approved by the Commissioner. *[S. InsCl&Corps]*

LITIGATION

On January 6, former savings and loan boss Charles Keating and his son, Charles Keating III, were convicted 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. Although sentencing was set for March 15, that date has been postponed; at this writing, sentencing is expected to take place in July.

DEPARTMENT OF INSURANCE

Commissioner: John Garamendi
(415) 904-5410
Toll-Free Complaint Number:
1-800-927-4357

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

Proposition 103—Hit by Courts and Legislature—Hailed by National Consumer Organization. The first several months of 1993 were not good ones for Proposition 103, the insurance rate reform initiative passed by California voters in November 1988. *[9:1 CRLR 74–75]* The initiative, which held its own throughout four years of insurance-industry-financed litigation challenging every conceivable aspect of the measure, suffered a severe blow on February 26 when Los Angeles County Superior Court Judge Dzintra I. Janavs struck down Commissioner Garamendi's rollback regulations. In *20th Century Insurance Company v. Garamendi*, the court agreed with the insurance industry's arguments that the Commissioner is not authorized to set rates; he is authorized only to approve them, and in fact must approve them if they result in a reasonable rate of return for the insurer. Further, Judge Janavs invalidated the Commissioner's generic rollback regulations because they are based in part on historical, industrywide, or average criteria and can have the effect of precluding insurers from introducing evidence of their actual financial condition at company-specific evidentiary hearings (*see* LITIGATION).

Additionally, the legislature—moribund on auto insurance rate reform for years both before and after the passage of Proposition 103—has now gotten into the act by entertaining several bills to amend the initiative and generally reduce the Commissioner's authority over the insurance industry. Although the language of the initiative precludes the legislature from amending it unless the new legislation "furthers its purposes," at least five pending bills would cut back on reforms made by Proposition 103 (*see* LEGISLATION). At the same time, the Second District Court of Appeal continues to consider Judge Janavs' March 1991 decision in *Amwest Surety Insurance Corp. v. Wilson*, in which the court upheld the validity of a bill exempting the surety industry from Proposition 103 as "furthering the purpose" of the proposition. *[11:3 CRLR 133–34]* The Second District's decision is expected to determine the scope of the legislature's authority to amend the embattled initiative.

Meanwhile, the National Insurance Consumer Organization (NICO) released a study in January indicating that Proposition 103 has already saved Californians $4.2 billion, in spite of the general refusal on the part of the insurance industry to refund mandated premium rollbacks. Prior to the passage of Proposition 103, rates in California were the third-fastest-rising in the nation. Since that time, however, rates in California have been largely frozen pending the outcome of the

industry's battle with DOI over implementation of the initiative. Comparing premiums actually paid with what would have been paid had the earlier trend continued, NICO estimated that Californians have saved $4.2 billion. The study was immediately disputed by the insurance industry, which said that any savings since the passage of Proposition 103 are the result of "fewer auto accidents, the recession, improved vehicle safety, and competitive pressures that have kept commercial property and casualty rates low across the country."

Life Insurance Disclosure Regulations. On March 19, the Commissioner published notice of his intent to repeal existing sections 2545–2545.5, Title 10 of the CCR, which require sellers of life insurance to disclose certain information to consumers, namely, a calculation which purports to measure the cost of life insurance over a given period of time, recognizing the time value of money. The calculation is known as the Surrender Cost Index (SCI). According to the Commissioner, this index theoretically facilitates comparison of relative policy costs from company to company, enabling consumers to compare disclosed index numbers among companies and simply choose the company with the lowest cost index. Although the SCI was adopted to help consumers "unravel the jumble of numbers typically encountered during a life insurance sales presentation," the Commissioner believes it is now anachronistic due to the increasing complexity of life insurance policies.

Thus, the Commissioner proposes to adopt new sections 2546–2546.13, Title 10 of the CCR, which would require life insurance sellers to furnish prospective policyholders with (1) a policy summary, and (2) a buyer's guide. The policy summary must contain, among other things, two sets of calculations—the Net Payment Comparison Index and the Yield Comparison Index (YCI), which combine to provide more relevant rate-of-return-type calculations enabling consumers to compare dissimilar policies and alternate savings mechanisms. The buyer's guide, a lengthy pamphlet-like informational guide, explains the use of the YCI. The proposed regulations also set forth definitions of key terms, methods of calculating these indexes, and specifications regarding both the policy summary and the buyer's guide. These proposed regulations are based on a new model developed by the National Association of Insurance Commissioners over the past decade; if adopted and approved, California would be the first state in the nation to reform life insurance disclosures based on the new model.

At this writing, DOI is scheduled to hold a public hearing on the proposed disclosure regulations on May 25 in Los Angeles.

Rate Hearing Timelines and Procedures. On March 17, DOI held a public hearing on its proposal to adopt new sections 2648.1–2648.3, Title 10 of the CCR, which would implement a provision of the Insurance Code added by Proposition 103 relating to hearings on requests for rate changes by insurance companies.

Insurance Code section 1861.05(c), as added by Proposition 103 and amended by AB 2875 (Lancaster) (Chapter 1257, Statutes of 1992) *[12:4 CRLR 149]*, provides that rate change applications made by insurers after July 1, 1993 shall be deemed approved 180 days after they are received by the Commissioner unless the applications have previously been disapproved by a final order after a hearing, or if extraordinary circumstances exist. Insurance Code section 1861.055 requires the Commissioner to adopt regulations setting forth timelines for scheduling and commencing hearings required by section 1861.05(c). Proposed section 2648.1 would specify that the Commissioner's timeline regulations apply to all proceedings commenced on so-called "prior approval" rate applications pursuant to section 1861.05; they do not apply to rollback exemption applications or so-called "file and use" applications authorized by *Calfarm Insurance Co. v. Deukmejian*, 48 Cal. 3d 805 (1989), nor do they apply to rate change applications filed before July 1, 1993 or refilings, modifications, or supplements to rate applications filed and approved prior to July 1, 1993.

Proposed section 2648.2 specifies that a rate change application shall be considered to have been received by the Commissioner on the date that the Commissioner gives public notice of the rate application pursuant to section 1861.05(c). The Commissioner does not publish the notice until the rate change application is reviewed and found to be complete. Proposed section 2648.3 contains timelines for the scheduling and commencement of evidentiary hearings on a rate change application within 45 days of the Commissioner's public notice, should a consumer request one, or should the Commissioner order one. Section 2648.3 provides that within 30 days after the filing of a defense by an insurer, the DOI administrative law judge (ALJ) assigned to the matter shall give written notice of a scheduling conference to be held within 30 days of that notice. During the scheduling conference, the ALJ shall set a date for the evidentiary hearing that is not more than 75 days from the date of the conference; the ALJ is permitted to delay this hearing date upon good cause shown.

At this writing, DOI staff are reviewing the comments received at the March 17 public hearing; the Department hopes to have the rules in place by July 1.

Good Driver Discounts. On April 13, DOI held a public hearing on its proposal to adopt section 2632.14.3, Title 10 of the CCR, to implement AB 2605 (Peace) (Chapter 1255, Statutes of 1992). AB 2605 provides that an insurer refusing to accept an applicant for a good driver discount policy (GDDP), or refusing to issue a GDDP when written application has been made by a good driver, shall furnish the applicant within ten days a written statement explaining the reason(s) relied on for denying coverage. The letter of refusal (showing that the applicant has been declined by an insurer admitted to write private passenger automobile liability insurance in California) shall be accompanied by a certificate of eligibility authorizing the applicant to obtain private passenger automobile liability coverage through the California Automobile Assigned Risk Plan (CAARP). *[12:4 CRLR 149]* CAARP is reserved for drivers who entitled to but are unable to procure auto insurance through ordinary methods (usually due to poor driving records); all auto insurers authorized to do business in California must participate in the CAARP program and write a certain percentage of CAARP business.

Among other things, DOI's proposed regulation would define the terms "refuses to accept an applicant," "refuses to issue a good driver discount policy," "furnish the applicant for insurance a written statement within ten days of the refusal," and "reason or reasons relied on for denying coverage"; clarify that when an agent refuses to accept an eligible applicant for a GDDP, the written letter of refusal shall be provided by that agent; provide that CAARP may not reject an application from a good driver with the letter of refusal described above, and the assigned insurer shall not cancel or refuse to issue a policy based on the alleged insufficiency of the letter of refusal; require insurers to notify applicants for GDDPs that they are entitled to a written letter of refusal within ten days of the refusal; and specify that, for purposes of CAARP eligibility, a written notice of cancellation or nonrenewal of an auto insurance policy issued by an admitted insurer to a good driver, sent for reasons other than nonpayment of premium, shall be regarded as a letter of refusal which must accompany or follow the certificate of eligibility.

At this writing, DOI staff are reviewing the comments received at the April 13 public hearing.

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

• ***"Substantial Increase in the Hazard Insured Against."*** In December 1992, the Department held a public hearing on proposed section 2632.19, Title 10 of the CCR, which would implement one of the key provisions of Proposition 103 passed by the voters in November 1988. Among other things, Proposition 103 added section 1861.03(c) to the Insurance Code; that subsection prohibits insurers from cancelling or "nonrenewing" an automobile insurance policy unless the cancellation or nonrenewal is based on one or more of the following justifications: (1) nonpayment of premium; (2) fraud or material misrepresentation affecting the policy or the insured; or (3) a "substantial increase in the hazard insured against." New section 2632.19 would define the term "substantial increase in the hazard insured against" by specifying certain circumstances which do and do not qualify. *[13:1 CRLR 83]* At this writing, DOI staff are still summarizing and analyzing the comments received at the public hearing; the Department will probably release modified regulatory language for an additional 15-day public comment period.

◦ ***Anti-Redlining Regulations.*** Also in December 1992, DOI held a public hearing on the Commissioner's proposed adoption of section 2646.6, Title 10 of the CCR, which 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]* Among other things, the rules would establish a system of bonuses and penalties to reward or punish insurers based upon the volume of policies written in underserved areas, and require insurers to submit detailed reports on the locations of their agents, offices, and customers; the racial, ethnic, and gender composition of their boards of directors, management, policyholders, and insurance applicants; their charitable contributions; and the availability of employees who speak languages other than English. At this writing, DOI is still summarizing the comments received, and plans to release modified language of the redlining regulations for an additional 15-day comment period by the end of June.

• ***Intervenor Compensation.*** On February 1, the Office of Administrative Law (OAL) approved DOI's adoption of new sections 2615.1–2623.9, Title 10 of the CCR, which create a new intervenor compensation system for DOI and establish an Office of the Public Advisor within the Department. *[12:4 CRLR 145; 12:2&3 CRLR 171]*

• ***Prelicensure and Continuing Education Requirements.*** On April 15, OAL approved DOI's adoption of new sections 2182 and 2186–88.7, Title 10 of the CCR, which establish time limitations within which a person who has twice failed a license qualification examination may not take further examinations, and establish requirements for prelicensure and continuing education for persons applying to be licensed as fire and casualty broker-agents and life agents. *[13:1 CRLR 84; 12:4 CRLR 146]*

◦ ***Automobile Theft and Loss Reporting Regulations.*** On April 1, OAL approved DOI's adoption of section 2191.2, Title 10 of the CCR, which requires insurers to report specific information regarding automobile thefts and total losses to the National Insurance Crime Bureau (NICB) and then await NICB's acknowledgement of receipt of the report before making any payment to the insured. *[12:4 CRLR 146]*

◦ ***Insurance Fraud Prevention Funding.*** On April 29, OAL disapproved DOI's 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 attorneys for the investigation and prosecution of automobile insurance fraud and workers' compensation fraud, respectively. *[12:2&3 CRLR 172]* OAL found that the rulemaking record did not contain substantial evidence to demonstrate the necessity for the distribution formula established by DOI; several provisions are unclear; the Department failed to adequately respond to several comments made during the rulemaking proceeding; and DOI failed to release modifications it made to the original proposal for an additional comment period. At this writing, DOI is responding to OAL's concerns and plans to resubmit the rulemaking package in late July.

Commissioner Creates Health Insurance Purchasing Cooperatives. "Health insurance purchasing cooperatives" (HIPCs) are the critical component of "managed competition" health care reform. The concept involves maintaining current medical providers and insurers, but organizing a new player—the HIPC—to represent consumer interests in negotiating coverages and bargaining over prices. The concept is favored by the Clinton administration in lieu of a major competing concept—the "single payor" system—where a single government agency receives premiums and makes payments.

"Managed competition" may take many forms, and the consequences of each are determined by detailed provisions which determine, for example, whether coverage is universal, who controls the HIPCs, how many HIPCs are created, and who pays for the additional costs of expanded coverage. During 1992, DOI's Walter Zelman developed SB 6 (Torres), which included an ambitious managed competition plan for California. *[12:2&3 CRLR 174]* The measure was enacted by the legislature but vetoed by Governor Wilson, who objected to the funding mechanism of employer contributions during a business recession. *[12:4 CRLR 149]* Zelman has since accepted an appointment at the White House and is now an architect of the long-awaited national proposal being developed by Hillary Rodham Clinton's health care task force. The Governor sponsored a more limited managed competition proposal, AB 1672 (Margolin), which won enactment and becomes effective on July 1.

AB 1672 creates no universal coverage and offers no additional revenues; it is intended to encourage expansion of health care benefits by small employers (those employing from three to fifty persons) by prohibiting many insurer practices, including midstream cancellation, exclusions (including those based on pre-existing conditions), application of unjustified "rating factors" to raise premiums, and sudden renewal increases without basis. The law requires variation of rates only within "rate bands," the offering of insurance to all small employers, guaranteed renewal of coverage, and standardized demographic rating factors. The thrust of the new law is to discourage "cream-skimming" where insurers provide coverage until claims increase, whereupon policies are cancelled, exclusions increased, or premiums drastically raised in order to maintain a pool of low-risk and low-cost employees. The intent is to compel a "cross-subsidy" to provide a minimum base of coverage for all employees of small businesses, which have a high percentage of uncovered persons. Large employers automatically achieve such cross-subsidies and preclude the exclusion of individual and small groups of employees through the use of their bargaining power; they bargain for benefits and rates for all of their many employees.

Also a part of the bill, and consistent with its concept, is a means for small employers to band together directly to negotiate on behalf of their employees in the

same manner and with the same bargaining power available to large employers. These "employer coverage purchasing pools" may exercise the same kind of leverage available to a large employer in precluding the excising of particular employees from coverage who become ill or who have a higher risk factor, and can generally obtain economy of scale benefits. The bill authorizes the Insurance Commissioner to "sponsor" small employer coverage purchasing pools. Accordingly, the Commissioner has negotiated with 18 private insurance carriers to provide standard health insurance packages for small businesses in six geographical areas, agreeing to rates based on location and age of employees. The coverage takes effect on July 1.

The Insurance Commissioner's negotiation of these rates and coverages varies somewhat from the HIPC model espoused by its advocates. Here, it is established by a public agency, which is also is the regulator of the industry involved. However, the essential feature is here to be tested: a negotiation with existing providers or insurance carriers to offer specified coverage and rates by an entity acting on behalf of a potentially large number of consumers. The success or failure of this early attempt at managed competition—market intervention involving the retention of insurance carriers which the single payor system would replace—will be watched by advocates on all sides.

Workers' Compensation System Reform Finally in Sight. After bungled attempts to overhaul the $11 billion workers' compensation system last year, the legislature appears to have placed structural reform of the system high on its agenda during 1993 (just after passage of the state budget). The length and depth of the economic recession in California and the growing realization that the state will not recover without substantial reform in the workers' comp area have finally prevailed over partisan politicking. *[13:1 CRLR 84; 12:4 CRLR 147–49]*

Governor Wilson has established a special task force to draft a comprehensive plan for overhauling the state's system, and has already signed one bill which is projected to save $100 million in the cost of medical evaluations of injured workers; for its part, the legislature has referred six reform bills to a special joint conference committee to hammer out a comprehensive reform package (*see* LEGISLATION).

Interestingly, lobbying against workers' comp reform has been fierce. In early May, radio advertisements paid for by the "Coalition for California's Future" began to air in an effort to persuade the public, particularly women, that legislators are up to no good in trying to enact workers' comp reform. The Coalition is bankrolled mostly by the California Applicants' Attorneys Association and the California Society of Industrial Medicine and Surgery—two organizations which represent the middlemen who profit most handsomely from the current system. Notwithstanding these efforts by insurers, doctors, and lawyers, workers' compensation system reform appears to have strong bipartisan support in 1993.

Allstate Pays Record Fine in Mishandling of Fire Claims. In late December, shortly before proceeding to a DOI disciplinary hearing, Allstate Insurance Company agreed to pay an unprecedented $1 million fine to settle DOI's charges that it mishandled claims from the devastating 1991 Oakland Hills fire. *[12:4 CRLR 147]* In return, Commissioner Garamendi dropped charges against seven of eight Allstate agents accused of improper practices. The license of agent Charles A. Strahan was suspended for three months, and will be on probation for another fifteen months.

LEGISLATION

AB 135 (Peace), SB 957 (Johnston), SB 871 (Johnston), AB 1512 (Brulte), and **SB 905 (Maddy)** would all amend provisions of the Insurance Code added by Proposition 103, which expressly provides that it may be amended by the legislature only to "further its purposes" (*see* MAJOR PROJECTS).

• ***AB 135 (Peace).*** Existing law, added by Proposition 103, provides with respect to rates for property and casualty insurance that no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory, or otherwise in violation of provisions regulating rates. Existing law also provides that in considering whether a rate is excessive, inadequate, or unfairly discriminatory, no consideration shall be given to the degree of competition and the Commissioner shall consider whether the rate mathematically reflects the insurance company's investment income. As amended April 15, this bill would instead provide that in a noncompetitive market, no rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this chapter, and that in a competitive market, no rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this chapter. The bill would provide that in a competitive market, the state shall not regulate an insurer's return on equity, expenses, efficiency standards, or price level for rates in effect on and after January 1, 1994. *[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]*

• ***SB 871 (Johnston).*** Existing law provides that the Insurance Commissioner shall 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. Existing law provides, however, for rate change applications made after July 1, 1993, that a rate change application 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 introduced March 4, this bill would define "receive" for that purpose to mean the date delivered to DOI. The bill would provide 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. *[S. Appr]*

• ***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]*

• ***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 April 12, this bill would delete that prohibition

and instead provide 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 would also provide that no insurer shall be required or permitted to seek reimbursement from the state of any premium taxes paid on premium earned during the 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. Both DOI and Proposition 103 sponsor Voter Revolt oppose SB 905. *[S. InsCl&Corps]*

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 March 5, 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). *[A. Jud]*

SB 684 (Torres), as amended April 20, would have effected a major systemic reform of the automobile insurance delivery system in California. Under this proposal, insurance premiums for a basic no-fault policy would be collected at the fuel pump, theoretically (according to its sponsors) eliminating uninsured drivers, enabling easier resolution of claims not involving "serious" injury, and even encouraging efficient use of gasoline and significantly reducing air pollution. Under the proposal, each registered vehicle would be issued a voucher for basic no-fault coverage at point of registration, and insurance companies would be required to accept the vouchers from qualified good drivers. This version of SB 684 was rejected in the Senate Insurance Committee on April 21, largely at the behest of CTLA, which strongly opposes all no-fault proposals.

As amended May 18, SB 684 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 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 March 15, this bill would except from this provision cases in which the amount of the repairs have been determined by the insurer. *[S. Jud]*

AB 456 (Brulte). 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 introduced February 11, this bill would require each owner of a private passenger motor vehicle, other than a motorcycle, to instead provide insurance that would provide personal injury protection benefits; owners of other motor vehicles and motorcycles would be required to provide insurance providing personal injury protection benefits to persons other than operators and occupants of the vehicles and to provide liability coverage. The bill would establish procedures for claiming those benefits, including requirements of arbitration of disputes in accordance with procedures specified in the bill, and would provide that a tort victim would have no right to recover any damages in tort for basic economic loss and, except in the case of serious injury, would have no right to recover noneconomic loss. This bill would also prohibit insurers from increasing premium rates for first-party benefits solely on account of prior payment of benefits or claims, as specified. Also, this bill would provide for the establishment of the California Basic Economic Loss Premium Exchange to assure the availability of basic economic loss coverage to all private passenger automobile insurance consumers who are entitled to obtain that coverage. *[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 2035 (Isenberg), as amended April 12, would 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, operative July 1, 1994. This bill's provisions are contingent upon the enactment of two unspecified Assembly bills. *[A. Jud]*

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 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 introduced February 8, this bill would delete the exception for employees and certain contracting agents, and would also delete the January 1, 1994, repeal date. *[A. F&I]*

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. *[A. Floor]*

SB 31 (Johnston). Existing law prescribes the evidentiary burden of proof for parties in workers' compensation claim cases; as introduced December 7, this bill requires lien claimants to meet the same burden of proof in workers' compensation claim cases.

Existing law defines a medical-legal expense as any costs and expenses incurred for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and interpreter's fees, for the purpose of proving or disproving a contested claim. This bill specifies when a contested claim exists, and provides that the costs of medical evaluations, diagnostic tests, and interpreters incidental to the production of a medical report do not constitute medical-legal expenses unless the medical report is capable of proving or disproving a disputed medical fact, the determination of which is essential to an adjudication of the employee's claim for benefits. This bill also provides that these costs are not incurred earlier than the date of receipt, by specified parties, of all reports and documents required by the Administrative Director of the Division of Industrial Accidents incidental to those services. This bill was signed by the Governor on April 3 (Chapter 4, Statutes of 1993).

AB 110 (Peace), as amended May 5, would make a number of revisions to the workers' compensation system. For example, existing law requires the Insurance Commissioner to approve or issue as adequate, for all admitted workers' compensation insurers, a classification of risks and premium rates relating to California workers' compensation insurance. This bill would repeal existing rate regulation provisions, and would require workers' compensation insurers to adhere to a uniform classification system and rating plan filed by a designated statistical agent. This bill would also revise provisions relating to vocational rehabilitation benefits, including but not limited to providing for fines for failure to comply with certain vocational rehabilitation service plan requirements; providing for a fee schedule for vocational rehabilitation services; placing limitations on referrals and on certain benefits; revising provisions concerning eligibility, scope, and discontinuance of benefits; and imposing a maximum expenditure for rehabilitation services for an employee.

With regard to stress claims, this bill would also provide that an employee shall demonstrate by a preponderance of the evidence that actual events of employment were predominant as to all causes combined of a psychiatric injury, were not common to all fields of employment, and were not generally inherent in the employees' regular and routine employment. It would also provide that no compensation shall be paid by an employer for a psychiatric injury claim filed by an employee after the employee has been given notice of a layoff or termination by that employer, unless specified conditions are met.

This bill would also revise provisions concerning medical examinations, including provisions relating to the conduct of examinations and payment provisions, and would limit the number of comprehensive medical-legal evaluations to one. *[Conference Committee on Workers' Compensation]*

AB 1300 (W. Brown). Existing law prohibits certain false or fraudulent practices in connection with workers' compensation claims. As amended May 5, this bill would—among other things—prohibit any person convicted of workers' compensation fraud from receiving or retaining compensation where the compensation was owed or received as a result of certain unlawful conduct for which the recipient of the compensation was convicted. *[Conference Committee on Workers' Compensation]*

AB 119 (Brulte), as amended May 5, would provide that no workers' compensation shall be paid for a psychiatric injury if the injury arose from a lawful, nondiscriminatory, good faith personnel action. The bill would also provide 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 would also provide that in specified circumstances where a claim for compensation for any injury sustained by an employee arising out of and in the course of employment is filed after notice of termination of employment or layoff, there shall be a presumption affecting the burden of proof that the claim is not compensable, as specified. *[Conference Committee on Workers' Compensation]*

SB 484 (Lockyer), as amended May 11, is the appropriations vehicle tied to the package of workers' compensation reform bills pending in the joint conference committee. It would appropriate $500,000 from the Workplace Health and Safety Revolving Fund to the Commission on Health and Safety and Workers' Compensation; loan $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 appropriate $2 million from the Workers' Compensation Administration Fund and $4 million from the general fund to the Division of Workers' Compensation. *[Conference Committee on Workers' Compensation]*

SB 983 (Greene), as amended May 5, would permit private employers and employee organizations to establish alternative workers' compensation programs through the collective bargaining process for employment in construction, maintenance, and related activities. The bill would prohibit a collective bargaining agreement that diminishes the entitlement of an employee to compensation; premium rates issued for these agreements would not be subject to the uniform clas-

sification system for workers' compensation insurance approved by the Insurance Commissioner. *[Conference Committee on Workers' Compensation]*

SB 30 (Johnston). Existing law provides for a schedule of medical fees that are presumed reasonable under the workers' compensation laws. As amended May 5, this bill would prohibit a provider of medical services from billing for services or supplies rendered under the workers' compensation laws in an amount greater than the lowest amount that would have been charged if the services had not been under the workers' compensation laws, as specified. *[Conference Committee on Workers' Compensation]*

AB 9 (Mountjoy), as amended April 12, 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]*

SB 4 (Johnston). The existing unemployment compensation disability law authorizes certain employers and self-employed persons to elect to be treated as employees for purposes of disability insurance, and requires that each self-employed person making that election be deemed, for purposes of determining benefit rights and contributions, to have received remuneration in the highest maximum amount stated in a specified statute. As amended January 25, this bill would instead require that an employer or self-employed person making the election described above be deemed, for purposes of determining benefit rights and contributions, to have received remuneration entitling him/her to the highest weekly benefit amount specified in that same statute.

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%. This bill would instead provide for a worker contribution rate of 1.3% for the period from January 1, 1993, to March 31, 1993, inclusive, for a worker contribution rate of 1.4% for the period from April 1, 1993, to December 31, 1993, inclusive, and for a worker contribution rate of not to exceed 1.3% in the 1994 calendar year.

Existing law entitles an employee, if, by reason of the employee's receiving wages from more than one employer during any calendar year, the wages received by the employee during the year exceed the remuneration upon which contributions are payable and the amount of contributions paid exceeds required amounts, to a refund or credit of excess disability benefit contributions. This bill would, until January 1, 1999, additionally entitle an employee, if, by reason of the employee's receiving wages from more than one employer during the 1993 calendar year, the sum of the amounts of that employee's contributions under specified statutes exceeds $459, to a refund or credit of excess disability benefit contributions.

Existing law provides for a waiver, under specified circumstances, of a waiting period during which time no disability payments are payable. This bill would provide, except with respect to employers and self-employed persons who have elected to be treated as employees, that the specified waiting period shall not be waived for any period of disability commencing on or after February 1, 1993, and prior to January 1, 1994.

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. This bill would make changes, except with respect to employers and self-employed persons who have elected to be treated as employees, in the computation of benefits for periods of disability commencing on or after February 1, 1993, and prior to January 1, 1994.

Existing law requires the Director of Employment Development to perform a study of revenues and costs with respect to the disability fund and to submit that study to the legislature on or before December 31, 1993. This bill would instead require that the above study be submitted to the legislature on or before June 30, 1993. *[S. Inactive File]*

SB 286 (Johnston). Existing law requires for certain policies of commercial insurance that the insurer, at least 45 days, or in some cases 60 days, but not more than 120 days, in advance of the end of the policy period, must give notice of nonrenewal and the reasons for the nonrenewal, if the insurer intends not to renew the policy or intends to make certain changes. As introduced February 16, this

bill would provide 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. *[A. F&I]*

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 introduced February 2, this bill would increase the minimum 45-day notice period to at least 60 days, and delete the separate notice provision for policyholders whose aggregate premium is $10,000 or less. *[A. Floor]*

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 introduced March 4, this bill would delete that exception. *[A. Floor]*

AB 2002 (Woodruff), as amended April 14, would be known as the Filante Health Care Act, and would authorize health care service plans, 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 would be based on actuarial considerations related to the differences in lifestyles. *[A. Health]*

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 April 28, this bill would require disability insurers providing group coverage, and group health care service plans, group nonprofit hospital service plans, and self-insured employee welfare benefit plans that provide for hospital, medical, and surgical expense benefits, to permit assignment of benefits when requested by the insured or plan member and direct reimbursement to the medical provider of those services, custodial parent, or, in the case of a Medi-Cal beneficiary, the state Department of Health Services. *[A. W&M]*

AB 1834 (Snyder). Existing law does not require health care service plans, disability insurers, and nonprofit hospital service plans to notify individuals covered under the group plans and policies prior to cancelling coverage due to nonpayment of premiums. As amended April 28, this bill would require those insurers and plans to do so. *[A. W&M]*

AB 2059 (Margolin). Existing law provides for the regulation of long-term care insurance by the Insurance Commissioner. Existing law requires every long-term care policy issued to an individual to contain a renewal provision that is either guaranteed renewable or noncancellable, as specified, provided that premiums on the policy are timely paid. As introduced March 5, this bill would require insurers offering long-term care insurance to comply with specified requirements to protect insureds against unintentional lapses in their coverage due to nonpayment of premiums. Among other things, this bill would require, at the time of issuance of an individual long-term care policy or certificate, that an applicant either designate in writing at least one other person to receive notice of lapse or termination of the policy or certificate, or sign a written waiver electing not to designate additional persons to receive notice.

This bill would provide that no individual long-term care policy or certificate shall lapse or terminate for nonpayment of premium unless the insurer gives notice of the lapse or termination to the insured, or his/her designee(s), at least 30 days prior to the effective day of the lapse or termination. This bill would also require a long-term care insurance policy or certificate to include a reinstatement of coverage provision in the event of a lapse, if the insurer is provided with proof of the insured's cognitive impairment or loss of functional capacity. *[A. Floor]*

SB 1146 (Johnston). Existing law provides that a health care service plan, 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 associated 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 health care service plan is punishable as a crime. As introduced March 5, this bill would prohibit those forms of refusal and discrimination by health care service plans, 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. *[S. Floor]*

AB 1100 (W. Brown), as amended April 12, would enact the Health Insurance Access and Equity Act and would, among other things, permit any person who is injured as the result of any unfair method of competition or any unfair or deceptive act or practice by a health, life, or disability insurer to bring a cause of action to recover damages or for other remedies; provide that every policy or certificate of life, disability, or life and disability insurance advertised, issued, or delivered to a resident of this state regardless of the situs of the contract or master group policy holder shall be subject to the provisions of the Insurance Code; require DOI to develop and adopt a single uniform health history and underwriting form to be used for all policies of disability insurance covering hospital, medical, or surgical expenses issued or delivered to a resident of this state; require DOI to develop and adopt standardized language for informed consent disclosure forms used by insurers when requiring HIV-related tests for ap-

plicants for disability insurance covering hospital, medical, or surgical expenses; and prohibit post-claims underwriting, as specified, and require all applications for policies of disability insurance covering hospital, medical, or surgical expenses, except in the case of guaranteed issue coverage, to contain specified information. *[A. Floor]*

SB 38 (Torres) is a reintroduction of SB 6 (Torres), which was vetoed by Governor Wilson on September 30, 1992. *[12:4 CRLR 149]* As amended May 13, this bill 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, with certain duties. The bill would require, on or after January 1, 1995, the corporations, the Commission, or another agency designated by the Commission, to enter into contracts with health plans for the purpose of providing health benefits coverage to all eligible persons. The bill would require, on or before January 1, 1995, the Commission to adopt regulations to implement these provisions and to prepare a plan, budget, and timetable for the transfer of funds and entitlements under the Medi-Cal program, as required by federal law, to the Commission. *[A. Appr]*

SJR 3 (Petris) urges the President and Congress of the United States to evaluate and author proposals for universal health care based on prescribed criteria. This measure was chaptered on May 11 (Chapter 28, Resolutions of 1993).

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 April 28, this bill would enact a comprehensive anti-redlining scheme with respect to certain automobile, fire, homeowner's, commercial, and mortgage guarantee insurance. It would require the annual submission of a disclosure report to the Insurance Commissioner providing certain information. It would require the issuance of certain reports and specify a grading system by the Commissioner. *[S. Appr]*

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 would require 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 would provide that the report would be a public record. *[S. Floor]*

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 from delivery; all premiums and policy fees paid are required to be returned to the owner if the policy is cancelled. As amended April 28, this bill would instead authorize the cancellation of any such policy or certificate of life insurance within 30 days following delivery, and require those policies to contain a notice of that provision.

The bill would also require offerings of life insurance policies that contain illustrations of nonguaranteed values to contain certain disclosures. It would require annual statements to policyowners and certificate holders to disclose the current accumulation value and current cash surrender value and would require life insurance policies and certificates which contain a surrender charge period to disclose the surrender period and penalties associated therewith. *[S. Floor]*

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 April 15, this bill would authorize 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 would authorize the Insurance Commissioner to adopt rules and guidelines establishing standards and requirements relative to these practices, and would require the Commissioner to issue a bulletin by June 30, 1994, setting forth the accounting practices and procedures for insurance futures contracts, unless, prior to that date, accounting practices and procedures are officially promulgated by a specified association of insurance commissioners. The bill would also prohibit 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. *[A. F&I]*

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 introduced March 1, this bill would additionally provide as a reason, with respect to a rate increase after renewal of a policy of professional liability insurance, an insurer's offer of renewal which notifies the policyholder that a rate increase application is filed and pending before the Insurance Commissioner, when that rate change is subsequently approved. *[S. Floor]*

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. *[S. Floor]*

SB 907 (Leonard), as amended April 27, would require every workers' compensation insurer, private self-insurer, and third-party administrator that administers self-insured employers workers' compensation claims, to maintain and file a utilization review and quality assurance plan that meets conforms to minimum specified guidelines. *[S. Appr]*

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. *[A. Floor]*

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 introduced February 24, this bill would establish additional requirements as to the amount and determination of those premium charges. *[S. Floor]*

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]*

SB 1098 (Torres). Existing law prohibits any policy of residential property insurance, on and after July 1, 1993, from being issued or renewed unless the named insured is provided a copy of the California Residential Property Insurance disclosure statement. As introduced March 5, this bill would prohibit any policy of commercial insurance, on and after July 1, 1994, from being issued or renewed unless the named insured is provided a copy of the California Commercial Property Insurance disclosure statement. The bill would also prohibit issuance or renewal of a policy of commercial property insurance on and after January 1, 1994, as guaranteed replacement cost coverage, if it contains a maximum limitation of coverage based on specified factors; prohibit issuance or renewal of a policy of commercial property insurance unless information relating to certain liability limits, deductibles, admitted status of the insurer, and building code upgrade coverage is indicated on the declarations page or on an attached separate disclosure; and limit the authority of the Insurance Commissioner to modify the disclosure statement to permit modification only upon request of an insurer, as specified. *[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. *[A. Floor]*

AB 1782 (Tucker). Existing law, the federal Community Reinvestment Act of 1977, authorizes an appropriate federal financial supervisory agency in connection with its examination of a financial institution to assess a financial institution's record of meeting the credit needs of its entire community, as specified, and to take that record into account with respect to its evaluation of an institution's application for a deposit facility. As amended April 28, this bill would require the Insurance Commissioner to annually publish a report setting forth specified information relative to insurers in this state. The bill would require insurers to annually submit a disclosure report, as specified, to the Commissioner; the requirements of the bill would be inapplicable to automobile insurance. *[A. W&M]*

SB 175 (Kelley), as introduced February 3, would provide 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. *[A. F&I]*

LITIGATION

On February 26, Los Angeles County Superior Court Judge Dzintra I. Janavs issued her long-awaited decision in ***20th Century Insurance Company v. Garamendi***, No. BS016789, the first "as applied" challenge to the validity of the rollback regulations adopted by Commissioner Garamendi to implement Proposition 103, as modified by the California Supreme Court in *Calfarm v. Deukmejian*, 48 Cal. 3d 805 (1989), which upheld the facial validity of the initiative. *[13:1 CRLR 85–86; 12:4 CRLR 145, 151–52; 12:2&3 CRLR 170–71]*

Among other things, 20th Century challenged the constitutionality of generic ratesetting formulae (subsections 2645.1–2645.9, Title 10 of the CCR) adopted by the Commissioner to calculate all of the components of appropriate "rates" (from which the required rollback would then be calculated). The Commissioner adopted the generic standards to enable the Department to deal efficiently with 460 petitions filed by insurers for exemption from Proposition 103's rollback requirement; the generic standards guided the admission of evidence by DOI administrative law judges in "company-specific" evidentiary hearings on those applications as promised by the initiative and *Calfarm*. However, the insurers claimed that the Commissioner's application of the generic formulae precluded them from being able to introduce relevant evidence demonstrating the actual financial condition of their own particular business enterprises in the evidentiary hearings, thus depriving them of due process.

In a serious blow to the Commissioner and to Proposition 103 sponsor Voter Revolt, Judge Janavs ruled that neither the initiative, *Calfarm*, nor the Commissioner's inherent powers "authorize [him] to adopt substantive regulations for the determination of the insurer rollback liability, or to engage in ratemaking." Instead, the relevant Insurance Code sections added by Proposition 103 provide for prior approval by the Commissioner of proposed rate changes and company-specific hearings with respect to filed rate change applications under certain circumstances. Although holding that the Commissioner is authorized to adopt regulations establishing the "lower boundary reasonable rate of return," defining the capital base to which the minimum reasonable rate of return applies, and specifying unreasonable or imprudent expenses for the rollback year, the court wrote: "Proposition 103 did not provide that the Commissioner shall fix, prescribe, or set rollback rates. Nor did *Calfarm* hold that the Commissioner should become a ratemaker....[T]here is a range of reasonable rates of return, and a rate filed by an insurer must be approved if it produces a return anywhere within that range....With respect to the formula, the Commissioner has no authority to adopt the formula to set a rate to determine rollbacks."

Because she found that the Commissioner is authorized to set a rate of return, Judge Janavs also focused on section 2645.6(a), which establishes a 10% lower boundary rate of return for property and casualty insurance. Exercising an "arbitrary and capricious" standard of review, Judge Janavs found that "there is substantial evidence in the record to support the 10% lower boundary reasonable rate determination for the rollback year...."

In a related ruling, Judge Janavs found that each insurer is constitutionally entitled to a full-blown, company-specific Administrative Procedure Act evidentiary hearings on its rollback exemption petition, at which it may "proffer all relevant evidence to show that the 10% rate of return and the minimum premium produced by the formula is confiscatory as to it." As such, the so-called "relitigation ban" in section 2646.4(e) is invalid. Further, the standard applicable to rollbacks is not "deep hardship or insolvency" but "whether the insurer is left with a reasonable rate of return, though at the lower boundary of the range of reasonable rates."

As a result of her 85-page ruling invalidating most of DOI's rollback regulations, Judge Janavs declared that Commissioner Garamendi's order requiring 20th Century to refund 12.203% of premiums paid during the Proposition 103 rollback period, plus interest, to be null and void.

Both Garamendi (through outside counsel Michael J. Strumwasser and Fredric Woocher) and intervenor Voter Revolt have appealed Janavs' decision to the Second District Court of Appeal; both have also filed a petition asking the California Supreme Court to take the case directly from the superior court.

In other Proposition 103 litigation, the California Supreme Court recently granted review in two cases challenging Commissioner Garamendi's authority to scrap former Commissioner Roxani Gillespie's rollback regulations and adopt his own. On March 25, the Supreme Court agreed to review 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). If the Court agrees to take the *20th Century* case directly from the superior court, it may delay its ruling in these two cases.

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 1992, 260,133 salespersons and 115,613 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 averaged 56% for salespersons and 48% for brokers (including retakes) during the 1991–92 fiscal year. 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 exceeding one year in length, of any new residential subdivisions consisting of five or more lots or units, DRE protects the public by requiring that a prospective purchaser or tenant be given a copy of the "public report." The public report serves two functions aimed at protecting purchasers (or tenants with leases exceeding one year) of subdivision interests: (1) the report discloses material facts relating to title, encumbrances, and related information; and (2) it ensures adherence to applicable standards for creating, operating, financing, and documenting the project. The commissioner will not issue the public report if the subdivider fails to comply with any provision of the Subdivided Lands Act.

The Department publishes three regular bulletins. The *Real Estate Bulletin* is circulated quarterly as an educational service to all current licensees. The *Bulletin* contains information on legislative and regulatory changes, commentaries, and advice; in addition, it lists names of licensees who have been disciplined for violating regulations or laws. The *Mortgage Loan Bulletin* is published twice yearly as an educational service to licensees engaged in mortgage lending activities. Finally, the *Subdivision Industry Bulletin* is published annually as an educational service to title companies and persons involved in the building industry.

DRE publishes numerous books, brochures, and videos relating to licensee activities, duties and responsibilities, market information, taxes, financing, and investment information. In July 1992, DRE began offering one-day seminars entitled "How to Operate a Licensed Real Estate Business in Compliance with the Law." This seminar, which costs $10 per attendee and is offered on various dates in a number of locations throughout the state, covers mortgage loan brokering, trust fund handling, and real estate sales.

The California Association of Realtors (CAR), the trade association joined primarily by agents and brokers working with residential real estate, is the largest such organization in the state; CAR projects a 1992 total membership of 126,000. CAR is often the sponsor of legislation affecting DRE. The four public meetings required to be held by the Real Estate Advisory Commission are usually scheduled on the same day and in the same location as CAR meetings.

MAJOR PROJECTS

CPIL Visits DRE. In March, Center for Public Interest Law intern Matt Wakefield spoke with several DRE officials regarding the Department's current projects and future goals. Highlights from those conversations include the following.

• According to DRE Commissioner Clark Wallace, DRE has no plans to propose a new license classification system based upon the various segments of the industry in which licensees currently practice. Under that type of system, applicants would be tested on the specific standards for the area(s) in which they intend to practice, as opposed to the current comprehensive test which is primarily aimed