adopt proposed changes to the Department's regulations under the Franchise Investment Law.

Section 310.100.2(a), Title 10 of the CCR, regarding the negotiated sale of a franchise, provides an exemption from the registration requirement of Corporations Code section 31110 for the offer and sale of a franchise and allows the sale of a franchise if certain conditions are met. The first condition—codified in subsection 310.100.2(a)(1)—requires the initial offer to be the offer registered under Corporations Code section 31111; the Commissioner proposes to amend this subsection and expand the exemption to include renewed and amended registrations. The Commissioner also proposes to modify the second condition—codified in subsection 310.100.2(a)(2)—to require the franchisor to reasonably assume that the prospective franchisee has the business or financial experience to be able to protect its own interests in connection with the transaction.

The Commissioner additionally proposes to delete the rest of the existing conditions in section 310.100.2, on the basis that franchisors sometimes use the provisions in the rule as an excuse for refusing to negotiate terms with a franchisee. As a consequence, the intent of the rule (to encourage some flexibility with respect to the offer and sale of the terms of a franchise) is undermined. Instead, the Commissioner proposes to adopt language in subsection (a)(3) which will require (1) that the franchisor amend its registered offer prior to selling the franchise to disclose which items have been negotiated with other franchisees, and (2) that the franchisor attach to the offering circular all notices filed in California during the past 12 months, if the negotiated sale was made within 12 months of the offer being made.

Section 310.114.1 sets guidelines for the preparation of the offering circular. The Commissioner proposes to amend section 310.114.1(b) to include guidance on how to describe the franchisee and the franchisor(s) in the offering circular; amend subsection 310.114.1(c), which contains special instructions for the Uniform Franchise Registration Application ("UFOC") to reflect the application of the instruction sheet to California transactions only; and amend UFOC instructions 1, 2, 3, and 5.

The Commissioner scheduled no public hearing on these regulatory changes; at this writing, written comments are accepted until February 12.

■ LITIGATION

After nearly two months of testimony and legal arguments, the federal criminal trial against former savings and loan boss Charles Keating and his son Charles Keating III on charges of racketeering, bank and securities fraud, and the interstate transportation of stolen goods went to the jury in late December; the charges stem from the $2.6 billion collapse of Lincoln Savings and Loan, and its parent company, American Continental Corp. (ACC), both owned by Keating. A 77-count federal indictment alleges that the two Keatings and three other officers of Lincoln and ACC, who have entered into a plea bargain, created sham profits for ACC through fraudulent sales of undeveloped land, and sold ACC junk bonds based on those false profits. The Keatings, who have pleaded innocent, face up to 510 years in prison if convicted on all 77 counts, as well as fines of $17 million and forfeiture of assets up to $250 million. The elder Keating is already serving a ten-year state court sentence for defrauding 25,000 investors out of $268 million by persuading them to buy worthless junk bonds instead of government-insured certificates. *[12:4 CRLR 144]*

Last July, in one of the numerous civil lawsuits stemming from Lincoln's failure, a federal jury ordered Keating and three co-defendants to pay over $3 billion in damages for conspiring to defraud investors; specifically, the jury awarded the 20,000 class action plaintiffs $600 million in compensatory damages and $1.5 billion in punitive damages from Keating, and $1.4 billion in compensatory damages and $900 million in punitive damages from Keating's three co-defendants. *[12:4 CRLR 144]* However, in October U.S. District Judge Richard M. Bilby reduced the total award to approximately $1 billion, cutting the total compensatory damages to $288.7 million, dismissing the punitive damages against all defendants except Keating, and reducing punitive damages against Keating to $750 million.

DEPARTMENT OF INSURANCE

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

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

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

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

The Department also performs the following functions:

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

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

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

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

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

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

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

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

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

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

MAJOR PROJECTS

Proposition 103 Rulemaking. On December 10, 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. For example, section 2632.19(a) sets forth nine circumstances which do not constitute a substantial increase in the hazard insured against, including the age, physical or mental health, any physical disability, and/or the occupation (or change in occupation) of either the insured or any principal or occasional driver of the insured vehicle; the age or cosmetic appearance of the insured vehicle; the addition, deletion, or change of vehicles insured; the termination or other change in the relationship between the insurer and the insurer's agent that issued, renewed, serviced, or was otherwise responsible in any manner for the insured's policy; and a change in the use of the insured vehicle. While several of these factors may justify a rate adjustment, they do not justify cancellation or nonrenewal under new section 2632.19(a).

Section 2632.19(b) sets forth circumstances which constitute a "substantial increase in the hazard insured against" for purposes of cancellation or nonrenewal, including the refusal or failure by the insured to provide to the insurer, within 30 days after reasonable written request, information necessary to accurately underwrite or classify the risk; extensive permissive use of the insured vehicle by persons other than the insured and principal or occasional drivers of the insured vehicle; the failure of the insured vehicle to comply with California and federal safety requirements, or the alteration or modification of the insured vehicle in a manner that renders it unsafe in violation of Vehicle Code section 24002; suspension or revocation of the license of the insured for any reason other than an insurer's failure to make a filing required by the Insurance Code; and change in the use of the insured vehicle to commercial use, if such a change in use is prohibited under the terms of the insurance policy or binder issued to the policyholder.

Sections 2632.19(c)–(e) set forth circumstances, for purposes of nonrenewal only, that constitute a substantial increase in the hazard insured against as a result of the accrual of points from traffic violations and accidents. Under subparts (c)–(e), an insured may accrue one point per year without constituting a substantial increase in hazard. Upon accrual of such a point, an insured may be considered to present a substantial increase in hazard only if he/she has accumulated at least three points in the previous three years, he/she is not a risk that would then be accepted as new business by the insurer, and part of the increase in hazard occurred during the most recent policy period. Two-point violations, such as driving under the influence or an at-fault accident which results in bodily injury or death, constitute a substantial increase in the hazard insured against and are grounds for nonrenewal (so long as they accrue during the most recent policy period).

At this writing, DOI staff is summarizing and analyzing the comments received at the public hearing; the Department has not yet determined whether it will modify the proposed regulatory language and release it for an additional 15-day public comment period.

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

• ***Unfair Claims Settlement Practices.*** On December 15, the Office of Administrative Law (OAL) approved the Department's adoption of sections 2692.1–2695.17, Title 10 of the CCR, the first regulations ever adopted by any Insurance Commissioner to implement the "unfair claims settlement practices" prohibition in Insurance Code section 790.03(h). *[12:4 CRLR 146; 12:2&3 CRLR 171; 12:1 CRLR 117–18]*

Among other things, the rules establish affirmative standards of conduct for auto, fire, life, and disability insurers; require insurers to pay claims within 30 days after they have been verified; bar "low-ball" settlement offers; prohibit discriminatory claims settlement practices based on the claimant's race, gender, sexual orientation, income, language, religion, national origin, place of residence, or physical disability; and allow the Commissioner greater discretion to impose fines for single violations and stiffer penalties for multiple or egregious violations.

Significantly, the rules exempt medical malpractice claims. Although the regulations represent a significant step toward the elimination of bad faith actions by insurers, the California Trial Lawyers Association criticized the medical malpractice exemption and contended that the rules may be ineffective due to the Department's serious lack of enforcement resources.

• ***Anti-Redlining Regulations.*** On December 3, 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). *[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 the hearing, the Commissioner argued that California's top auto insurers write far fewer policies and employ far fewer agents in central Los Angeles than in other cities. Industry officials responded by denying that the statistics cited by the Commissioner prove the ex-

istence of redlining; they claimed that it is reasonable for most of their sales to occur and employees to be located in areas where people can best afford their products.

At this writing, DOI is summarizing the comments received, and plans to modify the redlining regulations and publish them for an additional 15-day comment period.

• ***Intervenor Compensation.*** On November 4, DOI released a modified version of 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]* The Department reopened the public comment period on the modifications only until November 25; at this writing, DOI is preparing the rulemaking file for resubmission to OAL.

• ***Prelicensure and Continuing Education Requirements.*** On November 23, OAL rejected DOI's adoption of new sections 2182 and 2186–88.7, Title 10 of the CCR, which would 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. *[12:4 CRLR 146]* The proposed regulations were disapproved for failure to comply with the necessity, consistency, and clarity standards of Government Code section 11349.1. At this writing, DOI has not yet released a modified version of these regulatory proposals or resubmitted them to OAL for reconsideration.

• ***Placement of Insurance by Surplus Line Brokers with Nonadmitted Insurers.*** On November 25, OAL approved the Commissioner's permanent adoption of sections 2174.1–.14, Title 10 of the CCR, regarding documentary filings to be made and standards to be applied concerning the placement of insurance by surplus line brokers with nonadmitted insurers pursuant to Insurance Code section 1760 *et seq.* *[12:2&3 CRLR 172]* The regulations generally require the submission of audited financial statements from all carriers which are not licensed in California but wish to do business here; such carriers must have at least $15 million in capital and surplus, plus at least $5.4 million in U.S.-based assets.

• ***Automobile Theft and Loss Reporting Regulations.*** Following a public hearing in July 1992, the Commissioner adopted proposed section 2191.2, Title 10 of the CCR, which requires insurers to report specific information (including vehicle identification number) 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]* This regulatory action, which implements section 1874.6 of the Insurance Code, will be submitted to OAL for approval in early 1993.

• ***Insurance Fraud Prevention Funding.*** At this writing, DOI is still reviewing comments received on its proposal to adopt new sections 2692.1–2692.8 and 2693.1–2693.10, Title 10 of the CCR, which would establish a funding mechanism for auto insurance fraud prevention programs and workers' compensation fraud prevention programs, respectively. *[12:2&3 CRLR 172]* The Department plans to submit the regulatory package to OAL in March 1993.

Partisan Politics Precludes Workers' Compensation System Reform Again. After his September 23 veto of a three-bill legislative package fashioned by the Democrats and aimed at reforming California's infamous workers' compensation system, Governor Wilson ordered the legislature to convene a special session on October 8 to resume discussion of the matter. *[12:4 147–49]* Since the pre-election timing of the special session promised more partisan posturing than meaningful discussion, no one was particularly surprised when the legislature came up empty.

In an approach reminiscent of his 1992–93 budget battle strategy, Wilson introduced a 73-page proposal on a "take-it-or-or-leave-it" basis, demanding its enactment in a floor vote without committee hearings or amendments. Among other things, his proposal called for severe restrictions on mental stress claims, a cap on vocational rehabilitation retraining and education benefits, a reduction in the number of medical evaluations allowed in workers' compensation cases, and required use of managed care organizations by many claimants. The Governor also insisted that the system be redesigned to save employers $1 billion in premiums, and that the $1 billion in savings be documented, before any workers' compensation benefits are increased. After charging that the Governor's proposal favored physicians and the insurance industry, lawmakers debated it for seven hours and amended it so dramatically that Wilson announced the following day he would veto it if passed, thus abruptly ending the short-lived special session. At this writing, reform of the system—desperately needed to boost the state's sagging economy—must wait until 1993. (*See infra* LEGISLATION.)

Garamendi Rejects Another Workers' Compensation Premium Increase. On November 30, Commissioner Garamendi rejected the Workers' Compensation Insurance Rating Bureau's (WCIRB) latest request for a 12.6% increase in workers' compensation premium rates. This request follows closely on the heels of two previous rate increase requests of 11.9% in October 1991 and 23.1% in April 1992; in response to those requests, Garamendi approved only minimal increases—1.2% and 6.7%, respectively. *[12:4 CRLR 147]*

Technically, WCIRB requested amendments to section 2350, Title 10 of the CCR, commonly known as the Workers' Compensation Insurance Manual. Following public hearings on October 14–15, the Commissioner rejected the rate increase, stating that the request was based on "wildly inconsistent expense ratios" of various workers' compensation insurance companies. "The industry cannot be allowed to live off the 'fat' of a dysfunctional system while so many California employers today are forced to live on starvation diets." Garamendi indicated that he might reconsider the request if WCIRB provides more credible data.

Physicians' Health Care Plan Defeated at Polls. On November 3, California voters defeated Proposition 166, the California Medical Association's "Affordable Basic Health Care Act" requiring employers to provide health insurance to employees who work more than 17.5 hours per week. Theoretically, it would have covered 4.7 million of the current six million uninsured Californians, but it was criticized for nonexistent cost containment and quality controls and for placing too great a financial burden on businesses already struggling through the economic recession. *[12:4 CRLR 147; 12:2&3 CRLR 173–74]* A disparate collection of interests, including the insurance industry, consumer organizations, employers, and labor, opposed the doctors' measure, which was defeated by a 2–1 margin. Most observers now look to the incoming Clinton administration to lead the way to comprehensive health care reform.

LEGISLATION

AB 9 (Mountjoy), as introduced December 7, would—among other things—provide that workers' compensation laws shall be liberally construed only after it is determined that an injury in the course of employment has occurred and the injury

is both a "specific" injury, as defined, and results in serious physical or bodily harm; provide that an employer has the right to examine the entire claim file of its insurer concerning any claim against the employer, and may make copies at the employer's expense, but that the right does not extend to any document that the insurer is privileged from disclosing to the employer under the attorney-client privilege; provide that no provider of medical-legal services may be compensated for medical-legal services if the provider has failed to comply with the Labor Code or applicable regulations or has committed fraud upon the employer or insurer; and provide for the submission to arbitration of disputes between an employer and insurer concerning reserve estimates, negligent management of claims, and classification of employees, as specified. *[A. F&I]*

AB 27 (Hoge), as introduced December 7, would—among other things—provide that no workers' compensation shall be paid for a psychiatric injury unless the employee demonstrates by clear and convincing evidence that the mental disorder arose out of and in the course of employment; the employment conditions producing the mental disorder exist in a real and objective sense; and employment events that are sudden and extraordinary, not common to all fields of employment and not generally inherent in the employment, are the predominant cause of the injury.

Under existing workers' compensation law, liability exists for an injury sustained by an employee arising out of and in the course of employment and for death if the injury proximately causes death if—among other things—the injury is proximately caused by the employment. This bill would, in the case of death, require the employment to be the predominant cause of the death compared to all other causes and, with respect to general conditions of compensation, would similarly require employment to be the predominant cause of the injury compared to all other causes. *[A. F&I]*

SB 31 (Johnson), as introduced December 7, would require the Administrative Director of the Division of Workers' Compensation, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, to develop a workers' compensation information system, as specified. *[S. IR]*

SB 8 (Lockyer), as introduced December 7, would—among other things—require judicial arbitration of motor vehicle accident claims involving third-party liability for bodily injury if the amount in controversy does not exceed $50,000; provide for a five-year sentence enhancement and prohibit probation if a false or fraudulent insurance claim, along with previous false claims, involves $100,000 or more; make it a public offense for any automobile 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; and require persons involved in motor vehicle accidents to present their driver's license and other information without request, and would require presentation of proof of financial responsibility. *[S. Jud]*

SB 52 (Petris). 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 December 22, this bill would revise the definition of the term "policy of residential property insurance" to exclude a tenant's policy, a renter's policy, or a policy insuring individually owned condominium units that do not provide dwelling structure coverage. *[S. InsCl&Corps]*

SB 38 (Torres), as introduced December 8, would enact the California Health Reform Act of 1993; create the California Health Plan Commission; require the Commission to establish and maintain for all California residents a prescribed system of universal health care coverage to be known as the California Health Plan, except that the bill would provide that this provision does not become operative until such time as the legislature declares it to be operative and appropriates funds necessary to implement the provision; require the Commission to produce and deliver to the legislature a prescribed plan for implementation of the California Health Plan on or before July 1, 1995; and require the Commission, on or before July 1, 1994, to report in a certain manner to the legislature regarding the means by which needs for long-term care services can be met. *[S. InsCl&Corps]*

AB 16 (Margolin), as introduced December 7, would state the intent of the legislature regarding provision of health care services. Among other things, the bill would state the legislature's intent to establish a system of universal health coverage that guarantees access to quality affordable health care for every Californian; create a Health Standards Board of consumers, providers, business, labor, and government; crack down on billing fraud and eliminate incentives that invite abuse; ban insurance underwriting practices that waste billions of dollars trying to discover which patients are bad risks; establish a core benefits package through the Health Standards Board, guaranteeing a basic health benefits package that includes ambulatory physician care, inpatient hospital care, prescription drugs, and basic mental health services; allow consumers to choose where they receive health care to ensure a better fit between provider strengths and consumer needs; develop health networks that give consumers access to a variety of local health networks made up of insurers, hospitals, clinics, and doctors, to end the costly duplication of services and encourage the shared use of key technologies; guarantee every Californian a core benefits package set by the health standards board either through his or her employer or by buying into a high-quality public program; limit costs for small employers by allowing them to group together and form larger groups to purchase less costly health insurance, or to buy into the public program if it is the cheapest option; phase in business responsibilities, covering employees through the public program until the transition is complete; and improve preventive and primary care through community-based health solutions. *[A. Health]*

LITIGATION

The long-awaited writ trial in ***20th Century Insurance Company v. Garamendi***, No. BS016789, commenced on November 30 before Los Angeles County Superior Court Judge Dzintra I. Janavs, and concluded on December 1 with the court taking the matter under submission. At this writing, Judge Janavs is expected to render a decision in early March.

In the case, 20th Century challenges the validity of Commissioner Garamendi's order requiring it to refund over $100 million to auto, home, and business insurance policyholders under Proposition 103's rollback provision. Among other things, 20th Century disputes the Commissioner's authority to regulate an insurer's rate of return (as opposed to premium rates) and the constitutionality of generic regulations which were adopted by the Commissioner to implement the rollback provision and applied to 20th Century during administrative hearings it requested on the rollback order. *[12:4 CRLR 145, 151–52; 12:2&3 CRLR 170–71, 179–80; 12:1 CRLR 124–25]*

The case is yet another milestone in the four-year-old struggle over the implementation of Proposition 103, which was narrowly passed by the electorate in November 1988. Although voters decided

they wanted insurance rate regulation, they—as insurance policyholders and taxpayers—have now paid the legal costs of four years' worth of insurance industry efforts to limit the impact of the initiative, and have received little or nothing in exchange. Only a small number of companies has agreed to rollback refund settlements with the Commissioner, and very few of the initiative's other provisions have been fully implemented. At this writing, the only provision of the initiative which has been fully implemented in four years is Insurance Code section 12900, which converted the post of the Insurance Commissioner into an elective office.

In other Proposition 103-related litigation, a unanimous panel of the Second District Court of Appeal handed Commissioner Garamendi a major victory on December 17, when it upheld his authority to discard his predecessor's Proposition 103 regulations and issue his own. In ***Safeco Insurance Co. v. Garamendi***, No. B063893, the Second District ruled that former Commissioner Roxani Gillespie's so-called "amended decision" of June 15, 1990, in which she adopted several generic standards to be applied in both rollback and "prior approval" rate hearings under Proposition 103, constituted a quasi-legislative (*i.e.*, rulemaking) decision as opposed to a quasi-judicial (*i.e.*, adjudicatory) decision. Under the Administrative Procedure Act (APA), an agency's quasi-judicial decision becomes final and judicially reviewable 30 days after mailing of the decision. Such a decision generally applies rules or statutes to a specific individual and affects that individual's property rights; because of the due process implications, quasi-judicial decisions are generally considered final. However, an agency's quasi-legislative regulations may be reconsidered and amended at any time pursuant to the rulemaking procedures of the APA.

Under Gillespie's "amended decision" generic rules, Safeco and California State Automobile Association (CSAA) had been adjudged liable for $41 million and $92 million in Proposition 103 rollbacks, respectively. However, Commissioner Garamendi discarded those rules and adopted his own generic "fair rate of return" and rollback regulations (which are the subject of the *20th Century* case described above). Under Garamendi's rules, Safeco was determined to owe $88.7 million in rollbacks, while CSAA was adjudged liable for $126.2 million. Noting that ratesetting rules are "uniformly recognized as quasi-legislative" and that Gillespie's rollback regulations set forth detailed "definitions, formulas, and procedural rules for calculating rates," the court concluded that Gillespie's rules were quasi-legislative and subject to amendment by Garamendi.

In an interesting footnote, the Second District noted that "whether out of an abundance of legal caution or for whatever reason, the Commissioner has submitted a series of subsequent rate regulations to the Office of Administrative Law for its approval." However, the court found that "one of the several statutory exceptions [to the APA] provides that an agency need not submit to the OAL...any regulation which '[e]stablishes or fixes rates, prices, or tariffs,'" citing Government Code section 11343(a)(1). This footnote may inspire Commissioner Garamendi to forego OAL approval of future Proposition 103 regulations, as OAL has rejected Garamendi's rollback regulations at least four times. *[12:4 CRLR 145]*

As usual, the insurance industry will appeal the *Safeco* ruling.

On October 5, the U.S. Supreme Court agreed to review the U.S. Ninth Circuit Court of Appeals' June 1991 decision in ***In Re Antitrust Litigation***, 938 F.2d 919 (petition for certiorari granted in *Hartford Fire Ins. Co. v. California*). In this complex antitrust case, former California Attorney General John Van de Kamp and the attorneys general in 18 other states accused 32 defendant insurers, reinsurers (both foreign and domestic), and insurance associations of engaging in an illegal group boycott by conspiring to force the Insurance Service Office to withdraw its standard commercial general liability forms and replace them with ones that exclude pollution coverage and replace "occurrence" coverage with "claims-made" coverage. *[11:4 CRLR 138–39; 9:4 CRLR 97]* The trial court granted defendants' motion for summary judgment on grounds their alleged conduct is immunized from federal antitrust scrutiny under the McCarran-Ferguson Act. In its ruling, the Ninth Circuit reversed, finding that the alleged conduct does not qualify for McCarran-Ferguson immunity, largely because it does not attach to foreign insurance companies (or domestic companies which conspire with them).

In another complex case—this one arising out of the failure of Mission Insurance Company and its takeover and liquidation by former Commissioner Gillespie, the California Supreme Court recently ruled that Mission's reinsurers are entitled to set-offs on the money owed to the insolvent company, and those set-off rights take priority over the failed insurer's ability to pay all other debts, including the claims of policyholders. In ***Prudential Reinsurance Co. v. Superior Court***, 3 Cal. 4th 1118 (Nov. 30, 1992), the Supreme Court—in a 4–3 decision—rejected Commissioner Garamendi's argument that the companies which had issued reinsurance policies to Mission were obligated to pay the full amount of the policies (about $2 billion) without any set-off for debts owed by Mission to the reinsurers; Garamendi was attempting to recover as much money as possible for Mission policyholders. Chief Justice Malcolm Lucas found that Insurance Code sections 1031 and 1033 permit an insolvent insurer and reinsurer to set off debts and credits after the appointment of a liquidator.

In another case arising from a failed insurance company, the Second District Court of Appeal also ruled against Commissioner Garamendi. In ***Texas Commerce Bank v. Garamendi***, 11 Cal. App. 4th 460 (Nov. 30, 1992), the appellate court upheld Los Angeles Superior Court Judge Kurt J. Lewin's ruling that holders of municipal guaranteed investment contracts ("Muni-GICs") issued by Executive Life Insurance Company (ELIC), which was seized by Commissioner Garamendi in April 1991, are entitled to be treated the same as the company's life insurance policyholders. *[12:1 CRLR 120–21; 11:4 CRLR 132–33]* The court found that Muni-GICs are "annuities" under state law; as such, their holders are entitled to the same priority status as are ELIC's life insurance policyholders. At this writing, the Commissioner intends to appeal the Second District's ruling to the California Supreme Court.

In ***Attorney General's Opinion No. 92-804*** (Nov. 12, 1992), Attorney General Dan Lungren concluded that the meetings of a task force comprised of private citizens appointed by the Insurance Commissioner to render advice on public policy issues, which task force operates under the direction and timetable of the Commissioner and receives its resources from the Department of Insurance, are not required to be open to members of the public. The AG found that since the task force was created by the Commissioner and not by statute, it is not required to hold open meetings in accordance with the Bagley-Keene Open Meeting Act. According to the AG, the Act applies only to "state bodies," and the Commissioner does not fit within any of the Act's definitions of the term "state body."