

Department of Insurance

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Insurance is the only interstate business wholly regulated by the several states rather than the federal government. In California, this responsibility rests with the Department of Insurance (DOI), organized in 1868 and headed by the Insurance Commissioner. Insurance Code sections 12919 through 12937 set forth the Commissioner's powers and duties. Authorization for DOI is found in section 12906 of the 800-page Insurance Code; the Department's regulations are codified in Chapter 5, Title 10 of the California Code of Regulations (CCR).

The Department's designated purpose is to regulate the insurance industry in order to protect policyholders. Such regulation includes the licensing of agents and brokers, and the admission of companies to sell insurance products in the state. In California, the Insurance Commissioner licenses approximately 1,500 insurance companies that carry premiums of approximately \$65 billion annually. Of these, 600 specialize in writing life and/or accident and health policies.

In addition to its licensing function, DOI is the principal agency involved in the collection of annual taxes paid by the insurance industry. The Department also collects more than 175 different fees levied against insurance producers and companies.

The Department also performs the following functions:

- (1) it regulates insurance companies for solvency by tri-annually auditing all domestic insurance companies and by selectively participating in the auditing of other companies licensed in California but organized in another state or foreign country;
- (2) it grants or denies security permits and other types of formal authorizations to applying insurance and title companies;
- (3) it reviews formally and approves or disapproves tens of thousands of insurance policies and related forms annually as required by statute, principally related to accident and health, workers' compensation, and group life insurance;
- (4) it establishes rates and rules for workers' compensation insurance;
- (5) it preapproves rates in certain lines of insurance under Proposition 103, and regulates compliance with the general rating law in others; and
- (6) it becomes the receiver of an insurance company in financial or other significant difficulties.

The Insurance Code empowers the Commissioner to hold hearings to determine whether brokers or carriers are complying with state law, and to order an insurer to stop doing business within the state. However, the Commissioner may not force an insurer to pay a claim; that power is reserved to the courts.

DOI has over 1,200 employees and is headquartered in San Francisco. Branch offices are located in Los Angeles, Sacramento, and San Diego. The Commissioner directs 21 functional divisions and bureaus, including the Consumer Services Division and the Fraud Division.

Heavily negotiated by representatives of the Davis administration, the trial lawyers' association, consumer groups, and the insurance industry, and subject to numerous limitations set forth in a "trailer bill," SB 1237 authorizes a consumer to sue another person's insurance company in tort for failure to adhere to Insurance Code section 790.03(h), which prohibits companies from engaging in unfair claims settlement practices.

DOI's Consumer Services Division operates the Department's toll-free complaint line. Through its bureaus, the Division responds to requests for general information; receives, investigates, and resolves individual consumer complaints against insurance companies, agents, and brokers that involve violations of statute, regulations, or contractual provisions; initiates legislative and regulatory reforms in areas impacting consumers; and tracks trends in code violations and cooperates with law enforcement to bring deterrent compliance actions. Cases which cannot be resolved by the Consumer Services Division are transferred to the Compliance Bureau within the Legal Division, which is authorized to file formal charges against a licensee and take disciplinary action as appropriate, including cease and desist orders, fines, and license revocation.

The Department's Fraud Division (originally the Bureau of Fraudulent Claims) was established in 1979 to protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud. The Fraud Division is currently composed of three separate fraud programs: automobile, workers' compensation, and special operations (which includes property, health, life, and disability insurance fraud).

MAJOR PROJECTS

Governor Signs Third Party Bad Faith Bill

On October 7, Governor Davis signed SB 1237 (Escutia), which enacts the "Fair Insurance Responsibility Act of 2000." Heavily negotiated by representatives of the Davis administration, the trial lawyers' association, consumer groups, and

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the insurance industry, and subject to numerous limitations set forth in a "trailer bill," SB 1237 authorizes a consumer to sue another person's insurance company in tort for failure to adhere to Insurance Code section 790.03(h), which prohibits companies from engaging in unfair claims settlement practices (see LEGISLATION). These so-called "third-party bad faith actions" against a company with which the plaintiff has no contractual relationship were permitted under *Royal Globe Insurance Co. v. Superior Court*, 23 Cal. 3d 880 (1979), a landmark decision of the California Supreme Court. Subsequently, the same court—but with a markedly different composition—reversed *Royal Globe* in *Moradi-Shalal v. Fireman's Fund Insurance Co.*, 46 Cal. 3d 287 (1988). [8:4 CRLR 87] In *Moradi-Shalal*, the court found that "neither section 790.03 nor section 790.09 was intended to create a private cause of action against an insurer that commits one of the various acts listed in section 790.03, subdivision (h)."

In essence, *Moradi-Shalal* stripped the courts of authority to enforce the provisions of the Insurance Code that ban bad faith claims settlement practices by insurance companies, and placed that responsibility squarely and solely on the shoulders of the Insurance Commissioner. Since the *Moradi-Shalal* decision, however, consumers and plaintiffs' attorneys have consistently complained about the Department's failure to aggressively police bad faith practices by insurance companies. [16:2 CRLR 131–32] In March 1997, the State Auditor issued *Department of Insurance: Management of its Financial Affairs and Programs Needs Improvement*, in which the Auditor expressed concerns about the Department's ability to handle consumer complaints about insurer practices: "Because the department exhibits...financial and manage-

ment shortcomings, we are concerned that the department has limited effectiveness in meeting the public's need for protection from unlawful or unfair practices by insurance companies." Consumer Attorneys of California (CAOC), sponsor of SB 1237, asserted that—in the aftermath of *Moradi-Shalal*—insurance companies have no incentive to settle claims in a fair, reasonable, and prompt manner, and argued that insurer profits have increased tenfold since *Moradi-Shalal* at the expense of injured claimants. Thus, the proponents of SB 1237 contended that DOI's poor enforcement record leaves consumers without an effective remedy and at the mercy of insurer bad faith claims settlement practices. During legislative debate, the Department attempted to justify its record, citing 43 actions against insurers which resulted in the assessment of \$3,138,895 in fines since 1995. However, very few cases yielded substantial fines, and insubstantial fines will not deter profit-producing misconduct.

The impact of SB 1237 was somewhat muted by amendments in AB 1309 (Scott) which were demanded by Governor Davis.

Within days of Governor Davis' approval of SB 1237 and AB 1309, a number of companies—including State Farm, Farmers, Allstate, USAA, and Fireman's Fund—announced their intent to collect 400,000 signatures to place a referendum measure repealing the new laws on the March 2000 ballot.

SB 1237 invalidates *Moradi-Shalal* and adds section 2871 to the Civil Code, which requires liability insurers to handle third-party insurance claims consistent with the fair claims handling practices specified in section 790.03(h), and allows a third-party consumer to sue an insurer—for damages sustained on or after January 1, 2000—for bad faith in the handling, processing, or settlement of a claim made by a party after obtaining a favorable court judgment or arbitration award. Where the amount in controversy is less than \$50,000 (or is within policy limits if the policy limits do not exceed \$50,000), a claim-

ant and the insurer may resolve the claim by arbitration pursuant to a written arbitration agreement. The bill also provides that if the parties agree to submit a claim to and participate in arbitration, the insurer is conclusively presumed to have complied with its duty to act in good faith toward and deal fairly with third-party claimants (and thus is shielded from a bad faith lawsuit).

The impact of SB 1237 was somewhat muted by amendments in AB 1309 (Scott) which were demanded by Governor Davis. AB 1309 amends Civil Code sections 2870 and 2871 (as added by SB 1237) in a number of ways, including the following: (1) rather than authorizing a third-party suit to remedy a violation of any one of the sixteen subsections of Insurance Code section 790.03(h), AB 1309 instead limits the third-party cause of action to violations of twelve specified subsections of section 790.03(h); (2) AB 1309 restricts the third-party cause of action to claims involving bodily injury, wrongful death, or property damage resulting from an incident involving a motor vehicle; and (3) new subsections of section 2871 state that an insurer "shall not be considered to have violated its obligation to act in good faith and

deal fairly with a third-party claimant because of the insurer's honest mistake in judgment in connection with the settlement of a claim," and "the fact that an insurer did not settle a claim is not necessarily proof of bad faith" (see LEGISLATION).

Although insurers were involved in the negotiations over these bills, many vehemently oppose any reinstatement whatsoever of the *Royal Globe* third-party bad faith cause of action. Within days of Governor Davis' approval of SB 1237 and AB 1309, a number of companies—including State Farm, Farmers, Allstate, USAA, and Fireman's Fund—announced their intent to collect 400,000 signatures to place a referendum measure repealing the new laws on the March 2000 ballot.

DOI Identifies Communities Underserved By the Insurance Industry in 1996 and 1997

On May 3 and August 9, Commissioner Quackenbush released two reports identifying communities that are

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underserved by insurance companies licensed to do business in California. The two reports, which identify communities underserved by the industry in 1996 and 1997, respectively, follow the Department's March 1999 release of its first report on underserved communities in 1995. These reports must be issued pursuant to section 2646.6, Title 10 of the CCR, which requires the Insurance Commissioner to collect various categories of data from insurance companies and publish an annual report identifying ZIP code areas considered to be underserved in a variety of lines of insurance (including automobile, homeowners, fire, and liability other than automobile). Section 2646.6 is intended to enable the Commissioner to detect the widespread insurance industry practice of "redlining"—the industry's refusal or failure to sell insurance in low-income and minority communities.

Under subsection 2646.6(c), a community is deemed "underserved" if any of three conditions are found: (1) the proportion of uninsured motorists is ten percentage points above the statewide average as reflected in the most recent DOI statistics, *and* the per capita income of the community (as measured in the most recent U.S. Census) is below the fiftieth percentile for California, *and* the community (as measured in the most recent U.S. Census) is "predominately minority" (any community that is two-thirds or more minority); (2) the proportion of uninsured businesses or residences is ten percentage points above the statewide and/or Standard Metropolitan Statistical Area average, as determined by the Commissioner following a public hearing convened for the purpose of determining the number of uninsured businesses or residences in California; or (3) members of the community have contacted three or more agents or companies directly and have been declined for insurance for which they were ready, willing, able, and qualified to purchase.

The Commissioner's new reports only identify underserved communities meeting the requirements of subsection 2646.6(c)(1); they do not address communities which might alternatively qualify as underserved under subsections 2646.6(c)(2) or 2646.6(c)(3). Thus, in order to qualify as "underserved" for purposes of the 1996 report, a ZIP code area must be two-thirds minority, with a 39% uninsured motorist rate and per capita income less than \$17,776. The 1996 report looks much like the 1995 report [16:2 CRLR 128-30], only worse. In 1995, 151 California ZIP codes were underserved; in 1996, 159 ZIP code areas were underserved. Eighty-five of them were in Los Angeles County, with an additional thirteen underserved areas in the neighboring counties of Orange, Riverside, and San Bernardino. The per capita income in all communities identified as underserved in 1996 was \$10,275. California's minority populations are concentrated in these underserved communities: While 47% of the state's population was minority in 1996,

85% of the population in underserved ZIP code areas was minority. Most companies located less than 5% of their offices and agents in communities identified as underserved, considerably lower than the percentage of the state's population that lives in underserved areas (approximately 16%). While the statewide uninsured motorist rate was 29%, the uninsured motorist rate in underserved communities was 64%. While 13.62% of automobiles were registered in underserved ZIP code areas, only 6.34% of private passenger auto insurance policies were sold in underserved communities in 1996.

The Commissioner's 1997 report, released on August 9, revealed some changes. The number of underserved communities dropped from 159 in 1996 to 138 in 1997—a 13% decrease. Significantly, the uninsured motorist rate decreased to 21% statewide and 51% in underserved communities, and was the reason for the removal of many 1996-listed ZIP code areas from the 1997 "underserved" list. Only three Los Angeles ZIP codes were removed from the list, leaving 82 Los Angeles communities underserved. Seventeen of the underserved areas are in the San Francisco Bay Area, including two new areas added in 1997. Statewide, underserved communities were composed 86% of minorities in 1997, and per capita income in these communities was \$10,145.

Despite the apparent drop in the uninsured motorist rate in 1997, it continues to hover around 22% today, and the Commissioner's reports provide support for the necessity of SB 171 (Escutia) and SB 527 (Speier), which establish four-year pilot projects in Los Angeles and San Francisco counties to test a new "low-cost/low-coverage" auto insurance policy

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for low-income motorists with good driving records (see LEGISLATION). The purpose of these pilot projects is to provide low-cost automobile liability insurance to good drivers who demonstrate financial need, without imposing a subsidy on others. The bills are based on an actuarial study commissioned by the Senate Rules

Committee and performed by Donald Bashline. Bashline's report analyzed multiple alternatives, calculated a flat rate for the low-cost policies that would not result in premium increases for other drivers, and estimated that the pilot projects will result in \$260 million in savings to insured drivers by lowering uninsured motorist premiums (see agency report on SENATE OFFICE OF RESEARCH for related discussion).

Quackenbush Establishes "Science and Education" Funds With Northridge Earthquake Settlements

On April 27, May 14, and August 5, Commissioner Quackenbush issued press releases announcing that he has reached settlements with several large insurers over their handling of approximately 3,000 claims resulting from the 1994 Northridge earthquake; the settlements are to be deposited

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into several new funds intended to educate Californians about earthquake safety and repair.

In the April 27 press release, Quackenbush announced that he had reached an agreement with Twentieth Century under which the company would reenter the California homeowners insurance market; like most other insurers, Twentieth Century withdrew from the homeowners market immediately after the 1994 quake because—at that time—companies offering homeowners insurance were required to offer standard earthquake insurance as well. [15:2&3 CRLR 186; 15:1 CRLR 112] In 1995, upon the suggestion of Commissioner Quackenbush, the legislature created the California Earthquake Authority (CEA), a publicly managed, privately funded entity, to provide “barebones” earthquake insurance to consumers and to entice insurance companies to reenter the homeowners market. [16:1 CRLR 150–151] According to Quackenbush’s press release, Twentieth Century is a “new entrant into the CEA to spark additional competition in the homeowners insurance market.” Further, according to the press release, the agreement calls for Twentieth Century to deposit \$6 million into a new “Northridge Earthquake Hardship/Humanitarian Fund to provide financial assistance to insured and uninsured homeowners and nonprofit entities that suffered damage in the Northridge earthquake which has not yet been repaired. The agreement stipulates that applicants may apply for contributions from the fund, which will be administered by a third-party administrator.”

The Commissioner’s May 14 announcement noted that, “as part of the insurance industry’s response to his concerns arising from the 1994 Northridge earthquake, Fireman’s Fund has agreed to contribute \$550,000 to fund efforts by the Commissioner to communicate with and educate consumers regarding, among other things, earthquake preparedness and earthquake insurance.” The Commissioner also noted that he and Fireman’s Fund “will continue to work together to ensure that all valid Northridge earthquake claims were properly handled.”

On August 5, Quackenbush noted that he had reached “final settlement” with several additional companies over their handling of Northridge claims, including Farmers, State Farm, and Allstate. According to the press release, “the actions required by insurance companies by Commissioner Quackenbush will result in more than \$5 million in funding for earthquake safety education in schools, community and personal earthquake preparedness, earthquake mitigation and repair, and seismic science study.” Specifically, State Farm and Allstate each contributed \$2 million to the fund, and Farmers paid another \$1 million.

Implementation of FAIR Plan Amendments

Established in 1968 in Insurance Code section 10090 *et seq.*, the California FAIR Plan is intended to assure stability in the California property insurance market and to provide basic property insurance to eligible property owners in high-risk areas who are unable to obtain it in the normal market.

FAIR is an association of all property insurers in the state of California. All insurers participate according to the amount of business they write in the state. However, Insurance Code section 10094.2 requires the FAIR Plan Association, pursuant to regulations adopted by the Commissioner, to provide for a method to proportionately relieve an insurer from participation in the FAIR Plan if the insurer voluntarily writes (a) basic property insurance on risks located in brush hazard areas, (b) basic property insurance in designated inner city areas, or (c) business owners package insurance on risks located in designated inner city areas. The Commissioner proposed regulations to implement this provision in 1998; however, those regulations were disapproved by the Office of Administrative Law (OAL).

On June 25, DOI again published notice of its intent to adopt sections 2590 and 2590.1, Title 10 of the CCR, to establish the method whereby insurers that voluntarily write these policies might be relieved of their obligation to participate in the FAIR Plan. Section 2590 would define several terms used in the statute and regulations; section 2590.1 would require the FAIR Plan Association to adopt a fair and reasonable method that allows insurers whole or partial relief from participation in the Association. Under the method, an insurer shall be eligible for relief in proportion to the insurer’s total premium writings in the three categories listed above. Insurers must apply for relief, and report their voluntary premium writings in each of the three categories in an annual report. Under the regulations, the Association must submit its approved relief method to the Commissioner within 90 days of the effective date of the regulations.

On September 2, the Department held a public hearing on these proposed regulations, after which the Commissioner adopted them. At this writing, the proposed rules are pending at OAL.

Also related to the FAIR Plan, the Commissioner has issued an executive order revising the eligible geographic areas in which homeowners and businesses qualify for FAIR Plan property insurance. FAIR Plan eligibility was significantly expanded immediately after the 1994 Northridge earthquake and the mass-scale withdrawal of most insurers from the homeowners market. [15:1 CRLR 112–13] Because many of those companies are slowly returning to the market (see above), some policyholders located in “at risk” areas no longer have difficulty securing insurance. Thus, the Commissioner revised the eligible areas for the FAIR Plan and notified insurers that FAIR would nonrenew all policies in newly-ineligible areas of the state effective December 1, 1999.

Revised CAARP Plan of Operations

In 1947 in Insurance Code section 11620 *et seq.*, the legislature created the California Automobile Assigned Risk Plan (CAARP) to provide auto insurance for motorists unable to obtain coverage in the private market due to their driving records or other extraordinary circumstances. CAARP assigns drivers to private insurers based upon the companies’ share

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of the auto insurance market; its rates are recommended by an Advisory Committee and approved by the Department. The Commissioner has approved CAARP's Plan of Operations, which is codified at section 2400 *et seq.*, Title 10 of the CCR, and which sets forth the overall administrative and operating procedures for CAARP. However, the Department believes that the Plan of Operations has become substantially outdated by changes in assigned risk and related laws, and by plan experience.

Thus, on August 20, DOI published notice of its intent to adopt a new CAARP Plan of Operations which will completely supersede section 2400 *et seq.* According to the notice, the new CAARP Plan of Operations will not be included within the California Code of Regulations; instead, it will be incorporated by reference into a regulation published in the CCR. The new plan includes provisions governing, among other things, administrative matters, producer certification and performance standards, personal and commercial automobile coverage, and insurer performance standards. It also sets forth eligibility standards and criteria, application procedures, and apportionment of assignment provisions. According to the Department, the proposal updates the Plan of Operations in conformance with current policies and recent statutory additions, and thus will facilitate uniformity, reliability, and fairness in the operation of CAARP.

On October 25, the Department held a public hearing on its proposed new Plan of Operations for CAARP. At this writing, staff is compiling the comments received, and no action has been taken on the proposal.

DOI Proposes Regulations Governing Broker Fees

On August 20, DOI published notice of its intent to adopt sections 2189.1–2189.8, Title 10 of the CCR, to establish standards governing broker fees. While existing law prohibits insurance agents from charging customers a fee for an insurance transaction, no such prohibition applies to brokers. And while Insurance Code section 790.03(b) prohibits brokers and other licensees from making untruthful, deceptive, or misleading statements, and other sections of the Insurance Code generally prohibit unfair acts and practices in the insurance industry, these sections do not address acts and practices surrounding broker fees specifically.

Thus, the new regulations would define the term “broker fee” (to mean any fee, however labeled, charged by an insurance broker to provide services that constitute or arise out of the

transaction of insurance, as defined in Insurance Code section 35, but excluding fees charged for services not constituting or arising out of the transaction of insurance), and establish preconditions for the charging of a broker fee. For example, the regulations would require that a broker disclose to a consumer all material facts surrounding the fee, provide a consumer with a standard disclosure form prescribed by the regulations, and sign and have the consumer sign an agreement which contains certain language mandated by the regulations. In particular, the broker must disclose (if true) that an insurer may pay to the broker a commission in addition to the broker fee. Both the disclosure and the agreement must be in

English and in any other language principally used by the broker to advertise, solicit, or negotiate the sale and purchase of insurance.

The regulations also recite certain acts that are deemed unfair or deceptive. Among others, these include failure to provide a consumer with the standard disclosure, failure to complete all relevant portions of the broker fee

agreement before giving the agreement to the consumer for review, failure to provide a consumer with a fully completed copy of the broker fee agreement as soon as reasonably practicable, and failure to promptly refund an entire broker fee if the broker acts incompetently or dishonestly resulting in financial loss to the consumer (or, regardless of financial loss, if the broker commits certain listed acts of misfeasance or nonfeasance). The proposed regulations would also provide that certain practices of an insurer regarding the appointing and unappointing of agents are unfair and deceptive acts; and establish that a violation of the regulations by a broker constitutes grounds for the suspension or revocation of the broker's license.

On October 26, the Department held a public hearing on the proposed regulations, and—at this writing—is accepting written comments until November 12.

Fair Claims Settlement Practices Regulations

On August 13, DOI published notice of its intent to amend sections 2695.1–.14, Title 10 of the CCR, the regulations adopted by former Commissioner John Garamendi to imple-

ment and interpret the sixteen claims settlement practices barred by Insurance Code section 790.03(h) (see above). Among other things, these regulations establish affirmative standards of conduct for auto, fire, life, and disability insurers in handling claims; require insurers to pay claims within a specified number

of days after they have been verified; bar “low-ball” settlement offers; prohibit discriminatory claims settlement prac-

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tices based on the claimant's race, gender, sexual orientation, income, language, religion, national origin, place of residence, or physical disability; and allow the Commissioner greater discretion to impose fines for single violations and stiffer penalties for multiple or egregious violations. [13:1 CRLR 83; 12:4 CRLR 146; 12:2&3 CRLR 171]

Commissioner Quackenbush proposes to amend DOI's fair claims settlement practices regulations to (1) reorganize the subsections so they are easier to understand and use; (2) add or delete language for reasons of grammar and/or clarity; (3) eliminate unnecessary portions of the regulations in cases where existing statutes adequately cover the subject areas; and (4) add subsections or portions of subsections where necessary to set forth reasonable standards of conduct in the handling of claims.

Some of the changes are substantive. For example, DOI proposes to rewrite subsection 2695.4(a), entitled "Representation of Policy Provisions and Benefits," to state: "No insurer shall misrepresent, conceal or fail to disclose all benefits, coverages, time limits and other provisions of any insurance policy, bond and statute which may apply to a claim presented under the insurance policy or bond. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability." DOI also proposes to add new subsection (b)(5) to section 2695.7, entitled "Standards for Prompt, Fair and Equitable Settlements," which would read: "When a claim is adjusted for betterment, appreciation, or salvage, all justification for the adjustment shall be contained in the claim file. Any adjustment shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. The cost of labor is not subject to depreciation. The basis for any adjustment shall be fully explained to the claimant in writing." DOI believes this new subsection is necessary because Department examinations of insurers have revealed a claims handling pattern of failure to document adjustments in loss valuation.

DOI also proposes to amend several subsections of section 2695.8, entitled "Additional Standards Applicable to Automobile Insurance," to account for the fact that, in almost every automobile total loss claim adjusted in California, insurers utilize one or more computerized total loss valuation services in determining the value of a claim. Under the new subsections, insurers are still required to document that a value arrived at by a computerized service is supported by the value of actual comparable vehicles in the marketplace. DOI also proposes to add new subsection 2695.8(g), which would require an insurer that, by contract, directs, suggests, or recommends that an automobile be repaired in a particular repair shop to also (1) prominently disclose the contractual provision in writing to the insured at the time the insurance is applied for, and (2) if the claimant elects to have the vehicle

repaired at a shop of his/her choice, the insurer may not cap or discount the repair costs based on charges that would have been incurred had the vehicle been repaired by the insurer's chosen shop.

DOI also proposes to amend section 2695.9, concerning first-party residential and commercial property insurance, to reflect current caselaw defining the term "repair or replacement cost" to include any cost that an insured is reasonably likely to incur in repairing or replacing a covered loss, including but not limited to a general contractor's overhead and profit when those expenses are reasonably likely to be incurred. DOI's amendments to section 2695.9 would also preclude insurers from requiring that a property be repaired by a specific individual or entity, and prohibit an insurer from directing, suggesting, or recommending that a property be repaired by a specific individual or entity unless certain conditions are satisfied. Finally, DOI proposes to amend section 2695.11, regarding life and disability insurance claims, to set a 30-day timeframe within which an insurer that contests a claim must subsequently affirm or deny the claim, and to establish a five-day timeframe for the preauthorization of non-emergency medical services.

DOI held public hearings on these proposed amendments on October 19 in San Francisco and October 21 in Los Angeles; at this writing, staff is compiling and reviewing the comments received.

Update on Other DOI Rulemaking Proceedings

The following is an update on recent DOI rulemaking proceedings described in detail in Volume 16, No. 2 (Summer 1999) of the *California Regulatory Law Reporter*:

◆ **Emergency Regulations Governing Appeals of Workers' Compensation Disputes.** On June 18 and again on October 18, the Commissioner readopted new section 2509.40 *et seq.*, Title 10 of the CCR, on an emergency basis, to implement an express directive in AB 877 (Solis) (Chapter 517, Statutes of 1997) that requires the Commissioner—no later than January 1, 1999—to adopt regulations governing appeals to the Commissioner of various decisions regarding workers' compensation issues. These appeals stem from disputes over classification matters, experience ratings, and matters concerning the application of an insurer's rating plan. [16:2 CRLR 132-33] The emergency regulations establish a process for the handling of complaints and requests for action by insurers and the designated rating organization and for appeals to the Commissioner. Insurers and the designated rating organization are required to designate an office for the receipt of complaints and requests for action, and are required to acknowledge them. Workers' compensation insurers and the designated rating organization are required to make a decision on a complaint within a specified time period and are required to inform the complainant of his/her right to appeal to the Commissioner, including the right to a hearing before the Commissioner. Time limits for appeals to the Commis-

sioner, as well as the form of appeal, are established in the regulations. The rules set forth a provision for reconsideration and for judicial review. The regulations are designed to make the appeals process available to appellants who wish to represent themselves; they include a sample declaration of service form. At this writing, the emergency regulations are effective until February 16, 2000.

◆ **Supplemental Earthquake Coverage.** On May 11, OAL approved DOI's amendment of sections 2697.2 and 2697.6 and adoption of new section 2697.61, Title 10 of the CCR. These regulatory changes provide a new "optional-limits basic" residential earthquake insurance policy, to supplement CEA's current "mini-policy." Under the supplemental policy (which CEA participant insurers are not required to offer), homeowners may choose a 10% deductible (rather than the standard 15% deductible) and boost contents coverage to \$100,000 (from the currently-authorized \$5,000) and emergency housing coverage at \$15,000 (up from the current \$1,500). The lower deductible will cost the average policyholder about 80 cents more per \$1,000 of coverage (or about \$155 annually for the average home); the increased coverage for contents and emergency housing will add about 50 cents more per \$1,000 covered. [16:2 CRLR 133; 16:1 CRLR 151]

Commissioner Continues Effort to Secure Claims Payment for Holocaust Survivors

For the past two years, Commissioner Quackenbush has been participating in an effort by the National Association of Insurance Commissioners (NAIC) and the International Commission for Holocaust-Era Insurance Claims (ICHEIC) to secure payment of insurance claims on behalf of Holocaust survivors and heirs. During World War II, many Jewish families in Europe purchased life insurance policies as financial protection for loved ones who would survive the war. However, Nazi Germany did not preserve insurance policy documents, nor did it issue death certificates for Jews and others murdered in concentration camps during the Holocaust. As a result, many Holocaust survivors and their heirs have been unable to collect on policies purchased over 50 years ago. Several nationwide class action lawsuits have been filed against large European insurance companies on behalf of Holocaust survivors to ensure that they receive payment on legitimate claims; DOI has joined such an action pending in federal court in New York. Some of the companies that are refusing to pay claims of Holocaust victims are licensed in California and—for the past year—DOI, NAIC, and the ICHEIC have been working to bring these companies "to the table" and persuade them to honor their contractual commitments. The Commissioner estimates that approximately 20,000 California residents are Holocaust survivors

or the children of individuals who were among the six million killed by the Nazis during World War II. [16:2 CRLR 134-35; 16:1 CRLR 152-53]

This effort has resulted in legislation, litigation, and—recently—administrative action by the Commissioner. Following is an update on recent activity:

◆ **Legislation.** In 1998, then-Governor Wilson signed two bills important to this effort. SB 1530 (Hayden) (Chapter 963, Statutes of 1998) allocated \$4 million to DOI to establish an oversight committee for the purposes of developing and implementing a coordinated approach toward gathering and reviewing the archives of affected insurers, researching and investigating policies and claims made, and otherwise resolving the outstanding claims of Holocaust victims. Additionally, AB 1334 (Knox) (Chapter 43, Statutes of 1998), an urgency bill which took effect on May 22, 1998, provides that any Holocaust victim, or heir of a Holocaust victim, who resides in California and has a claim arising out of an insurance policy or policies purchased in Europe between 1920 and 1945 may bring a legal action to recover on that claim in any superior court in California. AB 1334 further provides that any action brought by a Holocaust victim or the heir or beneficiary of a Holocaust victim, whether resident or nonresident of this state, seeking proceeds of the insurance policy or policies issued or in effect between 1920 and 1945, shall not be dismissed for failure to comply with the applicable statute of limitations provided the action is commenced on or before December 31, 2010.

Governor Davis recently signed two additional bills related to this effort. AB 600 (Knox) (Chapter 827, Statutes of 1999) requires the Insurance Commissioner to establish and maintain the Holocaust Era Insurance Registry, which will contain records and information relating to insurance poli-

AB 600 (Knox) (Chapter 827, Statutes of 1999) requires the Insurance Commissioner to establish and maintain the Holocaust Era Insurance Registry, which will contain records and information relating to insurance policies issued by insurers in the state, either directly or through a related company, to persons in Europe which were in effect between 1920 and 1945.

cies issued by insurers in the state, either directly or through a related company, to persons in Europe which were in effect between 1920 and 1945. AB 600 requires insurers to file that information on Holocaust-era policies issued and claims made with the Commissioner for inclusion in the Registry, and sets forth penalties for failure to file or falsification of records filed. Additionally, AB

1660 (Shelley) (Chapter 85, Statutes of 1999) renames the oversight committee created in SB 1530 (Hayden) as the "Holocaust Era Insurance Claims Oversight Committee," with specified composition (including Holocaust survivors), and charges the Oversight Committee with reviewing and approving "any insurance settlement negotiation or offer relating to a Holocaust era insurance claim in which the Department is involved" (see LEGISLATION). At this writing, the Commissioner is preparing to engage in emergency rulemaking to implement the new legislation.

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◆ **Litigation.** At least four private lawsuits are currently pending against European insurance companies under the new jurisdiction authorized in AB 1334 (Knox). As noted above, new Civil Code section 354.5 vests California superior courts with jurisdiction to hear such cases and gives Holocaust survivors and heirs until 2010 to file such claims. The lead case is *Stern v. Generali*, No. BC185376 (Los Angeles County Superior Court), a bad faith lawsuit filed in late 1998 against Generali Assicurazioni, an Italian life insurance company that failed to pay a claim arising from an insurance policy purchased in 1929 by a Hungarian man who perished at Auschwitz. Generali moved to dismiss the case, arguing that it has insufficient contacts with the state of California to confer jurisdiction in California courts. After receiving evidence indicating that Generali has filed suit in California courts on at least a dozen occasions and has conducted millions of dollars worth of business with California clients since it was admitted to sell insurance in 1958, Judge Florence-Marie Cooper rejected Generali's motion in January 1999 [16:2 CRLR 138]; since then, the Second District Court of Appeal denied review on April 6, and the California Supreme Court followed suit on June 16. Meanwhile, on May 28, Judge Cooper denied similar defense motions in *Sladek v. Generali*, No. BC188679; *Babos v. Generali*, No. BC188680; and *Friedman v. Generali*, BC193182, permitting those cases to go forward. Further, Judge Cooper set the *Stern* case—in which the relatives of Mor Stern seek \$135 million in compensatory and punitive damages—to begin trial on February 9, 2000, and directed the parties to enter into settlement negotiations.

In June, however, counsel for Generali filed a peremptory challenge against Judge Cooper, seeking to prevent her from presiding over any of the four cases, on grounds she is "prejudiced against Generali or the interest of Generali" such that the company would not receive a fair and impartial trial. Judge Cooper disqualified herself from further participation in the matters, and they were transferred to Superior Court Judge James Otero in July.

On September 7, Judge Otero held a hearing on other motions made by Generali. The company challenged the constitutionality of section 354.5, as added by AB 1334. Although the statute may have conferred jurisdiction, Generali argued that statute itself conflicts with the due process clause of the U.S. Constitution. Plaintiffs insist that the law is constitutional as applied to Generali because of Generali's contacts with the state of California, but Generali contends that subjecting it to suit in California, where it maintains no offices or employees, is unfair. Counsel for Generali further argued that, in any event, California law does not apply in this matter because the policy in question was drafted and purchased in what is now the Czech Republic; Generali also contended that it is not responsible for the Stern claim because the Communist government took over its operations and liabilities after the war. Judge Otero deferred a ruling on

the motions, and ordered further briefing by the parties on a number of issues (including Czech law); briefing was due by October 22, and another hearing is scheduled for November 22.

◆ **Administrative Actions.** On June 22, Commissioner Quackenbush announced that he has initiated an administrative proceeding concerning the California-licensed subsidiaries of Munich Reinsurance ("Munich Re"), which DOI believes has failed to pay a significant number of Holocaust victims' claims. Quackenbush also announced his appointment of attorney Karl Rubinstein as Special Deputy Insurance Commissioner and Special Examiner; Rubinstein will work with approximately 100 DOI personnel to examine business records of four Munich Re parent companies and 13 of their subsidiaries that are licensed in California. According to DOI, none of these companies have yet entered into the ICHEIC process.

In late July, Commissioner Quackenbush announced that five other European insurance companies (including Allianz AG, the parent company of Fireman's Fund) are impeding the progress of the ICHEIC, and—as a result—are subjecting themselves to possible disciplinary action by the Department. All five companies are defendants in the class action still pending in New York.

After Governor Davis signed AB 600 in October, the Commissioner laid plans to subpoena the companies to compel compliance with the new Holocaust Registry Law. At this writing, DOI plans to issue subpoenas in November and hold two hearings in early December to determine insurance company willingness to comply with the law.

Commissioner's Chief of Staff Abruptly Resigns During Conflict of Interest Investigation

On July 23, DOI Chief of Staff William W. Palmer—one of the highest-paid state employees—abruptly resigned rather than face inquiries by two legislative committees and the Fair Political Practices Commission over the fact that, while a state employee, he has been operating a private law practice "on the side" in which he has sued a company affiliated with several insurance companies regulated by his employer.

Both the Senate Insurance Committee and the Assembly Insurance Committee began investigating Palmer in early July after being notified that Palmer—a \$195,000-per-year public servant—also serves as counsel to shareholders in a lawsuit against Berkshire Hathaway Inc., whose subsidiaries include insurance companies GEICO Corporation, Cypress Insurance Company, and Berkshire Hathaway Life Insurance.

On July 6, Commissioner Quackenbush delivered an 11-page letter defending Palmer's conduct to Senate Insurance Committee Chair Jackie Speier. In his letter, Quackenbush noted that Palmer was actually serving in four

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high-ranking positions at DOI: (1) "chief of my executive staff" (a "voluntary" unpaid position pending the hiring of a new Chief Deputy), (2) personal counsel to the Commissioner (also unpaid), (3) chief of the DOI unit that is attempting to recover insurance benefits for Holocaust victims (see above), and (4) Chief Executive Officer of the Department's Conservation and Liquidation Office (CLO). Quackenbush argued that Palmer was paid only for the CLO position, and that those funds "are not state funds" because they come from "the funds of the companies being supervised, all subject to court supervision." Quackenbush stated that in his capacity with CLO, Palmer is listed on court documents as the chief executive officer and/or president of approximately 69 companies that are under a court's jurisdiction because they have been taken over by an insurance regulator; his role is to supervise their operations while they are being sold for the benefit of policyholders and/or claimants. Quackenbush failed to discuss Palmer's outside law practice, instead emphasizing that Palmer is a "uniquely talented individual" who works 80 hours per week supervising 55 full-time CLO employees and approximately 100 outside at-will employees. In his letter, Quackenbush also acknowledged that Palmer disclosed the Berkshire Hathaway matter "to me and former Chief Deputies Ken Gibson and David Knowles. I find no fault with his actions...."

In his outside law practice, Palmer represented stockholders who owned shares of Blue Chip Stamp Company, a trading stamp company that merged with Berkshire Hathaway in 1983. At the time of the merger, Blue Chip stockholders were told they could exchange their shares for Berkshire shares. However, many shareholders failed to exchange their stocks, which were eventually turned over to the unclaimed property department of the state Controller's Office. In the years since then, the value of Berkshire stock has soared from \$962.50 to \$72,000 per share. For a finder's fee plus legal expenses, Palmer tracked down a number of former Blue Chip shareholders and helped them exchange their stock; additionally, he participated in the filing of a class action against Berkshire, alleging breach of fiduciary duty and other tort claims for failing to properly notify Blue Chip shareholders of their right to obtain Berkshire stock. During 1996, Palmer earned \$200,000 in outside legal income, in addition to his state salary.

After Palmer's resignation, Commissioner Quackenbush lauded his "remarkable skill" and willingness to take on so many different roles within his administration. Unpersuaded, the legislature enacted AB 427 (Scott) (Chapter 768, Statutes of 1999), which requires that any person appointed by the Insurance Commissioner to serve in the capacity of chief executive officer of the Department's Conservation and Liquidation Office is subject to Senate confirmation (see LEGISLATION).

LEGISLATION

"Tort Reform" Legislation

SB 1237 (Escutia) and AB 1309 (Scott) combine to overrule the California Supreme Court's decision in *Moradi-Shalal*

v. Fireman's Fund Insurance Co., 46 Cal. 3d 287 (1988), and permit a consumer—under certain circumstances—to sue another person's insurance company in tort for committing unfair claims settlement practices barred by Insurance Code section 790.03(h). [16:2 CRLR 131–32]

◆ **SB 1237 (Escutia)**, as amended July 8, enacts the "Fair Insurance Responsibility Act of 2000" (FAIR). SB 1237 requires insurers to act in good faith toward and deal fairly with third-party claimants, and further provides that if an insurer engages in unfair claims settlement practices with respect to a third-party claimant, the third-party claimant generally has the right, upon meeting certain conditions, to assert a cause of action against the insurer. Where the amount in controversy either does not exceed \$50,000, or is within policy limits and the policy limits do not exceed \$50,000, a claimant and the insurer may resolve the claim by arbitration pursuant to a written arbitration agreement. If the parties agree to submit a claim to and participate in arbitration, the insurer is conclusively presumed to have complied with its duty to act in good faith toward and deal fairly with third-party claimants. Governor Davis signed this bill on October 7 (Chapter 720, Statutes of 1999).

◆ **AB 1309 (Scott)**, as amended September 7, amends the provisions of SB 1237 in several important respects. AB 1309 (1) limits the application of SB 1237 to actions in which an individual brings the underlying claim for bodily injury or for property damage resulting from a motor vehicle collision; (2) defines "bodily injury," for purposes of this right of action, to exclude emotional distress that results from economic loss, and excludes emotional distress claims not accompanied by actual physical manifestations of the emotional distress; (3) makes a person convicted of a driving under the influence offense ineligible to file an action for bad faith; (4) specifies that an insurer does not violate its obligation to act in good faith because of the insurer's honest mistake in judgment in connection with the settlement of a claim, and specifies that the fact that the insurer did not settle a claim is not necessarily proof of bad faith; (5) requires, as a condition of filing an action for bad faith, that the plaintiff obtain a final judgment in an amount greater than a settlement offer rejected by the plaintiff in the underlying action on which the bad faith action is based; (6) specifies that SB 1237 applies prospectively to events or occurrences occurring on or after January 1, 2000, and to conduct of an insurer or its agents concerning accidents or losses that occur after that date; (7) exempts medical, legal, and health care malpractice insurers from this bill when the failure to settle is due to the policyholder's refusal to settle the claim, and the consent of the insured is required for settlement; and (8) requires a study by the State Auditor evaluating the effects of SB 1237 and AB 1309. The Governor signed AB 1309 on October 7 (Chapter 721, Statutes of 1999).

AB 1380 (Villaraigosa). As enacted in 1975, the Medical Insurance Compensation Reform Act (MICRA) limits the liability of health care providers for noneconomic damages

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for personal injury or death for professional negligence to \$250,000. As amended in May 1999, AB 1380 would require the Treasurer to annually adjust the MICRA cap to reflect the cumulative percentage change in the Consumer Price Index for all items published by the U.S. Bureau of Labor Statistics for the preceding calendar year. [*S. Appr*]

Auto Insurance

SB 171 (Escutia), SB 527 (Speier), SB 652 (Speier), and AB 1432 (Oller), all of which emerged from a joint conference committee during the late summer, attempt to attack the serious uninsured motorist problem in California [*16:2 CRLR 130-31*]:

◆ **SB 171 (Escutia) and SB 527 (Speier)**, as amended August 16, create—effective July 1, 2000—a four-year pilot project to test a low-cost automobile insurance policy for low-income good drivers residing in the counties of Los Angeles (SB 171) and San Francisco (SB 527). The bills require all insurers that participate in CAARP to participate in the pilot program in both counties. To be eligible to participate, a driver must meet the following criteria: (1) family income is less than 150% of the federal poverty level; (2) the driver is at least 19 years old, a good driver under the standards established in Proposition 103, and has three years of continuous driving experience; (3) the policy covers an automobile of \$12,000 or less in value; and (4) the driver is not a college student claimed as a dependent of another person for federal or state income tax purposes. The low-cost policy will provide coverage of \$10,000 for liability for bodily injury or death to one person, subject to a cumulative limit of \$20,000 for all persons, and \$3,000 for liability for damage to property (“10/20/3”). The bills also provide that the low-cost policy satisfies the state’s financial responsibility laws. The bills specify an initial \$450 annual rate for Los Angeles and an initial \$410 rate for San Francisco (subject to a surcharge on policies covering unmarried males between the ages of 19 and 24), until such time as the rates are adjusted in accordance with procedures established in the bill. Commencing January 1, 2001, CAARP must report to the legislature on an annual basis on the status of the pilot program. Governor Davis signed these bills on October 7 (Chapters 794 and 807, Statutes of 1999).

◆ **SB 652 (Speier)**, as amended August 24, deletes the January 1, 2000 sunset date on several “financial responsibility” laws that effectively require California drivers to carry automobile insurance, including Vehicle Code section 16028 (which requires a driver to provide evidence of financial responsibility upon the demand of a peace officer) and Vehicle Code section 4000.37 (which requires the Department of Motor Vehicles to demand proof of financial responsibility prior to registering or renewing the registration of a vehicle).

The deletion of the sunset dates extends these requirements indefinitely. SB 652 also authorizes DMV to suspend, cancel, or revoke the registration of a vehicle if the registration was attained by providing false evidence of financial responsibility or upon notification by an insurance company that the required coverage has been canceled. This bill, which was double-joined with SB 171 and SB 527 (see above) such that the sunset dates would not be extended unless the bills creating the low-cost/low-coverage pilot projects were signed by the Governor on October 9 (Chapter 880, Statutes of 1999).

AB 1432 (Oller). Existing law imposes a gross premium tax on insurers at a rate of 2.35% of the amount of premiums written. As amended September 9, AB 1432 provides a credit against tax for premiums paid by previously uninsured motorists who participate in the two new pilot programs established in SB 171 and SB 527 (see above). According to the legislative analysis of AB 1432, there are an estimated 1.5 million uninsured motorists in Los Angeles County and about 80,000 in San Francisco County. For each policy written on a previously uninsured person in Los Angeles County, the credit under this bill would be approximately \$10 on the \$450 per year premium. This would result in a loss of \$100,000 in premium tax for every 10,000 policies written in Los Angeles County. Proponents of AB 1432 point out that this “loss” represents premium tax that is not being collected currently because the credit applies only to program participants who were previously uninsured. The primary purpose

SB 940 (Speier) and AB 1050 (Wright) are double-joined bills designed to increase DOI’s revenue and direct that increased revenue toward enhanced auto insurance fraud detection and prosecution and improved consumer services.

of this premium tax credit is to provide an incentive to market the low-cost policies to motorists who are currently uninsured. This bill was signed by the Governor on October 7 (Chapter 808, Statutes of 1999).

SB 940 (Speier) and AB 1050 (Wright) are double-joined bills designed to increase DOI’s revenue and direct that increased revenue toward enhanced auto insurance fraud detection and prosecution and improved consumer services:

◆ **SB 940 (Speier)**. Existing law requires each insurer doing business in California to pay an annual fee not to exceed \$1 for each vehicle it insures, in order to fund increased investigation and prosecution of fraudulent automobile insurance claims and economic automobile theft. Revenues from the fee are available for distribution by the Insurance Commissioner to DOI’s Fraud Division, to the California Highway Patrol, and to district attorneys. SB 940, as amended August 24, requires each insurer, until January 1, 2007, pay an additional annual fee, not to exceed 50 cents, for each vehicle it insures, to fund DOI’s Bureau of Fraudulent Claims and an Organized Automobile Fraud Activity Interdiction Program, as directed by AB 1050 (see below).

SB 940 also requires insurers to pay an additional annual fee of 30 cents for each vehicle it insures to fund certain DOI consumer service operations related to automobile in-

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insurance. According to the language of the bill, 20 cents of this 30-cent fee on every car insured "shall be used to improve service to consumers through the Rating and Underwriting Services Bureau, the Claims Services Bureau, the Investigations Bureau, or any successor bureaus of the Department that may assume the consumer service functions of these bureaus. It is the intent of the Legislature that the highest priority for use of these revenues during the 1999-00 and 2000-01 fiscal years shall be to eliminate the backlog of consumer complaints relative to automobile insurance policies, insurers selling automobile policies, and agents and brokers selling those policies." The remaining ten cents of the 30-cent fee should be used to "improve the ability of the Department to respond to consumer complaints and information requests through the Department's toll-free telephone number, and for improving the ability of the Department to offer information about automobile insurance rates to the public." The bill requires DOI to develop a plan for the use of these new revenues and submit the plan to the Assembly and Senate Committees on Insurance. Governor Davis signed SB 940 on October 9 (Chapter 884, Statutes of 1999).

♦ **AB 1050 (Wright)**, the Organized Crime Prevention and Victim Protection Act of 1999, increases auto insurance anti-fraud funding, targets fraud control activities, and makes other reforms related to insurance fraud. In particular, the bill establishes, until January 1, 2007, a coordinated program of three to ten grants for district attorneys targeted at the successful prosecution and elimination of organized automobile fraud activity, funded by an additional fee which must be determined by the Commissioner and may not exceed 50 cents per vehicle insured per year in California; that fee is authorized in SB 940 (see above). AB 1050 also requires the Commissioner to adopt emergency regulations establishing the criteria to be used in awarding these grants. The Governor signed AB 1050 on October 9 (Chapter 885, Statutes of 1999).

SB 363 (Figueroa), as amended in May 1999, requires automobile insurance policies to provide coverage for the replacement of a child passenger restraint system that was in use by a child during an accident for which the policy is liable. The Governor signed this bill on July 26 (Chapter 183, Statutes of 1999).

AB 62 (Papan), as amended September 10, creates and establishes fees for a new type of production agency license, called a rental car agent license, which will authorize a rental car company or the franchisee of a rental car company to offer to its customers insurance of an authorized insurer for specified types of insurance, if the insurance is offered by a representative of the licensee who is an endorsee on the license and the insurance is sold as part of a vehicle rental transaction. The bill requires a licensee to maintain the name of each rental car representative who is an endorsee on the license, and to annually file with the Insurance Commissioner a certification of the number of endorsees, and a statement that no person other than an endorsee sells or offers insurance on its behalf and that all endorsees have completed train-

ing as required. The bill requires a rental car agent to provide informational brochures to customers relating to insurance offered, and specifies both required and prohibited conduct of a rental car agent. Finally, the bill authorizes the Commissioner to take certain remedial measures for violations of these provisions. These provisions become operative on January 1, 2001. The Governor signed AB 62 on October 5 (Chapter 618, Statutes of 1999).

SB 749 (Hughes), as amended August 30, is almost identical to AB 62 (Papan) (see above). [*A. Appr*]

AB 976 (Cardoza), as amended in April 1999, would enact the California Low-Cost Auto Insurance Policy Act, which would allow a person whose household income does not exceed 150% of the federal poverty level to satisfy the financial responsibility laws by purchasing a "10/20/3" Basic Benefits Automobile Insurance Policy (similar to the policy now permitted in Los Angeles and San Francisco under SB 171 and SB 527—see above). [*A. Ins*]

SB 519 (Lewis), as introduced in February 1999, would create a "mini-policy" that covers only the named insured and does not cover any other person whatsoever, including but not limited to any person using the motor vehicle with the insured's express or implied permission. SB 519, which was sponsored by DOI, would retain the existing "15/30/5" minimum coverage requirements. [*S. Ins*]

SB 944 (Johnson), as introduced in February 1999, would—among other things—authorize insurers to sell a "10/20/5" policy which covers named insured drivers only; limit fees paid to health care providers by that policy; and reduce recoveries for third parties making claims against that policy when those parties recover from collateral sources. [*S. Jud*]

Earthquake Insurance

AB 964 (Aroner). As noted above, the legislature created the California Earthquake Authority and authorized it to sell earthquake insurance; CEA is run by the CEA Governing Board. [*16:1 CRLR 150*] The Board is required to set aside 5% of its investment income to fund the Earthquake Loss Mitigation Program, a low-interest loan program authorized to make grants and loan guarantees to homeowners who retrofit their homes to protect against earthquake damage; currently, this program is available only to homeowners in Santa Clara and Ventura counties who have wood-frame homes built prior to 1979 without pre-existing earthquake, water or pest damage. As amended August 23, AB 964 requires the CEA, on or before July 1, 2000, to establish in the operational rules of the Earthquake Loss Mitigation Fund a plan for the expedited expansion of the residential retrofit program statewide, and to issue a report to the legislature on the status of the Program by the same date.

The bill also amends Insurance Code section 10089.27 to change the requirements for insurer participation in the CEA. Under that section, an insurer may not participate in the CEA unless every insurer affiliated with that insurer, as defined, or under common control with that insurer, as

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defined, also participates in the Authority. AB 964 sets forth, until January 1, 2004, a limited exemption to that statute to allow Pacific Select Property Insurance Company to continue to be a competitor in the earthquake insurance market in California, and to continue to provide independent insurance agents with a place in the California earthquake insurance marketplace. Pacific Select was established subsequent to the establishment of the CEA, is not a CEA member, and writes only earthquake insurance in California, in competition with CEA. Through a series of mergers, Pacific Select is now affiliated with Farmers Insurance Group, a CEA member. Without the exemption, either Farmers would be required to withdraw from the CEA or Pacific Select would be required to join the CEA. DOI supported the bill, which was signed by the Governor on October 6 (Chapter 715, Statutes of 1999).

AB 1453 (Assembly Insurance Committee), as amended June 23, extends the sunset date of DOI's pilot program for the mediation of the disputes between insured complainants and insurers arising out of the 1994 Northridge earthquake until January 1, 2005, and requires the Commissioner to report to the Governor and the legislature by August 1, 2004, on whether the pilot program should be extended and on other specified matters. The bill also appropriates an additional \$3,400,000 from the California Residential Earthquake Recovery Fund to DOI to fund the Earthquake Loss Mitigation Program which provides grants and loans to help pay for the retrofitting of high-risk residential dwellings owned or occupied by low- and moderate-income households (see above). The Governor signed AB 1453 on October 7 (Chapter 796, Statutes of 1999).

SB 622 (Speier), as amended August 26, would establish a statutory definition of the term "inception of the loss" for purposes of filing claims against earthquake insurance policies. Section 2071 of the Insurance Code, a statute of limitations governing earthquake and other homeowner claims, provides that a suit or action for a claim must be filed within twelve months of "inception of the loss" but does not define the term "inception of the loss." SB 622 would provide that, in cases of loss arising out of an earthquake, "inception of the loss" means that point in time when appreciable damage occurs and is or should be known to the insured, such that a reasonable insured, being diligent in the face of discovered facts, would be aware that his/her notification duty under the policy has been triggered.

According to DOI and Senator Speier, the purpose of SB 622 is to ensure that the existing rights of earthquake policyholders are preserved by codifying a definition of "inception of the loss" that is consistent with a ruling on this definition by the California Supreme Court in *Prudential-LMI Commercial Insurance v. Superior Court*, 51 Cal. 3d 674 (1990). In that case, the court stated, "We agree that 'inception of the loss' should be determined by reference to reasonable discovery of the loss and not necessarily turn on the occurrence of the physical event causing the loss. Accordingly, we find that California law supports the application of the following

delayed discovery rule for purposes of the accrual of a cause of action under Section 2071: The insured's suit on the policy will be deemed timely if it is filed within one year after 'inception of the loss,' defined as that point in time when appreciable damage occurs that is or should be known to the insured, such that a reasonable insured would be aware that his notification duty under the policy has been triggered." This issue is currently the subject of litigation pending in the California Supreme Court (see LITIGATION).

According to the author and the Department, damage from an earthquake may not become apparent for years, and even escapes the trained eye of professional insurance adjusters and home inspectors upon whom consumers rely. Senator Speier argues that adherence to a one-year statute of limitations is unfair in such cases. This bill stalled at the end of the 1999 legislative year due to intense insurance industry opposition. [*A. Inactive File*]

AB 481 (Scott). Existing law requires insurance companies to offer earthquake insurance in connection with the sale of a regular homeowners policy; specifies that the mandate to offer earthquake insurance coverage may be made prior to, concurrent with, or within 60 days following the issuance or renewal of a homeowners policy; and requires, if the initial offer is not accepted, an insurer to repeat the offer of earthquake insurance at least every other year. As amended in May 1999, AB 481 would clarify that an offer of earthquake insurance may be made at any time the homeowners insurance is in place. Specifically, this bill adds language to affirm that the law does not prevent an insurer from offering earthquake insurance on demand. [*A. Appr*]

Holocaust-Era Claims Legislation

AB 600 (Knox), as amended August 16, enacts the Holocaust Victim Insurance Relief Act of 1999. Among other things, the bill adds section 13800 to the Insurance Code, which requires the Commissioner to establish and maintain the Holocaust Era Insurance Registry. The Registry will contain records and information relating to insurance policies issued by insurers in the state, either directly or through a related company, to persons in Europe which were in effect between 1920 and 1945. This bill requires those insurers to file specific information regarding those policies with the Commissioner, who will enter that information into the registry. It also requires those insurers to certify as true certain additional information, makes it a crime to knowingly certify as true any material matter which the insurer knows to be false, and establishes a civil penalty of up to \$5,000 for each instance an insurer knowingly files false information related to the reporting requirements of the bill.

AB 600, an urgency bill which took effect immediately upon the Governor's signature, also requires the Commissioner to suspend the license of an insurer that fails to comply with the reporting requirements of the bill by the 210th day after the effective date of the requirements; and requires the Commissioner to adopt emergency regulations to imple-

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ment the measure within 90 days of the effective date of the bill. Governor Davis signed AB 600 on October 8 (Chapter 827, Statutes of 1999).

AB 1660 (Shelley). SB 1530 (Hayden) (Chapter 963, Statutes of 1998) added section 12967 to the Insurance Code, which requires DOI to develop and implement a coordinated approach to gather, review, and analyze the archives of affected insurance groups, and other archives and records, using onsite teams and an oversight committee, to provide for research and investigation into insurance policies, unpaid insurance claims, and related matters of victims of the Holocaust or of the Nazi-controlled German government or its allies, and the beneficiaries and heirs of those victims, and for losses arising from the activities of the Nazi-controlled German government or its allies for insurance policies issued before and during World War II by insurers who have affiliates or subsidiaries authorized to do business in California (see above). As amended June 15, AB 1660 renames the section 12967 oversight committee as the "Holocaust Era Insurance Claims Oversight Committee," and provides for the appointment of seven persons to that committee—four by the Governor and one each by the President pro Tempore of the Senate, the Speaker of the Assembly, and the Insurance Commissioner. The bill specifies that all Oversight Committee members must have experience in Holocaust claims cases, similar investigations, archival research, and international law; requires the Committee to include Holocaust survivors; and prohibits the appointment of any person with a potential or actual conflict of interest to the Committee. The bill also states that appointments to the Committee "shall be expedited because of the urgency due to survivors' needs."

The bill expressly charges the Oversight Committee with the following responsibilities: (1) review and make recommendations concerning any insurance settlement negotiation or offer relating to a Holocaust era insurance claim in which DOI is involved; and (2) review and make recommendations to the Commissioner on the priorities for expenditure of funds and use of resources by the Department for Holocaust era insurance claims-related activities. Further, in the event that any of the affected insurers proposes a settlement of any policy or group of policies relating to Holocaust era insurance claims, the bill expressly requires the Commissioner to confer with the Committee prior to the Department finalizing the settlement agreement. DOI may not finalize a proposed settlement of a Holocaust era insurance claim unless the Committee recommends that the proposed settlement is equitable.

Finally, AB 1660 requires DOI to biannually report to the insurance and budget committees of the legislature on its progress in identifying and resolving insurance claims of

Holocaust survivors and their beneficiaries and heirs; the report must also include an overview of current and anticipated expenditures in implementing SB 1530 and AB 1660. Governor Davis signed AB 1660 on July 12 (Chapter 85, Statutes of 1999).

Health/Disability Insurance

In October, Governor Davis signed a 21-bill package of legislation overhauling the state's regulation of managed care. Many of the bills in the package apply not only to health care provided through managed care plans but also to health care provided pursuant to traditional disability insurance policies regulated by the Insurance Commissioner, or otherwise affect DOI and/or insurers. Some of these bills are described below; for a complete description of the entire managed care package, see our agency report on the Department of Corporations under "Health Care Regulatory Agencies."

AB 78 (Gallegos), as amended September 8, transfers responsibility for the administration and implementation of the Knox-Keene Health Care Service Plan Act of 1975, under which most managed care plans are regulated, from the Department of Corporations to a new Department of Managed Care within the Business, Transportation and Housing Agency. The Department will be headed by a Director who is appointed by and serves at the pleasure of the Governor. The bill also establishes within DMC an Advisory Committee on Managed Care, an Of-

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fice of the Patient Advocate, and a Clinical Advisory Panel to provide expert assistance to the Director in ensuring that the external independent medical review system under AB 55 (Migden) (see below) is meeting the quality standards necessary to protect the public's interest. AB 78 requires the DMC Director, in conjunction with the Advisory Committee on Managed Care, to undertake a study to consider the feasibility and benefit of consolidating into DMC the regulation of other health insurers providing insurance through indemnity, preferred provider organization, and exclusive provider organization products, as well as through other managed care products regulated by DOI; and to submit a report and recommendation to the Governor and the legislature no later than December 31, 2001. AB 78 was signed by the Governor on September 27 (Chapter 525, Statutes of 1999).

AB 55 (Migden), as amended September 9, requires the new DMC to establish, commencing January 1, 2001, an independent medical review system (IMRS) for health plan enrollees to seek an independent review whenever health care services have been denied, delayed, or otherwise limited by a plan or one of its contracting providers based on a finding that the service is not medically necessary or appropriate. The independent reviews will be conducted by expert medical

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organizations independent of plans and certified by an accrediting organization, pursuant to conflict of interest provisions. The Department must adopt the determination of the independent review entity, which shall be binding on the plan. In cases where the enrollee's position prevails, the plan must either offer the enrollee the disputed health care service or reimburse the enrollee for care received if so directed by the Department. The bill also establishes an IMRS in DOI for review of similar decisions by disability insurers. AB 55 was signed by the Governor on September 27 (Chapter 533, Statutes of 1999).

SB 189 (Schiff). Existing law requires health plans and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for individual enrollees or insureds who have a terminal condition and meet certain specified criteria. This bill revises these criteria to instead require that the enrollee or insured have a life-threatening or seriously debilitating condition. SB 189 also imposes penalties on health plans and insurers that fail to promptly implement decisions issued by independent medical experts pursuant to the new Independent Medical Review System enacted in AB 55 (Migden) (see above), and directs health plans and insurers to reimburse patients if so ordered by an IMRS decision involving emergency services and urgent care. SB 189 was signed by the Governor on September 27 (Chapter 542, Statutes of 1999).

AB 12 (Davis), as amended September 7, requires health plans and certain disability insurers to provide or authorize a second opinion upon the request of a patient or a participating health professional treating a patient under five specified circumstances. The second opinion must be provided by an "appropriately qualified health care professional," meaning a primary care physician or a specialist who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. The bill also requires plans and insurers to authorize or deny the second opinion in an expeditious manner; requires plans and insurers to file timelines for responding to requests for second opinions by July 1, 2000, with the appropriate state agency; and requires that the timelines be made available to the public upon request. This bill was signed by the Governor on September 27 (Chapter 531, Statutes of 1999).

SB 59 (Perata), as amended September 9, requires health plans that review and approve, modify, delay, or deny requests by providers for authorizations for treatment to meet specified utilization review (UR) requirements, and requires the UR provisions to be applicable to health plans that delegate functions to contracting providers. Decisions to approve or deny requests by providers must be made within five business days, except when the enrollee's condition is such that five days could be detrimental or jeopardize the enrollee's recovery, in which case decisions must be made within 72

hours. The bill requires written responses denying, delaying, or modifying treatment to specify information describing the criteria used and clinical reasons for the decisions, and also information on how the enrollee may file a grievance. The bill further requires decisions denying care to include contact information regarding the provider responsible for the decision, and authorizes regulatory penalties in cases where health plans fail to comply with deadlines for decisions. SB 59 also establishes a similar UR system for specified health insurers. Finally, SB 59 requires that the criteria and guidelines used by health plans, health insurers, their provider groups and contracting utilization review managers, to authorize or deny health care services to be available to the public upon request. The Governor signed SB 59 on September 27 (Chapter 539, Statutes of 1999).

SB 21 (Figueroa), as amended September 8, provides that health plans and managed care entities, for services rendered on or after January 1, 2001, have a duty of ordinary care to provide medically appropriate health care service to their subscribers and enrollees where such health care service is a benefit provided under the plan, and makes such entities liable for any and all harm legally caused by the failure to exercise ordinary care in arranging for the provision of, or denial of, health care services when both of the following apply: (1) the failure to exercise ordinary care results in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee; and (2) the subscriber or enrollee suffers "substantial harm." The term "substantial harm" means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss. SB 21 also provides that a person may not maintain a cause of action against a health plan unless he/she has exhausted the procedures provided by any applicable internal grievance system or independent review system, with certain exceptions. SB 21 characterizes the managed care industry as engaging "in the business of insurance." Governor Davis signed SB 21 on September 27 (Chapter 536, Statutes of 1999).

AB 88 (Thomson), as amended September 8, requires health plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Health plans and disability insurers may provide the required mental health coverage through a separate specialized health care service plan or mental health plan, subject to certain conditions. Governor Davis signed AB 88 into law on September 27 (Chapter 534, Statutes of 1999).

SB 148 (Alpert), as amended July 13, requires health plans and specified disability insurance policies to provide coverage, on and after July 1, 2000, for the testing and treatment of phenylketonuria. The Governor signed this bill on September 27 (Chapter 541, Statutes of 1999).

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AB 39 (Hertzberg), as amended September 2, and **SB 41 (Speier)**, as amended July 2, require health plans and certain disability insurance policies, respectively, to cover approved prescription contraceptive methods effective January 1, 2000. Both bills permit certain religious employers to request contracts without such coverage. Governor Davis signed AB 39 on September 27 (Chapter 532, Statutes of 1999) and SB 41 on September 27 (Chapter 538, Statutes of 1999).

SB 5 (Rainey), as amended June 29, requires health plans and certain disability insurance policies to cover screening for, diagnosis of, and treatment for breast cancer after January 1, 2000. Governor Davis signed this bill on September 27 (Chapter 537, Statutes of 1999).

SB 205 (Perata), as amended August 24, requires health plans and disability insurance policies to cover all generally medically accepted cancer screening tests after January 1, 2000. The Governor signed SB 205 on September 27 (Chapter 543, Statutes of 1999).

SB 64 (Solis), as amended September 9, requires health plans and disability insurance policies to cover a variety of diabetic services and supplies. Governor Davis signed this bill on September 27 (Chapter 540, Statutes of 1999).

AB 1049 (Aanestad), as amended in May 1999, requires disability insurers that cover hospital, medical, or surgical expenses and that review and approve the medical necessity or appropriateness of requests by providers prior to, or concurrently with, the provision of health care services to insureds, to prominently indicate on each insured's identification card whether a separate telephone number must be called to verify eligibility for benefits and coverage. This bill also requires the insurer to provide a specified notice to the insured in this regard. The Governor signed AB 1049 on July 12 (Chapter 88, Statutes of 1999).

SB 475 (Dunn), as amended September 3, requires the Insurance Commissioner, in consultation with representatives of the Health Insurance Counseling and Advocacy Program, to annually prepare a consumer rate guide for long-term care insurance, and specifies the methods for distributing the consumer rate guide. The bill also requires insurers to include in the premium section of the "Long-Term Care Insurance Personal Worksheet" a statement informing applicants that a rate guide is available that compares policies sold by different insurers and the history of rate increases for those policies, and how to obtain a copy of the rate guide; and requires insurers to disclose, in the premium section of the personal worksheet, all rate increases and rate increase requests for any prior policies it has sold in any state. Finally, the bill requires insurers to provide and DOI to collect specified data on all long-term care policies issued by the insurer or purchased or acquired from another insurer in the United States on and after January 1, 1990.

This bill was signed by the Governor on October 6 (Chapter 669, Statutes of 1999).

AB 591 (Wayne), as amended August 26, would require health plans and certain disability insurers to provide coverage on or after January 1, 2000, for routine patient care costs related to treatment of an enrollee or insured in a clinical trial meeting specified requirements. This bill would require the plans and insurers to report annually to the appropriate commissioner relative to enrollees or insureds that were covered in this regard. The Commissioner of Corporations and the Insurance Commissioner would be required to prepare a joint annual summary report compiling the submitted plan and insurer information for submission to the legislature. [*S. Appr*]

Credit Insurance

AB 1456 (Scott), as amended June 23, permits the Insurance Commissioner to set credit insurance rates based on a target of a 60% loss ratio for all lines of credit insurance, including those for life, disability, involuntary unemployment, and property, by January 1, 2001. This bill also requires the Insurance Commissioner to make available to the public actual loss ratios for all lines of credit insurance on an annual basis.

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consumers as a result of excessive credit insurance rates. This measure is designed to clarify the standard for credit insurance rates and to ensure that the standard is applied to all lines of credit insurance. AB 2107 (Connelly) (Chapter 32, Statutes of 1992) was intended to permit the Commissioner to set rates at a standard based on a minimum 60% loss ratio. [*12:2&3 CRLR 178*] As finally enacted, however, the law resulted in a "cap" of 60% loss ratios so the Insurance Commissioner could not approve higher loss ratios. In March 1999, Consumers Union and Center for Economic Justice published *Credit Insurance: The \$2 Billion a Year Rip-Off—Ineffective Regulation Fails to Protect Consumers*, a report indicating that lack of adequate regulation of the credit insurance industry resulted in a loss of \$460.5 million to California consumers from 1995–1997. Had AB 1456 been in effect during that time period, consumers would have saved \$424 million of those overcharges. Governor Davis signed AB 1456 on September 16 (Chapter 413, Statutes of 1999).

Other Insurance-Related Legislation

AB 427 (Scott), as amended September 9, provides that any person appointed by the Insurance Commissioner to serve in the capacity of chief executive officer of the Department's Conservation and Liquidation Office shall be subject to Senate confirmation (see MAJOR PROJECTS). The Governor signed this bill on October 7 (Chapter 768, Statutes of 1999).

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AB 845 (Maddox), as amended May 25, is a DOI-sponsored bill that authorizes the Commissioner to issue a cease and desist order against any person acting as, or holding himself, herself, or itself out as, an insurance agent or broker without being so licensed, and against any person holding out that person as transacting, or transacting, the business of insurance without having been issued a certificate of authority. The Commissioner is authorized to issue the cease and desist order without holding a hearing prior to issuance of the order, and to impose a civil penalty of up to \$5,000 for each day the order is violated. The bill permits a person against whom a cease and desist order is issued to request the Commissioner for a hearing on the order, and to have a review of the hearing proceedings and the order, both pursuant to the Administrative Procedure Act. The Governor signed AB 845 on August 30 (Chapter 260, Statutes of 1999).

SB 1077 (Burton). With certain exceptions, Insurance Code section 769 requires that an insurer provide an insurance broker-agent with 120 days' advance notice prior to terminating or amending a written agency or written brokerage contract with the broker-agent if the contract has been in effect for at least one year. As amended August 16, this bill adds an additional exception providing that the 120 days' advance notice requirement does not apply if the broker-agent transfers ownership, control, or servicing of policies written with the insurer to another insurer, or to an entity directly or indirectly owned or controlled by an insurer, or to an entity directly or indirectly owning or controlling an insurer.

Section 769 also provides that an insurer is not required to renew any policy of insurance if a broker-agent is no longer the broker-agent of record with respect to the policy or in various other situations. SB 1077 provides that an insurer is also not required to compensate a terminated broker-agent under these circumstances. This bill also provides that an insurer is not required to renew any policy of insurance or compensate a terminated broker-agent if the broker-agent has transferred ownership, control, or servicing of policies written with the insurer to another insurer, or an entity owned or controlled by another insurer, or to an entity owning or controlling another insurer. Governor Davis signed this bill on October 7 (Chapter 753, Statutes of 1999).

SB 820 (Sher and Bowen), as amended September 3, enacts the Uniform Electronic Transactions Act, which generally applies to all electronic transactions (including online investing transactions) except to the creation and execution of wills and testamentary trusts and certain other transactions. This bill establishes uniform standards for conducting electronic transactions in California. Specifically, SB 820 provides that a record or signature may not be denied legal effect or enforceability solely because it is in electronic form; and a contract may not be denied legal effect or enforceability solely because an electronic record is used in its formation. If a law requires a record to be in writing, or provides consequences if it is not, an electronic record satisfies the law. If a law requires a signature, or provides consequences in the absence

of a signature, the law is satisfied with respect to an electronic record if the electronic record includes an electronic signature. The bill authorizes the provision of written information by electronic record, and sets forth provisions governing changes and errors, the effect of electronic signatures, and admissibility into evidence. Governor Davis signed SB 820 on September 16 (Chapter 428, Statutes of 1999).

AB 329 (Scott). Insurers hire attorneys to defend their insureds, and are increasingly hiring auditing firms to review the bills submitted by counsel for defending their insureds, to ensure that counsel is billing pursuant to the agreement between the insurer and counsel. As amended July 7, AB 329 adds section 11580.02 to the Insurance Code, which permits liability insurers to review bills submitted for the defense of its insureds, but prohibits insurers from compensating the auditor/reviewer based on any of the following: (a) a percentage of the amount by which a bill is reduced for payment; (b) the number of claims or the cost of services for which the reviewer has denied authorization or payment; or (c) an agreement that no compensation will be due unless one or more bills are reduced for payment. Governor Davis signed AB 329 on October 9 (Chapter 883, Statutes of 1999).

AB 802 (Dutra). Existing law requires any person engaged in business as an insurance agent or broker and who participates in the arrangement of a premium financing agreement and accepts compensation for arranging, directing, or performing services in connection with the premium financing agreement, to disclose to the insured, in a manner and form established by the Insurance Commissioner, the amount of that compensation. As amended August 16, this bill requires the amount of any periodic finance charge imposed for the coverage purchased and the annual percentage rate associated with those charges to be disclosed in the policy itself (or—if arranged pursuant to a separate premium financing agreement—in the premium financing agreement itself) and in the premium finance billings. This bill was signed by the Governor on September 15 (Chapter 388, Statutes of 1999).

AB 374 (Cunneen), as amended in April 1999, would require the Insurance Commissioner, in consultation with the Chief Information Officer and the Secretary of State, to adopt regulations creating minimal acceptable standards regarding the use in the insurance industry of digital signatures and public-key infrastructures. [*S. Ins*]

AB 1455 (Committee on Insurance), as amended in May 1999, is no longer relevant to the Department of Insurance.

LITIGATION

On July 28, the California Supreme Court agreed to decide an extremely important issue referred to it by the U.S. Ninth Circuit Court of Appeals in *Vu v. Prudential Property & Casualty Insurance Company*, 172 F.3d 725 (9th Cir. 1999). The Supreme Court will decide the application of Insurance Code section 2071—the statute of limitations requir-

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ing homeowners to file claims against their policies within twelve months of the “inception of the loss”—as an affirmative defense to any suit brought by an insurance policyholder against his insurer, where the insured timely notified the insurer of covered damage and the insurer investigated the claim but failed to discover the full extent of the damage.

In an all-too-typical case arising out of the January 1994 Northridge earthquake, Peter Vu contacted Prudential within days after the quake. Vu’s policy covered damage to his residence up to \$300,000 and damage to appurtenant structures up to \$30,000; both coverages

were subject to deductibles. Prudential’s adjuster inspected Vu’s home and advised him that he was entitled to \$2,500 for damage to appurtenant structures but that the \$3,900 in damage to his home was below his deductible. Relying on Prudential’s inspection and denial of his claim, Vu took no further action until August 1995, when he discovered substantial additional damage that had been caused by the earthquake. Vu hired an appraiser, who estimated that the earthquake damage to Vu’s home far exceeded his deductible. Vu filed a supplemental claim with Prudential, which denied the claim because it had been filed more than one year after “inception of the loss.”

Vu sued Prudential in federal court. When Prudential moved for summary judgment based on section 2071, Vu argued that Prudential is estopped from invoking the statute of limitations because his failure to comply with it was the direct result of his reasonable reliance on Prudential’s January 1994 inspection and representations. The district court granted the insurer’s motion and dismissed the case. Vu appealed.

Confused, the Ninth Circuit recited a string of three California appellate cases from 1995, 1996, and 1997 under which Prudential should have been estopped from relying on the statute of limitations in this circumstance. *Ward v. Allstate*, 964 F. Supp. 307 (C.D. Cal. 1997), whose facts are almost identical to those in *Vu*, is illustrative: “After the plaintiffs submitted a timely claim to Allstate, they relied on the representation of [Allstate’s adjuster],

a purported expert and agent of Allstate....For this reason, the plaintiffs allowed the limitations period to elapse without conducting a further investigation. This is precisely the type of situation contemplated by the estoppel doctrine. Allstate cannot be allowed to lull the plaintiffs into sleeping on their rights, and then use the limitations period as a sword to cut down their claims.” However, the Ninth Circuit noted that the California Supreme Court recently depublished a similar case, which the

Ninth Circuit took to mean that the Supreme Court “has not yet signed on to” the *Ward* rationale.

Further, the Ninth Circuit questioned whether this matter is controlled by the rule in *Neff v. New York Life Insurance Co.*, 30 Cal. 2d 165 (1947), in which the Supreme Court held “quite categorically that an insurer is not estopped from invoking the statute of limitations as an affirmative defense even if its denial of the claim proved erroneous and the insured relied on it.” According to the Ninth Circuit, “the court based this conclusion on three key considerations: (1) the insurer advised

the insured of the denial of the claim; (2) the relationship between the insurer and insured was entirely arms-length, so that the insured had no reasonable basis for believing he could rely on the insurer’s investigation; and (3) the insurer did not make any ‘deceptive assurances...tending to lull the insured...into a sense of security and to forbear suit for the statutory period.’” The Ninth Circuit pointedly questioned whether *Neff* is still good law in California, noting

that “the passage of time has undermined *Neff*’s key assumption that insurer and insured stand in an entirely arms-length relationship. In cases since *Neff*, California courts have taken a very different view of the relationship between insurer and insured.” The Ninth Circuit cited *Egan v. Mutual of Omaha Insurance Co.*, 24 Cal. 3d 809 (1979), for the proposition that “an insurer may have a quasi-fiduciary duty to the insured. This special relationship may form a sufficient basis for the insured to rely on the insurer’s inspection under the second prong of *Neff*.” At this writing, the Supreme Court has not yet held oral argument in *Vu v. Prudential*.

In 1999, the California Supreme Court and two appellate courts decided cases involving Proposition 213, which was championed by Commissioner Quackenbush and enacted by the voters in 1996. Among other things, Proposition 213 added

section 3333.4 to the Civil Code, which precludes uninsured motorists from recovering non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages in any action to recover damages arising out

of the operation of a motor vehicle (an uninsured motorist may still seek lost wages, medical expenses, and other economic damages). Proposition 213 also added section 3333.3 to the Civil Code, which provides that “in any action based on negligence, a person may not recover any damages if the plaintiff’s injuries were in any way proximately caused by the plaintiff’s commission of any felony, or immediate flight therefrom, and the plaintiff has been duly convicted of that felony.

The Supreme Court will decide the application of Insurance Code section 2071—the statute of limitations requiring homeowners to file claims against their policies within twelve months of the “inception of the loss”—as an affirmative defense to any suit brought by an insurance policyholder against his insurer, where the insured timely notified the insurer of covered damage and the insurer investigated the claim but failed to discover the full extent of the damage.

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In its first review of a case involving Proposition 213, the California Supreme Court unanimously held in *Hodges v. Ford Motor Company*, 21 Cal. 4th 109 (Aug. 2, 1999), that Civil Code section 3333.4 does not bar uninsured plaintiff Benjamin Hodges from suing Ford for non-economic damages (including punitive damages) for injuries he suffered in a car accident which he alleged was the result of defective design. The court analyzed the ballot arguments on Proposition 213 and determined the initiative was designed to "distinguish between law-abiding motorists who pay for liability insurance, on the one hand, and law-breaking uninsured motorists who refuse to pay for such insurance, on the other....There is no suggestion that it was intended to apply in the case of a vehicle design defect." The court further added that Proposition 213 was not intended "to benefit manufacturers of defective vehicles....Indeed, such a windfall would appear inconsistent with the long-standing public policy goal of requiring manufacturers to bear the costs of injuries from defective products."

A week later, in *Horwich v. Superior Court (Edward Acuna, et al., Real Parties in Interest)*, 21 Cal. 4th 272 (Aug. 9, 1999), the Supreme Court further narrowed the reach of section 3333.4. In this matter, uninsured motorist Melissa Acuna was killed in an auto accident. Her parents sued the driver of the other vehicle, Benjamin Horwich, for wrongful death. In his answer, Horwich alleged section 3333.4 as an affirmative defense and argued that Melissa's parents could not recover damages for the nonpecuniary value of the loss of her care, comfort, and society. The Acunas contended the statutory prohibition applies only to the uninsured owner or operator of the automobile; the trial court agreed, and the appellate court affirmed. After again reviewing the ballot argument history of the initiative, the California Supreme Court affirmed, ruling that Proposition 213 was aimed solely at "punishing persons who theretofore could recover fully from insured drivers without themselves obeying the financial responsibility laws. Logically, wrongful death plaintiffs who are neither the uninsured owner nor operator of the vehicle involved in the accident were not targeted since they do not contribute to this perceived unfairness, nor are they in a position to rectify it. They have not failed to take personal responsibility; and they can do nothing to reduce the 'skyrocketing' insurance costs assertedly attributable to uninsured motorists that Proposition 213 is intended to ameliorate. They are not part of the problem. Thus, we cannot deem them part of the solution."

In *Savnik v. Hall*, 74 Cal. App. 4th 733 (Aug. 30, 1999), the Third District Court of Appeal ruled that, while Proposition 213 may preclude an uninsured driver from recovering non-economic damages, it does not preclude his passenger from seeking and recovering non-economic damages. Plaintiffs Savnik and Conant, who were involved in an auto accident while Savnik was driving, sued defendant Hall for damages. The automobile driven by plaintiffs was not insured. Both Savnik and Conant were listed in DMV records as the owners of the automobile; however, both Conant and Savnik testified that Savnik had listed Conant as an owner without

her knowledge and that she never drove the car. At trial, the jury found that Conant was not an owner of the vehicle, and awarded both Conant and Savnik economic and non-economic damages. On appeal, the Third District reversed the award for non-economic damages as to Savnik, because there was no dispute that he was the owner of the vehicle and was not insured; thus, his award of non-economic damages is barred by section 3333.4. However, based upon the jury's finding that Conant was not the owner of the vehicle, the Third District upheld her award. "Vehicle ownership is a fact question for the jury to determine in light of all the circumstances....Since Conant did not contribute any funds to buy the Suburban, never drove it, and had no knowledge that her name was listed on the registration certificate, the jury's finding that she was not its 'owner' was abundantly supported. The trial court properly refused to reduce Conant's non-economic damage award."

In *Jenkins v. Los Angeles County*, 74 Cal. App. 4th 524 (Aug. 23, 1999), the Second District Court of Appeal was presented with a case requiring an interpretation of Civil Code section 3333.3. Appellant Jenkins admitted he stole a car in August 1995. Several hours later, two sheriff's deputies spotted Jenkins sitting in the parked car in a parking lot. When he saw the deputies, Jenkins put the car in reverse and commenced driving away. One of the deputies thought his partner was in danger of being hit by the car and shot Jenkins four times, rendering him a paraplegic. Jenkins pled guilty to a felony and was sentenced to two years in state prison. Jenkins later sued Los Angeles County and the deputies for negligence, numerous intentional torts, and violations of the Unruh Civil Rights Act. Defendants moved for summary judgment on grounds that Jenkins' action was barred by Civil Code section 3333.3. The trial court agreed that section 3333.3 barred the action and granted the motion for summary judgment.

On appeal, the Second District reversed. First, the court noted that section 3333.3 restricts the litigation bar to actions "based on negligence." Finding this language unambiguous, the court held that section 3333.3 "clearly is intended to limit the immunity to causes of action sounding in negligence, rather than to extend it to intentional torts," and reinstated Jenkins' intentional tort and civil rights claims. The court also found that the immunity language requires the convicted felon to be in "immediate flight" from the commission of the felony, and held that Los Angeles County "did not establish as a matter of law that the shooting occurred during the immediate flight from the commission of a felony," and reinstated Jenkins' negligence claim against the county as well.

In *PPG Industries, Inc. v. Transamerica Insurance Company*, 20 Cal. 4th 310 (May 10, 1999), the California Supreme Court narrowly ruled that an insurer sued for bad faith for failure to settle a claim cannot be forced to pay a punitive damages award against its insured. In this matter, Solaglas improperly installed a windshield in a truck that was later involved in a collision in Colorado; the window popped out and the driver was rendered a quadriplegic. The driver

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sued PPG (which had acquired Solaglas), which was insured by Transamerica. A jury awarded \$5.1 million in compensatory damages and \$1 million in punitive damages against PPG, finding that Solaglas had failed to properly install the windshield. Transamerica contributed up to the limits of its policy, but refused to pay the punitive damage award. PPG then sued Transamerica for breach of the covenant of good faith and fair dealing, and demanded that it cover the punitive damages award because it had failed to settle the lawsuit.

In a 4-3 decision, the Supreme Court found for the insurer, citing a "well-established rule" prohibiting an insurer from being forced to pay an insured's punitive damages. The majority held that "[h]ere, the punitive damages...were awarded not against the insurance company for its unreasonable failure to settle that lawsuit, but against the insured for its own morally reprehensible behavior in installing the windshield on the truck....[A]n insured may not shift to its insurance company, and ultimately to the public, the payment of punitive damages awarded in the third party suit against the insured as a result of the insured's intentional, morally blameworthy behavior against the third party."

Writing for a three-member dissent, Justice Mosk argued that the majority opinion went too far because it "favors all insurers over all their insureds" (emphasis original). Justice Mosk noted that a liability insurer has a duty to defend its insured and to indemnify its insured if found liable; further, the insurer has a duty to make reasonable efforts to settle a claim against its insured by the insured's victim. In discharging its duty to settle, "the insurer must give at least as much weight to its insured's interests as to its own, and must act as though it alone would have to bear any ensuing judgment....If the insurer breaches its duty to settle the claim of its insured's victim, it commits a tort against its insured, at least if its breach is 'wrongful.'...And if it commits such a tort, it is liable to it for damages to compensate for all the detriment that it proximately caused."

On May 19, Attorney General Bill Lockyer—on behalf of Commissioner Quackenbush and State Controller Kathleen Connell—filed a class action lawsuit against most DOI-licensed title insurance companies and escrow companies licensed by the Department of Corporations doing business in California. In *People v. Fidelity National Title Insurance Company, et al.*, No. 99AS02793 (Sacramento County Superior Court), the Attorney General alleged that the defendant title insurance and escrow companies, from 1970 to the present, (1) "intentionally took millions of dollars of escrow funds, which remained unclaimed in escrow accounts, that should have escheated to the State of California," (2) "charged home buyers and other customers improper fees for services that defendants did not and never intended to provide" (including fees for reconveyances that never occurred, delivery services that were not performed,

and illegal administration fees); and (3) "collected millions of dollars in interest payments, or payments in lieu of interest, from banks. None of this interest was paid to escrow depositors, as required by Insurance Code section 12413.5 and Financial Code section 17409."

According to a press release issued by Controller Connell, "as much as \$500 million is owed to Californians for the mishandling and diverting of escrow funds to industry profit....An escrow account should be at zero when the account is closed, with all charges and costs accounted for. Any remaining funds should be immediately returned to the buyers and sellers, and not commandeered as corporate income." At this writing, the Controller's Office is still auditing 114 title and 477 escrow companies in the state; most of the companies are reportedly cooperating and claim the lawsuit is based on a "misunderstanding" of the law.

Commissioner Quackenbush is appealing Alameda County Superior Court Judge Henry E. Needham, Jr.'s June 1998 decision in the consolidated cases of *Spanish Speaking Citizens' Foundation, Inc., et al. v. Chuck Quackenbush*, No. 796071-6, and *Proposition 103 Enforcement Project v. Chuck Quackenbush*, No. 796082-2. In those cases, Judge Needham issued a writ of mandate prohibiting the Commissioner from enforcing section 2632.8, Title 10 of the CCR, a key provision of the Department's so-called "auto rating factors" which imple-

ments Insurance Code section 1861.02(a), a provision added by Proposition 103 in 1988. [16:1 CRLR 155-56] Although the goal of section 1861.02 was to end so-called "territorial rating" or "redlining," whereby insurers base auto premiums primarily on the ZIP code in which the driver resides rather than his/her driving

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safety and experience record, the court found that Commissioner Quackenbush's regulations implementing section 1861.02 permit insurers to heavily weight the location where the vehicle is garaged in setting premiums. Further, Judge Needham found that "contrary to the requirement of Insurance Code section 1861.02(a)(4), respondent's regulations (10 CCR section 2632.1 *et seq.*) do not set forth the respective weight to be given each optional rating factor in determining automobile rates and premiums. Instead, 10 CCR section 2632.8 requires the averaging of all optional rating factors to arrive at a single weight for the optional factors...and the task of assigning 'weight' is delegated to insurers." Judge Needham also noted that the statute requires that each optional factor have a lesser effect on premiums than any of the mandatory factors. "Contrary to the requirements of Insurance Code section 1861.02(a), 10 CCR section 2632.8 permits insurers to use individual optional factors that have a greater impact in the determination of rates and premiums than one or more of the three mandatory factors...." The matter is currently pending before the First District Court of Appeal.