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, 607 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 triennially 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 1,100 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.

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

Commissioner Identifies Communities Underserved by the Insurance Industry in 1995

On March 12, Commissioner Quackenbush released the first of three reports identifying communities that are underserved by insurance companies licensed to do business in California. The report, which identifies communities underserved by the industry in 1995, represents Quackenbush’s first attempt to comply with section 2646.6, Title 10 of the CCR, which was adopted by former Commissioner John Garamendi in 1994 and requires the Insurance Commissioner to collect various categories of data from insurance companies and publish an annual report identifying communities considered to be underserved.

Section 2646.6 was initially proposed by former Commissioner Garamendi as a way to identify and curb the widespread insurance industry practice of “redlining”—the industry’s refusal or failure to sell insurance to low-income residents.
and minority communities. As originally drafted, the regulation would have (among other things) required insurers to annually provide specified information in a “Community Service Statement” to the Commissioner (and authorized the imposition of penalties if they failed to do so), allowed the Commissioner to use that information in considering rate increase applications, required the Commissioner to annually identify communities that are underserved by the insurance industry and to rank insurers by their willingness and ability to serve underserved communities, required low-ranking insurers to develop marketing plans targeting underserved communities, and required each insurer licensed to do business in California to maintain a statewide toll-free telephone number. The Office of Administrative Law (OAL) rejected that version of the rule in 1993, finding primarily that it exceeded the authority of the Insurance Commissioner. [14:1 CRLR 102] OAL finally approved a modified version of the regulation in 1994, but only after striking several subsections which it still found unauthorized. Essentially, OAL ruled that the Commissioner is permitted to collect and publish information from insurers; however, the Commissioner is not authorized to impose any particular service levels or requirements on insurers because—according to OAL—no law requires insurers to offer the same level of insurance services to all communities within the state. [14:4 CRLR 124-25; 14:2 & 3 CRLR 130-31]

As approved by OAL, section 2646.6 requires each insurer that writes in excess of $10 million in any one of ten specified lines of insurance (private passenger automobile liability, private passenger automobile physical damage, homeowners multiple peril, commercial multiple peril liability, commercial multiple peril nonliability, commercial automobile liability, commercial automobile physical damage, dwelling fire, commercial fire, and liability other than automobile) to annually compile and report to the Commissioner an array of information in a Community Service Statement. The section establishes no penalty for failure to report. For each line of insurance, the insurer must include the following information for each ZIP code in every county in California in which it sells insurance or maintains agents: (1) the total earned exposures and total earned premiums, and the total number of exposures new, exposures cancelled, and exposures nonrenewed; (2) the number of offices maintain in the ZIP code during the reporting period; (3) the number of independent, employed, or captive agents or agencies and the number of employed or independent claims adjusters maintaining offices (including home offices) in the ZIP code during the reporting period; (4) for an insurer distributing through direct solicitation, the number of direct mail or telephone solicitations for new insurance business made during the reporting period to addresses in the ZIP code; (5) the number of agents and claims adjusters maintaining offices in the ZIP code who identified themselves as conversant in a language other than English, listed by language; (6) the race or national origin, and gender, of each applicant on a separate detachable form that refers to the application (the form must state that this information is requested by the State of California in order to monitor the insurer’s compliance with the law and that the applicant is not required to provide the information, nor is the insurer permitted to use the information for underwriting or rating purposes); (7) the number of applications received for each of the ten lines of insurance specified above; and (8) the number of applications for which the insurer declined to provide coverage in the ten lines specified above.

From this information, the Commissioner is required to compile an annual report identifying communities which he/she finds to be underserved by the insurance industry. Under subsection 2646.6(c), a community may be 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 “predominantly 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 March 12 report covering 1995 only identifies underserved communities meeting the requirements of subsection 2646.6(c)(1); it does 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 this report, a ZIP code must be two-thirds minority, with a 39% uninsured motorist rate and per capita income less than $17,572.

According to the report, 151 California ZIP codes were underserved in 1995. Eighty-three of them are in Los Angeles County, with an additional eight underserved areas in the neighboring counties of Orange, Riverside, and San Bernardino. The per capita income in all communities identified as
underserved was $10,054. California’s minority populations are concentrated in these underserved communities: While 46% of the state’s population was minority in 1995, 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 65%. While 13% of automobiles were registered in underserved ZIP code areas, only 6% of private passenger auto insurance policies were sold in underserved communities.

The report’s Executive Summary noted that of the larger auto insurers in California, four wrote 7% or more of their auto liability insurance policies in underserved communities: 20th Century (11%), Auto Club of Southern California (8%), Mercury Insurance (8%), and Allstate (7%). Other large insurers were not above the statewide level of insurance sold in underserved communities. Farmers (6%) was at the statewide level, while State Farm (4%), Safeco (4%), and National General (4%) fell below the statewide level.

According to the report, dwelling fire insurance is sold at a much higher rate in underserved communities than is homeowners insurance. The difference between the products is that homeowners insurance covers not only loss due to fire, but also theft and liability. While 16% of California’s population resided in underserved communities, 21.6% of the fire insurance sold in California during 1995 was sold in underserved communities; only 6.62% of homeowners insurance was sold in underserved communities. Approximately 9–10% of all commercial insurance was sold in underserved communities, depending on the type of commercial coverage.

The report also documented a very low response rate to the voluntary race/national origin form that insurers are required to give to applicants. Over 65% of applicants for personal lines and 81% of applicants for commercial lines declined to disclose their race/national origin on the form. Because 1995 was the first year these data were collected, and because DOI expected significant resistance from the applicant population, DOI compared the 1995 non-response data to numbers it has since collected for 1997. These figures indicate that resistance has increased: In 1997, over 69% of applicants for personal lines and 82% of applicants for commercial lines declined to complete the form.

The executive summary noted that the most troubling portion of the 1995 data is in the area of private passenger auto insurance. According to the Commissioner, the data point to the need for a comprehensive effort to include underserved communities in the auto insurance market. Since the issuance of the report, both the Commissioner and the legislature have commenced efforts to lower the uninsured motorist rate (see below and LEGISLATION).

In the executive summary, DOI noted that insurers will probably counter the findings of the report by arguing that they are not responsible for the decisions of some people not to buy insurance. DOI asserted that, while some consumers go without insurance because they cannot afford it, others fail to acquire insurance because they lack adequate information about insurance, and are less trusting of the insurance industry than are those with insurance. The Department suggested that the information void can be filled by insurers, community-based organizations, and the Commissioner.

At this writing, Commissioner Quackenbush intends to release similar reports identifying California communities which were underserved in 1996 and 1997 by the end of 1999.

### Attacking the Uninsured Motorist Problem

DOI, numerous legislators, and consumer advocacy groups are mounting a multi-faceted attack on the problems posed by the significant number of uninsured drivers in California.

Vehicle Code section 16021 currently requires California drivers to “at all times be able to establish financial responsibility” (usually in the form of liability insurance), and Vehicle Code section 4000.37 requires the Department of Motor Vehicles to demand proof of financial responsibility prior to registering or renewing the registration of a vehicle in California. Under Vehicle Code section 16056, the minimum financial responsibility requirements are $15,000 for bodily injury or death for one person as a result of an accident, $30,000 for bodily injury or death for all persons as a result of an accident, and $5,000 property damage as the result of an accident (so-called “15/30/5” coverage). Vehicle Code section 16029 imposes financial penalties for driving without proof of financial responsibility. Ostensibly intended to encourage more drivers to buy insurance, Proposition 213—championed by Commissioner Quackenbush and passed by the voters in 1996—provides that a person who is in a car accident but who does not have automobile insurance may not be compensated for his/her pain and suffering, even if the person was not at fault in the accident (but see LITIGATION).

Despite these laws and the incentives they intend, DOI estimates that approximately 22% of California drivers are uninsured (down from the 29% statewide figure in 1995—see above). Further, several of the above-mentioned financial responsibility laws sunset on January 1, 2000, and many believe they should not be extended unless low-income drivers—many of whom are forced to choose whether to buy auto insurance or feed their children—are offered an affordable alternative such that they can comply with the law.

In mid-February, the Department released a series of reports prepared by its Policy Research Bureau on the uninsured motorist problem in California. DOI’s reports suggest
that the high cost of auto insurance in many areas of the state is a primary reason for the high uninsured rate. One of DOI's reports focused on the average annual premium price paid in 1998 by good drivers for 15/30/5 coverage in the 40 ZIP code zones with the highest uninsured rates, based upon data from five of the top ten insurers in California. In 22 of the 40 ZIP code areas located in Los Angeles, the 50th percentile price paid by consumers varied from a low of $458 to a high of $961. Only 10% of drivers in these areas were able to purchase insurance for $218 or less; 75% paid $618 or less, and 90% paid $848 or less. Thus, with per capita income of approximately $10,000 in these communities (see above), many consumers are required to contribute almost 10% of their annual per capita income to auto insurance in order to comply with the law. A DOI survey of drivers with uninsured vehicles indicated that 58% are interested in a "low-cost/low-coverage" (LCLC) policy, and that 45% of those presently insured with minimum limits coverage would also be interested in a LCLC policy. Thus, policymakers should focus on solutions which would lower the cost of the standard automobile insurance policy—perhaps by lowering the minimum coverages, or by changing the terms of the standard policy to lower the overall risk covered.

However, according to DOI, “motorists' income and the price of insurance explain only about one-half of the variation in the uninsured motorist rate.” While there is a strong correlation between high premiums and an increased uninsured motorist rate, DOI believes some consumers lack adequate information about insurance and have little trust in the insurance industry. According to the Commissioner, uninsured motorists are “more alienated from the insurance system” than insured motorists. Further, while most drivers indicated interest in a LCLC policy, “approximately 24% of uninsured motorists surveyed by DOI expressed no interest in such an alternative, indicating it will be difficult to find a solution for bringing this group into the insurance system.” Thus, “policymakers must address more than the price of insurance by targeting the attitudes of uninsured motorists through a comprehensive outreach effort to underserved communities.”

To address the first aspect of this problem, DOI is sponsoring SB 519 (Lewis), which would retain the 15/30/5 minimum coverage requirement but create a low-cost automobile insurance “mini-policy” that would exclusively cover the named insured, and not other persons who might use the vehicle (see LEGISLATION); DOI believes this restriction could lower the average cost of premiums by 10-15%.

For its part, the legislature is looking for independent actuarial advice on the best way to approach the uninsured motorist problem. Among other things, the legislature plans to seek advice on whether it can mandate lower premium costs for some without causing increases for others, and the impact of reducing the state's current coverage limits in order to lower premium costs. In April, the Senate Rules Committee approved the Senate Insurance Committee's request to hire an outside actuary to assist in the evaluation of legislative proposals regarding low-cost auto insurance. While the actuary's recommendations have not yet been received at this writing, Senators Martha Escutia and Jackie Speier have introduced proposals to reduce both the cost of auto insurance and the minimum coverage requirement (see LEGISLATION). It is likely that several of these bills will be referred to a conference committee later this year. The Davis administration has yet to disclose its position on these evolving bills.

The Battle Is On: Reinstating Third-Party Bad Faith Actions

With the election of Gray Davis as Governor and control of both legislative houses firmly in the hands of the Democrats, Consumer Attorneys of California (CAOC)—the major trade association of plaintiffs’ lawyers—will introduce 1999 legislation authorizing 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. 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 strips the courts of authority to enforce the provisions of the Insurance Code that ban bad faith claims practices by insurance companies, and places 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 settlement practices by insurance companies. In Bourhis v. Gillespie, No. 907349 (1990), San Francisco plaintiffs’ attorney Ray Bourhis charged that DOI and then-Insurance Commissioner Roxani Gillespie “systematically” failed to enforce California insurance laws and
that the Department routinely “destroyed evidence” of violations by insurers. Bourhis alleged that “tens of thousands” of complaints had been filed over the prior 30 years, and that the Department had “never enforced or prosecuted a single...violation in any of those cases.” In December 1990, San Francisco Superior Court Judge John Dearman issued a fairly extraordinary writ of mandate against Gillespie, essentially ordering her to enforce the law which she pledged to enforce when taking her oath of office. Specifically, Dearman held that Gillespie had failed to exercise her discretionary power to prosecute insurance companies that violated the law, and had failed to hold hearings in cases where consumers had registered legitimate complaints against insurers. Dearman ordered Gillespie to prosecute errant insurance companies, and to save consumer complaints against insurers for at least six months. [10:1 CRLR 110; 9:4 CRLR 97] Gillespie appealed.

That same year, the legislature passed SB 2569 (Rosenthal) (Chapter 1375, Statutes of 1990), which added sections 12921.1–.6 to the Insurance Code, requiring the Commissioner to “establish a program on or before July 1, 1991 to investigate complaints and respond to inquiries from [consumers]...and, when warranted, to bring enforcement actions against insurers.” [10:4 CRLR 122]

Shortly after taking office in 1991, Commissioner John Garamendi settled the still-pending Bouris case by agreeing to create a task force to (1) fashion regulations fleshing out the precise practices banned by Insurance Code section 790.03(h), and (2) examine and make recommendations for improving DOI’s enforcement system, pursuant to SB 2569. [11:3 CRLR 126] The 40-member task force was divided into six subcommittees, including a SB 2569 Consumer Complaint Handling Subcommittee. Following a lengthy rulemaking proceeding, the Department’s adoption of sections 2695.1–17, Title 10 of the CCR, was finally approved by OAL in December 1993. Among other things, the 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 practices 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]

Although DOI’s bad faith standards are clearer, whether its enforcement program has substantively improved remains an open question. During his 1998 reelection campaign, Commissioner Quackenbush touted his enforcement record, stating that during his first term as Commissioner, DOI levied fines in the amount of $36 million—six times the amount of fines levied by Garamendi during his term. However, almost one-half of the $36 million derived from a fine against Prudential—a sanction that resulted from an investigation carried out primarily by other states. [16:1 CRLR 148] Further, $36 million in fines levied against an industry which earns billions annually in profits is not exactly deterrent-producing.

At this writing, Senator Martha Escutia intends to amend the trial lawyers’ proposal into her pending SB 1237 (Escutia), to enact the “Fair Insurance Responsibility Act of 2000.” Escutia contends that the Department has failed to prosecute insurers for unfair claims practices and other violations of laws intended to protect policyholders. According to Escutia, from 1995 to 1996, DOI enforcement actions against insurers diminished by more than 50%. She further asserts that although the Department receives about 35,000 consumer complaints annually, only six insurance companies were fined for unfair claims practices in 1998. As amended, SB 1237 will define certain unfair claims settlement practices by insurers, and provide that if an insurer violates any of these standards, a third-party claimant would generally have the right, upon meeting certain conditions, to assert a private right of action, sounding in tort, and seeking all remedies and damages otherwise available in a tort action for breach of the duty of good faith and fair dealing. Escutia and the consumer groups which support the concept assert that without the right to sue, consumers are at the mercy of powerful insurance companies that can use delay and bullying tactics to avoid paying legitimate claims.

As expected, the insurance industry and business community have already registered opposition to the concept of permitting consumers to sue third-party insurers in tort. At this writing, the Davis administration has yet to announce its position on the issue.

**Commissioner Adopts Emergency Regulations Governing Appeals of Workers’ Compensation Disputes**

On February 22, Commissioner Quackenbush adopted 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). Among other things, AB 877 added subsection (c) to section 11753.1 of the Insurance Code, which 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.

Classification matters generally concern disputes about which classification of occupations, employment, and businesses a policyholder has been assigned to either by a workers’ compensation insurer or the designated rating
Update on Other DOI Rulemaking Proceedings

The following is an update on recent DOI rulemaking proceedings described in detail in Volume 16, No. 1 (Winter 1999) of the California Regulatory Law Reporter:

♦ Supplemental Earthquake Coverage. At this writing, DOI's proposal to amend sections 2697.2 and 2697.6, and add new section 2697.61, Title 10 of the CCR, is pending at OAL. This proposal would provide a new "optional-limits basic" residential earthquake insurance policy, to supplement CEA's current "mini-policy." [16:1 CRLR 151] Under the supplemental policy (which CEA participant insurers would not be 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.

♦ Placement of Insurance with Nonadmitted Insurers. On February 24, OAL approved the Commissioner's amendments to section 2174.1-14, Title 10 of the CCR. The new sections replace the Department's former "file and use" regulations applicable to surplus line brokers' use of nonadmitted insurers. Effective January 1, 1995, Insurance Code section 1765.1 was modified to give the Commissioner prior approval of surplus line carriers. Section 1765.1 now requires surplus line brokers to use nonadmitted carriers which have been approved by the Commissioner and placed on a list of eligible surplus line carriers. The amended regulations implement the 1995 statutory scheme. [16:1 CRLR 151]

Insurance Producer Licensing Working Group

On February 12, DOI's Insurance Producer Licensing Working Group issued its final report. The Working Group was convened by DOI in March 1998 to study the state's insurance licensing laws and recommend changes to the legislature and the Insurance Commissioner. DOI formed the Working Group in response to the introduction of five insurance licensing bills in 1998 (AB 1887 (Keeley), AB 2164 (Wayne), SB 1447 (Burton), SB 1633 (Johnson), and SB 2169 (Lewis)). The bills' authors agreed not to move forward with their legislation until after the Working Group had conducted its study and offered final recommendations. Following a series of six meetings, the Working Group released a December 1998 draft report and recommendations related to licensing requirements in the areas of credit insurance, rental car companies, motor car dealers, and Internet advertising of insurance products. [16:1 CRLR 151-52] The February 12 final report indicated no changes to those recommendations. However, the final report does include a description of "areas without consensus." Particularly with regard to marketing insurance products on the Internet, Working Group
members could not agree on whether certain terms (including solicitation, negotiation, effectuation, commission, and enrollment) should or should not be defined in the Insurance Code.

The Working Group also explored the subject of direct writers and whether statutory change is needed at the present time. Under section 35 of the Insurance Code, an insurance company’s certificate of authority permits “transacting insurance.” Members of the Working Group representing agents and brokers advocated a full licensure requirement for all persons transacting insurance whose activities include selling, soliciting, negotiating, advising, or counseling regarding the terms, benefits, or premiums of an insurance policy, or procuring or effecting insurance. Some members stated that no change to current law is needed, while others offered numerous hybrid alternatives to full licensure. The Working Group did not achieve consensus in this area and decided that further meetings and discussions are warranted.

Finally, some members of the Working Group raised as an area for further study the sale of health care service plans or HMO products. Neither the Insurance Code nor the Health and Safety Code (which contains the Knox-Keene Health Care Service Plan Act under which most health plans are regulated) contains a licensure requirement for persons who sell HMO products. Due to the fact that this issue contemplates regulatory implications outside DOI’s jurisdiction, the Department will work with the interested parties and the Department of Corporations outside the context of the Working Group to further discuss this issue.

**Commissioner Continues Push to Secure Restitution for Holocaust Survivors**

For the past year, Commissioner Quackenbush has been participating in an effort by the National Association of Insurance Commissioners (NAIC) and the International Holocaust Commission (IHC) to secure payment of insurance claims on behalf of Holocaust survivors and heirs residing in California. [16:1 CRLR 152–53]

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 countless untold others murdered in concentration camps during the Holocaust. As a result, many Holocaust victims 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 IHC 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.

In 1998, then-Governor Wilson signed two bills important to the effort. SB 1530 (Hayden) (Chapter 963, Statutes of 1998) allocated $4 million to DOI for the purpose of developing and implementing a coordinated approach to resolving the outstanding claims of Holocaust victims. Among other things, the bill directs DOI to work with the NAIC and other national and international entities involved with documenting or resolving Holocaust claims, and requires the Commissioner to suspend the certificate of authority (after full procedural due process) of any insurer that is failing to pay legitimate claims. 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. Further, AB 1334 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.

Two important developments related to those bills have recently occurred. First, in January, a Los Angeles County Superior Court upheld its AB 1334 jurisdiction over a bad faith insurance case against an Italian life insurance company, against a challenge that AB 1334 is unconstitutional because it subjects the company to the jurisdiction of a California court although it does little business in the state (see LITIGATION).

On April 30, Commissioner Quackenbush unveiled his plan to utilize the funds provided by SB 1530. Joined by Governor Davis, Attorney General Bill Lockyer, Treasurer Phil Angelides, Senator Hayden, Assemblymember Knox, and two Holocaust survivors, Quackenbush announced a multifaceted program to achieve payment of legitimate Holocaust-era claims. The Commissioner plans to mail letters to all insurance companies that do business in California, requesting that they inform DOI whether they, or any of their present or former affiliated companies, issued policies in Europe prior to World War II, and whether they will participate in the work of the IHC. The Commissioner has also formed a California Holocaust Insurance Settlement Alliance, a coalition of 28 groups and individuals who will mount an outreach effort to help identify Holocaust survivors and heirs who might be entitled to insurance restitution. As part of the outreach program, Quackenbush will publish print advertisements in 30 general circulation newspapers and Jewish publications throughout the state; send letters and restitution application forms to thousands of Holocaust survivors and heirs.
statewide; offer a toll-free number (888-CDI-INFO) dedicated solely to potential Holocaust insurance claimants; and update DOI’s Website to include a claim form for survivors and heirs, the history of Holocaust insurance restitution efforts, and information on companies that have failed to pay Holocaust insurance claims. Quackenbush vowed to “continue this fight until every legitimate claim is paid.”

LEGISLATION

SB 171 (Escutia), SB 527 (Speier), AB 976 (Cardoza), SB 519 (Lewis), SB 944 (Johnson), and SB 652 (Speier) would attack the uninsured motorist problem in California (see MAJOR PROJECTS):

♦ SB 171 (Escutia), as amended April 28, would require all insurers that participate in the California Automobile Assigned Risk Plan (CAARP) to also participate in a plan established by the Insurance Commissioner to offer a Lifeline Automobile Insurance Policy with an initial price of $300 or $400, depending upon a driver’s record, with 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 bill, sponsored by the Foundation for Taxpayer and Consumer Rights, would allow the purchase of this policy by California drivers 19 years of age or older, who are low-income residents (defined as those with household incomes up to 150% of the federal poverty level). A Lifeline Automobile Insurance Policy would not be available for purchase by any person who has a felony or misdemeanor conviction on his/her driving record pertaining to a violation of the Vehicle Code as recorded by the Department of Motor Vehicles.

The insurance industry opposes SB 171, contending that “the concept of a ‘flat-rate’ insurance policy ignores traditional principles of cost-based pricing and California law.” According to the industry, the cost of a policy in Chico is significantly lower than the cost of a policy in Los Angeles. A flat rate results in consumers paying too much in rural areas (thus violating California law prohibiting excessive rates) while the rate in Los Angeles will be too low (thus violating California law prohibiting inadequate rates). [S. Appr]

♦ SB 527 (Speier), as amended April 28, would establish a low-cost automobile insurance plan within CAARP, and would require insurers that participate in CAARP to also participate in the low-cost insurance plan. The bill would create two types of “10/20/3” low-cost automobile insurance policies: a “preferred driver A” policy and a “preferred driver A policy,” depending upon the driving record of the insured. SB 527 would limit the availability of either policy to persons with household incomes up to 200% of the poverty level, and would make it a misdemeanor to misrepresent income eligibility. [S. Appr]

♦ AB 976 (Cardoza), as amended April 20, would enact the California Low-Cost Auto Insurance Policy Act of 1999, 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. This bill is sponsored by the insurance industry, which claims that low-income drivers who may now be uninsured would be able to purchase an insurance policy costing at least 30% less than a standard minimum auto insurance policy. The bill’s sponsors and supporters contend that AB 976 would make a low-cost policy available without increasing costs for other insured drivers, and without unfair subsidies. [A. Ins]

♦ SB 519 (Lewis). Existing law generally provides that a policy covering an owned or leased vehicle affords coverage to the named insured as well as any to other person using the vehicle with the express or implied permission of the insured and within the scope of that permission, with limited exceptions. As introduced February 18, this bill would authorize an insurer to issue a policy of automobile insurance that exclusively covers 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 would retain the existing 15/30/5 minimum coverage requirements.

SB 519 is sponsored by DOI because “existing law does not permit the full range of automobile insurance policies that could benefit California motorists.” According to DOI, creating a low-cost automobile insurance “mini-policy” will lower premiums by 10–15% and increase both the affordability and availability of insurance coverage for economically disadvantaged drivers. DOI also argues that unlike a mandated low-cost insurance policy, the mini-policy created by SB 519 would not require middle-income drivers to pay higher insurance premiums in order to subsidize low-market rates for low-income drivers.” [S. Ins]

♦ SB 944 (Johnson), as introduced February 25, 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]

♦ SB 652 (Speier), as amended April 5, would—among other things—extend indefinitely the requirement that every applicant for renewal of a motor vehicle registration provide proof of financial responsibility; and authorize the Department of Motor Vehicles to suspend, cancel, or revoke vehicle registration when false evidence of financial responsibility is provided. [S. Jud]

SB 1237 (Escutia), as introduced February 26, would prohibit an insurer from discriminating against any injured party with a claim against a policy of insurance on the basis of the claimant’s race, national origin, religious affiliation, age, gender, or sexual orientation. As noted above (see MAJOR PROJECTS), Senator Escutia plans to amend SB 1237 to incorporate language which will 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 to sue another person’s insurance company in tort for
committing unfair claims settlement practices barred by Insurance Code section 790.03(h). [A. Jud]  

SB 622 (Speier), as introduced February 24, would establish a statutory definition of the term “inception of the loss” for purposes of earthquake insurance policies, and provide that no action for a loss caused by an earthquake may be commenced more than ten years after the date of the earthquake causing the loss. Specifically, SB 622 would provide that in the case of loss arising out of the hazard of earthquake, “inception of loss” means earthquake damage that has been sufficiently manifested so that a reasonable insured would be on notice of a potentially insured loss. The bill also provides that if an insured has complied with the notification requirements in the policy, any applicable period of limitations would be tolled until the insurer denies the claim in writing.  

Section 2071 of the Insurance Code, 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, in statute, define the term “inception of the loss.” 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. To take advantage of the benefits of a delayed discovery rule, however, the insured is required to be diligent in the face of discovered facts. The more substantial or unusual the nature of the damage discovered by the insured (e.g., the greater its deviation from what a reasonable person would consider normal wear and tear), the greater the insured’s duty to notify his insurer of the loss promptly and diligently.”  

According to the author and the Department, some insurers are denying their contractual obligations by denying claims for earthquake damage that are made by insureds more than twelve months after an earthquake. They argue that SB 622 does not establish new law and that, therefore, no contractual rights are impaired. Furthermore, the provisions of SB 622 are not retroactive; insurers already know that they are to pay these claims but are simply denying legitimate claims despite the law.  

The insurance industry opposes SB 622 for a variety of reasons, arguing that the bill will increase the cost of earthquake insurance, create a “fuzzy standard” for determining when loss occurs and that an earthquake alone should trigger a policyholder’s duty to make a claim, and have the effect of reopening hundreds of thousands of claims from the Northridge earthquake that have been properly closed. Of significance, the industry argues that SB 622 is unconstitutional because of its retroactive action upon contracts. [S. Ins]  

AB 964 (Aroner), as amended on April 27, would require the California Earthquake Authority (CEA), on or before July 1, 2000, to issue a report to the legislature on the status of the CEA’s Residential Retrofit Program. The Program was established on a pilot program basis in two counties in 1998, using CEA investment income, and entails homeowner referral to a pre-qualified engineering firm that inspects the home and determines what weaknesses can be corrected through retrofitting. Next, the homeowner is referred to a pre-screened contractor, who performs the work called for in the engineering report. The program is open to all homeowners who meet the criteria, including non-CEA homeowners. Currently the program is available to homeowners with wood-frame homes built prior to 1979 without pre-existing earthquake, water, or pest damage in Santa Clara and Ventura counties. CEA Residential Retrofit Loans have an interest rate of 5% for non-CEA policyholders and 4.75% for CEA policyholders. All CEA policyholders are eligible to a 5% discount upon completion of the retrofit.  

AB 964 would also delete the termination date of the Earthquake Mediation Program which was established in DOI to mediate disputed claims arising out of the Northridge earthquake. Currently, the program has a sunset date of January 1, 2000. [A. Appr]  

AB 1453 (Assembly Insurance Committee), as introduced on February 26, would delete the termination date of DOI’s Earthquake Mediation Program, thereby extending the mediation program indefinitely. [S. Ins]  

AB 481 (Scott), as introduced February 18, would require DOI to survey the earthquake preparedness of California’s K-12 public school system and report its findings to the legislature by December 31, 2001. [A. Appr]  

AB 600 (Knox), as introduced February 19, would require the Commissioner to establish and maintain the Holocaust Insurance Registry, which would 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 (see MAJOR PROJECTS). This bill would require those
insurers to file or cause to be filed that information with the Commissioner to be entered into the registry. It would also require those insurers to provide certain additional information under penalty of perjury, and would provide for certain civil penalties for knowingly filing false information about a policy, as required by these new provisions. The bill would appropriate these civil penalties from the general fund to DOI to be used to aid in the resolution of Holocaust insurance claims. [A. Appr]

AB 845 (Maddox), as amended April 20, is a DOI-sponsored bill that would authorize 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 would be 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 would permit 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. [A. Appr]

AB 1455 (Committee on Insurance), as introduced February 26, would require DOI—on or before July 1, 2000—to conduct a study of closed claims that provides the same kinds of information as the August 1990 study, Automobile Claims: A Study of Closed Claim Payment Patterns in California, prepared by the Statistical Analysis Bureau. The study must consist of a statistical closed claim study of automobile insurance claims closed during 1998, and must identify the component costs of claims, including but not limited to type of coverage and type of claims expense. The study must identify the factors affecting claims costs for each county as well as statewide. [A. Appr]

AB 749 (Hughes), as amended April 27, would create a new type of production agency license, called a rental car insurance limited license, which would authorize a rental car company to offer insurance to its customers if the insurance is offered by a representative of the licensee, and if the insurance is sold as part of a vehicle rental transaction in which the insurance charges are itemized in the rental agreement. An outgrowth of DOI's Insurance Producer Licensing Working Group (see MAJOR PROJECTS), SB 749 would require a licensee to maintain the name of each rental car representative, and to file all training materials used to train those representatives, with the Insurance Commissioner. It would authorize the Commissioner to take certain remedial measures for violations of these provisions and to adopt rules and regulations necessary to administer these provisions. [S. Floor]

AB 1456 (Scott), as amended April 29, would establish a standard of a target 60% loss ratio for all lines of credit insurance, including life, disability, involuntary unemployment, and property; and promulgate regulations adopting the new rates by January 1, 2001. [A. Appr]

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 on April 5, would instead require each insurer to pay an annual fee of $1.50 for each vehicle it insures for these purposes. The bill would additionally require each insurer to pay an additional fee of 50 cents for each vehicle it insures to fund certain DOI operations. [S. Appr]

AB 591 (Wayne), as amended April 7, would require health care service plans and certain disability insurers to cover health care costs associated with clinical trials. The bill would require insurers to cover these costs if the treatment is being provided for a life-threatening condition, or is related to the detection or treatment of cancer, and there is no clearly superior, non-investigational treatment alternative. The bill would require health plans and insurers to report annually to the appropriate commissioner relative to enrollees or insureds that were covered in this regard. AB 591 would require the Commissioner of Corporations and the Insurance Commissioner to prepare a joint annual summary report compiling the submitted plan and insurer information for submission to the legislature. [A. Appr]

SB 374 (Lewis). Existing law creates the California Insurance Guarantee Association and the California Life and Health Insurance Guarantee Association, which are associations established to insure the obligations of insurers that become insolvent. Existing law also sets forth priorities for payment of claims from assets of insolvent insurers, including certain claims made by these associations, but excluding certain categories of claims that are not covered claims for the purposes of payment by those associations. As introduced February 11, this bill would provide that these exclusions do not apply to guaranteed investment contracts, guaranteed interest contracts, funding agreements, deposit administration contracts, and certain unallocated annuity contracts that the California Life and Health Insurance Guarantee Association is not obligated to cover. [S. Appr]

SB 820 (Sher and Bowen), as amended April 15, would enact the Electronic Transactions Act, which would generally apply to all electronic transactions (including online insurance transactions) except to the creation and execution of wills and testamentary trusts and certain other transactions. The bill would provide that a record or signature may not be denied legal effect or enforceability solely because it is in electronic form. If a law requires a record to be in writing, or provides consequences if it is not, an electronic record would
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satisfy the law. If a law requires a signature, or provides consequences in the absence of a signature, the law would be satisfied with respect to an electronic record if the electronic record included an electronic signature. The bill would authorize the provision of written information by electronic record. The bill would set forth provisions governing changes and errors, the effect of electronic signatures, and admissibility into evidence. [S. Jud]

AB 374 (Cunneen), as amended April 27, 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. The term "digital signatures" is defined as electronic means to allow a person to apply a certifiable signature to an electronic document, just as a person would apply an ink signature to a paper document; verify that a party has in fact digitally signed a document or to establish and verify that a party could not have possibly signed the electronic document; and ensure that an electronic document has not been altered after a digital signature was applied to it. The phrase "public-key infrastructure" is defined as the collection of computer systems and policies to ensure the integrity of processes used for management and verification of digital signatures. If signed, the bill would become operative on July 1, 2001. [A. Appr]

LITIGATION

On January 25, Los Angeles County Superior Court Judge Florence-Marie Cooper rejected a challenge to the court's jurisdiction over a bad faith case against an Italian life insurance company for its failure to pay a claim arising from an insurance policy purchased in 1929 by a Hungarian man who perished at Auschwitz (see MAJOR PROJECTS). Stern v. Generali, No. BC185376, was brought under Civil Code section 354.5, recently added by AB 1334 (Knox) (Chapter 43, Statutes of 1998), which vests jurisdiction in such cases in California superior courts and gives Holocaust survivors and heirs until 2010 to file such claims. Through its local counsel, the life insurance company, Generali Assicurazioni, argued that it is unfair to subject it to California court jurisdiction because it maintains no offices in the state. Plaintiff's attorney presented evidence that the company has filed suit in California courts on at least a dozen occasions, and that it has conducted millions of dollars in business with California clients since it was admitted to sell insurance in 1929. Based on these facts, Judge Cooper concluded that "Generali has continuing and substantial contacts with California, sufficient to satisfy due process." The company has indicated that it will appeal Judge Cooper's ruling.

In Montes v. Gibbens, 71 Cal. App. 4th 982 (Apr. 29, 1999), the Second District Court of Appeal somewhat limited the reach of Proposition 213, an initiative enacted by the voters in 1996. Among other things, Proposition 213 added section 3333.4 to the Civil Code, which provides that uninsured persons involved in auto accidents may not recover noneconomic damages (pain and suffering), regardless of fault. Louis Montes was driving his employer's uninsured motor vehicle while in the course and scope of his employment, and was involved in a traffic accident with Thomas Gibbens, who was entirely at fault. Montes suffered numerous physical injuries. During arbitration and in superior court, Montes was awarded his medical costs and lost wages, but was denied non-economic damages because they were deemed barred by section 3333.4. On appeal, the Second District reversed, finding that "if the rationale for Proposition 213 is to 'encourage more uninsured drivers to buy auto insurance,' its application to [Montes'] case is off target as it is difficult to see how denying an employee noneconomic damages when involved in an accident operating his or her employer's motor vehicle will encourage the employer to buy motor vehicle insurance."

In UNUM Life Insurance Company of America v. Ward, 526 U.S. 358 (Apr. 20, 1999), the U.S. Supreme Court unanimously ruled that an insurer may not deny a claim for health benefits filed beyond the company's deadlines unless the insurer can show it suffered actual prejudice from the delay. The decision upholds California's "notice-prejudice rule" as a "law which regulates insurance," and thus outside the pre-emption provision of the federal Employee Retirement Income Security Act (ERISA).

Commissioner Quackenbush is appealing Alameda County Superior Court Judge Henry E. Needham, Jr.'s June 23, 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 implements 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 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.

On March 17, the California Supreme Court declined to review the Second District Court of Appeal's decision in *Arthur Andersen LLP v. Superior Court (Charles Quackenbush, Real Party in Interest)*, 67 Cal. App. 4th 1481 (Nov. 24, 1998). In that matter, the Second District held that certified public accountants owe a duty to the Insurance Commissioner to adequately disclose the financial condition of insurance companies, and may be liable to the Commissioner (as liquidator on behalf of the company's policyholders and creditors) for negligently-prepared audits of insurance companies. *Bily v. Arthur Young & Company*, 3 Cal. 4th 370 (1992), limits CPA liability for negligently-prepared audits to those with whom the CPA has privity of contract and certain other persons "who act in reliance upon those misrepresentations in a transaction which the auditor intended to influence." The Second District determined that the Insurance Commissioner—to whom audits of insurance companies must be submitted and who has the statutory responsibility of monitoring insurance companies to ensure their ability to pay insurance claims—"is within the universe of persons to whom an auditor in [Andersen's] position may be liable for negligent misrepresentation in an audit report pursuant to...Bily." The Second District decided only the legal issue of whether Andersen owed a duty to the Commissioner under *Bily*, not whether Andersen was negligent in auditing Cal-American's financial statements; that issue has been remanded for trial in superior court.

### Public Utilities Commission

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The California Public Utilities Commission (PUC) was created in 1911 to regulate privately-owned utilities and ensure reasonable rates and service for the public. Today, under the Public Utilities Act of 1951, Public Utilities Code section 201 et seq., the PUC regulates more than 470 privately-owned and operated gas, electric, telephone, water, sewer, steam, and pipeline utilities, as well as 4,300 truck, bus, railroad, light rail, ferry, and other transportation companies in California. The Commission grants operating authority, regulates service standards, and monitors utility operations for safety.

It is the duty of the Commission to see that the public receives adequate services at rates which are fair and reasonable both to customers and utility shareholders. Overseeing this effort are five commissioners appointed by the Governor with Senate approval. The commissioners serve six-year staggered terms.

The Commission has quasi-legislative authority in that it establishes and enforces administrative regulations, some of which are codified in Chapter 1, Title 20 of the California Code of Regulations (CCR). The Commission also has quasi-judicial authority; like a court, it may take testimony, subpoena witnesses and records, and issue decisions and orders. The PUC's Administrative Law Judge (ALJ) Division supports the Commission's decisionmaking process; PUC ALJs preside over evidentiary and other types of hearings and forward recommended decisions to the Commission, which makes all final policy, procedural, and other decisions. In its decisionmaking, the Commission attempts to balance the public interest and need for reliable, safe utility services at reasonable rates with the need to ensure that utilities operate efficiently, remain financially viable, and provide stockholders with an opportunity to earn a fair return on their investment. The PUC encourages ratepayers, utilities, consumer, and industry organizations to participate in its proceedings.

PUC staff—which include economists, engineers, ALJs, accountants, attorneys, administrative and clerical support staff, and safety and transportation specialists—are organized into twelve major divisions and offices, including industry-specific divisions addressing energy, telecommunications, rail safety and carriers, and water. The Commission's Consumer Services Division attempts to resolve consumer complaints regarding utility service, safety, and billing problems; its various branches provide consumers with information, analysis, conflict resolution, and advocacy services to help them make intelligent decisions about utility purchases. The San Francisco-based Public Advisor's Office and the Commission's outreach offices in Los Angeles and San Diego provide procedural information and advice to individuals and groups who...