This two-year bill is pending in the Assembly Committee on Housing and Community Development.

AB 889 (Mays) would extend the January 1, 1992 repeal date of section 5047.5 of the Corporations Code, which immunizes from liability directors or officers of certain nonprofit corporations who serve without compensation for acts or omissions committed in the exercise of the director's or officer's policymaking judgment. This two-year bill, which would extend the life of this provision until January 1, 1997, is pending in the Assembly Judiciary Committee.

LITIGATION:

On December 4, a Los Angeles Superior Court jury convicted financier Charles H. Keating on 17 of 18 state securities fraud counts stemming from the failure of Lincoln Savings and Loan. In ***People v. Keating***, the jury found Keating guilty of failing to tell bondholders and new bond buyers that regulators had indicated the institution could be seriously overextended. Following a nine-week trial, the jury spent eleven days deliberating and reviewing exhibits and testimony. Keating faces a maximum penalty of ten years in prison and $250,000 in fines; sentencing was scheduled for February 7. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 130; Vol. 11, No. 2 (Spring 1991) pp. 129–30; and Vol. 11, No. 1 (Winter 1991) p. 105 for extensive background information.)

On December 12, the Securities and Exchange Commission filed civil securities fraud and insider trading charges against Keating and nine others, alleging, among other things, that Keating earned $7.5 million through insider trading in the shares of Lincoln's parent company, American Continental Corporation, and that he engaged in a phony stock swap with David Paul, the former chair of another failed thrift, CenTrust Savings Bank of Miami. The 86-page civil complaint filed by the SEC in U.S. District Court for the Central District of California alleges that Keating and his co-defendants engaged in a complicated series of phony transactions and paper profits that helped keep Lincoln afloat until it was seized by regulators in April 1989.

Also on December 12, federal authorities presented Keating and four co-defendants with a 77-count indictment charging them with bank and securities fraud, conspiracy, misapplication of funds, and transporting stolen property. If convicted of these racketeering charges, Keating could be sentenced to up to 510 years in prison. In addition to these charges, Keating is also the defendant in a number of other pending actions, including ***People of the State of California v. American Continental Corporation (ACC)***, the Department's civil fraud action against Keating, the now-bankrupt ACC, and two of ACC's top officers. DOC's action is still pending in federal court in Arizona under U.S. District Court Judge Richard Bilby with trial scheduled to commence on March 2.

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:

Garamendi Orders $1.5 Billion in Proposition 103 Refunds After Governor Overrules OAL, Approves Emergency Rollback Regulations. On October 7, Governor Wilson overruled the Office of Administrative Law's (OAL) rejection of Commissioner Garamendi's emergency regulations implementing Proposition 103's rollback requirement.

Last August, following numerous public hearings and three revisions,

Commissioner Garamendi adopted new sections 2641.1–2647.1, Title 10 of the CCR, to implement the prior approval and rate rollback provisions of Proposition 103. These emergency regulations (known as ER-19A) were approved by OAL on August 13. However, the Department subsequently amended sections 2645.4, 2645.5, and 2645.6 to specify criteria for determining an insurer's rollback obligation. DOI submitted these regulatory changes (known as ER-20) to OAL on an emergency basis on August 23, and newly appointed OAL Director Marz Garcia rejected them on September 3. Garcia concluded that the Commissioner failed to established the existence of an "emergency" to justify their urgency approval. The Commissioner immediately appealed to the Governor. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 131–32; Vol. 11, No. 3 (Summer 1991) pp. 129–30; and Vol. 11, No. 2 (Spring 1991) pp. 121–22 for extensive background information on DOI's rollback regulations.)

In overruling OAL, Governor Wilson stated that DOI's implementation of Proposition 103 since its passage in 1988 has been accomplished, "if at all," solely through emergency regulations, such that OAL is somewhat justified in arguing that DOI is abusing the emergency rulemaking process. However, the Governor noted that "the inherent difficulty of creating an entirely new system of regulation must be acknowledged. . . .[I]n the present case, the evidentiary record is extensive . . . [and] the regulations were apparently derived from hearings in which public participation was substantial." The Governor also observed that the insurance industry has been unrelenting in challenging not only the initiative but "every attempt by the commissioner to adopt substantive regulations implementing Proposition 103," such that judicial scrutiny of the initiative and DOI's rules has been and continues to be available. The Governor concluded that "the public interest will not be served by more administrative delay. Insurers and consumers are entitled to the swift determination of the insurers' rollback liability and to a comprehensive judicial determination of the viability of the initiative's central provisions, as implemented, without any further unnecessary delay."

Following the Governor's ruling, the Commissioner issued the first series of rollback orders commanding fourteen insurance companies to mail $1.5 billion in rebate checks to their policyholders immediately. Garamendi's October 16 orders targeted six of California's ten largest insurers, including Allstate ($243.6 million), State Farm ($234.6 million), and CSAA ($157 million). Although most insurers continue to refuse to pay the required rollbacks, have demanded administrative hearings on the precise rollbacks ordered, and hope for victory in already-filed lawsuits challenging the Commissioner's application of Proposition 103's rollback requirement (*see infra* LITIGATION), the Automobile Club of Southern California became the first major auto insurer to comply with its rebate order on October 24, when it announced it would refund more than $80 million to its 1989 policyholders by the end of November. Other companies which have voluntarily agreed to issue rebates include Norcal Mutual Insurance Company and Southern California Physicians Insurance Exchange, both medical malpractice insurers.

Although litigation challenging the Proposition 103 rules is pending, the Department has initiated the normal rulemaking process to make its emergency regulations permanent. DOI's ER-19A emergency rules expired on December 11, but on that day the Department filed them as permanent rules with OAL and requested their extension as emergency regulations pending OAL's review and approval; an OAL decision was expected by mid-January. On December 13, DOI published notice of its intent to permanently adopt its ER-20 regulations (amended sections 2645.4, 2645.5, and 2645.6, Title 10 of the CCR), and scheduled a public regulatory hearing for January 30 in San Francisco.

DOI scheduled a December 16 administrative hearing on 20th Century's protest to the Commissioner's $106 million rebate order, but that hearing was scuttled by 20th Century's lawsuit (*see infra* LITIGATION). DOI also held a December 20 prehearing conference on the Mercury Group's objection to Garamendi's $65.1 million rebate order. At this writing, all parties are awaiting OAL's decision on the permanent rollback regulations.

No-Fault Auto Insurance Debate Continues. After maintaining neutrality on the issue of no-fault auto insurance in the past, Commissioner Garamendi now contends there cannot be a solution to California's automobile insurance crisis that does not include a no-fault component. Garamendi's auto insurance reform proposal, announced in September, was praised by proponents of no-fault including Consumers Union (CU), Governor Wilson, and the insurance industry, but came under sharp criticism by no-fault opponents including consumer advocate Ralph Nader and the California Trial Lawyers Association. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 23, 34, and 131 for background information.)

Republican legislators Senator Frank Hill and Assemblymember Ross Johnson have jumped on the no-fault bandwagon and prepared a no-fault initiative for the November 1992 ballot which is similar to SB 941 (Johnston), killed in the legislature last year. The initiative, which includes a minimum policy of $15,000 in personal injury coverage for a flat rate of $220 and contains a provision which allows accident victims to sue only if injuries are serious and permanent, was scheduled for early January submission to the Attorney General for preparation of a title and summary. The legislators will then need $500,000 to circulate the initiative for the 384,974 signatures necessary to put the initiative on the November ballot. The funds needed are to come from past Hill and Johnson campaign contributions, mail solicitations, and insurance industry sources.

The initiative announcement followed the release of a no-fault premium study performed by the RAND Corporation's Institute for Civil Justice. The Institute examined 21 possible no-fault plans; the results indicated that a typical plan with a $15,000 personal injury benefit would reduce total costs of injury compensation by 22% by cutting transaction costs and eliminating compensation for noneconomic losses. The study also showed that the average compensation for all injuries would be reduced under a no-fault plan by 13%, from $3,645 to $3,182. The study did not analyze a no-fault plan similar to that endorsed by Commissioner Garamendi, which includes property damage reforms, proposals to cut fraud, repair and medical costs, and mandatory arbitration of smaller accident cases as part of a comprehensive auto insurance package. (*See supra* report on VOTER REVOLT for related discussion.)

DOI Releases Regulations Defining Unfair Claims Settlement Practices. On October 22, the Department published notice of its intent to adopt new sections 2695.1–.18, Title 10 of the CCR, its long-awaited unfair claims settlement practices regulations. The proposed regulations were developed by the Department in conjunction with its Consumer Complaints and Unfair Practices Task Force, and are intended to fully define with sufficient specificity the full range of unfair acts

or types of conduct prohibited by Insurance Code section 790.03(h). (See CRLR Vol. 11, No. 4 (Fall 1991) p. 132 and Vol. 11, No. 3 (Summer 1991) pp. 126–27 for background information.)

In its initial statement of reasons, DOI notes that during 1990, its Claims Services Bureau opened over 20,000 files on complaints regarding claims handling by DOI licensees. These complaints involve a wide range of objections to the claims handling practices of insurers, but the majority of complaints involve delay by insurers in processing and paying claims. The second largest category of complaints concerns disputes over the amount of payment due; that is, how to value a claimant's loss. The largest number of loss-dispute complaints arise from personal and commercial automobile coverage. Another significant portion arise from claims made pursuant to personal, fire, and allied lines policies.

Among others, DOI's proposed regulations set forth the following standards applicable to all insurers:

-Every insurer's claims files must contain all documents, notes, and workpapers (including copies of correspondence) which reasonably pertain to a claim in such detail that events and dates of events can be reconstructed and the licensee's actions can be determined; all claims files are subject to examination by the Commissioner.

-Insurers shall disclose to the claimant all benefits, coverage, or other provisions of the insurance policy under which the claim is presented, and shall not deny a claim on the basis of the claimant's failure to exhibit property unless there is documentation in the claims file of (1) demand by the insurer and unreasonable refusal by the claimant, or (2) the breach of any policy provision providing for the exhibition of property.

-No insurer shall require a claimant to give notification of a claim or proof of a claim within a specified time period unless such limits are set forth in the policy.

-Upon receiving notice of a claim, an insurer must acknowledge receipt of the claim and provide necessary claim forms, instructions, and reasonable assistance within 15 calendar days with respect to personal policies, and within 21 calendar days with respect to commercial policies, title policies, and bonds. Failure of an insurance agent to promptly transmit notice of a claim to the insurer shall be imputed to the insurer if the insurer has knowledge of prior failure(s) to promptly transmit notice and has failed to take remedial measures.

-Upon receiving notice of a claim, an insurer must begin any necessary investigation of the claim within 15 calendar days with respect to personal policies and within 21 calendar days with respect to commercial policies.

-Upon receiving proof of a claim, an insurer shall accept or deny the claim, in whole or in part, within 40 calendar days. (This deadline is extended to 80 calendar days if the insurer reasonably believes that the claimant has submitted a false or fraudulent claim.) If an insurer needs more time, it must provide the claimant with written notice of the need for additional time, and specify the reasons therefor and the information it requires in order to make a determination.

-An insurer shall tender payment within 30 calendar days after its affirmation of coverage and/or liability.

-Where an insurer denies a first-party claim in whole or in part, it must do so in writing and provide a statement of the factual basis for the denial; if the denial is based upon a specific policy provision, the written denial shall include a reference thereto. An insurer which denies a third-party claim in whole or in part or disputes liability or damages must do so in writing. In either case, the written denial must notify the claimant that he/she may have the matter reviewed by DOI, and provide DOI's address and telephone number.

-Insurers must reply within 15 calendar days to any communication from a claimant regarding a claim which reasonably suggests that a response is expected.

-All insurers must adopt standards for the prompt investigation and processing of claims within 60 days after the effective date of these regulations.

-When contacted by DOI for information concerning a claim, insurers must provide a complete written response to DOI within 21 calendar days.

-No insurer shall request a claimant to sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing.

-No insurer shall base or vary its claims settlement practices upon the claimant's race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

In addition to the above standards which apply to all insurers, DOI proposes additional line-specific regulations applicable to automobile, fire, surety, title, life and disability, and workers' compensation insurance. For example, the rules governing auto insurance set forth the methodology to be utilized in determining the cash value of an automobile and standards for replacing a car with a "comparable automobile"; prohibit insurers from requiring that an automobile be repaired at a specific repair shop and from requiring that a claimant travel an unreasonable distance either to inspect a replacement automobile, obtain a repair estimate, or have an automobile repaired at a specific repair shop; and require insurers to provide claimants with a copy of the written estimate upon which a repair settlement is based.

The regulations also state that a single act enumerated in Insurance Code section 790.03(h) and defined in these rules, when knowingly committed, or knowing failure to comply with any provision of these rules, shall constitute a violation of section 790.03(h) and these regulations. Insurers may also violate section 790.03(h) and these regulations when they commit acts contrary to the statute or rules "with such frequency as to indicate a general business practice." Where the Commissioner has a reasonable basis to believe that a licensee is committing violative acts with such frequency as to constitute a general business practice, or where DOI has received multiple consumer complaints against the licensee and is proceeding against the licensee pursuant to Insurance Code sections 790.05 or 790.06, the licensee is rebuttably presumed to have violated the statute; the licensee may rebut the presumption by demonstrating that at least 90% of the claims handled by the licensee within a credible sampling of all claims handled in California are in compliance with the provisions which the licensee has allegedly violated.

Any licensee who violates any unfair claims settlement regulation is subject to all applicable monetary penalties and/or other administrative actions, including suspension or revocation of an insurer's certificate of authority or an agent's license.

Finally, section 2695.16 of the regulations establish detailed reporting requirements applicable to all insurers. The regulations require all insurers to maintain, on a calendar year basis, a complete record of each complaint which it has received during the preceding three years. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, the date each

complaint was received, and the date each complaint was concluded or resolved. In addition to this record, the regulations require all insurers which write personal policy insurance to make a detailed statistical report to the Commissioner on an annual basis.

The Department held a public hearing on its proposed regulations on December 19 in San Francisco. The regulations were generally well-received; insurers primarily objected to the reporting requirements in section 2695.16. The Department is currently evaluating the comments received, and expects to release a modified version of its regulatory package during the spring. DOI hopes to have the regulations in place by late spring or early summer.

Department Proposes Permanent Intervenor Compensation Regulations. Among other things, Proposition 103 amended preexisting law to permit a greater level of public participation in specified DOI rulemaking and adjudicatory proceedings, and requires the Commissioner to establish an "intervenor compensation program" whereby consumer representatives may recover their advocacy fees and expenses if they participate in such a proceeding and make a substantial contribution to the Commissioner's adoption of any order, regulation, or decision. For the past few years, DOI has operated under emergency regulations which are similar to the Public Utilities Commission's (PUC) intervenor compensation scheme. (See CRLR Vol. 10, No. 1 (Winter 1990) p. 1 for extensive background information.) However, over the past few months, DOI has worked with consumer group representatives to draft a regulatory scheme which will encourage consumer representation and participation in numerous DOI proceedings.

On November 29, the Department published notice of its intent to adopt new sections 2615.1–2622.10, Title 10 of the CCR. The new regulations specify the rights and duties of consumer intervenors and procedures for intervention in both rulemaking (quasilegislative) and adjudicatory (quasijudicial) proceedings. DOI's proposed rules are distinguishable from the PUC's rules in four primary aspects:

(1) The Department's regulations provide for interim funding for eligible intervenors, while the PUC's rules require an intervenor to wait until the entire proceeding has concluded before compensation eligibility is even determined.

(2) DOI's rules call for payment of intervenor attorneys' and witness fees at prevailing market rates during adjudicatory proceedings (such as ratesetting) involving a particular company or companies, whereas the PUC imposes a strict $150/hour cap on intervenor fees regardless of the experience of or market value commanded by intervenor counsel. For adjudicatory proceedings, the Department pays the compensation award from its Fund for Intervenor Compensation, and the insurer at issue in the proceeding is required to reimburse the Department's Fund. During rulemaking proceedings, intervenor counsel and witnesses are compensated at the average prevailing rate paid by the Department to independent contractors with similar qualifications and background. The Department pays for intervenor compensation awarded for rulemaking proceedings.

(3) The Department's rules require the Commissioner to rule on a petition for compensation within specified time limits; the absence of time limits in the PUC's rules frequently works extreme hardship on PUC intervenors.

(4) DOI's regulations permit consumer intervenors to apply for and receive compensation from the Department for intervention in specified judicial proceedings involving insurance issues; the PUC's rules have no counterpart to this provision. Such intervenors must apply for attorneys' fees in the relevant judicial proceeding, however, and reimburse the Department if they are successful.

In addition, DOI's rules establish a Public Advisor within the Department of Insurance, whose role is to ensure that full and adequate participation by members of the public is secured in DOI proceedings. The Public Advisor will advise members of the public on intervention procedures, advise the Commissioner on measures he/she should employ to assure open consideration and public participation in DOI's proceedings, and encourage methods to ensure full public participation and diversity reflective of all segments of California consumers, including low-income and minority consumers.

DOI was scheduled to conduct public hearings on its intervenor compensation regulations on January 27 in Long Beach and January 28 in San Francisco.

Prelicensure and Continuing Education for DOI Licensees. On November 25 and 26, DOI held public hearings on its proposed adoption of sections 2182 and 2186–2188.7, Title 10 of the CCR. New section 2182 would specify that a person who twice fails an examination for a fire and casualty broker-agent license or a life insurance license must wait thirty days before retaking the examination; if that person again fails twice, he/she must wait an additional sixty days before retaking the exam. New sections 2186–2188.7 would implement Insurance Code section 1749 *et seq.*, which requires the Commissioner, effective January 1, 1992, to establish prelicensing and continuing education requirements for fire and casualty broker agents and life insurance agents. Under the statute, the Commissioner is required to establish a curriculum board which is to develop prelicensing and continuing education programs for these licensees, complete with acceptable courses and standards for providers and instructors. Pursuant to the statute, proposed regulatory sections 2186–2188.7 set forth detailed prelicensing and continuing education programs as developed by the curriculum board. DOI is currently evaluating and responding to the comments made at the public hearings, and plans to release a modified version of the regulations for further comment in early 1992.

Huge CAARP Rate Increase Requested. In October, DOI instituted a rulemaking proceeding to amend section 2498.3, Title 10 of the CCR, to substantially increase premium rates for private passenger automobiles covered by the California Automobile Assigned Risk Plan (CAARP). CAARP was instituted in 1947 to provide state-mandated minimum liability insurance for drivers who are unable to obtain it in the voluntary market; all auto insurers in the state are required to write a specified number of CAARP policies as a cost of doing business in California. The CAARP governing board has recommended an average rate increase of 207.8% for bodily injury and property damage liability coverages, 132.9% for medical payments coverage, and 174.6% for uninsured motorist coverage. Consumer groups decry the proposed increases, contending that low-income drivers already victimized by insurer redlining will be unable to afford CAARP insurance. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 40 for background information.) The Department was scheduled to hold regulatory hearings on the rate increase request on January 6–10.

The battle over CAARP rates began in 1989 when CAARP filed an application with then-Commissioner Roxani Gillespie for a 112% increase; after hearings, Gillespie denied that increase in December 1989, amid allegations that CAARP is seriously mismanaged and beset by fraud and inefficiency. The CAARP board appealed the denial to

the Los Angeles County Superior Court, and meanwhile requested a 160% rate increase. The court reversed Gillespie's denial in the middle of DOI administrative hearings on the 160% increase; although she filed an appeal of the ruling, Gillespie granted an 85% increase during the pendency of the hearings. In April 1991, the appellate court reversed the trial court, holding that insurers are not entitled to a fair rate of return on CAARP policies exclusively; the profit level to which they are entitled under Proposition 103 and its judicial interpretation must be calculated on the overall business of the insurer. That decision has been granted review by the California Supreme Court.

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

-On November 14–15 and December 16, DOI held public hearings on its proposal to add sections 2191(a)–(d) to Title 10 of the CCR, pertaining to the inspection of all private passenger vehicles prior to obtaining collision and/or comprehensive auto insurance coverage. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 134 for background information.) During the hearings, members of the insurance industry, although supporting the premise that the proposal would reduce the likelihood of fraudulent auto claims based on preexisting damage, expressed concerns about the alleged complexity and length of the inspection form; the difficulty in conducting a full chassis, engine, and drive train inspection; problems in identifying aftermarket rather than factory-installed equipment and assessing the working order of that equipment; and the disadvantages, including cost, of sending notice letters regarding the mandatory inspection via certified mail, as required by the proposed regulations. In response to the comments, DOI revised various aspects of the regulations and extended the public comment deadline to January 10. The revisions include limiting the chassis inspection to visible damage, shortening and simplifying the inspection form, and modifying the language of the notice letter.

-On November 13, the Governor upheld OAL's rejection of DOI's new section 2173, Title 10 of the CCR, which would have prevented surplus lines brokers from placing automobile bodily injury, property damage liability, or medical payment insurance with nonadmitted insurers unless the business has been offered to and refused by CAARP. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 134–35 for background information.) Surplus lines brokers are licensed by DOI and are the only brokers authorized to place insurance with nonadmitted insurers. Under Insurance code section 1763, a surplus lines broker may solicit and place insurance with nonadmitted insurers only if such insurance cannot be procured from a majority of the insurers admitted for the particular class(es) of insurance. In effect, section 2173 would provide as a matter of law that an applicant potentially eligible for insurance through CAARP can never satisfy the conditions for obtaining surplus lines coverage specified in Insurance Code section 1763. In his opinion, the Governor stated that section 2173 is not authorized by or consistent with the Insurance Code (specifically section 1763), and is not reasonably necessary to effectuate the purpose of the Insurance Code.

-Last June, DOI adopted emergency regulations designed to prevent insurer abuse of federally mandated flood insurance. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 133–34 and Vol. 11, No. 3 (Summer 1991) p. 130 for background information.) However, the emergency regulations expired on October 21, leaving DOI without regulations to protect consumers from insurer abuse. According to DOI counsel Patricia Staggs, permanent regulations were not filed with OAL because OAL indicated they would not be approved. DOI plans to redraft and adopt flood insurance regulations in the near future.

-DOI continues to review comments received at an August 19 public hearing on its proposed adoption of section 2646.6, Title 10 of the CCR, which would provide a framework for combatting redlining (the refusal to sell insurance in low-income and minority communities). Under the proposed rule, insurers would be required to provide data on their sales in target communities; based upon these figures, DOI would allow a rate of return on equity from 6.5% to 13.5%, depending upon the company's level of service. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 40 and 134 for background information.)

Commissioner Releases Report on SB 2569 Implementation. In early December, the Commissioner issued a seven-page report claiming compliance with SB 2569 (Rosenthal) (Chapter 1375, Statutes of 1990), which requires the Department to submit as part of its annual report to the Governor detailed information regarding the operation of the consumer complaint handling process utilized by DOI's Consumer Services Division, and suggestions for legislative improvement (Insurance Code section 12921.1(j)). (See CRLR Vol. 11, No. 4 (Fall 1991) p. 132 and Vol. 11, No. 3 (Summer 1991) pp. 126–27 for detailed background information.) Among other things, the report outlined the number of telephone and written inquiries received by the Department during 1990; provided a general description of how consumer complaints against insurance companies are handled; noted that 140 of DOI's 800 personnel (17.5%) work in the Consumer Services Division; and set forth a summary of legislative action sponsored by the Department regarding enforcement. In compliance with Insurance Code section 12921.1, DOI has established a toll-free complaint number, standardized its complaint forms, and adopted guidelines for disseminating complaint and enforcement information to the public.

Judge Approves Executive Life Sale. On December 26, Los Angeles County Superior Court Judge Kurt J. Lewin approved the $3.55 billion sale of Executive Life Insurance Company to a French investor group, clearing the way for the largest rehabilitation of a failed U.S. insurer to date. The Department seized Executive Life's assets and placed it in conservatorship in April 1991. (See CRLR Vol. 11, No. 4 (Fall 1991) pp. 132–33 and Vol. 11, No. 3 (Summer 1991) p. 129 for background information.)

The approved bid was made by a French investor group led by Altus Finance, a $12.4 billion investment and financial services holding company affiliated with state-owned French bank Credit Lyonnais. Under the terms of the agreement, Altus will pay $3.25 billion for Executive Life's junk bond portfolio; an additional $300 million in capital will be provided by MAAF, a Paris-based mutual insurance company with $5.3 billion in assets. The surviving insurance company, to be renamed Aurora National Life Assurance Company, will be run by MAAF; plans detailing this transformation were to be released in January. Until the court finally approves the takeover, a conservator will continue to make 70% payments to holders of annuities, and 100% death benefit payments to life insurance policyholders.

Altus' winning bid represented a $500 million increase over its original offer for Executive Life, due mainly to competitive bidding among three potential buyers. (Although eight groups submitted bids to the Commissioner, all but three were disqualified as being financially inadequate.) On November 6, the Commissioner rejected a bid by the National Organization of Life and Health

Guaranty Associations, a group which coordinates guaranty funds in 47 states, because it was unable to meet necessary financial conditions. This rejection left Executive Life with only two suitors, Altus and a partnership headed by investment banker Hellman & Friedman; each group boosted its offer 3–4% prior to the deadline for bids. On November 14, the Commissioner announced that he would recommend to Judge Lewin that Altus be permitted to purchase and rehabilitate Executive Life. The decision was based primarily on the bidders' respective treatment of the junk bond portfolio; Altus proposed to immediately rid the insurer of nearly all the bonds, while the Hellman group would have sold off the bonds gradually. The Commissioner viewed retention of the bonds as unnecessarily risky to the company.

The terms of the approved bid, when combined with the contribution of roughly $2 billion from state guaranty associations, assure that more than 95% of all Executive Life policyholders will receive 100% of their contract values up to $100,000. But how much the policyholders with contracts exceeding $100,000 will eventually receive is much less clear, due to current litigation regarding $1.85 billion in Executive Life's municipal guaranteed investment contracts (Muni-GICs). The Commissioner considers these to be speculative investments, not insurance policies or annuities; the holders of these securities, Garamendi asserts, should wait in line with other creditors. On November 15, however, Judge Lewin issued a decision which mandates that Muni-GIC holders be treated the same as consumers who purchased insurance policies from the company. The Commissioner appealed Lewin's decision to the California Supreme Court, which transferred the dispute to the Second District Court of Appeal on November 20. At this writing, a decision has not yet been reached by the court. If Lewin's ruling is upheld, the payout to policyholders with contracts exceeding $100,000 would be roughly 72 cents on the dollar. If Lewin's ruling is overturned in favor of Garamendi's position, the return to these policyholders would rise to 89 cents on the dollar.

Policyholders who do not want to participate in the new company will be able to withdraw their funds prior to transfer, based on a liquidation value set by the court. Those selecting this option, however, are expected to receive considerably less than those who remain under the Altus deal.

Although only two procedural hurdles stand in the way of finalizing the Altus-MAAF takeover (the disposition of the Muni-GICs and final court approval of the takeover plan), more fundamental questions remain. MAAF, the firm that will take over Executive Life, is a small French insurer known mainly for discount auto coverage. The insurance business of MAAF is less than half the size of the $10 billion Executive Life, and it is a relatively new player in the life insurance market. MAAF began selling life insurance in 1979; only 10% of its business is attributable to life insurance. In addition, MAAF's top executive, Jean Claude Seys, has spent most of his career in banking and began his insurance career in 1990 when he was named to head MAAF. These apparent inconsistencies have led some analysts to speculate that MAAF has little interest in a long-term commitment to Executive Life (Aurora), and rather is hoping for a quick financial turnaround that would allow it to resell the company at a profit.

Commissioner Slashes Rate Hike in Workers' Compensation. On December 5, Commissioner Garamendi approved a workers' compensation insurance rate increase of 1.2%, thus granting only a fraction of the 11.9% increase recommended by the Workers' Compensation Insurance Rating Bureau (WCIRB), an insurance industry association.

The Commissioner noted several reasons for his approval of only a minimal rate increase. First, WCIRB had not adequately justified the need for such a large increase. Commissioner Garamendi cited 1990 figures which showed that the four largest sellers paid dividends ranging from 16–25% of premiums written. Second, the imposition of an 11.9% increase during the current economic slump would work an undue hardship on businesses. The Commissioner received over 550 letters from employers and trade associations opposing the rate increase, and he recognized that many businesses cannot afford increased costs at a time when revenues are falling. Finally, the Commissioner suggested that instead of seeking large rate increases, the industry should institute more safeguards against fraud and work towards reforming the system. California's workers' compensation system has been criticized because its costs are among the highest in the nation while its benefits are among the lowest.

Industry representatives expressed concern over the Commissioner's decision and reiterated their position that the requested rate increase of 11.9% is necessary to keep the system financially viable. The industry maintains that the increasing amount of litigation in the workers' compensation field, nearly one in seven claims, mandates higher rates in order to assure compensation for injured workers.

Earthquake Insurance on Shaky Ground. California's mandatory earthquake insurance program was slated to take effect on January 1, but the viability of the program has come under increasing attack from Commissioner Garamendi. The law creating the program was initiated by former Governor Deukmejian shortly after the October 1989 Loma Prieta earthquake, and is intended to fill the gap left by conventional earthquake insurance, which normally has a deductible of 10%. The law requires all privately insured homeowners to pay a $12–$60 annual surcharge for earthquake coverage, thus creating a state pool of $250 million annually to offset the cost of the deductible. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 134 for background information.)

The program was scheduled to start in July 1991 but, at the urging of the Commissioner, it was postponed until January 1, 1992. After studying the program, the Commissioner stated that the state pool would be seriously underfunded and that a substantial increase in the surcharge paid by homeowners was necessary. After Governor Wilson failed to support these suggestions, the Commissioner argued that the program should be scrapped in favor of an earthquake relief fund. Commissioner Garamendi made this suggestion at a November 6 hearing of the Senate Subcommittee on Earthquake Insurance, after which Governor Wilson sharply rebuked Garamendi for his comments and called for support of the existing program.

The situation is further complicated by the failure of some insurers to include the earthquake surcharge on their January statements. The insurers complain that DOI took too long to send out financial information, making it difficult to account for the changes in their rating programs. These insurers and DOI are currently debating whether unbilled homeowners will be covered by earthquake insurance.

Finally, the legislature failed to include any statutory mechanism to enforce participation in the program. In August 1991, DOI adopted new sections 2698–2698.21, emergency regulations that would have implemented the program. Among other things, these

regulations gave the Commissioner the power to prohibit the issuance or renewal of a policy for which the surcharge had not been paid. However, OAL disapproved the emergency regulations on October 4, concluding that the enforcement mechanism is not authorized by the statute. DOI's subsequent attempt to adopt regulations to implement the program, scheduled to be filed with OAL on January 13, contains no provision whatsoever regarding enforcement of participation in the program.

Health Care Reform in 1992? Six million Californians—four million of whom have jobs—have no health insurance. This long-term crisis finally captured the attention of the legislature during 1991, as it considered SB 36 (Petris) and AB 321 (Margolin), both of which would restructure California's health care delivery system (albeit in very different ways). (*See infra* LEGISLATION; *see also* CRLR Vol. 11, No. 3 (Summer 1991) pp. 128–29 and 130–31 for background information on these bills.) Plagued by its usual paralysis on issues involving the insurance industry and physicians, however, the legislature adjourned in September without achieving a solution, leaving the "players" to squabble among themselves and jockey for position in preparation for the 1992 legislative year.

During the fall, the players lined up as follows:

-The doctors, as represented by the powerful California Medical Association (CMA), drafted a statewide ballot initiative which would require employers of five or more people to offer basic, low- cost health insurance to workers and their dependents. Employers would pay 75% of the premium, with employees paying the rest. Subsidies for small businesses would be available, funded by $2 billion in new sales taxes and redirection of existing state funds toward increased payments to physicians serving the poor in the Medi-Cal program. Over six years, the program would have extended health care benefits to all uninsured California residents. After unsuccessfully floating its proposal in the legislature last year, CMA quietly circulated a first draft of its ballot initiative during the late summer.

-Opposed to increased governmental regulation of its products and rates, the insurance industry formed a campaign committee—the "Consumer Health Insurance Coalition"—to keep CMA's initiative off the ballot, spending $300,000 to conduct polls and focus groups, finance an anti-doctor public relations campaign, and distribute slick brochures characterizing CMA's initiative as a self-serving plan which would shift the cost of taking care of uninsured patients from physicians to business.

-Not to be outdone, a group of employers led by the restaurant industry, retailers, and hotel/motel owners formed "Health Coalition '92," also opposed CMA's draft ballot proposal. These employers, joined by a small business trade association, fiercely oppose any measure which requires businesses to provide insurance for their workers. They argue that if medical and claims processing costs are reduced, employers will offer coverage without a government mandate.

-San Francisco's Health Access Coalition, a broad-based organization of 170 consumer, labor, and religious groups and sponsor of SB 36 (Petris), also criticized CMA's initiative as "designed only to benefit doctors." Health Access has supported several successive Petris bills aimed at establishing a Canadian-style, state-run, single-payor health care system in California—a proposal which is naturally opposed by both physicians and insurers.

Confronted with such well-organized opposition before it had even finished drafting its initiative, CMA dropped its proposal on October 22, and began to negotiate with the Health Access Coalition over a so-called "pay or play" proposal, under which businesses would be required either to provide basic health insurance for their employees or pay a tax to support a government-sponsored plan for people who cannot afford coverage.

Meanwhile, on December 4, the president of the Los Angeles-based AIDS Health Care Foundation won approval from the Secretary of State to circulate a health care initiative for signatures in an attempt to qualify it for the November ballot. Michael Weinstein's two-page proposal would simply require the Governor and the legislature to create a program providing health insurance for all Californians. The initiative does not dictate the precise fashion in which this should be accomplished, but outlines a seven-point plan which calls for a "pay or play" system for employers, redirection of existing health care expenditures instead of new taxes (other than the tax on employers who refuse to provide coverage for employees), medical cost containment measures, and the expansion of preventive care. With regard to the legislature's continuing stagnancy on this issue, Weinstein noted, "What we are looking for is a political mandate for health care reform. We need something to get people off the dime."

For his part, Commissioner Garamendi has assigned the task of developing the Department's comprehensive health insurance reforms to Walter Zelman, Special Deputy for Health Issues. Zelman convened a panel of experts in the field of health care financing and delivery on October 16. Over the next few months, the panel is charged with exploring the possible integration of health-related elements of other insurance products—including workers' compensation, auto personal injury, homeowners', and disability insurance—into a comprehensive health care insurance system, and access to cost-effective wellness programs and preventive care, especially for children and low-income individuals and families.

At a November 14 health care conference sponsored by Blue Cross, Garamendi stated that "[i]t's time to define access to health care as a right . . . one that government is obligated to deliver and to protect." He hinted that his proposals may ultimately call for radical change in California's existing employment-based health insurance system: "We should think big, propose real solutions, not patchwork fixes." Garamendi was expected to outline his health care reform proposals by February.

LEGISLATION:

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

AB 306 (Friedman), as amended July 15, would provide that where there is reasonable cause to believe that a claim for bodily injury or property damage presented to a private passenger

automobile insurer by a third party may be fraudulent, the claim shall not be paid unless the insurance carrier has first obtained positive identification of the person claiming personal injury or property damage. This two-year bill is pending in the Senate Committee on Insurance, Claims and Corporations.

SB 233 (Robbins), as amended April 29, would provide that when an insurer's rating plan for auto insurance is filed for review and approval by the Commissioner pursuant to Proposition 103, the Commissioner shall, to the maximum extent possible, consider a reduction in premium rates for automobile insurance for individuals who commute to work using means other than a motor vehicle for which the principal operator is insured under that auto insurance policy. This two-year bill is pending in the Assembly Insurance Committee.

AB 1375 (Brown), as amended September 10, is the Assembly Speaker's alternative to no-fault auto insurance. While it would eliminate liability for vehicular property damage in most cases (and allow those claims to be handled on a no–fault basis), it would largely leave the current fault–based tort system intact for personal injury claims. It would eliminate the current requirement that insurers offer property damage uninsured motorist coverage, but would require that collision coverage and comprehensive coverage be offered, as specified.

AB 1375 would also require insurers to participate in the California Auto Plan, which would sell minimum liability coverage to qualifying low–income, good drivers at a reduced, unspecified premium. The bill would also reinstate the so–called "*Royal Globe*" private cause of action for bad faith claims handling by insurers, which was invalidated by the California Supreme Court in *Moradi–Shalal v. Fireman's Fund Insurance Companies* (see CRLR Vol. 8, No. 4 (Fall 1988) p. 87 for background information). This two-year bill is pending in the Senate Appropriations Committee.

SB 340 (Torres), as amended August 19, is Senator Torres' compromise between SB 841, Senator Johnston's no-fault bill which was defeated in the Senate Judiciary Committee on May 28 (see CRLR Vol. 11, No. 3 (Summer 1991) p. 128 for background information), and Speaker Brown's AB 1375. This two-year bill stalled in the Assembly Insurance Committee on August 20, but remains pending there as a two-year bill.

AB 1984 (Connelly), as amended May 30, would provide that any person engaged in the business of insurance is required to act in good faith toward, and to deal fairly with, policyholders and others, as specified. Except in the area of workers' compensation insurance and insurers, the bill would reinstate the *Royal Globe* private cause of action against an insurer for bad faith, by providing that a policyholder or other person may bring an action against an insurer or other licensee of DOI for a violation of the good faith requirement and other statutory provisions that prohibit unfair and deceptive practices, and may recover compensatory and exemplary damages. This two-year bill is pending in the Assembly inactive file.

AB 744 (Moore). DOI's Bureau of Fraudulent Claims is supported by, among other things, an assessment on insurers not to exceed $1,000 per year. As amended August 29, this bill would, in addition to that assessment, impose an assessment of $250 on any insurer issuing, amending, or renewing any policy of automobile insurance insuring a vehicle where the named insured is, at that time, residing in Los Angeles County. The bill would require the Bureau to establish a pilot project in Los Angeles County to combat automobile insurance fraud, and the additional assessment would be used exclusively for that purpose. This two-year bill is pending in the Senate inactive file.

AB 624 (Bane) would provide that it is unlawful for any automobile repair dealer to offer or give any discount intended to offset a deductible required by a policy of insurance covering a motor vehicle. This two-year bill is pending in the Assembly Public Safety Committee.

AB 2042 (Lancaster) would require the California Automobile Assigned Risk Plan to use rates that are actuarially sound so that there is no subsidy of the plan, and require the Commissioner to approve necessary rate increases. This two-year bill is pending in the Senate Insurance Committee.

AB 2078 (Gotch), as amended May 6, would reenact those repealed provisions of the Robbins-McAlister Financial Responsibility Act which require drivers to provide evidence of financial responsibility; a violation of those provisions would be grounds for a civil penalty. This two-year bill, which would also prohibit reporting or disclosing a violation of those provisions to the DMV, is pending in the Senate Insurance Committee.

SB 784 (Robbins) would, on and after July 1, 1992, if the Commissioner has made a specified finding regarding affordability by January 1, 1992, require the Department of Motor Vehicles (DMV) to refuse registration or renewal of registration of a motor vehicle if the owner has failed to provide DMV with specified evidence of financial responsibility. This two-year bill is pending in the Senate Insurance Committee.

SB 1139 (Killea) would create a limited-term task force for investigating the costs, benefits, and workability of pay-as-you- drive automobile insurance. This two-year bill is pending in the Senate Insurance Committee.

SB 122 (Robbins), as amended August 20, would authorize DOI's Bureau of Fraudulent Claims to impose a special assessment on insurers for calendar year 1992 on insured vehicles in a designated county to fund a program to reward persons whose information leads to the arrest and prosecution of vehicle thieves or the issuance of a warrant for suspected theft ring members or chop shop operators, or the arrest and filing of an indictment or information against suspected theft ring members or chop shop operators. This two-year bill is pending in the Assembly Ways and Means Committee.

SB 36 (Petris), as amended April 4, would dramatically restructure California's health care delivery system by establishing the state as the principal payor of medical care, and shifting financing from an employer-based system to a tax-based system. The bill would extend basic health benefits, including long-term care, to every resident of California. An administering commission would determine provider rates, control capital expenditures, and determine individual hospital budgets, similar to the health insurance system in Canada. This two-year bill is pending in the Senate Revenue and Taxation Committee.

AB 321 (Margolin), as amended July 2, would enact the California Family Health Plan Act and create a system for the delivery of perinatal health services to all high-risk women in the state and health care to all children 18 years of age and younger. While existing law provides a variety of health care services through the state and local governments, this bill attempts to encompass the field by providing a general entitlement to perinatal and children's services for all persons not otherwise covered by a state or private program. This two-year bill is pending in the Senate Rules Committee.

AB 502 (Margolin) would require the Commissioner to study the extent of private health insurance or health coverage purchased by employers, employees, and individuals; the bill would appropriate $275,000 from the Insurance

Fund to pay the costs of the study and report. This two-year bill is pending in the Senate Insurance Committee.

SB 921 (Committee on Insurance, Claims and Corporations), as amended September 5, would provide that each person who offers, solicits, or delivers health coverage on behalf of any insurer shall provide a written disclosure to be delivered at the time of initial solicitation, in a specified form, and containing specified information. This two-year bill is pending in the Assembly Insurance Committee.

SB 925 (Committee on Insurance, Claims and Corporations), as amended September 13, would provide that multiple employer welfare arrangements are under DOI's jurisdiction in the manner specified in a provision of the federal Employee Retirement Income Security Act, and provide that no multiple employer welfare arrangement may solicit or issue insurance in California unless it possess a valid certificate of authority. This two-year bill is pending in the Assembly Insurance Committee.

SB 364 (Robbins), as amended July 2, would provide that all companies providing specified insurance in this state and all nonprofit hospital plans doing business in this state must establish a toll-free telephone number to receive telephone calls regarding claims, complaints, questions, or other inquiries. This two-year bill is pending in the Senate inactive file.

LITIGATION:

Once again, the insurance industry is pursuing a barrage of litigation aimed at invalidating the Commissioner's latest attempt to implement Proposition 103, passed by the voters in 1988. The new lawsuits, filed in both state and federal courts, challenge the validity of DOI's emergency rollback regulations. (*See supra* MAJOR PROJECTS for related discussion.) The insurers are entitled to an administrative hearing on a rollback order (and the Commissioner has ordered the commencement of several rollback hearings at this writing), but chose to go to court before fully exhausting their administrative remedies.

Pending in the U.S. District Court for the Northern District of California are ***Fireman's Fund v. Garamendi***, No. C91-2854, and ***United States Fidelity and Guaranty v. Garamendi***, No. C91-2855, in which the plaintiffs primarily challenge the regulations' 10% cap on the rate of return allowed insurers during the year following the passage of Proposition 103, for purposes of computing a company's rollback liability. The plaintiffs argue that the cap amounts of a "taking" of their property in violation of the fifth amendment. In October, attorneys for the Commissioner moved for dismissal, arguing that the federal court should abstain from ruling on the insurers' claims and permit the state administrative process to continue unimpeded, followed (if necessary) by challenges in state courts. At this writing, U.S. District Judge Charles Legge has yet to issue a ruling.

By October, dozens of other insurance companies challenging the regulations had joined as plaintiffs in an amended complaint filed before Judge Dzintra Janavs in Los Angeles County Superior Court, ***Hartford Steamboiler Inspection and Insurance Co. v. Garamendi***, No. BC023983. All state court Proposition 103-related litigation has been assigned to Judge Janavs by the state Judicial Council and coordinated into the ***Proposition 103 Implementation Cases***, No. JCCP2419. The SAFECO companies filed a separate, similar suit, ***General Insurance Co. of America v. Garamendi***, No. BC036620, which challenges the authority of Commissioner Garamendi to substitute new rollback regulations for those adopted by former Commissioner Gillespie. Under Gillespie's regulations, a DOI administrative law judge adjudged SAFECO to be liable for only $17.5 million in rebates; however, in October, Garamendi applied his rules to SAFECO's books and ordered the company to refund $110 million.

On November 14, 20th Century Insurance Company and 21st Century Casualty Company filed ***20th Century Insurance Co. v. Garamendi*** in San Francisco County Superior Court, contesting Commissioner Garamendi's authority to regulate the rate of return earned by insurance companies rather than the rates they charge. The companies maintain that rate of return regulation is appropriate in the context of natural monopolies, such as electric utilities, but is inconsistent with the structure of the California insurance industry and the text of Proposition 103. Observers note that the companies are essentially challenging the ruling of the California Supreme Court in *Calfarm v. Deukmejian*, 48 Cal. 3d 805 (1989), in which the court invalidated Proposition 103's "substantial threat of insolvency" standard, substituted a "fair rate of return" standard, and acknowledged the Commissioner's broad rulemaking authority to establish a fair rate of return.

On December 3, an angry Judge Janavs ordered the *20th Century* case removed from its San Francisco venue and transferred to her court, and accused the company's attorney, Gary Fontana of Thelen, Marrin, Johnson & Bridges, of bad faith in filing the lawsuit in San Francisco. Fontana claimed that he sought only to obtain a ruling on the merits of his case before December 16, when DOI's administrative hearing on 20th Century's rollback liability was scheduled to begin, and that "on the basis of inquiries made in good faith" he did not believe he could get a hearing in Judge Janavs' courtroom before December 16. In response to cross-examination by Fredric Woocher, counsel for the Commissioner, Fontana admitted that he was aware all Proposition 103 cases were coordinated before Judge Janavs and aware that Judge Janavs hears matters on short notice; he also testified that he did not attempt to contact Judge Janavs' courtroom, but contacted only one of the writ courtrooms at the Los Angeles County Courthouse. Woocher requested an order imposing sanctions on Fontana and 20th Century for bad faith "forum-shopping" in an attempt to exhaust the resources of the Commissioner.

On December 13, Judge Janavs denied 20th Century's petition for writ of administrative mandate for failure to exhaust administrative remedies; thus, 20th Century must first challenge its rollback order in DOI administrative hearings before the court will rule on its contentions.

California State Automobile Association Inter-Insurance Bureau v. Garamendi, No. BC044991, was filed on December 24 in Los Angeles County Superior Court. As in the SAFECO case described above, CSAA contends that Commissioner Garamendi is not authorized to amend the rollback regulations of former Commissioner Gillespie, under which CSAA was adjudged to be free from any rollback liability. Under Garamendi's October order, CSAA must refund $157 million.

On December 5, the Second District Court of Appeal heard oral argument by appellants, including Commissioner Garamendi, in ***Allstate Insurance Co. v. Garamendi***, No. B050439. The case centers around Proposition 103's addition of section 1861.02 to the Insurance Code; that section requires auto insurance rates to be based on three enumerated factors (insured's driving safety record, number of miles driven annually, and years of driving experience), plus additional factors approved by the Insurance Commissioner which show a substantial relationship to the risk of loss. The intent of section 1861.02 was to outlaw

so-called "territorial rating," under which a driver's premium rates are based almost solely on his/her ZIP code. In April 1990, then-Commissioner Gillespie adopted emergency regulations to implement section 1861.02; consistent with the intent of Proposition 103, the regulations embraced what is described as a "tempered approach" to ratesetting. The tempered approach tends to equalize auto insurance rates for drivers living in different localities.

In the insurance industry's lawsuit challenging the regulations, the superior court enjoined enforcement of the auto rating factors (see CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 140 for details); subsequently, Commissioner Gillespie adopted new regulations to comply with the court order. The amended regulations permit use of ZIP codes in ratesetting and are still in effect. The superior court ruled that by equalizing territorial rates, which are based on real geographic cost differentials, some drivers would be subsidizing others in violation of Insurance Code section 1861.05's prohibition against discriminatory rates. On appeal, attorneys for the Commissioner argued that Insurance Code section 1861.05 does not apply to Proposition 103's ban on territorial rating, in order to enable Garamendi to adopt new auto rating regulations which use the "tempered approach." At this writing, the court has not yet issued a ruling.

In ***State Farm Fire and Casualty Co. v. Von Der Lieth***, No. S019059 (Dec. 16, 1991), the California Supreme Court ruled that State Farm may be held liable for subsidence damages incurred by a homeowner. The ruling was viewed as a surprise defeat for insurers due to the explicit exclusion of earth movement losses in most homeowners' policies and increasingly pro-insurer rulings by the Supreme Court.

The suit arose from the Von Der Lieths' request that State Farm pay the full policy limit of $231,000 to help cover the cost of stabilizing their home against further damage from landslides in the Big Rock Mesa area of Malibu. State Farm paid $14,076 to repair cracks that began to appear in the home but refused to pay the policy limit, stating that its homeowners' policy expressly excluded losses caused by earth movement or natural groundwater. In the suit, the Von Der Lieths claimed that the state had destabilized the mesa when the Pacific Coast Highway was built in 1933. In addition, the county was blamed for allowing homes to be built on the mesa without a sewer system to drain away water which further eroded the property. The Von Der Lieths maintained that this third-party negligence was covered by their homeowners' policy, and in 1990 a jury agreed, awarding them $56,500 in costs and bad faith damages against State Farm. The Second District Court of Appeal, however, overturned the verdict, upholding the policy exclusion for losses caused by earth movement.

A unanimous Supreme Court reversed the Second District's decision, stating that the jury had correctly determined that third-party negligence was the proximate cause of the loss and that State Farm was liable under the homeowners' policy. The decision is expected to spur action in the insurance industry; it is likely that some insurers will specifically exclude third-party negligence coverage or charge for it as an additional coverage.

On November 14, the California Supreme Court denied the insurance industry's petition for review of the Third District Court of Appeal's decision in ***Sanford v. Garamendi***. In that case, the Third District ruled that banks (but not bank subsidiaries) may now engage in the insurance agency and brokerage business under Proposition 103. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 138 for detailed background information on this case.)

On October 17, the California Supreme Court denied the CAARP governing board's petition for review of the Second District Court of Appeal's August 1991 decision in ***California Automobile Assigned Risk Plan v. Garamendi***, in which the court ruled that CAARP rates may be set by the Commissioner pursuant to pre-Proposition 103 procedures. (See CRLR Vol. 11, No. 4 (Fall 1991) p. 139 for background information.)

On October 3, the California Supreme Court denied the insurer's petition for review of the Fourth District Court of Appeal's decision in ***Weiner v. Fireman's Fund Insurance***. However, the Supreme Court decertified the Fourth District's opinion, which created an exception to *Moradi-Shalal*'s ban on third-party bad faith actions against insurance companies by allowing civil suits by third parties for intentional infliction of emotional distress when an insurer's conduct is "so extreme as to exceed all bounds of that usually tolerated in a civilized society." (See CRLR Vol. 11, No. 4 (Fall 1991) p. 139 for background information.)

DEPARTMENT OF REAL ESTATE

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

The Real Estate Commissioner is appointed by the Governor and is the chief officer of the Department of Real Estate (DRE). DRE was established pursuant to Business and Professions Code section 10000 *et seq.*; its regulations appear in Chapter 6, Title 10 of the California Code of Regulations (CCR). The commissioner's principal duties include determining administrative policy and enforcing the Real Estate Law in a manner which achieves maximum protection for purchasers of real property and those persons dealing with a real estate licensee. The commissioner is assisted by the Real Estate Advisory Commission, which is comprised of six brokers and four public members who serve at the commissioner's pleasure. The Real Estate Advisory Commission must conduct at least four public meetings each year. The commissioner receives additional advice from specialized committees in areas of education and research, mortgage lending, subdivisions and commercial and business brokerage. Various subcommittees also provide advisory input.

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

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

In sales or leases of most residential subdivisions, the Department protects the public by requiring that a prospective buyer be given a copy of the "public report." The public report serves two functions aimed at protecting buyers of subdivision interests: (1) the report requires disclosure of material facts relating to title, encumbrances, and similar information; and (2) it ensures adherence to applicable standards for creating, operating, financing, and documenting the project. The commissioner will not issue the public report if the subdivider fails to comply with any provision of the Subdivided Lands Act.

The Department publishes three major publications. The *Real Estate*