the point of a fountain pen than the point of a gun." Paraphrasing folk singer Woody Guthrie, Los Angeles County Superior Court Judge Lance Ito, who presided over the criminal trial of ***People v. Keating***, prefaced his sentence and fine of former savings and loan kingpin Charles H. Keating, Jr. On April 10, Ito gave Keating the maximum ten-year prison sentence, fined him $250,000, and ordered him jailed immediately. Keating, 68, was convicted on December 4 on 17 counts of securities fraud counts stemming from the failure of Lincoln Savings and Loan. *[12:1 CRLR 116]*

People of the State of California v. American Continental Corporation (ACC), the Department's civil fraud action against Keating, the bankrupt ACC, and two of ACC's top officers, is still pending before U.S. District Judge Richard M. Bilby. *[12:1 CRLR 116]* At this writing, the Department is monitoring the ongoing jury trial against Keating and several co-defendants in consolidated class actions, which commenced in March in Tucson. DOC will reevaluate the utility of pursuing its lawsuit against Keating and/or his co-defendants if and when a judgment is returned against them.

DEPARTMENT OF INSURANCE

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Insurance is the only interstate business wholly regulated by the several states, rather than by the federal government. In California, this responsibility rests with the Department of Insurance (DOI), organized in 1868 and headed by the Insurance Commissioner. Insurance Code sections 12919 through 12931 set forth the Commissioner's powers and duties. Authorization for DOI is found in section 12906 of the 800-page Insurance Code; the Department's regulations are codified in Chapter 5, Title 10 of the California Code of Regulations (CCR).

The Department's designated purpose is to regulate the insurance industry in order to protect policyholders. Such regulation includes the licensing of agents and brokers, and the admission of insurers to sell in the state.

In California, the Insurance Commissioner licenses approximately 1,300 insurance companies which carry premiums of approximately $63 billion annually. Of these, 600 specialize in writing life and/or accident and health policies.

In addition to its licensing function, DOI is the principal agency involved in the collection of annual taxes paid by the insurance industry. The Department also collects more than 170 different fees levied against insurance producers and companies.

The Department also performs the following functions:

(1) regulates insurance companies for solvency by tri-annually auditing all domestic insurance companies and by selectively participating in the auditing of other companies licensed in California but organized in another state or foreign country;

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

(3) reviews formally and approves or disapproves tens of thousands of insurance policies and related forms annually as required by statute, principally related to accident and health, workers' compensation, and group life insurance;

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

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

(6) becomes the receiver of an insurance company in financial or other significant difficulties.

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

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

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

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

MAJOR PROJECTS:

Governor Again Overrules OAL's Rejection of Proposition 103 Rollback Regulations. On February 14, Governor Wilson overruled Office of Administrative Law (OAL) Director Marz Garcia's rejection of sections 2641.1–2647.1, Title 10 of the CCR, DOI's emergency regulations designed to implement the rate rollback provisions of Proposition 103.

The Valentine's Day ruling marked the second time the Governor has overruled his own appointee's rejection of the Department's emergency rollback regulations. Last October, Wilson overrode a similar rejection, paving the way for Commissioner Garamendi to order $1.5 billion in rebates and to continue administrative hearings on several insurers' challenges to those orders. *[12:1 CRLR 116–17; 11:4 CRLR 131–32]* Because emergency rules are effective for only 120 days and they were due to expire on December 11, DOI filed two rulemaking packages with OAL that day: permanent rollback regulations to replace those which were expiring, and another set of emergency rules to avoid any lapse in the regulations should OAL require revisions in the permanent rules. On January 10, OAL rejected both packages. Following negotiations with OAL, DOI submitted an amended version of the emergency rules on January 15.

In a ruling that was similar to his September 1991 rejection, OAL Director Garcia rejected them on January 23, for failure to satisfy the authority and consistency standards of Government Code section 11349.1. Specifically, Garcia found that the regulatory scheme embodied in the emergency rules allegedly "restricts an insurer's right to obtain relief from confiscatory rates," in violation of state statute and the California Supreme Court's opinion in *Calfarm v. Deukmejian*, 48 Cal. 3d 805 (1989). The regulatory scheme involves use of a "single, consistent methodology" (a mathematical calculation using numbers drawn mostly from company-specific data but partly from norms established by the Commissioner, plus several variances which may be claimed by insurers in specified circumstances). The use of the single "generic" model developed by the Department through years of rulemaking and established in DOI regulations, without exception (other than the variance opportunities) and without ability on the part of insurers to "relitigate" the methodology, was said to be the only way to ensure

consistency and enable the Department to handle the challenges of 450 insurers to rollback orders.

However, Garcia interpreted *Calfarm* to require the Commissioner to "carefully scrutinize" the regulatory mechanism by which rates are established to ensure that insurers have an adequate remedy for relief from confiscatory rates, and rejected the rules because he interpreted the confluence of sections 2644.1 and 2646.4(e) to prohibit the Commissioner from approving any rate which is not the result of the regulations' required calculations and/or any of three grounds for a variance from those required calculations. Garcia found this "limitation on the commissioner's discretion to approve a rate" to be unauthorized and violative of the prescription of *Calfarm*. He expressly found the relitigation bar in section 2646.4(e) to be "inconsistent with the insurer's right to [a] fair and meaningful hearing and contradictory to *Calfarm*." In sum, Garcia concluded: "The Commissioner is not authorized to override an insurer's right to relief from confiscatory rates in the interest of efficient administrative practices." Garcia also noted that he had made these same objections in his September 1991 ruling, and that DOI's modifications to the offending regulations were "cosmetic" and unresponsive to either Garcia's concerns or the public comment registered by the insurance industry.

On January 30, Commissioner Garamendi appealed Garcia's ruling to Governor Wilson. Garamendi complained about OAL's repeated rejection of the rollback regulations in spite of the fact that DOI had modified them on numerous occasions to meet OAL's concerns; every time DOI agreed to a modification, OAL would release it for public comment, encounter the usual barrage of opposition by the insurance industry, and decide that DOI's modification made specifically to meet OAL's objections was no longer satisfactory. On the merits, Garamendi stressed the dicta in *Calfarm* which recognized the "broad discretion" of the Insurance Commissioner to fashion rules to implement Proposition 103. He disputed the notion that the rules somehow limit his discretion and rejected OAL's concerns with the ban on "relitigating" the formula: "The regulation does not preclude the Commissioner from entertaining suggestions for different rules; it simply requires that those suggestions be made in a rulemaking petition rather than in a company-specific hearing. That is, of course, the soundest policy."

A footnote in Garamendi's appeal underscores the political overtones in this dispute. In footnote 12, the Commissioner correctly notes the "rich irony" in OAL's position on these regulations. "In the usual case, an agency has evolved a policy, it invariably follows that policy, but it refuses to give the public notice of the policy by putting it in a regulation. That is the familiar problem of 'underground regulations,' eradication of which is a major mandate of OAL....Here, the Department of Insurance has done precisely what OAL ordinarily seeks—and what administrative law authorities uniformly encourage: the explicit adoption of policy as regulations. And suddenly, it is OAL, not the agency, that is insisting on escape clauses and loopholes, on clauses that leave unclear the scope of the agency's policy."

The legislature leapt into the fray on February 10 by approving an advisory resolution urging the Governor to overrule Garcia (*see infra* LEGISLATION).

Governor Wilson's February 14 reversal was similar to his October 1991 reversal: "For reasons that in no way affirm the merits of the Commissioner's appeal, but rather in order to hasten final adjudication of substantive as well as procedural questions arising from Proposition 103, I choose to exercise my power to resolve the dispute by overruling the decision of OAL." Defending OAL's "scrupulous[] fulfill[ment of] its responsibility" and castigating DOI for "more than three years of false starts and misuse of the regulatory process" and "insurers and their lawyers" for abuse of process, the Governor overruled OAL so that DOI could continue its administrative hearings on individual challenges and a test case could emerge—one that would provide "clear guidance from the courts" on the validity of Garamendi's "comprehensive and largely inflexible regulatory methodology." Governor Wilson also announced that "no further appeals on Proposition 103 regulations will be considered by this Office," in effect denying DOI the administrative appeal route mandated by Government Code section 11349.5; this action will force DOI to turn to the courts to overturn any future unfavorable OAL decisions regarding Proposition 103 regulations.

Emergency sections 2641.1–2647.1 are effective until June 11. In the meantime, DOI released a revised version of its proposed permanent sections 2641.1–2647.1 for a 15-day comment period ending on April 9. To assuage OAL and the insurance industry, the modified regulations soften the "relitigation bar" in section 2646.4(e). As modified, the section permits the ALJ to admit "evidence he/she finds relevant to the determination of whether the rate is excessive or inadequate (or, in the case of a proceeding under Article 5, relevant to the determination of the minimum confiscatory rate), whether or not such evidence is expressly contemplated by these regulations, provided the evidence is not offered for the purpose of relitigating a matter already determined by these regulations or by a generic determination."

In other Proposition 103 rulemaking, OAL still has not approved on a permanent basis DOI's adoption of sections 2645.4–2645.6, Title 10 of the CCR, rules which also affect a company's rollback obligation. Under these rules, which were approved as emergency regulations in October 1991 and reapproved as emergency regulations on February 20, an insurer's rollback obligation will be calculated under a maximum 10% rate of return. These rules also establish tests for determining whether insurers have inappropriately strengthened their reserves, and the appropriate type and amount of fixed expenses which may be included in the fair rate of return calculation (which expressly excludes unreasonable executive compensation). *[11:4 CRLR 131; 11:3 CRLR 129–30]* These rules were scheduled to expire on June 20.

Governor's Ruling Permits Rollback Hearings to Continue: 20th Century Ordered to Refund $102 Million; Mercury Settles. Governor Wilson's February 14 reversal of OAL's ruling enabled DOI to complete two lengthy administrative hearings on insurers' challenges to their rollback liability, as calculated by the Commissioner under his methodology. In late 1991, 20th Century had been ordered to refund $106 million, and the Mercury Group was directed to rebate $65.1 million to its policyholders. Following a protracted and interrupted adjudicatory hearing, DOI Administrative Law Judge Elizabeth LaPorte concluded that 20th Century owes $101.8 million under Proposition 103's rollback provision, which averages out to $157 per policyholder (or 12.2% of the premiums paid between November 1988 and November 1989); Commissioner Garamendi adopted her recommendation on May 8—nearly three years to the day from the date upon which the California Supreme Court upheld the facial constitutionality of Proposition 103 in *Calfarm*. The Commissioner's ruling set the stage for the long-awaited "as applied" challenge to the application of the rules adopted by the Commissioner to a specific company which has exhausted its administrative remedies. The challenge

came on May 24, when 20th Century filed its lawsuit in Los Angeles County Superior Court, *20th Century Insurance Co. v. Garamendi*, No. BS016789.

In brighter news for consumers, the Mercury Insurance Group agreed in late May to refund 10.2% of the 1988–89 premiums paid by its policyholders. The percentage, plus interest, totals approximately $46 million. At the time the settlement was announced, the Department had completed Mercury's adjudicatory hearing, but no recommendation had been made by the ALJ. Commissioner Garamendi called the settlement "a major breakthrough" and urged the rest of the industry to follow the lead of Mercury and the Automobile Club of Southern California, which agreed last October to refund $80 million to its policyholders. *[12:1 CRLR 117]*

DOI Revises Regulations Defining Unfair Claims Settlement Practices. On April 10, the Department released a revised version of its landmark regulations defining unfair claims settlement practices. The proposed regulations were developed by DOI in conjunction with its Consumer Complaints and Unfair Practices Task Force, and are intended to define with specificity the full range of unfair acts or types of conduct prohibited by Insurance Code section 790.03(h). *[12:1 CRLR 117–18; 11:4 CRLR 132]*

The major changes made by DOI to its originally-proposed regulations include the following:

–The definition of the term "licensee" in section 2695.2(n) was revised to mean any person who holds a license or certificate of authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" expressly includes surplus line brokers and special lines surplus line brokers.

–Section 2695.1(e) was amended to clarify that these regulations do not apply to liability insurance for the professional negligence of health care providers as defined in Code of Civil Procedure section 364(f)(1) and (2).

–With respect to all policies, upon receiving notice of a claim, every insurer must acknowledge receipt of the claim and provide necessary claim forms, instructions, and reasonable assistance within 15 calendar days. Originally, section 2695.5(a) required acknowledgement within 15 calendar days for personal policies but permitted 21 calendar days for commercial policies, title policies, and bonds. Similarly, revised section 2695.6(a) requires all insurers to begin any necessary investigation within 15 calendar days of the receipt of a claim.

–Section 2695.6(g) was amended to provide that "no insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low."

–DOI deleted sections 2695.14(a) and (b), which previously provided that a single act enumerated in Insurance Code section 790.03(h) or these regulations, when knowingly committed, shall constitute a violation of section 790.03(h) and these regulations; and that acts defined in these regulations, when performed with such frequency as to indicate a general business practice, shall constitute a violation of section 790.03(h). Also deleted in the revised version is section 2695.14(d), which created a rebuttable presumption that a licensee has violated section 790.03(h) and these regulations "where the Commissioner has a reasonable basis supported by credible evidence to believe that a licensee is committing acts with such frequency as to constitute a general business practice, or where the Department has received multiple consumer complaints as defined in these regulations against the licensee and has proceeded against the licensee...." Under the now-deleted section, an insurer could rebut the presumption by demonstrating that at least 90% of the claims handled by the licensee within a credible sampling of all claims handled are in compliance with these regulations.

–Finally, the Department substantially modified section 2695.16, which established detailed reporting requirements applicable to all insurers. This section was the subject of considerable opposition by the insurance industry.

DOI received public comments on the revised regulations until May 11; at this writing, the Department is reviewing the comments received. It hopes to issue a final revised version for additional comments in July, and has until October 22 to submit the regulatory package to OAL.

Update on Intervenor Compensation Regulations. On January 27 and 28, DOI held public hearings on its proposal to adopt new sections 2615.1–2622.10, Title 10 of the CCR. Pursuant to Proposition 103, these regulations would create an intervenor compensation mechanism whereby representatives of consumer interests may recover their advocacy fees and expenses if they participate in specified DOI proceedings and make a substantial contribution to the Commissioner's adoption of any order, regulation, or decision. The rules would also establish a Public Advisor's Office within the Department; the Public Advisor's role is to ensure full and adequate participation by members of the public and representation of all segments of California consumers in DOI proceedings. *[12:1 CRLR 119; 10:1 CRLR 1]*

After incorporating some of the comments received into the proposed regulations, DOI released a modified version of the intervenor compensation rules on April 22. The major change in the modified regulations is the elimination of the two-tiered definition of "market rates" to be paid intervenor counsel and expert witnesses. Previously, the rules authorized payment of the prevailing market rate during adjudicatory proceedings, and the average prevailing rate paid by DOI to independent contractors with similar qualifications during rulemaking proceedings. The two-tiered system has been eliminated, and for purposes of these regulations, the term "market rate" is defined as "the average billing rates of comparable attorneys, advocates or experts in Los Angeles and the San Francisco Bay Area."

DOI reopened the public comment period on the proposed regulations until May 8; at this writing, the Department is reviewing the comments received and preparing the rulemaking file for submission to OAL. Until these regulations are approved, DOI continues to operate under sections 2631.1–2631.6, previously adopted emergency intervenor compensation regulations.

23% Increase in Workers' Compensation Rates Requested Despite Widespread Criticism of State System. The Workers' Compensation Insurance Rating Bureau (WCIRB), an industry association, recently recommended a 23.1% increase in premium rates to become effective July 1, 1992. The recommendation recognized the unpopularity of rate increases during tough economic times, but cited rising industry losses and the high costs associated with the workers' compensation system in calling for the increase. California's workers' compensation system has been widely criticized as one of the least efficient in the nation, with high costs to the employer and low benefits to the injured employee. *[12:1 CRLR 121]* WCIRB's request comes on the heels of Commissioner Garamendi's December 1991 slashing of a proposed 11.9% increase to 1.2%, at which time he suggested that insurers crack down on fraud and systemic problems to defray costs; he has called the latest proposal "a clear signal that the system is out of control." The Commissioner promised to carefully scrutinize the requested rate increase

(which requires an amendment to section 2350, Title 10 of the CCR) at public hearings on May 13 in San Francisco and May 14 in Los Angeles.

The rising dissatisfaction with the California system is expected to lead to major legislative reform; the Senate and the Assembly are currently entertaining over 80 pieces of reform legislation. In addition, on May 24, the Council on California Competitiveness called the state's workers' compensation program "a national embarrassment" and urged cuts in benefits for stress claims and vocational rehabilitation. The Council also proposed instituting tighter cost controls on medical care and scrapping the current ratesetting system to encourage competition among insurers. Despite this mounting interest in overhauling the system, little headway has been made to date.

Other DOI Rulemaking. The following is a status update on rulemaking proceedings instituted by the Department of Insurance in recent months:

–Preinsurance Auto Inspection Regulations. On March 17, OAL approved DOI's adoption of new section 2191, Title 10 of the CCR, pertaining to the inspection of all private passenger vehicles prior to obtaining collision and/or comprehensive auto insurance coverage. The purpose of these regulations is to reduce the likelihood of fraudulent claims based on preexisting damage. *[12:1 CRLR 120; 11:4 CRLR 134]* On April 7, OAL approved slight amendments to the section to conform with the Governor's March 30 approval of AB 1995 (Filante), the latest version of the Preinsurance Inspection Law (*see infra* LEGISLATION). The amendments change the effective date of the regulation to May 1, 1992, omit motorcycles from the scope of the regulation, and add language from AB 1995 to the "notice letter" portion of the regulation for purpose of clarification.

–Prelicensure and Continuing Education Requirements. Following November 1991 public hearings, DOI continues to review the comments received on its proposal to adopt sections 2182 and 2186–2188.7, Title 10 of the CCR. These regulatory changes implement Insurance Code section 1749 *et seq.*, which requires the Commissioner to establish a curriculum board to develop prelicensing and continuing education requirements for fire and casualty broker agents and life insurance agents. The new sections include detailed prelicensure and CE programs developed by the curriculum board. Based on the comments received at the public hearings, DOI hoped to release a modified version of the proposed rules by the end of June.

–Insurance Fraud Prevention Funding. On March 20, DOI commenced two rulemaking proceedings to direct funding toward insurance fraud prevention programs. The first package implements SB 953 (Senate Committee on Insurance, Claims and Corporations) (Chapter 1222, Statutes of 1991). SB 953 amended Insurance Code section 1872.8, part of the Insurance Fraud Prevention Act, which created the Bureau of Fraudulent Claims (BFC) within DOI and established a funding mechanism for the investigation and prosecution of automobile insurance fraud. Insurers fund BFC programs through a per-vehicle-insured assessment mechanism, and the Commissioner allocates funding from the monies collected to BFC and to California district attorneys for purposes of increased investigation and prosecution of automobile insurance fraud cases. SB 953 permitted an increase in the per-vehicle-insured assessment (from 50 cents to $1 per vehicle) and revised the way in which funds from the pool are allocated.

The Department proposes to adopt new sections 2692.1–2692.8, Title 10 of the CCR, to implement SB 953. Among other things, the new regulations would establish the annual fee at $1 per vehicle insured and provide for quarterly assessment of insurers, provide that program funds be distributed on a semi-annual basis, set forth criteria to be used by the Commissioner in allocating the funds to local district attorneys, and specify information which must be include in district attorneys' reports.

The second fraud prevention package implements SB 1218 (Presley) (Chapter 116, Statutes of 1991), which added sections 1872.83 and 1872.9 to the Insurance Code to require the reporting of suspected fraud in workers' compensation insurance and establish a funding mechanism for enhanced investigation and prosecution of workers' compensation insurance fraud (an annual assessment to be fixed by the newly established Fraud Assessment Commission, plus certain fines deposited into the Workers' Compensation Fraud Account in the Insurance Fund). Among other things, proposed regulatory sections 2693.1–2693.10, Title 10 of the CCR, would set forth procedures for the Commissioner's distribution of monies from the fund to BFC and local district attorneys for the purpose of increased investigation and prosecution of workers' compensation fraud, establish the application procedure, and specify the information to be included in district attorneys' reports.

DOI held public hearings on these proposed rules on May 7, and is currently reviewing the comments received. It hopes to release a modified version of the regulations for an additional comment period later this summer.

–Placement of Insurance with Nonadmitted Insurers by Surplus Line Brokers. The Commissioner recently announced his intent to adopt new sections 2174.1–2174.14, Title 10 of the CCR, regarding documentary filings to be made and standards to be applied concerning the placement of insurance by surplus line brokers with nonadmitted insurers pursuant to Insurance Code section 1760 *et seq.* "Surplus line brokers" and "special lines surplus line brokers" are licensed by DOI and are the only brokers authorized to place insurance with nonadmitted insurers. Section 1765.1 of the Insurance Code authorizes the Commissioner to (1) require any surplus line broker or special lines surplus line broker licensed by the Commissioner to provide full and complete information regarding the financial stability, reputation, and integrity of any nonadmitted insurer with which such licensee has dealt or proposes to deal in the transaction of insurance business; and (2) after examining the information received from the licensee, to order the licensee in writing to place no further insurance business with the nonadmitted insurer if the Commissioner believes such order to be in the public interest. Sections 2174.1–2174.14 would generally specify when licensees should file information on nonadmitted insurers and what information should be filed; set forth the standards for evaluating the financial stability, reputation, and integrity of nonadmitted insurers; and establish procedures relating to orders to place no further business with specified nonadmitted insurers. DOI was scheduled to hold public hearings on this proposal on July 28 in San Francisco and July 29 in Los Angeles.

–CAARP Rate Increases. In December and January, DOI held lengthy public hearings on the proposal of the governing board of the California Automobile Assigned Risk Plan (CAARP) to increase its private passenger automobile insurance rates. The CAARP board seeks an average 207.8% increase in bodily injury and property damage coverage, 132.9% increase in medical payments coverage, and 174.6% increase in uninsured motorist coverage. Since the commencement of the rulemaking proceeding in October 1991, consumer groups have been fighting the proposed increases, contending that low-income drivers already victimized by insurer redlining will be unable to afford

CAARP insurance, and will go uninsured. (*See supra* report on PUBLIC ADVOCATES; *see also 12:1 CRLR 119–20.*) At this writing, no decision on the proposal has been announced.

Earthquake Insurance Program Likely to be Scuttled. The Green, Hill, Areias, Farr California Residential Earthquake Recovery Fund, enacted by the legislature at the urging of former Governor Deukmejian after the 1989 Loma Prieta earthquake, will likely be abandoned due to mounting political skepticism of its financial viability. The program was designed to ease homeowner expenses in the event of a major quake, but has been severely criticized by Commissioner Garamendi as being inadequately funded if a major quake centered in an urban area strikes in the next few years. *[12:1 CRLR 121–22; 11:4 CRLR 134]* Opposition to the program has been growing steadily, despite recent earthquakes in both northern and southern California which caused extensive damage to residential structures. Residents in these affected area may file a claim if they paid the 1992 program surcharge on their homeowners' insurance or if they have not yet been billed. Those who have been billed but have refused to pay are not eligible.

Governor Wilson, who earlier criticized Commissioner Garamendi for politically sabotaging the program, has grudgingly joined the ranks of those calling for its demise. The Commissioner has been accused of scuttling the recovery fund in an attempt to avoid the political embarrassment of running a potentially deficit-ridden program. The ill-fated program is the subject of several bills including AB 2049, which would repeal the law creating the program (*see infra* LEGISLATION).

Pacific Mutual Chosen to Rehabilitate First Capital After Late Bidding Flurry. Four groups recently submitted offers to buy failed First Capital Life Insurance Company, which was seized by DOI in May 1991 after thousands of policyholders, frightened by First Capital's junk bond holdings, cashed in their policies. *[11:3 CRLR 129]* Shearson Lehman Brothers was first to bid on February 5, offering to infuse $50 million into the insurer. Policyholders would receive 100% of their policy value if they hold on to their policies for five years. Those cashing out before the end of five years would receive anywhere from 75–95% of the policy value, depending on the length of time they wait before cashing out. First Capital has 190,000 life insurance policyholders and 62,000 annuity holders in 49 states.

However, shortly before the bidding deadline, Pacific Mutual Insurance, Transamerica Occidental Life, and a group led by Leucadia National Corporation filed formal offers. The new offers closely paralleled the $50 million bid by Shearson Lehman.

On April 24, Commissioner Garamendi announced that he had selected Pacific Mutual as the winner in the bidding contest. The insurer, which is based in Newport Beach, is one of the largest on the west coast, with nearly $50 billion in assets. The acquisition of First Capital would roughly double Pacific Mutual's policyholders and give it 40% more assets. The bid calls for the insurer to inject $50 million into First Capital. Policyholders may immediately cash out their policies at 90% of their value or may retain their policies and receive 100% of their value in five years; Pacific Mutual has guaranteed an interest rate of at least 4% per year. Commissioner Garamendi chose the bid because of its guarantee of security and high dollar return to policyholders.

The Commissioner's decision is not final, since the plan must be approved by the Los Angeles County Superior Court. In addition, the other bidders are free to sweeten their offers prior to the final decision.

Garamendi Offers Intriguing Alternative in Gridlocked Health Care Insurance Debate. Four separate health insurance proposals are currently before the legislature or electorate.

Although it purportedly abandoned its proposal last winter *[12:1 CRLR 122]*, the California Medical Association (CMA) circulated for signatures and submitted a statewide ballot initiative for petition qualification on April 30; CMA's ballot initiative has now qualified for the November ballot. The proposal basically mandates health insurance provision by employers of five or more persons for employees working more than 17.5 hours per week and on the job more than 2.5 months, and their families. Exclusions would be prohibited. The average cost per family would be approximately $250 per month, which would be borne 75% by employers and 25% by employees. The benefits would be limited to 20 doctor visits and 45 hospital days per year; all elective procedures (including abortions) are excluded. CMA contends that 70% of the current uninsured population would be reached by the proposal and basic health care coverage would be achieved. Many of those newly covered would be previous Medi-Cal recipients, allowing for substantial public savings.

Critics of CMA's plan contend that it excludes large numbers of those most in need, imposes a disproportionate burden on barely surviving small businesses, and violates federal law currently prohibiting states from requiring employers to provide health insurance. The most vociferous critic of the plan is Health Access, a broad-based coalition of public interest and consumer groups attempting to enhance access to medical care. Health Access argues that the doctors' initiative includes no measures to contain medical costs, nor does it promise reduction in the enormous administrative costs of the current system of fragmented insurance claim paperwork burdening providers. The CMA initiative is widely viewed as an effort to obtain substantial additional revenues for basic health care and for enhanced physician remuneration without improving the efficiency of the system, leaving many without coverage, and without any sacrifice by the medical providers who have gained disproportionately from the medical price increases over the past decade. (*See supra* report on CONSUMERS UNION for related discussion.)

Health Access' alternative was proposed as SB 36 (Petris); that bill was killed on the Senate floor on January 30 and the plan has since been amended into SB 308 (Petris) (*see infra* LEGISLATION). The current version is a universal health care coverage single-payor system with the following major features. All California residents would be covered; benefits include preventive care, mental health, and long-term care. Consumers may choose an open plan (fee for service) or a prepaid health plan option, allowing for choice of provider. The system would be administered through a California Health Care Commission, which will serve as a single payor, bargaining for rates with hospitals and other providers, reviewing hospital capital improvements of over $500,000, and centralizing all claims and payments. The fifteen-member Commission will include four members appointed by the Governor, four by the Assembly Speaker, four by the Senate Rules Committee, and three by the Insurance Commissioner.

Proponents of SB 308 argue that this system, modeled after the Canadian plan, will provide substantial savings in administrative efficiency. The system would be financed by a 10% payroll tax imposed in place of existing health care insurance contributions. Small business contributors (under 25 employees) would be subsidized during the first three years of operation. Employees would contribute a

1.5% income tax surcharge if their annual earnings exceed 250% of the federal poverty level ($16,623 for one person, $33,400 for a family of four). State government will continue Medi-Cal contributions, and special health care funds (such as the tobacco tax account) would be transferred to the Commission administering the new system. Existing fee-for-service insurance may be sold to provide benefits above and beyond the limited coverage offered through state guarantee.

Critics of the Health Access plan contend that the administrative savings are largely ephemeral, the system sacrifices beneficial competition between contending insurance plans, it costs too much—particularly for hard-pressed employers now unable to afford medical insurance coverage for their employees, and it will set up a "buyer's monopoly"—leading to hidden and inefficient cross-subsidies of persons with unlimited medical service demands but lacking priority justification.

Governor Wilson has proposed allowing small businesses to more readily form "insurance pools" to jointly negotiate favorable health insurance premium terms, and allowing them to exclude many benefits now minimally required by California law in all policies. The Wilson proposal would also forbid insurers from rejecting workers with pre-existing conditions—a current problem where workers are forced to change employers and the subsequent insurer excludes the new employee or his/her dependents from coverage.

Critics of the Wilson measure argue that it undermines the basic provision of understood and legally mandated minimum coverage of existing health policies, and fails to provide more revenue, lower costs, increased efficiency, or enhanced coverage on any meaningful level. In other words, it does virtually nothing of consequence.

The fourth proposal now before the legislature is arguably the most interesting, and is widely acknowledged as a creative attempt to balance the difficult competing interests involved. It has been proposed by Commissioner Garamendi and was drafted at his direction by Walter Zelman, former executive director of California Common Cause and now Garamendi's Special Deputy on Health Issues. The proposal, outlined in a 36-page report entitled *California Health Care in the 21st Century*, is now included in two legislative vehicles—SB 6 (Torres) and AB 502 (Margolin) (*see infra* LEGISLATION). The Garamendi plan consolidates the health care components of all workers' compensation, automobile, and health plans into a single unified health care system. As with the Health Access plan, all Californians would be guaranteed comprehensive health care benefits. All employers and employees would pay premiums into a single fund, with smaller employers and poorer employees paying lower rates. Hence, the Garamendi plan spreads costs across a much wider base than do the two competing plans, arguably minimizing dislocation.

Health Insurance Purchasing Corporations organized regionally would collect all premiums and purchase private health insurance for all Californians. Hence, the plan retains most of the benefits of a single-payor plan in controlling provider charges and minimizing claims and administrative costs, while allowing for continued insurance competition. At least two health plans in each region would charge consumers nothing for the minimum state-assured benefits. Insurers could charge additional sums for coverage beyond the state minimums, subject to the generic authority of the Commissioner to regulate all insurance charges through the prior approval powers conferred in Proposition 103.

The $34 billion plan will require legislative approval and will be opposed by small insurance companies, liability attorneys, and some employers. However, independent experts not associated with any of the contending interests are impressed by the sophistication, balance, and practicality of the proposal. Dr. Paul Torrens, Professor of Public Health at UCLA, has publicly hailed it as a "nationally significant" alternative.

Insiders at the Capitol believe that all of the health care insurance measures (including many other bills which are more narrow than those described above; *see infra* LEGISLATION) are likely to be thrown into a conference committee negotiation at the end of the session. However, it is doubtful that any meaningful health care reform will emerge without additional revenue or other tax alterations, unlikely given the state's serious budget shortfall in 1992–93.

LEGISLATION:

AB 2431 (Bronzan). Proposition 103 provides that a notice of cancellation or nonrenewal of a policy of automobile insurance shall be effective only if it is based upon specified grounds, including a substantial increase in the hazard insured against. As amended May 12, this bill would define "a substantial increase in the hazard insured against" to mean, subsequent to policy issuance, any of the following: (1) that the insured has filed three or more claims in the past five years, excluding claims for which a driver other than the insured is at fault; (2) the insured has been convicted of driving under the influence of drugs or alcohol; (3) the motor vehicle has been altered or modified in a manner that renders it unsafe, as specified; (4) an insured has had his/her driver's license suspended or revoked; or (5) other circumstances determined by the Insurance Commissioner to demonstrate a verifiable increase in risk pursuant to a request for that determination by an insurer. *[A. W&M]*

ACR 84 (Sher) requests the Governor to overturn immediately OAL's January 23 rejection of proposed Proposition 103 rollback regulations issued by the Insurance Commissioner in order that insurance consumers may receive insurance rebates. (*See supra* MAJOR PROJECTS for related discussion.) This resolution was chaptered on February 13 (Chapter 1, Resolutions of 1992).

AB 2445 (Horcher), as amended May 7, would provide that no surplus line broker may solicit from and place with any nonadmitted foreign or alien insurer any automobile bodily injury, property damage liability, or medical payment insurance covering private passenger automobiles or motorcycles unless the insurer has submitted certain documentation to DOI and met certain requirements. *[A. W&M]*

SB 1605 (Peace), as amended March 31, would provide that where an insurer refuses to accept an applicant for a good driver discount policy or refuses to issue a good driver discount policy when written application has been made, the refusing insurer shall furnish the applicant with a written statement within ten days explaining the reason(s) relied upon for denying insurance coverage. Existing law requires that the Department of Motor Vehicles (DMV) be notified when a CAARP insurer rejects an application for insurance coverage; this bill would instead require notification to DOI. *[A. Floor]*

SB 2060 (Hill), as introduced February 21, is a reintroduction of SB 941 (Johnston), a no-fault auto insurance bill killed by the legislature in 1991. *[11:4 CRLR 23, 34, 131]* It would require each owner of a private passenger motor vehicle, other than a motorcycle, to purchase insurance that would provide personal injury protection benefits for basic economic loss of up to $15,000 actual payout per person for health care expenses, for loss of earnings up to $1,000 per month, and other benefits, as specified.

Persons injured in a motor vehicle accident would generally be entitled to receive those benefits regardless of fault. *[S. Jud]*

SB 1371 (Deddeh). Proposition 103 states that a person is qualified to purchase a good driver discount policy if, among other things, he/she has been licensed to drive a motor vehicle for the previous three years and meets certain traffic violation criteria for the three previous years. One of these criteria provides that the person seeking the discount must not have been the driver principally at fault in a motor vehicle accident resulting in the bodily injury or death of any person. Existing law provides that the Insurance Commissioner shall adopt regulations setting guidelines for use by insurers in determining fault. As amended April 22, this bill would provide that an insurer which acts in accordance with the regulations issued by the Commissioner is entitled to recover attorneys' fees and costs where legal action challenging a determination results and a court sustains the insurer's determination of fault. *[S. Floor]*

SB 2030 (Torres). Existing law requires that, upon delivery of a policy of private passenger automobile insurance, the insurer must give the insured a notice explaining the manner in which the insurer's rating plan provides for an increase in the premium upon accidents or convictions. As amended May 13, this bill would require that notice to explain the manner in which the rating plan provides for any change in the premium based upon accidents or convictions.

Existing law requires those insurers to notify the insured of the right to be informed of any increase in the premium by virtue of involvement in an accident or a conviction; that notice must be given not less than twenty days prior to policy renewal. This bill would require that notice to be given not less than 45 days prior to policy renewal, and would require every insurer that subsequently changes a premium based upon information obtained directly from the DMV or utilizes any other secondary source of information containing DMV information to inform the insured, in writing, of the source of the information and that such information is being relied upon.

This bill would also require, for insurers transacting automobile, residential property, and life insurance, that a disclosure form be provided to purchasers of insurance coverage; that form shall contain the specific information about the insurance policy offered by the insurer in easily understood language and in a clear and uniform manner. *[S. Appr]*

AB 1995 (Filante) delayed from April 1 to May 1 specified provisions of law which require insurers to inspect passenger automobiles prior to the issuance or amendment of collision and comprehensive coverage with respect to insureds not formerly insured with that insurer or not formerly insured with that insurer for the same coverage. This bill also amends existing law to authorize an insurer to defer inspection on additional and replacement vehicles for up to seven business days following the effective date of coverage, and authorizes the extension of that seven-day period to a period not to exceed thirty days. This bill was signed by the Governor on March 30 (Chapter 21, Statutes of 1992).

SB 1640 (Roberti), as amended April 21, would direct the Insurance Commissioner to conduct a study and report to the legislature on or before July 1, 1993, concerning the development of alternatives for improving the efficiency and cost-effectiveness of existing dispute resolution mechanisms related to automobile insurance claims. *[S. Appr]*

AB 2811 (Brulte). Existing law requires the Insurance Commissioner to approve or issue a reasonable plan for the equitable apportionment among certain insurers of applicants for automobile bodily injury and property damage liability insurance who are unable to procure that insurance through ordinary methods; this plan is commonly known as the California Automobile Assigned Risk Plan (CAARP). As amended April 2, this bill would require hearings on proposed CAARP rate revisions to be conducted pursuant to the administrative adjudication provisions of the Administrative Procedure Act, as specified. *[S. InsCl&Corps]*

AB 3607 (Ferguson), as amended March 31, would have exempted from existing safety helmet requirements the driver of a motorcycle, motor–driven cycle, or motorized bicycle who operates that vehicle and his/her passenger, provided that each driver or passenger who is not wearing a safety helmet is covered by insurance or a health care plan which covers hospital, medical, and surgical expenses resulting from head injuries sustained while operating that vehicle in an amount of not less than $50,000, or has equivalent coverage. This bill was rejected by the Assembly Transportation Committee on April 6.

AB 2875 (Lancaster). Proposition 103 requires the Insurance Commissioner to notify the public of any application by specified insurers for a rate change; that application is deemed approved 60 days after public notice, except as specified. As introduced February 19, this bill would provide, notwithstanding those exceptions, that a rate change application is deemed approved 90 days after the rate application is received by the Commissioner unless that application has been disapproved by a final order of the Commissioner subsequent to a hearing. *[A. Ins]*

AB 1672 (Margolin). Existing law requires, as to certain policies of automobile insurance, that an insurer—at least twenty days prior to policy expiration—deliver or mail to the named insured at the address shown in the policy either a written or verbal offer of renewal of the policy contingent upon payment of premium as stated in the offer, or a notice of nonrenewal of the policy containing or accompanied by a statement that upon written request by the named insured made not later than one month following the expiration of the policy period, or delivered to the insurer, the insurer will notify the insured in writing, within twenty days of his/her request, the reason(s) for that nonrenewal. This bill would require the offer of renewal to be written and delete the requirement that the notice of nonrenewal contain or be accompanied by the above statement.

Existing law provides that when an automobile insurance policy is canceled and the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer is required upon written request of the named insured, if mailed or delivered to the insurer not less than fifteen days prior to the effective date of cancellation, to specify in writing the reason(s) for the cancellation. This bill would delete that provision, and would instead require that any notice of cancellation or nonrenewal of automobile insurance include a written statement of the reason(s) for the cancellation or nonrenewal. *[S. Conference Committee]*

AB 3657 (Horcher), as amended April 21, would provide for the regulation of health benefit plans for enrolled employees of a small employer, as defined, and their dependents. All carriers writing, issuing, or administering health benefit plans to small employers would be subject to the bill. This bill would allow small employers to voluntarily form purchasing associations and designate a single regional purchasing pool to negotiate and contract with carriers or other licensed entities for employer group coverage. *[A. W&M]*

SB 1333 (Torres). Existing law provides for an Office of Statewide Health Planning and Development within the Health and Welfare Agency; the Office has

certain health planning, research development, and data collection responsibilities. As amended March 10, this bill would require that the Office develop a uniform claim format to be used when professional health care services are provided on a fee-for-service basis. The bill would also require that all carriers require a completed uniform claim form, or the electronic equivalent, in each instance a carrier provides coverage for professional health care services. *[A. Ins]*

SB 6 (Torres), as amended April 20, and ***AB 502 (Margolin)***, as amended April 20, would enact the California Health Reform Act of 1992; create the California Health Plan Commission; and require the Commission to establish and maintain for all California residents a prescribed system of universal health care coverage to be known as the California Health Plan. These bills are sponsored by Commissioner Garamendi (*see supra* MAJOR PROJECTS). *[A. Ins, S. InsCl&Corps, respectively]*

SB 248 (Maddy), as amended April 29, and ***AB 2001 (Brown)***, as amended February 27, would enact the Affordable Basic Health Care Act of 1992, requiring every non-exempt employer to provide basic health care coverage to each employee and dependent, including—among other things—payment of at least 75% of the lowest premium for basic health care coverage the employer offers each covered employee and dependent. The bills would require all health insurers to offer to all employers with 100 employees or fewer, within the service area of the health insurer, basic health care coverage; the bills would also require the insurer to charge a single community rate in the same geographic region for basic health care coverage, except that the premium rate offered to those employers would be prohibited from exceeding by more than 30% the community rate for basic health care coverage in the same geographic region, as described. These bills are sponsored by the California Medical Association (*see supra* MAJOR PROJECTS). *[A. W&M, S. InsCl&Corps, respectively]*

AB 14 (Margolin), as amended February 3, would enact a phased-in program to provide health coverage to all currently uninsured California residents through the use of a "pay or play" requirement for employers. All employers, employees, and individuals must either purchase health care coverage on their own ("play") or pay an assessment into the state Health Care Trust Fund which would purchase a basic health plan on their behalf. The "play" requirement applies to employees and their dependents and involves a 75%/25% cost sharing relationship for employees and 50%/50% for dependents, with a 2% cap on employees' share. *[S. InsCl&Corps]*

AB 2575 (Margolin), as amended March 31, would direct the Insurance Commissioner to conduct a study and report the findings to the legislature on or before July 1, 1993, concerning the need for universal health coverage, as specified. *[A. W&M]*

AB 2070 (Isenberg), and ***AB 755 (Hansen)***, as amended March 2, would each enact a comprehensive scheme for providing health insurance to small employer groups which would—among other things—provide that each small employer insurance carrier, except a self-funded employer, shall fairly and affirmatively market health benefits coverage to all small employers in a service area in which the carrier makes coverage available or provides benefits; require every small employer carrier, as a condition of transacting business in this state, to offer small employers at least two health care plans; regulate the premium rates charged by small employer carriers for health benefits subject to this bill; and prohibit a carrier from excluding from coverage any person by reason of evidence of individual medical uninsurability. *[S. InsCl&Corps]*

SB 1904 (Johnston), as amended April 21, would allow any disability insurer, health care service plan, health care provider, or group of medical service providers to become certified to provide managed care to injured employees and would specify the procedure for certification. This bill would allow a self-insured employer or the insurer of an employer to contract with a certified managed care organization to provide medical services, as specified. This bill would allow an employee to receive immediate emergency medical treatment that is compensable from a medical service provider who is not a member of the managed care organization. This bill would require insurers or self-insured employers who contract with a managed care organization for medical services to give notice to employees of eligible medical service providers and such other information as the Director of the Division of Industrial Accidents may prescribe. *[A. Ins]*

AB 2570 (Margolin). Existing law prohibits certain false and fraudulent claims in connection with workers' compensation insurance, as specified; a violation of that prohibition is a crime punishable as specified. As amended March 30, this bill would additionally authorize restitution to be ordered for a violation, including restitution for any medical evaluation or treatment services obtained or provided.

Existing law provides that the Insurance Commissioner shall approve or issue as adequate for all admitted workers' compensation insurers a classification of risks and premium rates, uniform as to all insurers affected. This bill would provide, instead, that an insurer shall not issue, renew, or continue in force any workers' compensation policy using classifications or merit rating systems other than those approved and issued by the Commissioner. In order to change any rate, an insurer would be required to file a complete rate application with the Commissioner, and the Commissioner would be required to notify the public of any rate change application. *[A. W&M]*

SB 1585 (Bergeson). Existing law, with respect to workers' compensation, prohibits an agreed or qualified medical evaluator or consulting physician from offering or accepting any rebate as inducement for the referred evaluation or consultation. As amended April 21, this bill would include within that prohibition the spouse or dependent of the qualified medical evaluator or consulting physician or an employee or employer of any of them. This bill would also prohibit an agreed or qualified medical evaluator, or a spouse, employer, employee, or any party with whom the evaluator has entered into an agreement to perform part of a medical-legal evaluation from referring a person to a laboratory, pharmacy, clinic, or health care facility in which one of these has a proprietary interest, unless there is a valid medical need and there is no alternative provider or facility available within a 50-mile radius. *[A. Ins]*

AB 2367 (Mountjoy), as amended April 30, would have provided that workers' compensation laws shall be liberally construed only after it is determined that an injury in the course of employment has occurred and the injury is both a "specific" injury, as defined, and results in serious physical or bodily harm. This bill would also have provided that for a cumulative injury to be compensable, an employee must demonstrate by preponderance of the evidence that the injury was substantially caused by actual activities of employment. This bill was rejected by the Assembly Insurance Committee on May 5.

AB 3704 (Mountjoy). Existing law provides that neither an agreed nor a qualified medical evaluator, who performs evaluations relating to workers' compensation, nor a physician who consults with an agreed or qualified medical

evaluator, shall offer, accept, deliver, or receive any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the evaluation consultation. As amended April 21, this bill would have extended that prohibition to any other physician who performs or provides either medical-legal evaluations or treatment, any attorney or any other representative who represents any party to an action, and any alleged injured worker or claimant or any agent, employee, or operative of any of those persons. This bill was rejected by the Assembly Insurance Committee on May 5.

SB 1630 (Leonard), as amended April 21, would provide that workers' compensation premium rates shall not be excessive, inadequate, or unfairly discriminatory, and would require the Insurance Commissioner to approve or issue, as adequate for all admitted workers' compensation insurers, a classification of risks and minimum premium rates relating to California workers' compensation insurance. This bill would also delete a provision of existing law which states that no classification of risks and premium rates or system of merit rating shall permit a discount of basic premium rates or premium resulting from the application of those rates unless the discount results from the application of experience rating or schedule rating. This bill would also delete existing law which requires the expense provision included in the classification of risks and premium rates approved or issued by the Commissioner to be uniform as to all insurers. *[A. Ins]*

SB 1539 (Lockyer), as amended April 21, would change the name of DOI's Bureau of Fraudulent Claims to the Bureau of Insurance Fraud. Also, existing workers' compensation law provides that a psychiatric injury is compensable if it is a mental disorder that causes disability or need for medical treatment, it is diagnosed, and the employee demonstrates by a preponderance of the evidence that actual events of employment were responsible for at least 10% of the total causation from all sources contributing to the psychiatric injury. This bill would revise the threshold requirement for compensation of psychiatric injuries to require that the actual events of employment shall be a significant contributing factor of the total causation of the psychiatric injury from all sources. This bill would also provide that no medical-legal evaluation shall be performed or liability for expenses incurred by the employer or employee, during the first fifteen days after the filing of the notice of a workers' compensation claim. *[A. Ins]*

AB 2608 (B. Friedman). Under existing law, insurance may be transacted only with admitted insurers. However, a surplus line broker may solicit and place insurance with nonadmitted insurers but the insurance must not be able to be procured from a majority of the insurers admitted for the particular class or classes of insurance that the surplus line broker is attempting to place. If the insurance cannot be so procured from admitted insurers, it may be procured from nonadmitted insurers if it is not placed for the purpose of procuring a rate lower than the lowest rate of an admitted insurer. As amended April 8, this bill would instead require the insurance placed with nonadmitted insurers to be unavailable from insurers admitted for the class of insurance. It would require each surplus line broker to be responsible to ensure that a diligent search is made among insurers that are admitted to transact and are actually writing the particular type of insurance in this state before procuring the insurance from a nonadmitted insurer. It would require each surplus line broker to file with the Commissioner a written report, that shall be kept confidential, regarding insurance placed with a nonadmitted insurer, and would require the report to include specified information. *[A. W&M]*

SB 1542 (Green), as amended April 20, would have—among other things—authorized DOI, annually on or before July 10, to file with a county auditor a certified copy of a statement of earthquake surcharges, unpaid and delinquent for 60 days or more on July 1. This bill was rejected by the Senate Insurance, Claims and Corporations Committee on April 22.

SB 1543 (Green), as introduced February 18, would have excluded mobilehomes from the definition of covered residential property for purposes of the Green, Hill, Areias, Farr California Residential Earthquake Recovery Act. This bill was rejected by the Senate Insurance, Claims and Corporations Committee on April 22.

AB 2049 (Isenberg), as amended May 11, would repeal the Green, Hill, Areias, Farr California Residential Earthquake Recovery Act; provide for the payment of claims arising before the repeal; require the refund of fees to policyholders by insurers and for reimbursement of insurers by the Commissioner for return of those fees; and require the Insurance Commissioner to adopt appropriate regulations. *[S. InsCl&Corps]*

SB 1666 (Johnston). Existing law grants authority to the Insurance Commissioner to examine, as specified, the business and affairs of insurers. As amended April 21, this bill would—among other things—grant the Commissioner additional and broader authority, as specified, to examine the activities, operations, financial condition, and affairs of all persons transacting the business of insurance in this state or otherwise subject to the jurisdiction of the Commissioner, and would require the Commissioner to conduct an examination of every insurer admitted in this state not less frequently than once every five years. *[S. Floor]*

SB 1923 (Marks), as introduced February 21, would revise existing law regarding unfair practices in the business of insurance to specifically include, as an unfair practice, discrimination based on an individual's race, religion, national origin, marital status, or sexual orientation in the rates charged for any contract of insurance or in other benefits payable or in any other of the terms and conditions of the contract. *[S. InsCl&Corps]*

AB 3176 (Lempert). 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 amended May 12, 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. This bill would also 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, 1993, insurers that offer policies of homeowners' insurance and also offer commercial insurance to also make available liability coverage in specified coverage amounts for licensed family day care homes. This requirement would be conditioned upon a written finding by the Insurance Commissioner that the private marketplace for liability coverage for licensed family day care homes has failed to make this coverage reasonably available. *[A. W&M]*

AB 3336 (Brulte). Existing law does not require the Insurance Commissioner to provide the text of emergency regulations and other specified information to persons who have filed a request for notice of regulatory action with DOI prior to their submission to OAL for approval. As introduced February 20, this bill would require the Commissioner to issue a notice of proposed emergency action to interested parties at least ten days prior to the sub-

mission of emergency regulations to OAL. *[A. Floor]*

AB 2107 (Connelly) repeals a credit life insurance law which former Senator Alan Robbins admitted taking a $12,200 bribe to help enact in 1985. That law froze credit life and disability insurance rates at those provided in regulations in effect on March 5, 1985, and stripped the Insurance Commissioner of the authority to regulate credit life insurance. As a result, consumers have been charged $30–$40 million in excess premiums, according to the bill's sponsor, Consumers Union. *[11:3 CRLR 33]* This bill repeals the rate freeze and restores the Insurance Commissioner's authority to regulate credit life, credit disability, and joint life and disability insurance. Among other things, it requires the Commissioner to adopt regulations to become effective no later than January 1, 1994, specifying prima facie rates for these lines of insurance based on presumptive loss ratios, not to exceed 60%; the bill requires the Commissioner to consider certain factors in the ratemaking process. This bill was signed by the Governor on April 8 (Chapter 32, Statutes of 1992).

The following is a status update on bills reported in detail in CRLR Vol. 12, No. 1 (Winter 1992) at pages 122–24:

H.R. 9 (Brooks), the Insurance Competitive Pricing Act, is federal legislation which would amend the McCarran-Ferguson Act to eliminate the antitrust exemption applicable to the business of insurance where the conduct of an individual engaged in such business involves (1) price-fixing; (2) allocating with a competitor a geographical area in which, or persons to whom, insurance will be offered for sale; (3) unlawfully tying the sale or purchase of one type of insurance to that of another type, or of any other service or product; or (4) monopolizing, or attempting to monopolize, any part of such business. The bill would retain the exemption for conduct involving the making of a contract, or engaging in a combination or conspiracy to (1) collect or disseminate historical loss data; (2) determine a loss development factor applicable to such data; or (3) perform actuarial services if such contract, combination, or conspiracy does not involve restraint of trade. This bill passed the House Judiciary Committee; Representative Brooks expects to move the bill to the House floor this session.

AB 306 (Bronzan), as amended February 20, would require group disability insurers which offer coverage for disorders of the brain to also offer coverage in the same manner for the treatment of biologically-based severe mental disorders. This bill would also authorize an insurer—with respect to specified provisions regarding coverage for disorders of the brain—to reserve the right to confirm diagnosis and to review the appropriateness of specific treatment plans as necessary to ensure that coverage is provided for only those diagnostic and treatment services which are medically necessary. *[S. InsCl&Corps]*

SB 233 (Presley) would provide that when an insurer's rating plan for auto insurance is filed for review and approval by the Commissioner pursuant to Proposition 103, the Commissioner shall, to the maximum extent possible, consider a reduction in premium rates for automobile insurance for individuals who commute to work using means other than a motor vehicle for which the principal operator is insured under that auto insurance policy. *[A. Ins]*

AB 1375 (Brown) is the Assembly Speaker's alternative to no-fault auto insurance. While it would eliminate liability for vehicular property damage in most cases (and allow those claims to be handled on a no-fault basis), it would leave the current fault-based tort system largely intact for personal injury claims. It would eliminate the current requirement that insurers offer property damage uninsured motorist coverage, but would require that collision coverage and comprehensive coverage be offered, as specified. AB 1375 would also require insurers to participate in the California Auto Plan, which would sell minimum liability coverage to qualifying low-income, good drivers at a reduced, unspecified premium. The bill would also reinstate the so-called "*Royal Globe*" private cause of action for bad faith claims handling by insurers, which was invalidated by the California Supreme Court in *Moradi-Shalal v. Fireman's Fund Insurance Companies. [8:4 CRLR 87] [S. Appr]*

SB 340 (Torres) is Senator Torres' compromise between SB 941, Senator Johnston's no-fault bill which was defeated in the Senate Judiciary Committee in May 1991 *[11:3 CRLR 128]* and Speaker Brown's AB 1375. *[A. Ins]*

AB 744 (Moore). DOI's Bureau of Fraudulent Claims is supported by, among other things, an assessment on insurers not to exceed $1,000 per year. This bill would, in addition to that assessment, impose an assessment of $250 on any insurer issuing, amending, or renewing any policy of automobile insurance insuring a vehicle where the named insured is, at that time, residing in Los Angeles County. The bill would require the Bureau to establish a pilot project in Los Angeles County to combat automobile insurance fraud, and the additional assessment would be used exclusively for that purpose. *[S. inactive file]*

AB 2042 (Lancaster) would require CAARP to use rates that are actuarially sound so that there is no subsidy of the plan, and require the Commissioner to approve necessary rate increases. *[S. InsCl&Corps]*

AB 2078 (Gotch) would reenact those repealed provisions of the Robbins-McAlister Financial Responsibility Act which require drivers to provide evidence of financial responsibility; a violation of those provisions would be grounds for a civil penalty. This bill would also prohibit reporting or disclosing a violation of those provisions to the DMV. *[S. InsCl&Corps]*

SB 36 (Petris), as amended January 14, would have dramatically restructured California's health care delivery system by establishing the state as the principal payor of medical care, and shifting financing from an employer-based system to a tax-based system. The bill would have extended basic health benefits, including long-term care, to every resident of California. An administering commission would have determined provider rates, controlled capital expenditures, and determined individual hospital budgets, similar to the health insurance system in Canada. This bill was rejected by the Senate on January 30, but its provisions have been amended into ***SB 308 (Petris)***, which is pending in the Assembly Insurance Committee. This bill is sponsored by Health Access (*see supra* MAJOR PROJECTS).

AB 321 (Margolin), as amended March 19, would enact the California Family Health Plan Act and create a system for the delivery of perinatal health services to all high-risk women in the state and health care to all children 18 years of age and younger. While existing law provides a variety of health care services through the state and local governments, this bill attempts to encompass the field by providing a general entitlement to perinatal and children's services for all persons not otherwise covered by a state or private program. *[S. H&HS]*

SB 921 (Committee on Insurance, Claims and Corporations) would provide that each person who offers, solicits, or delivers health coverage on behalf of any insurer shall provide a written disclosure to be delivered at the time of initial solicitation, in a specified form, and containing specified information. *[A. Ins]*

SB 925 (Torres). Existing law regulates Medicare supplement ("Medigap") insurance; as amended April 20, this bill

would revise that law in various ways. For example, this bill would prohibit the cancellation or nonrenewal of policies except for specified reasons; revise provisions relating to required and optional benefits; authorize Medicare select coverage to be provided through preferred providers; provide for a six-month open enrollment period upon enrollment in Medicare; and prohibit the sale of Medicare supplement coverage that would provide an individual with more than one policy or certificate. *[A. Ins]*

SB 364 (Robbins) would provide that all companies providing specified insurance in this state and all nonprofit hospital plans doing business in this state must establish a toll-free telephone number to receive telephone calls regarding claims, complaints, questions, or other inquiries. *[S. inactive file]*

SB 122 (Killea), as amended February 20, is no longer relevant to DOI.

The following bills died in committee: ***AB 1984 (Connelly)***, which would have provided that any person engaged in the business of insurance is required to act in good faith toward, and to deal fairly with, policyholders and others, as specified; ***AB 624 (Bane)***, which would have provided that it is unlawful for any automobile repair dealer to offer or give any discount intended to offset a deductible required by a policy of insurance covering a motor vehicle; ***SB 784 (Robbins)***, which would have, if the Commissioner had made a specified finding regarding affordability by January 1, 1992, required the Department of Motor Vehicles (DMV) to refuse registration or renewal of registration of a motor vehicle if the owner has failed to provide DMV with specified evidence of financial responsibility; and ***SB 1139 (Killea)***, which would have created a limited-term task force for investigating the costs, benefits, and workability of pay-as-you-drive automobile insurance.

LITIGATION:

On January 22, the Second District Court of Appeal issued a ruling in ***Allstate Insurance Co. v. Gillespie***, No. B050439, the Department's appeal of a two-part preliminary injunction issued by the Los Angeles County Superior Court in May 1990, restraining former Commissioner Roxani Gillespie from enforcing regulations she adopted to implement Proposition 103's so-called "auto rating factors" in Insurance Code section 1861.02. Consistent with the letter and spirit of Proposition 103, the regulations adopted a "tempered approach" which tends to equalize rates for drivers living in different localities. *[12:1 CRLR 124–25; 10:2/3 CRLR 140]* The appellate court agreed with all the parties that, because Commissioner Garamendi has allowed Gillespie's auto rating factor regulations to lapse, the first portion of the preliminary injunction (precluding the Insurance Commissioner from enforcing the regulations) is moot. As to the second part of the injunction (which prevents the Insurance Commissioner from adopting any regulations similar to those struck down by the superior court), the court refused to issue an advisory opinion on the validity of regulations not yet adopted by Commissioner Garamendi.

On February 14, Los Angeles County Superior Court Judge Dzintra I. Janavs dismissed both ***General Insurance Co. of America v. Garamendi***, No. BC036620, and ***California State Automobile Association Inter-Insurance Bureau v. Garamendi***, No. BC044991. In these cases, SAFECO and CSAA challenged the authority of Commissioner Garamendi to substitute new rollback regulations for those adopted by former Commissioner Gillespie. *[12:1 CRLR 124]* Judge Janavs ruled in favor of "the need for uniformity in implementing Proposition 103," and found that both Proposition 103 and the California Supreme Court in its *Calfarm v. Deukmejian* decision contemplate all rollbacks being based on the same criteria of general applicability.

On March 9, U.S. District Court Judge Charles A. Legge dismissed both ***Fireman's Fund v. Garamendi***, No. C91-2854, and ***United States Fidelity and Guaranty v. Garamendi***, No. C91-2855, two federal court challenges to the 10% rate of return set by Commissioner Garamendi in his Proposition 103 rollback regulations (*see supra* MAJOR PROJECTS). The insurers contended that the rate cap amounted to confiscation of their property without just compensation and without due process. *[12:1 CRLR 124]* In a 70-page opinion, Legge rejected the consolidated claims on a variety of grounds. First, he said many of the legal issues were not ripe for determination because specific premium rates had not yet been set for the companies. He also noted that the emergency regulations containing the rate cap may lapse if not renewed or adopted as permanent regulations. Finally, he noted that a state court forum has been established in Los Angeles for coordinated handling of all Proposition 103 challenges, which makes it appropriates for the federal courts to abstain until state agencies and courts have completed their proceedings on these issues.

As noted above (*see supra* MAJOR PROJECTS), 20th Century Insurance Company has become the first insurer to exhaust its administrative remedies on its rollback liability and file an "as applied" challenge to the constitutionality of Proposition 103. Before it gained this dubious distinction, however, it was fined over $9,200 by Los Angeles County Superior Court Judge Dzintra I. Janavs for bad faith in filing a lawsuit challenging DOI's rollback regulations in San Francisco Superior Court instead of Los Angeles, where all Proposition 103 challenges have been coordinated for years. After dismissing the action for failure to exhaust administrative remedies, Judge Janavs slapped 20th Century attorney Gary Fontana with the hefty fine for "forum shopping" in an attempt to exhaust the resources of the Commissioner. *12:1 CRLR 124]*

The insurance industry lost another of its interminable challenges to Proposition 103 on April 14 when the Second District Court of Appeal unanimously upheld Judge Janavs' September 1990 ruling that 400 insurance companies are not exempt from the initiative's rollback provisions because former Insurance Commissioner Gillespie failed to schedule an administrative hearing on their demand for exemptions within 60 days. The insurers contended that their exemption demands were "deemed" approved within 60 days after filing under Insurance Code section 1861.05(c) in the absence of the Commissioner's decision to hold a hearing on the demand. Judge Janavs ruled, and the Second District agreed in ***Wilshire Insurance Co. v. Gillespie***, No. B054071, that section 1861.05(c) is applicable to the Commissioner's new authority to preapprove rate changes, and has nothing to do with the rollback requirement.

On March 5, San Francisco Superior Court Judge Ira Brown, sitting by special assignment by the Judicial Council, denied the insurance industry's motion for summary judgment on its claim that "recoupment fees" assessed by DOI constitute an unlawful tax in ***National Fire Insurance Co. of Hartford v. Garamendi***, No. 918689. The Department has had to spend over $2 million on outside counsel to defend its implementation of the initiative, plus an additional $2 million per year to fund its in-house counsel, their support staff, and a new rate regulation division; to finance these costs, DOI has assessed companies a "recoupment fee" since the passage of the initiative in 1988. Other companies subsequently filed the same claims in ***Allegiance Insurance Co. v. Garamendi***, No. BC043168, in Los Angeles on April 15. At this writing, both actions are still pending, and Fred Woocher, outside counsel representing the

Department, may attempt to consolidate the cases.

In yet another Proposition 103 case, the California Supreme Court rebuffed a 1990 attempt by former Attorney General John Van de Kamp to force insurers into offering "good driver discounts" as required by Proposition 103. Frustrated at then-Insurance Commissioner Gillespie's failure to implement the initiative, Van de Kamp's office filed suit against Farmers, charging it (in part) with a violation of the unfair business practices act for its refusal to offer 20% good driver discounts as required by Proposition 103. Farmers demurred, claiming the state should exhaust its administrative remedies through the Department of Insurance. Although both the trial court and the court of appeal overruled the demurrer to the unfair business practices claim, the California Supreme Court reversed. Writing for the 6–1 majority in ***Farmers Insurance Exchange v. Superior Court***, No. S016912 (Apr. 6, 1992), Chief Justice Malcolm Lucas stayed the case, relying on the primary jurisdiction doctrine developed in the federal courts and not the exhaustion doctrine argued by the insurer. Justice Mosk dissented, noting that the primary jurisdiction doctrine does not and never has existed in California, and that DOI is "understaffed and overburdened with litigation relating to Proposition 103," such that the Attorney General's assistance in enforcing the law was welcomed.

On February 25, the Second District Court of Appeal held that an insurer was obligated to defend its insured in suits brought for harm caused by toxic chemical dumping 35 years before coverage began. In ***Montrose Chemical Corp. of California v. Admiral Insurance Co.***, No. B048757, the appellate court said the insured, Montrose, was entitled to defense costs for claims resulting from its dumping of DDT in the late 1940s that resulted in damage through the 1980s. The insurer argued for application of the "manifestation of loss" rule, which would preclude coverage because Montrose knew or should have known of the contamination problems long before the effective date of Admiral's coverage. The trial court agreed. However, the Second District reversed, declining to apply the "manifestation of loss" rule to third-party claims. Instead, the court applied the "continuing injury" trigger of coverage, relying heavily on language in Admiral's insurance policy which defined "occurrence" as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of [Montrose]." Under this view, the timing of the cause of the injury or damage is immaterial, as is the date of discovery of the injury or damage, and it is only the effect which matters. "[I]f injury or damage is continuous or progressive throughout successive policy periods, coverage is triggered under the policies in effect for all periods." On May 21, the California Supreme Court granted Admiral's petition for review in this case, which has attracted nationwide attention.

On March 24, the U.S. District Court for the Northern District of California held that an insurer was obligated to defend an insured accused of misrepresentation stemming from the advertising of manufactured homes it sold. In ***American States Insurance Company v. Canyon Creek***, No. 90-2376, the court said the insured, Napa Estates Venture, was entitled to be defended by the insurer because of the "advertising injury" coverage in its comprehensive general liability (CGL) policy. Napa Estates Venture sold manufactured housing in Napa; it was subsequently sued by four homeowner groups and the Napa County District Attorney's Office for intentional and negligent misrepresentation and unfair business practices. While the court did not find Napa Estates' intentional misdeeds constituted an "occurrence" as defined by the policy, the court was willing to find coverage under the "advertising injury" provision of the policy. The court refused to accept the insurer's contention that this coverage applies only when the insured engages in dissemination of promotional material to the public at large. Instead, the court adopted a broad reading of the coverage and found that advertising in periodicals and distribution of promotional materials to potential purchases who toured the homes constituted "advertising activity."

The holding of the *American States* court relates to ***Bank of the West v. Superior Court***, 226 Cal. App. 3d 835 (1991), now under review by the California Supreme Court. *[11:2 CRLR 126, 186]* The appellate court decision held that the standard CGL policy including the phrase "unfair competition" must be broadly interpreted given its ambiguity. Specifically, the insured there argues that ambiguity must be interpreted in favor of coverage and that the phrase "unfair competition" in the advertising coverage section includes more than the negligent advertising or standard common law business torts urged by the insurer. Instead, the insured contends that the reference in the advertising injury clause to "unfair competition" writes into coverage the entire scope of the "unfair competition" statute of California—Business and Professions Code section 17200. Since that section has been interpreted to apply to any unlawful or unfair act in competition, including the selling of obscene literature, hiring illegal aliens, violating mobile home rules, antitrust violations, and selling endangered whale meat, the affirmance of such a broad definition will have momentous implications on both insurance companies' duty to defend and on their direct scope of coverage.

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.

The Department primarily regulates two aspects of the real estate industry: licensees (as of September 1991, 257,599 salespersons and 96,310 brokers, including corporate officers) and subdivisions.

License examinations require a fee of $25 per salesperson applicant and $50 per broker applicant. Exam passage rates average 67% for both salespersons and brokers (including retakes). License fees for salespersons and brokers are $120 and $165, respectively. Original licensees are fingerprinted and license renewal is required every four years.

In sales or leases of most residential subdivisions, the Department protects the public by requiring that a prospective buyer be given a copy of the "public