Developments in California Insurance Law—2007

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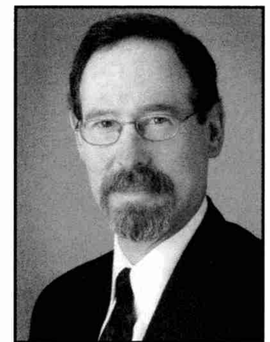

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1. INTRODUCTION

This article reviews 2007 developments in three areas of California Insurance law: enacted legislation; selected case law decisions; and insurance regulatory actions.

2. LEGISLATION

The following are significant insurance-related bills signed into law in 2007. All are effective January 1, 2008 unless noted otherwise.

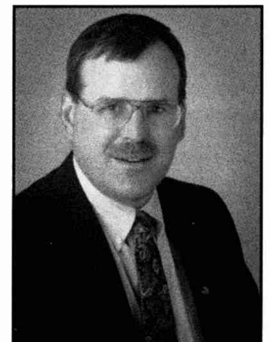
Automobile Insurance

Assembly Bill No. 645 (2007-2008 Reg. Sess.) (Feuer) Traffic Violations—Adjudication: prohibits courts from concealing or "masking" significant two-point traffic violations through traffic school. Examples of such two-point violations include reckless driving, DUI, leaving the scene of an accident, speed contests, and driving on the wrong side of a divided highway.

Assembly Bill No. 797 (2007-2008 Reg. Sess.) (Coto) Insurance Agents: creates a limited automobile-only insurance agent license that is narrower than the existing personal lines agent license.

Property Insurance

Senate Bill No. 430 (2007-2008 Reg. Sess.) (Machado) California Earthquake Authority: allows the governing board of the California Earthquake authority to assess participating insurers in the amount of $1.3 billion to fund any potential shortfall of claims-paying capital in the event of an earthquake on or after December 1, 2008. CEA participating insurers will provide this capital to the CEA in proportion to their share of the California homeowners' insurance market.



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Regulation of the Insurance Business

Assembly Bill No. 522 (2007-2008 Reg. Sess.) (Duvall) Nonadmitted Insurers: repeals the sunset date of January 1, 2008 on current law providing an insured with the right to cancel a policy with a nonadmitted insurer within five days.

Assembly Bill No. 1401 (2007-2008 Reg. Sess.) (Aghazarian) Insurance Fraud—Assessments: increases the fraud assessment for insurers from $1,300 to $5,100, and clarifies that insurers may recoup the annual $1.80 per vehicle "special purpose assessments" (formally referred to as "fees") through a surcharge on premiums.

Workers Compensation

Assembly Bill No. 338 (2007-2008 Reg. Sess.) (Coto) Workers Compensation—Permanent Disability: allows an injured worker to recover the maximum of 104 weeks of temporary disability benefits over a period of five years from the date of the injury. Existing law allows recovery within two years from the commencement of benefit payments.

Assembly Bill No. 812 (2007-2008 Reg. Sess.) (Hernandez) Workers Compensation Audits: requires an employer to pay a premium equal to three times the most recent estimated annual premium if the employer fails to provide reasonable access to payroll records for a payroll verification audit.

Assembly Bill No. 1073 (2007-2008 Reg. Sess.) (Nava) Workers Compensation: makes the 24-visit cap on chiropractic treatments, physical therapy, and occupational therapy inapplicable to postsurgical services if those services comply with the postsurgical treatment

schedule established by the director of the Division of Workers Compensation.

Senate Bill No. 316 (2007-2008 Reg. Sess.) (Yee) Insurance—Insurer Reserves: excludes workers compensation insurance from the reserve requirement in Insurance Code section 11558 and mandates a study of workers compensation insolvencies within the past 10 years.

Life Insurance

Assembly Bill No. 720 (2007-2008 Reg. Sess.) (De Leon) Insurance—Life-Only License: establishes two new limited insurance agent licenses: a life-only agent license and an accident and health agent license. These would be in addition to the current full life agent license that allows transaction both life and disability/health insurance.

Senate Bill No. 357 (2007-2008 Reg. Sess.) (Cox) Life Insurance—Group Policies: decreases the number of employees needed to qualify for a group life insurance from 10 to two. Allows the premium for group life insurance to be paid entirely by employees and eliminates the requirement that 75% of employees choose to be covered by group life insurance. The bill also increases the allowable amount of life insurance coverage for dependents and increases the age for eligible dependents from 22 to 24 years for purposes of group life insurance. The bill decreases the number of employees needed to qualify for group disability insurance from three to two.

Health Insurance

Assembly Bill No. 12 (2007-2008 Reg. Sess.) (Beall) Adult Health Coverage Program—Santa Clara County: creates the Adult Health Coverage Expansion Program as a pilot program in Santa Clara County. The program would provide health care coverage to eligible employees of participating small businesses (50 or fewer employees).

Assembly Bill No. 554 (2007-2008 Reg. Sess.) (Hernandez) Public Employees—Health Benefits: expands the group of employers eligible to participate in the California Employers' Retirement Benefit Trust Fund administered by CalPERS to include all California public employers. Allows agencies that contract with CalPERS for employee health benefits to prefund the future cost of their retiree health insurance benefits and other post-employment benefits.

Assembly Bill No. 1302 (2007-2008 Reg. Sess.) (Horton) Health Insurance Portability and Accountability: extends the sunset on the Health Insurance Portability and Accountability (HIPAA) Implementation Act of 2001 and the California Office of HIPAA Implementation from January 1, 2008 to July 1, 2010.

Assembly Bill No. 1324 (2007-2008 Reg. Sess.) (De La Torre) Health Care Coverage—Treatment Authorization: Existing law provides that a health care service plan or a health insurer that authorizes a specific type of treatment by a health care provider shall not rescind or modify the authorization after the provider renders the service in good faith and pursuant to the authorization. Assembly Bill No. 1324 expands that criteria by additionally specifying that a health care service plan or a health insurer is precluded from rescinding or modifying its authorization for <u>any reason,</u> including its subsequent rescission, cancellation, or modification of the contract or its subsequent determination that it did not make an accurate eligibility determination. The statute also states that it is not the intent of the Legislature to instruct a court as to whether these provisions make a change to existing law.

Assembly Bill No. 1750 (2007-2008 Reg. Sess.) (Health Committee) "Specialized" Health Insurance (Urgency Statute, Effective October 13, 2007, except as noted): This bill, sponsored by the California Health and Human Services Agency, contains provisions intended to bring California into compliance with the federal Deficit Reduction Act of 2005 and recent revisions to federal Medicaid regulations, as well as to clarify state law regarding the County Medical Services Program. Other provisions, effective January 1, 2008, create a definition of "specialized health insurance policy" consistent with the term "specialized health care service plan" in the Knox-Keene Act.

Assembly Bill No. 14 (2007-2008 Reg. Sess.) (Laird) Discrimination—Civil Rights Act of 2007: cross-references protected classes in many anti-discrimination provisions located in 12 state codes to the Unruh Civil Rights Act (Civil Code 51) or to Government Code section 11135, whichever is appropriate, harmonizing these anti-discrimination statutes. In doing so, the bill would expand the protected classes in some statutes to encompass those recently added to the Unruh Civil Rights Act or to Government Code 11135. This bill would not affect the Insurance Code.

3. CASE DECISIONS

CALIFORNIA SUPREME COURT

1.The California Supreme Court confirms the validity of the "genuine dispute" doctrine, including its application to factual disputes and the availability of summary judgment in proper cases. (*Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713.)

Wilson was injured in a car accident. After settling with the other driver's insurer, she sought the uninsured motorist policy limits from her own insurer. The insurer denied the claim based on information showing she was not seriously injured and had been adequately compensated by the other driver's carrier, plus reim-

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COMMENT: In this case, it was not absolutely clear from the verdict form whether the damages were awarded on the tort claims or the contract claims or both, nor was it clear whether the damages were duplicative or overlapping. In complex business tort cases, it is often the case that appellate courts have trouble interpreting verdict forms. Perhaps those forms are drafted in haste, toward the close of trial, at the same time that the parties and the trial court are wrestling with jury instructions. It may be a good idea to develop a tentative draft of a verdict form in advance, especially when a trial involves hybrid tort and contract claims.

The court mentioned that the "election" doctrine has fallen into disfavor in California. Unfortunately, there is no California case (as far as I know) that unequivocally repudiates it, and this court had no occasion to do so under the facts of the case. (Nor did it have the binding authority to do so, since it was a Federal court construing California law.) Thus, until the doctrine is really dead, it will serve as a trap for the unwary practitioner.

Insolvency Law Committee Legislative Activities

By Donna Parkinson

Over the past year, the Insolvency Law Committee has continued its active involvement in the submission and approval of legislation. The Committee's Affirmative Legislative Proposal ("ALP") to allow renewal of personal property judgment liens was approved by the State Bar Board of Governors. The Committee expects the ALP to be introduced into the State legislature as a bill for the 2008 legislative session. In the coming months, the Committee hopes to finalize and submit three other ALP's regarding: (1) the correction of erroneous references to bankruptcy and insolvency in various California statutes; (2) the revision of the Code of Civil Procedure to clarify how to perfect judgment liens against foreign corporations; and (3) the amendment of California's anti-deficiency laws to provide limited purchase money protection to homeowners who face deficiency judgments after a foreclosure. ■

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bursement of her medical costs. Wilson sued for bad faith, asserting unreasonable denial of policy benefits. The trial court granted summary judgment for the insurer on the ground that a reasonable dispute existed regarding the scope of Wilson's injuries. The Court of Appeal reversed, holding that the insurer could not assert the genuine dispute doctrine because its investigation of the insured's medical condition was inadequate at the time it denied coverage.

The Supreme Court granted review to address whether, as lower courts had held, an insurer does not act in bad faith when it disputes the existence or amount of coverage based on a genuine legal or factual disagreement with its insured. The Court confirmed that an insurer may properly obtain summary judgment based on the "genuine dispute" doctrine when, under all the circumstances, there is no triable issue as to the reasonableness of the insurer's conduct. (*Wilson, supra,* 42 Cal.4th at p. 724.)

The Supreme Court expressly disagreed with the Court of Appeal's assertion that an insurer adjusting a claim for bodily injuries must in all cases conduct an independent medical examination, or else consult the insured's treating physician, in order to avoid bad faith liability. The Supreme Court held that it is difficult to state "a general rule as to how much or what type of investigation is needed to meet the insurer's obligations under the implied covenant." (*Wilson, supra,* 42 Cal.4th at p. 723.) The Court explained that "[i]n some cases, review of the insured's submitted medical records might reveal an indisputably reasonable basis to deny the claim without further investigation." (*Ibid.*)

The Supreme Court nevertheless affirmed the Court of Appeal's decision to reverse the summary judgment for the insurer on the bad faith claim because a jury could find that it acted unreasonably in two ways: (1) by denying the insured's uninsured motorist claim based on reasons that were not supported by the available medical evidence; and (2) by failing to conduct further investigation—such as contacting the insured's treating physicians or conducting an independent medical exam—to verify the extent of her injury. (*Wilson, supra,* 42 Cal.4th at pp. 721-724.) Justices Chin and Baxter dissented, stating that the insurer acted reasonably as a matter of law under the circumstances presented here because the insured's own experts "had difficulty agreeing on the extent of her injury or the proper course of treatment." (*Id.* at pp. 726-729.)

2. Evidence of reinsurance agreements is not discoverable. *(Catholic Mut. Relief Soc. v. Super. Ct. (2007) 42 Cal.4th 358.)*

The plaintiffs sued the Roman Catholic Archdiocese of San Diego for alleged childhood abuse. They secured an order compel-

ling discovery of reinsurance agreements covering the potential liability of the Archdiocese's primary liability insurer, the Catholic Mutual Relief Society. The plaintiffs contended the discovery was authorized by Code of Civil Procedure section 2017.210 and was necessary to facilitate settlement of the underlying tort action. Section 2017.210 allows litigants to secure pre-trial discovery of "the existence and contents of any agreement under which any insurance carrier may be liable to satisfy in whole or in part a judgment that may be entered in the action or to indemnify or reimburse for payments made to satisfy the judgment."

The Court of Appeal granted the insurer's petition for writ of mandate, holding the statute did not provide for discovery of reinsurance agreements or information concerning the non-party insurer's financial condition.

In a 4-3 decision, the Supreme Court affirmed the judgment of the Court of Appeal. The Supreme Court held section 2017.210 does not apply to reinsurance agreements, which are ordinarily not discoverable in a tort action against an insured defendant. The majority held the statute was ambiguous, and the legislative history indicated that it authorized discovery only regarding the existence and terms of the primary liability policy potentially covering the defendant's tort liability and whether the primary carrier contested coverage. The majority also explained that Section 2017.210 does not authorize plaintiffs to discover "the assets of the insurance companies" providing primary liability insurance, including those companies' reinsurance and capital reserves. (*Catholic Mut. Relief Soc., supra,* 42 Cal.4th at p. 373.)

Three justices dissented on the ground that Section 2017.210 was not ambiguous and was worded broadly enough to authorize discovery of reinsurance policies. However, the dissenting justices agreed that "section 2017.210 does not 'authorize broad discovery of the financial health of the liability insurer or its ability to meet its contractual obligations under its policies.'" (*Catholic Mut. Relief Soc., supra,* 4242 Cal.4th at p. 377.)

COURTS OF APPEAL

1. *Belz v. Clarendon Am. Ins. Co.* (Dec. 28, 2007, B193314) __ Cal.App.4th __ 2007 WL 4555259 (Second Dist., Div. One). An insurance company is liable for default judgment entered against its insured unless it proves actual prejudice from lack of notice of the lawsuit, i.e., a substantial likelihood that it would have achieved a more favorable result if given an opportunity to defend its insured.

2. *Village Northridge Homeowners Assn. v. State Farm Fire & Cas. Co.* (Dec. 17, 2007, B188718) __ Cal.App.4th __ 2007 WL 4374571 (Second Dist., Div. Eight). An insured who settled its coverage claim and released its insurer from further liability may keep the settlement proceeds and sue the insurer for misrepresenting the policy limits in order to recoup the difference between the settlement amount and the amount the parties would have agreed upon to settle the claim had there been no misrepresentation.

3. *LA Sound USA, Inc. v. St. Paul Fire & Marine Ins. Co.* (2007) 156 Cal.App.4th 1259. An insurer that rescinds policy due to material misrepresentations on the application may recover costs incurred defending the insureds under a reservation of rights only to the extent it bears the burden of proving the allocation of defense costs to each insured.

4. *Zurich American Ins. v. Super. Ct.* (2007) 155 Cal. App.4th 1485. The attorney-client privilege is not limited solely to the client's communications with counsel because "confidential communications include information transmitted to persons 'to whom disclosure is reasonably necessary for the transmission of the information,' and those to whom disclosure is reasonably necessary for 'the accomplishment of the purpose for which the lawyer is consulted.'" Accordingly, if "legal advice is discussed or contained in the communication between [an insurer's] employees, then to that extent, it is presumptively privileged. A communication reflecting a discussion of litigation strategy which expresses that the strategy is in response to advice of counsel would come within the privilege."

5. *Archdale v. American Intern. Specialty Lines Ins. Co.* (2007) 154 Cal.App.4th. A cause of action for bad faith based on insurer's failure to accept a reasonable settlement offer within policy limits accrues on entry of judgment against insured exceeding policy limits, and limitations period is tolled pending appeal from that judgment; cause of action for bad faith based on insurer's failure to accept a reasonable settlement offer within policy limits sounds in contract or tort, and amount of excess judgment can be recovered as contract damages under Civil Code section 3300 because such damages are reasonably foreseeable at the time of contracting; where plaintiff seeks contract damages for breach of insurer's implied duty to accept reasonable settlement offer within policy limits, four-year statute of limitations applies, where plaintiff seeks tort damages for such breach, two-year statute of limitations applies; where insurer refuses settlement offer on the ground its policy affords no coverage and its coverage position is later vindicated, insurer will have no liability for damages flowing from such refusal.

6. *Lazy Acres Market, Inc. v. Tseng* (2007) 152 Cal.App.4th 1431. Insured could not state cause of action against insurer-

appointed defense counsel for malpractice or breach of fiduciary duty based on counsel's failure to disclose conflict of interest, where insurer settled action against insured without contribution from insured, and insured's complaint did not allege that a better result could have been obtained but for counsel's breach of duty; where insured's complaint alleged that insurer had duty to defend, fees and costs insured incurred to hire separate counsel on discovering appointed counsel's conflict were not recoverable from appointed counsel.

7. *Zenith Ins. Co. v. Cozen O'Connor* (2007) 148 Cal. App.4th 998. Counsel retained and paid by ceding insurer had no attorney-client relationship with reinsurer and thus owed no duty of care to it; reinsurer was not the intended beneficiary of contract between ceding insurer and counsel, and could not have been, in light of potential conflict of interests of ceding insurer and reinsurer; nor was an attorney-client relationship between counsel and reinsurer created by implication from reinsurer's communications with counsel, counsel's communications to reinsurer on matters of common interest to reinsurer and ceding insurer, or reinsurer's indirect payment of counsel's fees through reimbursements to ceding insurer.

8. *Rappaport-Scott v. Interinsurance Exchange of the Automobile Club* (2007) 146 Cal.App.4th 831. The rule that an insurer may be liable in tort for failing to accept a reasonable settlement offer within policy limits, which applies in third-party liability cases, does not apply in first-party underinsured motorist cases. The insurer's duty in first-party cases is "not to unreasonably withhold benefits due under the policy," and as a matter of law it is not unreasonable for an insurer to withhold policy benefits in a first-party case where there is "a genuine dispute between the insurer and the insured as to coverage or the amount of payment due." A genuine dispute is established where there is a vast difference between the benefits initially demanded by the insured and the amount ultimately awarded by the arbitrator.

9. *ACS Systems, Inc. v. St. Paul Fire and Marine Ins. Co.* (2007) 147 Cal.App.4th 137. The insurer owed no duty to defend its insured against a class action complaint alleging that the insured sent unsolicited faxes in violation of the federal and state law and seeking statutory penalties and damages for negligence and invasion of privacy because: (1) the policy's "advertising injury" coverage provision extended only to liability stemming from an invasion of the secrecy interest by the content of a communication concerning victim, not to liability stemming from an invasion of the victim's seclusion interest by the means, manner and/or method of the communication; and (2) assuming that the underlying complaint alleged "property damage" as defined in the policy, coverage was nevertheless foreclosed because an intended fax transmission cannot be an accident within the meaning of the property damage coverage provision, and because the policy's exclusion for "'property damage that's expected or intended by the protected person'" also barred coverage.

4. INSURANCE REGULATION

As the business of insurance is regulated by the states, the actions and initiatives of the California Insurance Commissioner and the Department of Insurance have a significant impact on the practice of California insurance law. Insurance Commissioner Steve Poizner was inaugurated January 8, 2007 after his election in November 2006 to succeed John Garamendi. Commissioner Poizner took action in a number of areas, including increasing resources for investigation and enforcement of insurance fraud and disciplinary actions; improving responses to natural disasters such as the January 2007 agricultural freeze and the October 2007 firestorms in Southern California; and expanding the state's Low Cost Automobile Insurance Program to all California counties in an effort to reduce the number of drivers without the required automobile liability insurance.

Below are a few additional regulatory actions and developments of interest in the past year:

Title Insurance Regulations: On November 23, 2007, after an extended regulatory process, a complex set of regulations governing title insurers and rates for title insurance took effect at Title 10, California Code of Regulations sections 2355.1 *et seq.* Among other things, the regulations require insurers to submit statistics regarding premium, losses, and expenses and establish a system for the regulation of title rates if specified conditions are present after data collection period. The Department of Insurance has also established a web-based application for the comparison of California title insurance rates by consumers.

Property and Casualty Rate Regulations: On April 4, 2007, substantial revisions to the regulations governing the prior approval of property and casualty insurance rates by the Commissioner became effective. (Cal. Code Regs., tit. 10, §§ 2642.5 *et seq.*) The regulations, among other things, set the standards under which the Department of Insurance calculates whether property and casualty insurance rates are "excessive" or "inadequate" under general rule of Insurance Code section 1861.05, subdivision (a). Among the significant changes to the regulations is the replacement of a system of "generic factors" set by the Commissioner as components of the ratemaking formula with industry standards

for those components based on available statistics. Interestingly, there has been an even more recent development regarding the regulations that will play out through 2008. The regulations allow for variances from the rate under specific circumstances. The Department of Insurance has indicated that it will conduct a regulatory workshop to solicit ideas to make the variances more workable in practice to increase the likelihood of rate filings and price competition in the insurance markets.

Automobile Insurance Rates. With respect to automobile rates in particular, the Department of Insurance has continued the implementation of 2006 revisions to the "Territorial" Rating Factor regulations. (Cal. Code Regs., tit. 10, § 2632.5.) This amendment reduced the weight that insurers may assign to the insured's geographical location in calculating rates for automobile insurance, thereby placing more emphasis on driving record, driving experience, and annual miles driven.

Broker and Agent Distinction. California law distinguishes between insurance brokers and agents in that an insurance agent transacts insurance on behalf of the insurer, whereas a broker transacts insurance with, but not on behalf of, the insurer. Generally, the consequence of the distinction is that brokers may charge the insured fees while the agent may not. In practice, the determination of whether an insurance producer is an agent or a broker is highly fact sensitive. While proposed regulations delineating the issue were dropped under the prior administration, Commissioner Poizner has appointed a Task Force made up of industry and Department representatives to consider the issue and propose a method to resolve the problem.

Public Participation. The Department of Insurance implemented new standards for public compensation in rate proceedings. (Cal. Code Regs., tit. 10, § 2661.1 *et seq.*) Under the new so-called "intervenor regulations," a public interest group may seek compensation from the Insurance Commissioner in instances where it has contested an insurer rate filing, but the insurer is not yet in an adversarial proceeding with the Department of Insurance. Under the new rules, the Commissioner can order compensation if the insurer withdraws its filing prior to commencement of a proceeding. Prior to the new regulations, a public interest group was only entitled to compensation after intervening in a formal rate proceeding and making a substantial contribution to the Insurance Commissioner's final decision. A coalition of insurance trade associations has filed suit challenging these regulations.

The Insurance Law Standing Subcommittee welcomes questions and comments regarding these and other insurance law topics. ■

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> The shares have been duly authorized and validly issued and are fully paid and non-assessable. 2007 Opinions Report, Part V, Section D.2 (page 66).

In describing this opinion the Corporations Committee states:

> The parts of this opinion are closely interrelated and are addressed in this and in the following two subsections. The 'duly authorized' part relates to creation of the shares under the articles and bylaws rather than their issuance. The steps required to approve a particular share issuance are covered by the 'validly issued' part of this opinion. 2007 Opinions Report page 66 (footnotes omitted).

Both the 2005 and 2007 versions of the Opinions Report provide that a "duly authorized" opinion should not be given for capital stock, the terms of which are prohibited by California's General Corporations Law:

> As the TriBar Report notes [TriBar Third Party 'Closings' Opinions Report (1998) § 6.2.1], the 'duly authorized' opinion also covers whether the applicable state corporation law permits shares having the characteristics of the shares of capital stock that are the subject of the opinion. Accordingly, the 'duly authorized' opinion should not be given as to capital stock if the terms of that stock are prohibited by the GCL. [California General Corporation Law]. 2007 Opinions Report, Part V, Section D.2 (page 67).

The Corporations Committee's position (that the "duly authorized" opinion addresses compliance with the GCL) has also generated debate. The Corporations Committee's 1989 opinions report is silent on whether the "duly authorized" opinion addresses whether any of the terms of capital stock are prohibited by the GCL. Some practitioners assume that the "duly authorized" opinion addresses only the process of approving the shares and the status of the shares under the Company's articles and bylaws, but it *does not* address whether any features of the shares are prohibited by the GCL. Particular concerns were raised by practitioners with respect to features of preferred stock. Separately, some expressed the view that whether the terms of stock violate applicable state corporation law is more properly the province of the "validly issued" part of this opinion rather than the "duly authorized" part of the opinion.