joined to the predominant action, which is the section 790.05 Order to Show Cause action, alleging violations of Insurance Code section 790.03, subdivision (h), predominantly based upon alleged violations of the Fair Settlement Practices Regulations.

56. Counsel for the Department contended that the actions joined together in the consolidated OSC were appropriately joined because the consolidated OSC is an "umbrella action." The contention lacks any legal support. A careful search of the authorities relating to pleading, joinder and severance found authority for liberal joinder of separate actions alleging common questions of law and fact, as well as support for severance, if those common questions of law and fact factors do not predominate, but none that support joining non-like kind actions ordinarily required to be pleaded and proved separately as an "umbrella action."

IMPROPER JOINDER OF "STATUTORY ALLEGATIONS" (PARAGRAPHS 69-74)

57. The "Statutory Allegations," set forth in the consolidated OSC's Paragraphs 69-74, constitute the improper joinder a dissimilar action to the main section 790.05/790.03 action, without sufficient common issues of law and fact to permit joinder and consolidation. Paragraph 69 through 74 seek to allege that violations of statutes other than Insurance Code section 790.03 can become violations of Insurance Code section 790.03, subdivision (h), because violations of other provisions of the Insurance Code reflecting alleged violations of other duties incumbent upon insurers carrying on business in the State of California are also alleged to be violations of section 790.03, subdivision (h). The argument is circular and unpersuasive.

58. The joinder in the consolidated OSC of these dissimilar actions also violates the requirements of Insurance Code section 790.06, which requires as a condition precedent to bringing an action based upon alleged commission of an act or omission or unfair or deceptive practice not specifically listed in section 790.03, subdivision (h), as a violation of section 790.03, subdivision (h), through a separate and preceding hearing process pursuant to section 790.06. Pursuit of a preceding section 790.06 Order to Show Cause proceeding is statutorily mandatory in order to first prove that any alleged violation of those other statutes may also constitute actionable violations of section 790.03, subdivision (h). It was

undisputed that the section 790.06 process has not been followed with respect to these alleged "Statutory Allegations."

59. For example, in Paragraph 69, alleged violation of Insurance Code section 10172.5, subdivision (a) (failure to pay interest on life insurance proceeds) is alleged to also constitute an unfair or deceptive settlement practice, in violation of Insurance Code section 790.03, subdivision (h) (5). The allegation fails to state any factual basis to claim that the named respondents failed to act in good faith, a mandatory element of pleading and proof with respect to a section 790.03, subdivision (h) (5) action; fails to set forth facts that any respondent failed to settle any specific claim with any specific insured; fails to set forth any facts to indicate that the action or inaction of the subject respondents constituted a general business practice; and failed to plead anything other than what appears to be an error. Paragraph 69 fails to set forth the minimum predicates required to plead a cause of action that any named respondent failed to act in good faith and/or knowingly engaged in a general business practice actionable under any provision of Insurance Code section 790.03, subdivision (h) (5). Paragraph 70 and 71 suffer the same fate for the same reasons. Additionally, none of the alleged statutory violations in these Paragraphs of the consolidated OSC have been first proved to be additional unfair methods of competition and unfair and deceptive acts or practices in the business of insurance through the statutorily mandated precedent process set forth in section 790.06.

60. Paragraph 72 alleges that the respondents violated Insurance Code section 790.03, because the "TORCHMARK COMPANIES" failed to provide the statutory fraud notice on claims forms, as required by Insurance Code section 1879.2. The allegation makes no sense in the enforcement and penalty seeking contexts of the consolidated OSC. The respondent TORCHMARK COMPANIES are the very parties that are to be protected by the provision, thus, any failure to meet that standard could not possibly harm a consumer, and could only possibly harm the respondents. The Paragraph fails to allege or explain how respondents' violation of a provision of law (if proved) enacted solely to protect respondents could conceivably constitute an unlawful or deceptive claims or settlement practice by respondents.

61. Paragraph 73, without any factual basis whatsoever, alleges that respondents made a false statement to an examiner or to the Insurance Department pertaining to the business of the insurer during the course of the 2002 and 2006 Market Conduct Examinations with the intent to deceive, in violation of Insurance Code section 790.03, subdivision (e). No facts are advanced in Paragraph 73 that even hint at the identity of any such respondent making any such representation, what specific representations were made, the maker of any such statement, and most important, that any particular or specific statement was made by the speaker with the intention to deceive.

62. The Motion to Strike thus has merit with respect to its challenges to each of Paragraphs 69-73, inclusive. Each of these Paragraphs must be dismissed, but with leave to amend, and, as appropriate, to be pursued through the section 790.06 process, if the Department elects to pursue its contentions that the statutory violations alleged in these

Paragraphs of the consolidated OSC constitute additional unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

IMPROPER JOINDER OF DIRECT ALLEGATIONS OF VIOLATIONS OF SECTION 790.03 PARAGRAPHS 56, 64, 66, and 67

63. A few Paragraphs of the consolidated OSC allege direct violations of various subdivisions of section 790.03, subdivision (h), with one of its 16 subparts. Paragraph 73 was dealt with just above, leaving the allegations of Paragraphs 56, 66 and 67.

64. Paragraph 56 alleges that "TORCHMARK COMPANIES,"[12] "failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear,"[13] thus violating the requirements of section 790.03, subdivision (h) (5) in a number of instances; broadly and nonspecifically alleging UNITED AMERICAN committed 23 such violations, AMERICAN INCOME, "in one (1) instance and as a general business practice," with two total violations, and GLOBE, one.

65. Paragraph 56 fails to allege subdivision (h) (5)'s statutory requirement that an insurer's failure to effectuate prompt, fair and equitable settlement must also reflect in those efforts a failure to act in good faith; to wit, violation of subdivision (h) (5)'s standards requires pleading and proof that the accused insurer must have acted in bad faith in failing to effectuate the particular settlement. Paragraph 56 fails to plead the statute correctly, fails to plead any facts that support an allegation that any of the three named insurers acted in bad faith in any particular settlement, and fails to name any specific instance with any specific settlement where a specific insurer violated the requirements of subdivision (h)(5) with respect to any specific insured. These defects are fatal to Paragraph 56, and require its dismissal, with leave to amend, in the face of the challenge of the Motion to Strike.

66. Paragraph 64 alleges that in five unidentified instances, with unidentified insured's claims, three respondent insurers demonstrated a failure to adopt and implement "reasonable standards" for prompt investigation and processing of claims, violating section 790.03, subdivision (h) (3).[14] This allegation also seeks to incorporate the Fair Settlement Practices Regulations as requirements for defining and determining what does and does not constitute "reasonable standards" for prompt investigation and processing of claims. The Fair Settlement Practices Regulations seek to tightly and without exception define what constitutes "reasonable standards" in all circumstances and in all cases, in direct derogation of the authority set forth just below. The allegations are legally and factually deficient.

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[12] The allegations that "TORCHMARK COMPANIES" committed violations is a defect that appears repeatedly in the consolidated OSC. Such allegations are overboard and nondescript in light of the fact that TORCHMARK did not do or fail to do anything other than own the named individual respondents. Such overbroad allegations violate the pleading requirements of Government Code section 11503.

[13] The allegations of this Paragraph plead the statutory language, in direct contravention of the prohibition against such pleading mirroring the language of the statute contained in Government Code section 11503.

[14] The Paragraph pleads the statute, in direct violation of section 11503's prohibition of such pleading.

67. The question of what constitutes reasonableness does not lend itself to a bright-line definition. Reasonableness hinges upon the underlying factual circumstances which, in turn, vary from case to case.[15] In applying a reasonableness standard, the Court has consistently eschewed bright line rules, instead emphasizing the fact-specific nature of the reasonableness inquiry, to be decided on a case-by-case basis.[16]

68. Paragraph 64 pleads none of the required material facts and elements for a determination of reasonableness; no specific transactions are identified, no acts or omissions are identified that are allegedly unreasonable, and none of the conduct alleged to be unreasonable can be found in the allegation. Paragraph 64's allegations, as pled in the consolidated OSC, are *ipsa dixit.*[17] Mindful that California is a notice pleading jurisdiction, and thus notice of the charges need only be sufficient to provide reasonable notice, still, no notice at all is not notice. It is conceivable the defects in this allegation can be amended, so Paragraph 64 is dismissed without prejudice.

69. Paragraph 66 charges that three respondents upon four unidentified instances, "failed to represent correctly," pertinent policy provisions to unidentified insureds, in violation of section 790.03, subdivision (h)(1). The allegations fail for similar reasons as Paragraphs 56 and 64; there are no allegations of what was misrepresented, to whom the misrepresentations were made, what the misrepresentations were, what the true facts were, that any insured relied to his or her detriment on any misrepresentation, or that harm came of it.

70. In addition, Paragraph 66 has another defect. Section 790.03, subdivision (h)(1), only makes actionable an actual misrepresentation; the statute does not speak to "failure to correctly represent the policy provisions." Not only does Paragraph 66 plead the statute's language, a pleading practice that is specifically prohibited by Government Code section 11503, it pleads the statute's language and requirements legally incorrectly, changing and diminishing the burden of proof. These omissions are distinctions with substantial differences. Paragraph 66's allegation misconstrues the plain meaning of subdivision (h)(1)'s legal requirements for proof of a violation of its provisions. Paragraph 66 thus fails and must be dismissed, with leave to amend to correct the defects pointed out here.

71. Paragraph 67 alleges a single instance of UNITED AMERICAN making a knowing misrepresentation, allegedly in violation of section 790.03, subdivision (h)(1). There are no facts contained in the allegation regarding what the representation was, to whom it was made, why and/or how it was false, or any allegation that the representation was knowingly made when the true facts were known to the speaker to be other than stated. The allegation suggests a single alleged instance of alleged misrepresentation constitutes a general business practice of the insurer. A single instance of a misrepresentation cannot

[15] *Bonifield v. County of Nevada* (2001) 94 Cal.App.4th 298, 305.
[16] *Ohio v. Robinette* (1996) 519 U.S. 33, 33-34.
[17] It is so because I say it is so.

reflect or constitute a general business practice within the meaning of section 790.03, subdivision (h), as a matter of law. Paragraph 67 must be dismissed with prejudice.

IMPROPER JOINDER OF ACCUSATION SEEKING TO SUSPEND/REVOKE INSURANCE CODE SECTION 704, SUBDIVISION (B)

72. Paragraph 75 alleges that the facts alleged in Paragraphs 50 through 73 demonstrate that respondents have not carried out their contracts in good faith, and constitute grounds for the Insurance Department to suspend for a period not exceeding one year, after hearing, the respective Certificates of Authority of respondents pursuant to Insurance Code section 704, subdivision (b).

73. Insurance Code section 704 provides, in pertinent part, as follows:

> The Department may suspend the Certificate of Authority of an insurer for not exceeding one year whenever he finds, after proper hearing following notice, that such insurer engages in any of the following practices:
>
> [¶] ... [¶]
>
> (b) Not carrying out its contracts in good faith.
>
> [¶] ... [¶]

74. In the instance of Paragraph 75, as with the other challenges regarding improper joinder of dissimilar actions in this consolidated OSC, the Motion to Strike is being treated, among other things, as a Motion to Sever. As with the other similar challenges, motion must be granted, as it is on solid legal footing. An action pursuant to Insurance Code section 704, subdivision (b) constitutes an inquiry into whether an insurer is carrying out its contracts (there are none specifically alleged in any of the Paragraphs under review, only generic claims grouped by respondent insurer) in good faith; or, to look at it from the converse, it is incumbent upon the Department to allege and prove that the manner in which one or more of the respondents insurers failed to carry out one or more specific contract obligations evidenced bad faith in the discharge of those contractual obligations.

75. A section 704, subdivision (b) action is of considerably different character and quality than that of the core action brought pursuant to sections 790.05 and 790.03; with different pleading and proof standards, different evidentiary and factual bases, and markedly different legal standards to be applied. An action pursuant to Insurance Code sections 790.05 and 790.03, focuses on, as alleged in detail in Paragraph 74, an inquiry into whether there exist unfair and unlawful settlement claims settlement practices. None of the common legal and factual questions normally required to support even a very liberal joinder are present between the 790.03/790.05 and the 704, subdivision (b) actions. There exists no allegation anywhere in the consolidated OSC that provides a legal or factual basis for linking these two actions together. Paragraph 75 is severed from and dismissed from this action, as improperly

joined to this action, but without prejudice to its being brought as a separate action, as it should have been.

76. Paragraph 77 suffers from a similar defect. To the extent that Paragraph 77 attempts to squeeze in an action pursuant to section 704, subdivision (b) by listing it in a chain citation of all conceivable Insurance Code sections and regulations alleged to have been violated in the entire consolidated OSC, that portion is severed as well.

77. Paragraph 76, as Paragraph 74 does, seeks to piggyback the allegations contained in Paragraphs 53, 55, 56 and 66 as a legal and factual basis to carry a claim of entitlement to monetary penalties pursuant to Insurance Code section 10234.3, subdivision (b), and to suspend respondents' Certificates of Authority, and/or issue an order having respondents cease marketing any particular policy form of long-term care insurance, pursuant to the authority of Insurance Code section 10234.4. These allegations are non-like-kind claims, and as set forth in the discussions of Paragraphs 53, 55, 56 and 66 above, these claims are improperly joined together with the other dissimilar claims. The penalties sought pursuant to the provisions alleged in Paragraph 76 are not legally available in the primary section 790.055/790.03 action, but must be brought and sought in a separate action, if there is any factual and legal merit to the claims. Paragraph 76's claims are improperly joined to this action and must be severed.

78. Paragraph 78 is an example of vague and circular pleading. Paragraph 78 states that the Department has alleged that each act identified in Paragraphs 50 through 73 constitutes an unfair method of competition or unfair or deceptive act or practice within the meaning of Insurance Code section 790.03. Under the circumstances and considering the findings and determinations set forth above, Paragraph 78 is circular and meaningless, an allegation lacking an allegation, and is dismissed with leave to amend.

MOTION TO DISMISS ACTION BASED ON INSURANCE CODE SECTION 790.06

79. Counsel for the Department acknowledged that an action seeking enforcement and penalties for unfair methods of competition or unfair or deceptive acts or practices, pursuant to section 790.03, subdivision (h), may not be brought simultaneously with and joined to an action seeking to establish a new unfair method of competition or unfair or deceptive act or practice through the Order to Show Cause process of Insurance Code section 790.06. Counsel acknowledged that these actions are separate, and that the section 790.06 procedure must precede the 790.03, subdivision (h) enforcement procedure. Thus, these actions must be severed and proceed in the legislatively mandated order. Recognizing this, counsel moved to dismiss the portions of the action based upon Insurance Code section 790.06 during the oral argument on the Motion to Strike. The motion was granted.

80. Based upon the identical rationale, the attempted use of the Department's Fair Claims Settlement Practices Regulations to create new unfair methods of competition or unfair or deceptive acts or practices in the business of insurance by reference to the standards set forth in the various Regulations, and then seeking to enforce those newly incorporated

unfair methods of competition or unfair or deceptive acts or practices through section 790.03, subdivision (h), and seeking penalties pursuant to section 790.035, is just as inappropriate procedurally, and just as unfounded legally, as attempting to bring both a 790.05/790.03 and a 790.06 action simultaneously.

"UNFAIR CLAIMS PRACTICES" ALLEGATIONS (PARAGRAPHS 50-73) AND THE "FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS"-BASED ALLEGATIONS

81. Paragraph 30 of the consolidated OSC states that CCR, title 10, chapter 5, subchapter 7.5, Article I (section 2695, et. seq., and its numerous subparts and subdivisions) contain the "Fair Claims Settlement Practices" Regulations (the Regulations). The preamble of section 2695 of which states the purpose of the Regulations:

> ... to promote the good faith, prompt, efficient and equitable settlement of claims. *These regulations delineate certain minimum standards for the settlement of claims which, **when violated knowingly on a single occasion or performed** with such frequency as to indicate a general practice, shall constitute an unfair claims settlement practice within the meaning of Insurance Code section 790.03(h). Other acts not specifically delineated in this set of regulations may also be unfair settlement practices subject to Insurance Code section 790.03. All licensees are expected to have thorough knowledge of such regulations.* (Italics and bold added)

82. The leadoff Regulation in the Department's Fair Claims Settlement Practices Regulations is the "trigger" or bridging provision, CCR, title 10, section 2695.1, which provides, in pertinent part, as follows:

> (a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, ***when either knowingly committed on a single occasion, or performed*** with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Department has promulgated these regulations in order to accomplish the following objectives:
>
> (1) To delineate certain minimum standards for the settlement of claims which, *when violated **knowingly on a single occasion or performed** with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code section 790.03 (h);*
>
> [¶] ... [¶]
>
> (3) To discourage and monitor the presentation *to insurers* of false and fraudulent claims;

[¶] ... [¶]

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices. *Other methods, act(s), or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices and subject to California Insurance Code section 790.03(h) and/or California Insurance Code section 790.06.* These regulations are applicable to the handling or settlement of all claims subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with section 790, except as specifically provided...

[¶] ... [¶]

(f) All licensees, as defined in these regulations, shall have thorough knowledge of the regulations contained in this subchapter;

(g) Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.

[¶] ... [¶] (Italics and bold added)

83. The trigger, or bridging subdivision of section 2695, subdivision (a)(1), set forth above, recites as authority supporting and underlying its promulgation and legal effectiveness, Insurance Code sections 790.034, 790.10, 1871.1, 12340-12417, inclusive, 12921 and 12926, and sections 11152 and 11342.2 of the Government Code. As set forth below, neither section 11152 nor 11342.2 of the Government Code support this claim for statutory legal authority and legal efficacy for the trigger/bridging Regulation, section 2596.1, as it is sought to be applied in this particular consolidated OSC.

84. Most of the charging allegations contained between paragraphs 50 and 68, and, indeed, the core of the main action in the consolidated OSC, rely upon the language of the quoted trigger or bridging provision language of Regulation section 2695.1, subdivision (a) (1) for authority to determine violations of section 790.03, subdivision (h) and then use those violations to impose penalties on respondents. Each one of the numerous subparts of Regulation section 2695.1-17, cited in support of the individual charging Paragraph allegations in the consolidated OSC between Paragraphs 50 and 68, rely upon this trigger Regulation section 2695.1, subdivision (a) (1) as a bridge between alleged violations of the newly engrafted duties, requirements and responsibilities of insurers set forth in the various subdivisions of these Regulations, and the Insurance Code sections 790.03, subdivision (h)/ 790.035 authority to impose penalties and other sanctions and for the authority to call those violations unfair and/or deceptive claims practices within the meaning of Insurance Code section 790.03.

85. In this consolidated OSC, the Department seeks to use the trigger/bridging provision language of section 2695.1, subdivision (a) (1), to rewrite the language of section 790.03, subdivision (h) and significantly dilute its proof requirements. Counsel for the Department candidly conceded during oral argument that, in so doing, the burden of proof and the evidentiary requirements to establish a violation pursuant to Insurance Code section 790.03, subdivision (h) is substantially lessened, and the range of potential violations of subdivision (h) is hugely expanded.

86. None of the Regulations charged in Paragraphs 50-74 as a basis for violations and entitlement to penalties and other remedies contain any provision or language in the alleged Regulation itself that supports the imposition of a penalty or other sanction for failure to meet the standards set forth in any of those Regulations. The only manner in which to obtain the penalties sought in this consolidated OSC is through the trigger/bridging provision in section 2695.1, subdivision (a) (1) that seeks to add violations of the duties and standards set forth in the Regulations as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance within the meaning of section 790.03, subdivision (h) primarily, and other subdivisions of section 790.03. By proceeding in this fashion, the Department seeks to use the standards set in the Fair Settlement Practices Regulations to create new section 790.03, subdivision (h) unfair methods of competition and unfair and deceptive acts or practices in the business of insurance, without going through the Insurance Code section 790.06 mandatory precedent process to create new section 790.03, subdivision (h) unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. The failure in this action to follow the statutorily mandated precedent process set forth in section 790.06 for each of these Paragraphs 50-74 allegations based wholly or in part upon breaches of the standards or duties in these Regulations to create and then punish new section 790.03, subdivision (h) violations is fatal to each and every one of these allegations.

CORRELATION BETWEEN PARAGRAPHS AND REGULATIONS ALLEGED

87. The Paragraphs of the consolidated OSC charging violations of one or more of the Department's Fair Settlement Practices Regulations as a basis for alleging violations of section 790.03, subdivision (h) and entitlement to penalties pursuant to section 790.035, and the Regulation forming the basis of each such allegation are as follows:

Paragraph 50: 2695.4 (c);

Paragraph 51: 2695.11 (b);

Paragraph 52: 2695.7 (b) (3);

Paragraph 53: 2695.7 (b) (1);

Paragraph 54: 2695.7(g);

Paragraph 55: 2695.7(g);

Paragraph 57: 2695.7 (d);

Paragraph 58: 2695.7 (b);

Paragraph 59: 2695.7 (c) (1);

Paragraph 60: 2695.7 (b);

Paragraph 61: 2695.5 (e) (2);

Paragraph 62: 2695.5 (b);

Paragraph 63: 2695.3 (a);

Paragraph 65: 2695.3 (b) (1); and

Paragraph 68: 2695.6.

88. Each and every one of the charging allegations contained in the Paragraphs listed must be read in conjunction with the language of the trigger Regulation, section 2695.1, subdivision (a) (1), in order to provide a bridge to attain the remedies only available through sections 790.03 and 790.035. With respect to these particular charging Paragraphs set forth just above contained in this particular consolidated OSC, the legal efficacy of the trigger provision, Regulation section 2695.1, subdivision (a) (1), as applied to these particular allegations, is dispositive regarding whether these allegations stand or fall in response to the Motion to Strike. As is set forth below, due to the fact that the trigger Regulation, section 2695.1, subdivision (a) (1) constitutes an impermissible extension of the Department's authority as applied in this consolidated OSC in these particular Paragraphs, the bridging link between the Regulations allegedly violated and the remedial provisions of sections 790.03 and 790.035 fails as a matter of law, and thus, each of the allegations these Paragraphs enumerated above also fail as a matter of law, and the Motion to Strike has merit with respect to these allegations.

REGULATORY "INTERPRETATION" OF SECTION 790.03, SUBDIVISION (h)

89. Counsel for the Department contends that the use of the definition in the Department's Fair Settlement Practices trigger/bridging Regulation, section 2695.1, subdivision (a) (1) is a lawful and permissible extension of the Department's authority to "interpret" the statutory language found in section 790.03, subdivision (h). As set forth below, the language in Regulation section 2695.1, subdivision (a) (1) does not interpret the language of section 790.03, subdivision (h), but rather rewrites, adds words and punctuation that does not appear in the statute, and thus seeks to redefine the statutory language of subdivision (h). By so doing, the Regulation dramatically and impermissibly expands the

scope, nature and reach of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance far beyond those the Legislature wrote into section 790.03, and particularly subdivision (h). This dramatic and unwarranted expansion in the scope, nature and reach of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance, as the Department has attempted to apply them in this consolidated OSC, in the specific Paragraphs enumerated above, violates well-settled principles of law, as well as circumvents the exclusive section 790.06 process and procedure set up specifically to add to the list of Legislatively approved unfair and deceptive claims practices.

DIRECT COMPARISON OF SECTION 790.03, SUBDIVISION (h) AND THE TRIGGER REGULATION, SECTION 2796.1, SUBDIVISION (a) (1)

90. Insurance Code section 703.03, subdivision (h) provides as follows:

> The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.
>
> [¶] ... [¶]
>
> (h) *Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices*:
>
> [¶] ... [¶] (Italics added to key language)

91. CCR, title 10, section 2695.1, the trigger Regulation, provides, in pertinent part, as follows:

> (a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, ***when either*** knowingly committed ***on a single occasion, or performed*** with such frequency as to indicate a general business practice, [18]are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Department has promulgated these regulations in order to accomplish the following objectives:
>
> (1) To delineate certain minimum standards for the settlement of claims which, ***when violated*** knowingly ***on a single occasion or performed*** with such frequency as to indicate a general business practice ***shall constitute an unfair***

[18] The Section 2596.1 purported redraft of the language of section 790.03, subdivision (h) is indicated in italicized, bold in the trigger Regulation quotation, including a key comma and additional words added in the Regulation's subdivision (a) (1) that do not appear in the statutory text in the original.

claims settlement practice within the meaning of Insurance Code section 790.03 (h);[19]

THE STATUTORILY REQUIRED INTERFACE BETWEEN INSURANCE CODE SECTIONS 790.03 AND 790.06

FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS AS APPLIED IN THIS CONSOLIDATED OSC MAY NOT CIRCUMVENT THE REQUIRED 790.06 PROCESS-THE EXCLUSIVITY OF SECTION 790.03, SUBDIVISION (h)

92. Enacted as part of the same statutory scheme, Insurance Code section 790.03 and 790.06 must be read together and harmonized.[20] In particular, Insurance Code section 790.06 is interrelated to and interlinked with Insurance Code section 790.03, in that following the process set forth in Insurance Code section 790.06 is a mandatory condition precedent to adding additional unfair methods of competition and unfair and deceptive acts or practices in the business of insurance to the enumerated practices the Legislature established in section 790.03, subdivision (h) in particular or its other subdivisions.

93. Insurance Code section 790.06 provides as follows:

> Whenever the Department shall have reason to believe that any person engaged in the business of insurance is engaging in the state in any method of competition or any act or practice in the conduct of the vision business that is not defined in section 790.03, and that the method is unfair or that the act or practice is unfair or deceptive... He or she may issue and serve upon that person an order to show cause containing a statement of the methods, acts or practices alleged to be unfair or deceptive and a notice of hearing thereon.

94. Going through the 790.06 order to show cause and proof process described in the statute quoted above is a Legislatively required condition precedent to prosecution and pursuit of penalties pursuant to 790.03 and 790.035 for any allegedly unfair method of competition and/or unfair and deceptive act or practice in the business of insurance not already identified and described in section 790.03. As noted above, none of the duties, requirements or standards required, or practices and procedures proscribed in the Fair Settlement Practices Regulations appear anywhere in section 790.03; these are additional standards and guidelines and prohibited practices added exclusively by regulatory action of the Department.

95. The Department already conceded, as it must, that procedurally, the Department may not prosecute proceedings to both establish additional unfair methods of

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[19] The italicized and bolded language in subdivision (a) (1) beginning with such is the "trigger" provision, linking the Regulations with section 790.03 and its remedies set forth in section 790.035.

[20] One of the primary tasks in statutory interpretation is the requirement to harmonize all provisions of a statutory scheme if possible. *Day v. City of Fontana* (2001) 25 Cal.4th 268, 272, quoting *People v. Lawrence* (2000) 24 Cal.4th 219, 230, *Hartford Fire Insurance Company v. Macri* (1992) 4 Cal.4th 318, 326, and *Wells v. Marina City Properties, Inc.* (1981) 29 Cal.3d 781, 788.

competition and unfair and deceptive acts or practices in the business of insurance pursuant to section 790.06, and to simultaneously seek penalties pursuant to sections 790.03 and 790.035 for the unlawful practice sought to be newly established, for to do so would violate the insurer's right to basic due process of law preserved by the section 790.06 process.[21]

96. Section 790.06 constitutes a legislatively mandated exclusive order of procedure; the Legislature has provided that is legally impermissible to subject an insurer to the penalties for any new unfair method of competition and unfair and deceptive act or practice in the business of insurance heretofore not listed in Section 790.03, unless it is first determined through a separate action pursuant to section 790.06 to constitute a new unfair method of competition and unfair and deceptive act or practice in the business of insurance. The Legislature has determined that any practice or procedure alleged to constitute a unfair methods of competition and unfair and deceptive acts or practices in the business of insurance not listed in section 790.03 requires pleading and proof in the precedent section 790.06 action that the subject practice or procedure constitutes an unfair method of competition and unfair and deceptive act or practice in the business of insurance pursuant to 790.06, before pursuing a section 790.05/790.03 Order to Show Cause action seeking section 790.035 penalties.

97. A December 30, 2010, ruling by the Superior Court, County of Sacramento in response to a Petition for a Writ of Mandate and/or Declaratory Relief, is appended to the Motion to Strike as an Exhibit. Although not binding or precedential, the ruling contains the court's analysis of a similar issue of construction as raised here. In the Superior Court matter, the court looked at whether postclaims underwriting and rescission practices were included within the practices condemned by section 790.03, analyzing that claim in a very similar manner as is applicable to assessing whether the claims processing practices detailed in the Fair Settlement Practices Regulations can become prohibited practices within the ambit of section 790.03 without going through the 790.06 process. The court's reasoning is both instructive and persuasive and thus provides some guidance here. The relevant portion of the court's ruling is as follows:

> Insurance Code section 790.03 defines "unfair methods of competition and unfair and deceptive acts or practices in the business of insurance" to include nine categories of actions, none of which include post-claims underwriting and rescission based thereon. (Insurance Code section 790.03, subdivisions (a)-(i).) ... *Nothing in the language or structure of Insurance Code section 790.03 indicates that the list of actions is anything but exclusive.* The statute does not contain language commonly found in other statutes setting forth a list of included or excluded items, such as "including, but not limited to." The Legislature could have easily included postclaims underwriting[22] within the

[21] See the *Western General Insurance* discussion and citation below.

[22] By the same reasoning, the Legislature could have just as easily included in the unlawful practices set forth in the Regulations under review here in this consolidated OSC, Regulations, sections 2796.1-.17, or the other conduct in the "statutory violations" portions of the consolidated OSC into the text of section 790.03. The Legislature's failure to do so is legally significant.

definition of unfair methods of competition or unfair or deceptive acts or practices, had it intended Insurance Code section 790.03 to cover this practice.

Most importantly, however, is the fact that the legislative intent articulated in Article 6.5 supports the conclusion that *the Legislature reserved for itself, and only itself, the right to categorically define unfair methods of competition and unfair or deceptive acts or practices* (citing the Insurance Code section 790.06 process as the exclusive process by which an alleged act or omission not listed in the 16 subdivisions of section 790.03, subdivision (h) may become a new unfair method of competition or unfair or deceptive act or practice). (Italics added)

Article 6.5 applies to all persons engaged in the business of insurance (Insurance Code section 790.01) and prohibits such persons from engaging in "any trade practice ***which is defined in this article as, or determined pursuant to this article to be***, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance" (Insurance Code section 790.02 (emphasis in original).) The express purpose of Article 6.5 "is to regulate trade practices in the business of insurance... ***by defining, or providing for the determination of***, all such practices in the state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." (Insurance Code section 790 (emphasis in original).)

During oral argument, the Department argued that postclaims underwriting resulting in rescission constitutes an unfair settlement practice[23], which is defined by Insurance Code section 790.03, subdivision (h). Insurance Code section 790.03, subdivision (h) expressly defines an "unfair claims settlement practice" as including 16 specific types of actions. (Citation omitted) ***Again, the Legislature could have easily defined unfair settlement practices to include postclaims underwriting, had it intended Insurance Code section 790.03, subdivision (h) to cover this practice.***[24] (Bold and italics added)

98. Applying the principle of *expressio unius est exclusion alterius*, the Legislature's expressed intention to make exclusive the list of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance set forth in section 790.03, any additional purportedly unlawful settlement practice is necessarily prohibited, unless the process set forth in Section 790.06 is followed, or the Legislature adds it itself. In so doing, the Legislature both fully occupied this field and thus preempted the Department

[23] Similar to the Department's argument here regarding those acts and/or omissions covered by the Regulations at issue or the alleged violations of other statutes sought to be made violations of section 790.03, subdivision (h).
[24] Superior Court of California, County of Sacramento, Ruling on Submitted Matter: Granting in Part and Denying in Part Petitioner Association of California Life and Health Insurance Companies' Petition for Writ of Mandate and/or Declaratory Relief, Case number 34-2010-80000634-CU-WM-GDS, pages 8 through 10.

from using the process of adopting "interpretative" regulations as an alternative to following the section 790.06 process.

99. Since the Legislature has, as pointed out by the Superior Court, expressed its intention to exclusively occupy the field regarding the ability to add new unfair methods of competition and unfair and deceptive acts or practices in the business of insurance to the list of such prohibited practices set forth in Insurance Code section 790.03, and in particular, section 790.03, subdivision (h), there are only two legally permissible methods to adding to that list of practices prohibited by section 790.03; either the Legislature adds a new prohibited practice itself, or, the Department may proceed through the exclusive mechanism and process the Legislature has provided to add a new prohibited practice contained in section 790.06. By fully occupying the field, the Legislature has preempted and foreclosed what the Department seeks to accomplish in this particular consolidated OSC through the use of the trigger/bridging Regulation, section 2596.1, subdivision (a). These legal limitations also require that if the Department seeks to add any or all of the practices set forth in the Fair Settlement Practices Regulations to the list of prohibited practices enumerated in section 790.03, it must proceed through the process set forth in section 790.06, or by persuading the Legislature to adopt its point of view and enact an additional subdivision to the statute. There is no legally permissible third pathway with respect to adding additional unfair methods of competition and unfair and deceptive acts or practices in the business of insurance to section 790.03.

PRIOR ADJUDICATION-*WESTERN GENERAL INSURANCE*

100. Respondents contend that the essence of this matter has been previously adjudicated in an earlier matter of very similar dimension and scope, in which a different Department's counsel unsuccessfully sought to advance nearly the identical legal arguments in support of a similar consolidated OSC against a different responder insurer, Western General Insurance Company, seeking to use the same Regulations in the same fashion as here; to establish new unfair methods of competition and unfair and deceptive acts or practices in the business of insurance, without having either a specific legislative addition to section 790.03 or going through the section 790.06 process.[25] In that *Western General Insurance* matter[26], decided in 2010, Judge Dash found substantially in conformity with the conclusions above and the Sacramento Superior Court analysis, concluding that the Department could not, through the enforcement mechanism of a nearly identical 790.05/790.03 enforcement action, lawfully add the Fair Claims Settlement Practices Regulations as new unfair methods of competition and unfair and deceptive acts or practices in the business of insurance and enforce those standards through section 790.03 and 790.035. He pointed out that the Department had remedies to address the practices that were causing the Department concern, one of which was to seek to establish those practices as new unfair

[25] *In the Matter of the Order to Show Cause and Statement of Charges Against Western General Insurance Company*, Department's Case no. UPA 2008 00018, OAH Case No 2010030989, decided August 17, 2010, Hon. Ralph B. Dash, Presiding.

[26] A copy of the transcript of the *Western General* proceedings, in which Judge Dash made the quoted comments and enunciated his rulings, was attached as an exhibit to the Motion to Strike.

methods of competition and unfair and deceptive acts or practices in the business of insurance through the mandatory process and procedure set forth in section 790.06, as the Legislature commanded, or to persuade the Legislature to directly add the practice or practices of concern to the specific provisions of section 790.03. Having done neither, Judge Dash dismissed the consolidated OSC in the *Western General* matter, with leave to pursue the matter in the legislatively authorized fashion.

101. In the *Western General* matter, Judge Dash drew a sharp distinction, pointing out the existence of a bright line between lawful and permissible application of the Regulations to the community of regulated insurers as guidance, a list of best practices and/or a set of safe harbors, and where that line is crossed into impermissible invasions of the Legislative prerogative and/or circumvention of the process set forth in section 790.06. He made it quite clear that the use of the Fair Settlement Practices Regulations in the same fashion in the *Western General* case as exists in Paragraphs 50 through 68 in this consolidated OSC, cross that bright line, and may not lawfully be used to create additional actionable unfair settlement practices, adding to those set forth in section 790.03, without specific approval of the Legislature or via the 790.06 process set forth by the Legislature to add an additional allegedly unfair or deceptive practice to those the Legislature specifically identified in section 790.03.

INTERPRETATION AND CONSTRUCTION OF SECTION 790.03, SUBDIVISION (H)

102. The Department contends that the correct construction of section 790.03, subdivision (h) is contained in the trigger/bridge Regulation section 2695.1, subdivision (a), that the Department is legally authorized to interpret section 790.03, subdivision (h) as it has done, and that deference must be given to the Department's interpretation of its own statutory authority, contained in section 790.03, subdivision (h), as it has expressed that interpretation in regulation section 2695.1, subdivision (a). As a result, the Department contends that a violation of any one of the 16 sub parts of section 790.03, subdivision (h) may be proved by either one single knowing violation, or through proof of a general business practice. The Department's contention is reflected in the text of the trigger/bridge Regulation section 2695.1, subdivision (a), where this construction is specifically stated by adding words "on a single occasion," and "or performed,"[27] that do not exist in the original text of section 790.03, subdivision (h). Thus the Department contends that the statutory language of section 790.03, subdivision (h) creates a disjunctive standard of proof, and has reflected that view in Regulation section 2695.1, subdivision (a), spelling that out. As set forth above, the Department's counsel candidly acknowledged that such a disjunctive standard of proof constitutes a significant diminution of the quantum and quality of proof required to prove a violation.

[27] The text of section 790.03, subdivision (h), as set forth above, at the critical points substantively changed by the regulatory rewrite reads, " ... Knowingly committing or performing with such frequency... ." The word "performing" in the statute is in the progressive tense, in the regulation it has been changed to past tense, "performed."

103. The Department's contentions lack factual and legal support and in fact are directly refuted by well-settled statutory and case authority. The standard of proof that the Legislature enacted for a violation in section 790.03, subdivision (h) is conjunctive; that proof of a violation requires both proof of a knowing violation, and proof the violation is part of a general business practice. No less than the California Supreme Court confirms this analysis.

104. Despite the fact that section 790.03 subdivision (h), proscribes 'knowingly committing or performing with such frequency as to indicate a general business practice' the various specified unfair claims-settlement practices, the *Royal Globe*[28] majority held that a single violation knowingly committed is a sufficient basis for such an action.[29] **Without exception we reject *Royal Globe's* holding that an action under section 790.03 could be based upon a single wrongful act**. Such unanimity of disagreement strongly suggest that we erred in our contrary holding.[30] (emphasis added) The *Moradi-Shalal* decision held that the Insurance Commissioner is authorized to impose administrative sanctions **if investigation reveals a pattern of unfair settlement practices as opposed to a single wrongful act**.[31] (emphasis added).

"RESIDENT EXPERTISE"/DEFERENCE TO AGENCY INTERPRETATION CLAIM

105. Counsel for the Department cited both the *Yamaha*[32] case and the *Spray, Gould*[33] case for the proposition that great deference should be given to the Department's Fair Settlement Practices Regulations, because they reflect the "resident expertise" of the Department and with such deference, the Regulations are a lawful exercise of the Department's authority to expound, explain and flesh out the meaning of statutes within the Department's mandate. The contention has solid legal support for the general proposition advanced, but fails to take note of the rather significant exception to this general rule, into which these Regulations as applied in this consolidated OSC squarely fall.

106. Counsel indeed correctly points out that these Regulations, indisputably adopted through the Administrative Procedure Act process, are entitled to some measure of deference, and even a presumption of correct and lawful interpretation of the statutes they purport to explain and elaborate, as a result of going through the APA adoption process.[34]

> If an agency has adopted an interpretive rule in accordance with Administrative Procedure Act provisions — which include procedures (e.g., notice to the public of the proposed rule and opportunity for public comment)

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[28] *Royal Globe Insurance v. Superior Court* (1979) 23 Cal.3d 880, 890-91.
[29] *Moradi-Shalal v. Fireman's Fund Insurance Companies* (1988) 46 Cal.3d 287, 294.
[30] *Id.*, at 303.
[31] *Carlton v. St. Paul Mercury Insurance Company* (1994) 30 Cal.App.4th 1450, 1459, fn. 1.
[32] *Yamaha Corporation of America v. State Board of Equalization* (1988) 19 Cal.4th 1, 4.
[33] *Spray, Gould & Bowers v. Associated International Insurance Company* (1999) 71 Cal.App.4th 1260.
[34] *Id.*

that enhance the accuracy and reliability of the resulting administrative "product" — that circumstance weighs in favor of judicial deference.[35]

107. But rather than being dispositive, as counsel for the Department contends, the conclusion that deference is due is subject to a well-settled and oft-applied exception. Deference is only the first step in the analysis and is not the final and conclusive determinant. The remainder of the analysis required by the pertinent authorities requires evaluation of whether and the exception to the general principle applies to the regulation(s) being evaluated. When the applicability of the exception to the general presumption of deference to resident expertise is evaluated, the deference must be set aside.

108. In the case of quasi-legislative regulations, the court has essentially two tasks. The first duty is 'to determine whether the [agency] exercised [its] quasi-legislative authority within the bounds of the statutory mandate.'[36] As the *Morris* court made clear, this is a matter for the independent judgment of the court. 'While the construction of a statute by officials charged with its administration, including their interpretation of the authority invested in them to implement and carry out its provisions, is entitled to great weight, nevertheless 'Whatever the force of administrative construction ... final responsibility for the interpretation of the law rests with the courts.' Administrative regulations that alter or amend the statute or enlarge or impair its scope *are void* and *courts not only may, but it is their obligation to strike down such regulations.*'[37] This duty derives directly from statute. 'Under Government Code section 11373 [now § 11342.1], '[e]ach regulation adopted [by a state agency], to be effective, must be within the scope of authority conferred....' Whenever a state agency is authorized by statute 'to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute...'[38]

109. Counsel for the Department contends that the decision in *Moradi-Shalal* made it even more important than ever that the Department be permitted wide deference to its "resident expertise," and be afforded even more broad deference and latitude to enact consumer protection regulations such as the ones at issue here, because the consumer's private right of action using Insurance Code section 790.03 was abolished by the decision. The contention lacks legal support and merit, and is directly refuted by a specific passage in the *Moradi-Shalal* decision itself.

110. The *Moradi-Shalal* decision, echoed in the *Carlton*[39] decision, directly rebuts the construction contention advanced by the Department. In addition, the contention is incomplete and inaccurate, an appeal to emotion rather than persuasive legal authority and misconstrues by omission the specifics of the *Moradi-Shelal,* and, by reference, the *Carlton*

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[35] *Id.*
[36] *Morris v. Williams* (1967) 67 Cal.2d 733, 748.
[37] *Id.*, italics added.
[38] *Yamaha Corporation of America v. State Board of Equalization* (1998) 19 Cal.4th 1, 4, citing *Morris, supra*, 67 Cal.2d at p. 748, fn. omitted and Government Code section 11342.2, italics added by *Morris* court.
[39] *Carlton v. St. Paul Mercury Insurance Company, supra.*

decisions. The contention thus fails to address the salient issue here, whether the Regulations under review here improperly and impermissibly expand the scope of section 790.03.

111. *Moradi-Shalal* did indeed abolish a private right of action against an insurer based upon section 790.03. But it did not, as counsel's contentions suggest, strip all rights of actions from consumers against insurers, or remove or prohibit a wide range of preexisting rights of action available to individual aggrieved consumers against an insurer to redress unfair claims settlement practices:

> Common law causes of action such as fraud, infliction of emotional distress, breach of contract, or breach of the covenant of good faith and fair dealing, remain available to persons injured by insurer misconduct. Moreover, it limited its holding to prospective application.[40]

THE EFFECTS OF THE DEPARTMENT'S INTERPRETATION AND CONSTRUCTION OF SECTION 790.03, SUBDIVISION (H)

112. Counsel for the Department acknowledged in oral argument that the trigger/bridge Regulation, section 2596.1, subdivision (a), does indeed attempt to interpret and construe the language of section 790.03, subdivision (h) disjunctively; to use the "or" in subdivision (h) to create an alternative standard. This result cannot be accomplished without reading subdivision (h) with a commas and additional text expressing alternatives that do not appear in the original language of section 790.03, subdivision (h). The text of Regulation section 2596.1 seeks to add a comma and interpretative additional text to subdivision (h) where the comma and the text do not exist in the original text of the statute to produce the disjunctive standard the Department contends is correct, permitting proof of a violation of subdivision (h) through either proof of a knowing violation, in which case a single act might suffice, or proof of a general business practice. The Department actually amends section 790.03, subdivision (h) through the text of the trigger Regulation section 2596.1, and then pulled that interpretation down into section 2596.1, subdivision (a), where the Regulation parses out the conjunctive, two-pronged standard of subdivision (h) into the two disjunctive parts the Department contends it has the right to interpret into existence; violations can be proved via either a single knowing act or by proof of a general business practice. Counsel acknowledged that the disjunctive interpretative construction of subdivision (h) the Department has sought to create through the use of the trigger Regulation section 2695.1 greatly lowers the burden of proof and the quantity and quality of evidence necessary for the Department to prove a violation of section 790.03, subdivision (h). No authority was advanced nor was any found that the Department has been given the authority by the Legislature to lower the burden of proof and the quantum and quality of evidence required to prove an alleged violation of section 790.03, subdivision (h). And, as set forth above, both the California Supreme Court in *Moradi-Shalal* and the California Court of Appeal in the *Carlton* matter specifically and pointedly rejected the Department's disjunctive, single knowing act sufficient for proof of a violation interpretation.

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[40] *Moradi-Shalal, supra*, p. 305

113. The Department's interpretation has the additional effect of incorporating all of the Department's suggested best practices/guidelines/safe harbors for claims processing procedures that appear in the Fair Settlement Practices Regulations and adding them to the 16 subdivisions of section 790.03, subdivision (h) as additional unfair methods of competition and unfair and deceptive acts or practices in the business of insurance as additional prohibited methods of unfair and deceptive settlement acts or practices. Such an interpretation hugely expands the 16 specific practices the Legislature saw fit to adopt and authorize in subdivision (h)'s subparts. This massive augmentation of the specific enumerated prohibited unfair and deceptive settlement practices set forth in section 790.03, subdivision (h) and its 16 subparts is ipso facto violative of the statutory and case authorities set forth above. Additionally, as set forth above, this attempted augmentation of the prohibited practices enumerated in section 790.03, subdivision (h) cannot lawfully occur without either specific legislative mandate or successfully navigating the legislatively mandated process and procedure set forth in section 790.06. The Department's de facto amendment of section 790.03, subdivision (h) through the use of Regulation section 2596.1 is the quintessence of what the statutory and case authorities set forth above specifically prohibit; a regulation "expanding the scope and reach" of the statute through the vehicle of purported regulatory interpretation.

114. The Legislature's choice of language and punctuation, choosing to enact a two-pronged, conjunctive standard of proof, creates a legislatively imposed limitation that the Department may not unilaterally alter, rewrite or relax under the guise of "interpretation" via Regulations. The Legislature's adoption of section 790.06 as part of the same statutory scheme evidenced the Legislature's intention to fully occupy the field of defining what constitutes an unfair method of competition and unfair and deceptive acts or practices in the business of insurance, and, by doing so, has preempted what the Department seeks to do here. If the Legislature sought to create an alternative, disjunctive burden and standard of proof for a violation of one or more of the unlawful practices identified in subdivision (h), such as the trigger provision Regulation section 2695.1, and subdivision (a), seeks to create, the Legislature could have easily done so, either by merely adding the comma and text as the Department did in Regulation section 2596.1, or by some other expression of intention to authorize the Department to add new unlawful practices via regulatory fiat instead of by going through the section 790.06 process. The Legislature did not elect to do so, and none of the authorities cited, found and/or reviewed provide the Department the authority to unilaterally do so, as it seeks to do through this consolidated OSC.

RENDERING PROVISIONS OF A STATUTE SURPLUSAGE

115. The Department's proposed construction of section 790.03, subdivision (h) also violates another key maxim of statutory interpretation, that a proposed interpretation of the statute that renders any operative provision of that statute surplusage is to be rejected.[41]

[41] *Hartford Fire Insurance Company v. Macri* (1992) 4 Cal.4th 318, 326, quoting *Wells v. Marina City Properties, Inc.* (1981) 29 Cal.3d 781, 788. *Estate of Newman* (1994) 25 Cal.App.4th 472, 484, also the authorities set forth in footnote 20.

Regulation section 2695.2, subdivision (k) (1) states, "Knowingly committed means performed with actual, implied, or constructive knowledge, including, but not limited to that which is implied by operation of law." The Department seeks here to define the "knowingly committed" language of section 790.03, subdivision (h) via Regulation section 2695.1, subdivision (a) (1), incorporating the definition in section 2596.2, subdivision (k) (1). Thus defined, a single "knowingly committed" and thus 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."

116. Construing section 790.03, subdivision (h) as the Department suggests, in the disjunctive, and making a single act "knowingly committed," as defined by the Department's Regulations, renders the second portion "general business practices" portion of section 790.03, subdivision (h) superfluous and meaningless. With such a broad definitional construction of "a single act knowingly committed," in all but the most extraordinary of circumstances, the portion of section 790.03, subdivision (h) prohibiting unfair methods of competition and unfair and deceptive acts or practices in the business of insurance as part of the general business practice will be completely ignored and unnecessary. It is almost inconceivable, under such a statutory interpretation, that it would ever be necessary to attempt to prove any prohibited practice was part of a general business practice, when such a relaxed, broad and relatively easy alternative is readily available.

117. Such a construction is disfavored as held in a long line of California cases, as the authorities cited above require that all portions of the statute are to be given effect and harmonized, to the extent that they logically and rationally can be. The portion of the statute that prohibits a general business practice becomes a nonissue if any single act construed to be knowingly committed via the constructive or implied knowledge definitional provision can create a knowing violation through what would otherwise be viewed as a non-actionable a single act of inadvertence. The well-settled case authority routinely states that the Legislature must be presumed to have written the statute in such a fashion that all portions of the statute were to be given effect. The construction of the statute advanced by the Department renders the back end, the second proof prong of the statute, superfluous, ineffective, and thus violates this well-settled rule of statutory construction.

118. The Department is not lacking in remedies. If any of the claims processing best practices/guidelines/safe harbors set forth in the Fair Settlement Practices Regulations, appearing as the basis for alleged violations in Paragraphs 50-68 in the consolidated OSC are of such a concern to the Department that they are believed to constitute additional unfair or deceptive practices, the door is always open for the Department to file proceedings pursuant to Insurance Code section 790.06, plead and prove that that the concerning specific conduct and/or behavior constitutes an additional unfair or deceptive practice that should be added to the 16 enumerated practices listed in section 790.03, and proceed from there. This process, both mandatory and exclusive per the Legislature, may not be circumvented by regulatory drafting or "interpretation." Since this is precisely what is sought to be accomplished in the identified Paragraphs 50-68 set forth above of the consolidated OSC, and is the sole legal basis supporting the action in those enumerated Paragraphs set forth above, those Paragraphs,

and the allegations made in them that depend upon the advancing of regulatory standards as additional unlawful unfair or deceptive practices, fail as a matter of law. These allegations must be dismissed. As there is no conceivable method by which those specific allegations may be rephrased in a fashion that would not run afoul of these standards set forth above, the dismissal of these allegations is with prejudice and without leave to amend.

INTERFACE WITH SECTION 790.035 AND LATER AMENDMENTS OF SECTION 790.03

119. Counsel for the Department contends that two amendments added to Insurance Code section 790.03 since 2001, and the existence and the addition of section 790.035 to the statutory scheme of which section 790.03 belongs, reflects legislative awareness and endorsement of the Department's authority to enact and the legal efficacy of enforcement of the Fair Settlement Practices Regulations. Counsel contends that these developments raise a presumption that the Legislature was both aware of the Regulations and that the Legislature, in amending the statute and not condemning the Regulations purporting to interpret it, implicitly approved and validated the Regulations. The contention lacks merit as it is speculative and based upon assumptions and not on any facts indicating that the Legislature even paid attention to the rather collateral matter of the Regulations at issue when it adopted what the Legislature itself characterized as non-substantive, technical changes to section 790.0-3 when it was amended.

120. Counsel contends that section 790.035 was a legislative response to the 1988 *Moradi-Shalal* decision,[42] which had the effect of eliminating an individual's ability to bring a first party bad faith/unlawful settlement practices action against an insurer based upon private enforcement of the provisions of section 790.03 and its numerous sub parts. Counsel contends that decision in *Moradi-Shalal*, the amendments to section 790.03 and the addition of section 790.035 reflect the Legislature's endorsement of the necessity of the Department taking a more active role in protecting consumers who lost the opportunity to directly sue insurers as a result of *Moradi-Shalal*. Relying on the *Yamaha*[43] case again, counsel contends that the Legislature's failure to condemn the Fair Claims Settlement Regulations' interpretation of section 790.03, subdivision (h) during the process of amending section 790.03 on two occasions shows that there was awareness of the Regulations by the Legislature, and that this awareness therefore validates the Regulations by implication.

121. The contention lacks merit. It was not disputed that *Moradi-Shalal* changed the legal landscape with respect to who has the authority to bring actions against insurance companies based upon section 790.03 for unfair and deceptive claims practices. The *Yamaha* case, like several others, stands for the general proposition that initial deference needs to be given to a regulatory agency when it enacts regulations that purport to elaborate upon and provide detail and specifics of the statutes that are within that regulatory agency's statutory mandates. But *Yamaha* does not stand for the proposition, nor does it authorize

[42] *Moradi-Shalal v. Fireman's Fund Insurance Co.* (1988) 46 Cal.3d 287.
[43] *Yamaha Corporation of America v. State Board of Equalization* (1988) 19 Cal.4th 1, 4.

what the Fair Settlement Practices Regulations here seek to do, de facto amending and greatly expanding the scope and punitive reach of section 790.03, subdivision (h), without going through the process set forth specifically in section 790.06. Nor does it stand for the proposition of indirect endorsement of extending the Department's reach without specific and express Legislative approval far beyond what is authorized by section 790.03, its numerous subdivisions, and particularly that set forth in subdivision (h) and its 16 specific unlawful practices, adding hundreds of new potential violations and penalties, and unilaterally substantially reducing the burden and quantum of proof Legislatively required to prove a violation set forth in subdivision (h). In fact, the contention requires the implicit repeal of section 790.06, which is the existing legislative mandate for how the Department is required to proceed with what it seeks to do through Regulation section 2596.1. It also assumes, without any factual basis, that the Legislature may have implicitly approved the Regulations for some of their salutary purposes, but mindful of the restriction the Legislature already wrote into law in section 790.06, saw no need to condemn what it had already legislatively prohibited.

122. The contentions here require finding cause and effect where only general correlation exists, and perhaps not even that. The implication, the assumption and the implied legislative endorsement of the Department's Fair Settlement Practices Regulations being used in the manner in which they are in this consolidated OSC, that counsel suggests is mandated by *Yamaha,* simply does not exist.

123. The enactment of section 790.035 dos not supplant or change the interpretation required of the language of section 790.03, subdivision (h), nor does it suggest or imply that the Department's reinterpretation of that language to change its scope, reach, substance, meaning and proof standards. There is no express or implied endorsement within section 790.035 approving the effect of hugely broadening the scope and reach of section 790.03 through the Fair Settlement Practices Regulations. Section 790.035 is a back-end provision. Section 790.035's authorization to the Department to determine "an act," relates only to the amount of the penalty, and only comes into play after a determination that a knowing and unlawful business practice has been proved pursuant to section 790.03, subdivision (h).

124. Counsel's suggestion that the section 790.035 authorization to the Department to determine "an act" reflects Legislative authorization and endorsement of the Department's authority to construe subdivision (h) through the Regulations tortures the construction of both statutes. The Department's authority to determine an "act" pursuant to section 790.035 only comes into play after a violation of the standards of section 790.03 have been pleaded and satisfactorily proved, and 790.035 has nothing to do with the standards of proof for a violation of section 790.03 and does not come into play, if and only if, an adverse finding under section 790.03 first occurs.

125. There is nothing about the amendment of section 790.03 nor the enactment of section 790.035 that provides any express or implicit endorsement of the Department's redefinition of the language of subdivision (h) through the enactment of the Fair Settlement Practices Regulations. Before and after the amendments to section 790.03 and the enactment

of section 790.035, the Department was and is still required to plead and prove that any particular allegedly unlawful claims practice is both knowing and is a part of a general business practice, and to go through the section 790.06 process if it seeks to expand the scope of section 790.03.

DEPARTMENT'S OTHER CONTENTIONS

126. All of the Department's contentions contained in the Department's counsel's lengthy written brief and attachments, and lengthy oral arguments in opposition to the Motion to Strike, were carefully researched and considered in making the rulings and order set forth herein. Some of those contentions deserve separate mention here, as they focus attention on the issues encompassed by the attempt in the majority of the consolidated OSC to redefine the meaning of section 790.03, subdivision (h) by regulatory fiat, and then using that redefined and substantially augmented authority to seek the relief sought through the consolidated OSC.

127. A portion of the preliminary statements of the Market Conduct Examination Report is enlightening. At page 5 in the Preliminary Findings area of the Market Conduct Examination Report following the forward, entitled, "Results of Reviews of Consumer Complaints and Inquiries, and Previous Examinations,' the following appears:

> The companies were the subject of 20 California consumer complaints and inquiries between July 16, 2005, and July 16, 2006, in regard to the line of business reviewed in this examination. The review showed alleged noncompliance with respect to the following: Failure to provide written notice of the need for additional time every 30 calendar days to determine whether a claims (sic) should be accepted or denied; failure to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance; failure to begin investigation and provide necessary forms, instructions, and reasonable assistance within 15 calendar days upon receiving notice of claim; failure to accept or deny the claim within 40 calendar days upon receipt of proof of claim; and failure to respond to Department of Insurance claim inquiries within 21 calendar days of receipt of such inquiry. The examiners focused on these issues during the course of the file review.

128. The explanatory statement early on in the Market Conduct Examination Report discloses that all of the alleged violations identified in this explanatory paragraph are based upon alleged violations of the Department's Fair Claims Settlement Practices Regulations, using the Regulation section 2596.1 rewrite of section 790.03, subdivision (h)'s language to establish alleged violations. Nowhere in the consolidated OSC can any information be found regarding the 20 California consumers who complained or "inquired," nor can there be found any allegation about any specific wrongdoing alleged to have been the responsibility of any identified respondent with respect to any of these 20 California

consumers. Nor can it be ascertained how many of those 20 California consumers were persons who merely inquired of the Department about a claim or person who actually filed a complaint. If actual California consumer claims do exist, the failure of any allegation n the consolidated OSC to mention any such consumer or "inquirer," any specific claim or transaction, and so forth, tends to support one of respondents' points that the allegations contained in the consolidated OSC are so vague and ambiguous that respondents are unable to ascertain where such consumer complaints and claims may reside in the consolidated OSC, the identity of the consumer(s) in the alleged transaction, and/or the identity of the allegedly offending insurer.

FAILURE TO PLEAD WITH SUFFICIENT SPECIFICITY

129. One of the core challenges contained in the Motion to Strike is a challenge to the overbreadth, vagueness and imprecision of the allegations set forth in Paragraphs 50 through 82. The challenges have merit. As the consolidated OSC is drawn from and models the conclusions and statements made in the Market Conduct Examination Report, which is a broad and general document and lacks specificity about any particular claim, claimant, or particular act, the allegations in the consolidated OSC based upon that model are similar. As Judge Dash commented in the *Western General* matter, "If you have the facts and information, plead them." That has not been done here.

130. Some portions of the 2008 Market Conduct Examination Report[44] are enlightening, in that they shed light on this particular issue of pleading vagueness. In the "Forward," the following language appears at page 2:

> The examination period covered the claims handling practices of the aforementioned companies during the period July 16, 2005, through July 15, 2006. The examination was made to discover, *in general*, if these and other operating procedures of the companies conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of section 790.03 and title 10, California Code of Regulations, sections 2695, et. al.
>
> [¶] ... [¶]
>
> The report is written in a report by exception format. The report does not present a comprehensive overview of the subject insurer's practices.[45] The report *contains a summary* of pertinent information about the lines of business examined, details of the noncompliant or problematic activities that were

[44] The preliminary remarks sections, such as the Preamble, Statements of Purpose and Forward are the same, regardless of which version of the Market Conduct Examination Report one examines.

[45] This statement may easily be read as a concession that the examination did not seek or develop facts and evidence or information that could prove any respondent culpable of any unfair methods of competition and unfair and deceptive acts or practices in the business of insurance as a matter of general business practice.

discovered during the course of the examination and the insurer's proposal for correcting the deficiencies. (Italics added)

131. In the portion of the report entitled "Scope of the Examination," at page 3, the following language appears:

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the companies for use in California including any documentation maintained by the companies in support of positions or interpretation of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) consumer complaints *and inquiries* about these companies handled by the CDI during the same time period and a review of previous CDI market conduct examination reports on these companies.

[¶] ... [¶] (Italics added)

132. At page 4 of the Preamble of the Market Conduct Examination Report, in a portion entitled, "Executive Summary of the Claim Sample Reviewed," the following appears:

The claims reviewed were closed from July 16, 2005, and July 15, 2006, referred to as the review period. The examiners randomly selected 51 GLAIC claims files, four LNLIC claims files, 297 UAIC claims files, 22 UILIC claims files, and 300 AILIC claims files for examination. The examiner cited 501 alleged claims handling violations of the Fair Claims Settlement Practices regulations and/or California Insurance Code section 790.03 from the sample file review.

Findings within the scope of this report included: failure to provide an explanation of benefit with claim payment; failure to include a written basis for the denial; failure to include a statement in the written denial advising the claimant that he or she may have the matter reviewed by the Department of Insurance; failure to disclose benefits that may apply to the claim presented; attempting to settle a claim by making a settlement offer that was unreasonably low; and failure to investigate and failure to effectuate prompt, fair, and equitable settlement of a claim.

133. The Market Conduct Examination Report by its own statements and disclosures never purports to be anything other than a random review with very general findings and conclusions, omitting by design the specifics of claims, claimants, dates, and specific insurers. The remainder of the Public Report, appended and incorporated into the consolidated OSC, is consistent with this preliminary explanation of its contents, containing no specificity that, when read in conjunction with the allegations in the Paragraphs of the consolidated OSC, would provide the reader with any specific detail regarding which claims were at issue, which insurers were allegedly violating the provisions cited, and so forth.

PLEADING STANDARDS

134. Government Code sections 11503 and 11504, which set the statutory standards for APA pleading, recognize, as the Department correctly points out, that California is a notice pleading jurisdiction, and that liberality and pleading is to be encouraged. For example, section 11503 provides, in pertinent part:

> The Accusation shall be a written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the respondent is charged to the end that the respondent will be able to prepare his defense. It shall specify the statutes and rules which the respondent is alleged to have violated ***but shall not consist merely of charges phrased in the language of such statutes and rules***. (Bold and italics added)

135. Immediately following the pleading requirement provisions in the APA is Government Code section 11506, which further defines APA pleading standards by setting forth the requirements for a responsive pleading in the form of a Notice of Defense. In pertinent part, those provisions are as follows:

> (a) Within 15 days after service of the accusation the respondent may file with the agency notice of defense in which the respondent may:
>
> [¶] ... [¶]
>
> (2) Object to the accusation upon the ground that it does not state acts or omissions upon which the agency may proceed.
>
> (3) Object to the form of the accusation on the ground that it is so indefinite or uncertain that the respondent cannot identify the transaction or prepare a defense.
>
> [¶] ... [¶]
>
> (5) Present new matter by way of defense.
>
> [¶] ... [¶]

> An accusation is required to initiate the proceeding and must specify 'the statutes and rules which the respondent is alleged to have violated ....' (Gov.Code, § 11503.) The fulfillment of this requirement is a statutory predicate for disciplinary action. It follows the finding must be based upon the accusation. Here it was not. Disciplinary action cannot be founded upon a charge not made.
>
> [¶ ... [¶]
>
> As we have said, the APA requires, as a predicate to disciplinary action, the accusation specify 'the statutes and rules which the respondent is alleged to have violated.' (Gov.Code, § 11503.) This provides a constitutionally required notice to the accused of the standards by which his conduct is to be measured. It permits discipline to be imposed only for violation of an ascertainable standard of conduct.[46]

136. The key operative language in section 11503, "ordinary and concise language describing the acts and omissions with which respondent is charged," elaborated upon in the *Wheeler* decision, requires pleading with sufficient specificity that "the respondent will be able to prepare his defense." Section 11506 permits the respondents to attack the pleading based upon a failure to meet this standard, requiring pleading allegations in ordinary and concise language describing the acts and omissions with which the respondent is charged. The standards also permit challenge to any allegation as legally defective that is essentially a restatement of the legal basis upon which the allegation is based.

137. Few, if any, of the allegations in Paragraphs 50 through 82, and their numerous subparts, conform to these requirements and standards, broad and liberal though they may be. The Department's notice pleading contentions were carefully considered. Both the statutes cited and the cases advanced in support of counsel's liberality of notice pleading contention, and construing the APA pleading statutes, require a conclusion that counsel's contentions regarding the vague and nondescript contents of the Paragraphs constituting the substance of the consolidated OSC, Paragraphs 50-82, lack merit. The allegations set forth in Paragraphs 50-84 fail to plead causes of action with sufficient clarity, certainty and specificity to meet the notice pleading requirements described above.

138. Paragraph 56 contains an illustrative example of the deficits described generally above. Paragraph 56 alleges as follows:

> In twenty-six (26) instances, the Department alleged that TORCHMARK COMPANIES failed to effectuate prompt, fair and equitable settlement of

[46] *Wheeler v. State Board of Forestry* (1983) 144 Cal.App.3d 522, 527, citing *Button v. Board of Administration* (1981) 122 Cal.App.3d 730, 738–739, *In Re Ruffalo* (1968) 390 U.S. 544, 88 S.Ct. 1222, 20 L.Ed.2d 117 and *Cannon v. Commission on Judicial Qualifications* (1975) 14 Cal.3d 678, 696; *Wheeler* cited approvingly for the same legal principal in *Smith v. State Board of Pharmacy* (1995) 37 Cal.App.4th 229, 240.

claims in which liability had become reasonably clear in violation of Insurance Code section 790.03, subdivision (h) (5).[47] As examples,

a. In sixteen (16) instances, UNITED AMERICAN unilaterally "repriced" actual charges and/or discounted charges for healthcare services, including charges for room and board, by ten to twenty per cent (10% to 20%) instead of paying reasonable and customary charges as provided by policy provisions, resulting in reduced benefits to policyholders. The Department alleged that TORCHMARK COMPANIES followed a general claims processing practice of discounting charges by the same percentage as discounts it had contracted for in non-insurance programs even though the discounts did not apply to the insurance programs.[48] In other instances, UNITED AMERICAN discounted charges in the same amount as in contracts entered into by third-party networks even though TORCHMARK COMPANIES did not have direct contacts with the discounted providers. TORCHMARK COMPANIES did not ensure that policyholders were not responsible for the difference as a result of the discounts.

b. In at least one (1) instance, and alleged as a general business practice, AMERICAN INCOME failed to pay the usual and customary charge for knee prosthetic implants and joint implants. Instead, the company utilized an informal, unverified, and general Internet search by an adjuster to come up with a price for the implant, without any quality or suitability verification, rather than utilize standardized published medical data and pricing guidelines. AMERICAN INCOME only paid $4,050 for a joint implant rather than the charge of $33,804, without validating the actual cost of the implant device with the correct model number and manufacturer's information.[49]

c. In at least one instance (1), AMERICAN INCOME denied payments using an incorrect maximum limit.

d. In at least one (1) instance, UNITED AMERICAN reduced benefits on a long-term care policy claim for the first 20 days as a Medicare offset, without verifying that Medicare had remitted payment. In this instance, and alleged as a general business practice, UNITED AMERICAN failed to adopt procedures to consistently verify Medicare remittances before reducing benefit payments for skilled nursing facility expenses. Violations of California Insurance Code section 10232.92, and/or section 10232.95 covering long-term

[47] Section 790.03, subdivision (h)(5) requires pleading and proof that the insurer's actions were not in good faith, and that the actions were knowingly committed or performed with such frequency as to indicate a general business practice. This allegation fails to mention these critical and essential legal requirements.
[48] There is no allegation that explains the specifics of this claim factually, or how this vaguely stated practice constitutes bad faith.
[49] A single instance general business practice is an oxymoron. This claim is oft repeated in Paragraph 56's subparts.

care policies are subject to additional penalties and remedies, pursuant to Insurance Code section 10234.2.

e. In six (6) other instances, UNITED AMERICAN deemed valid charges ineligible as covered benefits, and delayed the application of premium benefits.

f. In at least one (1) instance, GLOBE failed to apply a good risk provision benefit under a cancer policy.

Out of the 26 instances cited, the alleged violations were allocated[50] as follows:

(1) The Department alleged that UNITED AMERICAN failed to attempt in good faith to effectuate prompt, fair and equitable settlements in twenty three (23) instances, in violation of Insurance code section 790.03, subdivision (h) (5);

(2) The Department alleged that AMERICAN INCOME failed to attempt in good faith to effectuate prompt, fair and equitable settlements in two (2) instances, in violation of Insurance Code section 790.03, subdivision (h) (5);

(3) The Department alleged that GLOBE failed to attempt in good faith to effectuate prompt, fair and equitable settlements in one (1) instance, in violation of Insurance Code section 790.03, subdivision (h) (5).

139. Paragraph 56 is fairly typical of the manner in which the charging allegations of the consolidated OSC are set forth. Paragraph 56 is a model of sweeping and overbroad claims lacking the minimum detail required by the APA pleading standards set forth above. In addition, the allegations of Paragraph 56 fail to properly and correctly plead the legal elements of section 790.03, subdivision (h) (5). None of the allegations of Paragraph 56 correctly plead the legal standard set forth in subdivision (h) itself, which requires pleading and proof that the violations were both knowing and were part of a general business practice. Even though there is no specific standard against which a certain number of claims becomes a general business practice, it is certainly evident that the number of claims alleged in these various subdivisions of Paragraph 56 do not meet those subdivision (h) minimum standards. The "allocation" of those 26 allegedly actionable claims among the three individual respondent insurers named in the allocation provisions further dilutes the number of claims assignable to each individual respondent insurer, and further weakens the argument that any of these allegations reflect pleading and potential proof of a general business practice.

[50] The consolidated OSC uses the word "allocated" in several multi-claim allegations, but fails to disclose what the term means.

140. Paragraph 64 provides another, but somewhat different, example of the problems with pleading encountered throughout the consolidated OSC. Paragraph 64 reads, in pertinent part, as follows:

> In six (6) instances, the Department alleged that TORCHMARK COMPANIES failed to adopt and implement reasonable standards for the prompt investigation and processing of claims under its insurance policies, in violation of California Insurance Code section 790.03, subdivision (h) (3). As examples, a life settlement check was issued to an incorrect payee.[51] In one instance, the company[52] submitted an incorrect report of annuity settlement proceeds to the Internal Revenue Service. In another instance, the companies placed claims on its pending list for up to 16 months without monitoring, follow-up or appropriate closing procedures. In another instance, the company failed to investigate and pay a claim without any file activity for 58 days.

141. Section 790.03, subdivision (h) (3) states that if an insurer knowingly commits or performs with such frequency as to indicate a general business practice a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies, the insurer may be held liable for the penalties set forth in section 790.035.

142. A mere six instances cannot constitute a general business practice, absent disclosure of some facts that are not evident anywhere in this record. Paragraph 64 fails to allege even that the six instances recited in the Paragraph constitute an unlawful general business practice. Subdivision (h) (3) does not make actionable simple inadvertence, processing errors, or mistakes, as proof is required that the failure to implement the reasonable standard for prompt investigation and processing of claims required by the subdivision also mandates pleading and proof that the failure to adopt and implement those standards was knowing, thus ruling out any inadvertent mistakes and errors in processing claims. The factual allegations set forth in Paragraph 64 appear to be little more than mistakes; inadvertent processing errors, evident from the plain and clear reading of the allegations in the Paragraph itself, and there is no allegation that suggests or alleges otherwise.

143. In a third different example of pleading insufficiency, Paragraph 73 is entitled, "Making a False Statement to the Insurance Department." Paragraph 73 reads as follows:

> In (2) instances, the Department alleges that TORCHMARK COMPANIES have made a false statement to an Examiner or the Insurance Department pertaining to the business of the insurer during the course of the 2002 and 2006 Market Conduct Examinations with intent to deceive, in violation of

[51] The pleading fails to identify which company, particularly problematic since there are no direct allegations against Torchmark, yet the Paragraph alleges Torchmark as the actor.
[52] "The company" is again unidentified.

California Insurance Code section 790.03, subdivision (e). On two separate occasions, officers of TORCHMARK COMPANIES made commitments, promises, representations or other statements to the Department's Field Claims Bureau examiners relating to improvement modifications to its claims processing computerized systems to correct deficiencies in its Explanation of Benefits, which the companies have failed to perform.

144. Insurance Code section 790.03, subdivision (e) provides that making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into his condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine it's condition or into any of its affairs, or, with like intent, willfully admitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer is guilty of an unfair method of competition and unfair and deceptive act or practice in the business of insurance.

145. Here, unlike section 790.03, subdivision (h), a single knowing and intentional act or omission not amounting to a general business practice can constitute a violation of section 790.03, subdivision (e). Paragraph 73 fails to plead and allege what the alleged intentionally false statements were, who made the statement, or to whom the person or persons at the Department. These allegations lacked minimum specificity and are impermissibly overbroad, vague and imprecise.

THE DEMANDS (PARAGRAPHS 79-82)

146. Paragraphs 79 through 82 set forth a series of prayers and remedial "Demands," "pursuant to California Insurance Code sections 704, 790.035, 790.05, 790.08, 10234.2, 10234.3, 10234.4, 10234.5, and 12976." These Paragraphs rely for their efficacy and sufficiency upon Paragraphs 50-78, which the demands incorporate by reference. As such, the demands, Paragraphs 79 through 82 suffer the same fate as the Paragraphs that support them.

LIMITATIONS OF THIS ORDER/THESE RULINGS

147. This ruling is not meant to suggest that the Department's Fair Claims Settlement Practices Regulations, sections 2695.1-17, are invalid, unenforceable or unlawful in all instances and for all purposes. This ruling also does not mean to suggest that those Regulations do not have some salient and useful purposes within the legislatively delegated parameters of the Department's authority to enlighten, elaborate, discipline, police and clarify and provide guidance to the industry pursuant to the statutes and case law set forth above. As discussed above, various subdivisions of Regulation section 2695 set forth the Department's elaboration of its view of what constitutes the best practices and its preferred methodology for handling and processing claims, and as such, provides guidance and direction with respect to best practices, against which insurers may be advised as to what the Department believes are successful and appropriate approaches to processing and handling

claims, as well as safe harbor provisions to provide protection for insurers who handle and process claims in accordance with these regulatory guidelines, providing some shield against attack claiming unfair dishonest or unlawful claims handling practices.

148. The only manner in which the Regulations are being held invalid in this instance is the manner in which they are being applied through the trigger Regulation section 2695.1, subdivision (a) to rewrite and redefine section 790.03, subdivision (h) and change its standards and burdens of proof, seeking to add numerous new unlawful practices delineated by the section 2695 Regulations to the 16 enumerated specific unlawful claims practices set forth in Insurance Code section 790.03, subdivision (h), in derogation of the Legislatively mandated process for making additions to the unlawful practices set forth in subdivision (h) set forth in Insurance Code section 790.06. Thus, this ruling should be interpreted with reference to the individual facts and circumstances of the allegations of this particular consolidated OSC, and the manner in which those allegations employed the trigger Regulation section 2695.1, and, in particular, subdivision (a) to create additional unlawful practices against which respondents are subjected to penalties and other sanctions for failure to comply with those Regulations.

149. Contrary to numerous comments in briefing and argument, the Department is not left without remedies or other satisfactory avenues for the Department to seek redress on behalf of consumers. The Department continues to have available to it the ability to establish through pleading and proof any new unfair method of competition and unfair and deceptive act or practice in the business of insurance for any of those practices raised in this consolidated OSC that remain of concern to the Department, through the process of a section 790.06 action, or pursuit of specific and clearly identified individual claims by aggrieved consumers, seeking common law remedies at law and equity for conduct that also violates the specific standards of section 790.03. Granting the Motion to Strike and concluding that the application of the Regulations under review is barred legally in the manner in which the Regulations are sought to be applied in this consolidated OSC, requiring the Department to resort to seeking its remedies through the legislatively mandated avenues set forth above, by no means constitutes leaving the Department without sufficient tools to regulate the industry.

EVIDENTIARY HEARING DATES

150. The rulings herein grant the relief sought in the Motion to Strike. It may be that the Department will elect to amend and replead some of the allegations. At the present time, there is no viable pleading before this tribunal upon which to conduct an evidentiary hearing, and thus there is no basis to retain the evidentiary hearing dates that have previously been set. Since there is no valid reason to retain the evidentiary hearing dates, those dates are vacated here, with leave to select new dates if circumstances so warrant. The Notice of Hearing setting those evidentiary hearing dates is vacated.

ORDER

THEREFORE, GOOD CAUSE APPEARING:

1. The Motion to Strike is GRANTED IN PART AND DENIED IN PART.

2. The allegations of the consolidated OSC based upon Insurance Code section 790.06 are SEVERED as improperly joined, and are DISMISSED from this action.

3. The consolidated OSC is DISMISSED WITH PREJUDICE as it relates to respondents LIBERTY NATIONAL LIFE INSURANCE COMPANY and UNITED INVESTORS LIFE INSURANCE COMPANY.

4. The Accusation brought pursuant to Insurance Code section 704, subdivision (b) is SEVERED as improperly joined, and DISMISSED from this action.

5. As set forth in the section entitled "Allegations Based on Regulations, Paragraphs 50; 51; 52; 53; 54; 55; 57; 58; 59; 60; 61; 62; 63; 65; 67; and 68 are each DISMISSED WITH PREJUDICE and WITHOUT LEAVE TO AMEND.

6. Paragraph 75, 76, 80 and the portion of Paragraph 77 referring to Insurance Code section 704, subdivision (b) as a basis of action are SEVERED as improperly joined, and DISMISSED from this action.

7. Paragraphs 78, 79, 81 and 82 are SEVERED as improperly joined, and DISMISSED from this action. The Paragraphs of the consolidated OSC alleging violations of Insurance Code sections 10234.2, et seq., and 12976 are SEVERED from the action as improperly joined, and are dismissed from this action.

8. All other Paragraphs of the consolidated OSC not specifically addressed above are DISMISSED WITH LEAVE TO AMEND, with any amendment to be consistent with the standards set forth herein.

9. In all other respects not specifically addressed above, the Motion to Strike is OVERRULED.

10. The evidentiary hearing dates of October 28, 2012 through February 19, 2013 (60 trial days), are hereby VACATED, and may be rescheduled, if circumstances warrant.

DATED: August 15, 2012

STEPHEN J. SMITH
Administrative Law Judge
Office of Administrative Hearings

DECLARATION OF SERVICE

Case Name: Globe Life & Accident Insurance Company **OAH No.: 2011090887**

I, Zendie Tolentino, declare as follows: I am over 18 years of age and am not a party to this action. I am employed by the Office of Administrative Hearings. My business address is 2349 Gateway Oaks Drive, Suite 200, Sacramento, CA 95833. On August 21, 2012, I served a copy of the following document(s) in the action entitled above:

ORDER ON DEMURRERS AND MOTIONS TO STRIKE AND DISMISS

to each of the person(s) named below at the addresses listed after each name by the following method(s):

[*see attached service list or*]

Department of Insurance
Attn: Raelena Gamble
45 Fremont Street, 21st Floor
San Francisco, CA 94105
Via US mail

Robert W. Hogeboom
Attorney at Law
Barger & Wolen LLP
633 W. Fifth Street., 47th Floor
Los Angeles, CA 90071-2043
Via US Mail

Mary Ann Shulman, Counsel
Department. of Insurance
45 Fremont Street, 21st Floor
San Francisco, CA 94105
Via US Mail

☒ **United States Mail.** I enclosed the document(s) in a sealed envelope or package addressed to the person(s) at the address(es) listed above, and placed the envelope or package for collection and mailing, in accordance with the Office of Administrative Hearings' ordinary business practices, in Sacramento, California. I am readily familiar with the Office of Administrative Hearings' practice for collecting and processing documents for mailing. Correspondences are deposited in the ordinary course of business with the United States Postal Service in a sealed envelope or package with postage fully prepaid. [□ by certified mail].

☐ **Email or Electronic Transmission.** Based on a court order or the agreement of the parties to accept service by Email or electronic transmission, I caused the document(s) to be sent to the person(s) at the Email address(es) listed above

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. This declaration was executed at Sacramento, California on August 21, 2012.

/s/
Zendie Tolentino, Declarant

Association of California Insurance Companies, et al. v. Dave Jones
Los Angeles County Superior Court Case No. BC463124

DECLARATION OF SERVICE

I am a citizen of the United States, over the age of 18 years, and not a party to or interested in this action. I am employed in the County of Sacramento, State of California and my business address is Greenberg Traurig, LLP, 1201 K Street, Suite 1100, Sacramento, CA 95814. On this day I caused to be served the following document(s):

PLAINTIFFS' REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF DECLARATORY JUDGMENT

☒ by placing ☐ the original ☒ a true copy into sealed envelopes addressed and served as follows:

Lisa Chao
Deputy Attorney General
Office of the Attorney General
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213)897-2488
Facsimile: (213) 897-5775

Attorney for Defendant
DAVE JONES, California Insurance Commissioner

☐ **BY MAIL**: I am familiar with this firm's practice whereby the mail, after being placed in a designated area, is given fully prepaid postage and is then deposited with the U.S. Postal Service at Sacramento, California, after the close of the day's business.

☐ **BY PERSONAL SERVICE**: I caused such envelope to be delivered by hand.

☐ **BY OVERNIGHT COURIER**: I caused such envelope to be placed for collection and delivery in accordance with standard overnight delivery procedures for delivery the next business day.

☒ **BY ELECTRONIC SERVICE**: I caused such document(s) to be transmitted by electronic mail delivery to the following e-mail address: lisa.chao@doj.ca.gov.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on December 14, 2012 at Sacramento, California.

Lynne Koroush
LYNNE KOROUSH