Court of Appeal, Third Appellate District
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IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT

(Sacramento)

ASSOCIATION OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANIES,

Plaintiff and Appellant,

v.

DEPARTMENT OF INSURANCE et al.,

Defendants and Appellants.

C073105

(Super. Ct. No. 34201180000998CUWMGDS)

Health insurers challenge temporary regulations (Guidance) issued by the Department of Insurance with express legislative authorization, to implement legislation (Stats. 2010, ch. 658, § 13, Assem. Bill No. 2470 (AB 2470)) concerning rescission, cancellation, and non-renewal of health benefit plans issued by disability insurers. (Ins. Code, §§ 10273.7, subd. (g), 106 [disability insurance includes insurance for injury, disablement or death resulting from accidents and disablements resulting from sickness, and health insurance means individual or group disability insurance policy that provides

coverage for hospital, medical, or surgical benefits]; unless otherwise set forth, statutory references that follow are to the Insurance Code.)

Association of California Life & Health Insurance Companies (ACLHIC) appeals from a trial court judgment insofar as it denied in part ACLHIC's petition for writ of mandamus and declaratory and injunctive relief. (Code Civ. Proc., §§ 1060, 1085; Gov. Code, § 11350.) The Department of Insurance and its Commissioner (collectively, the Department) cross-appeal from the judgment insofar as the trial court granted the writ petition in part, i.e., (1) the court ruled that Guidance 2274.50, which requires insurers to notify insureds of the right to administrative review of policy termination, is invalid to the extent it requires notice where the insurer's stated ground for termination does not afford administrative review; and (2) the court ruled that Guidance 2274.53, which addresses a grace period with continued coverage before nonrenewal for nonpayment, is partially invalid because it potentially compels insurers to provide a month of free coverage.

On appeal, the parties debate whether the challenged Guidance provisions exceed the Department's authority or are otherwise vague, overbroad, or arbitrary. We agree with the parties that most of the contentions are not rendered moot by the subsequent promulgation of almost-identical permanent regulations. We allowed filing of an amicus curiae brief by the California Medical Association in support of the Department.

We conclude the trial court erred in ruling Guidance 2274.50 and 2274.53 invalid. We reverse the judgment on those two points but otherwise affirm the judgment.

FACTS AND PROCEEDINGS

In 2010, the Legislature enacted AB 2470, adding and amending provisions of the Insurance Code governing disability insurers that provide health care insurance (§§ 10123.135, 10273.4, 10273.6, 10273.7, 10384.17, 10713), as well as provisions of the Health and Safety Code. The details of these statutes and Guidance/regulations

appear in our discussion, *post*. The main purpose of AB 2470, as reflected in the legislative history, was to "protect[] consumers from having their health insurance coverage canceled or rescinded when they need care[,] by maintaining their current coverage while allowing regulators to independently analyze and adjudicate on any rescission, cancellation, or limitation of a policy." (Assem. Health Com., Analysis of AB 2470 (2009-2010 Reg. Sess., Concurrence in Sen. Amendments, as amended Aug. 27, 2010, pp. 3-4.)

AB 2470 included a provision that "On or before July 1, 2011, the commissioner may 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 [APA] (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). 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." (§ 10273.7, subd. (g).)

The Department initially issued Guidance 2470:2 on July 1, 2011.

ACLHIC challenged the Guidance in a petition for peremptory writ of mandate (Code Civ. Proc., § 1085) and declaratory and injunctive relief (Gov. Code, § 11350; Code Civ. Proc., § 1060). After the Department amended the Guidance on November 21, 2011, responding to some of ACLHIC's concerns, ACLHIC filed an amended pleading, seeking to invalidate some provisions of the Guidance on the grounds they exceed the scope of the Department's authority, are vague or ambiguous, and/or conflict with existing law.

In December 2012, the trial court entered judgment rejecting ACLHIC's challenges to the Guidance with two exceptions. First, the court ruled Guidance 2274.50(a), which required an insurer to notify the insured of a right to review by the Department commissioner, was invalid, but only to the extent it required such notice in

situations where there was no statutory right to such review. Second, the trial court ruled Guidance 2274.53, which addressed a 30-day grace period to avoid nonrenewal of a policy for nonpayment, was invalid because it created a new substantive requirement not found in the statutes that insurers potentially must provide a period of free coverage to insureds who do not pay the overdue premium by the end of the grace period.

The Department later promulgated pursuant to the APA permanent regulations, filed with the Secretary of State on November 20, 2013, and operative January 1, 2014 (Register 2013, No. 47). (Cal. Code Regs., tit. 10, §§ 2274.50-2274.60.)

DISCUSSION

I

Mootness

As indicated, AB 2470 authorized the Department to issue the Guidance as temporary regulations not subject to the APA formalities until it adopted formal regulations under the APA. (§ 10273.7, subd. (g); see, Gov. Code, §§ 11340.5 [no agency shall issue regulation unless it has been adopted as a regulation and filed with the Secretary of State], 11342.600 [" 'Regulation' means every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure"].)

The Department promulgated formal regulations under the APA after the trial court entered judgment in this case.

The parties agree the permanent regulations do not render moot this appeal from the Guidance, because most of the permanent regulations are nearly identical to the Guidance. (*Montalvo v. Madera Unified Sch. Dist. Bd. of Education* (1971) 21 Cal.App.3d 323, 329 [expiration of regulation that is subject of an appeal does not render the appeal moot where a material portion of the regulation is reenacted]; accord,

Californians for Political Reform Found. v. Fair Political Practices Com. (1998) 61 Cal.App.4h 472, 480.) However, the Department argues two issues are moot. We discuss them, *post*.

II

Legal Principles and Standard of Review

As indicated, the Legislature expressly authorized the Department to issue the "Guidance" as temporary regulations not subject to the APA formalities and to promulgate permanent regulations under the APA. (§ 10273.7, subd. (g); Gov. Code, § 11340 et seq.) Such regulations must be consistent with and not in conflict with the statutes and reasonably necessary to effectuate the statutory purpose. (Gov. Code, § 11342.2.) The Guidance and subsequent formal regulations are quasi-legislative rules, as opposed to interpretive rules. (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 10.) "[T]here are two categories of administrative rules and . . . the distinction between them derives from their different sources and ultimately from the constitutional doctrine of the separation of powers. One kind--quasi-legislative rules--represents an authentic form of substantive lawmaking: Within its jurisdiction, the agency has been delegated the Legislature's lawmaking power. [Citations.] Because agencies granted such substantive rulemaking power are truly 'making law,' their quasi-legislative rules have the dignity of statutes. When a court assesses the validity of such rules, the scope of its review is narrow. If satisfied [1] that the rule in question lay within the lawmaking authority delegated by the Legislature, and [2] that it is reasonably necessary to implement the purpose of the statute, judicial review is at an end." (*Id*. at pp. 10-11.) These issues do not present a matter for independent judgment of an appellate court; rather, both issues come to this court " ' "freighted with [a] strong presumption of regularity . . . ." [Citation.] Our inquiry necessarily is confined to the

question whether the [rule] is "arbitrary, capricious or [without] reasonable or rational basis." [Citation.]' " (*Id*. at p. 11.)

Despite *Yamaha*'s statement that the court does not review de novo the question whether the rule is within the scope of the agency's authority, the Supreme Court dropped a footnote that "even quasi-legislative rules are reviewed independently for consistency with controlling law. A court does not, in other words, defer to an agency's view when deciding whether a regulation lies within the scope of the authority delegated by the Legislature. The court, not the agency, has 'final responsibility for the interpretation of the law' under which the regulation was issued. [Citations.]" (*Id*. at p. 11, fn. 4.) More recently, the Supreme Court stated, "When a regulation is challenged on the ground that it is not 'reasonably necessary to effectuate the purpose of the statute,' our inquiry is confined to whether the rule is arbitrary, capricious, or without rational basis [citation] and whether substantial evidence supports the agency's determination that the rule is reasonably necessary [under the APA] (Gov. Code, § 11350, subd. (b)(1)). [¶] At the same time, when an implementing regulation is challenged on the ground that it is 'in conflict with the statute' (Gov. Code, § 11342.2) or does not 'lay within the lawmaking authority delegated by the Legislature' [citation], the issue of statutory construction is a question of law on which a court exercises independent judgment. [Citation.] In determining whether an agency has incorrectly interpreted the statute it purports to implement, a court gives weight to the agency's construction," with greater weight allowed in situations where the agency has a comparative interpretive advantage over the courts. (*Western States Petroleum Assn. v. Board of Equalization* (2013) 57 Cal.4th 401, 415 (*Western States Petroleum*).) We review the trial court's judgment de novo. (*Burden v. Snowden* (1992) 2 Cal.4th 556, 562.)

In contrast to quasi-legislative rules, interpretive rules are an agency's legal opinions that do not implicate the exercise of a delegated lawmaking power. (*Yamaha, supra*, 19 Cal.4th at p. 11.) The agency's expertise warrants some deference, but a lesser

degree of judicial deference, since interpretation of statutes is within the courts' constitutional domain. (*Ibid*.)

Here, the Guidance is the substantive product of a delegated *legislative* power conferred on the Department and is therefore subject to the review standard for quasi-legislative rules.

III

ACLHIC's Appeal

A. GUIDANCE 2274.50

ACLHIC argues Guidance 2274.50, which requires notice to insureds before cancellation or nonrenewal of a policy, exceeds the Department's authority in various respects and is impermissibly vague.

1. Overbreadth

ACLHIC argues Guidance 2274.50 is invalid in its entirety because it is overbroad, in that it requires insurers to notify insureds of a right to administrative review whenever a policy is being cancelled or non-renewed, even though the statute (§ 10273.7) affords a right to review only in limited situations. ACLHIC believes the trial court properly ruled that Guidance 2274.50 is overbroad but, instead of invalidating Guidance 2274.50, the court improperly "re-wrote" Guidance 2274.50 to require notice of a right to review only if the policy is being dropped for a stated ground for which the Insurance Code affords review.

However, we agree with the Department's cross-appeal that the trial court erred in ruling the Guidance overbroad, because the right to administrative review depends on the insured's allegations, not the insurer's stated grounds for termination.

Section 10273.7, subdivision (a), provides: "A policyholder, certificate holder, or other insured who *alleges* [italics added] that a policy or coverage has been or will be

canceled, rescinded, or not renewed in violation of Section 10713, 10273.4, 10273.6, 10384.17, or 10384, or any regulations promulgated thereunder, may request a review by the commissioner." The specified statutes cover multiple matters. (§ 10713 [health benefit plans are renewable except for nonpayment of premiums, fraud or intentional misrepresentation, breach of contract, or withdrawal of the carrier from the market]; § 10273.4 [group plans are renewable with the same exceptions]; § 10273.6 [individual plans are renewable with the same exceptions]; § 10384.17 [insurer may rescind plan but only for fraud or intentional misrepresentation and only within two years of policy issuance]; § 10384 [prohibits postclaims underwriting (rescission due to insurer's failure to complete underwriting before issuing policy)].)

Guidance 2274.50(a) states, "Each insurer who cancels, rescinds or non-renews, or sends a notice of intent to cancel, rescind or non-renew, a policy of health insurance shall provide to the policyholders, certificate holders or other insureds a notice of the right to request a review by the commissioner. . . ." The form prescribed by 2274.50(b) includes language that "You may request a review by the California Insurance Commissioner if you believe your health insurance policy or coverage has been or will be wrongly cancelled, rescinded or not renewed. . . ." It does not require the policyholder to identify the statute allegedly violated. The permanent regulation contains the same language. (Cal. Code Regs., tit. 10, § 2274.50.)

Thus, the right to review depends on the insured's *allegations* (§ 10273.7, subd. (a)), not on the ground asserted by the insurer for rescission or termination. An insured may allege the stated ground is a pretext. An insurer will not necessarily know what the insured will allege until the insured requests review by the commissioner.

ACLHIC claims a cancellation due to lack of eligibility, for example, would not trigger the right to a review. However, an asserted ground of ineligibility may implicate issues of fraud or prohibited postclaims underwriting, for which there would be a right to administrative review under the statute.

Accordingly, Guidance 2274.50 properly requires notice of the right to request review any time the insurer wants to cancel, rescind, or nonrenew a policy, and the trial court erred in finding it overbroad.

2. Delivery by Mail

ACLHIC argues Guidance 2274.50 is invalid for mandating first-class mail as the method of delivery for notice of the insured's right to administrative review, exceeding the statutory authority of AB 2470 and conflicting with the federal Electronics Signatures in Global and National Commerce Act, 15 U.S.C. section 7001 et seq. (the "E-Signature Act"). ACLHIC does not contend the Guidance conflicts with California statutes regarding electronic transmissions (former § 38.5; Civ. Code, § 1633.1 et seq.) and we therefore need not consider them. We conclude ACLHIC's contentions lack merit.

Guidance 2275.50(a) states "The notice of the right to request a review by the commissioner shall be part of, accompany, or be sent simultaneously with any notice of intent to cancel, rescind or non-renew . . . [or] with any notice of cancellation, nonrenewal or rescission . . . . The insurer shall send the notice via first-class mail to the policyholder's, certificate holder's or other insured's most recent address known to the insurer." The permanent regulation contains the same substance in subdivision (b). (Cal. Code Regs., tit. 10, § 2274.50(b).)

That AB 2470 does not dictate the method of delivery does not mean the Guidance exceeds statutory authority; the agency is allowed to " ' " ' "fill up the details" ' " ' " of the statutory scheme. (*Association of California Ins. Cos. v. Poizner* (2009) 180 Cal.App.4th 1029, 1047-1048.) In the cited case, a statute enacted by voter initiative permitted compensation for consumer interest participation in the insurance ratesetting process. Insurers contended a regulation, which allowed for compensation when the matter was resolved by settlement rather than a formal rate hearing, exceeded the statutory authority. The appellate court held: "The absence of any specific provisions

regarding the proceedings in which compensation is authorized does not mean that regulations as to such issues exceed statutory authority, but only that the electorate did not itself choose to determine the issue and instead deferred to and relied upon the expertise of the Commissioner and the Department. [Citation.]" (*Id*. at p. 1048.)

ACLHIC claims delivery by first-class mail is not "necessary" and would not further AB 2470's purposes. However, ACLHIC fails to show it is arbitrary or capricious. A declaration of ACLHIC's vice president of government affairs opined that first-class mail imposes an unnecessary cost and burden on insurers, and electronic notice is "as a general matter" the preferred method of doing business in today's economy and has the added bonus of benefitting the environment. She offered no evidence about cost or burden. The trial court ruled ACLHIC had not demonstrated through any "convincing" evidence that the burden and expense was undue in relation to the objective. Moreover, first-class mail is considered a reasonably speedy and secure means of delivery for important business and personal documents, as noted by the trial court. (See e.g. Code Civ. Proc., §§ 116.130 [mail means first class mail]; 415.30 [service of summons by mail]; 684.120 [service of court papers by first class mail].) The commissioner could reasonably determine that first-class mail provides the best assurance that insureds will receive notice.

The E-Signature Act, regarding which the trial court allowed supplemental briefing, does not warrant a contrary conclusion. The federal law provides that an electronic record generally satisfies a requirement that a record be "in writing." (15 U.S.C. § 7001(a), (c), (i).) If a statute or regulation requires that information relating to a transaction in or affecting interstate commerce be provided to a consumer in writing, "the use of an electronic record to provide or make available . . . such information satisfies the requirement that such information be in writing," provided certain conditions are met including obtaining affirmative consent of the consumer to use electronic records in lieu

of a physical writing. (15 U.S.C. § 7001(c).) It is "the specific intent of the Congress that [the E-Signature Act] . . . apply to the business of insurance." (15 U.S.C. § 7001(i).)

However, the E-Signature Act expressly exempts from its reach any notice of "the cancellation or termination of health insurance or benefits or life insurance benefits (excluding annuities) . . . ." (15 U.S.C. § 7003(b)(2)(C).) That exception applies here, because the notice of right to review is tied to termination of health coverage. (Guidance 2274.50(a).) The notice of right to review "shall be part of, accompany or be sent simultaneously with" any notice of intent to terminate or, if not sent with a notice of intent to terminate, "shall be part of, accompany or be sent simultaneously with" notice of actual termination. (*Ibid*.)

ACLHIC argues the federal law (1) exempts only notice of cancellation or termination, not notice of right to a review, (2) exempts only cancellation or termination, not rescission, and (3) exempts only notice of cancellation or termination, not notice of *intent* to cancel or terminate. ACLHIC offers no authority supporting its stilted reading of the federal law and indeed cites no authority whatsoever discussing application of the federal law. Moreover, despite ACLHIC's point that rescission extinguishes a contract as if it never existed (Civ. Code, § 1688), rescission certainly results in a termination of benefits, and the federal law exempts any notice that terminates health benefits.

ACLHIC suggests notice by mail would be "potentially confusing," but offers no evidence or authority. In any event, nothing stops an insurer from also sending an electronic copy of the notice in addition to sending notice by first-class mail.

The requirement of first-class mail is proper.

3. Notice of Right to Review Simultaneous with Notice of Grace Period

ACLHIC argues Guidance 2274.50(a) is invalid for mandating that the notice of right to review accompany the grace period notice required by Guidance 2274.53(b) for nonrenewals due to nonpayment.

Guidance 2274.50(a) provides in part: "Each insurer who cancels, rescinds or non-renews, or sends a notice of intent to cancel, rescind or non-renew a policy of health insurance shall provide to the [insureds] a notice of the right to request a review by the commissioner. The notice of the right to request a review by the commissioner shall be part of, accompany, or be sent simultaneously with any *notice of intent to cancel, rescind, or non-renew* [italics added], including but not limited to the notice required by subdivision (b) of [Guidance] 2274.53 . . . ." In turn, Guidance 2274.53 is titled "Grace period" but addresses grace periods in the context of nonrenewals for nonpayment. It implements statutes requiring notice regarding renewal for nonpayment and a grace period. (§§ 10273.4, 10273.6, 10713.)

ACLHIC argues Guidance 2274.50 thus impermissibly requires the notice of grace period to accompany the notice of the insured's right to request review by the commissioner. ACLHIC argues the Department does not have the authority to require that the grace period notice and the right-to-review notice be mailed at the same time, and there is no need for them to be sent at the same time. ACLHIC argues, "[w]hile at first glance this may not seem significant, from an operational point of view, sending notices in this manner will create enormous undue expense and burden for insurers and, more importantly, will create confusion for California insurance consumers."

We agree the contention is insignificant. Additionally, ACLHIC fails to show how sending notice of the grace period would create confusion. ACLHIC merely cites its vice president's declaration asserting conclusions, unsupported by evidence, that this

"will create unnecessary confusion for California consumers and create additional undue expense and burden for the insurers."

4. Claimed Conflict with Insurance Code Section 510

ACLHIC contends Guidance 2274.50 -- by requiring insurers to give insureds pre-termination notice of the right to request administrative review and the need to do so by contacting the Department "as soon as possible" within 30 days (in order to maintain coverage pending review) -- conflicts with section 510, which provides generally that an insurance policy issued to a new insured must include "a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. . . ."

However, contrary to ACLHIC's position, the Guidance's form notice does *not* tell insureds to contact the commissioner "first." Nor does it tell insureds *not* to attempt resolution with the insurer/agent/broker. That the Guidance does not expressly require the notice to direct insureds to contact the insurer first does not render the Guidance in conflict with section 510, pursuant to which new insureds would have been advised upon issuance of the new policy to attempt resolution with the insurer first in the event of a dispute. Insureds can easily contact the insurer first and still timely contact the Department for a review within the 30 days. But even if insureds choose to contact the Department first, ACLHIC fails to show grounds to invalidate the Guidance. Guidance 2274.50 implements section 10273.7, which gives health insurance policyholders who are threatened with loss of insurance coverage an unconditional right to request review by the commissioner. To the extent of any conflict between sections 510 and 10273.7, the latter would control as the more specific statute. (*Lake v. Reed* (1997) 16 Cal.4th 448, 464 [a more specific statute governs over a more general one].)

We conclude Guidance 2274.50 is valid in its entirety, and the trial court erred in ruling it partially invalid.

B. GUIDANCE 2274.53 - GRACE PERIOD

This provision implements statutes governing *nonrenewal* of policies due to nonpayment and requires a 30-day grace period to run *after* the last premium payment is used up. ACLHIC says the trial court correctly ruled that Guidance 2274.53(a) is partially invalid because it potentially results in a month of free coverage for an insured who allows the policy to nonrenew. But ACLHIC argues the court did not go far enough and should have held the entire Guidance 2274.53 invalid as exceeding the Department's authority. We agree with the Department's cross-appeal that the trial court erred in ruling the Guidance partially invalid. We reject ACLHIC's other arguments.

1. The Statutory and Regulatory Language

Guidance 2274.53 expressly states it implements sections 10273.4 (renewal of group health benefit plans), 10273.6 (renewal of individual health benefit plans), and 10713 (renewal of health benefit plans).

Before AB 2470, each of those statutes stated that health benefit plans issued by disability insurers were renewable with specified exceptions, including "nonpayment of the required premiums. . . ." (Former § 10273.4, Stats. 1999, ch. 83, § 125; former § 10273.6, Stats. 1998, ch. 107, § 26; former § 10713, Stats. 1997, ch. 336, § 24.)

AB 2470 added language -- "[n]onpayment of the required premiums . . . if [the insured or employer] has been duly notified and billed for the premium [or charge] and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements [of federal statutes] and any subsequent rules or regulations has elapsed," and (a)(2) the insurer "shall continue to provide coverage as required by [the insured's] policy during the period described in paragraph (1)." (§§ 10273.4, subd. (a), 10273.6, subd. (a), 10713, subd. (a)(1); Stats.

2010, ch. 658; see also, § 10713, subd. (a)(2) [“An insurer shall continue to provide coverage as required by the policyholder’s, contractholder’s, or small employer’s policy during the period described in paragraph (1). Nothing in this section shall be construed to affect or impair the policyholder’s, contractholder’s, small employer’s, or insurer’s other rights and responsibilities pursuant to the subscriber contract”].)

Guidance 2274.53 provided in part:

“For purposes of Insurance Code sections 10273.4, 10273.6, and 10713:

“(a) The minimum 30-day grace period shall end no sooner than the thirtieth day following the last day of coverage for which the insurer has received payment.

“(b) In order for [an insured] to have been ‘duly notified,’ the insurer must have sent to the [insured] notice of nonrenewal due to nonpayment, separately from the initial premium billing statement, no later than the first day after the last day of coverage for which the insurer has received payment.

“(c) The notice of nonrenewal due to nonpayment required by subdivision (b) above must provide instructions for making the premium payment necessary in order to maintain coverage in force.

“(d) In the event the necessary premium payment is delivered to the insurer on or before the last day of the minimum 30-day grace period, the insurer shall continue coverage beyond the grace period without interruption pursuant to the terms of the policy or certificate. . . .”

The new permanent regulation is mostly the same as the Guidance, except in two respects. First, the permanent regulation requires the insurer to send notice of *intent* to nonrenew, rather than notice of nonrenewal. (Cal. Code Regs., tit. 10, § 2274.53(b).) Second, the new regulation no longer compels the insurer to send notice no later than the first day after paid coverage ends, but rather offers alternatives.

Thus, regulation 2274.53 provides:

“For purposes of Insurance Code sections 10273.4, 10273.6 and 10713:

“(a) The minimum 30-day grace period shall end no sooner than the thirtieth day following the last day of coverage for which the insurer has received payment.

“(b) In order for a policyholder, certificate holder or other insured to have been ‘duly notified,’ the insurer must have sent to the policyholder, certificate holder or other insured a notice of intent to nonrenew due to nonpayment:

“(1) After a sufficient interval of time has passed since the sending of the initial premium billing statement to make it possible, in the ordinary course, for:

“(A) The [insured] to receive the billing statement,

“(B) The [insured] to send the required premium payment to the insurer, and

“(C) The insurer to receive the premium payment; but

“(2) No later than the first day after the last day of coverage for which the insurer has received payment. However, an insurer may also satisfy the requirement stated in this Paragraph (b)(2) . . . by:

“(A) Sending the notice of intent to nonrenew due to nonpayment after the first day after the last day of coverage for which the insurer has received payment, and

“(B) Providing a grace period that:

“1. Begins on the first day after the last day of coverage for which the insurer has received payment and

“2. Extends through the last day of the 30-day period whose first day is the day the insurer sends the notice of intent to nonrenew due to nonpayment. . . .” (Cal. Code Regs., tit. 10, § 2274.53(b).)

Because the permanent regulation differs from the Guidance, we consider the parties’ arguments in light of the permanent regulation. ACLHIC argues the permanent regulation does not render the Guidance moot, because there may be insurers who were subjected to penalties under the Guidance while it was still in effect. However, this lawsuit presented only a facial challenge to the Guidance, not a challenge to any

provision as applied in a particular case. Moreover, ACLHIC failed to show that the Guidance or the permanent regulation compels free coverage.

2. Claim of Free Coverage

A "grace period" is "A period of extra time allowed for taking some required action (such as making payment) without incurring the usual penalty for being late. Insurance policies typically provide for a grace period of 30 days beyond the premium's due date, during which the premium may be paid without the policy's being canceled . . . ." (Black's Law Dictionary (10th ed. 2014) p. 813; see also, Merriam-Webster's Collegiate Dictionary (11th ed. 2006) p. 542 [grace period is "a period of time beyond a due date during which a financial obligation may be met without penalty or cancellation"].) In general, "a grace provision does not contemplate free insurance, but is merely an extension of an opportunity to pay, and ultimate payment for the period is expected. [Fn. omitted.] This premise is exemplified by a contractual provision stipulating that any premium in default should be deducted from the amount of insurance payable. [Fn. omitted.]" (5 Couch on Insurance, § 76:57.)

ACLHIC argues, and the trial court agreed, that the Guidance (by running the grace period from the last day of paid coverage) is invalid as creating a new substantive requirement not found in the statutes (which run the grace period from the date of notice), potentially requiring insurers to provide a month of free coverage to insureds who do not pay by the end of the grace period. The trial court said the Guidance conflicted with case law (*Mackey v. Bristol West Ins. Services of Cal., Inc*. (2003) 105 Cal.App.4th 1247, 1259-1260 (*Mackey*)) allowing insurers to adjust their billing practices by advancing premium due-dates so that the grace period will occur during time for which the insured has already paid. Having found the Guidance exceeded the scope of the statutes, the court said it was unnecessary to address ACLHIC's due process argument.

The trial court erred because ACLHIC has failed to show the Guidance/regulation imposed a duty to provide *free* coverage for the grace period, and *Mackey* is inapposite.

As a preliminary matter, we observe that ACLHIC assumes the statutory language "duly notified" and "date of notification" allow insurers to send notice of nonrenewal with the bill before its due date, i.e., before default. (§ 480 ["An insurer is entitled to payment of the premium as soon as the subject matter insured is exposed to the peril insured against"].) The Department disagrees, arguing that the statutes -- by saying insureds must be "duly notified *and* billed for the premium" (italics added) -- mean notice of nonrenewal and billing must be two different things. Also, if the words referred to the same thing, says the Department, the Legislature would have used the words "duly notified *of* and billed for the premium" (italics added).

We question ACLHIC's reliance on the general provision of section 480, because more specific statutes governing disability insurers allow a period of several days before premium payments are considered to be in default. Thus, section 10291.5, subdivision (b)(12), states the commissioner shall not approve any disability policy for insurance (except group disability insurance as stated in § 10270.95) "[i]f it does not contain provision for a grace period of at least the number of days specified below for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force provided, that the grace period to be included in the policy shall not be less than seven days for policies providing for weekly payment of premium, not less than 10 days for policies providing for monthly payment of premium and not less than 31 days for all other policies." (§ 10291.5, subd. (b)(12).) Section 10350.3 provides: "A disability policy shall contain a provision which shall be in one of the two forms set forth herein. Form A shall be used in a policy in which the insurer does not reserve the right to refuse any renewal. Form B shall be used in a policy in which an insurer reserves the right to refuse any renewal [not at issue in health benefit plans]. The clause in parentheses may only be added if the policy contains a cancellation provision.

In the blank in each such form shall be inserted a number; not less than '7' for weekly premium policies, '10' for monthly premium policies, and '31' for all other policies. [¶] Form A. [¶] Grace Period: A grace period of . . . days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof). . . ."

Thus, it was within the delegated lawmaking authority and was reasonable for the Insurance Commissioner to issue the regulation that the insured must already be in default of payment before the notice of nonrenewal for nonpayment is sent. ACLHIC fails to show that the regulation is arbitrary, capricious or without reasonable or rational basis. (*Western States Petroleum, supra*, 57 Cal.4th at p. 415.)

Moreover, even assuming for the sake of argument that the billing statement can serve as the statutory notice for nonrenewal under sections 10273.4, 10273.6, and 10713, that would not resolve ACLHIC's claim about free coverage. For example, consider a one-year policy that expires on May 31st, and the insurer has advanced due dates such that the monthly premium for May was due on April 15th and was paid. Thus, the last day of paid coverage is May 31st. Before May 15th, the insurer sends a bill for a new premium to renew the policy for another year beginning June 1st and notice of nonrenewal if the new premium is unpaid by June 15th. The May15th payment is to cover June -- the first month of the renewed policy. But the insured does not pay. Under the statutes as interpreted by ACLHIC, coverage ends on June 15th, but under the regulation coverage ends on June 30th. (Cal. Code Regs., tit. 10, § 2274.53.) However, even under ACLHIC's interpretation, there would still be potential "free" coverage from June 1st to June 15th.

In any event, ACLHIC fails to show any regulatory mandate for free coverage.

ACLHIC cites nothing prohibiting an insurer from contractually obligating payment of premiums during the nonrenewal grace period, and other statutes and

regulations (1) call for payment of premiums during a grace period by employers with group policies, and (2) with respect to individuals' policies, allow the insurer to deduct from any claims payments the amount due for unpaid premiums in individuals' policies.

Thus, section 10369.8 provides: "A disability policy may contain a provision in the form set forth herein. [¶] Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom." The regulations state this provision is inapplicable to group policies. (Cal. Code Regs., tit. 10, § 2232.37 ["An insurer shall not include in any group disability policy any provision for the deduction of any premium or any portion thereof from any claim upon its payment. (Ins. C. 10369.8.)"].) Instead, a regulation specific to group policies expressly make employers with group policies liable for payment of the premium during the grace period: "A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the employer shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force." (Cal. Code Regs., tit. 10, § 2232.19.) Administrative "Instructions" published with this regulation note a group policy is harder to replace than an individual policy and "it is inconsistent with the nature of group insurance to allow coverage during a grace period without requiring the payment of premiums accruing during such period." (Cal. Code Regs., tit. 10, § 2232.19.)

In response to the Department's reliance on the foregoing provisions, ACLHIC merely maintains those provisions have no bearing here because they do not discuss when a grace period must commence. However, the provisions show that the insurer loses nothing with employer-sponsored group plans or when a claim is made during the grace period.

That leaves only the situation of an individual insured who fails to pay the premium but makes no claim.

ACLHIC maintains that insurers lose even if the insured makes no claim, because the rate structure is based on projected premiums paid by insureds sufficient to cover anticipated claims plus expenses and profit for the insurer. Insurers must collect premiums from everyone in the risk pool in order to have sufficient funds to pay for insureds who do submit claims. ACLHIC also argues that, even if no claims are made, insurers still lose out if an insured simply decides to change insurers and not to pay for the last month of coverage during the initial policy term. However, ACLHIC cites nothing precluding a contractual obligation for the individual-insured to pay for coverage during the grace period. That an insurer may have trouble collecting from an insured in the event the insured goes elsewhere for insurance after nonrenewal and expiration of an unpaid grace period does not mean the coverage is "free."

Mackey, supra, 105 Cal.App.4th at pages 1263-1264, does not help ACLHIC. *Mackey* dealt with cancellation (not nonrenewal) of automobile insurance under Insurance Code section 662, which requires at least 10 days' notice of cancellation for nonpayment. (*Id*. at pp. 1259, 1265.) There, the insurer sent notice of cancellation two months into the policy, 13 days before the premium was due, and purported to cancel the policy one day after the due date. (*Id*. at pp. 1261, 1265.) The question in *Mackey* was whether an insurer could fulfill the 10-day notice requirement by sending the cancellation notice *before* the date on which the premium was due. (*Ibid*.) The appellate court answered no. (*Id*. at p. 1262.) "It is apparent that the Legislature intended to provide policyholders with a 10-day period *after default* [orig. italics] before the insurer can effectively cancel the policy. This additional notice was intended to provide policyholders who default in payment of their premium an opportunity during the 10-day period to pay the past due premium and keep the policy in force or to secure other insurance. Accordingly, the notice of cancellation for 'nonpayment of premium' issued at a point in time when Mackey had not failed to discharge his premium payment obligation was invalid and unenforceable . . . ." (*Id*. at pp. 1265-1266.) A different

automobile insurance case held a pre-default notice of nonrenewal in the event of default of the new premium sufficed to end the policy at expiration of the initial term without payment having been made. (*Kates v. Workmen's Auto Ins. Co*. (1996) 45 Cal.App.4th 494.) There, however, the statutes expressly allowed expiration upon notice by the insurer of an offer to renew contingent upon payment of premium as stated in the offer. (*Id*. at p. 503.) The statutes at issue here contain no such provision.

ACLHIC points to *Mackey*'s rejection of the insurer's argument that it would be financially unfair to require notice of cancellation to postdate payment defaults, because it would give a period of free insurance to people who do not pay. (*Mackey, supra*, 105 Cal.App.4th at p. 1263.) Citing a New Jersey case construing a New Jersey statute, *Mackey* said, " 'the problem of free insurance where a notice post-dates default can be minimized by proper scheduling on the part of insurance companies.' [Citation.] . . . 'If a policyholder's initial premium payment, pro rated on a per diem basis, provides coverage through May 30, for instance, an insurer can choose to set the second premium due date at May 15. In such a situation, the policyholder has already paid for the fifteen days that comprise the [New Jersey] statutory notice period in the event that he or she defaults. If during the course of the policy the insured's carry date moves forward to May 15 due to a change in coverage, we see no reason why the insurer cannot at that point adjust the premium due date to May 1 or require an additional premium payment at the time of the change in coverage that will carry the policyholder to the same date as under the previous policy. The proposed solution remedies the free insurance problem.' [Citation.]" (*Id*. at pp. 1263-1264.)

However, as we have seen, advance due-dates would merely minimize, not solve, the problem of which ACLHIC complains (potential free coverage) unless the insurer advanced the due date more than 30 days -- a problematic proposition for marketability.

We also agree with amicus curiae that, although insurers may in some cases have difficulty recouping payment for the grace period, the grace period for health benefit plans is vital in protecting safe continuity of medical care.

Our conclusion that ACLHIC has failed to show that the Guidance/regulation improperly mandates free coverage beyond statutory authority also disposes of ACLHIC's argument that the Guidance/regulation violates substantive due process (U.S. Const., 14th Amend., § 1; Cal Const., art. I, §§ 7, 15).

We conclude the trial court erred in "striking" subdivision (a) of Guidance 2274.53.

3. Remainder of 2274.53 Not An Excess of Authority

ACLHIC argues Guidance/regulation 2274.53(b) is invalid because it exceeds the Department's authority by running the 30-day grace period from the last day of paid coverage rather than the date of notice of nonrenewal. ACLHIC's entire argument on this point is: "Sub[division] (a) [grace period shall end no sooner than the 30th day following the last day of coverage for which the insurer has received payment] is intertwined with the entirety of this Section 2274.53. For example, subsection (d) [coverage will continue if insurer receives payment by the last day of the grace period] refers back to the last day of . . . 'the minimum 30-day grace period' that has been stricken. As explained above, 'courts cannot rewrite the regulations.' [Citation.] As a result, the entire section is invalid."

However, we have explained the trial court erred in striking the Guidance's 30-day grace period, thus defeating the basis for ACLHIC's argument.

4. Vagueness

ACLHIC argues Guidance/regulation 2274.53(b) is vague and incomprehensible for several reasons. ACLHIC points to the statutory mandate that the Office of Administrative Law review APA regulations for clarity (Gov. Code, § 11349.1, subd.

(a)(3)) and argues the trial court erred in concluding clarity was a matter for determination by the Office of Administrative Law, not the courts. Even assuming clarity is subject to judicial review, ACLHIC's arguments fail.

First, ACLHIC claims it is impossible to determine what it governs because the title is "Grace period," while the text refers to "notice of nonrenewal." We need not address this throwaway point made without analysis or supporting authority.

Second, they claim the Guidance requirement that the notice of nonrenewal be sent separately from the initial billing statement is unclear as to whether it must be sent at a different time or the same time on a separate piece of paper or in a separate envelope. This argument is frivolous on its face and in any event is moot now that the permanent regulation states the notice of nonrenewal must be sent long enough after the billing statement for the insured to have sent and the insurer to have received payment. (Cal. Code Regs., tit. 10, § 2274.53(b).)

The third claim is that it is impossible for an insurer to comply with the timing requirement because the Guidance says notice of nonrenewal for nonpayment must be sent by the first day after the last day of paid coverage, which means notice of nonrenewal must be sent on the due date for the premium, which is the first day of the 30-day grace period. This conflicts with ACLHIC's position that insurers can advance the due date to be due before the actual period of coverage. Moreover, the permanent regulation changed it from notice of nonrenewal to notice of *intent* to nonrenew, specified notice must await an interval of time to allow payment, and notice need not be sent by the first day after the last day of paid coverage. (Cal. Code Regs., tit. 10, § 2274.53(b)(2).)

The fourth contention argues insurers would need to send notice of intent to cancel and a grace period at the beginning of each month to all insureds, regardless whether they will pay late. ACLHIC's vice president submitted a declaration attesting that Guidance 2274.53, by stating notice of nonrenewal must be sent no later than the first day after the last day of paid coverage, required insurers to send out notice of intent to cancel with

every billing statement, and that in her experience many insureds pay at the end of their last payment's coverage, leading to an absurd result that insureds will get a notice of cancellation before the end of the payment-due period. Based on her knowledge of insurers' billing practices, her analysis of the Guidance "and common sense," she predicted thousands of unnecessary notices, unsettling to insureds who will think they are being cancelled when they have every intention of paying before the end of the payment due date. However, Guidance 2274.53 applies to nonrenewals, and the new permanent regulation no longer requires notice no later than the first day after the last day of paid coverage and further makes clear that notice of nonrenewal cannot be sent with the initial billing statement but must await an interval of time sufficient for the insured to send and the insurer to receive payment.

The fifth contention is that the insurer is unfairly obligated to provide coverage for an unlimited period of time if the insurer does not send the notice of nonrenewal by the first day after the last day of paid coverage. Any such problem was fixed by the permanent regulation.

Finally, ACLHIC repeats its complaint, which we have already rejected, that there is no justification for having to send notice of right to review (2274.50(a)) with notice of grace period (2274.53(b)).

We conclude Guidance/regulation 2274.53 is valid in its entirety.

C. GUIDANCE 2274.56

ACLHIC argues Guidance 2274.56 improperly conditions an insurer's right to rescind a policy for an insured's willful misrepresentation on the insurer's having completed an adequate medical underwriting before issuing the policy.
" 'Underwriting' " is " 'the process, fundamental to the concept of insurance, of deciding which risks to insure and which to reject in order to spread losses over risks in an

economically feasible way.' " (*Hailey v. California Physicians' Service* (2007) 158 Cal.App.4th 452, 465 (*Hailey*).)

ACLHIC argues Guidance 2274.56 conflicts with existing law allowing rescission when insurers later discover insureds' misrepresentations. The contention lacks merit because the Guidance/regulation simply implements the statutory duty imposed on insurers to use due diligence to resolve questions before issuing the policy (§ 10384 [prohibits "postclaims underwriting"]) and expressly states the issue for administrative decision is whether the evidence establishes that the insurer has satisfied section 10384. To the extent ACLHIC fears administrative decisionmakers may apply an inappropriate evidentiary standard and undo a rescission for an insurer's minor lapse during initial underwriting, that presents an "as applied" challenge which is beyond the scope of this lawsuit's facial challenge to the Guidance/regulation.

1. The Statutes and Guidance/Regulation

Postclaims underwriting is defined in and banned by section 10384, which predates AB 2470, and 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." (§ 10384; Stats. 1993, ch. 1210, § 8 [Assem. Bill No. 1100].) As indicated, "Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulted to the insured from sickness," and health insurance means "an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits." (§ 106.)

Guidance 2274.56 provides:

"(a) An insurer must demonstrate [changed to 'submit evidence' in the permanent regulation] that a rescission or, if based on information submitted on or with the application, a cancellation was not or is not due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application before issuing the policy or certificate. In addition to providing information about the insurer's underwriting of the coverage proposed to be rescinded, an insurer may submit information pertaining to any internal or external review conducted prior to or after the rescission. To establish that it completed medical underwriting, and that it resolved all reasonable questions arising from written information submitted on or with the application, before issuing the policy or certificate, the insurer shall submit evidence of the following to the extent, *if any* [italics added], that the insurer undertook to perform the indicated activity: [¶] (1) That the insurer followed its medical underwriting guidelines prior to issuance of the policy proposed to be rescinded; [¶] (2) That the insurer sought to obtain the applicant's PHR (Personal Health Record), if available; [¶] (3) That the insurer sought health history information from external verifiable sources . . . ; [¶] (4) That the insurer obtained and evaluated commercially available medical underwriting information for the applicant [e.g., claims data from prior insurers]; [¶] (5) That the insurer checked the applicant's current or prior claims history with the insurer and its affiliates; . . . [¶] [(10)-(13) That the insurer followed up to resolve any inconsistency, ambiguity, or insufficiency.]

"(b) An insurer seeking to rescind, or to cancel on the basis of information submitted on or with the application . . . must submit [all available] evidence that the rescission or cancellation investigation preceding the rescission or cancellation complied with the requirements of [Guidance] 2274.78.

"(c) [Insurer shall submit evidence the insured engaged in fraud or intentional misrepresentation to induce issuance of coverage.]

"(d) To demonstrate an allegation of fraud, the insurer shall submit all available evidence [that the insured provided a false answer on the application or omitted an answer, knowing of its falsity or with reckless disregard for its truth or falsity, to induce coverage, and the insurer granted coverage in reliance on the false answer or omission and would not otherwise have granted coverage].

"(e) To demonstrate . . . intentional misrepresentation of material fact, the insurer shall submit all available evidence [¶] . . . [¶] [that] [t]he insured answered the question untruthfully or omitted the requested information deliberately, and not due to mistake, inadvertence, carelessness, negligence or other innocent reason . . . .

"(f) In cases involving cancellation on the basis of information submitted on or with the application and in cases involving rescission, Department staff shall, after reviewing the information received pursuant to [Guidance 2274.55(c)(1) [] and any information received pursuant to [Guidance] 2274.61(a)] *determine whether the evidence, considered as a whole, establishes that the insurer has satisfied the requirements of Insurance Code section 10384*.

"(g) In cases involving cancellation on the basis of information submitted on or with the application and in cases involving rescission, the assigned administrative law judge shall, after any hearing pursuant to [Guidance] 2274.58, *determine whether the evidence, considered as a whole, establishes that the insurer has satisfied the requirements of Insurance Code section 10384*. [Italics added.]

"(h) *Under no circumstances shall subdivision (a) of this* [*Guidance*] *2274.56 be construed to create a requirement that an insurer must engage in each of the activities enumerated in paragraphs (a)(1) through (a)(13) of this section in order to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application*." (Guidance 2274.56; italics added.)

We note that Guidance 2274.78 referred to in subparagraph (b), above, is not part of the record. Regulation 2274.78 sets time limits for an investigation and notice to the

insured in the event the insurer receives information after issuance of the policy, raising a question whether the insured misrepresented or omitted material information. (Cal. Code Regs., tit. 10, § 2274.78.)

The permanent regulation rearranged and renumbered some subdivisions (e.g., (g) redesignated as (f) and (h) redesignated as (b)) and changed "insurer must demonstrate" to "insurer must submit evidence" in subdivision (a), but is otherwise substantially the same.

2. Analysis

In essence, ACLHIC's position is that Guidance 2274.56(a), (f), and (g) conflict with existing law, which supposedly allows an insurer to rescind a policy for fraud by the insured *even if* the insurer discovers the fraud through the insurer's own unlawful postclaims underwriting. However, ACLHIC cites no authority supporting this proposition. Instead, ACLHIC cites authority, e.g., that both parties to an insurance contract have a duty to act in good faith, that insurers are entitled to rely on applicants' answers to questions, and that insurers can rescind a policy after issuance when it later learns the insured concealed or misrepresented facts relevant to the insurer's decision to issue coverage. (E.g., §§ 332, 10110.2; *Colony Ins. Co. v. Crusader Ins. Co*. (2010) 188 Cal.App.4th 743, 749-750; *Nieto v. Blue Shield of California Life & Health Ins. Co*. (2010) 181 Cal.App.4th 60, 75-76.)

Like the ban on postclaims underwriting (§ 10384), fraud is addressed under the Insurance Code article on interpretation of policies. (§ 10380 et seq., Ins. Code, Div. 2, Part 2, Ch. 4, Art. 6.) Section 10380 provides: "The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer." (§ 10380.)

Rescission for fraud is addressed in section 10384.17, which provides:

"(a) A health insurer shall not rescind a health insurance policy, or limit any provisions of a health insurance policy, once an insured is covered under the policy unless the insurer can demonstrate that the insured has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy.

"(b) [Insurer must give notice to insured.]

"(c) Notwithstanding subdivision (a) [*sic*: (b)] of Section 10273.4 [insurer may decline to renew if can demonstrate fraud or intentional misrepresentation of material fact by insured] or any other provision of law, after 24 months following the issuance of a health insurance policy, a health insurer shall not rescind the policy for any reason, and shall not cancel the policy, limit any of the provisions of the policy, or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. *Nothing in this subdivision shall be construed to alter existing law that otherwise applies to a health insurer within the first 24 months following the issuance of a health insurance policy*." (§ 10384.17; italics added.)

"Existing law" at the time section 10384.17 was enacted in 2009 (Stats. 2009, ch. 406, § 2 (Assem. Bill No. 108)) included section 10384 (Stats. 1993, ch. 1210, § 8 (Assem. Bill No. 1100)). Thus, the statutes contemplate that insurers may discover fraud after issuance of the policy but do not allow postclaims underwriting prohibited by section 10384. Since section 10384 explicitly makes postclaims underwriting unlawful, the practice is an unfair business practice. (*Ticconi v. Blue Shield of California Life & Health Ins. Co*. (2008) 160 Cal.App.4th 528, 542.) When an insurer seeks to rescind for fraud after issuance of the policy, it is appropriate for the Department to inquire whether the insurer has violated section 10384's ban on postclaims underwriting.

Section 10384's ban on postclaims underwriting addresses the problem of insurers waiting until a claim has been filed to obtain information and make underwriting

decisions that should have been made before the policy issued. (*Hailey, supra*, 158 Cal.App.4th at p. 465.) The insurer asks the applicant for some information before issuing the policy but does not follow up until after a claim arises, at which point the insurer tries to "dig up" a reason to avoid paying the claim. (*Ibid.*) The harm from postclaims underwriting is manifest, and its prohibition prevents the unexpected cancellation of health care coverage at the time coverage is most needed. (*Id.* at pp. 465, 467.)

ACLHIC suggests Guidance/regulation 2274.56 unfairly allows the Department to undo a rescission for some minor or immaterial lapse by the insurer during initial underwriting, thereby punishing the insurer's negligence rather than the insured's fraud. We disagree, because the Guidance/regulation expressly states in subdivisions (g) and (h) that the issue for administrative decision is whether the insurer has satisfied the requirements of section 10384 (banning unlawful postclaims underwriting). To the extent an administrative decisionmaker goes beyond that scope, that may present an as-applied challenge, which is beyond the scope of the facial-challenge lawsuit. (*Tobe v. City of Santa Ana* (1995) 9 Cal.4th 1069, 1084 [an as-applied challenge contemplates analysis of the facts of a particular case to determine the circumstances and consider whether application in those particular circumstances deprived the party of a protected right].) A party mounting a facial challenge must show that no set of circumstances exist under which the law would be valid, i.e., that the statute or regulation inevitably poses a present total and fatal conflict with applicable prohibitions. (*Association of California Ins. Cos. v. Poizner*, *supra*, 180 Cal.App.4th at p. 1054.)

ACLHIC argues in its reply brief that we must conclude an insurer can rescind for fraud by the insured even if the insurer did not complete medical underwriting, in order to harmonize section 10384 with provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Health and Saf. Code, § 1340 et seq.) governing managed health care service plans, which arrange for services for members through a contracted provider

network, under the jurisdiction of the Department of Managed Health Care rather than the Department of Insurance. (§ 740, subd. (g); Cal. Code Regs., tit. 10, § 1300.43 et seq.; *Williams v. California Physicians' Service* (1999) 72 Cal.App.4th 722, 729 (*Williams*).) The Knox-Keene Act's statutory prohibition on postclaims underwriting contains a qualifier that it "shall not limit a plan's remedies described in subdivision (a) of Section 1389.21." (Health and Saf. Code, § 1389.3.) In turn, Health and Safety Code section 1389.21 states a health care service plan shall not rescind a plan contract once an enrollee is covered "unless the plan can demonstrate [within 24 months] that the enrollee has performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the contract." (Health and Saf. Code, § 1389.21, subd. (a).)

However, we cannot "harmonize[]" the statutes as urged by ACLHIC because, despite similarities between the two (*Kavruck v. Blue Cross of California* (2003) 108 Cal.App.4th 773, 780, fn. 3), they are different (*Williams, supra*, 72 Cal.App.4th at pp. 728-732 [Insurance Code did not apply to Knox-Keene plans]; the pertinent statutory language differs; and rules of statutory construction as well as the legislative history of AB 2470 reveal the Legislature was aware of the difference.

Thus, the Knox-Keene Act's ban on postclaims underwriting is qualified by a right to rescind for fraud. In contrast, section 10384 does not contain a similar qualifier. We cannot read such a qualifier into section 10384's ban on postclaims underwriting, because rules of statutory construction prevent us from adding what was omitted, i.e., if a statute contains a certain provision on one subject and omits it in the same or another statute on related subject, the omission is evidence of a different legislative intent. (*Bruns v. E-Commerce Exchange, Inc*. (2011) 51 Cal.4th 717, 726-728.) Plus, the legislative history shows the Legislature knew it was omitting such qualifier from section 10384.

A bill analysis of AB 2470 shows: "Under Knox-Keene [Health & Safety Code, sections 1389.3, 1389.21], the statute provides that the prohibition against post-claims

[underwriting] does not restrict a plan's ability to rescind coverage in cases where the patient has engaged in willful misrepresentation. The section of law prohibiting post-claims underwriting in the Insurance Code [section 10384] does not include the same specific reference to rescissions based on willful misrepresentation." (Assem. Health Com., Analysis of AB 2470 (2009-2010 Reg. Sess., concurrence in Sen. Amendments, as amended Aug. 27, 2010, pp. 2-3.) Thus, the Legislature knew it was omitting from section 10384 what was expressly included in the Knox-Keene Act. We find unpersuasive the unsupported argument in ACLHIC's reply brief that the Legislature must have omitted the qualifier from section 10384 because other Insurance Code provisions allow insurers to rescind for fraud or intentional misrepresentation by the insured.

ACLHIC focuses on the dishonest applicant, ignoring the underhanded insurer. (See, Assem. Health Com., Analysis of AB 2470 (2009-2010 Reg. Sess., concurrence in Sen. Amendments, as amended Aug. 27, 2010, pp. 2-3 ["It is well publicized that health plans and insurers have paid large bonuses to their employees for rescission of policies, practiced illegal rescission, and put[] patients in harm's way by rescinding their health coverage when they need it most"].) The California Supreme Court touched on this matter in the course of holding that a statutory incontestability clause (prohibiting the insurer from contesting the policy after it has been in force for two years) barred the insurer from denying coverage after the policy had been in effect for two years, even if the sickness first manifested itself before the policy issued. (*Galanty v. Paul Revere Life Ins. Co*. (2000) 23 Cal.4th 368, 388.) The insurer did not seek to rescind for fraud, but *Galanty* found it "nevertheless appropriate . . . to address the argument that enforcing the statutory incontestability clause as written will reward dishonest applicants for disability insurance and place an undue burden on insurers to cover undisclosed risks. . . . An incontestability clause 'does not condone fraud but merely establishes a time limit within which it must be raised.' [Citation.] . . . Such clauses reflect the legislative policy

judgment that it is reasonable and proper to give the insured ' " ' "a guaranty against possible expensive litigation to defeat his claim after the lapse of many years" ' " ' while, at the same time, ' " ' "giv[ing] the company time and opportunity for investigation, to ascertain whether the contract should remain in force." ' " ' [Citation.]" (*Ibid.*)

The lesson for this case is that an applicant's dishonesty will not necessarily excuse an insurer's unlawful postclaims underwriting.

ACLHIC also argues the Department is judicially estopped from asserting that rescission may be forfeited by an insurer's failure to comply with the regulation addressing postclaims investigations, because in a prior lawsuit filed by ACLHIC the Department took a position in the trial court that a different regulation -- 2274.78 (imposing time limits and notice requirement for insurer investigation of new information after policy issuance) -- was for regulatory enforcement and violation did not preclude rescission. Judicial estoppel prevents a party from taking a position "totally inconsistent" with a position asserted with success in a prior proceeding. (*The Swahn Group, Inc. v. Segal* (2010) 183 Cal.App.4th 831, 841-842.) Judicial estoppel is an equitable remedy subject to the trial court's discretion. (*Ibid.*) ACLHIC fails to discuss the trial court's decision not to apply judicial estoppel (on the ground that this is a facial-challenge case and the Guidance does not on its face condition rescission on compliance with the postclaim investigation regulation) and fails to show any abuse of discretion in that decision. The appellate contention is accordingly forfeited. (*Keyes v. Bowen* (2010) 189 Cal.App.4th 647, 655-656 [trial court's judgment is presumed to be correct, and the appellant has the burden to prove otherwise].)

ACLHIC argues Guidance/regulation 2274.56(e) -- by calling on the insurer to submit evidence that the insured's untruthful answers were "deliberate[]" and "not due to mistake, careless[], negligence or other innocent reason" -- conflicts with existing law supposedly equating carelessness with intentional misrepresentations. However, the cited authority referred to statements made carelessly *and* recklessly (e.g., *Yellow Creek*

Logging Corp. v. Dare (1963) 216 Cal.App.2d 50, 57), whereas the Guidance/regulation refers to carelessness in the context of an innocent reason. Moreover, the Guidance/regulation merely tells the insurer to submit all available evidence of deliberate untruthfulness or omission. ACLHIC fails to meet its burden in this facial challenge to show that the regulation inevitably poses a present total and fatal conflict with applicable prohibitions. (*Association of California Ins. Cos. v. Poizner, supra*, 180 Cal.App.4th at p. 1054.)

We conclude Guidance/regulation 2274.56 is valid.

D. GUIDANCE 2274.57

ACLHIC argues this regulation exceeds the Department's authority because it creates new requirements (time limit and form of notice) for rescission not found in the statutes.

Guidance/regulation 2274.57 provides in part: "In addition to any other evidence required to be submitted pursuant to this article, the insurer shall submit: [¶] (a) Its evidence demonstrating that it has timely delivered to the policyholder, certificate holder or other insured any notice required under this article, Section 2274.78, or Insurance Code section 10273.4, 10273.6, 10273.7, 10384.17 or 10713, and that the form of any such notice complied with all applicable legal requirements . . . ." (Cal. Code Regs., tit. 10, § 2274.57.)

Insofar as the regulation merely calls for compliance with statutes, it obviously does not exceed statutory authority. Regulation 2274.78 gives the insurer 15 days to begin a post-issuance claims investigation and seven days to notify the insured of the investigation. The insurer shall complete the investigation within 90 days after notice unless the insurer can demonstrate good cause for delay and shall give notice of its findings to the insured within seven days. (Cal. Code Regs., tit. 10, § 2274.78.)

Nothing in the cited regulations state any consequence for failure to comply with the time limit or form of notice. Section 10400 authorizes the Insurance Commissioner to impose monetary penalties or suspend or revoke licenses for violation of the statutes or orders of the commissioner made in accordance therewith. It is within the regulatory agency's purview to establish these rules for administration of its regulatory oversight of these matters. (*Association of California Ins. Cos. v. Poizner*, *supra*, 180 Cal.App.4th at pp. 1047-1048.)

E. GUIDANCE 2274.58

ACLHIC argues Guidance 2274.58 (renumbered as permanent regulation 2274.59) exceeds the Department's authority and is overbroad, because it creates a new substantive requirement not found in the statutes, i.e., that the insurer submit its evidence to the Department within 15 days of requesting an administrative appeal.

The Guidance/regulation provides in part: "(a) Within 15 days after receipt of an order by the commissioner to reinstate [an insured], the insurer shall either reinstate [the insured] or request a hearing pursuant to subdivision (c) of Insurance Code section 10273.7. In order to request a hearing pursuant to [the statute], the insurer shall submit any and all of the evidence required to be submitted pursuant to Sections 2274.56, 2274.57 or 2274.60 that is applicable . . . to the commissioner . . . ." (Guidance 2274.58; Cal. Code Regs., tit. 10, § 2274.59.)

ACLHIC fails to show anything wrong in the 15-day regulation. That it does not appear in a statute does not make it wrong. The agency is allowed to fill in details not expressly appearing in a statute. (*Association of California Ins. Cos. v. Poizner, supra*, 180 Cal.App.4th at pp. 1047-1048.) ACLIC does not show the timeline is unreasonable or unnecessary. The insurer presumably could not have decided to rescind the policy without the necessary evidence and will have already compiled the evidence for the initial administrative review.

ACLHIC also argues Guidance 2274.58(g) (now regulation 2274.59(h)) is overbroad and exceeds the Department's authority by imposing on the insurer "the burden of proving, by a preponderance of the evidence, every fact necessary to establish that the insurer satisfied all legal requirements pertaining to the cancellation, rescission or nonrenewal." ACLHIC offers no supporting authority or persuasive analysis but merely complains this is an onerous burden on an insurer who may have merely violated a minor technical regulatory requirement and potentially provides a defense to a dishonest insured who engaged in fraud. The contention is not persuasive.

F. GUIDANCE 2274.60(b)

This provision addresses the role of Department staff in the initial review of an insurer's administrative appeal and provides: "Department staff evaluating the insurer's request for a hearing . . . shall in each case determine whether the evidence is or is not sufficient to establish that the insurer has satisfied all legal requirements pertaining to the cancellation, rescission or nonrenewal. In the event Department staff determines that the cancellation, rescission or nonrenewal is contrary to existing law, the order to reinstate the [insured] shall [identify what provisions of law were unsatisfied and cite the factual basis for each determination] . . . ." (Cal. Code Regs., tit. 10, § 2274.60.)

ACLHIC argues this provision exceeds the scope of the Department's authority and is overbroad, in that it could include the insurer's noncompliance with timing and notice requirements that do not fall within the Department's statutory authority to consider in determining whether a rescission or cancellation is lawful. ACLHIC merely refers back to its argument about Guidance 2274.58(g), which we have found lacking.

As to ACLHIC's appeal, we conclude ACLHIC fails to show any basis to reverse the trial court's judgment insofar as it denied ACLHIC's claims.

IV

The Department's Cross-Appeal

Having already discussed these matters, we repeat them here for clarity.

A. <u>NOTICE OF RIGHT TO REQUEST REVIEW</u>

The Department argues the trial court erred in concluding that Guidance 2274.50's requirement of notice of the insured's right to request review was overbroad. We agree, as we have already explained in our discussion of ACLHIC's appeal.

B. <u>GRACE PERIOD</u>

The Department argues the trial court erred by concluding that Guidance 2274.53's provision about the grace period improperly mandates a period of free coverage unauthorized by AB 2470. We agree with the Department, as we have already explained.

DISPOSITION

The judgment is reversed insofar as it invalidates Guidance 2274.50 and 2274.53. The judgment is otherwise affirmed. The Department shall recover its costs on appeal. (Cal. Rules of Court, rule 8.278(a).)

HULL, Acting P. J.

We concur:

BUTZ, J.

MURRAY, J.

IN THE

Court of Appeal of the State of California

IN AND FOR THE

THIRD APPELLATE DISTRICT

MAILING LIST

Re: Association of California Life & Health Insurance Companies v.
Department of Insurance et al.
C073105
Sacramento County
No. 34201180000998CUWMGDS

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