SB 719 (Craven). Existing law provides that no HCSP, including a specialized HCSP, shall request reimbursement for overpayment or reduce the level of payment to a provider based solely on the allegation that the provider has entered into a contract with any other licensed HCSP for participation in a benefit plan that has been approved by the Commissioner. As amended May 17, this bill would provide instead 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 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. *[S. InsCl &Corps]*

■ LITIGATION

On July 8, former savings and loan boss Charles Keating and his son, Charles Keating III, were sentenced following their January 1993 convictions by a federal jury on charges of racketeering, bank and securities fraud, conspiracy, and the interstate transportation of stolen goods. *[13:1 CRLR 82]* The elder Keating, who is already serving a ten-year state sentence for defrauding 25,000 investors out of $268 million by persuading them to buy worthless junk bonds instead of government-insured certificates, was found guilty on all 73 counts brought against him; his son was found guilty of all 64 counts brought against him. *[13:2&3 CRLR 126]* The elder Keating was sentenced to 12 years and 7 months in federal prison for the racketeering and securities violations; his son was sentenced to eight years and one month.

In ***Mirkin v. Wasserman***, 5 Cal. 4th 1082 (Sept. 9, 1993), the California Supreme Court considered whether plaintiffs, who purchased securities at a price allegedly affected by misrepresentation, can plead a cause of action for deceit under Civil Code sections 1709 and 1710 without alleging that they actually relied on the misrepresentations. Plaintiffs bought shares of the common stock of Maxicare Health Plans, Inc., between October 17, 1985, and February 29, 1988; plaintiffs purported to represent all persons who purchased the common stock or 11.75% senior subordinated notes issued by Maxicare. Plaintiffs alleged that Maxicare, after appearing to experience substantial growth and profits in 1985 and 1986, began to suffer large losses; the value of Maxicare stock gradually dropped from a high of $28.50 per share in 1986 to a low of $1.50 per share in 1988. Plaintiffs also alleged that defendants, beginning in 1985, made numerous misrepresentations about Maxicare's prospects and financial status in prospectuses for the 1985 and 1986 public offerings, in documents filed with the Securities Exchange Commission and in other public communications. According to plaintiffs, these misrepresentations inflated the price of Maxicare securities, thus allowing them to sell for more than their true value.

In their first consolidated amended complaint, plaintiffs purported to state causes of action for deceit and negligent misrepresentation. After conceding that they could not plead that they had actually read or heard the alleged misrepresentations, plaintiffs argued that the so-called "fraud-on-the-market" doctrine obviates the need to plead and prove actual reliance in cases where material misrepresentations are alleged to have affected the market price of stock.

The court initially noted that "[i]t is settled that a plaintiff, to state a cause of action for deceit based on a misrepresentation, must plead that he or she actually relied on the misrepresentation." The court noted that plaintiffs, attempting to justify their failure to plead actual reliance on the alleged misrepresentations, argued that the price of securities traded in an open and developed market, such as a national stock exchange, adjusts in response to material information, whether such information is true or false; in this way, plaintiffs asserted, misrepresentations are reflected in the market price of a security, and someone who relies on the market price as indicating the actual value of a security relies, albeit indirectly, on the misrepresentation. The court commented that plaintiffs' argument amounts, in essence, to a plea to incorporate the fraud-on-the-market doctrine into the common law of deceit.

The court held that California law does not permit plaintiffs to state a cause of action for deceit without pleading actual reliance, finding that no California court has expressly adopted the fraud-on-the-market doctrine and refusing to read an implied adoption into decisions offered in support of plaintiffs' position.

Further, the court rejected plaintiffs' arguments for changing the law by incorporating the fraud-on-the-market doctrine; among other things, the court noted that state and federal law provide other remedies that do not require the pleading or proof of actual reliance. The court concluded that "[t]o incorporate the fraud-on-the-market doctrine into the common law of deceit would only bring about difficulties that the state legislature and the federal courts have apparently attempted to avoid. Nor would the proposed expansion of the common law of deceit offer benefits sufficient to offset the difficulties, since the state and federal securities law already offer remedies that give plaintiffs the benefit of a presumption of reliance. Under these circumstances, there is insufficient justification for upsetting the policy choices that the existing laws reflect."

DEPARTMENT OF INSURANCE

Commissioner: John Garamendi
(415) 904-5410
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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 insur-

ance 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

Court Decision and Appeal Appear to Prompt Proposition 103 Rollback Settlements. Last February, Proposition 103 suffered its first significant defeat when Los Angeles County Superior Court Judge Dzintra I. Janavs struck down Commissioner Garamendi's regulations implementing the initiative's rollback requirement. *[13:2&3 CRLR 130–31, 139–40]* Since then, both Commissioner Garamendi and Proposition 103 sponsor Voter Revolt have sought and been granted review of Judge Janavs' decision directly by the California Supreme Court (*see* LITIGATION). These decisions, which are moving Proposition 103 and its rollback requirement closer to their final destiny, appear to have prompted a rash of insurer decisions to settle with the Commissioner (or vice versa) on their rollback liabilities.

In mid-May, California Casualty Group agreed to refund $5 million to those who held policies in 1989, and to cut its rates by 7% during the coming year for an added savings of $11.2 million. Voter Revolt criticized the Commissioner for approving this settlement; under the invalidated rollback regulations which are now on appeal, California Casualty owed $24 million to policyholders.

On May 24, Geico Insurance Company, California's eleventh-largest insurer, agreed to refund $21 million to 1989 policyholders, 37% of the amount it was ordered to pay in October 1991 under the old rollback regulations. The company estimated that about 90,000 policyholders would receive rebates averaging $233 apiece.

On August 15, Safeco Corporation announced its plans to refund $40 million to about 360,000 Californians who held policies during 1989, for an average refund of $111 per property or casualty policy and $159 per automobile policy. Commissioner Garamendi had originally ordered Safeco to pay $110.3 million in Proposition 103 rollbacks. Safeco also agreed to dismiss one lawsuit pending in the California Supreme Court and another pending in the court of appeal.

And on August 17, Allstate Insurance Company—the second-largest homeowner insurer and the third-largest auto insurance carrier in the state, and one of the companies which has resisted Proposition 103 from the day it was passed by the voters—agreed to pay $110 million to 2.9 million California policyholders in Proposition 103 rollbacks. Again, Voter Revolt's Harvey Rosenfield criticized the settlement as "pitifully small," as Allstate had been adjudged liable for $243.6 million by Commissioner Garamendi in October 1991. Allstate also agreed to withdraw a brief it recently filed in support of 20th Century Insurance Company in the California Supreme Court (*see* LITIGATION) and to drop other pending legal proceedings against the Department.

In all, Commissioner Garamendi estimates that the Department has secured approximately $725 million in rollbacks for California consumers. Denying charges by Rosenfield and others that he is agreeing to rollback settlements for political reasons, the Commissioner and his staff assert that immediate settlements are preferable to waiting several more years while the Department and the courts continue to untangle the complexity of Proposition 103.

Commissioner Commences New Rulemaking Proceeding and Public Investigative Hearing to Develop Proposition 103 Auto Rating Factors and Good Driver Discount Regulations. On July 22, the Office of Administrative Law (OAL) reapproved (for the ninth time) DOI's emergency adoption of sections 2632.1–2632.18, Title 10 of the CCR. Among other things, Proposition 103 sought to end so-called "territorial rating" or "zip code rating"; thus, Insurance Code section 1861.02 requires auto insurers to base premium rates on three mandatory factors—the insured's driving safety record, the number of miles driven annually by the insured, and the insured's number of years of driving experience—and other rating factors that the Commissioner may adopt by regulation "that have a substantial relationship to the risk of loss." Further, the proposition provides that these factors must be applied in the order specified in the statute. The proposition also provides that any person who has been licensed to drive for the previous three years, who has not received more than one violation point count as determined by Vehicle Code section 12810, and who has not been principally at fault in an accident resulting in bodily injury or death is qualified to purchase a good driver discount insurance policy, the premium for which must be at least 20% below the premium the insured would otherwise have been charged for the same coverage. These interim emergency regulations 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 factors in determining rates, and set guidelines for determining a driver's status as a good driver.

These interim regulations have been in effect since August 1990; their adoption by former Commissioner Roxani Gillespie followed a May 4, 1990 decision by then-Los Angeles County Superior Court Judge Miriam Vogel invalidating Gillespie's previous auto rating factor regulations. Those regulations—dubbed "the tempered regulations"—required that the weights assigned to various rating factors be "tempered" so that—notwithstanding the weight that would be assigned to a rating factor if calculated purely on the basis of a sequential analysis of the mandatory and optional factors—the second mandatory factor in Proposition 103 (number of miles driven annually) would account for less of the premium than is accounted for by the

first mandatory factor (driving safety record), the third mandatory factor (number of years of driving experience) would in turn account for less than the second mandatory factor, and the weight of any and all optional factors used by an insurer would in turn be less than that accounted for by the third mandatory factor.

The "tempered regulations" contained two limitations on the use of premiums calculated in accordance with the tempered approach. First, no premium calculated with the weights prescribed by the tempered approach could exceed the premium that would have been charged if calculated by a sequential analysis of all mandatory and optional factors. Second, the regulations contained a consumer price index cap, such that no premium calculated by the tempered approach could exceed the premium that was charged or would have been charged in the immediately preceding calendar year, as adjusted to reflect any increase in the consumer price index.

Commissioner Gillespie's "tempered regulations" were invalidated by Judge Vogel in May 1990 on grounds they did not necessarily permit rating factors to have an effect on rates as determined actuarially, and thus were "unfairly discriminatory" and violative of insurance Code section 1861.05. The court expressly held that section 1861.02's requirement that rates be based on the application of the three mandatory rating factors in decreasing order of importance is subordinate to section 1861.05, which requires that rates not be unfairly discriminatory. Judge Vogel also rejected the rate caps contained in the regulations. *[10:2&3 CRLR 140]* Commissioner Gillespie appealed Judge Vogel's decision to the Second District Court of Appeal, and adopted the emergency interim regulations currently in effect in August 1990. Unlike the tempered regulations, the interim regulations require insurers to determine the effect of each rating factor by statistical methodologies referred to as sequential analyses. Unlike the tempered regulations, the interim regulations include age, gender, marital status, and academic standing as optional rating factors, and no consumer price index-based cap is imposed. Commissioner Gillespie stated she would reinstate the tempered regulations if the Department won its appeal of Judge Vogel's decision.

When Commissioner Garamendi took office in January 1991, he continued the appeal in order to obtain a judicial determination of the validity of a tempered approach, but simultaneously announced his rejection of Gillespie's tempered regulations and the rate cap and his intent to completely rewrite the auto rating factor regulations. For this reason, the Second District Court of Appeal dismissed DOI's appeal of Judge Vogel's opinion as moot in January 1992. *[12:2&3 CRLR 179]*

Since he took office, Commissioner Garamendi's staff has been attempting to develop regulations which comply with both Insurance Code sections 1861.02 and 1861.05. According to staff's statement of emergency submitted with the latest readoption of sections 2632.1–2632.18, "the task is very complex. The development of rating regulations involve [sic] issues of statistical analysis, relativities and weights for mandatory rating factors, specification of optional rating factors, applicability of mandatory and optional rating factors to different coverages, relativities and weights for optional rating factors, effect of coverage amounts, effect of make and model on premium, effect of vehicle value on premium, use of industry vehicle rating 'symbols,' definitions of rating factors and creation or elimination of variability, consumer dislocation, market dislocation, non-class rated coverages, and Proposition 103 goals of affordable and available insurance, among other topics. Further, the regulations require consideration of the quantity and quality of existing private and public data (data credibility), insurers' data gathering capabilities, circumstances when alternative data sources may be used, the manner in which alternative data may be used, competition, and antitrust matters."

Recently, Commissioner Garamendi announced a two-pronged approach to finally adopting permanent auto rating factor regulations. On July 23, the Commissioner commenced a new rulemaking proceeding to adopt permanent regulations (sections 2632.1–2632.16, Title 10 of the CCR), and published proposed regulations which are somewhat similar to the interim regulations, but which 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 "variance" and specify the manner in which variance must be modified, if necessary. The Commissioner set a September 17 initial public hearing on these proposed regulations.

Simultaneously, the Commissioner announced that DOI will hold a public investigative hearing, "at a time and place to be specified," concerning the four alternative methodologies for determining weights of rating factors set forth in proposed section 2632.6. According to the announcement, "the investigative hearing will be in the nature of a symposium of persons having technical expertise in insurance ratemaking, statistics, and actuarial matters." The investigative hearing will take place in two phases. In Phase I, interested persons are to submit written materials and comments on the weighting methodologies to the Commissioner by October 1. According to the announcement, "comments and other papers must be in the nature of technical or other appropriate analysis of weighting methodologies or problems imposed by the requirements of Insurance Code section 1861.02 and Proposition 103 generally. Comments in the nature of legal argument or general expressions of opinion regarding public policy are not germane to the technical inquiries of this symposium and should not be submitted." To kick off the inquiry, DOI published an abstract written by DOI employees Lyn Hunstad and Robert Bernstein which applies five different weighting methodologies to data from a large insurer and compares the results. Phase II will consist of a hearing upon 30 days' notice, at which time comments submitted during Phase I will be discussed by the participants. At this writing, the Commissioner has not yet announced date of the Phase II hearing.

DOI to Hold Investigative Hearing on Telephone Quote Accuracy and Availability. In November 1992 and the spring of 1993, DOI conducted an anonymous telephone quote survey to obtain quotes for private passenger automobile coverage. DOI designed a driver profile representing a good driver seeking basic liability and physical damage coverage, and its goal was to find out if insurers are complying with the provisions of Proposition 103 requiring them to offer good driver policies. After the survey, DOI published a report entitled *Study of Telephone Quote Accuracy and Availability: The Private Passenger Automobile Insurance Maze*, which identifies the companies which provided inaccurate phone quotes, engaged in discriminatory practices, and—in general—made it difficult for California consumers to purchase insurance.

Of 396 quotes received by DOI from agents or sales representatives of 24 insurance companies, only 71 matched the official company quotes. The companies which were most inaccurate are Farmers, Hartford, and Fireman's Fund, all with zero correct quotes. The companies which were most accurate include CSAA (40% of its quotes were accurate), Allstate (25% were accurate), and State Farm (20% were accurate). Some companies refused to quote rates to the Department's good driver sur-

veyor, which is a violation of the Insurance Code; and others (including Hartford, Fireman's Fund, and Safeco) stated that they would not provide auto insurance without the purchase of homeowners' insurance, which may be an antitrust violation. The insurance industry immediately disputed the Department's report, arguing that the sample used by DOI was too small to result in any valid conclusions. Further, the industry stated that DOI contacted too many independent agents and not the companies directly; consumers should expect different quotes from independent agents because they are competing against one another for business. DOI acknowledged that it made no effort to statistically validate the survey, but instead randomly chose names from the telephone directory as any consumer might.

On September 15, DOI announced that it would conduct a series of public investigative hearings on October 19 in Los Angeles and October 21 in San Francisco to inquire into the reasons for the inaccurate quotes and discuss steps which should be taken to eliminate inaccurate telephone quotes. DOI also plans to explore several recommendations made by staff as a result of the survey, including a proposed requirement that agents and insurers should be required to provide, upon request, a written premium quotation either in person or by mail to the consumer, which must include policy limits, type and year of vehicle, other rating criteria used, and any credits or discounts available to the insured. Under this recommendation, the agent or insurer would be required to honor the written quote if the consumer chooses to purchase a policy. Staff also recommended that insurers should be required to maintain a toll-free telephone number which consumers may call to obtain a quote; and provide sales representatives with specific written guidelines covering the basic eligibility criteria, coverage guidelines, and company quotation procedures for all new business, especially for good drivers.

Licensing of Insurance Claims Analysis Bureaus. On August 11 and 18, DOI held public hearings on its proposal to adopt new sections 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. A CAB is a nonprofit corporation which receives, compiles, and disseminates insurance claims information and provides education and training, solely for the purpose of preventing and suppressing insurance fraud. These regulations specify the qualifications for CAB licensure, the conditions under which the insurance claims information will be disseminated by CABs, the provisions for anti-fraud education and training of CAB members or subscribers, and the penalties to be assessed against licensed CABs for noncompliance with these regulations.

Among other things, the proposed regulations require CABs to promulgate rules which are binding on the CAB's members/subscribers; these rules must set forth the methods and procedures for the collection of automobile insurance claims data information which shall allow such data to be deposited into the Automobile Insurance Claims Depository (AICD) pursuant to Insurance Code section 1876 *et seq.* The rules specify that the collection and compilation of the claims information by licensed CABs shall be solely for the purpose of preventing insurance fraud and shall not be offered to any member/subscriber in a manner which will make such data susceptible to use for the development of insurance rates, rating plans, or underwriting rules. Within 24 hours of receipt from a member/subscriber, the CAB must deposit insurance claims information regarding automobile bodily injury claims with the AICD and to any affected member/subscriber within 24 hours of compilation. On May 1 of each year, each licensed CAB must file a report with DOI detailing the scope and extent of the CAB's activities in California for the preceding year, including the total number of insurance claims received and compiled, the percentage of reports generated to members/subscribers, the total number of complaints received and the percentage of errors corrected.

At this writing, DOI staff is reviewing the comments received on the proposed regulations.

Rulemaking to Establish Special Investigative Units. On August 12 and 25, DOI held a public hearing on its proposal to adopt sections 2698.40–.45, Title 10 of the CCR. Insurance Code section 1875.20 *et seq.* requires every insurer admitted to do business in California to maintain a special investigative unit (SIU) or division to investigate suspected fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds. However, existing law does not prescribe specific acts which are to be performed by SIUs, define SIU personnel or the attendant duties and functions of SIUs, or specify the role the SIU should play in an insurer's systematic anti-fraud strategy. Further, existing law does not set forth any provisions for the oversight of the maintenance and operations of SIUs by DOI's Fraud Division.

DOI's proposed regulations state that the purpose of an SIU is to detect and investigate suspected fraudulent claims and to deter insurance fraud and reduce insurance costs. The SIU is to meet these primary objectives through the establishment of a systematic and effective method to detect and investigate fraudulent claims and to provide for their appropriate disposition, to educate and train all claims handlers to identify possible insurance fraud through matching specific claims against known patterns and trends indicating possible fraud, and to facilitate insurer communications with DOI's Fraud Division. An SIU is required to have adequate staffing and organization, and the staff shall have sufficient expertise to assure timely investigation and disposition of cases of suspected fraud. Finally, an SIU is required to cooperate with the 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.

Under the proposed rules, every insurer is required to furnish the Fraud Division with a list of the insurer's personnel, or the name of the organization with which the insurer has contracted for the maintenance of the SIU, who will communicate with the Fraud Division on matters related to the investigation of fraudulent claims. Within 90 days of the effective date of these regulations, every insurer is required to submit a report setting forth the manner in which the insurer is complying with the Insurance Code and these regulations. Annually, thereafter, every insurer shall submit an update specifying any significant changes in the initial report.

At this writing, DOI is reviewing the comments received on the proposed regulations.

Rulemaking to Implement AB 1672 (Margolin). On June 28, DOI adopted emergency regulations to implement AB 1672 (Margolin) (Chapter 1128, Statutes of 1992); both the statute and the regulations became effective on July 1. 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." *[13:2&3 CRLR 132–33]* In adopting emergency sections 2233–2233.99 (nonconsecutive), Title 10 of the CCR, the Commissioner stated that AB 1672 "teems with ambiguities and uncertainties, may of which could be exploited by some segments of the insurance industry in order to

evade the Act's requirements and frustrate the Legislature's intent in enacting the law." The Commissioner attempted to clarify the ambiguities through bulletins issued on April 15 (No. 93-3) and June 25 (93–4), but some matters were beyond the scope of a bulletin; thus, the Commissioner decided to adopt regulations to define key terms in the statute, specify the applicability of AB 1672 to various types of small employer health benefit plans, and clarify the answers to "the flood of inquiries which this Department has received" since the bill was signed in 1992.

Among other things, the emergency regulations provide the following:

• Sections 2233 and 2233.10 define key terms in the statute and attempt to bring as many sources of health coverage as possible within the jurisdiction of AB 1672. This would include, for example, individual policies issued to employees, or benefit plan designs issued to trustees of a fund established by employer(s) and union(s) to benefit the members of the union when those plans are made available to small employers that have not entered into bona fide collective bargaining agreements with the union. The purpose of section 2233.10 is to ensure that good risks that carry lower premiums do not have another market source that may charge lower rates, leaving only poor risks under the jurisdiction of AB 1672.

• Existing law does not define the term "renewal," but the renewal date determines when a health insurance plan issued before July 1, 1993 becomes subject to certain provisions. Section 2233.20 provides that the date upon which a small employer's health benefit plan established prior to July 1, 1993 shall be deemed to be renewed will be the later of two choices: the first premium due date on or after July 1, 1993, or the date upon which any premium rate and renewal guarantee granted to a specific small employer before July 1, 1993 by the insurance carrier expires. This provision is designed to ensure that carriers will not unreasonably delay bringing their existing business into compliance with AB 1672.

• Section 2233.22 defines the term "disenrollment" as used in Insurance Code section 10711(d), to protect small businesses from being penalized for actions beyond their control, such as cessation of small business status.

• Section 2233.40 resolves the inconsistency between federal law and existing California law regarding rates for Medicare-eligible persons. California has only one risk category for employees over 65, whereas federal law allows for two risk categories depending on whether the private sector coverage is primary or secondary to Medicare. This regulation allows for two risk categories.

• Section 2233.50 makes explicit the intent of AB 1672 to provide all eligible employees and dependents with health care coverage. This section requires that all eligible employees and dependents excluded from a small employer's health plan, for any reason, be given a 30-day period in which to enroll in the health plan commencing on July 1.

• Section 2233.52 clears up ambiguities in existing law by requiring that a carrier shall credit the time an employee or dependent has been covered by qualifying coverage against pre-existing conditions limitations or waiting period requirements in that carrier's health benefit plan.

• Section 2233.70 implements existing law requiring that "stop loss" coverage not be issued to self-insured small employers unless those small employers' plans impose limitations on coverage of newly eligible persons no stricter than those set forth in the law.

• Section 2233.80 defines the term "participation requirements" because existing law imposes restrictions on carriers' application of participation requirements but does not define the term. "Participation requirements" are standards set by a carrier requiring that a stipulated minimum percentage of a small employer's eligible employees must be enrolled as a condition of sale. Section 2233.82 states that a carrier shall not determine whether a small employer is satisfying the carrier's participation requirements more frequently than on each anniversary of the small employer's health benefit plan.

These emergency regulations expire 120 days from their effective date.

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

• ***Life Insurance Disclosure Regulations***. Following a May 25 hearing and its review and consideration of public comments, DOI released a modified version of its regulatory action repealing sections 2545–2545.5 and adopting new sections 2546–2546.13, Title 10 of the CCR, which would 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. *[13:2&3 CRLR 131]* The modifications are primarily minor and technical in nature; however, they increase the face amount of exempted policies from $5,000 to $10,000, and lengthen the compliance period by when insurers must fully comply with these regulations to 180 days after their effective date. The extended comment period ends on September 30.

• ***Rate Hearing Timelines and Procedures***. On July 12, OAL approved DOI's emergency adoption of new sections 2648.1, 2648.2, 2648.3, and 2648.4, Title 10 of the CCR, which establish timelines for scheduling and commencing administrative hearings on insurers' applications for rate changes pursuant to Insurance Code section 1861.05(c) filed with the Department after July 1, 1993. Rate change applications filed under section 1861.05(c) are deemed approved by the Commissioner unless they are rejected after a DOI administrative hearing within 180 days of the Commissioner's receipt of the application, or unless extraordinary circumstances exist. *[13:2&3 CRLR 131]*

The timelines in these regulations apply only to rate change applications filed under section 1861.05(c) after July 1; and such a rate change application is deemed received by the Department on the date that it is received by DOI's Rate Filing Bureau in San Francisco. Within 14 days of receipt, the Commissioner will review an application for completeness using the detailed filing checklist set forth in section 2648.4; if the application is not complete, the applicant will be informed why within the 14-day period. An applicant whose application is rejected as incomplete may request a hearing within ten days of notice of incompleteness, and a hearing will be held within ten days of DOI's receipt of a request for one.

Once an application is determined to be complete, the Commissioner will publish a public notice of the application, as required by section 1861.05, within ten days of that determination. Notice of the Commissioner's decision to hold a hearing on the application will be provided within 60 days after public notice has been given. Within 20 days of publication of the Commissioner's decision to hold a hearing, the Commissioner or a DOI administrative law judge (ALJ) will give written notice of a scheduling conference to all parties to the proceeding and any other persons interested in intervening in the proceeding; the scheduling conference must be held within 30 days of the notice. During the scheduling conference, the ALJ shall set a date for commencement of the hearing that is less than 180 days from the date the application was received by the Department. Section 2648.3 also establishes factors which may justify a continuance of the hearing beyond the 180-day period.

These emergency rules are effective for 120 days; DOI is expected to submit

the rulemaking record to OAL on their permanent adoption in the near future.

• ***CAARP Coverage for Good Drivers.*** At this writing, DOI staff is still reviewing comments received on the Department's proposed adoption of section 2632.14.3, Title 10 of the CCR. This rulemaking action will implement 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]* At this writing, section 2632.14.3 has not yet been submitted to OAL for approval.

• ***"Substantial Increase in the Hazard Insured Against."*** At this writing, DOI staff is still preparing the rulemaking record on its proposed adoption of section 2632.19, which will define the term "substantial increase in the hazard insured against"—one of the three acceptable grounds for cancellation or nonrenewal of an automobile insurance policy established by Proposition 103. *[13:2&3 CRLR 132; 13:1 CRLR 83]* At this writing, DOI intends to submit the rulemaking record to OAL in mid-October.

• ***Anti-Redlining Regulation.*** On September 17, DOI finally submitted proposed section 2646.6, Title 10 of the CCR, to OAL for review. The proposed rule would establish standards designed to curb the widespread industry practice of "redlining" (refusal to sell insurance to low-income and minority communities). *[13:1 CRLR 83–84; 12:4 CRLR 145–46]* At this writing, the rule is still pending at OAL.

• ***Insurance Fraud Prevention Funding.*** Following an April 29 disapproval, DOI modified the rulemaking packages on its adoption of new sections 2692.1–2692.8 and 2693.1–2693.10, Title 10 of the CCR, which would establish a mechanism for the distribution of funds to district attorney's offices for the investigation and prosecution of automobile insurance fraud and workers' compensation fraud, respectively. *[13:2&3 CRLR 132; 12:2&3 CRLR 172]* On August 25, DOI resubmitted both packages to OAL, where they are pending at this writing.

Executive Life Sale Completed. On September 3, following rejection of last-minute appeals to the Second District Court of Appeal and the California Supreme Court, Commissioner Garamendi relinquished his conservatorship over the failed Executive Life Insurance Company and sold it to a French investment concern led by Mutuelle Assurance Artisinale de France. The action caps over two years of negotiation and rehabilitation efforts since Garamendi's April 1991 seizure of the company, which was failing due to heavy investments in junk bonds. *[11:3 CRLR 129]* Earlier, Garamendi had succeeded in selling Executive Life's junk bond portfolio to another set of French investors for $3.25 billion; in the September 3 transaction, Mutuelle agreed to assume about $7 billion in assets and to put about $300 million into Executive Life, which will now operate under the name Aurora National Life Insurance Company.

California policyholders will be fully covered for the first $100,000 of their policy value. All policyholders will soon receive a letter notifying them of the exact value of their accounts; they will then have 45 days in which to decide whether to opt out and cash in their accounts, or stay with the new company for at least five years. Aurora has estimated that 92% of all policyholders who opt in will likely recover their entire investment. Those who are not fully covered will probably receive about 86% of their account balances beyond the first $100,000.

LEGISLATION

AB 110 (Peace), AB 1300 (W. Brown), AB 119 (Brulte), SB 484 (Lockyer), and **SB 983 (Greene)** comprise a five-bill workers' compensation reform package signed by the Governor on July 16. Each bill was joined to the others, such that all had to be signed or none would take effect; and the bills were urgency bills, such that they took effect immediately upon the Governor's signature. Governor Wilson and the legislature project that the cost-cutting measures in the bills will save approximately $1.5 billion, to be divided equally between premium relief for employers and increased benefits for injured workers. The legislature's passage and Governor's approval of the bills signal the end of a decade-long stalemate over the issue, during which time the system has bloated to its current $12 billion level while benefits to injured California workers are among the lowest in the nation.

• ***AB 110 (Peace)***, as amended May 5, revises numerous aspects of the existing workers' compensation (WC) system. Among many other things, it reduces WC premium rates by 7% from the rates in effect on July 1, 1993, and increases the maximum weekly benefits paid to injured workers effective July 1, 1994. It revises the grounds for cancellation of WC insurance policies, requires either a ten- or thirty-day notice of cancellation, and contains other disclosure requirements aimed at assisting employers in determining their rights and responsibilities under WC policies.

The bill restructures the Industrial Medical Council (IMC) within the Department of Industrial Relations, which is responsible for oversight and administrative functions concerning the medical treatment and evaluation of injured workers; among other things, AB 110 requires the IMC to adopt guidelines for the treatment of industrial injuries, including but not limited to appropriate and inappropriate diagnostic techniques, treatment modalities, length of treatment, and appropriate specialty referrals. The bill also changes the way in which the IMC appoints physicians to serve as qualified medical evaluators (QMEs) and establishes additional qualifications for appointment and reappointment as a QME.

With some exceptions, AB 110 also bans a QME or a physician consulting with a QME from referring an injured worker for any WC medical services to a clinical laboratory for diagnostic nuclear medicine, radiation oncology, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the referring physician or his/her immediate family has a financial interest in the entity receiving the referral.

The bill significantly revamps the vocational rehabilitation (VR) benefits available under WC law. It sets a $16,000 cap on all VR services, including maintenance allowance payments; provides for a cap on counselors' fees of no more than 30% of total cost of VR services; places a 52-week limit on maintenance allowance payments; restricts an employee to one VR plan unless a new plan is needed through no fault of the employee; removes an existing requirement for a 90-day meeting between a VR counselor and a qualified injured worker prior to the development of a VR plan; and prohibits rehabilitation counselors and insurers from making referrals to facilities or programs in which they hold a financial interest. AB 110 also adds new grounds for termination of an employer's liability for VR services.

AB 110 also revises existing provisions related to medical-legal evaluations to, among other things, provide for examinations by the injured worker's treating physician, limit the number of additional examinations, revise provisions relating to payment for those examinations, and specify that no medical-legal evaluations shall be performed prior to 60 days after the employer is notified of the WC claim. The bill also extends an employer's ability to control the cost of health care treatment of injured workers through use of man-

aged care programs. This bill was signed by the Governor on July 16 (Chapter 121, Statutes of 1993).

• ***AB 1300 (W. Brown)***. Existing law prohibits certain false or fraudulent practices in connection with WC claims. As amended May 5, this bill makes various changes to strengthen existing anti-fraud workers' compensation procedures. Among other things, it prohibits a health care provider from performing a medical evaluation for which the evaluator must be certified as a QME, unless the provider is certified; provides that half of the fees recovered from an attorney or law firm related to the use of a runner or capper shall be allocated to the Attorney General or the local prosecuting district attorney for investigation and prosecution of WC fraud and half to the existing Workers' Compensation Fraud Account in the Insurance Fund; provides that any contract for professional services obtained by a clinic, laboratory, or health care provider under fraudulent circumstances is void, and any fees collected pursuant to the void contract are recoverable as additional civil penalties; requires restitution to be ordered for medical evaluations or treatment in connection with fraudulent WC claims; provides that any person who offers to a WC adjuster or any adjuster who accepts specified considerations as compensation, inducement, or reward for the referral or settlement of any claim is guilty of a felony; requires the employee, insurer, employer, and the attorneys for each party in a WC dispute to file a statement under penalty of perjury with the Workers' Compensation Appeals Board that they have not violated the anti-fraud statutes; requires that an individual or organization advertising legal services for WC benefits include the name of at least one attorney associated with the individual or organization in the advertising; prohibits persons convicted of WC fraud from collecting benefits associated with a fraudulent claim; and authorizes the Attorney General, local district attorney, or interested person to bring a civil action for the crime of employing runners, cappers, steerers, or other persons to procure clients to obtain WC benefits. This bill was signed by the Governor on July 16 (Chapter 120, Statutes of 1993).

• ***AB 119 (Brulte)***, as amended May 5, creates new and higher standards of causation in all psychiatric injury cases by requiring an applicant for benefits for psychiatric injury to demonstrate by a preponderance of the evidence that the actual events of employment were the predominant cause among all other causes combined. It also provides that no WC shall be paid for a psychiatric injury if the injury arose from a lawful, nondiscriminatory, good faith personnel action. The bill also provides that no compensation shall be paid by an employer for a psychiatric injury claim filed by an employee after the employee has been laid off or terminated, unless certain conditions are met. This bill was signed by the Governor on July 16 (Chapter 118, Statutes of 1993).

• ***SB 983 (Greene)***, as amended May 5, permits private employers and employee organizations to establish alternative WC programs through the collective bargaining process for employment in construction, maintenance, and related activities. The bill prohibits a collective bargaining agreement that diminishes the entitlement of an employee to compensation; premium rates issued for these agreements will not be subject to the uniform classification system for WC insurance approved by the Insurance Commissioner. This bill was signed by the Governor on July 16 (Chapter 117, Statutes of 1993).

• ***SB 484 (Lockyer)***, as amended May 11, is the appropriations vehicle of this package of WC reform bills. It appropriates $500,000 from the Workplace Health and Safety Revolving Fund to the new Commission on Health and Safety and Workers' Compensation in the Department of Industrial Relations (formerly the Health and Safety Commission); loans $4.6 million from the general fund to the Department of Corporations to cover start-up costs to fund implementation of the reform package; and appropriates $2 million from the Workers' Compensation Administration Fund and $4 million from the general fund to the Division of Workers' Compensation. This bill was signed by the Governor on July 16 (Chapter 119, Statutes of 1993).

SB 30 (Johnston). Existing law authorizes the Insurance Commissioner to regulate WC premium rates by adopting minimum rates. This bill replaces the current minimum rate law on January 1, 1995 with a "file and use" rating system using advisory loss costs and requiring a uniform plan for data collection purposes. Rates may not tend to impair or threaten the solvency of an insurer or tend to create a monopoly. Rates are presumed to create a monopoly if the insurer's market share is 20% or more of the premiums written by all insurers, excepting the State Compensation Insurance Fund. In making these determinations, the Commissioner may give consideration to past and prospective loss and expense experience in this state, dividends or savings, and other relevant factors. This bill was signed by the Governor on July 27 (Chapter 228, Statutes of 1993).

SB 1005 (Lockyer), as amended May 11, restructures the Health and Safety Commission within the Department of Industrial Relations, renames it the Commission on Health and Safety and Workers' Compensation, and charges it with conducting an ongoing examination of the workers' compensation system and the state's activities to prevent occupational injury and disease. (*See* agency report on Cal-OSHA for related discussion.) This bill was signed by the Governor on July 27 (Chapter 227, Statutes of 1993).

SB 223 (Lockyer), as amended September 8, made clean-up changes to the five-bill package described above. This bill was signed by the Governor on October 11 (Chapter 1242, Statutes of 1993).

SB 4 (Johnston). The existing unemployment compensation disability law generally requires each worker to pay contributions at specified rates to the Disability Fund, which is continuously appropriated for the purpose of providing disability benefits to workers who are unemployed due to injury or sickness not related to work. It provides that the rate of worker contributions for calendar years 1993 and 1994 shall not exceed 1.25%, except as provided. As amended September 7, this bill instead provides for a worker contribution rate of up to 1.3%. It also authorizes the Director of the Employment Development Department, at his/her discretion, to increase or decrease, by up to 0.1%, the rate of worker contributions determined pursuant to the aforementioned provisions, up to a maximum worker contribution rate of 1.3%, if he/she determines the adjustment is necessary to reimburse the Disability Fund for disability benefits paid or estimated to be paid to individuals covered by these provisions or to prevent the accumulation of funds in excess of those needed to maintain an adequate fund balance.

Existing law provides that an individual shall be deemed disabled on any day in which, because of his/her physical or mental condition, he/she is unable to perform his or her regular or customary work. This bill provides that, for purposes of these provisions relating to eligibility for disability benefits, if an individual participates in a vocational rehabilitation plan, as specified, regular or customary work shall, upon completion of the plan, mean only that employment for which the individual has been retrained under the vocational rehabilitation plan.

Existing law provides for a waiver, under specified circumstances, of a waiting period during which time no disability payments are payable. This bill repeals the

aforementioned provisions relating to the waiver of a waiting period for disability payments.

Existing law makes an individual ineligible for unemployment insurance disability benefits for any day of unemployment and disability the individual receives, or is entitled to receive, temporary disability indemnity or temporary disability benefits, as provided, in the form of cash payments. This bill additionally makes an individual ineligible for unemployment disability insurance benefits for any day for which the individual receives, or is entitled to receive, permanent disability benefits for the same injury or illness under the workers' compensation law of this state, any other state, or the federal government.

Existing law provides a schedule of the weekly benefit amounts payable for unemployment disability benefits based on the amount of wages paid an individual for employment by employers in the highest calendar quarter and specifies that, for periods of disability commencing on or after January 1, 1991, the weekly benefit amount shall not exceed $343 or the maximum workers' compensation temporary disability indemnity weekly benefit amount, whichever is less. This bill decreases to $336 the maximum weekly benefit amount for periods of disability commencing on or after January 1, 1991.

Existing law requires that a claimant establish medical eligibility for each uninterrupted period of disability by filing a first claim for disability benefits, and for subsequent periods of uninterrupted disability after the period covered by the initial certificate or any preceding continued claim, by filing a continued claim for those benefits supported by the certificate of a treating physician or practitioner containing specified information. It requires that the first and any continuing claim of an individual who obtains care and treatment outside this state, be supported by a certificate of a treating physician or practitioner duly licensed or certified by the state or foreign country in which the claimant is receiving the care and treatment. This bill makes various changes with respect to the information required to be included in the certificate of a treating physician or practitioner. It also authorizes the Employment Development Department, if a physician or practitioner licensed by and practicing in foreign country is under investigation by the Department for filing false claims and the Department does not have legal remedies to conduct a criminal investigation or prosecution in that country, to suspend the processing of all further certifications until the physician or practitioner fully cooperates and continues to cooperate with the investigation, and prohibits a physician or practitioner licensed by and practicing in a foreign country who has been convicted of filing false claims with the Department from filing a certificate in support of a claim for disability benefits for a period of five years. This bill was signed by the Governor on October 2 (Chapter 748, Statutes of 1993).

SB 871 (Johnston). Proposition 103 requires the Insurance Commissioner to notify the public of any application by specified insurers for a rate change, and provides that the application is deemed approved 60 days after public notice, except as specified. However, a rate change application made after July 1, 1993 is deemed approved 180 days after the application is received by the Commissioner unless that application has been disapproved by a final order of the Commissioner subsequent to a hearing or extraordinary circumstances exist (*see* MAJOR PROJECTS). As amended August 19, this bill defines the term "receive" for that purpose to mean the date delivered to the Department of Insurance, and provides that the provision relating to applications being deemed approved after 180 days applies to any refilings, modifications, or supplements to any rate application after July 1, 1993, with respect to rate applications originally made before July 1, 1993. This bill was signed by the Governor on September 30 (Chapter 646, Statutes of 1993).

SB 905 (Maddy). Existing law prohibits any insurer that makes refunds pursuant to premium reduction requirements added by Proposition 103 from requiring insurance agents or brokers to refund to the insurer any portion of their commissions which the insurer claimed, and the Insurance Commissioner allowed, as an expense in determining the insurer's actual return. Existing law specifies that the above prohibition does not affect policyholder refunds payable after a decision in a rate-of-return hearing. As amended May 27, this bill instead provides that in determining the amount of an insurer's rollback obligation, each insurer shall be given full credit for all premium taxes, commissions, and brokerage expenses that the insurer actually paid during the rollback period. It also provides that no insurer shall be required or permitted to seek reimbursement from the state of any premium taxes paid on premiums earned during the Proposition 103 rollback period or reimbursement from any employee or third-party contractor of an insurer of any compensation paid to them for services rendered during the rollback period. This bill was signed by the Governor on October 11 (Chapter 1248, Statutes of 1993).

AB 438 (Burton). Existing law makes it a misdemeanor or a felony for any automotive repair dealer or its employees or agents to knowingly offer or give any discount intended to offset a deductible required by a policy of insurance covering a motor vehicle for making repairs to the motor vehicle. As amended August 26, this bill excepts from this provision cases in which the amount of the repairs has been determined by the insurer and the repairs are performed in accordance with that determination or in accordance with provided estimates that are accepted by the insurer. This bill was signed by the Governor on September 25 (Chapter 462, Statutes of 1993).

SB 206 (Torres). Existing law prohibits an insurer from terminating a written agency contract to transact private passenger automobile insurance solely on the basis of the loss ratio experience developed by the private passenger automobile insurance business underwritten through that agency or solely because the insurance agency submitted applications to the insurer for automobile insurance pursuant to Proposition 103's Good Driver Discount provisions. Under existing law, these provisions do not apply to an agent who is an employee of an insurer, or to an agent who by contractual agreement either represents only one insurer or group of affiliated insurers or who is required by contract to submit risks to a specified insurer or group of affiliated insurers prior to submitting them to others. Under existing law, these provisions will be repealed on January 1, 1994. As amended August 24, this bill deletes the exception for employees and certain contracting agents; provides that for an agent who is an employee of an insurer, or an agent who by contract either represents only one insurer or group of insurers or is required by contract to submit risks to a specified insurer or group of affiliated insurers prior to submitting them to others, these provisions are not intended to prevent the insurer from managing the profitability of its business through the exercise of lawful management techniques, as specified; and extends the January 1, 1994 repeal date to January 1, 1997. This bill was signed by the Governor on October 10 (Chapter 1059, Statutes of 1993).

AB 288 (Polanco). Existing law requires insurers issuing commercial policies of insurance to give notice, at least 45 days but not more than 120 days in advance of the end of the policy period, of nonrenewal (and the reasons therefor),

conditional renewal upon changed terms or conditions, or an increase the premium rate by more than 25%. Where the aggregate premium is $10,000 or less a notice of at least 60 days but not more than 120 days is required, as specified. As amended June 14, this bill increases the minimum 45-day notice period to at least 60 days; deletes the separate notice provision for policyholders whose aggregate premium is $10,000 or less; and provides that the provisions prohibiting notice of nonrenewal earlier than 120 days in advance of the end of the policy period do not apply to professional liability policies issued to health care providers. This bill was signed by the Governor on July 12 (Chapter 103, Statutes of 1993).

AB 2309 (Woodruff). Existing law authorizes a disability insurance policy to provide for payment of all or a portion of a health care provider's charges without requiring that the insured first pay the expenses. As amended August 30, this bill requires group health care service plans (HCSPs) to authorize and permit assignment of a Medi-Cal beneficiary's benefits to the state Department of Health Services. This bill was signed by the Governor on October 2 (Chapter 744, Statutes of 1993).

AB 1834 (Snyder). Existing law does not require HCSPs, disability insurers, and nonprofit hospital service plans to require group contractholders or policyholders to notify their subscribers or insureds of any notice of cancellation by the plan or insurer. As amended August 25, this bill requires those insurers and HCSPs to do so, and also requires those insurers and HCSPs to provide written notice of cancellation to the group contractholders or policyholders. This bill also requires the notice of cancellation to include information regarding the conversion rights of persons covered under the plan contract or group policy. This bill was signed by the Governor on October 10 (Chapter 1154, Statutes of 1993).

AB 2059 (Margolin). AB 1672 (Margolin) (Chapter 1128, Statutes of 1992) regulates the provision of health insurance or similar coverage to small employer groups, generally requires HCSPs and insurers that sell small employer group coverage to fairly and affirmatively market that coverage to all small employer groups, and imposes additional requirements relating to rates, discontinuance, and other matters (*see* MAJOR PROJECTS). As amended July 8, this bill, for that purpose, includes a guaranteed association within the definition of "small employer," and defines "guaranteed associations" to include certain nonprofit professional or industrial associations that include one or more small employers. This bill was signed by the Governor on July 26 (Chapter 217, Statutes of 1993).

AB 1100 (W. Brown), as amended September 8, enacts the Health Insurance Access and Equity Act to prohibit several discriminatory insurance practices affecting people with AIDS. Among other things, the bill prohibits the Commissioner of Corporations from approving any HCSP contract which does not conform to specified requirements; requires HCSPs to provide an actuarial basis for underwriting decisions upon the request of the Commissioner; prohibits HCSPs from engaging in specified postclaim underwriting practices; provides that every policy or certificate of disability insurance marketed, issued, or delivered to a resident of this state regardless of the situs of the contract or master group policyholder shall be subject to the provisions of the Insurance Code, except as specified; requires the Insurance Commissioner to develop and adopt standardized language for informed consent disclosure forms for applicants for life or disability income insurance who take an HIV-related test; with respect to standards and provisions in disability insurance policies, requires policy questions relating to medical conditions to be clear and unambiguous, and application questions to be based on medical information that is reasonable and necessary for medical underwriting purposes; shortens the time limits for certain defenses, as specified, and prohibits disability insurers from engaging in postclaims underwriting; expands the recordkeeping requirements of life and disability insurers pertaining to the rescission, termination, or nonrenewal of a policy or contract; and requires all employers to provide employees an outline of coverage, and upon termination, notification of continuation, extension, and conversion rights. This bill, which was supported by Consumers Union and a number of AIDS advocacy organizations, was signed by the Governor on October 11 (Chapter 1210, Statutes of 1993).

SB 649 (Leslie). Existing law authorizes DOI to impose various fees, including various fees based upon the cost of performing regulatory functions. As amended May 4, this bill requires the Bureau of State Audits, on or before April 1, 1994, to publish an audit of DOI to determine if certain rates, fees, or charges are based upon DOI's actual costs. The bill provides that the report would be a public record. This bill was signed by the Governor on October 11 (Chapter 1247, Statutes of 1993).

SB 1065 (Mello). Existing law authorizes every individual life insurance policy to be returned by the owner for cancellation not less than 10 days nor more than 30 days after delivery; all premiums and policy fees paid are required to be returned to the owner if the policy is cancelled. As amended August 16, this bill adds additional provisions which permit a senior citizen, as defined, to cancel any policy of life insurance within 30 days following delivery, as specified; it requires those policies to contain a notice of that provision. Those provisions will be inapplicable to individual life insurance policies issued in connection with a credit transaction or issued under a contractual policy change or conversion privilege provisions contained in a policy. This bill additionally makes those provisions inapplicable to noncontributory employer group life insurance contracts. The bill also requires offerings of life insurance policies to senior citizens that contain illustrations of nonguaranteed values to contain certain disclosures. It requires annual statements to senior citizen policyowners to disclose the current accumulation value and current cash surrender value, and requires life insurance policies for senior citizens which contain a surrender charge period to disclose the surrender period and penalties associated therewith. This bill was signed by the Governor on September 26 (Chapter 516, Statutes of 1993).

SB 554 (Beverly). Existing law limits the investments that may be made by insurers. Existing law, among other things, authorizes certain domestic incorporated insurers to invest in hedging transactions and positions in interest rate futures contracts or options on interest rate futures contracts and in the purchase and sale of exchange traded options on stock indices, stock index futures contracts, or options on stock index futures contracts. As amended July 6, this bill authorizes any domestic incorporated insurer having admitted assets of a specified amount to purchase insurance futures contracts, purchase call options on insurance futures contracts, and sell put options on insurance futures contracts in bona fide hedging transactions, as specified. The bill authorizes the Insurance Commissioner to adopt rules and guidelines establishing standards and requirements relative to these practices. The bill requires the Commissioner to issue a bulletin by June 30, 1994, setting forth the accounting, reporting, and valuation practices and procedures for insurance futures contracts, unless, prior to that date, accounting practices and procedures are officially promulgated by the National Association of

Insurance Commissioners. The bill also prohibits an insurer from engaging in these hedging transactions until a bulletin has been issued or these accounting practices and procedures are promulgated, whichever comes first. This bill was signed by the Governor on July 30 (Chapter 232, Statutes of 1993).

SB 581 (Deddeh). Existing law limits an increase in premiums, reduction in limits, or change in the condition of coverage during a policy period, as specified, with respect to a policy of commercial insurance unless based upon certain reasons. As amended May 26, this bill additionally provides as a reason, with respect to a change in the rate of a policy of professional liability insurance for a health care provider, an insurer's offer of renewal which notifies the policyholder that a rate change application is filed and pending before the Insurance Commissioner, when that rate change is subsequently approved. It provides that the change shall not be retroactive. This bill was signed by the Governor on October 11 (Chapter 1198, Statutes of 1993).

SB 429 (Lewis). The existing California Automobile Assigned Risk Plan is required to contain, among other things, provisions showing the basis upon which premium charges are made, and the manner of payment thereof. As amended July 7, this bill establishes additional requirements as to the amount and determination of those premium charges. This bill was signed by the Governor on October 10 (Chapter 1133, Statutes of 1993).

SB 175 (Kelley), as amended July 13, provides that insurers and their agents, while they are investigating suspected fraud claims, shall have access to all relevant public records that are required to be open for inspection. This bill was signed by the Governor on September 8 (Chapter 323, Statutes of 1993).

AB 135 (Peace). Existing law provides that it is unlawful to make a false automobile insurance claim. As amended June 28, this bill would enact the Automobile Insurance Truth in Advertising Act to provide that any advertisement, as specified, which solicits persons to present or file automobile insurance claims or to engage or consult counsel to consider an automobile insurance claim, shall contain or include, as specified, a notice or statement that making a false or fraudulent automobile insurance claim is a felony punishable by up to five years in prison or by a fine of up to $50,000 or, if the fraud exceeds $50,000, double the value of the fraud, or by both imprisonment and fine; provide that any advertisement or other device designed to produce leads based on a response from a person to present or file an automobile insurance claim or to engage or consult counsel shall disclose that an agent may contact the individual if that is the fact; prohibit an advertisement, as defined, from using deceptive or misleading names or words or symbols implying that a governmental agency or charitable institution is connected with the advertisement; and provide that any advertiser, as defined, who violates these provisions is guilty of a misdemeanor. *[A. F&I]*

SB 957 (Johnston). Existing law, added by Proposition 103, provides that the rate charged for a good driver discount policy shall comply with specified criteria and be at least 20% below the rate an insured would otherwise be charged for the same coverage. As amended April 15, this bill would authorize 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. *[S. InsCl&Corps]*

AB 1512 (Brulte). Existing law provides that the Insurance Commissioner may appoint administrative law judges with respect to proposed insurance rate change hearings. As introduced March 4, this bill would delete that authority. *[A. F&I]*

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, 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 2035 (Isenberg), as amended June 14, would—contingent upon the enactment of two unspecified Assembly Bills effective January 1, 1994—prohibit 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, as defined; impose 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; and provide that a breach of that duty is actionable, as specified. The bill would become operative July 1, 1994. *[A. Jud]*

SB 684 (Torres), as amended May 18, would require motor vehicle insurers to report specified information to the Commissioner, and require the Commissioner to make the information available to the public and local law enforcement officials. Among other things, this bill would also require each insurer to pay an annual fee of $1.10 for each vehicle under an insurance policy it issues; $0.10 of that fee would be used for the Automobile Insurance Claims Depository, $0.45 would be distributed to local law enforcement agencies for investigation and prosecution of automobile fraud cases; and $0.55 would be distributed to DOI's Bureau of Fraudulent Claims. *[S. Jud]*

AB 456 (Johnson). Under existing law, a person may recover damages for an injury arising out of the operation of a motor vehicle from a person who is liable in tort. Existing law generally requires every driver and owner of a motor vehicle to maintain a form of financial responsibility, which generally is a policy of liability insurance. As amended June 15, this bill would require 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; require insurers to offer additional benefits; provide in any accident caused in whole or part by the negligence of a personal protection benefits insured, that person would be exempt from liability except as specified; prohibit an uninsured motorist from bringing an action for property damage except for damage that exceeds $5,000; limit health care fees, and would require health care providers to provide insurers with a sworn statement under penalty of perjury; and would require disputes to be submitted to arbitration. *[A. F&I]*

AB 574 (Johnson). Existing law requires an applicant for a driver's license to file an application with the Department of Motor Vehicles (DMV) and take an examination testing, among other things, the applicant's understanding of traffic signs

and signals. As amended March 22, this bill would additionally require 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. *[A. Trans]*

AB 2033 (Caldera). Existing law requires the Insurance Commissioner to approve or issue a reasonable plan for the equitable apportionment among liability insurers of applicants for automobile liability insurance who are otherwise unable to obtain that insurance. As amended April 15, this bill would create 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. The bill would require members to sell basic automobile insurance, and would provide for the redistribution of premiums among members, as specified. The bill would provide for a maximum rate until a specified date.

Existing law requires owners of motor vehicles to maintain in force one of the forms of financial responsibility specified in law. This bill would require DMV to require proof of financial responsibility upon registration of a motor vehicle. AB 2033 would become operative only if other unspecified bills are chaptered before it is chaptered; AB 2033 would remain in effect only until January 1, 1999. *[A. F&I]*

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 accidents 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, 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 9 (Mountjoy), as amended May 20, would—among other things—provide 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; provide that the psychiatric aggravation of a physical injury or disease arising outside of the course and scope of employment is not compensable; provide that no compensation shall be paid for a psychiatric injury claim filed after the employee has been laid off or terminated unless the employee has established in a civil action otherwise authorized by law that the personnel action was illegal, discriminatory, or in bad faith; and provide that an employer has the right to examine the entire claim file of its insurer concerning any claim against the employer, except those documents which the insurer is privileged from disclosing to the employer under the attorney-client privilege. *[A. F&I]*

AB 2034 (Polanco). Existing law authorizes the Administrative Director of the Division of Workers' Compensation to prepare and establish an official medical fee schedule for medical services, provided pursuant to the workers' compensation laws, for industrial accidents. Existing law does not provide for a medical fee schedule for medical costs incurred under a policy of automobile liability insurance. As amended April 19, this bill would provide 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 the above-specified schedules for industrial accidents, except as specified. This bill would also require the Insurance Commissioner, in consultation with the Administrative Director, to adopt rules and regulations implementing and coordinating these requirements with the workers' compensation laws regarding medical fee schedules, as specified.

This bill would prohibit a health professional from charging a fee for covered services in excess of the fee schedules adopted by the Commissioner and would require insurers to report to DOI's Bureau of Fraudulent Claims improper actions by health professionals in connection with a claim for services. This bill would also require the Commissioner to issue regulations establishing an arbitration system for resolution of fee disputes between health professionals and insurers. *[A. F&I]*

AB 997 (Tucker). Existing law requires every private employer to secure the payment of workers' compensation by obtaining insurance or becoming self-insured. Where an employer fails to secure these payments, the Director of Industrial Relations is required to issue a stop order prohibiting the use of labor by the employer and to assess monetary penalties of $2,000–$10,000 per employee at the time the appeal becomes final. As amended May 12, this bill would require the uninsured employer to pay, in addition to these 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. *[A. F&I]*

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, 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. Floor]*

AB 2002 (Woodruff), as amended June 28, would be known as the "Filante Health Care Act." It would authorize HCSPs, nonprofit hospital service plans, and disability insurers to provide rate incentives for covered individuals or enrollees, as the case may be, to adopt healthful lifestyles, as prescribed, the rate incentives to be based on actuarial considerations related to the differences in lifestyle. The bill would require the Commissioner of Corporations to adopt guidelines by June 30, 1994, and would permit the Commissioner to adopt regulations defining a "healthful lifestyle" for HCSPs. It would also require the Insurance Commissioner to adopt guidelines and would permit the Commissioner to adopt regulations defining a "healthful lifestyle" for disability insurers and nonprofit hospital service plans. *[S. InsCl&Corps]*

SB 1146 (Johnston). Existing law provides that a HCSP, a self-insured employee welfare benefit plan, a disability insurer, a life insurer, 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 asso-

ciated with disability in that person's offspring, but which causes no adverse effects on the carrier. Existing law contains similar provisions prohibiting rate discrimination and commission discrimination on that basis. Violation of these provisions with regard to a HCSP is punishable as a crime. As introduced March 5, this bill would prohibit those forms of refusal and discrimination by HCSPs, self-insured employee welfare benefit plans, disability insurers other than disability income insurers, 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.

Existing law also provides that no life or disability insurer shall fail or refuse to accept an application or to issue insurance, or issue or cancel insurance, except with regard to reasons applicable alike to persons of every race, color, religion, national origin, ancestry, or sexual orientation, and that these reasons shall not, of themselves, constitute a risk for which a higher rate, premium, or charge may be required. This bill would additionally provide that, effective until January 1, 2002, except as otherwise permitted by law, these insurers shall not fail or refuse to accept an application or to issue insurance, cancel insurance, charge a higher rate or premium, or place a limitation on coverage, on the basis of a test of a person's genetic characteristics, as specified. However, the bill would permit a life or disability income insurer to decline an application or enrollment request, charge a higher rate or premium, or place a limitation on coverage, on the basis of a test of a person's genetic characteristics, with regard to policies issued or delivered on or after January 1, 1994, which are contingent upon review or testing for other diseases or medical conditions, subject to certain informed consent and privacy protections. *[A. Health]*

SB 38 (Torres), a reintroduction of SB 6 (Torres) (which was vetoed by Governor Wilson on September 30, 1992 *[12:4 CRLR 149]*) has been amended into **SB 1098 (Torres)**. As amended September 8, SB 1098 would create the California Health Plan Commission, with specified powers and duties, which would 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. *[S. Conference Committee]*

SB 1106 (Torres). Existing law prohibits admitted insurers, excluding automobile and workers' compensation insurers, from failing or refusing to accept an application for, or issuing a policy to, an applicant for that insurance, or cancelling that insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every marital status, sex, race, color, religion, national origin, or ancestry; nor may sex, race, color, religion, national origin, or ancestry of itself constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance. As amended August 24, this bill would enact a comprehensive anti-redlining scheme with respect to certain automobile, fire, homeowner's, 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, as specified; 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, 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. F&I]*

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

AB 1667 (Hoge). Existing law establishes a California Insurance Guarantee Association and specifies those insurers which are required to be members of the Association; it exempts certain classes of insurance from assessments and other requirements of the Association. As amended May 12, this bill would specifically enumerate those exempt classes of insurance and provide 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. *[S. InsCl&Corps]*

SB 1066 (Mello), as amended April 15, would prohibit 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, as specified. It would provide for

certain administrative penalties for any violation of that requirement. *[S. Appr]*

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, 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). Existing law prohibits certain discriminatory practices by admitted insurers, as specified. As amended July 8, this bill would create, in DOI, an Insurance Availability Study Commission 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]*

SB 286 (Presley), as amended August 19, is no longer relevant to the Department of Insurance.

LITIGATION

On June 3, the California Supreme Court granted the petitions of Commissioner Garamendi and Voter Revolt and agreed to transfer their appeals of the trial court's decision in ***20th Century Insurance Company v. Garamendi***, No. BS016789 (Feb. 26, 1993), from the Second District Court of Appeal to the high court. In her February ruling, Los Angeles County Superior Court Judge Dzintra I. Janavs invalidated the Commissioner's regulations implementing Proposition 103's rollback requirement, and declared null and void the Commissioner's order requiring 20th Century to refund over $100 million to its 1989 auto, home, and business insurance policyholders. *[13:2&3 CRLR 139–40]* At this writing, briefing in the matter is ongoing; the case has not been set for oral argument.

In a related ruling, the Supreme Court refused to consolidate the ***20th Century*** case with the insurance industry's appeals of the Second District Court of Appeal's decisions in ***Safeco Insurance Co. v. Garamendi***, 14 Cal. App. 4th 1141 (1992) *[13:1 CRLR 86]*, and ***State Farm Mutual Automobile Insurance Co. v. Garamendi***, 15 Cal. App. 4th 546 (1993). In those cases, the appellate court held that Commissioner Garamendi is authorized to scrap the rollback regulations of his predecessor and adopt his own rules to guide calculation of a company's rollback liability.

On August 19, a panel of the Second District Court of Appeal heard oral argument in ***Amwest Surety Insurance Company v. Wilson***, No. B05839, regarding the extent to which the legislature may amend Proposition 103. The initiative states that the legislature may amend it only to "further its purpose." In this matter, the Commissioner and Voter Revolt contend that the legislature's passage of AB 3798 (Johnston) (Chapter 562, Statutes of 1990), which exempted surety companies from the rollback and prior approval provisions of Proposition 103, does not "further the purpose" of the initiative and is thus beyond the authority of the legislature. *[13:2&3 CRLR 130; 11:3 CRLR 133–34]* Resolution of this issue is critical, as several bills are pending in the legislature which would eviscerate the provisions of Proposition 103 enacted by the voters (*see* LEGISLATION).

On August 24 in ***ACL Technologies, Inc. v. Northbrook Property and Casualty Insurance Company***, 17 Cal. App. 4th 1773, the Fourth District Court of Appeal affirmed the trial court's decision and ruled that the "sudden and accidental" exception to the pollution exclusion contained in the 1973 version of the standard comprehensive general liability (CGL) insurance policy does not require coverage for damage arising from gradual leakage from underground storage tanks. *[11:4 CRLR 139]* Focusing on the language of the policy and finding that a covered pollution incident must be both "sudden" and "accidental," the court held that "there is no way that we could come to any other conclusion than that...the 'sudden and accidental' language in the CGL pollution exclusion does not allow for coverage for gradual pollution." In the words of the court, "gradual is the opposite of sudden"; thus, the exception to the exclusion does not apply, the pollution exclusion applies, and clean-up costs are not covered under a standard CGL policy.

On June 29, the U.S. Supreme Court issued a splintered decision in ***Hartford Fire Insurance Co., et al. v. California, et al.***, No. 91-1111, affirming in part and reversing in part the decision of the U.S. Ninth Circuit Court of Appeals in *In Re Antitrust Litigation*, 938 F.2d 919 (1992). In that decision, the Ninth Circuit held that domestic insurers lose their antitrust immunity under the federal McCarran-Ferguson Act when they engage in a group boycott with foreign insurers. *[13:1 CRLR 86]* On this issue, the Supreme Court unanimously reversed, holding that McCarran-Ferguson Act immunity applies to activities (not entities), and extends to otherwise unlawful conspiracies that include foreign reinsurers. However, a 5–4 majority found that plaintiffs' (nineteen states) group boycott allegations against the industry fit within the narrow boycott exception to the Act's immunity, such that they should proceed to trial. A different 5–4 majority held that foreign-owned companies may be sued under U.S. antitrust law for activities taken outside the United States. The Court remanded the matter back to the Ninth Circuit, which—barring settlement—presumably will remand it to the district court for discovery proceedings and trial.

DEPARTMENT OF REAL ESTATE

Commissioner: Clark E. Wallace
(916) 739-3684

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 commissioner's principal duties include determining administrative policy and enforcing the Real Estate Law in a manner which achieves maximum protection for purchasers of real property and those persons dealing with a real estate licensee. The commissioner is assisted by the Real Estate Advisory Commission, which is comprised of six brokers and four public members who serve at the commissioner's pleasure. The Real Estate Advisory Commission must conduct at least four public meetings each year. The commissioner receives additional advice from specialized committees in areas of education and research, mortgage lending, subdivisions and commercial and business brokerage. Various subcommittees also provide advisory input.

DRE primarily regulates two aspects of the real estate industry: licensees (as of September 1993, 255,158 salespersons and 115,974 brokers, including corporate officers) and subdivisions. Certified real estate appraisers are not regulated by DRE, but by the separate Office of Real Estate Appraisers within the Business, Transportation and Housing Agency.

License examinations require a fee of $25 per salesperson applicant and $50 per broker applicant. Exam passage rates av-