receiving complaints and inquiries about plans. *[A. Inactive File]*

**AB 2649 (Woodruff)**. Existing law requires a licensed HCSP, within thirty days after any change in the information contained in its application for licensure, other than financial or statistical information, to file an amendment thereto in the manner the Commissioner of Corporations may by rule prescribe setting forth the changed information. As amended May 4, this bill would, instead, authorize a licensed plan to give written notice to the Commissioner annually, as provided, of specified changes. *[S. InsCl&Corps]*

**AB 3749 (Margolin)**, as amended April 14, would require all HCSPs and policies of disability insurance to provide coverage for screening, diagnosis, treatment of, and surgery for cervical cancer and cervical dysplasia, as well as a screening test for cervical cancer and sexually transmitted disease. The bill would also require all HCSPs and policies of disability insurance to provide coverage for contraceptive management and methods and preconception care management. An employer that is a religious organization, or an insurer that is a subsidiary of a religious organization, would not be required to offer coverage for forms of contraception that are inconsistent with the religious organization's religious and ethical principles. *[A. Floor]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at pages 99–100:

**SB 930 (Killea)**, as introduced March 4, 1993, and **SB 469 (Beverly)**, as amended September 10, 1993, would—among other things—enact the California Limited Liability Company Act, authorizing a limited liability company to engage in any lawful business activity; set forth the duties and obligations of the managers of a limited liability company; and establish requirements and procedures for membership interests in limited liability companies, including voting, meeting, and inspection rights. SB 469 is expected to be amended to prohibit law firms from forming limited liability companies, in light of concerns over how such arrangements would affect the financial responsibility of law firm partners in legal malpractice claims. *[A. Rev&Tax; A. Rev&Tax]*

**AB 1057 (Conroy)**. Existing law requires applicants for an escrow agent's license to file, and escrow agents to maintain, a bond. Under existing law, an applicant or licensee may obtain an irrevocable letter of credit approved by the Commissioner of Corporations in lieu of the bond. As introduced March 2, 1993, this bill would instead permit an applicant or licensee to obtain an irrevocable letter of credit in a form which shall be approved by the Commissioner in lieu of the bond. The bill would also provide that the Commissioner shall be entitled to recover the administrative costs that are specific to processing claims against irrevocable letters of credit. *[S. BC&IT]*

**AB 1031 (Aguiar)**. Existing law requires licensed escrow agents to annually submit to the Commissioner of Corporations an audit report containing audited financial statements covering the calendar year. As amended May 17, this bill would provide that if the independent accountant who was engaged to complete those reports and financial statements resigns or is dismissed, the licensed agent must so notify the Commissioner. The bill would also require the independent accountant to submit a copy of the report and statements at the same time that a copy is submitted to the licensed escrow agent. *[S. BC&IT]*

**AB 1125 (Johnson)**, as amended April 12, 1993, would require the Commissioner to conduct an inspection and examination of a new escrow agent licensee within six months of licensure. The costs of the inspection and examination would be paid by the licensee to the Commissioner. *[S. BC&IT]*

**AB 1923 (Peace)**. Existing state law provides for the disclosure of certain account charges and deposit information relative to savings associations, credit unions, and industrial loan companies. As amended April 7, this bill repeals those provisions in deference to recent federal regulatory changes. This bill was signed by the Governor on May 9 (Chapter 68, Statutes of 1994).

**AB 2306 (Margolin)**, as amended May 19, 1993, would add to the acts that constitute grounds for HCSP disciplinary action the failure of a plan to correct prescribed deficiencies identified by the Commissioner. *[S. InsCl&Corps]*

**AB 2002 (Woodruff)**, as amended January 26, is no longer relevant to the Department of Corporations.

The following bills died in committee: **AB 1533 (Tucker)**, which would have reduced the maximum charge which check cashers may impose for cashing a payroll check with identification from 3% to 1% and without identification from 3.5% to 1.5%, or $3, whichever is greater; **SB 719 (Craven)**, which would have provided that no specialized HCSP that provides or arranges for dental services shall request reimbursement for overpayment or reduce the level of payment to a provider based on the fact that the provider has entered into a contract with any other HCSP for participation in a supplemental dental benefit plan that has been approved by the Commissioner; **SB 1118 (Rogers)**, which would have exempted any offer of a security for which an offering statement under Regulation A of the Securities Act of 1933 has been filed but has not yet been qualified; and **SB 666 (Beverly)**, which would have specifically required the Commissioner to adopt rules containing specified requirements to implement existing law which permits certain securities to be qualified by permit if the application is a small company application and meets certain requirements.

## LITIGATION

At this writing, the California Supreme Court is reviewing the Second District Court of Appeal's decision in ***People v. Charles H. Keating***, 16 Cal. App. 4th 280 (1993). In its ruling, the Second District affirmed a jury verdict in which the former savings and loan boss was found guilty of defrauding 25,000 investors out of $268 million by persuading them to buy worthless junk bonds instead of government-insured certificates. *[12:2&3 CRLR 169]*

In his appeal (No. S033855), Keating primarily challenges the trial court's jury instructions stating that Keating could be convicted under theories that he was either the direct seller of false securities in violation of Corporations Code sections 25401 and 25540, or a principal who aided and abetted the violations. Keating was convicted on 17 counts, all violations of sections 25401 and 25540. The major issue raised by Keating is whether aiding and abetting of a section 25401 crime statutorily exists; Keating claims that criminal liability is restricted to direct offerors and sellers, and that the evidence failed to prove he personally interacted with any of the investors. The Supreme Court unanimously voted to hear Keating's appeal of his state conviction, for which he received a ten-year prison term and a $250,000 fine. However, even if his state conviction is set aside by the court, Keating must serve a twelve-year term in federal prison based on his January conviction by a federal jury for racketeering, conspiracy, and fraud. *[13:4 CRLR 110]* At this writing, the matter has been fully briefed; the court has not yet scheduled oral argument.

# DEPARTMENT OF INSURANCE

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Insurance is the only interstate business wholly regulated by the several states,

rather than by 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 12931 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 insurers to sell in the state.

In California, the Insurance Commissioner licenses approximately 1,300 insurance companies which carry premiums of approximately $63 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 170 different fees levied against insurance producers and companies.

The Department also performs the following functions:

(1) 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) grants or denies security permits and other types of formal authorizations to applying insurance and title companies;

(3) 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) establishes rates and rules for workers' compensation insurance;

(5) preapproves rates in certain lines of insurance under Proposition 103, and regulates compliance with the general rating law in others; and

(6) 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 800 employees and is headquartered in San Francisco. Branch offices are located in San Diego, Sacramento, and Los Angeles. The Commissioner directs 21 functional divisions and bureaus.

The Underwriting Services Bureau (USB) is part of the Consumer Services Division, and handles daily consumer inquiries through the Department's toll-free complaint number. It receives more than 2,000 telephone calls each day. Almost 50% of the calls result in the mailing of a complaint form to the consumer. Depending on the nature of the returned complaint, it is then referred to Claims Services, Rating Services, Investigations, or other sections of the Division.

Since 1979, the Department has maintained the Bureau of Fraudulent Claims, charged with investigation of suspected fraud by claimants. The California insurance industry asserts that it loses more than $100 million annually to such claims. Licensees currently pay an annual assessment of $1,000 to fund the Bureau's activities.

## MAJOR PROJECTS

**New Commissioner to Run DOI in 1995.** Commissioner John Garamendi—the state's first elected Insurance Commissioner—is currently seeking the Democratic nomination for the office of Governor in the 1994 election. Those seeking to replace Garamendi as Insurance Commissioner include Democrats Art Torres, currently chair of the Senate Committee on Insurance, Claims and Corporations, and Burt Margolin, currently chair of the Assembly Health Committee; and Republicans Jim Conran, who recently resigned after three years as Director of the Department of Consumer Affairs, Assemblymember Charles Quackenbush, and Wes Bannister, an insurance agent who was the Republican nominee in 1990. At this writing, the primary is scheduled for June 7.

**DOI Focuses on Redlining Issue.** For the past three years, Commissioner Garamendi and DOI staff have been concerned with the widespread industry practice of "redlining" (the refusal or failure to sell insurance to low-income and minority communities), and have attempted to fashion regulatory mechanisms which will enable the Insurance Commissioner to detect and sanction redlining and promote the opposite behavior, which is colloquially referred to as "greenlining." In this regard, DOI has primarily focused on a major rulemaking proceeding to adopt regulations designed to curb redlining in auto, homeowners', fire, and some commercial lines of insurance. However, the Office of Administrative Law (OAL) has thwarted total fulfillment of DOI's goal by disapproving the anti-redlining regulations in November 1993, and only approving parts of them in April 1994; the Commissioner's petition for review of OAL's recent disapproval is currently pending in the Governor's office (*see below* for a detailed discussion of these regulations).

Recently, DOI has expanded its anti-redlining focus to other activities, including the following:

• ***Redlining Hearings.*** On April 15 in Los Angeles and April 18 in Oakland, Commissioner Garamendi and U.S. Representative Joseph P. Kennedy III, chair of the House Subcommittee on Consumer Credit and Insurance and author of a tough federal anti-redlining bill, presided over public hearings and received testimony from individuals and businesses who have been harmed by alleged insurance company discrimination based on geographical location, race, gender, sexual orientation, or other illegal rating factors. Over 200 people attended each of the hearings, many of whom presented testimony.

At the hearings, owners of South Central Los Angeles businesses destroyed in the April 1992 riots testified that the commercial insurance policies they were forced to purchase from a Caribbean-based company due to domestic insurer redlining were worthless because the company was illegally selling policies in California. Their testimony reflected a theme which was repeated consistently throughout the hearings: Very few licensed insurers sell policies to those who live or work in low-income or minority communities; the few who do have a *de facto* monopoly on the provision of insurance and have inflated their premiums beyond the community's ability to pay; and members of the community thus have two options—go uninsured and hope nothing happens, or purchase policies from questionable companies and hope they are still in business and willing to fulfill their obligations when something happens. Insurance industry representatives contended that the problem is not redlining but affordability. Because low-income neighborhoods often have higher crime rates and other risks, premiums must rise commensurate with those statistical risks.

• ***1994 Auto Insurance Survey.*** In conjunction with the hearings, DOI released a survey which dramatically illustrates the impact of ZIP code within a region on insurance rates. For example, a 19-year-old male who has two years of driving experience and logs 15,000 miles per year would pay $1,852 for auto insurance if he lives in the Norwalk area of Los Angeles,

$2,321 if he lives in Pasadena, $2,721 if he lives in Pacific Palisades, $4,063 if he lives in South Central Los Angeles, and $4,192 if he lives in Silver Lake/Echo Park. A married couple with two late-model cars—who each drive 12,000 miles per year, each have one speeding ticket, and who have a 17-year-old son who occasionally drives one of their cars—would pay $4,528 if they live in Norwalk, $4,928 if they live in Pasadena, $6,164 if they live in Pacific Palisades, $8,349 if they live in South Central Los Angeles, and $8,731 if they live in Silver Lake/Echo Park. A 65-year-old driver who drives 7,500 miles annually and has no violations would pay $531 if he lives in Norwalk, $597 if he lives in Pasadena, $727 if he lives in Pacific Palisades, $1,057 if he lives in South Central Los Angeles, and $1,068 if he lives in Silver Lake/Echo Park.

• ***Greenlining Hearings***. Following the redlining hearings and OAL's approval of a portion of DOI's anti-redlining regulations (*see below*), the Department's strategy has taken a new twist. On May 23, DOI plans to hold "greenlining" hearings in an attempt to persuade insurers to switch from overseas investment to investing in California's cities. DOI has invited bankers, insurance company executives, and minority investors and entrepreneurs to the hearings in an attempt to open lines of communication. This effort was given a boost on May 6, when Commissioner Garamendi and the Farmers Insurance Group announced a joint effort to increase the number of policies the company sells in traditionally underserved areas. Under its initial five-year plan, Farmers says it will pursue methods to increase the presence of inner-city agents, expand its minority media advertising, adopt and publicize a company toll-free line, and take other measures to market to underserved parts of California.

• ***Regulations to Prohibit Redlining in Surety Insurance***. On April 8, DOI published notice of its intent to adopt new section 2646.7, Title 10 of the CCR, which is patterned after DOI's generic anti-redlining regulations (*see below*) but which focuses specifically on surety insurance. Surety bonds are required in order to obtain a contractor's license and for construction projects. Specifically, the new regulations would require surety insurers to annually compile and report to the Commissioner specified information related to the number of applications received and granted for surety bonds for construction projects, the total number of surety bonds for construction projects provided to minority-owned firms, the total dollar amount of surety bonds issued for construction projects generally and for minority-owned firms. The Commissioner will compile these data on an annual basis and make the data on each surety insurer available for public inspection. The regulations define the term "minority" to mean American Indian or Alaskan Native, Asian or Pacific Islander, African-American, or Latino. At this writing, DOI is scheduled to hold a public hearing on these proposed regulations on May 23 in Oakland.

**OAL Approves Parts of DOI's Anti-Redlining Regulations**. Following OAL's November 1993 rejection of section 2646.6, Title 10 of the CCR, which seeks to establish standards designed to curb redlining in specific lines of insurance, the Commissioner addressed the issues cited by OAL and resubmitted the rulemaking file on March 9.

Three years in the making, section 2646.6 (as submitted to OAL) would require insurers to annually provide specified information to the Commissioner about their record of service to underserved communities; allow the Commissioner to use that information in considering rate change applications; require the Commissioner to annually identify communities which are "underserved by the insurance industry" and report on services provided by insurers to underserved communities; require the Commissioner to rank insurers by willingness and ability to serve underserved communities; require lower-ranked insurers to develop marketing plans targeting underserved communities; require insurers which decline to provide coverage in an underserved area to provide a statement of reasons to applicants; and require insurers to maintain and advertise a statewide toll-free telephone number.

In its original rejection, OAL primarily concluded that the Commissioner lacks the authority to adopt the anti-redlining regulations, and that he is erroneously interpreting several provisions of the Insurance Code which prohibit "discrimination" in the offer or sale of specified insurance policies and numerous other state statutes as authorizing him to address racial or ethnic discrimination. On this and many other issues, OAL agreed with the insurance industry that these statutes authorize the Commissioner to address not racial discrimination but price discrimination ("[w]hat is prohibited by the term 'unfairly discriminatory' is discrimination between groups of insureds with like loss experience..."). *[14:1 CRLR 102; 13:1 CRLR 83–84; 12:4 CRLR 145–46]*

On April 20, OAL released a new "approval in part/disapproval in part" decision in which it severed particular phrases and provisions which found to be objectionable, and then approved the remainder of the regulation as fashioned by OAL. Critics—including the Insurance Commissioner—contend this practice is unlawful. They argue that the Administrative Procedure Act permits OAL to approve or disapprove a regulation in its entirety; nothing in the APA permits OAL to rewrite a regulation and then approve it. *[7:4 CRLR 10–11]* In 1987, OAL was sued over another "approval in part/disapproval in part" decision in which it similarly struck subsections of a lengthy regulation adopted by the Board of Chiropractic Examiners and then approved it as modified by OAL; after four years of litigation and negotiations, however, the case was settled without reaching that particular issue. *[11:3 CRLR 182–83]*

Generally, OAL disapproved specific portions of section 2646.6 which it found to establish or impose an obligation on the part of insurers to provide a particular level of service to a particular community. OAL argued that no provision of law establishes such an obligation; according to OAL, "the level of service provided to a particular community is governed by the operation of the normal insurance market" (with specified exceptions). Although OAL recognized that the Commissioner is authorized "to adopt regulations reasonably necessary to enforce existing statutes that prohibit unlawful discrimination in the issuance of insurance," it struck any provision that it deemed to "establish[] an obligation to provide a particular level of service throughout the state or to a particular community."

Specifically, OAL approved the following portions of section 2646.6, which become effective on May 20:

• Subsection (a) requires insurers to annually submit specified information in a "Community Service Statement," and will enable the Commissioner to know which carriers are providing services to underserved communities; however, OAL struck the last sentence of subsection (a), which set forth penalties for violating the reporting requirements.

• Subsection (b) describes the types of information which must be annually submitted by insurers in their Community Service Statement; however, OAL struck subsection (b)(3), which would have required (among other things) insurance offices to be open at least 37.5 hours per week.

• Subsection (c) requires the Commissioner to annually compile the information in all insurers' Community Service Statements and report to the public those communities (by ZIP code) which the Commissioner finds to be underserved by

the insurance industry. The provision states that a community may be deemed underserved in three ways: (1) the proportion of uninsured motorists is ten percentage points above the statewide average; 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; (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; 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.

• Subsection (d) requires any insurer who declines to provide coverage to any applicant in an underserved community to provide a written statement specifying the reason(s) the insurer declined the application; the statement must disclose the telephone number of DOI's toll-free complaint hotline.

• Subsection (e) (formerly subsection (i)) requires insurers to include in their Community Service Statements the number and percentage of existing policies insuring risks in underserved communities and in all other communities; the number and percentage of offices maintained in the underserved communities and in all other communities; and, for insurers who advertise principally through direct solicitation, the number and percentage of direct mail and telephone solicitations for new insurance business made to addresses in the underserved communities and in all other communities.

• Subsection (f) (formerly subsection (j)) permits the Commissioner to introduce the information collected pursuant to these regulations in any proceeding conducted by DOI to determine whether an insurer's rates are unfairly discriminatory or otherwise in violation of Chapter 9, Part 2, Division 1 of the Insurance Code.

OAL struck the following provisions:

–former subsection (e), which would have required the Commissioner to consider the information in an insurer's Community Service Statement in reviewing rate applications filed by that insurer;

–former subsection (f), which would have set forth the weighting to be applied to the data submitted by insurers on the Community Service Statement, as well as the provisions for ranking each insurer on the Commissioner's "Community Service Index" (*see below*);

–former subsection (g), which would have required insurers to submit specified information about the race and gender of its top management, and its contracting and marketing practices regarding minority groups;

–subsection (h), which would have required the Commissioner to analyze the data submitted under subsection (a) and develop a public "Community Service Index" or ranking of how well each insurer provides insurance services to underserved communities, and required low-ranking insurers to develop a five-year marketing plan designed to increase the number of policies in underserved communities; and

–subsection (k), which would have required each insurer to maintain a statewide toll-free telephone number.

On May 5, Commissioner Garamendi filed a petition with the Governor's Office, seeking a reversal of OAL's disapproval of the rejected portions of section 2646.6. Among other things, the Commissioner argued that numerous state statutes (including the Unruh Civil Rights Act) affirmatively require businesses to make their goods and services available to consumers on a nondiscriminatory basis and clearly authorize the Insurance Commissioner to both identify illegal discrimination and "tak[e] measures best calculated to eradicate it." In response to OAL's theory that no law requires insurers to provide a particular level of service to any particular community, the Commissioner asserted that "the regulations do not require a level of service above or beyond that level which insurers are already providing on a *discriminatory* basis, but merely create a framework for the *uniform* provision of *the same* insurance services to *all* communities within the state" (emphasis original).

On May 10, OAL filed a response to DOI's petition, again arguing that "[t]he Commissioner's expansive reading of statutes that prohibit unlawful discrimination is clearly wrong." According to OAL, "[t]he Unruh Civil Rights Act does not require uniform provision of the same insurance services to all communities within the state. Unruh does not prohibit a business from discriminating between and among its customers or potential customers based upon legitimate business reasons, such as economic factors." OAL again opined that "[t]he Commissioner's interpretation that Unruh or Insurance Code section 679.71 requires the same level of insurance services to all communities within the state...alters or amends or enlarges the scope of the Unruh Civil Rights Act and Insurance Code section 679.71," and reiterated its finding that "the parts of rule 2646.6 that embody this interpretation are void."

At this writing, the Commissioner's petition and OAL's response are pending at the Governor's office, awaiting his decision.

**DOI Explores Other Insurance Availability Issues.** During the spring and early summer, DOI investigated the availability and affordability of other lines of insurance, including the following:

• ***FAIR Property Insurance.*** On February 17, the Department held an investigatory hearing on the California Fair Access to Insurance Requirements (FAIR) Plan, which was established by the legislature soon after the Watts riots. FAIR is a nonprofit insurance pool established to assure the availability of basic property insurance to persons who, after diligent effort, have been unable to obtain insurance through normal channels. The California FAIR Plan Association consists of all insurers admitted to conduct property insurance in California. Each such insurer shares in the financial responsibilities generated by the Plan, in the same proportions as its "premiums written" to aggregate "premiums written" by all insurers in the Plan. The Plan is administered by a governing committee of nine voting insurer-members and four non-voting miscellaneous members appointed by the Governor.

The Commissioner specifically requested testimony from consumers and insurers on the issues of premium subsidization (if any) by the unaffected market; notice to insureds regarding new coverages; discounts for fire hazard mitigation; the assessment and credit system; claims settlement practices; and training methods for agents, brokers, and adjusters. At this writing, DOI staff is compiling and analyzing the comments received, and may make recommendations for legislative and/or regulatory changes to the California FAIR Plan.

• ***Non-Automobile Lines of Insurance.*** Last fall, DOI held a series of hearings on the availability of several types of non-automobile insurance, including commercial liability, surety, and homeowners' insurance, professional malpractice insurance for midwives, contractors insurance, and environmental insurance. *[14:1 CRLR 104]*

In January, DOI released a summary entitled *Report on the Availability and Affordability of Non-Automobile Lines of Insurance in California for 1993.* In this report, the Department summarized its findings from hearings on the availability of commercial, contractors, homeowners, and surety insurance, and professional malpractice insurance for midwives. Although

many commenters at the hearings expressed concerns about race-based redlining and presented anecdotal evidence of unavailability and unaffordability of all the lines of insurance under scrutiny, the only line designated as unaffordable and unavailable in California under Insurance Code section 1857.9 is malpractice insurance for midwives. In the hospital setting, lay and nurse midwives must have malpractice insurance in order to maintain hospital privileges and, in order to obtain malpractice insurance, they must have a physician present at each hospital delivery. Physicians are not always able or willing to supervise midwives for a number of reasons (including exposure to additional malpractice liability for the supervision). Insurance carriers which issue malpractice coverage to supervising physicians frequently add a surcharge for the extra coverage which is passed on to the midwife; one midwife testified that she had to pay $9,000 for her own coverage and another $8,000 for her supervising physician's surcharge—all in a year in which she earned $30,000 as a midwife.

According to the Commissioner, "as untenable a situation as this may seem, it is even worse when it comes to insurance for home births." DOI reports that only one admitted carrier writes policies which cover home births; premiums range from $12,000–$13,000 per year and policies are limited to midwives whose practice does not exceed 5% home births.

Consequently, DOI designated insurance for midwives as unaffordable and unavailable pursuant to Insurance Code section 1857.9; this designation will require insurers to report premium and loss data for this line of insurance to the Department, which will enable the Commissioner to undertake an economic and, to some degree, an actuarial analysis of this market.

In April, the Department released another report called *Availability and Affordability of Environmental Liability Insurance for Hazardous Waste Facilities*. In its report, DOI noted that state law requires the Department of Toxic Substances Control (DTSC), before it issues or renews a permit to operate a hazardous waste facility, to ensure that the owner or operator of the facility establishes and maintains financial assurance and responsibility for compensating third parties for damages that might arise from the operation of the facility. The DOI investigative panel generally found that hazardous waste control laws have created the need for more hazardous waste transport, storage and disposal (TSD) facilities. Large TSD facilities exist, but their services are too expensive for small-quantity waste generators; thus, small TSD companies are needed. However, the cost of environmental insurance remains prohibitive for small businesses (most policies have minimum limits of $1 million at a premium of $15,000–$25,000), and this unaffordability is exacerbated by the fact that environmental liability insurance is offered by only a handful of admitted carriers. Therefore, small businesses, at this time, will need to rely on alternative coverage mechanisms in order to satisfy DTSC's financial responsibility requirements; these coverage mechanisms include letters of credit and certificates of deposit. DOI encouraged DTSC to investigate the viability of alternative noninsurance mechanisms that will satisfy the financial responsibility requirement, and suggested that the legislature consider establish a market assistance program or a joint underwriting authority to substitute for the absent marketplace.

• ***Homeowners' and Earthquake Insurance***. On May 6, the Department announced its scheduling of a public investigative hearing concerning the availability of homeowners' and earthquake insurance. Insurance Code sections 10081–10089.3 require insurers to offer earthquake coverage with every homeowners' policy. As a result of the devastating January 17 Northridge earthquake, however, DOI believes that insurers are either refusing to write new homeowners' and/or earthquake business; are substantially restricting the new business they write in either one or both of these lines; or are neither renewing nor writing any business in either one or both of these lines. DOI's notice came none too soon; on May 11, 20th Century Insurance Group—the fourth largest writer of earthquake policies in southern California—announced it must triple its earthquake insurance rates or withdraw entirely from the homeowners'/earthquake market. Similar announcements from other carriers are expected to follow. At this writing, another public hearing is scheduled for May 24 in Los Angeles.

**Rulemaking Proceeding and Public Investigative Hearing to Develop Proposition 103 Auto Rating Factors and Good Driver Discount Regulations**. On January 27 in San Francisco, DOI held a hearing in Phase II of its current rulemaking proceeding to adopt permanent regulations (sections 2632.1–2632.16, Title 10 of the CCR) establishing and defining the factors (and their relative weights) which insurers may consider in setting auto insurance rates (including good driver discount rates) under Proposition 103. The proposed regulations under consideration contain four alternatives for determining the weight which may and should be accorded to rating factors in setting rates and premiums. The alternatives (which are set forth in proposed section 2632.6) vary from general requirements which leave the methodology to an insurer's discretion, to methodologies which define the term "variance" and specify the manner in which variance must be modified, if necessary. *[14:1 CRLR 101–02; 13:4 CRLR 111–12]*

At this writing, Department staff is compiling and analyzing the comments made, and plans to republish the final version of DOI's proposed auto rating factors for a full 45-day comment period. DOI's implementation of Proposition 103 appears to have been placed on the back burner pending the California Supreme Court's decision in *20th Century Insurance Company v. Garamendi* (*see* LITIGATION).

In the meantime, OAL reapproved (for the eleventh time) DOI's emergency adoption of sections 2632.1–2632.18, Title 10 of the CCR, on March 17. These interim emergency regulations—which have been in effect since August 1990 and will apparently remain in effect until the Commissioner completes the ongoing rulemaking proceeding—define relevant statutory terms used in both the auto rating factor and good driver discount provisions of Proposition 103, set forth the additional factors which may be used by insurers to determine auto insurance rates, specify the weight which may be assigned to those additional factors in determining rates, and set guidelines for determining a driver's status as a good driver.

**DOI to Publish Regulations on Telephone Quote Accuracy and Availability**. In response to comments made at last October's public investigative hearings on the high percentage of inaccurate quotes for private passenger automobile coverage *[14:1 CRLR 101; 13:4 CRLR 112–13]*, DOI is currently drafting regulations to address this problem. Staff anticipates that the regulations will be released for public comment this summer.

**Minimum Reserve Standards for Disability Insurance**. On April 15, DOI published notice of its intent to adopt new Article 3.5 (sections 2310–15), Title 10 of the CCR, which will establish specific minimum reserve standards for disability insurance. The ability of insurers to fulfill obligations under their contracts depends upon the establishment of adequate reserves. Without minimum standards, it is more likely that insurers may underprice products and fail to set aside adequate amounts in reserves for future claims to

gain market share; according to the Commissioner, that practice imperils their claims-paying ability and perhaps their solvency. Insurance Code section 10489.1 *et seq.* establishes minimum reserve standards for life insurance; Insurance Code section 10489.95 requires the Commissioner to establish similar standards for disability insurance.

The proposed regulations will set minimum reserve standards, inform insurers of the tests that will be used by the Commissioner to determine whether reserves are adequate; list the elements that will be taken into account; set forth various actions which may be taken when inadequacy is found; provide for situations that are exceptions to the general rule; and name the three categories of reserves and require adequacy in each category.

At this writing, DOI is not scheduled to hold a public hearing on these proposed regulations, but is accepting written comments on them until May 31.

**Other DOI Rulemaking.** The following is a status update on other DOI rulemaking proceedings covered in detail in recent issues of the *Reporter*:

• ***DOI Establishes Maximum Prima Facie Rates for Credit Life and Credit Disability Insurance.*** On April 18, the Commissioner announced his adoption of amendments to sections 2248–2248.20, Article 6.7, Title 10 of the CCR, and the adoption of new Article 6.8 (sections 2248.30–.47), Title 10 of the CCR; this regulatory action establishes maximum prima facie rates for credit life and credit disability insurance policies, pursuant to AB 2107 (Connelly) (Chapter 32, Statutes of 1992). *[14:1 CRLR 102–03]* Although the regulations became effective on May 14, they will not be enforced until November 10. Since this rulemaking pertains only to the fixing of rates, it is exempt from the timeframe requirements of the Administrative Procedure Act (APA) under Government Code section 11343(a)(1) and from review by OAL.

• ***Licensing of Insurance Claims Analysis Bureaus.*** On March 16, OAL rejected DOI's proposal to adopt new section 2698.30–.36, Title 10 of the CCR, to implement Insurance Code section 1871 *et seq.* regarding the licensure of insurance claims analysis bureaus (CABs) to assist the public, regulators, law enforcement, prosecutors, and insurers in suppressing and preventing insurance claims fraud. *[14:1 CRLR 103; 13:4 CRLR 113]* OAL found that DOI failed to establish necessity for most of the proposed provisions; some of the provisions fail to satisfy the clarity standard in Government Code section 11349.1; the Commissioner lacks authority to impose some of the proposed requirements; and DOI failed to comply with the procedural requirements of the Administrative Procedure Act. DOI has 120 days in which to cure the deficiencies cited by OAL and resubmit the regulations for review and approval.

• ***Rulemaking to Establish Special Investigative Units.*** On May 3, OAL approved DOI's adoption of new sections 2698.40–.45, Title 10 of the CCR; these regulations define the duties, function, and role of the special investigative units (SIUs) which each admitted insurer is required to maintain. SIUs investigate suspected fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds. Among other things, SIUs are required to cooperate with DOI's Fraud Division and other law enforcement agencies and authorized governmental agencies to assure compliance with the Insurance Code, and to provide a prompt response to requests made in the course of any criminal or civil investigation. *[14:1 CRLR 103–04; 13:4 CRLR 113]*

• ***Rulemaking to Implement AB 1672 (Margolin).*** On April 28, DOI readopted emergency regulations to implement AB 1672 (Margolin) (Chapter 1128, Statutes of 1992), which became effective on July 1, 1993. AB 1672, which added sections 10198.6–.9 and 10700–10749 to the Insurance Code, dramatically restructured California's market for health insurance for employees of "small employers." Emergency sections 2233–2233.99 (nonconsecutive), Title 10 of the CCR, define key terms in the statute, clarify existing ambiguities in the law, and attempt to bring as many sources of health coverage as possible within the jurisdiction of AB 1672. These emergency regulations also reflect changes to AB 1672's small employer provisions (Insurance Code sections 10700–10718.6) made by bills enacted during 1993. *[14:1 CRLR 104; 13:4 CRLR 113–14; 13:2&3 CRLR 132–33]* The emergency regulations are effective for another 120-day period.

• ***Life Insurance Disclosure Regulations.*** On April 28, OAL approved DOI's repeal of sections 2545–2545.5 and adoption of new sections 2546–2546.8, Title 10 of the CCR, which require sellers of life insurance to adhere to new disclosure requirements to enable consumers to more readily compare the costs and benefits of life insurance policies. *[13:4 CRLR 114; 13:2&3 CRLR 131]*

• ***CAARP Coverage for Good Drivers.*** On April 5, OAL approved DOI's adoption of section 2632.14.3, Title 10 of the CCR. This rulemaking action implements AB 2605 (Peace) (Chapter 1255, Statutes of 1992), which provides that an insurer which refuses to issue a good driver discount policy to an eligible good driver must state its refusal in writing and provide the applicant with a certificate of eligibility authorizing the applicant to obtain private passenger automobile liability coverage through the California Automobile Assigned Risk Program (CAARP). *[13:2&3 CRLR 131–32]*

**Intervenor Compensation Rates.** Last fall, DOI conducted a survey and requested written comments on how to determine the "market rates" of attorneys who represent consumer interests in certain DOI proceedings; under regulations adopted by DOI in 1993, these attorneys and their expert witnesses—if they make a substantial contribution to the Commissioner's adoption of any order, regulation, or decision—may be awarded "intervenor compensation" at market rates, defined as "the average billing rates of comparable attorneys, advocates or experts in Los Angeles and the San Francisco Bay Area." Initially, DOI set "market rates" by placing a cap on intervenor compensation fees at $195 per hour, but that scheme was invalidated by San Francisco Superior Judge Stuart Pollak in *Minority/Low-Income/Consumer Coalition v. Garamendi*, No. 942151 (June 1993); Judge Pollak instructed DOI to abandon the cap and devise a new way to determine "market rates." *[14:1 CRLR 104–05; 12:2&3 CRLR 171; 12:1 CRLR 119]*

On March 10, Judge Pollak approved the Commissioner's use of what he calls a "blended rate," which is calculated by adding the fees attorneys would get for the hours worked at their desired hourly rates and then dividing that figure by the total number of attorney hours. According to the Attorney General's Office, the Commissioner prefers this method because it enables him to avoid assessing the worth of individual attorneys. While acknowledging that use of the blended rate will create unusual incentives for use of staff resources within intervenor groups and will not yield (or even approach) the rates paid by the insurance industry to its lawyers, Judge Pollak held that it is "reasonable" and within the Commissioner's discretion.

**State Auditor Determines That DOI Cannot Identify Its Costs for Implementing Proposition 103 and Performing Examinations.** On April 6, the Bureau of State Audits (BSA) released its financial audit assessing whether certain fees levied by DOI against licensees under Insurance Code sections 12979 and 736 were based on DOI's actual costs of enforcing Proposition 103 and conducting

examinations of insurance companies. The audit also reviewed whether the actual costs of Proposition 103 implementation and DOI's examination activities exceeded the revenues from the fees or whether the fees exceeded the costs. The audit focused on fiscal year 1992–93.

BSA reported that although DOI could separately identify revenues from fees collected to cover the costs of implementing Proposition 103, it could not separately identify the associated costs of enforcement. Further, DOI was unable to document the costs of its examinations of insurance companies. According to BSA, DOI did not design its accounting system to distinguish the expenditures for Proposition 103 from the costs of performing other regulatory activities; further, DOI could not provide a reliable alternative methodology for identifying Proposition 103 costs.

BSA determined that because DOI could not identify the costs related to the enforcement of Proposition 103 and its examination of insurance companies, DOI may be overcharging or undercharging insurance companies for Proposition 103 examinations. BSA noted that, overall, DOI has collected more in revenues for operations than it has needed to cover operating costs. In fact, DOI had sufficient resources not only to pay for the costs of its regulatory activities, but also to lend over $20 million to other funds during fiscal year 1992–93.

In response to BSA's audit, DOI noted that when Commissioner Garamendi assumed office in 1991, "he found not only that substantive programmatic areas had been inadequately addressed by previous commissioners, but also that the Department's infrastructure was inadequate for the magnitude of the programs it needed to support." Specifically, DOI observed that had the Department's computerized accounting system been updated in 1988 when major program increases resulting from Proposition 103 took effect, DOI would have been able to prevent the problems cited in BSA's report. The Department noted that it has already redesigned its accounting system and that it is implementing a staff time/activity reporting system, which will enable DOI to calculate the actual cost of services and validate the amount of its fees and rates. The new reporting system is scheduled to be implemented by July 1.

## LEGISLATION

**SB 1395 (Leslie)**, as amended May 17, is a direct outgrowth of BSA's audit of DOI's Proposition 103 enforcement activities (*see above*). As amended May 17, this bill would require DOI to adopt an accounting system that will allow it to accurately identify costs incurred for specified regulatory activities and to link the costs to fees collected for those regulatory activities; require DOI to determine the actual cost of providing each examination, and the cost of implementing Proposition 103, and to set fees based on actual costs; require DOI to provide a schedule of fees and justification to specified entities; and require BSA to complete an audit of the schedule of fees to determine if the fees are equal to the actual cost of providing each regulatory activity. *[S. Appr]*

**SB 1452 (Kopp)**. Existing law requires the written consent of the Attorney General prior to the employment of counsel for representation of any state agency or employee in any judicial proceeding. There is an express exception provided to specified state agencies and to the Insurance Commissioner with respect to certain delinquency proceedings. As amended May 17, this bill would delete the exception provided to the Commissioner, remove the specific authority of the Commissioner to employ counsel in connection with delinquency proceedings, and provide that the Attorney General has the authority to appoint and employ any legal counsel that he/she deems necessary to assist the Commissioner in the performance of his/her duties. This bill would require the Attorney General, upon request of the Commissioner, to petition the court for determination in the event the Commissioner and the Attorney General disagree as to the need to employ counsel outside of state service or the compensation of that counsel. DOI opposes this bill. *[S. Appr]*

**AB 3586 (O'Connell)**. Existing law requires the Insurance Commissioner to disseminate complaint and enforcement information on individual insurers to the public, including the ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. *[11:3 CRLR 126–27; 10:4 CRLR 122]* As introduced February 25, this bill—which is sponsored by Mercury Casualty Insurance—would require that private passenger automobile insurance ratios be calculated as the number of complaints received to total car years earned in the period studied. *[S. InsCl&Corps]*

**AB 2601 (Johnson)**, as introduced January 27, would require the Commissioner to promulgate a regulation setting forth the criteria that DOI will apply to determine if a consumer complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer. This bill would also require the Commissioner to provide to the insurer a description of any complaint against the insurer that the Commissioner has received and has deemed to be justified at least thirty days prior to public release of a report. *[S. InsCl&Corps]*

**AB 3570 (Isenberg)**, as amended April 7, would provide that when a judgment for punitive damages is entered against a defined insurer on or after January 1, 1995, the plaintiff shall, within ten days, provide the Insurance Commissioner or the Commissioner of Corporations, as specified, with a copy of the judgment, a brief recitation of the facts of the case, and copies of relevant pleadings as determined by the plaintiff. Under the bill, willful failure to comply with this provision would subject the plaintiff or his/her attorney to sanctions at the discretion of the trial court. This bill would require the Insurance Commissioner and the Commissioner of Corporations to adopt regulations that, to the maximum extent practicable, guarantee that awards for punitive damages entered against insurers are not paid for, directly or indirectly, by policyholders or enrollees. *[A. Fluor]*

**AB 3751 (Margolin)**, as amended May 18, would create the Insurance Fraud Civil Penalties Account in the Insurance Fund for the deposit of moneys collected by DOI, to be used solely for the investigation and prosecution of insurance fraud. *[A. W&M]*

**AB 2890 (Statham)**. Under existing law, where two or more policies affording valid and collectible liability insurance apply to the same motor vehicle, it is conclusively presumed that the insurance afforded by the policy in which the motor vehicle is described or rated as an owned automobile is primary and the insurance afforded by any other policy or policies is excess. As amended May 12, this bill would provide that where two or more policies affording liability insurance that apply to the same motor vehicle in an occurrence out of which a liability loss shall arise, and one policy is primary and one or more policies are excess, then the insurer issuing the policy that is primary shall provide the defense until the policy limit of the primary policy has been exhausted by payments, or the insurer issuing the policy that is primary offers in settlement the full amount of its policy limits. It would provide that, upon notice from the primary insurer that its duty to defend has ended, as specified, the excess insurers shall provide the defense. If they refuse to do so, the primary insurer would provide the defense but would be entitled to recover costs and interest from the excess insurers. *[S. InsCl&Corps]*

**SB 1381 (Torres)**. Under existing law creating the California FAIR Plan (*see above*), insurers who voluntarily write commercial property insurance or basic property insurance on risks located in areas designated as brush hazard areas by the Insurance Commissioner will, to that extent, be proportionately relieved of the liability to participate in the Plan. As amended April 21, this bill makes similar provision for insurers who voluntarily write basic property insurance or business owners package insurance on risks located in areas designated as inner-city areas by the Commissioner. The bill would additionally require the Commissioner to develop by July 1, 1995, a pamphlet which provides information to small business owners and others on the key features of, and suggested ways of, purchasing commercial property insurance. *[A. Ins]*

**AB 3568 (Margolin)**. Existing law requires the offer of earthquake insurance coverage to disclose certain information, including any deductible related to earthquake damage. As amended May 5, This bill would provide that every policy of residential property insurance covering individually owned condominium units for loss or damage from earthquakes shall disclose specified loss assessment coverage information. *[A. Floor]*

**AB 3569 (Margolin)**, as amended April 26, would authorize the Insurance Commissioner, when a state of emergency is declared, to issue an order to all insurers writing property insurance prohibiting the cancellation or nonrenewal of policies except for nonpayment of premium or fraud. *[A. W&M]*

**AB 3682 (Margolin)**. Existing provisions of law, which will become operative on January 1, 1995, prohibit workers' compensation insurance rates that impair or threaten the solvency of an insurer or create a monopoly, and provide for the filing of rates with the Insurance Commissioner. As amended April 26, this bill would also require the Commissioner to disapprove a filing if the rates are unfairly discriminatory. *[A. W&M]*

**AB 1880 (Bates)**. Existing law requires all employers to provide for the payment of workers' compensation benefits to employees for injuries arising in the course of employment, and also provides for a system of unemployment disability compensation to injured employees for nonindustrial accidents. As amended January 14, this bill would establish a system of comprehensive compensation in lieu of participation in workers' compensation and unemployment disability programs. Participation would be voluntary with employers and employees. The system would provide for the payment of health benefits and lost income for injuries, without regard to whether the injury was job-related.

Under existing law, the State Compensation Insurance Fund may insure an employer against certain specified liabilities. This bill would provide that the Fund may also insure an employer against his/her liability occurring within the state for comprehensive coverage pursuant to this system of comprehensive compensation.

The bill would permit health care service plans (HCSPs), nonprofit hospital service plans, and disability insurers to offer these plans but would require licensure by the Insurance Commissioner. *[S. IR]*

**SB 1910 (Greene)**, as amended May 17, would require HCSP contracts, disability insurance policies, and nonprofit hospital service plan contracts issued, amended, delivered, or renewed in this state on or after January 1, 1995, that provide health or dental coverage under an employer-sponsored plan to employees over 60 years of age and their dependents, to make the same coverage available to those employees and their dependents, after the employee's separation from employment and until he/she reaches 65 years of age, at no more than 102% of the applicable group rate.

This bill would further require public and private employers to counsel employees who are 60 years of age or older, and who are covered by an employer-sponsored health or dental plan, or both, prior to the separation of that employee from employment regarding the availability and cost of health coverage. *[S. Appr]*

**AB 3749 (Margolin)**, as amended April 14, would require all HCSPs and policies of disability insurance to provide coverage for screening, diagnosis, treatment of, and surgery for cervical cancer and cervical dysplasia, as well as a screening test for cervical cancer and sexually transmitted disease. The bill would also require all HCSPs and policies of disability insurance to provide coverage for contraceptive management and methods and preconception care management. An employer that is a religious organization, or an insurer that is a subsidiary of a religious organization, would not be required to offer coverage for forms of contraception that are inconsistent with the religious organization's religious and ethical principles. *[A. Floor]*

**SB 1832 (Bergeson)**, as amended May 17, would require certain HCSPs to permit women enrollees to seek obstetrical and gynecological physician services directly from an obstetrician and gynecologist under terms and conditions as may be agreed upon between the contractholder and the plan. This bill would provide that the terms and conditions of the plan contract shall not discriminate against obstetricians and gynecologists as primary care physicians relative to other physicians designated as primary care physicians.

This bill would prohibit certain disability insurers, a HCSP, or a nonprofit hospital service plan that authorizes a specific type of treatment by a provider from rescinding or modifying this authorization after the provider renders the health care service in good faith and pursuant to the authorization.

Among other things, this bill would, with certain exceptions, prohibit the release of any information by certain disability insurers, a HCSP, or a nonprofit hospital service plan to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider that are covered by the plan, unless authorized to do so by the employee.

This bill would state the intent of the legislature to establish standards for disability insurers and HCSPs to use in assessing claims and requests for authorization of services. This bill would require DOI and the Department of Corporations (DOC) to jointly establish a cost-benefit panel to consider whether particular procedures, services, drugs, or devices may be excluded from coverage by HCSP contracts or disability insurance policies because they are considered experimental or not medically necessary or appropriate. *[S. Appr]*

**AB 3571 (Margolin)**, as introduced February 25, would state the intent of the legislature to establish standards for disability insurers and HCSPs to use in assessing claims and requests for authorization of services. This bill would require DOI and DOC to jointly establish a cost-benefit panel to consider whether particular procedures, services, drugs, or devices may be excluded from coverage by HCSP contracts or disability insurance policies because they are considered experimental or not medically necessary or appropriate. *[A. W&M]*

**AB 3572 (Martinez)**, as amended April 25, would require HCSP contracts, disability insurance policies providing coverage for hospital, medical, and surgical benefits, and nonprofit hospital service plan contracts issued, amended, delivered, or renewed in this state on or after January 1, 1995, to provide coverage for the participation of an enrollee, insured, or subscriber in a clinical trial that meets certain criteria. This bill would further require HCSPs, disability insurers, and nonprofit hospital service

plans to approve and provide reimbursement for the patient care costs, as defined, of participation of an enrollee, insured, or subscriber who gives voluntary informed consent to participate in an approved clinical trial. *[A. Floor]*

**AB 3260 (Bornstein)**, as amended April 26, would require a HCSP, disability insurance policy, or nonprofit hospital service plan whose terms require binding arbitration to settle disputes and restrict, or provide for a waiver of, the right to a jury trial, to include a specified disclosure. This bill would require any HCSP, disability insurance policy, or nonprofit hospital service plan that includes a term requiring binding arbitration in case of a medical malpractice claim or dispute to provide for the selection of a neutral arbitrator. This bill would authorize a petition to be filed with the court to appoint an arbitrator in certain instances. In the case of HCSPs, this bill would limit the requirement for selection of a neutral arbitrator to cases or disputes involving $50,000 or less. In the case of disability insurers and nonprofit hospital service plans, it would expressly prohibit waiver of these requirements.

Existing law requires certain judgments against specified licensed health care professionals by a court to be reported by the clerk of the court to the appropriate licensing agency. This bill would require an arbitration under a HCSP contract for any death or personal injury resulting in an award for an amount in excess of $30,000 to be a judgment for purposes of the above-described provision of law. *[A. W&M]*

**SB 1388 (Russell)**. Existing law provides that a certificate of authority to transact insurance shall not be issued to any insurer owned, operated, or controlled, directly or indirectly, by any other state, or province, district, territory, or nation, or any governmental subdivision or agency thereof. However, the ownership or financial control, in part, of an insurer by any other state of the United States, or by a foreign government, or by any political subdivision or agency of a state or foreign government, does not restrict the Insurance Commissioner from issuing, renewing, or continuing in effect the license of that insurer to transact in this state the kinds of insurance business for which that insurer is otherwise qualified under the provisions of existing law and under its charter provided the insurer has satisfied the Commissioner that it meets specified standards. As amended April 14, this bill would delete the general prohibition and authorize partial ownership or financial control provided that the insurer complies with all other requirements for issuance, renewal, or continuation of a license and unless the Commissioner finds that the insurer has violated specified prohibitions. The bill would also provide that the failure to submit requested information to the Commissioner constitutes grounds for denial of an application. The bill would also state legislative intent. *[S. Floor]*

**SJR 36 (Russell)**, as introduced February 10, would memorialize the United States Congress to adopt appropriate resolutions encouraging the states to adopt interstate compacts for the regulation of interstate insurance, and to consent to the adoption of those compacts. *[A. Ins]*

**SB 1355 (Torres)**, as amended May 17, would enact the Homeowners' Bill of Rights to require, among other things, insurers selling or renewing homeowners' insurance to identify if the following coverages are offered: guaranteed replacement coverage for structures, stated value coverage for structures, depreciated value coverage for structures, contents coverage, additional living expenses coverage, liability coverage, and landscape coverage, as specified. It would require insurers to notify a policy applicant that a sample policy is available upon acceptance of policy application. Beginning January 1, 1996, it would require every person employed or contracted by an insurer to perform the service of a claims adjuster in any loss exceeding 10% of the value of insured property to be licensed by DOI if the adjuster regularly performs claims adjustment services in this state, except as provided for out-of-state adjusters in specified circumstances. The bill requires that policyholders be informed as to whether the policy is issued by an insurer licensed to do business in California, and requires DOI to establish minimum standards for the adjustment of a loss. Specified information regarding rejection for, or changes in, specified types of insurance policies would be required to be reported to the insured, who would be given an opportunity to respond.

Existing law sets out a California Standard Form Fire Insurance Contract which, among other things, provides in the event of loss that the insured must provide certain information, and must submit to an examination under oath conducted by the insurer. This bill would, with respect to an examination of an insured by an insurer under oath as to "requirements in case loss occurs" and other provisions, specify rights of the insured. The bill would also require the Insurance Commissioner to establish a task force of a maximum of 12 individuals, as specified, to review and propose amendments to the existing Standard Form Fire Insurance Contract, on or before March 1, 1995, and would state that these provisions are in effect until June 30, 1996, and as of that date are repealed. DOI would be required to only pay direct travel expenses of the members. The bill would also revise certain provisions contained in the Standard Form Fire Insurance Contract with respect to actual cash value of property, policy cancellation, and requirements in case loss occurs, as specified.

The bill would require insurance agents and brokers issuing policies of homeowners' insurance to complete continuing education classes, and require DOI to develop a simple, uniform format for declarations pages of homeowners' policies.

Existing law provides that if a loss is not rebuilt or replaced, an insured covered by a valued policy shall receive either the replacement value of the loss or the face amount of the policy, whichever is less. This bill would instead provide that the insured receive the replacement value of the loss or the face amount of the policy, whichever is specified on the policy. *[S. Floor]*

The following is a status update on bills reported in detail in CRLR Vol. 14, No. 1 (Winter 1994) at pages 105–08:

**AB 2128 (W. Brown)**. Insurance Code section 790.03 prohibits certain acts or practices in the business of insurance that constitute unfair methods of competition or are unfair or deceptive. As introduced June 2, 1993, this bill would require any person engaged in the business of insurance to act in good faith toward current and prospective policyholders and other persons intended to be protected by any policy of insurance. Reversing the California Supreme Court's decision in *Moradi-Shalal v. Fireman's Fund Insurance Companies, 46 Cal. 3d 287 (1988) [8:4 CRLR 87], and reinstating the so-called "Royal Globe"* cause of action, this bill would authorize third-party claims against an insurer or licensee for violation of specified laws and regulations prohibiting unfair competition and unfair or deceptive acts or practices. This bill would provide that the rights and remedies provided by the above-specified laws, and the rights and remedies arising out of a covenant of good faith and fair dealing, expressed or implied in any insurance contract or policy, shall constitute mandated benefits implied in every insurance contract or policy. This bill is sponsored by the California Trial Lawyers Association (CTLA). *[S. Jud]*

**AB 1674 (Margolin)**. Under existing law, persons insured under policies of private passenger automobile insurance have a right to be informed, upon request, of any change in premium based upon acci-

dents or convictions and, in the event of cancellation, the right to be informed, upon written request, of the reason for cancellation. Under existing law, a notice of cancellation of certain types of property insurance is required to be in writing, and to inform the insured that, upon written request, the insured is entitled to be informed of the reason for cancellation. As introduced March 4, 1993, this bill would revise those provisions to provide that the reason for a change in premium or coverage, or the reason for cancellation, must accompany the notice of change in premium or coverage or notice of cancellation. The bill would require notice of increases in premiums for life insurance. The bill would require notices of nonrenewal of private passenger automobile insurance or certain property insurance to be in writing and to contain a statement of reasons. The bill would require notice of renewal or nonrenewal of private passenger automobile insurance to be given at least 45 days, instead of 20 days, prior to policy expiration, and would make related changes. *[S. InsCl&Corps]*

**AB 1770 (Margolin)**. Existing law generally requires a group policy of health insurance to provide for conversion rights to an insured whose coverage is terminated. Existing law provides that those requirements do not require an insurer to issue a converted policy covering any person if such person is entitled to be covered by Medicare. As amended August 17, 1993, this bill would instead require an insurer to offer a converted policy to any person entitled to be covered by the federal Medicare program to the extent that the converted policy does not duplicate Medicare benefits. *[S. Inactive File]*

**AB 2002 (Woodruff)**. Existing law imposes various requirements on health insurers and health plans with respect to scope of coverage, and provides for basic medical services to qualified low-income individuals under the Medi-Cal program, administered by the state department of health services. As amended January 26, this bill would state the intent of the legislature to establish a system of universal access to health care while also achieving other goals including controlling health care costs and maintaining the quality of health care in California. *[A. Conference Committee]*

**SB 1146 (Johnston)**. Existing law provides that a HCSP, a self-insured employee welfare benefit plan, or a nonprofit hospital service plan may not refuse to enroll any person or accept any person as a subscriber or insured solely by reason of the fact that the person carries a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier, as specified. Existing law contains similar provisions prohibiting rate discrimination and commission discrimination on that basis. A willful violation of these provisions by a HCSP is punishable as a crime. As amended April 19, this bill would delete the limitation on those prohibitions that those reasons for refusal or discrimination be the sole reasons for that refusal or discrimination. The bill also would instead prohibit those forms of refusal and discrimination by HCSPs, self-insured employee welfare benefit plans, and nonprofit hospital service plans on the basis that the person carries a gene which may, under some circumstances, be associated with disability in that person or that person's offspring. *[A. Ins]*

**SB 38 (Torres)**. Existing law prohibits a HCSP or health insurer from denying or conditioning a Medicare supplement contract or policy on account of the applicant's claims experience or medical condition if the application is submitted during the six-month period beginning when an individual, who is 65 years of age or older, first enrolls for benefits under Medicare Part B. As amended April 25, this bill would delete the qualification that the individual be 65 years of age or older.

Under existing law, an individual enrolled in Medicare Part B by reason of disability is entitled to open enrollment under these Medicare supplement provisions for six months after he/she reaches age 65. This bill would provide, instead, that an individual eligible for Medicare by reason of disability is entitled to open enrollment under these provisions for six months after he/she enrolls in Medicare Part B. *[A. Health]*

**SB 1098 (Torres)**, as amended September 8, 1993, would create the California Health Plan Commission, with specified powers and duties, to establish and maintain a program of universal health coverage to be known as the California Health Plan. The bill would require that, under the plan, all California residents would be eligible for the same federally required package of comprehensive health care services, and all California residents would be eligible to participate without regard to employment status or place of employment in accordance with applicable federal requirements. The bill would require the Commission to establish and fund regional health insurance purchasing corporations (HIPCs), with certain duties. The bill would require, on or after January 1, 1995, the HIPCs, the Commission, or another agency designated by the Commission, to enter into contracts with health plans for the purpose of providing health benefits coverage to all eligible persons. The bill would require, on or before January 1, 1995, the Commission to adopt regulations to implement these provisions and to prepare a plan, budget, and timetable for the transfer of funds and entitlements under the Medi-Cal program, as required by federal law, to the Commission. *[A. Conference Committee]*

**SB 1106 (Torres)**, as amended August 24, 1993, would enact a comprehensive anti-redlining scheme with respect to certain automobile, fire, homeowners', commercial, and mortgage guarantee insurance, as specified; establish the Commission on Insurance Redlining which would analyze and evaluate the extent to which insurance redlining exists; require the Commission to report its findings to the legislature, the Governor, local entities, and the public by March 1, 1995; make a $300,000 appropriation from the Insurance Fund to the Commission for these purposes; provide that the provision creating the Commission would remain in effect only until December 31, 1995; require the biennial submission of a disclosure report to the Insurance Commissioner providing certain information; require the issuance of certain reports and specify an evaluation system by the Commissioner; require the Commissioner to establish a schedule of fees to be paid by insurers to cover the actual administrative and operational costs, as specified, arising from the implementation and requirements of the provisions added by this act; and limit the costs of implementation of these provisions to $500,000. *[A. W&M]*

**SB 773 (Hart)**. Existing law provides that applicants for a child day care license shall attend an orientation conducted by the state Department of Social Services prior to licensure, as specified. As introduced March 3, 1993, this bill would require that orientation to disclose that insurers offering commercial and homeowners' insurance are required to offer liability insurance for family day care homes.

Existing law prohibits the arbitrary cancellation of a policy of homeowners' insurance solely on the basis that the policyholder is engaged in a licensed family day care business at the insured location. This bill would prohibit the arbitrary cancellation of a policy of homeowners' or commercial rental insurance solely on the basis that the policyholder or occupant, or both, are engaged in a licensed family day care business at the insured location. This bill would also require, on and after July 1, 1994, insurers that offer policies of

homeowners' insurance and also offer commercial insurance to also make available liability coverage for licensed family day care homes. The bill would also provide that this provision shall not be construed to require an insurance company to make available liability insurance to a homeowner operating a licensed family day care home, if the homeowner is not a policyholder of that company. *[A. Ins]*

**SB 907 (Leonard)**, as amended June 9, 1993, would require every workers' compensation insurer, private self-insurer, and third-party administrator that administers self-insured employers workers' compensation claims, to certify that a utilization review and quality assurance plan that conforms to minimum specified guidelines has been established and implemented. *[A. Ins]*

**AB 1667 (Hoge)**. Existing law establishes a California Insurance Guarantee Association and specifies those insurers that are required to be members of the Association. It exempts certain classes of insurance from assessments and other requirements of the Association. As amended January 19, this bill specifically enumerates those exempt classes of insurance, and provides that any insurer admitted to transact only those classes or kinds of insurance excluded from specified provisions shall not be a member of the Association.

Existing law provides that the Association shall be managed by a board of governors serving for three-year terms. Those terms expire each year. This bill provides that those terms expire each year on December 31.

The bill also, among other things, does all of the following with respect to the California Insurance Guarantee Association:

–revises the definition of the terms "insolvent insurer" and "covered claims," and defines the term "ocean marine insurance";

–revises certain policy construction and cancellation provisions with respect to insurer insolvency;

–revises the authorization of the Association to submit reports and make recommendations to the Insurance Commissioner regarding the financial condition of member insurers, and certain examination and other report requirements;

–revises insolvency premium provisions; and

–specifies certain notice provisions with respect to an ancillary liquidator.

Existing law provides for the California Life and Health Insurance Guarantee Association. The statute that established that Association abolished the California Life Insurance Guaranty Association and the Robbins-Seastrand Health Insurance Guaranty Association. This bill provides that the California Life and Health Insurance Guarantee Association is created by the merger of the Robbins-Seastrand Health Insurance Guaranty Association with and into the California Life Insurance Guaranty Association and that the Association succeeds to the rights, property, and obligations of the predecessors, as specified.

This bill also revises provisions dealing with the applicability of specified disability insurance policies issued outside of California to an employer whose principle place of business and majority of employees are located outside of California. This bill was signed by the Governor on February 10 (Chapter 6, Statutes of 1994).

**AB 998 (Tucker)**. Existing law prohibits as an unfair method of competition and as an unfair and deceptive practice in the business of insurance the making of any misleading statement or representation as to specified terms of insurance policies. In addition, the Insurance Commissioner may disapprove the form of credit life and disability policies if they contain misleading provisions, and shall disapprove the forms of specified extended health insurance policies if the Commissioner finds they are misleading. As introduced March 1, 1993, this bill would specifically authorize the Insurance Commissioner to examine policy forms and to prohibit the use of forms that are deceptive or misleading. *[S. InsCl&Corps]*

**AB 1782 (Tucker)**, as amended July 8, 1993, would create an Insurance Availability Study Commission within DOI for specified purposes. The bill would specify membership and require a report to be issued to the Governor, legislature, and Insurance Commissioner no later than October 1, 1995. The bill would appropriate $500,000 from the Insurance Fund for specified purposes. These provisions would be repealed on January 1, 1996. *[S. InsCl&Corps]*

The following bills died in committee: **AB 135 (Peace)**, which would have—among other things—enacted the Automobile Insurance Truth in Advertising Act to provide that any advertisement which solicits persons to present or file automobile insurance claims or to engage or consult counsel to consider an automobile insurance claim shall contain a notice that making a false or fraudulent automobile insurance claim is a felony; **SB 957 (Johnston)**, which would have authorized insurers to file a rate for insureds who do not qualify as good drivers for an amount less than that required pursuant to existing provisions where the insurer can demonstrate actuarially credible experience that justifies a lower rate for that class of insured; **AB 1512 (Brulte)**, which would have deleted the current authority of the Insurance Commissioner to appoint administrative law judges with respect to proposed insurance rate change hearings; **AB 2035 (Isenberg)**, which would have prohibited a cause of action alleging general damages for bodily injury resulting from an automobile collision from being filed in a justice, municipal, or superior court unless the court first determines that the injuries involved are serious, and imposed a duty on third-party insurers to deal fairly and in good faith with all parties to the action once such a determination is made, but not before; **SB 684 (Torres)**, which would have required motor vehicle insurers to report specified information to the Commissioner, and required the Commissioner to make the information available to the public and local law enforcement officials; **AB 456 (Johnson)**, which would have—among other things—required each motor vehicle required to be registered in this state to be insured for basic personal protection, subject to various limits including an aggregate limit of $50,000 per person; **AB 574 (Johnson)**, which would have required an applicant for the issuance or renewal of a driver's license to qualify for a Good Driver Discount insurance policy, as defined, or, in the alternative, to file proof of financial responsibility, as specified, with the Department of Motor Vehicles; **AB 2033 (Caldera)**, which would have created the California Basic Liability Coverage Premium Exchange, consisting of all insurers licensed to write and engaged in writing within this state basic liability coverage for private passenger automobiles, required members to sell basic automobile insurance, and provided for the redistribution of premiums among members; **AB 9 (Mountjoy)**, which would have—among other things—provided that the workers' compensation law shall be liberally construed after the employee has established all conditions for compensability, including injury arising out of and occurring in the course of employment, by a preponderance of evidence; **AB 2034 (Polanco)**, which would have provided that any charge for provision a covered service, as defined, by any health professional for any injury resulting from an automobile accident occurring on or after January 1, 1994, shall not exceed charges permitted under specified schedules for industrial accidents, except as specified; **AB 997 (Tucker)**, which would have required an uninsured employer to pay, in addition to specified penalties, the approximate amount of

workers' compensation insurance premiums the employer would have been liable for during the period of time the employer was uninsured; and **SB 1066 (Mello)**, which would have prohibited the issuance of any life insurance policy or certificate, except credit life insurance, life insurance where the death benefit is $25,000 or more, and noncontributory group life insurance, unless the benefit payable at death equals or exceeds the cumulative premiums to be paid for the first ten years, plus interest thereon.

## LITIGATION

What started out as a routine insurance industry appeal of a Proposition 103-related loss in court erupted in controversy during the spring. In January, the industry petitioned the California Supreme Court to review the Second District Court of Appeal's decision in ***Amwest Surety Insurance Company v. Wilson***, 20 Cal. App. 4th 1275 (Dec. 8, 1993); in that case, the appellate court struck down a 1990 statute exempting surety companies from the rollback and prior approval provisions of Proposition 103 because it does not "further the purposes" of the initiative and is thus beyond the authority of the legislature. *[14:1 CRLR 108; 13:2&3 CRLR 130; 11:3 CRLR 133–34]*

As usual, numerous insurance companies filed *amicus curiae* briefs in support of the petition. The controversy focuses on the identity of one of the attorneys for *amicus* Surety Company of the Pacific; he is none other than former Governor George Deukmejian, who appointed four of the six sitting Supreme Court justices (one position is vacant at this writing), is a former law partner of Chief Justice Malcolm Lucas, and is the former employer of Justice Marvin Baxter (Baxter served as Deukmejian's appointments secretary). Proposition 103 author Harvey Rosenfield, the Proposition 103 Enforcement Project, and consumer groups and public interest organizations across the state all cried foul, calling on Deukmejian to withdraw as counsel and asserting that, if he does not, a majority of the Supreme Court members have a conflict of interest which requires them to recuse themselves from the decision. The court granted the industry's petition for review on February 24.

The scenario of a former governor who appointed most of the justices returning to appear before his own appointees in a case challenging the validity of a bill he signed is apparently unprecedented. In a press release accompanying his formal request that the Deukmejian-appointed justices recuse themselves from participating in the case, Rosenfield characterized the situation as follows: "The insurance industry has hired former Governor George Deukmejian to convince the California Supreme Court—a majority of which Deukmejian appointed—to uphold the validity of anti-103 legislation sponsored by convicted lobbyist Clay Jackson and signed by Deukmejian in 1990." In addition, Deukmejian accepted campaign contributions from surety insurance companies, including $243,000 from Surety Company of the Pacific. Deukmejian's participation in the case has caused several political observers to conclude that, even if the Deukmejian-appointed justices have no actual conflict of interest, the apparent conflict of interest presented by Deukmejian's appearance (coupled with a recent and well-publicized investigation into Chief Justice Lucas' insurance industry-financed trips to Thailand, Hawaii, and Austria) tarnishes the integrity of the judiciary and suffices to require them to recuse themselves from the case. However, on April 14, the four justices—Malcolm Lucas, Joyce Kennard, Armand Arabian, and Marvin Baxter—denied Rosenfield's request without explanation. And on May 12, the court rejected a last-ditch request by Rosenfield, several public interest organizations, Senator Art Torres, and Assemblymember Burt Margolin to bar Deukmejian from participating in the case. At this writing, the case is being briefed and no date for oral argument has been set.

Another major Proposition 103 case is still pending before the California Supreme Court. The final brief in ***20th Century Insurance Company v. Garamendi***, No. S032502, was filed on August 25, 1993; oral argument has finally been scheduled for June 7. The *20th Century* case is a direct appeal from Los Angeles County Superior Court Judge Dzintra I. Janavs' February 1993 invalidation of the Commissioner's regulations implementing Proposition 103's rollback requirement. *[13:4 CRLR 122; 13:2&3 CRLR 139–40]*

In ***Manufacturers Life Insurance Company, et al. v. Superior Court (Weil Insurance Agency, Real Party in Interest)***, 23 Cal. App. 4th 1629 (Apr. 4, 1994), the First District Court of Appeal held that the Unfair Insurance Practices Act (UIPA), Insurance Code section 790 *et seq.*, and its limited administrative remedy is not the sole vehicle for redress of an unlawful group boycott by insurers, and that an aggrieved plaintiff may pursue state antitrust remedies under the Cartwright Act. However, on May 2, the court decided to rehear the case on its own motion.

Plaintiff Weil was a broker of and consultant on a form of life insurance known as "settlement annuities"; a settlement annuity is an annuity purchased by a liability carrier to fund a structured (periodic payment) settlement in a personal injury action. It was plaintiff's practice to advise and educate injury claimants and their attorneys with information concerning the underlying features of settlement annuities, in particular their actual costs. According to the court, "[s]uch disclosures were inimical to a plan defendants had formed to market settlement annuities as a way for liability carriers to settle injury claims below their cash settlement value." Thus, defendants allegedly coerced and induced suppliers of annuities to stop doing business with plaintiff; as a result, plaintiff's business was destroyed.

Weil brought suit against the insurers, asserting (among other things) statutory claims under the UIPA and two provisions of the Cartwright Act (California's general antitrust law), Business and Professions Code sections 16720 and 16721.5. In the trial court, defendants demurred on the statutory claims, asserting that the Cartwright Act is superseded by the UIPA and that there is no private cause of action under the UIPA; the only remedy for a violation of the UIPA is a cease and desist order issued by the Insurance Commissioner. The trial court sustained the demurrers.

On appeal, the First District reversed, finding nothing in the UIPA which purports to supplant the Cartwright Act "so as to provide the sole basis by which unlawful conduct of the type alleged here may be subjected to legal restraint or may otherwise produce legal consequences." The court noted that the UIPA itself "expresses an affirmative intention and expectation that it will preserve intact existing remedies for insurance industry misconduct," and observed that "[i]f the legislature wished to exempt the insurance industry from the Cartwright Act, it knew full well how to do so." At this writing, the rehearing is pending.

## DEPARTMENT OF REAL ESTATE

*Commissioner: Clark E. Wallace*
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The Real Estate Commissioner is appointed by the Governor and is the chief officer of the Department of Real Estate (DRE). DRE was established pursuant to Business and Professions Code section 10000 *et seq.*; its regulations appear in Chapter 6, Title 10 of the California Code of Regulations (CCR). The