that he could be convicted under theories that he was either the direct seller of false securities in violation of Corporations Code sections 25401 and 25540, or a principal who aided and abetted the violations. The issue is whether aiding and abetting of a section 25401 crime statutorily exists; Keating claims that criminal liability is restricted to direct offerors and sellers, and that the evidence failed to prove he personally interacted with any of the investors.

DEPARTMENT OF INSURANCE

Commissioner: John Garamendi
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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

The Race for Insurance Commissioner Narrows. On June 7, California voters limited their choice for Insurance Commissioner to Democrat Art Torres and Republican Charles Quackenbush, two candidates with very different backgrounds and views on insurance regulation. Commissioner John Garamendi, who chose to seek the Democratic nomination for Governor rather than pursue another term as Insurance Commissioner, lost the nomination to state Treasurer Kathleen Brown. *[14:2&3 CRLR 129]*

Torres, a Latino with twenty years' experience in the legislature, has chaired the Senate Insurance Committee since 1992. He supports Proposition 103 and favors aggressive regulation of the insurance industry, expansive coverage for consumers, and sweeping powers for the Commissioner. Should Torres win in November, he would be the first Latino to hold statewide office in this century.

Quackenbush, a former Army captain and entrepreneur from Silicon Valley, has been an assemblyman for eight years. He characterizes himself as a political moderate who believes the unfettered marketplace can force premium rates down and increase availability because more insurers will be attracted to California. He has historically questioned Proposition 103, but has pledged to enforce it if elected. Quackenbush, whose campaign is being handled by Governor Wilson's former deputy chief of staff, is strongly supported by the insurance industry, and has accepted hundreds of thousands of dollars in campaign contributions from the industry.

Garamendi's Rollback Rules Affirmed by California Supreme Court. On August 17, the California Supreme Court unanimously upheld the constitutionality of Commissioner Garamendi's regulations implementing the rollback provisions of Proposition 103 (*see* LITIGATION). The high court's decision in *20th Century Insurance Company v. Garamendi* was a tremendous and long-awaited victory for Garamendi and the Department, Proposition 103 author Harvey Rosenfield, and the team of Fred Woocher and Mike Strumwasser—private attorneys from Santa Monica who have defended Proposition 103 in the relentless onslaught of industry-financed litigation since it was passed by the voters on November 8, 1988. *[12:4 CRLR 151–52]* The ruling affirming the validity of Commissioner Garamendi's regulations implementing Proposition 103's rollback provision and his application of those regulations to 20th Century comes over five years after the same court unanimously upheld the facial constitutionality of the initiative in *Calfarm v. Deukmejian*, 48 Cal.3d 805 (1989). *[9:3 CRLR 86–87]*

Unfortunately for Commissioner Garamendi's political aspirations, the decision came too late to help him in his bid for the Democratic nomination for Governor. Although the *20th Century* matter was fully briefed by August 25, 1993, the Supreme Court did not schedule oral argument in the matter until June 7, 1994—the day of the primary election.

Homeowners Insurance "Crisis" Claimed by Industry, Belittled by Consumer Groups, Ignored by Legislature. During the summer, most of the state's largest sellers of homeowners insurance —asserting huge losses and borderline insolvency after paying claims resulting from the Northridge earthquake—announced their intent to cease or restrict the sale of homeowners and earthquake insurance in California. Specifically, 20th Century announced on May 11 that it must triple its earthquake insurance rates or withdraw from the California homeowners insurance market entirely. *[14:2&3 CRLR 132]* State Farm, Farmers, and Allstate stopped selling new homeowners policies in mid-June; all expressed hope that they could continue to renew existing policies, but demanded increased deductibles and/or a substantial rate hike (both of which must be preapproved by the Commissioner). By the end of August, eight of the ten largest sellers of homeowners insurance had restricted their offer and sale of policies in California, and Republic Insurance Group—a Texas-based company which has written homeowners, fire, and earthquake insurance in California since 1906—announced its intent to leave the state entirely.

The industry uniformly demanded several legislative changes, including a repeal of Insurance Code section 10081, which requires all insurers who sell homeowners insurance in California to also offer earthquake insurance; and enactment of a new state-backed earthquake insurance pool to replace the flawed and now-defunct Green-Hill-Areias-Farr California Residential Earthquake Recovery Fund initiated by the Deukmejian administration after the 1989 Loma Prieta earthquake. *[12:2&3 CRLR 173; 12:1 CRLR 121–22; 11:4 CRLR 134]* Insurers also called on the federal government to pass the industry-sponsored National Disaster Protection Act then pending in Congress, which would impose a surcharge on all homeowners policies (adjusted for regional risk of earthquakes, hurricanes, wildfires, or other catastrophes) to help cover claims resulting from natural disasters.

The industry's announced withdrawal from the California homeowners market presented election-year problems for the Commissioner, the legislature, and the Wilson administration, as the unavailability of homeowners insurance would delay or scuttle real estate sales (most lenders require homeowners insurance as a condition of mortgage lending) and threaten California's fragile economic recovery. However, as the summer, the legislative session, and the election wore on, government's treatment of the industry turned from initial assistance to skepticism to inaction.

For his part, the Commissioner sought to use state law and his powers to stem the tide of market withdrawal. Under California law, homeowners insurers must offer earthquake coverage with homeowners policies, policyholders are entitled to renew their policies at the same deductible, and the Insurance Commissioner must preapprove any rate changes. In mid-June, when 20th Century announced its intent to leave the homeowners market immediately, Commissioner Garamendi negotiated a plan under which the company could stop offering new policies and, starting July 23, renew homeowners policies without earthquake coverage if it would agree to offer two more annual renewals of existing policies. On June 22, Garamendi ordered the Fair Access to Insurance Requirements (FAIR) program to offer residential earthquake and fire insurance statewide, in order to ensure insurance availability so as not to disrupt the real estate market. FAIR is a nonprofit insurance pool established to assure the availability of basic property insurance to persons who, after diligent effort, are unable to obtain insurance through normal channels; it consists of all insurers admitted to write property insurance in California, and each insurer is required to cover a policy volume in the same proportion as its market share. *[14:2&3 CRLR 131]* At the same time, Garamendi approved a 100% increase in FAIR plan earthquake premium rates (to $2.50 per $1,000 of coverage) and a 20% increase in fire insurance rates.

On July 13, a coalition of consumer groups issued a 16-page letter warning policymakers that "the only 'crisis' in California today is the one that the insurance industry itself is manufacturing, in an attempt to leverage unwarranted rate increases and stampede elected officials into legislating a taxpayer-subsidized bailout of the insurance industry." The letter—which was co-signed by the Proposition 103 Enforcement Project, Consumer Action, the Utility Consumers' Action Network (UCAN), the Economic Empowerment Foundation (EEF), and the Center for Public Interest Law—noted that, for 23 years (since the 1971 Sylmar earthquake), southern California homeowners have paid insurance premiums which include an annual 2–6% "catastrophic load factor" in anticipation of another severe seismic disturbance. Additionally, the consumer groups asserted that insurance companies have been selling earthquake insurance at a price often equal to 50% of the cost of the regular homeowners policy and have insisted on deductibles that exclude coverage for all but the most severe quakes. "As a result, notwithstanding the complaints and machinations of the insurance industry, there is no company in California today that is unable to pay the claims arising from the Northridge earthquake."

The groups noted that property-casualty insurers enjoyed $5.8 billion in profits in 1992 (notwithstanding Hurricane Andrew, which caused $16 billion in damages), and another $18.5 billion in profits in 1993. In terms of the $7 billion cost of the Northridge earthquake, they asserted that State Farm—with a consolidated surplus of $20 billion—could pay all of the claims by itself and have more than $13 billion left to spare. The groups noted that 20th Century is the only carrier in California to have claimed that the cost of claims arising from the earthquake has endangered its ability to continue operations, and called that situation "a self-inflicted wound. Twentieth Century's often-criticized underwriting process of localizing its sales almost exclusively in the well-to-do neighborhoods of the San Fernando Valley produced record profits for the company—until that same lucrative geography became the epicenter of the January earthquake."

The consumer groups argued that the insurance industry's "crisis" stems not from the Northridge earthquake but from several years of relatively low interest rates. "Insurance companies make most of their profit from the investment of the premiums we pay, not from the net proceeds of underwriting." Since the 1988 passage of Proposition 103, which required a rate rollback, preapproval by the Insurance Commissioner of most rate changes, and has blocked an estimated $4.2–$6 billion in rate increases in California *[13:2&3 CRLR 130–31]*, "the insurance industry has been anxiously awaiting an excuse to raise rates." The coalition urged California policymakers to follow Florida's example in the wake of Hurricane Andrew: In response to the same threats and complaints by the insurance industry after having to satisfy the obligation for which it had contracted and been paid, the Florida insurance commissioner imposed a moratorium on insurance rate hikes and withdrawals from the marketplace. "That prompt action saved Floridians millions of dollars, and probably short-circuited another national 'crisis' by serving notice on the industry that regulators would react sharply to efforts by insurers to exploit a disaster for their own financial purposes."

The groups urged the legislature and/or the Commissioner to impose a similar moratorium on cancellation or non-

renewal of homeowners policies, establish a joint underwriting authority to ensure the availability of homeowners and earthquake coverage to new customers under Insurance Code section 1861.11, resist the industry's cry for repeal of Insurance Code section 18001, initiate public proceedings to investigate the companies' demands for higher rates and deductibles, and reject the industry's demands for taxpayer-subsidized state or federal bailout programs. Instead, the consumer organizations called for the creation of a taxpayer-controlled public nonprofit insurance corporation to sell all homeowners insurance in California. "In exchange for accepting responsibility for earthquake losses—a responsibility insurers desperately want to shirk—the public fisc should be compensated with the right to sell the more profitable homeowners insurance in California." The groups also called on the Commissioner to investigate and punish unlawful cancellations and nonrenewals, impose severe penalties for failure to settle disaster claims fairly, and commence an antitrust investigation into the companies' simultaneous declarations of their intent to withdraw from the California market.

After initially assisting 20th Century by negotiating a phased withdrawal from the homeowners market (including a suspension of section 18001), the Department received complaints that the company was cancelling policies it had just renewed under the agreement. On July 20, DOI announced an investigation into 20th Century's practices; several weeks later (just after the August 17 California Supreme Court decision requiring it to pay its policyholders $119 million in Proposition 103 rollbacks—*see above*), 20th Century raised the estimate of its losses from the Northridge quake from $685 million to $815 million. Reeling from the rollback decision, quake losses, and a sharp decrease in the value of its publicly-traded stock, the company began negotiations with Commissioner Garamendi for an arrangement which would enable it to continue operating in California. On September 14, Garamendi approved an unusual rate increase: To shore up the company's declining reserves, the Commissioner permitted 20th Century to increase its auto rates by 6%; that increase will be reduced to 3% when the company's surplus is equal to one-third of its annual premiums. In exchange, the company agreed to deposit $1 million of its surplus in Oakland area banks to help support economic development in that community and to donate $50,000 to nonprofit community activities. Garamendi noted his intent to require the company to refund the full amount of its Proposition 103 rollback obligation. The Commissioner also announced the commencement of public hearings on September 28–29 for consideration of rate and/or deductible increases requested by other insurers.

Meanwhile, the legislature took no action on any of the bills introduced to address the "crisis"—with one exception: It passed AB 3569 (Margolin), which would permit the Governor, upon a finding by the Insurance Commissioner that a property insurance availability crisis exists, to impose a moratorium on the cancellation or nonrenewal of policies except for specified reasons (such as nonpayment of premium). However, Governor Wilson vetoed the bill on September 30 (*see* LEGISLATION). Several industry-sponsored bills—including AB 1132 (Conroy) and SB 212 (Russell), both of which would have created new state earthquake insurance pools, and AB 1388 (McDonald), which would have suspended (until January 1, 1997) the requirement that earthquake coverage be offered with homeowners policies—never made it out of committee.

Proposition 103 Auto Rating Factors and Good Driver Discount Regulations. Following a year of public hearings, DOI submitted sections 2632.1–2632.16, Title 10 of the CCR, proposed permanent regulations which establish the criteria to be used in setting rates and premiums for private passenger automobile insurance under Proposition 103, to the Office of Administrative Law (OAL) on July 12. The proposed regulations also set forth criteria pertaining to good driver discounts, the availability of good driver discount policies from insurers, and the determination of eligibility for such a discount. *[14:2&3 CRLR 132; 14:1 CRLR 101–02; 13:4 CRLR 111–12]*

Proposition 103 requires auto rates to be based primarily on three "mandatory" factors (the insured's driving safety record, the number of miles driven annually, and the number of years of experience the driver has been licensed to drive in any jurisdiction) and any "optional" factors which the Commissioner adopts by regulation. Proposed section 2632.5 defines the three mandatory factors, and sets forth the following permissive factors: vehicle characteristics (*e.g.*, engine size, safety and protective devices, and anti-theft devices); type of use of vehicle; usage patterns of the vehicle; primary, or occasional driver of the vehicle, or percentage of use of the vehicle by the rated driver; average claims cost in a geographical area as defined in Insurance Code section 11628; average accident frequency in a geographic area as defined in Insurance Code section 11628; multi-car household; persistency (defined as a discount given for renewals with the same or an affiliated insurer), without consideration of driving safety record; academic standing; nonsmoker; and gender. The proposed rules prohibit insurers from using any rating factor not set forth therein; the rules further prohibit insurers from using any rating factor, discount, types of limits of coverages or deductibles, make, model, value, cost of repair, or auto symbol of the insured vehicle in the development of rates "in a manner that does not bear a substantial relationship to loss." In terms of the weight to be accorded to the various rating factors, section 2632.7 specifies that the factors are to be applied sequentially, starting with the mandatory factors; as to the optional factors, "the order of analysis of the optional factors shall be determined by the insurer, subject to the approval of the Commissioner."

Pursuant to Proposition 103, the rules require auto insurers to set their rates so that a good driver, as defined in Insurance Code section 1861.025, is charged at least 20% less than the lowest rate available to a comparable driver who is not a good driver; regarding eligibility for the good driver discount, the rules implement section 1861.025 by defining driver violation points and setting forth guidelines for determining "principally at-fault" accidents. The rules also permit insurers to offer discounts to premiums for completion of driver training or defensive driving courses and any other discounts permitted by law, so long as such discounts are uniformly promoted and offered to the public.

On August 23, OAL issued a decision approving all of the proposed regulations except sections 2632.5 (the auto rating factors) and 2632.11 (which requires auto insurers to submit their "class plan" of auto rates to the Commissioner for review within 180 days of the effective date of the regulations). OAL rejected section 2632.5 because it failed to clearly define the point system to be used for evaluating the driver's safety record (first mandatory factor) and failed to apply two of the three mandatory factors to the calculation of uninsured and underinsured motorist coverage, comprehensive coverage, and physical damage coverage; OAL rejected section 2632.11 because insurers cannot comply with it until section 2632.5 is approved. At this writing, DOI is in the process of modifying the rejected regulations in preparation for another public comment period and resubmission to OAL. The remainder of the regulations took effect on September 22.

DOI Initiates Rulemaking on Telephone Quote Accuracy and Availability. On September 2, DOI published notice of its intent to adopt section 2632.14.4, Title 10 of the CCR, to require auto insurers to maintain toll-free telephone numbers and provide telephone and/or written price quotes for automobile insurance. The Department initiated the rulemaking proceeding in response to comments made at its October 1993 public investigative hearings on the high percentage of inaccurate quotes for private passenger automobile coverage. *[14:1 CRLR 101; 13:4 CRLR 112–13]*

Proposed section 2632.14.4 would require auto insurers to maintain toll-free telephone numbers for the purpose of providing price quotations to "good drivers" as defined in Insurance Code section 1861.025, and to list those numbers with directory assistance. Insurers must offer and sell insurance to good drivers by providing telephone price quotes to consumers via the toll-free telephone number, and provide good drivers with the name and address of an agent nearest the caller who can provide the caller with an application. If a good driver calls an insurer on a toll number and requests a price quote, the insurer must either provide the quote or refer the caller to its toll-free number. Under the proposed rule, agents are required to provide telephone price quotes to consumers or refer them to the insurer's toll-free telephone number. Insurers and agents are barred from conditioning provision of a quote on payment of a fee or on the caller's production of his/her motor vehicle report, and agents are further barred from charging a fee for referrals to an insurer's toll-free telephone number.

To enable the insured to determine what coverages he/she has been quoted and what prices have been charged for the coverages, the section further provides that when insurers and agents provide a good driver with a telephone price quote, they must tell the caller that he/she is entitled to an itemization of the price quote either by telephone or in writing. Every telephone itemization shall provide the caller with the total price quoted for the policy and an itemization of the total price quoted. The section also requires insurers and agents to provide good drivers with written price quotes setting forth an itemization of the total price quoted, and includes a standardized format which must be used for written price quotes. The regulation would further require insurers to provide good drivers with a declarations page which sets forth the total price charged for the policy and an itemization of the total price charged, to enable the insured to determine what coverages he/she has been sold, what prices have been charged, and what fees, surcharges, discounts, and credits have been applied. Also on the declarations page, the insurer must list the mandatory and optional auto rating factors used in rating the policy.

The proposed regulation also states that individuals who provide information indicating that they are good drivers shall be presumed good drivers for purposes of obtaining a price quote; however, it excuses insurers from providing price quotes when they are asked to provide quotes for a non-good driver or when the insurer is exempted from the "offer and sell" requirement under Insurance Code section 1861.15.

Finally, the section requires insurers to honor written price quotes by providing coverage at the price and on the terms quoted until the date a rate change affecting the quote is approved by the Commissioner; insurers and agents must keep copies of written price quotes for six months. However, the person who is the subject of a written price quote shall not be entitled to purchase at the price quoted if a material fact was not disclosed at the time the quote was made, or if the good driver will not exclude a non-good driver from the policy. The section requires insurers to provide their agents and employees with written guidelines on providing price quotes; requires insurers to keep records concerning their toll-free numbers and the agents to whom callers were referred, and to file these records with the Commissioner annually; and prevents insurers from avoiding their obligation to offer and sell insurance to good drivers by barring them from conditioning the provision of a quote or the sale of the coverage requested by a good driver on the purchase of another line of insurance.

At this writing, DOI is scheduled to hold public hearings on these proposed regulatory changes on October 25 in Los Angeles and October 27 in San Francisco.

Commissioner to Implement Workers' Compensation Reforms. In July, Commissioner Garamendi published notice of his intent to implement SB 30 (Johnston) (Chapter 228, Statutes of 1993), which repeals—effective January 1, 1995—the existing minimum rate system for workers' compensation insurance and replaces it with a competitive, "file and use" system (Insurance Code sections 11730–39). SB 30 was part of a seven-bill package which finally overhauled some of the more glaring defects in California's workers' compensation system. *[13:4 CRLR 115–16]*

Under the new system, the Workers' Compensation Insurance Rating Bureau develops and submits for the Commissioner's approval pure premium rates, a uniform experience rating plan, a uniform statistical plan, and regulations related to the recording and reporting of data pursuant to the uniform experience rating plan, uniform statistical plan, and classification system developed by the Bureau. The pure premium rates published by the Bureau are advisory only; however, the uniform experience rating plan, the uniform statistical plan, the classification system, and the compliance with the regulations are mandatory.

In July, the Commissioner commenced three rulemaking proceedings to implement the workers' compensation package:

- In Proceeding RH-324, DOI proposes to adopt new sections 2509.30, 2509.31, 2509.32, 2509.33, and 2509.34, Title 10 of the CCR, to regulate how workers' comp insurers must file their rates, rating plans, and supplementary rating information with DOI, and specify the information which must be included in each filing and the procedures for their disapproval.
- In Proceeding RH-325, DOI proposes to repeal sections 2350, 2353, 2318.5, and 2352.1, Title 10 of the CCR, the Department's minimum rate regulations under the old rating system, effective January 1, 1995.
- Finally, in Proceeding RH-326, DOI proposes to amend section 2350, Title 10 of the CCR, to reduce basic minimum workers' comp rates by approximately 15%, subject to an August 31 public hearing, review by an administrative law judge, and approval by the Commissioner. At this writing, the rate reductions could take effect as early as October 1.

At this writing, all three regulatory proposals await adoption by the Commissioner and approval by OAL.

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

- ***Anti-Redlining Regulations.*** On April 20, OAL released an "approval in part/disapproval in part" decision on section 2646.6, Title 10 of the CCR, Commissioner Garamendi's regulation to discourage redlining in the provision of auto, homeowners, commercial, and fire insurance. As submitted, section 2646.6 would have required insurers to annually provide specified information to the Commissioner in a "Community Service Statement" covering their record of service to underserved communities; allowed the Commissioner to use that information in considering rate change applications; required the Commissioner to annually compile a "Community Service Index"

identifying communities which are "underserved by the insurance industry" and report on services provided by insurers to underserved communities; required the Commissioner to rank insurers by willingness and ability to serve underserved communities; required lower-ranked insurers to develop marketing plans targeting underserved communities; required insurers which decline to provide coverage in an underserved area to provide a statement of reasons to applicants; and required insurers to maintain and advertise a statewide toll-free telephone number. OAL essentially rewrote the regulation to eliminate any provision which, in OAL's opinion, established or imposed an obligation on the part of insurers to provide a particular level of service to a particular community; however, OAL approved the portions of the regulation permitting the Insurance Commissioner to gather (and requiring insurers to submit) extensive information on the level of insurance services provided. In an attempt to salvage the provisions stricken by OAL, Commissioner Garamendi petitioned Governor Wilson to reverse OAL's decision on May 5. *[14:2&3 CRLR 130–31]*

On June 3, the Governor released a decision upholding OAL. Wilson found that the disapproved portions of the proposed regulation are not necessary to enforce the anti-discrimination provisions of state law. He noted that unfair discrimination is already prohibited in California under the Unruh Civil Rights Act and Insurance Code sections 1861.03 and 1861.05, but said that a business is not prohibited from discriminating between and among its customers or potential customers based on legitimate business reasons, such as economic factors. According to Wilson, "the Commissioner's disapproved regulations assume 'underservice' is synonymous with 'unfair discrimination.'...Underservice is not the same thing as unlawful discrimination. The Commissioner is fully empowered to remedy unfair discrimination. He is not, however, authorized to define, or compel insurers to cure, underservice. Underservice is not illegal."

Following the Governor's decision, DOI modified some of the disapproved provisions and resubmitted them to OAL on August 25. Among other things, the resubmitted provisions require insurers to report the number of agents or agencies maintaining offices by ZIP code. At this writing, these changes are pending at OAL.

• ***Regulations to Prohibit Redlining in Surety Insurance.*** On May 23, DOI held a public hearing on its proposed adoption of new section 2646.7, Title 10 of the CCR, which is patterned after DOI's generic anti-redlining regulations (*see above*) but which focuses specifically on surety insurance. Section 2646.7 would require surety insurers to annually compile and report to the Commissioner specified information related to the number of applications received and granted for surety bonds for construction projects, the total number of surety bonds for construction projects provided to minority-owned firms, the total dollar amount of surety bonds issued for construction projects generally and for minority-owned firms. The Commissioner will compile these data on an annual basis and make the data on each surety insurer available for public inspection. The regulations define the term "minority" to mean American Indian or Alaskan Native, Asian or Pacific Islander, African-American, or Latino. *[14:2&3 CRLR 130]*

At the hearing, insurance industry representatives objected to the proposed regulation, arguing that the reporting requirements would be burdensome and would increase the cost of providing insurance (which will eventually be borne by the consumer); they also contended that inquiring about the race of applicants would be difficult and possibly offensive. None of the representatives of minority-owned construction firms present objected to being asked about the racial make-up of their firm's ownership or management; however, they argued that the scope of the regulation should be amended to require the collection of data on "minority-owned and -controlled firms" rather than "minority-owned firms," to avoid distortion of the data by counting firms which are only owned by a minority "front" person.

At this writing, DOI is making modifications to the originally-proposed language, and plans to release it for a 15-day comment period later this fall.

• ***Minimum Reserve Standards for Disability Insurance.*** On May 31, DOI began its consideration of the public comments received on its proposed adoption of new Article 3.5 (sections 2310–15), Title 10 of the CCR, which will establish specific minimum reserve standards for disability insurance. *[14:2&3 CRLR 132–33]* The proposed regulations will set minimum reserve standards, inform insurers of the tests that will be used by the Commissioner to determine whether reserves are adequate; list the elements that will be taken into account; set forth various actions which may be taken when inadequacy is found; provide for situations that are exceptions to the general rule; and name the three categories of reserves and require adequacy in each category. At this writing, the Commissioner has not yet adopted these regulations.

• ***Rulemaking to Implement AB 1672 (Margolin).*** On September 7, DOI readopted emergency regulations to implement AB 1672 (Margolin) (Chapter 1128, Statutes of 1992), which became effective on July 1, 1993. AB 1672, which added sections 10198.6–.9 and 10700–10749 to the Insurance Code, dramatically restructured California's market for health insurance for employees of "small employers." Emergency sections 2233–2233.99 (nonconsecutive), Title 10 of the CCR, define key terms in the statute, clarify existing ambiguities in the law, and attempt to bring as many sources of health coverage as possible within the jurisdiction of AB 1672. These emergency regulations also reflect changes to AB 1672's small employer provisions (Insurance Code sections 10700–10718.6) made by bills enacted during 1993. *[14:1 CRLR 104; 13:4 CRLR 113–14; 13:2&3 CRLR 132–33]* The emergency regulations are effective for another 120-day period.

• ***Licensing of Insurance Claims Analysis Bureaus.*** On March 16, OAL rejected DOI's proposal to adopt new section 2698.30–.36, Title 10 of the CCR, to implement Insurance Code section 1871 *et seq.* regarding the licensure of insurance claims analysis bureaus (CABs) to assist the public, regulators, law enforcement, prosecutors, and insurers in suppressing and preventing insurance claims fraud. *[14:2&3 CRLR 133; 14:1 CRLR 103; 13:4 CRLR 113]* DOI decided not to resubmit these proposed regulations to OAL.

Health Care Debate Centers on Proposition 186. On November 8, California voters will express their opinion on Proposition 186, a ballot initiative which proposes to replace existing private health insurance policies and public health care programs with a government-run, "single payer" health care program. The initiative, dubbed the California Health Security Act, would provide lifetime medical coverage, including long-term care, and dental, vision, mental health, and prescription drug coverage to all Californians. Currently, over 6 million Californians (80% of whom are employed or are family members of an employed person) are not covered by any form of health insurance because their employers do not provide health coverage, they earn too little to afford private coverage, and they earn too much to qualify for Medi-Cal.

The program would be administered by a new, elected Health Commissioner, and financed by increased payroll taxes on all employers, a 2.5% income tax increase for all individuals (and an additional 2.5%

income tax increase for individuals with annual incomes above $250,000), and a $1-per-pack surcharge on cigarettes. In addition, the initiative allows the legislature to redirect existing Medi-Cal funds into the system. The proposal assumes that by eliminating private insurance, its enormous overhead and administrative costs, and existing out-of-pocket costs in the form of premiums, deductibles, and copayments, the system would save enough money to underwrite its extensive benefits menu.

Proponents argue that insurers take thirty cents of every health care dollar for administrative costs, overhead, and executive salaries, and that the existing insurance system (both public and private) is riddled with hidden costs, loopholes, exclusions, and uncertainty. Opponents contend that the proposed system is largely untried, government is incapable of administering a health care system, and the revenue to be generated by the initiative will not be enough to cover its costs—thereby leading to higher tax increases and/or cuts in other worthy and needed government programs.

Department to Close Los Angeles Conservation and Liquidation Division. DOI recently announced that it will close its Conservation and Liquidation Division office in Los Angeles and terminate 67 employees by the end of the year. The Division and its top three officials will relocate near DOI's offices in San Francisco. The Division is responsible for conserving and liquidating insurance companies that experience financial or other problems. The closure follows two critical audits by the State Auditor, who found that the Division has made improper decisions and has lax procedures or no established procedures for important aspects of its operations. *[14:2&3 CRLR 13–14; 12:4 CRLR 38, 147]*

LEGISLATION

AB 1132 (Conroy), as amended July 7, and **SB 212 (Russell)**, as amended July 7, would both have created a new California Earthquake Underwriting Pool within DOI; effective January 1, 1995, insurers could offer homeowners policies without offering earthquake coverage, and all earthquake coverage would be issued through the state-run pool (*see* MAJOR PROJECTS). These bills died in committee.

AB 1388 (McDonald), as amended August 29, would have suspended, until January 1, 1997, the requirement that earthquake insurance be offered with homeowners insurance (*see* MAJOR PROJECTS). This bill died in committee.

The following is a status update on bills reported in detail in CRLR Vol. 14, Nos. 2 & 3 (Spring/Summer 1994) at pages 134–38:

SB 1395 (Leslie), as amended July 1, is a direct outgrowth of a critical report by the Bureau of State Audits (BSA) finding that DOI is unable to identify its costs of enforcing Proposition 103 or examining insurance companies. *[14:2&3 CRLR 133–34]* The bill requires DOI to adopt an accounting system that will allow it to accurately identify the costs of its regulatory activities and to link the costs to fees collected for those regulatory activities; provides that, on and after October 1, 1995, DOI may not levy specified fees unless they comply with the requirements of the bill; requires examination fees to be based on the actual cost of the examination, and requires fees imposed in connection with rate regulation provisions added by Proposition 103 to be based on the actual administrative and operational costs arising from those provisions; requires DOI to provide a schedule of fees and justification to specified entities; and requires BSA to complete an audit of the schedule of fees to determine if the fees are in compliance with the bill. This bill was signed by the Governor on September 27 (Chapter 965, Statutes of 1994).

AB 3586 (O'Connell). Existing law requires the Insurance Commissioner to disseminate complaint and enforcement information on individual insurers to the public, including the ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. *[11:3 CRLR 126–27; 10:4 CRLR 122]* As amended August 11, this bill requires that private passenger automobile insurance ratios be calculated as the number of complaints received to total car years earned in the period studied. This bill was signed by the Governor on September 26 (Chapter 893, Statutes of 1994).

AB 2601 (Johnson), as amended August 19, also requires that—for purposes of the Commissioner's dissemination of complaint information described above—private passenger automobile insurance ratios must be calculated as the number of complaints received to total car years earned in the period studied. Further, this bill requires the Commissioner to promulgate a regulation that sets forth the criteria that DOI shall apply to determine if a complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer; requires the Commissioner to provide to the insurer a description of any complaint against the insurer that the Commissioner has received and has deemed to be justified at least thirty days prior to public release of a report, as specified; and requires an insurer to provide information to DOI regarding a person who the insurer designates to receive complaints, as specified. This bill was signed by the Governor on September 26 (Chapter 892, Statutes of 1994).

AB 3570 (Isenberg), as amended August 17, provides that when a judgment for punitive damages is entered against a defined insurer or health care service plan (HCSP) on or after January 1, 1995, the plaintiff shall, within ten days, provide the DOI Commissioner or the Commissioner of Corporations, as appropriate, with a copy of the judgment, a brief recitation of the facts of the case, and copies of relevant pleadings as determined by the plaintiff. Under the bill, willful failure to comply with this provision subjects the plaintiff or his/her attorney to sanctions at the discretion of the trial court. This bill was signed by the Governor on September 28 (Chapter 1061, Statutes of 1994).

AB 3751 (Margolin), as amended August 26, provides specifically that the statute of limitations for a workers' compensation fraud offense commences upon discovery of the offense.

Existing law prohibits certain specified acts with respect to false and fraudulent insurance claims. This bill provides that a violation of certain of those acts additionally gives rise to civil liability of up to $5,000 per claim or act, plus an assessment of not more than three times the amount of each claim for compensation submitted. The bill specifies the allocation of any recovered civil penalty. This bill was signed by the Governor on September 25 (Chapter 841, Statutes of 1994).

AB 2890 (Statham). Under existing law, where two or more policies affording valid and collectible liability insurance apply to the same motor vehicle, it is conclusively presumed that the insurance afforded by the policy in which the motor vehicle is described or rated as an owned automobile is primary and the insurance afforded by any other policy or policies is excess. As amended August 19, this bill provides that where two or more personal policies affording liability insurance that apply to the same motor vehicle in an occurrence out of which a loss shall arise, and one policy is primary and one or more policies are excess, then each insurer shall pay for the cost of defense in proportion to the percentage of total damages paid by that insurer, as specified. This bill was signed by the Governor on September 30 (Chapter 1252, Statutes of 1994).

SB 1381 (Torres). Under existing law creating the California FAIR Plan (*see*

MAJOR PROJECTS), insurers who voluntarily write commercial property insurance or basic property insurance on risks located in areas designated as brush hazard areas by the Insurance Commissioner will, to that extent, be proportionately relieved of the liability to participate in the Plan. As amended April 21, this bill makes similar provision for insurers who voluntarily write basic property insurance or business owners package insurance on risks located in areas designated as innercity areas by the Commissioner. The bill additionally requires the Commissioner to develop by July 1, 1995, a pamphlet which provides information to small business owners and others on the key features of, and suggested ways of, purchasing commercial property insurance. This bill was signed by the Governor on August 21 (Chapter 316, Statutes of 1994).

AB 3568 (Margolin). Existing law requires the offer of earthquake insurance coverage to disclose certain information, including any deductible related to earthquake damage. As amended August 17, this bill provides that every policy of residential property insurance or policy endorsement covering an individually owned condominium unit for loss or damage from earthquakes shall disclose, in a specified typeface, specified loss assessment coverage information if it excludes, limits, or changes coverage for loss assessment. This bill, which requires the Insurance Commissioner to issue a bulletin specifying the language of the required disclosure, was signed by the Governor on September 19 (Chapter 658, Statutes of 1994).

AB 3569 (Margolin), as amended August 10, would have authorized the Insurance Commissioner, when a state of emergency is declared, to call a public hearing to determine whether certain property insurance has been made substantially less available or more costly by the events caused by the declared emergency, and authorized the Governor to make an order prohibiting the cancellation or nonrenewal of policies except for nonpayment of premium or fraud (*see* MAJOR PROJECTS). This bill was vetoed by Governor Wilson on September 30; among other things, Wilson contended that the bill "grants the Governor and the Insurance Commissioner interdependent powers, creates confusion regarding exercise of executive authority, blurs responsibilities between the Governor and the Insurance Commissioner, and is constitutionally suspect."

AB 3682 (Margolin). Existing provisions of law, which will become operative on January 1, 1995, prohibit workers' compensation insurance rates that impair or threaten the solvency of an insurer or create a monopoly, and provide for the filing of rates with the Insurance Commissioner (*see* MAJOR PROJECTS). As amended August 18, this bill requires that rates shall not be unfairly discriminatory, as specified.

Existing law, which will also become operative on January 1, 1995, prohibits any advisory organization from issuing or insurer from using any classification system or rate, as applied or used, that violates specific provisions against discrimination or the Unruh Civil Rights Act, including any arbitrary economic discrimination by an insurer. This bill removes arbitrary economic discrimination by an insurer from that prohibition. This bill was signed by the Governor on September 21 (Chapter 732, Statutes of 1994).

SB 1910 (Greene), as amended August 26, requires HCSP contracts, disability insurance policies, and nonprofit hospital service plan contracts issued, amended, delivered, or renewed in this state on or after January 1, 1995, that provide hospital, medical, or surgical expense coverage under the plan of an employer subject to federal continuing medical insurance requirements (hereafter "COBRA") to permit an employer to provide extended coverage to eligible former employees and their spouses. In order to be eligible for extended coverage, the employee must be over sixty years of age on the date employment ends, and have worked for the employer for at least the five prior years. The bill additionally requires any employer subject to these provisions to provide continuation coverage for an eligible employee and the employee's spouse, if the employee continues coverage under COBRA. The employer is required to provide notice of the availability of continuation coverage, and the employee or spouse is required to elect to continue coverage under these provisions. The coverage will begin after the COBRA coverage ends, on the same terms as the COBRA coverage, at a premium not to exceed 213% of the applicable group rate, as defined. The coverage will end automatically on the occurrence of a specified event. This bill was signed by the Governor on September 30 (Chapter 1144, Statutes of 1994).

SB 1832 (Bergeson), as amended August 29, requires HCSPs to reimburse providers for emergency services and care without prior authorization in specified circumstances; provides procedures for obtaining authorization and resolving disagreements in circumstances where, in the opinion of the emergency or attending physician or other provider, a patient who has received emergency care may not be safely discharged; provides an exception to certain of these provisions for a provider who has a contract with a HCSP for providing emergency and necessary medical care, and for a HCSP that has 3,500,000 enrollees and maintains a prior authorization system that meets certain criteria; prohibits certain disability insurers, a HCSP, or a nonprofit hospital service plan that authorizes a specific type of treatment by a provider from rescinding or modifying this authorization after the provider renders the health care service in good faith and pursuant to the authorization; and prohibits, with certain exceptions, the release of any information by certain disability insurers, a HCSP, or a nonprofit hospital service plan to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider that are covered by the plan, unless authorized to do so by the employee. This bill was signed by the Governor on September 15 (Chapter 614, Statutes of 1994).

AB 3260 (Bornstein), as amended August 24, requires a HCSP, disability insurance policy, and a nonprofit hospital service plan, as defined, that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial, to include a specified disclosure; requires any HCSP, disability insurance policy, or nonprofit health care service plan that includes a term that requires binding arbitration in case of a medical malpractice claim or dispute to provide for the selection of a neutral arbitrator by the parties in those cases or disputes for which the total amount of damages claimed is $50,000 or less; provides that the single neutral arbitrator shall have no jurisdiction to award more than $50,000; provides that certain procedures for court appointment of an arbitrator shall be followed if the parties are unable to agree on the selection of an arbitrator; and expressly prohibits waiver of these requirements.

Existing law requires certain judgments against specified licensed health care professionals by a court to be reported by the clerk of the court to the relevant licensing agency. This bill requires an arbitration under a HCSP contract for any death or personal injury resulting in an award for an amount in excess of $30,000 to be a judgment for purposes of the above-described provision of law. This bill was signed by the Governor on September 19 (Chapter 653, Statutes of 1994).

SB 1388 (Russell). Existing law provides that a certificate of authority to transact insurance shall not be issued to

any insurer owned, operated, or controlled, directly or indirectly, by any other state, or province, district, territory, or nation, or any governmental subdivision or agency thereof. However, the ownership or financial control, in part, of an insurer by any other state of the United States, or by a foreign government, or by any political subdivision or agency of a state or foreign government, does not restrict the Insurance Commissioner from issuing, renewing, or continuing in effect the license of that insurer to transact in this state the kinds of insurance business for which that insurer is otherwise qualified under the provisions of existing law and under its charter, provided the insurer has satisfied the Commissioner that it meets specified standards. As amended April 14, this bill deletes the general prohibition and authorizes partial ownership or financial control provided that the insurer complies with all other requirements for issuance, renewal, or continuation of a license and unless the Commissioner finds that the insurer has violated specified prohibitions. The bill also provides that the failure to submit requested information to the Commissioner constitutes grounds for denial of an application. The bill also states legislative intent. This bill was signed by the Governor on August 26 (Chapter 334, Statutes of 1994).

SJR 36 (Russell), as introduced February 10, memorializes the United States Congress to adopt appropriate resolutions encouraging the states to adopt interstate compacts for the regulation of interstate insurance, and to consent to the adoption of those compacts. This measure was chaptered on June 23 (Chapter 45, Resolutions of 1994).

SB 1355 (Torres), as amended August 26, would have enacted the Homeowners' Bill of Rights that would generally have applied to a policy defined as a "policy of residential property insurance," and would have required, among other things, those insurers selling or renewing homeowners' insurance to identify in the declarations page of the policy the following limits of liability: additional living expenses coverage, liability coverage, and loss assessment coverage regarding individually owned condominiums, as specified. The bill would have required a policy applicant to be notified that a sample policy is available upon acceptance of a policy application; prohibited an insurer from assigning more than two adjusters to a claim during a six-month period without, upon each change in adjuster, timely providing the claimant a written summary of the significant activities, as defined, and agreements relating to the claim; authorized, in the case of a home loss as a result of a President- or Governor-declared disaster, the purchase of another dwelling; specified the rights of an insured with respect to an examination of the insured by an insurer under oath as to "requirements in case loss occurs" and other provisions relating to certain residential property insurance; and required insurance agents and brokers issuing policies of homeowners' insurance to complete a specified approved course.

Existing law provides that if a loss is not rebuilt or replaced, an insured covered by a valued policy shall receive either the replacement value of the loss or the face amount of the policy, whichever is less. This bill would have instead provided that the insured receive the replacement value of the loss or the face amount of the policy, whichever is specified on the policy. The bill would also have revised certain provisions contained in the Standard Form of Fire Insurance Policy with respect to actual cash value of property, policy cancellation, and requirements in case loss occurs, as specified. This bill was vetoed by the Governor on September 30; although acknowledging that SB 1355 includes many provisions that would be helpful to consumers who experience the loss of a home, Wilson expressed concern that the bill's provisions "may result in an inability to prosecute arsonists."

AB 1674 (Margolin). Under existing law, if the Insurance Commissioner finds that liability insurance for a designated class of risk is not readily available, the Commissioner may authorize the formation of voluntary market assistance programs, which must meet specified requirements. If, after a hearing, the Commissioner determines that a market assistance program has failed to provide adequate liability insurance coverage, the Commissioner may order the creation of a temporary joint underwriting association. Every insurer writing liability insurance is a member of the association, which has powers and duties specified by statute. The association continues in existence for one year from the date of its creation unless renewed because of a determination of the necessity of its continued existence. The association is required to have a plan or operation to provide for liability insurance for designated types of risks, subject to the approval of the Commissioner. These provisions were to be repealed on December 31, 1994; as amended July 1, this bill extends the repeal date to January 1, 1996. This bill was signed by the Governor on September 27 (Chapter 951, Statutes of 1994).

SB 1146 (Johnston). Existing law provides that a HCSP, a self-insured employee welfare benefit plan, or a nonprofit hospital service plan may not refuse to enroll any person or accept any person as a subscriber or insured solely by reason of the fact that the person carries a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Existing law contains similar provisions prohibiting rate discrimination and commission discrimination on that basis. A willful violation of these provisions with regard to a health care service plan is punishable as a crime. As amended August 8, this bill deletes the limitation on those prohibitions that those reasons for refusal or discrimination be the sole reasons for that refusal or discrimination; instead, the bill prohibits those forms of refusal and discrimination by HCSPs, self-insured employee welfare benefit plans, and nonprofit hospital service plans on the basis of a person's genetic characteristics, as defined, 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 additionally provides that, effective until January 1, 2002, except as otherwise permitted by law, no admitted insurer licensed to issue disability policies for hospital, medical, and surgical expenses shall fail or refuse to accept an application for that insurance, or fail or refuse to issue that insurance, cancel that insurance, charge a higher rate or premium, or place a limitation on coverage, on the basis of a person's genetic characteristics. It prohibits discrimination in fees and commissions of agents or brokers for writing or renewing a disability policy, other than disability income, on the basis of a person's genetic characteristics which may, under some circumstances, be associated with disability in that person or that person's offspring. It similarly prohibits discrimination in fees and commissions with respect to a life or disability income policy on the basis of a test of a person's genetic characteristics. The bill also prohibits an insurer from requiring a test for the presence of a genetic characteristic for the purpose of determining insurability other than in accordance with specified informed consent and privacy protection requirements, as specified. This bill was signed by the

Governor on September 22 (Chapter 761, Statutes of 1994).

SB 38 (Torres). Existing law prohibits a HCSP or health insurer from denying or conditioning a Medicare supplement contract or policy on account of the applicant's claims experience or medical condition if the application is submitted during the six-month period beginning when an individual, who is 65 years of age or older, first enrolled for benefits under Medicare Part B. As amended July 7, this bill would have deleted the qualification that the individual be 65 years of age or older.

Under existing law, an individual enrolled in Medicare Part B by reason of disability is entitled to open enrollment under these Medicare supplement provisions for six months after he/she reaches age 65. This bill would have provided, instead, that an individual eligible for Medicare by reason of disability is entitled to open enrollment under these provisions for six months after he/she enrolls in Medicare Part B. The bill would have authorized a HCSP or health insurer to establish a contract price for enrollees under 65 years of age based upon the claims experience of that group. On September 30, Governor Wilson vetoed this bill, claiming that the net effect of the bill would be to significantly increase the costs of Medicare benefits, which would have the effect of pricing most disabled individuals out of the market and limiting the choice of benefit packages now available to seniors.

SB 773 (Hart). Existing law authorizes the Insurance Commissioner to authorize the formation of a market assistance program to aid in providing various forms of liability insurance. As amended August 23, this bill would have required the existing market assistance program for family day care homes to be continued in effect at least until January 1, 1996; provided that if certain requirements of the program have been met, the program may continue beyond that date; and provided that if those requirements are not met by January 1, 1996, and the Insurance Commissioner files a statement with the Secretary of State to that effect, then certain other provisions would become operative. This bill would have prohibited 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. If the market assistance program requirements are not met, this bill would also have required 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 have provided 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.

On September 30, Governor Wilson vetoed this bill, claiming that SB 773, which addresses family day care providers' difficulty in finding liability insurance, "is a solution searching for a problem." Despite the contentions of supporters that liability insurance for family day care homes is often unavailable, inadequate, or expensive, Wilson contended that "[c]overage is both available and inexpensive." This bill was supported by the California Women's Law Center, Child Care Law Center, Children's Advocacy Institute, Community Child Care Coordinating Council, California Federation of Family Day Care Providers, and the California Association of Education of Young Children; it was opposed by the Association of California Insurance Companies, Alliance of American Insurers, Personal Insurance Federation, and State Farm.

The following bills died in committee: **SB 1452 (Kopp)**, which would have revised existing law requiring the written consent of the Attorney General prior to the employment of outside counsel for representation of any state agency or employee in any judicial proceeding; **AB 1880 (Bates)**, which would have established a system of comprehensive compensation in lieu of participation in workers' compensation and unemployment disability programs; **AB 3749 (Margolin)**, which would have required all HCSPs and disability insurance policies to provide coverage for screening, diagnosis, treatment of, and surgery for cervical cancer and cervical dysplasia, as well as a screening test for cervical cancer and sexually transmitted disease; **AB 3571 (Margolin)**, which would have stated the intent of the legislature to establish standards for disability insurers and HCSPs to use in assessing claims and requests for authorization of services; **AB 3572 (Martinez)**, which would have required HCSP contracts, disability insurance policies providing coverage for hospital, medical, and surgical benefits, and nonprofit hospital service plan contracts issued, amended, delivered, or renewed in this state on or after January 1, 1995, to provide coverage for the participation of an enrollee, insured, or subscriber in a clinical trial that meets certain criteria; **AB 2128 (W. Brown)**, which would have required 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, reversed the California Supreme Court's decision in *Moradi-Shalal v. Fireman's Fund Insurance Companies*, 46 Cal. 3d 287 (1988) *[8:4 CRLR 87]*, reinstated the so-called "*Royal Globe*" cause of action, and authorized 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; **AB 1770 (Margolin)**, which would have required an insurer to offer a converted policy to any person entitled to be covered by the federal Medicare program to the extent that the converted policy does not duplicate Medicare benefits; **AB 2002 (Woodruff)**, which would have stated the intent of the legislature to establish a system of universal access to health care while also achieving other goals including controlling health care costs and maintaining the quality of health care in California; **SB 1098 (Torres)**, which would have created the California Health Plan Commission, with specified powers and duties, to establish and maintain a program of universal health coverage to be known as the California Health Plan; **SB 1106 (Torres)**, which would have enacted a comprehensive anti-redlining scheme with respect to certain automobile, fire, homeowners', commercial, and mortgage guarantee insurance; **SB 907 (Leonard)**, which would have required every workers' compensation insurer, private self-insurer, and third-party administrator that administers self-insured employers workers' compensation claims, to certify that a utilization review and quality assurance plan that conforms to minimum specified guidelines has been established and implemented; **AB 998 (Tucker)**, which would have specifically authorized the Insurance Commissioner to examine policy forms and to prohibit the use of forms that are deceptive or misleading; and **AB 1782 (Tucker)**, which would have created an Insurance Availability Study Commission within DOI for specified purposes.

LITIGATION

On August 17, the California Supreme Court issued a unanimous decision upholding the constitutionality of Commissioner Garamendi's Proposition 103 rollback regulations in ***20th Century Insurance Company v. Garamendi***, 8 Cal. 4th 216 (1994).

Enacted by the voters on November 8, 1988, Proposition 103 contains (among many other things) a rate rollback requirement during a specified year, a mechanism

for relief from the rate rollback requirement, and a "prior approval" system whereby most insurance rate changes must be approved by the Insurance Commissioner prior to their use. Insurance Code section 1861.01(a), the rate rollback provision, states that "[f]or any coverage for a policy for automobile and any other [specified] form of insurance...issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987." Section 1861.01(b), the rollback relief mechanism, states: "Between November 8, 1988, and November 8, 1989, rates and premiums reduced pursuant to subdivision (a) may be only increased if the commissioner finds, after a hearing, that an insurer is substantially threatened with insolvency." Sections 1861.01(c) and 1861.05 establish the "prior approval" system for rates preapproved by the Commissioner after November 8, 1989.

The regulations at issue include sections 2645.1–2645.9 and 2646.1–2646.5, Title 10 of the CCR (the rollback regulations implementing section 1861.01), and sections 2641.1–2647.1, Title 10 of the CCR (the rate regulations implementing section 1861.05). On February 26, 1993, Los Angeles County Superior Court Judge Dzintra I. Janavs invalidated the rate regulations primarily because, as applied to the calculation of rollbacks, they include a ratemaking formula which incorporates company-specific data and yields a maximum rate which a particular company is permitted to charge during the rollback year. Judge Janavs held that neither Proposition 103, the Supreme Court's earlier decision in *Calfarm v. Deukmejian*, 48 Cal. 3d 805 (1989), 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." Although holding that the Commissioner is authorized to adopt regulations establishing the "lower boundary reasonable rate of return," Judge Janavs ruled that "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." *[13:2&3 CRLR 139–40]*

The Commissioner, Proposition 103 author Harvey Rosenfield, and the insurance industry filed cross-appeals of Judge Janavs' rulings; the Commissioner and Rosenfield petitioned the Supreme Court to take the matter directly from the superior court. The Supreme Court agreed to hear the case in June 1993.

In its opinion, the Supreme Court engaged in an exhaustively detailed analysis of the language and legislative history of Proposition 103 *[9:1 CRLR 73–75]*, its *Calfarm* decision which affirmed the facial constitutionality of the initiative (and reinterpreted the "substantially threatened with insolvency" standard to permit insurers to recoup a "fair rate of return" during the rollback year) *[9:3 CRLR 86–87]*, the regulations adopted by Commissioner Garamendi to implement the rollback and prior approval provisions of the initiative *[11:4 CRLR 131; 11:3 CRLR 129–30; 11:2 CRLR 121–22]*, the company-specific adjudicative hearing before DOI Administrative Law Judge (ALJ) Elizabeth LaPorte in which the regulations were actually applied to 20th Century (and which resulted in an order requiring 20th Century to reduce its rollback year rates by 1.11% below the 1987 rate, rather than to a point 20% below that rate) *[12:2&3 CRLR 170]*, and the bench trial to Judge Janavs which resulted in her February 1993 ruling.

Writing for the unanimous court, Justice Stanley Mosk responded directly to thirteen identified issues raised by the parties, including the following:

• The litigation is not moot because the regulations at issue were disapproved on at least four occasions by OAL. In fact, "[t]he rate regulations—both generally and specifically as to rollbacks—do indeed come within the rate-setting exception [to the Administrative Procedure Act rulemaking requirement], hence fall outside the OAL review requirement."

• The superior court applied the correct standards of review to the various agency decisions at issue in the case. Because the Commissioner's adoption of rate regulations (including his adoption in regulations of generic criteria developed through adjudicative proceedings) is quasi-legislative decisionmaking, judicial review of whether the rate regulations actually adopted by the Commissioner are necessary and proper for the implementation of Proposition 103 is appropriately restricted to the "arbitrary-or-capricious" standard rather than the more intrusive "independent judgment" test.

• The insurers' contention that Proposition 103's rate rollback requirement is facially invalid as confiscatory was already decided against them in *Calfarm*; "[t]here is simply no reason to revisit the issue here."

• The insurers' contention that the rate regulations as to rollbacks are invalid as statutorily unsupported "insofar as they relate to procedure" was also decided in *Calfarm*, wherein the court recognized the Commissioner's "broad discretion to adopt rules and regulations as necessary to promote the public welfare...."

• The insurers' contention that the rate regulations as to rollbacks are invalid as statutorily unsupported "insofar as they relate to substance" was not decided in *Calfarm*. On this issue, the court held that Proposition 103 not only permits the Commissioner to adopt rules to "resolve various interstitial legal, policy, and technical issues[,]...Proposition 103 effectively requires the Commissioner to adopt rules.... [W]e believe that, as construed in *Calfarm*, Proposition 103 does indeed authorize the Insurance Commissioner to adopt substantive rate regulations to implement the rate rollback requirement provision."

• On the key issue of the validity of the rate regulations as to rollbacks with respect to the ratemaking formula, the Supreme Court held that "[t]he superior court's conclusion in this regard is substantially erroneous."

Here, as in other parts of the decision, the court emphasized the critical distinction between the calculation of rates for the rollback year and the calculation of "preapproved" rates for future years—a distinction which, according to the Supreme Court, the superior court missed and the insurance industry "profoundly" misread. When confronted with "prior approval" applications for future years, Proposition 103 requires the Commissioner to determine whether a proposed rate is below "excessive" and above "inadequate"; if the proposed rate falls within that range, the Commissioner must approve it. For the rollback year, however, Proposition 103 requires the Commissioner "to determine whether, for an individual insurer, a maximum rate for the rollback year higher than 80% of the 1987 rate is required to avoid confiscation and, if so, what such higher maximum rate is....To do so, he must, as it were, 'make' a rate. And to do that, we believe, he may proceed by formula rather than case by case. Indeed, it is arguable that he *should* proceed in that fashion (emphasis original)." In making rollback determinations, the court noted that "[i]t would exalt form over substance, and entail the needless expense of time and money, to hold that the commissioner could only disapprove a perhaps numberless succession of insurer-proposed rates fixed above the minimally confiscatory until finally he was required to approve such a rate that happened to hit the proper level—instead of simply determining the

minimally confiscatory rate at the outset. Proposition 103 as construed in *Calfarm* does not require the commissioner to take a passive role when an active one is not barred."

• On the details of the ratemaking formula and the factors used therein, the court rejected a wide variety of insurer contentions: "Not only is the ratemaking formula not internally inconsistent, it is also not confiscatory or arbitrary, discriminatory, or demonstrably irrelevant to legitimate policy." According to the court, a ratemaking scheme which is "novel" or "formulaic" is not necessarily invalid; a challenged price control mechanism which is not confiscatory and is enacted to further a legitimate public interest should be upheld against a constitutional challenge "unless no reasonably conceivable set of facts could establish a rational relationship between the regulation and the government's legitimate ends" (citation omitted).

Here, the court found that Proposition 103 "is demonstrably relevant to the policy of protection of consumer welfare—a policy that the voters were free to adopt, and did in fact adopt....Further, it is not arbitrary, taking an approach to rates that is a reasonable one, although not the only such approach. Lastly, it is not discriminatory. To the extent that it may be said to disfavor insurers and favor their insureds, it does so well within the limits marked out by due process jurisprudence since at least the late 1930's."

• The Supreme Court also reversed Judge Janavs' invalidation of the so-called "relitigation bar" in section 2646.4(e), Title 10 of the CCR, which precludes insurers involved in quasi-adjudicative proceedings to apply the rollback regulations from relitigating matters already determined either in the regulations or by a generic determination. The court called section 2646.4(e) "unobjectionable" because "[i]n adjudication, the judge applies declared law; he does not entertain the question whether its underlying premises are sound." Additionally, the court noted that section 2646.4(e) expressly permits insurers to introduce, and requires the ALJ to admit, evidence relevant to the determination whether a proposed rate is confiscatory.

• On the validity of the rate regulations as to rollbacks as applied to 20th Century, the Supreme Court disagreed with nearly every finding of the superior court. The high court found that most of Judge Janavs' findings in this area were "fatally tainted" by her "erroneous belief that confiscation does not require 'deep financial hardship'" within the meaning of *Jersey Central Power & Light Co. v. FERC*, 810 F.2d 1168 (D.C. Cir. 1987). *[13:2&3 CRLR 140]* On this issue, the Supreme Court agreed with ALJ LaPorte that proof of confiscation requires a showing of deep financial hardship, which 20th Century failed to allege and did not prove. At most, 20th Century alleged and proved that compliance with Commissioner Garamendi's rollback order would cause a "slowdown in growth....Put otherwise, its business would have been 'less prosperous as a result of' the rate rollback....Such a 'diminution in value, however has never mounted to the dignity of' confiscation" (citations omitted).

As a result of the court's reinstatement of Commissioner Garamendi's order, 20th Century must refund to its 1989 policyholders a total of $119 million. At this writing, 20th Century intends to petition the U.S. Supreme Court to review the decision.

Another major Proposition 103 case is still pending before the California Supreme Court. In ***Amwest Surety Insurance Company v. Wilson***, 20 Cal. App. 4th 1275 (Dec. 8, 1993), the Second District Court of Appeal struck down a 1990 statute exempting surety companies from the rollback and prior approval provisions of Proposition 103 because it does not "further the purposes" of the initiative and is thus beyond the authority of the legislature. *[14:2&3 CRLR 139; 14:1 CRLR 108; 13:2&3 CRLR 130]* At this writing, the case is being briefed and no date for oral argument has been set.

On rehearing in ***Manufacturers Life Insurance Company, et al. v. Superior Court (Weil Insurance Agency, Real Party in Interest)***, 27 Cal. App. 4th 67 (July 29, 1994), the First District Court of Appeal held that an insurance brokerage may not bring a private cause of action for redress of an unlawful group boycott under the Unfair Insurance Practices Act (UIPA), Insurance Code section 790 *et seq.*, but it may pursue antitrust remedies under the Cartwright Act, Business and Professions Code section 16720 *et seq.*, and injunctive and restitutionary relief under the Unfair Competition Act (UCA), Business and Professions Code section 17200 *et seq. [14:2&3 CRLR 139]*

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

Weil brought suit against the insurers, asserting (among other things) statutory claims under the UIPA, the Cartwright Act, and the UCA. The trial court sustained defendants' demurrers on the Cartwright Act claims, but concluded that Weil had stated claims under the UIPA and the UCA. Defendants appealed.

The primary issue on appeal was the insurers' contention that the UIPA, which prohibits acts of "boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance," supplants the Cartwright Act and the UCA "so as to provide the sole basis by which unlawful conduct of the type alleged here may be subjected to legal restraint or may otherwise produce legal consequences." The court noted that the UIPA itself "expresses an affirmative intention and expectation that it will preserve intact existing remedies for insurance industry misconduct," and observed that "[i]f the legislature wished to exempt the insurance industry from the Cartwright Act, it knew full well how to do so." Additionally, the court "observe[d] a certain illogic in referring to the UIPA as providing an 'exclusive remedy' when...it provides no private remedy at all [under *Moradi-Shalal v. Fireman's Fund Insurance Companies*, 46 Cal. 3d 287 (1988)]. Nor does it empower the Commissioner to redress private injuries." Further, the First District found that violations of the Cartwright Act may constitute the predicate acts for a claim under the UCA. Accordingly, the appellate court ordered the trial court to vacate its prior orders, reinstate the Cartwright Act and UCA claims, and dismiss the UIPA claims.

At this writing, the insurers plan to petition the California Supreme Court to review the First District's decision.

DEPARTMENT OF REAL ESTATE

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The Real Estate Commissioner is appointed by the Governor and is the chief officer of the Department of Real