Insurance Law Committee Annual Report On Developments in California Insurance Law – 2009

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This article reviews significant developments in three areas of California insurance law: legislation, published case law, and new regulations promulgated by the California Department of Insurance (CDI) and the Department of Managed Heath Care, the regulator of HMOs in California (DMHC).

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I. Legislation

The following are a few of the more significant insurance related bills that were signed into law during 2009 and went into effect Jan. 1, 2010 (unless otherwise specified in the law or otherwise specified in this article).

A. Health

A.B. 23 Cal-COBRA--Premium Assistance

Chapter 3 (Jones)

Requires health plans and health insurers to provide notice of the availability of premium assistance under the federal American Recovery and Reinvestment Act of 2009 to qualified beneficiaries who may be eligible for that assistance. The bill also allows a qualified beneficiary eligible for the federal premium assistance to elect Cal COBRA coverage within sixty days and allows individuals enrolled in Cal COBRA coverage as of February 17, 2009 to request application of the federal premium assistance. The bill also authorizes the DMHC and the CDI to adopt emergency regulations in the event that any federal assistance is or becomes available to persons eligible for Cal COBRA. **Effective May 12, 2009**

A.B. 108 Twenty-Four Month Rescission Period

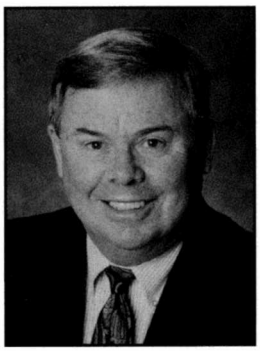
Chapter 406 (Hayashi)

Prohibits health insurers and health plans from rescinding coverage of an individual policy after twenty-four months for any reason, even if fraud could be proven. Applies to all health insurance as defined under section 106(b) of the Insurance Code, which includes specialized and indemnity supplemental health insurance products.

A.B. 119 Gender Rating Prohibition

Chapter 365 (Jones)

Prohibits the use of gender in determining health insurance premium rates. Applies to all health insurance as defined under section 106(b) of the Insurance Code, which includes specialized and indemnity supplemental health insurance products. The bill does not apply to other lines of business, such as life or other disability insurance. **Effective: January 1, 2011.**



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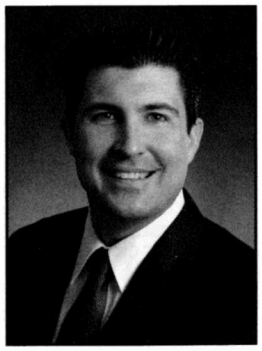

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A.B. 389 Long Term Care Insurance

Chapter 101 (Saldana)

For long term care policies that were sold prior to rate stabilization, the bill raises the lifetime expected loss ratio for that portion of the premium attributable to rate increases to at least 70% on or after January 1, 2010. The underlying policy would still be deemed reasonable in relation to the premium at a 60% expected lifetime loss ratio. Also allows the Insurance Commissioner to approve a rate increase at less than a 70% loss ratio if the insurer can demonstrate that the rates are necessary to protect the financial condition of the insurer, including further reductions in capital and surplus. The bill additionally allows the CDI more flexibility to review long term care actuarial filings.

A.B. 1541 HR 2 Conformity

Chapter 542 (Health Committee)

Extends from thirty days to sixty days the time period an individual or dependent, who has lost or will lose coverage under the Healthy Families Program, Access for Infants and Mothers (AIM), or Medi-Cal, has to request enrollment in group coverage without being considered a late enrollee. The bill conforms to HR 2 (the federal "Children's Health Insurance Program Reauthorization Act of 2009").

S.B. 630 Cleft Palate Reconstructive Surgery

Chapter 604 (Steinberg)

Under current law, health insurers and health plans are required to cover reconstructive surgery. This bill expands the definition of reconstructive surgery to include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. **Effective: July 1, 2010.**

B. Life Insurance

A.B. 76 Life and Annuity Consumer Protection Fund

Chapter 75 (Yamada)

Extends the operation of the Life and Annuity Consumer Protection Fund that requires the moneys deposited therein, from a fee levied against insurers based upon each individual life insurance and annuity product worth a specified amount or more issued to a resident of the State, to be dedicated to protecting consumers of certain insurance products. Requires the Insurance Commissioner to annually publish on its website a report detailing specified aspects of protections for consumers of insurance.

S.B. 98 Life Insurance: Contracts and Viatical Settlements

Chapter 343 (Calderon)

Provides that trusts and special purpose entities, where one or more beneficiaries do not have an insurable interest in the life of the insured, violate the insurable interest laws and the prohibition against wagering on life. Revises and recasts the law relating to viatical settlements to define those and other financial arrangements as life settlements. Prohibits a person from entering into, brokering, or soliciting life settlements without a license. Specifies licensure and regulatory requirements.

C. Other

A.B. 83 Torts: Personal Liability Immunity

Chapter 77 (Feuer)

Provides that medical, law enforcement, and emergency personnel who in good faith and at no cost render emergency medical or nonmedical care at the scene of an emergency shall not be liable for any civil damages resulting from any act or omission. Provides the same liability exemption for any other person who renders emergency medical or nonmedical care or assistance at no cost unless the act or omission is a result of gross negligence or willful misconduct. **Effective: August 6, 2009.**

A.B. 409 Insurance Guarantee Association

Chapter 105 (Garrick)

Amends existing law that requires the State Insurance Guarantee Association to collect premium payments from member insurers sufficient to cover the obligations of an insurer that has become insolvent. Provides that the initial premium charge shall be adjusted by applying the same rate of premium charge as initially used to each insurer's written premium as shown on the annual statement for the second year following the year on which the initial premium charge was based.

A.B. 866 Earthquake Authority

Chapter 480 (Niello)

Amends existing law that requires the Earthquake Authority to issue a basic residential earthquake insurance policy to any owner of a qualifying residential property and to report annually on the authority's conditions and affairs. Requires the Earthquake Authority to make the annual report by a specified date each year. Requires that the report be posted on the authority's website.

D. Privacy

A.B. 470 Insurance Information Confidential

Chapter 112 (Niello)

Amends existing law that prohibits insurance institutions, agents, or insurance-supported organization from disclosing personal or privileged information collected in connection with an insurance transaction unless a specified exception applies. Autho-

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rizes the disclosure of information from an accident report, supplemental report, or investigative report to an insured's lawyer if the insured is otherwise entitled to obtain the report.

S.B. 226 Identity Theft

Chapter 40 (Alquist)

Provides that when multiple identity theft offenses occur in multiple jurisdictions and all of the offenses involve the same defendant or defendants and either the same personal identifying information of one person or the same scheme or substantially similar activity, then jurisdiction for all offenses, including offenses connected together to an underlying identity theft offense, is proper in any one of the counties where the offenses occurred. Requires the consideration of similar aspects of the crimes.

E. Property & Casualty

A.B. 5 Civil Discovery: Electronic Discovery Act

Chapter 5 (Evans)

Establishes procedures for a person to obtain discovery of electronically stored information, documents and land, or other property in the possession of any other party to an action under the Civil Discovery Act by means of copying, testing, or sampling in addition to inspection. Relates to protective orders regarding copying, testing, or sampling. Provides the court shall not impose sanctions for electronically stored information lost as the result of the good faith operation of an information system. **Effective June 29, 2009.**

A.B. 91 Vehicles: DUI: Ignition Interlock Device

Chapter 217 (Feuer)

Requires ignition interlock device manufacturers to provide certain information to the Department of Motor Vehicles. Requires the DMV to establish a pilot program in specified counties that requires, as a condition of being issued a restricted driver's license, a driver's license, or having the privilege to operate a motor vehicle reinstated, a person to install an ignition interlock device on all vehicles they own or operate and to participate in an alcohol and drug assessment program and pay a fee.

A.B. 328 Electronic Transactions: Exceptions

Chapter 433 (Calderon C)

Removes insurance provisions from the exception to the authorization for certain electronic transactions. Provides that an automobile insurer may only deliver documents electronically when engaging in an electronic transaction. Authorizes required notice for certain types of insurance on risks or operations to be made electronically with the consent of the parties. Allows an insurer to pay covered claims by a transfer of electronic funds. Prohibits an insurer from requiring the insured to consent to electronic payment.

A.B. 601 Motor Vehicle Insurance

Chapter 247 (Garrick)

Extends the sunset on a $0.30 per vehicle insured in California from January 1, 2010 to January 1, 2015 to support a variety of consumer protection functions of the CDI and to support public outreach concerning California's low-cost automobile insurance program.

A.B. 1179 Motor Vehicle Insurance: Damage Assessments

Chapter 141 (Jones)

Amends existing law that regulates the conduct of motor vehicle insurers relative to insureds or claimants and provides insurers are required to provide each insured with an Auto Body Repair Consumer Bill of Rights. Requires the information regarding a consumer's right to seek and obtain an independent repair estimate directly from a registered auto body repair shop for repair of a damaged vehicle, even when pursuing an insurance claim for repair of that vehicle, be included in the bill of rights.

A.B. 1200 Motor Vehicle Insurance: Direct Repair Program

Chapter 387 (Hayashi)

Amends existing law prohibiting insurers from requiring that an automobile be repaired at a specified automotive repair dealer and providing that such insurer may suggest or recommend a specific repair dealer under specified circumstances. Authorizes an insurer to provide a claimant with specific truthful and nondeceptive information regarding the services and benefits available to the claimant during the claims process.

F. Workers' Compensation

A.B. 361 Workers' Compensation

Chapter 436 (Lowenthal)

Provides that, regardless of whether an employer has established a medical provider network or entered into a contract with a health care organization, an employer that authorizes medical treatment shall not rescind or modify that authorization after medical treatment has been provided for any reason. Provides these provisions shall not be construed to alter the benefits or terms and conditions of any contract.

A.B. 1093 Workers' Compensation

Chapter 272 (Yamada)

Provides that, for purposes of determining whether to grant or deny a workers' compensation claim, if an employee is

injured or killed by a third party in the course of the employee's employment, no personal relationship or connection shall be deemed to exist between the employee and the third party based only on a determination that the third party injured or killed the employee solely because of the third party's personal beliefs relating to his or her perception of the employee's personal characteristics.

S.B. 186 Workers' Comp Medical Treatment: Physicians
Chapter 565 (DeSaulnier)

Relates to existing law that requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of employment and provides the employee with the right to be treated by his or her personal physician from the date of the injury if specified requirements are met. Deletes the repeal date for these provisions pertaining to an employee's pre-designation of a personal physician.

S.B. 313 Workers' Compensation: Penalty Assessments
Chapter 640 (DeSaulnier)

Relates to workers' compensation employer penalty assessments. Increases that assessment to a specified amount per employee during the period the employer was uninsured. Provides various formulas for calculating the amount an employer would have paid in workers' compensation premiums in cases where an employer is uninsured, insured, or becomes insured during the period for which a penalty is being determined.

II. CASE REVIEW

A. California Supreme Court

In 2009, the California Supreme Court published opinions on insurance law in the following five cases:

1. *21st Century Insurance Co. v. Superior Court (Quintana),* 47 Cal. 4th 511 (2009).

When plaintiff Silvia Quintana was injured in an automobile accident, she received a $1,000 no-fault payment under her own auto insurance policy for her medical expenses (med-pay) and then sued the person who caused the accident. In her lawsuit, she recovered $6,000 from the wrongdoer, which compensated her for all her damages, including her medical expenses. From her recovery, Quintana paid about $2,100 in attorney's fees and litigation costs. Her insurer—21st Century Insurance Company—sought reimbursement for the med-pay benefit, but she and 21st Century disagreed whether reimbursement was required.

California cases have applied the equitable made-whole rule that guarantees an insured's full compensation before an insurer is reimbursed. 21ST Century accepted $600 in reimbursement, which represented the $1,000 med-pay payment less the attorney's fees Quintana incurred to recover that $1,000. Quintana sued 21st Century, however, contending she should not have had to reimburse 21ST Century at all. She claimed that, although for her $6,000 loss she had received a total of $7,000 ($6,000 from the wrongdoer and $1,000 from 21st Century), she had not been fully compensated under the made-whole rule because she had paid over $2,000 in attorney's fees and costs.

The Supreme Court unanimously agreed with 21st Century, concluding that

> although the made-whole rule applies in the med-pay insurance context, and the insured must be made whole as to all damages proximately caused by the injury, liability for attorney[s'] fees is not included under the made-whole rule. Those fees instead are subject to a separate equitable apportionment rule (or pro rata sharing) that is analogous to the common fund doctrine.

In so deciding, the court expressly disagreed with a federal district court opinion that had come to the opposite result—*Chong v. State Farm Mutual Automobile Insurance Co.*, 428 F. Supp. 2d 1136 (S.D. Cal. 2006).

In a concurring opinion, Justice Kennard summarized the error in Quintana's argument:

> The net effect of adopting plaintiff's proposed rule . . . would be to convert automobile insurance medical payment coverage into litigation expense coverage, thereby giving insureds a benefit for which they have not paid and forcing automobile insurers to bear a risk they did not contractually agree to assume.

2. *Delgado v. Interinsurance Exchange of the Automobile Club of Southern California*, 47 Cal. 4th 302 (2009).

The Interinsurance Exchange of the Automobile Club of Southern California (ACSC) insured Reid under a policy covering his liability for bodily injury caused by an "occurrence," defined as "'an accident . . . which, during the policy period, results in bodily injury . . .'" Delgado sued Reid, alleging that Reid assaulted and battered Delgado in the mistaken and unreasonable belief that such conduct was required for Reid's self-defense. ACSC declined to defend Reid, asserting that his assaultive conduct could not be considered an "accident" within the meaning of the policy's coverage clause.

In a unanimous opinion, the California Supreme Court agreed. The opinion clarified the law of "accident" in several respects. First, the court explained and distinguished prior opinions that had suggested an intentional act could be considered an "accident" if it was unexpected from the perspective of the injured party. The court explained that, in determining whether an "accident" occurred, the *courts must focus on the insured's conduct, not on the perspective of the injured party*.

The court also explained that *events preceding or precipitating the insured's conduct should not be considered* in evaluating whether the insured's conduct was an "accident." The courts should consider only the events that begin with the insured's conduct. Where no unexpected events follow the insured's conduct, but rather the conduct and its consequences occur as intended by the insured, there is no "accident."

Finally, the court explained that *an insured's subjective beliefs or motives cannot transform deliberate, assaultive conduct into an "accident."* Thus, it is irrelevant whether the insured believed, reasonably or unreasonably, that the conduct was necessary, justified or lawful, or that the injured party consented to the conduct.

3. *Sentry Select Insurance Co. v. Fidelity & Guaranty Insurance Co.*, 46 Cal. 4th 204 (2009).

In *Sentry Select Insurance Co. v. Fidelity & Guaranty Insurance Co.*, the California Supreme Court accepted the Ninth Circuit's certified question of law concerning the application of former Insurance Code section 11580.9(b). Under the former statute, if a leased commercial vehicle was involved in an accident with one or more other vehicles and its owner was "engaged in the business of renting or leasing motor vehicles without operators," then the owner's insurance policy was conclusively presumed to be excess to any other insurance covering the loss. Identifying a split of authority in the California Court of Appeal, the Ninth Circuit questioned whether it should look to the nature of the insured's *primary* business in determining whether it was "engaged in the business of renting or leasing motor vehicles without operators" within the meaning of former subdivision (b), or whether the focus should be on the factual circumstances surrounding the lease of the *particular* commercial vehicle involved in the accident when making that determination.

One month after the Ninth Circuit certified its question to the California Supreme Court, the California Legislature amended the statute, deleting the specific language in question and replacing it with the phrase "who in the course of his or her business rents or leases motor vehicles without operators." The Supreme Court noted that this amendment

> [E]liminates any ambiguity as to whether the leasing of commercial vehicles must be 'a regular part of the insured's business' [citation] in order for the conclusive presumption to apply under the amended language. Section 11580.9(b) now clearly provides that the renting or leasing of commercial vehicles without operators in the course of *any business* can qualify for the conclusive presumption that the insured's coverage is excess, where all the statutory requirements are otherwise met.

The Supreme Court then held that it need not resolve the apparent split of authority regarding when to apply the former statute because the conclusive presumption applied as a matter of law under either test where the owner of the leased commercial truck that was involved in the accident "routinely leased nearly three-quarters of its commercial fleet of trailers to independent truckers with whom it contracted for hauling jobs. . . . Such leasing activity cannot within reason be viewed as 'merely incidental' to [the owner's] hauling business."

4. *Fairbanks v. Superior Court (Farmers New World Life Insurance Co.)*, 46 Cal. 4th 56 (2009).

The plaintiffs in *Fairbanks v. Superior Court* sued Farmers New World Life Insurance claiming that it engaged in deceptive and unfair practices in the marketing and administration of life insurance policies. Plaintiffs alleged various causes of action, including one under the Consumers Legal Remedies Act. As to that cause of action, the trial court granted Farmers' motion for judgment on the pleadings. The issue wound its way up to the California Supreme Court.

In a unanimous opinion authored by Justice Kennard, the California Supreme Court held that life insurance is not subject to the Consumers Legal Remedies Act. That Act prohibits certain unfair or deceptive acts and practices in a "transaction intended to result or which results in the sale or lease of goods or services to any consumer." The Supreme Court held that life insurance is not a "good" or "service" and thus not subject to the Act's remedies.

The plaintiffs argued that the sale of life insurance is a service because an insurer may provide ancillary services in connection with that sale, such as advice to an insured regarding what policy to select. Employing logic that extends beyond the insurance context, the Supreme Court rejected that argument. It explained that

> Ancillary services are provided by the sellers of virtually all intangible goods – investment securities, bank deposit accounts and loans, and so forth. The sellers of virtually all these intangible items assist prospective

customers in selecting products that suit their needs, and they often provide additional customer services related to the maintenance, value, use, redemption, resale, or repayment of the intangible item. Using the existence of these ancillary services to bring intangible goods within the coverage of the Consumers Legal Remedies Act would defeat the apparent legislative intent in limiting the definition of 'goods' to include only 'tangible chattels.'

5. *State of California v. Allstate Insurance Co.,* 45 Cal. 4th 1008 (2009)

The State of California sued its insurers, seeking coverage after it was held liable for soil and groundwater contamination caused by the escape of pollutants which the State had discharged into containment ponds. The insurers claimed coverage was barred because (1) the policies contained pollution exclusions and the "sudden and accidental" exceptions to the exclusions were inapplicable because the discharges into the ponds were neither sudden nor accidental; (2) the State on one occasion intentionally discharged pollutants from the ponds; (3) the damages were expected because the State failed to take reasonable measures to prevent discharges from the ponds; and (4) even if some of the damages were covered because they were caused by discharges that were sudden and accidental, the State was required to prove how much of its liability was traceable to those discharges.

In an opinion filed March 9, 2009, the California Supreme Court reversed the trial court's summary judgment in favor of the insurer, holding:

a. In determining whether the sudden and accidental exceptions to the pollution exclusions applied, the focus must be on the discharges that gave rise to property damage. Here, the State was not held liable for discharging pollutants into the containment ponds, but for polluting the land and groundwater outside the ponds. Thus, the relevant discharges for application of the pollution exclusions are those in which, due to the State's negligence, pollutants were released from the ponds into the surrounding soil and groundwater.

b. Coverage for damage caused by the State's intentional discharge of pollutants from the ponds during a heavy rainstorm to prevent a larger, uncontrolled discharge of pollutants was not barred by the pollution exclusions. Liability policies cover damages resulting from acts undertaken to prevent a covered source of injury from occurring, even if the act would otherwise not be covered. Coverage in this situation encourages the taking of measures to mitigate or prevent damage.

c. The State's failure to take adequate measures to prevent future discharges in the event of heavy rainstorms, even if unreasonable, only demonstrated negligence, which was covered by the policies, and therefore did not establish that the future discharges were expected and non-accidental.

The State was not required to prove how much of its liability is traceable to sudden and accidental discharges, as opposed to gradual leakage from the ponds, to obtain coverage. Where an indivisible amount of property damages is caused by both covered and excluded risks, the insured's inability to allocate the damages by cause does not excuse an insurer from its duty to indemnify because the entirety of the damages are sums which the insured is obligated to pay for because of non-excluded property damage. The Supreme Court disapproved of *Golden Eagle Refinery Co. v. Associated International Insurance Co.*, 85 Cal. App. 4th 1300 (2001) and *Lockheed Martin Corporation v. Continental Insurance Co.*, 134 Cal. App. 4th 187 (2005) insofar as they hold that an insured must show not only a covered cause contributed substantially to the damages for which the insured was held liable, but must also show how much of an indivisible amount of damages resulted from covered causes.

B. California Court of Appeal

The California Court of Appeal published numerous opinions on insurance law in 2009. Among the most significant of these decisions are the following:

1. *Zhang v. Super. Ct. (California Capital Ins. Co.),* 178 Cal. App. 4th 1081 (2009) [Fourth Dist., Div. Two] [*Moradi-Shalal v. Fireman's Fund Ins. Companies,* 46 Cal. 3d 287, 304-305, (1988) does not bar UCL claim based on alleged fraudulent conduct that would violate Insurance Code section 790.03].

2. *Griffin Dewatering Corp. v. Northern Ins. Co. of New York,* 176 Cal. App. 4th 172 (2009) [Fourth Dist., Div. Three] [Insurer that denies a defense based on an incorrect policy interpretation is not liable for bad faith if the interpretation was objectively reasonable].

3. *Bosetti v. United States Life Ins. Co. in City of New York,* 175 Cal. App. 4th 1208 (2009) [Second Dist., Div. Three] [Cap on long-term disability coverage for "[t]otal [d]isability . . . due to a mental, nervous or emotional disorder" is an ambiguous term that must be read in favor of the insured so as to not exclude mental ailments arising from physical causes, or physical ailments arising from mental causes – i.e., it must be limited to disabilities caused and marked solely by mental causes and symptoms].

4. *Yeager v. Blue Cross of California,* 175 Cal. App. 4th 1098 (2009) [Second Dist., Div. Eight] [Health and Safety Code sec-

tion 1374.55 only requires a health plan to offer infertility treatment coverage; it does not mandate the amount or cost of the coverage].

5. *Maystruk v. Infinity Ins. Co.,* 175 Cal. App. 4th 881 (2009) [Second Dist., Div. Four] [INSURANCE CODE section 758.5, which prohibits insurers from limiting coverage of repairs at non-preferred auto repair shops based on charges that would have been incurred at preferred shops, does not apply to a two-tier coverage system (e.g., 100% of preferred costs; 80% of preferred costs) where the percentage for non-preferred costs is not tied to the amount that would have actually been charged at a preferred shop].

6. *State Farm General Ins. Co. v. Mintarsih,* 175 Cal. App. 4th 274 (2009) [Second Dist., Div. Three] [In the context of a duty to defend, an insurer is not obligated to pay the costs, including attorneys' fees, attributable to claims that were not potentially covered under the policy, nor must the insurer cover damages for willful acts or acts "intimately connected" thereto per INSURANCE CODE section 533].

7. *Estate of Prindle,* 173 Cal. App. 4th 119 (2009) [Third Dist.] [Absent proof of collusion, an insurer that declines to defend its deceased insured's personal representative in action seeking damages based on insured's negligence is liable for the ensuing $7 million judgment regardless of policy limits].

8. *Troyk v. Farmers Group, Inc.,* 171 Cal. App. 4th 1305 (2009) [Fourth Dist., Div. One] [Service charge assessed for the payment in full of the stated insurance premium is itself a premium that must be stated in the policy under INSURANCE CODE section 381].

9. *Safeco Ins. Co. of America v. Parks,* 170 Cal. App. 4th 992 (2009) [Second Dist., Div. Six] [Insurer may be liable for the bad faith refusal to defend even if another insurer defends the insured, provided the policy limits of the defending insurer are far below the amounted claimed and far below the policy limits of the insurer who declines the defense. Insurer must investigate whether it has issued any policies potentially covering claim against the insured, and he or she can be liable in bad faith if it declines to defend on the ground there was no potential coverage under the policy relied upon by the insured, where there was potential coverage under another policy].

III. INSURANCE REGULATIONS

The DMHC and CDI each promulgated regulations in 2009 affecting the business of insurance in California.

DMHC's "Timely Access to Non-Emergency Health Care Services " Regulation – These regulations were authorized under HEALTH & SAFETY CODE section 1367.03, added by A.B. 2179 (2001-2002 Reg. Sess.). The regulations establish standards and requirements to ensure that enrollees of health care service plans are given access to needed health care services in a timely manner. The Office of Administrative Law approved the regulations in late 2009, with a January 17, 2010 effective date.

CDI's "Pay As You Drive" Regulation (California Code of Regulations, Title 10, Chapter 5, Subchapter 4.7, section 2632.5) – Insurance Commissioner Poizner proposed Pay As You Drive (Usage Based Auto Insurance Premium) regulations as a means to encourage Californians to drive less, and to benefit drivers who do so. This regulation authorizes (but does not require) auto insurers to offer verified mileage rate programs, pursuant to which the consumer's auto insurance premiums are directly tied to the number of miles driven. By statute, (CAL. CODE INS. § 1861.02), the number of miles driven is the second mandatory rating factor for establishing auto insurance rates, but insurers generally base premiums solely on a customer's own estimation of miles driven. In addition to allowing insurers to peg rates to the *actual* mileage driven by an insured, the Insurance Commissioner also hopes that Pay As You Drive programs will produce environmental benefits by discouraging excessive driving. The new rules became effective in October 2009. ■