compensation of persons retained to review claims shall not be based on a percentage of the amount by which a claim is reduced for payment; the bill's restrictions do not apply to Medi-Cal. This bill was signed by the Governor on August 22 (Chapter 544, Statutes of 1992).

AB 2516 (Bentley). Existing law exempts from provisions regulating the sale, lease, or offer, or the advertising in connection therewith, of financial services offered in the ordinary course of business by a state or federal credit union, among other entities. This bill additionally excludes the financial services offered in the ordinary course of business by an authorized industrial loan company, a licensed consumer finance lender, a licensed commercial finance lender, a licensed personal property broker, or persons licensed pursuant to the Real Estate Law. This bill was signed by the Governor on August 20 (Chapter 530, Statutes of 1992).

SB 506 (McCorquodale), which would have created the Department of State Banking and Savings and Loan, was vetoed by the Governor on September 30.

AB 3469 (T. Friedman) was amended to pertain solely to savings and loan institutions (*see infra* agency report on DEPARTMENT OF SAVINGS AND LOAN for related discussion).

The following bills died in committee: **SB 1552 (McCorquodale)**, which would have required the boards of specified corporations to establish at least two committees composed of independent directors to provide analysis and recommendations to the board concerning an audit of internal company operations and procedures and an evaluation of compensation of company officers and executives; **AB 3159 (Cannella)**, which would have authorized the Department of Consumer Affairs to license "financial planners," as defined; **AB 3827 (Conroy)**, which would have permitted a licensee or applicant for an escrow agent's license to obtain an irrevocable letter of credit in an form which shall be approved by the Commissioner of Corporations in lieu of a bond; **AB 83 (Kelley)**, which would have reenacted provisions of law stating that no cause of action may be maintained against a person serving without compensation as a director or officer of a tax-exempt nonprofit corporation subject to specified provisions of the nonprofit corporation law organized to provide charitable, educational, scientific, social, or other forms of public service on account of any negligent act or omission by that person without a court order, as specified; **SB 488 (Mello)**, which would have specified that the comparable insurance or guaranty of shares acceptable to the Commissioner for specified purposes is to be provided by a guaranty corporation licensed pursuant to this bill; and **AB 1597 (Floyd)**, which would have permitted the Commissioner to refuse to issue a permit for the qualification of securities in a recapitalization or reorganization unless, in addition to finding that the proposed plan and issuance of securities is fair, just, and equitable to all security holders affected, the Commissioner finds that the proposed plan does not result in the termination or impairment of any labor contract covering persons engaged in employment in this state and negotiated by a labor organization, collective bargaining agent, or other representative.

■ LITIGATION

On July 10, in one of the numerous lawsuits stemming from the failure of Lincoln Savings and Loan, a federal jury ordered financier Charles Keating, Jr., 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 co-defendants. *[12:2&3 CRLR 169; 11:4 CRLR 130]* However, U.S. District Court Judge Richard Bilby had instructed the jury that it could not award punitive damages against any defendant other than Keating; it is unclear whether Judge Bilby will allow the $900 million award. Keating, already in prison on California criminal convictions stemming from the same activities, sent no lawyers to defend him in the damages phase of this civil proceeding, claiming that he could not afford to. Keating was scheduled to go on trial in Los Angeles in October on federal criminal charges of fraud, conspiracy, and racketeering stemming from the 1989 collapse of Lincoln.

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

Wilson Refuses to Overrule OAL's Fourth Rejection of Proposition 103 Rollback Regulations; "As Applied" Challenge Proceeds to Court. On June 8 and July 15, then-Director of the Office of Administrative Law (OAL) Marz Garcia rejected DOI's proposed adoption of sections 2641.1–2647.1, Title 10 of the CCR, the Department's regulations designed to implement the rate rollback provisions of Proposition 103. Garcia's actions marked the third and fourth times he has rejected the rollback rules, and immediately prompted the Senate Rules Committee to reject his appointment as OAL Director. (*See supra* agency report on OAL for related discussion.)

Last February, after Garcia rejected the Department's rollback regulations (on both an emergency and permanent basis) for the second time, Governor Wilson overruled him for the second time to enable DOI to complete an ongoing administrative hearing on an individual company's rollback order challenge, so that a test case could emerge for judicial review. *[12:2&3 CRLR 169–70]* Wilson's action thus breathed life into the rules for another 120-day period, which ended on June 11. In his June 8 action, Garcia rejected the Department's proposed extension of the emergency rules for another 120-day period. In his July 15 decision, Garcia rejected the Department's proposal to permanently adopt the rules, finding that DOI had addressed only one of the four deficiencies noted by OAL in its January rejection.

In his February ruling reversing OAL for the second time, Governor Wilson warned the parties that "no further appeals on Proposition 103 regulations will be considered by this Office," in effect denying Commissioner Garamendi the appeal route mandated by Government Code section 11349.5. Thus, following OAL's fourth rejection, Commissioner Garamendi filed suit (*Garamendi v. Garcia*, No. BC057533) in Los Angeles County Superior Court, seeking a court order compelling Garcia to approve the regulations. However, the Commissioner dismissed his action on July 27, stating that it does not serve the public interest for one state agency to sue another. Despite the Governor's warning, Garamendi asked Wilson to reverse OAL's rejection on August 3, noting that lengthy DOI administrative hearings on challenges to rollback orders filed by GEICO and State Farm had been interrupted by OAL's July 15 ruling.

On August 24, Governor Wilson declined to overrule OAL, primarily on grounds that "[s]ince the Commissioner's last appeal, a significant test case has begun moving through the courts. The challenge of 20th Century Insurance Company to their [sic] rollback order, determined by the Commissioner under these regulations, is set for trial in November of this year. The case contains most of the critical issues in the Proposition 103 debate, and will be extremely important in providing direction concerning the validity of the rollback regulations and procedures established by Commissioner Garamendi....Now that the dispute is in court, my intervention is no longer necessary or useful. Commissioner Garamendi must fight this out in court with the insurers he is responsible for regulating." (*See infra* LITIGATION for further discussion of the *20th Century* case.)

Other Proposition 103 Rulemaking. Following is a status update on other DOI rulemaking proceedings to implement provisions of Proposition 103:

• ***Administrative Fees.*** On July 27, OAL separated out section 2647.1 from the Commissioner's package of rollback regulations and approved it. Section 2647.1 imposes a range of fees on insurers (based on an insurer's California-derived direct premiums written in the preceding calendar year) to reimburse DOI for expenses incurred in administering a wide variety of programs mandated by Proposition 103, including prior approval of certain insurance rates, review and approval of private passenger auto rating plans, prevention of unfairly discriminatory rates, and related litigation defense and legislative programs. At the request of the Commissioner, OAL also ruled that the effective date of the fee regulation was July 27.

• ***Intervenor Compensation.*** On August 20, OAL disapproved the Department's proposed adoption of sections 2615.1–2623.10, Title 10 of the CCR. Pursuant to Proposition 103, these regulations establish an intervenor compensation mechanism whereby representatives of consumer interests may recover their advocacy fees if they participate in specified DOI proceedings and make a substantial contribution to the Commissioner's adoption of any order, regulation, or decision. *[12:2&3 CRLR 171]* OAL found that the rulemaking record failed to satisfy the necessity, clarity, consistency, and reference standards of Government Code section 11349.1, and that DOI failed to summarize and respond to all comments received on the proposed regulations and comply with other technical requirements of the Administrative Procedure Act. At this writing, DOI is revising its rulemaking record and expects to release a modified version of the proposed regulatory action for an additional 15-day public comment in early November.

Until these regulations are approved, DOI continues to operate under sections 2631.1–2631.6, previously adopted emergency intervenor compensation regulations. On August 20, OAL approved DOI's emergency readoption of these regulations for another 120-day period.

• ***Generic Rollback Standards.*** On July 28, OAL approved DOI's adoption of sections 2645.4–2645.6, Title 10 of the CCR, which establish—for purposes of Proposition 103's rate rollback requirement—generic standards for reserve adequacy, efficiency standards, reasonable levels of executive compensation, minimum after-tax, non-confiscatory rate of return, and leverage factors. *[12:2&3 CRLR 170; 11:4 CRLR 131]*

Commissioner Renotices Redlining Regulations. On September 17, Commissioner Garamendi republished notice of his intent to adopt new section 2646.6, Title 10 of the CCR, which would establish standards designed to curb the widespread industry practice of "redlining" (the refusal to sell insurance to low-income and minority communities). DOI previously published this proposed regulatory action in May 1991 and held a public hearing on the issue in August 1991. *[11:4 CRLR 134; 11:3 CRLR 130]*

Generally, proposed section 2646.6 requires insurers to compile, maintain, and file with the Commissioner on an annual

basis a "Community Service Statement" setting forth, by ZIP code, for certain lines of insurance, information about premiums, offices, agents, mail or telephone solicitations, languages spoken, race or national origin and gender of applicants or policyholders, and applications declined. The Commissioner would then report to both the public and the legislature those communities which are inadequately served by insurers in order to increase public awareness of the problem. In addition, the rule authorizes the Commissioner to adjust the permitted rate of return to reflect whether an insurer is providing service to underserved communities; that is, the Commissioner may increase the allowable rate of return if the percentage of policies an insurer has in force in underserved communities meets or exceeds a specified number, and decrease the rate of return for companies which provide inferior or discriminatory service to underserved communities. (*See supra* report on PUBLIC ADVOCATES for related discussion.)

Finally, the rule requires each property-casualty insurer admitted to do business in California to maintain and advertise a toll-free telephone number for the purpose of allowing California residents to obtain information about purchasing insurance coverage from that insurer. The toll-free number shall be prominently featured in each of the insurer's advertisements, including telephone directories.

DOI was scheduled to hold a public hearing on this proposed regulatory action on December 3 in Los Angeles.

Automobile Theft and Loss Reporting Regulations. On July 24, DOI published notice of its intent to add section 2191.1 to Title 10 of the CCR, to implement Insurance Code section 1874.6 (Chapter 948, Statutes of 1990). That section requires insurers to report covered private passenger automobiles involved in theft and salvage total losses, including the vehicle identification number (VIN) and any other information which may be required, to a national, centralized organization engaged in automobile loss prevention and approved by the Commissioner. The purpose of the statute is the prevention of insurance fraud schemes; because the VIN and other identifying information will be reported to a central data collecting and investigation bureau, the likelihood of fraudulent claims (including multiple theft claims regarding the same vehicle) is minimized.

Regulatory section 2191.1 would require insurers to report thefts and total losses to the National Insurance Crime Bureau (NICB) within specified timeframes; the insurer must await NICB's acknowledgement of the receipt of the report before making any payments to the insured. If NICB indicates that it has reasonable cause to believe that the loss may have been caused by the criminal or fraudulent act of any person, the insurer must report this information to DOI and its Bureau of Fraudulent Claims immediately, suspend the processing of the claim, and promptly begin an investigation.

The Department held a public hearing on this proposed regulatory action on September 16, but no oral testimony was received. At this writing, staff is reviewing the written comments received, and hopes to release a modified version of the regulatory action for an additional comment period in the near future.

Status Update on Other DOI Rulemaking. Following is a status update on other DOI rulemaking proceedings discussed in detail in previous issues of the *Reporter*:

• ***Unfair Claims Settlement Practices***. On August 24, DOI released its second modified version of sections 2695.1–2695.17, Title 10 of the CCR, its landmark regulations defining unfair claims settlement practices. The proposed regulations were developed by DOI in conjunction with its Consumer Complaints and Unfair Practices Task Force, and are intended to define with specificity the full range of unfair acts or types of conduct prohibited by Insurance Code section 790.03(h). *[12:2&3 CRLR 171; 12:1 CRLR 117–18]*

The major changes made by DOI on August 24 to its originally proposed regulations include the following:

–DOI deleted entirely section 2695.16, which would have established detailed reporting requirements applicable to all insurers. This section was the subject of considerable opposition by the insurance industry.

–Section 2695.2(d), which defines the term "claims agent," was amended to state that an attorney retained by an insurer to defend a claim brought against an insured is not a claims agent.

–Section 2695.2(o), which defines the term "notice of claim," was amended to state that for purposes of claims brought pursuant to excess liability insurance policies, umbrella liability insurance policies, or excess property insurance policies, "notice of claim" means any written notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against such a policy and notification that a condition giving rise to the insurer's obligation under such a policy has arisen.

–Section 2695.4(e) was amended to provide that no insurer shall be precluded from including in any release a provision requiring the claimant to waive the provisions of Civil Code section 1542, if 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. For purposes of this subsection, insurers are not required to provide the above explanation or disclosure if the claimant is represented by an attorney at the time the release is presented for signature.

–Section 2695.7 was amended to include a caveat repeated twice in the body of the section. The caveat provides that nothing in subsection 2695.7(b)(1) or (c)(1) requires an insurer to disclose any information that could reasonably be expected to alert a claimant that the claim is being investigated as a suspected fraudulent claim.

–Section 2695.7(g) was completely rewritten to provide that no insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The section sets forth seven factors to guide the Commissioner in determining whether a settlement offer is unreasonably low.

On August 31, DOI issued a third modified version of the unfair claims settlement practices regulations, in which it made further minor changes to the text. The Department reopened the public comment period on the proposed regulatory action until September 15. At this writing, DOI staff is reviewing the comments received, and hopes to file the rulemaking record with OAL by October 22.

• ***Prelicensure and Continuing Education Requirements***. On June 17 and July 20, DOI released modified versions of proposed sections 2182 and 2186–2188.7, Title 10 of the CCR. This regulatory action implements Insurance Code section 1749 *et seq.*, which requires the Commissioner to establish a curriculum board to develop prelicensing and continuing education (CE) requirements for fire and casualty broker agents and life insurance agents. The new sections include detailed prelicensure and CE requirements, including attendance standards and methods of DOI approval of courses and providers. DOI reopened the public comment period until August 20. At this writing, staff is reviewing the comments received, and expects to submit the rulemaking record to OAL by October 13.

• ***Insurance Fraud Prevention Funding***. On May 7, DOI held a public hearing on two proposed rulemaking packages designed to direct funding toward automobile and workers' compensation insurance fraud prevention programs

operated by DOI's Bureau of Fraudulent Claims and local district attorney's offices. New sections 2692.1–2692.8, Title 10 of the CCR, would establish a funding mechanism for auto insurance fraud prevention programs, and new sections 2693.1–2693.10, Title 10 of the CCR, would establish a funding mechanism for workers' compensation insurance fraud prevention programs. *[12:2&3 CRLR 172]* At this writing, DOI staff is reviewing the comments received and making modifications to the proposed rules; the rulemaking package has not yet been submitted to OAL for review and approval.

• ***Placement of Insurance by Surplus Line Brokers with Nonadmitted Insurers***. On June 12, OAL approved DOI's emergency 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]* These emergency regulations are effective for 120 days. On July 28 and 29, the Department held public hearings on its intent to adopt the emergency regulations on a permanent basis. At this writing, staff is reviewing the comments received at the public hearing, and expects to submit the rulemaking record to OAL by October 12.

"The Good, the Bad, and the Ugly." In late August, DOI released its second annual ranking of the 50 largest auto, homeowner, health, and life insurers doing business in California. Under SB 2569 (Rosenthal) (Chapter 1375, Statutes of 1990), the Department is required to establish guidelines for the dissemination of complaint and enforcement information on individual insurers to the public, including but not limited to license status; number and type of complaints closed within the last full calendar year (with analogous statistics from the prior two years for comparison); number and type of violations found; number and type of enforcement actions taken; the ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both; and any other information the Department deems is appropriate public information regarding the complaint record of an insurer that will assist the public in selecting an insurer. *[11:4 CRLR 132]* The publicly-released rankings are based upon an insurer's complaint ratio—the number of justified consumer complaints per $1 million in premiums written.

In both the auto and homeowners lines, USAA had the best record; National Colonial Insurance had the worst record in auto insurance, and Farmers Exchange (a unit of Farmers Insurance Group) had the worst record in homeowners insurance. Of the largest auto insurers, Mercury Casualty, Farmers Insurance Exchange, Allstate, and Mercury Insurance had poor records; of the largest homeowners insurers, 20th Century, CSAA (AAA of Northern California), Safeco, and Allstate had poor records. In the health insurance line, Unum Life of America had the best record and American Service Life had the worst record; of the largest health insurers, Travelers Insurance, Connecticut General Life, John Alden Life, and Aetna Insurance had poor records. In the life insurance line, Aid Association for Lutherans had the best record and United Insurance of America had the worst record; of large life insurers, Massachusetts Indemnity & Life, Prudential Insurance of America, and Jackson National Life had poor records.

Workers' Compensation: Throwing Good Money at a Bad System. Last spring, the Workers' Compensation Insurance Rating Bureau (WCIRB) recommended a 23.1% increase in workers' compensation premium rates. *[12:2&3 CRLR 171–72]* Following May 13–14 public hearings on the necessary amendments to section 2350, Title 10 of the CCR, Commissioner Garamendi approved only a 6.7% increase. Although OAL did not approve the regulatory change until August 4, it became effective on July 1. This marks the second increase in workers' compensation grudgingly allowed by Commissioner Garamendi; in October 1991, WCIRB requested an 11.9% increase, of which Garamendi approved 1.2%. *[12:1 CRLR 121]*

Predictably, WCIRB immediately requested another rate increase in September; this time, the Bureau insists that a 12.6% increase is necessary. The Commissioner is not expected to rule on the new request until late November.

California's workers' compensation system has a well-deserved and widespread reputation as one of the most inefficient, ineffective, and expensive in the country. The legislature attempted to deal with this albatross through a three-bill package aimed at reducing medical and legal costs, eliminating fraud and abuse, revamping vocational rehabilitation benefits, and controlling stress claims (*see infra* LEGISLATION), but the Wilson administration declined to participate in the legislative negotiations and the Governor vetoed the bills on September 23, calling them "fig leaf reforms and cosmetic changes." Before he took action on the bills, Governor Wilson ordered the legislature into an October 8 special session to deal with the worker's compensation system, but the pre-election timing of the session portends excessive partisan politicking rather than a sincere effort to deal with the issue on its merits.

Health Care Stalemate Continues. Once again, all meaningful attempts to revamp California's health care system were stymied in 1992. Of the numerous proposals covered previously *[12:2&3 CRLR 173–74]*, only a scaled-back version of Commissioner Garamendi's proposal—embodied in SB 6 (Torres)—was passed by the legislature, but was vetoed by Governor Wilson on September 30 (*see infra* LEGISLATION). AB 502 (Margolin), a similar Garamendi-sponsored bill, died in committee. SB 308 (Petris), the Health Access Coalition's universal health care coverage single-payor bill modeled after the Canadian system, died its final death in August when the Senate refused to concur in Assembly amendments. SB 248 (Maddy) and AB 2001 (Brown), both of which contained the California Medical Association's "Affordable Basic Health Care Act" requiring most employers to provide basic coverage to employees, died in committee; thus, CMA must pursue its proposal through Proposition 166 on the November ballot.

DOI Charges Allstate Mishandled Oakland Hills Fire Claims. On September 23, Commissioner Garamendi announced that the Department charged Allstate Insurance Company and eight of its agents with 153 illegal underwriting and claims handling acts in connection with the devastating 1991 Oakland Hills fire. Garamendi stated that he would seek the maximum penalty against the insurer and the agents, including combined fines of up to $2.5 million, suspension or revocation of the agents' licenses, and a one-year suspension of Allstate's license to operate in California. Allstate issued a statement affirming the company's commitment to "getting to the bottom of the issues" addressed by DOI and "resolving them as quickly as possible and in the best interests of our customers."

At this writing, Allstate and its agents are scheduled to appear at a January 11 hearing on DOI's charges.

Auditor General Evaluates DOI's Regulatory Practices Aimed at Controlling Insurer Insolvencies. In June, the Office of the Auditor General (OAG) released a fairly critical report on its audit of DOI's regulatory practices aimed at early detection of problems that can lead to an insurer's insolvency. OAG's review included an evaluation of fourteen insol-

vent insurers, of which nine were incorporated in California. These insolvencies include Great Republic Insurance Company *[11:4 CRLR 133]*, Executive Life Insurance Company, and First Capital Life Insurance Company of San Diego *[11:3 CRLR 128]*.

Although OAG found that DOI identified problems which contributed to the insolvencies, it did not always take prompt and decisive action. Instead of taking effective regulatory action to correct the problems and mitigate the harm to policyholders. Instead, DOI frequently relied on informal, inadequate, and time-consuming mechanisms that failed to yield any appreciable results. (*See supra* agency report on OAG for a more detailed summary of the audit.)

Commissioner Garamendi's response to the audit report was quite positive. He generally concurred with the report's findings and noted that, under his supervision, DOI has already implemented many of the recommendations suggested by OAG. Specifically, the Commissioner noted that significant advances in automating the financial analysis process have resulted in the creation of an early warning system which considers data not used previously. Also, DOI has secured funding to form a full-time Troubled Companies Unit for a one-year trial period. The Unit will be responsible for the full-time monitoring of those companies identified as being in need of immediate regulatory attention, and will also be the core group which supports troubled company teams formed to handle specific troubled companies.

LEGISLATION

SB 10 (Lockyer), a major auto insurance reform bill, was passed by the legislature on the last day of the session and vetoed by Governor Wilson on September 26. Opposed in its final form by the trial lawyers, insurance industry, and physicians' lobbies, SB 10 contained numerous provisions which would cut the costs of litigating auto insurance claims. Among other things, the bill would have increased the jurisdiction of small claims court to $10,000 for auto accident cases; attorneys could represent parties in small claims court, but their contingency fee would be limited to 20% of any recovery unless the court awards a higher fee. The bill would also have required judicial arbitration of all automobile personal injury cases under $50,000, and provided for increased sanctions where an appellant does not improve the arbitration decision by 20% or more in his/her favor. The bill would also have required insurers to offer to sell a "no-litigation" policy in which the insured agrees to submit any third-party "non-serious" bodily injury claim arising out of an auto accident to binding arbitration. It also would have limited double recoveries by modifying the collateral source rule in personal injury cases arising out of an auto accident; any settlement, arbitration, or judgment award would be reduced by any benefits received from health insurers or auto insurers under a first-party policy, up to a maximum of $3,000.

To control health care costs, SB 10 would have established a fee schedule for health care provided to a person injured in an automobile accident; the schedule would be promulgated by the Insurance Commissioner and based on the workers' compensation fee schedule.

SB 10 would also have required mandatory exchange of information between parties to an auto accident at the time of an injury accident; required drivers to notify their own insurers of an injury accident; and required an injured party to notify a third-party insurer of a potential claim within ten days of discovering the injury and learning the identity of the third-party insurer. The bill would have reduced existing financial responsibility requirements, and required vehicle owners to show proof of insurance coverage at the time of vehicle registration. It also would have established a target price of less than $350 for the sale of a basic policy without property damage liability coverage (Senator Lockyer contended that such a policy could be sold for $288), and a target price of less than $450 for a basic policy with property damage liability coverage.

In his veto message, Governor Wilson stated that the bill "fails to achieve comprehensive reform of the auto insurance system because it doesn't address the underlying forces causing the greatest increases in costs, particularly in the bodily injury liability system." The Governor—a no-fault insurance advocate—indicated a preference for a bill modeled after SB 941 (Johnston), a 1991 no-fault bill that was killed in the Senate Judiciary Committee (which is chaired by Senator Lockyer). *[11:3 CRLR 23–24, 33, 128, 131]*

AB 2329 (Peace) requires printed, radio, and television advertising by attorneys, medical care providers, and others soliciting the filing of a workers' compensation claim to include a notice specifying the penalties for filing a false or fraudulent claim. This bill was signed by the Governor on September 25 (Chapter 904, Statutes of 1992).

The following is a status update on bills reported in detail in CRLR Vol. 12, Nos. 2 & 3 (Spring/Summer 1992) at pages 174–79:

AB 69 (Margolin), SB 1539 (Lockyer), and **SB 1904 (Johnston)** comprised a package of triple-joined workers' compensation reform bills, such that none would become operative unless all three were enacted. All three were vetoed by Governor Wilson on September 23. The major provisions of the bills are as follows:

• ***AB 69 (Margolin)*** would have provided, among other things, that the employee and the employer may obtain only one evaluation of the employee's condition each (unless a referee finds that there is good cause to permit more); limited the employer's and the employee's evaluation costs (and any necessary tests or consultations) to $2,500 each; provided that the employee may not obtain evaluations for 60 days after the injury is reported, except in emergencies; reduced evaluation fees by 20% and then frozen fees for two years; and limited evaluation fees to 50% of the fee schedule amount in noncompensable cases. It would have required the Department of Industrial Relations' Division of Workers' Compensation to adopt a defense attorney fee schedule, and clarified that judges may deny payment for permanent disability evaluations which cannot be rated or which were obtained prior to any dispute between the employer and the injured worker; regarding the medical fee schedule, AB 69 would have established the fee schedule as maximum rather than presumptive, and required the fee schedule to cover hospitals, drugs, and new procedures.

Regarding stress claims, the bill would have required the worker to prove that workplace events were the predominant cause of a psychiatric injury (rather than the 10% in current law); barred claims filed after termination unless the worker proves that a sudden and extraordinary workplace event caused the psychiatric injury; and made claims resulting solely from lawful terminations and layoffs not compensable.

Regarding vocational rehabilitation, AB 69 would have reduced the employee's permanent disability benefits by up to 10% for vocational rehabilitation maintenance allowance payments received; capped allowable benefits for the various elements of vocational rehabilitation plans; and limited maintenance benefits to 52 weeks, beginning when the plan is approved.

AB 69 also would have required licensure for workers' compensation insurance adjustors effective January 1, 1994, and

beefed up penalties for workers' compensation insurance fraud.

• ***SB 1539 (Lockyer)*** would have increased maximum indemnity benefits from the current $336 per week to $448 per week for temporary disability, effective for injuries occurring after July 1, 1993; from the current $140 per week to $162 per week for permanent disability in cases where the worker's permanent disability rating is less than 25%, effective for injuries occurring after January 1, 1994; and from $148 per week to $170 per week for permanent disability benefits in cases where the worker's disability rating is greater than 25%, effective for injuries occurring after January 1, 1994.

• ***SB 1904 (Johnston)*** would have authorized employers to use a managed care organization to provide workers' compensation medical care if the employer provides health insurance for workers, and allowed employees to receive medical treatment from their own physician if the doctor was designated before the injury and agrees to accept managed care restrictions. It would also have repealed the existing minimum rate law regulating workers' compensation insurance effective January 1, 1994, and replaced it with a system of competitive rating based on the recommendations of the Workers' Compensation Rate Study Commission.

In his veto message, Governor Wilson noted that the package contained "potentially meritorious provisions," but stated "there are so many exceptions and limitations to the application of the reforms that most of the cost savings predicted by the authors would likely not be realized....This package is not nearly adequate to provide the measure of reform so clearly and urgently required if our workers' compensation system is not to continue to put California's jobs climate in serious jeopardy. It will preserve the gross inefficiencies of the system, exacerbate the burden on small employers, and increase the cost of workers' compensation to California employers." Subsequently, Governor Wilson called the legislature into an October 8 special session to address the workers' compensation issue (*see supra* MAJOR PROJECTS).

AB 2811 (Brulte). Existing law requires the Insurance Commissioner to approve or issue a reasonable plan for the equitable apportionment among certain insurers of applicants for automobile bodily injury and property damage liability insurance who are unable to procure that insurance through ordinary methods; this plan is commonly known as the California Automobile Assigned Risk Plan (CAARP). This bill requires judicial review of rate revision proceedings to be in accordance with specified standards. This bill was signed by the Governor on September 29 (Chapter 1256, Statutes of 1992).

AB 2605 (Peace) provides that where an insurer refuses to accept an applicant for a good driver discount policy or refuses to issue a good driver discount policy when written application has been made, and where the applicant meets the criteria for a good driver discount policy, the refusing insurer shall furnish the applicant with a written statement within ten days explaining the reason(s) relied upon for denying insurance coverage. Existing law requires that the Department of Motor Vehicles (DMV) be notified when a CAARP insurer rejects an application for insurance coverage; this bill instead requires notification to DOI. This bill was signed by the Governor on September 29 (Chapter 1255, Statutes of 1992).

AB 2875 (Lancaster). Proposition 103 requires the Insurance Commissioner to notify the public of any application by specified insurers for a rate change; that application is deemed approved 60 days after public notice, except as specified. This bill provides, notwithstanding those exceptions, that a rate change application is deemed approved 180 days after the rate application is received by the Commissioner unless that application has been disapproved by a final order of the Commissioner subsequent to a hearing. This bill was signed by the Governor on September 29 (Chapter 1257, Statutes of 1992).

AB 2042 (Lancaster) would have required CAARP to use rates that are actuarially sound so that there is no subsidy of the plan, and would have required the Commissioner to approve necessary rate increases. This bill was vetoed by the Governor on September 30.

AB 2078 (Gotch) would have enacted provisions similar to repealed provisions of the Robbins-McAlister Financial Responsibility Act which require drivers to provide evidence of financial responsibility; a violation of those provisions would have been grounds for a civil penalty. This bill was vetoed by the Governor on September 30.

SB 6 (Torres) was sponsored by Commissioner Garamendi as a first step towards comprehensive reform of California's health care financing and delivery system. As passed by the legislature on August 27, the bill would have created the seven-member California Health Plan Commission composed of business, labor, and consumer representatives, and charged with establishing—within certain guidelines—the California Health Plan, a system of universal health coverage for all California residents. The bill would have required the Commission to develop a unified system, including health insurance and the health components of auto insurance and workers' compensation; establish regional health insurance purchasing corporations which would contract with and pay a uniform but risk-adjusted premium to private health plans for individuals choosing to enroll therein, and assure that, in each region, individuals have a choice of at least two plans which charge no additional premiums to subscribers choosing to enroll. The Plan would be financed by assessments on employers, employees, and self-employed persons; costs would be controlled through competition between plans, reductions in administrative costs and inappropriate care, co-payments, and the adoption of an overall health care budget. Under SB 6, the Commission would sunset in 1995, the target date for implementation of the universal coverage system.

Governor Wilson vetoed SB 6 on September 30. Noting its "commendable goals," the Governor stated that the bill "cannot be separated from the economic realities facing California business and our state," and criticized the bill's funding mechanism for "burden[ing] our employers, particularly our small employers, with yet another mandate of entitlements for our citizens, when we cannot assure that the economic engine of our state can support that entitlement in both the near and the long term."

AB 1672 (Margolin), sponsored by the Wilson administration, enacts a comprehensive scheme for providing health insurance to small employer groups by, among other things, requiring health care service plans (HCSPs) and other health plans to fairly and affirmatively offer, market, and sell health benefits coverage to all small employers in a service area in which the carrier makes coverage available or provides benefits; authorizing the creation of the California Small Group Reinsurance Fund, to provide reinsurance to those electing to participate; providing for the adoption of regulations by the Commissioner of Corporations and the Insurance Commissioner; and transferring the California Major Risk Medical Insurance Program from the Business, Transportation and Housing Agency to the Health and Welfare Agency. This bill was signed by the Governor on September 28 (Chapter 1128, Statutes of 1992).

SB 1333 (Torres). Existing law

provides for an Office of Statewide Health Planning and Development within the Health and Welfare Agency; the Office has certain health planning, research development, and data collection responsibilities. This bill requires that the Office, after consultation with the Insurance Commissioner, the Commissioner of Corporations, the State Director of Health Services, and the Director of Industrial Relations, adopt specified uniform billing form formats acceptable for billing under certain federal law. This bill was signed by the Governor on September 28 (Chapter 1133, Statutes of 1992).

AB 306 (Bronzan) requires group disability insurers which offer coverage for disorders of the brain to also offer coverage in the same manner for the treatment of biologically-based severe mental disorders, and includes bipolar disorders in addition to delusional depressions within those biologically-based severe mental disorders. This bill also authorizes an insurer—with respect to specified provisions regarding coverage for disorders of the brain—to reserve the right to confirm diagnosis and to review the appropriateness of specific treatment plans as necessary to ensure that coverage is provided for only those diagnostic and treatment services which are medically necessary. This bill was signed by the Governor on August 9 (Chapter 462, Statutes of 1992).

SB 925 (Torres), an urgency bill known as the Medicare Supplement Act of 1992, enacts comprehensive provisions regulating HCSP contracts that supplement Medicare (frequently called "Medigap" policies) by—among other things—establishing requirements for a disclosure form and for disclosures in connection with applications, including a buyer's guide; imposing various requirements on HCSPs offering Medicare supplement contracts, including requirements related to marketing, and would prohibit twisting, high pressure tactics, and cold lead advertising, as defined; and requiring contracts to be approved by the Commissioner of Corporations. This bill was signed by the Governor on July 21 (Chapter 287, Statutes of 1992) and became effective immediately.

SB 921 (Committee on Insurance, Claims and Corporations) appropriates $254,000 to DOI from the Insurance Fund for purposes of implementing the Medicare Supplement Act of 1992. This bill was signed by the Governor on September 27 (Chapter 1014, Statutes of 1992).

AB 2608 (B. Friedman) requires that insurance placed with nonadmitted insurers be unavailable from insurers admitted for that class of insurance; requires that each surplus line broker be responsible for ensuring that a diligent search is made among insurers that are admitted to transact and are actually writing the particular type of insurance in this state before procuring the insurance from a nonadmitted insurer; and requires each surplus line broker to file with the Commissioner a written report, that shall be kept confidential, regarding insurance placed with a nonadmitted insurer, and requires the report to include specified information. This bill was signed by the Governor on September 29 (Chapter 1205, Statutes of 1992).

AB 2049 (Isenberg) repeals the Green, Hill, Areias, Farr California Residential Earthquake Recovery Act; provides for the payment of claims arising before the repeal; and requires the refund of fees to policyholders by insurers and for reimbursement of insurers by the Commissioner for return of those fees. *[12:2&3 CRLR 173; 12:1 CRLR 121–22]* This bill was signed by the Governor on September 29 (Chapter 1251, Statutes of 1992).

SB 1666 (Johnston) expands the Commissioner's authority, as specified, to examine the activities, operations, financial condition, and affairs of all persons transacting the business of insurance in this state or otherwise subject to the jurisdiction of the Commissioner, and requires the Commissioner to conduct an examination of every insurer admitted in this state not less frequently than once every five years. This bill was signed by the Governor on September 8 (Chapter 614, Statutes of 1992).

AB 3336 (Brulte). Existing law does not require the Insurance Commissioner to provide the text of emergency regulations and other specified information to persons who have filed a request for notice of regulatory action with DOI prior to their submission to OAL for approval. This bill requires the Commissioner to issue a notice of proposed emergency action, including a copy of the proposed emergency regulation, to interested parties at least five working days prior to the submission of emergency regulations to OAL. This bill was signed by the Governor on September 20 (Chapter 793, Statutes of 1992).

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

SB 233 (Presley) was substantially amended and is no longer relevant to DOI.

The following bills died in committee: **AB 2431 (Bronzan)**, which would have, for purposes of Proposition 103's auto rating factors, defined the term "a substantial increase in the hazard insured against"; **AB 2445 (Horcher)**, which would have provided that no surplus line broker may solicit from and place with any nonadmitted foreign or alien insurer any automobile bodily injury, property damage liability, or medical payment insurance covering private passenger automobiles or motorcycles unless the insurer has submitted certain documentation to DOI and met certain requirements; **SB 1371 (Deddeh)**, which would have provided that an insurer which acts in accordance with specified regulations issued by the Commissioner is entitled to recover attorneys' fees and costs where legal action challenging a determination results and a court sustains the insurer's determination of fault; **SB 2030 (Torres)**, which would have required an insurer to explain the manner in which its rating plan provides for any change in the premium based upon accidents or convictions; **SB 1640 (Roberti)**, which would have directed the Insurance Commissioner to conduct a study and report to the legislature concerning the development of alternatives for improving the efficiency and cost-effectiveness of existing dispute resolution mechanisms related to automobile insurance claims; **AB 3657 (Horcher)**, which would have provided for the regulation of health benefit plans for enrolled employees of a small employer, as defined, and their dependents; **SB 248 (Maddy)** and **AB 2001 (Brown)**, which would have enacted the California Medical Association's Affordable Basic Health Care Act of 1992, re-

quiring every non-exempt employer to provide basic health care coverage to each employee and dependent, including—among other things—payment of at least 75% of the lowest premium for basic health care coverage the employer offers each covered employee and dependent; **AB 14 (Margolin)**, which would have enacted a phased-in program to provide health coverage to all currently uninsured California residents through the use of a "pay or play" requirement for employers; **AB 2575 (Margolin)**, which would have directed the Insurance Commissioner to conduct a study and report the findings to the legislature concerning the need for universal health coverage; **AB 2070 (Isenberg)** and **AB 755 (Hansen)**, which would have enacted a comprehensive scheme for providing health insurance to small employer groups which would—among other things—require each small employer insurance carrier, except a self-funded employer, to fairly and affirmatively market health benefits coverage to all small employers in a service area in which the carrier makes coverage available or provides benefits; **AB 2570 (Margolin)**, which would have—among other things—authorized restitution to be ordered in specified circumstances involving false and fraudulent workers' compensation claims; **SB 1585 (Bergeson)**, which would have, with respect to workers' compensation, prohibited the spouse or dependent of the qualified medical evaluator or consulting physician or an employee or employer of any of them from offering or accepting any rebate as inducement for the referred evaluation or consultation; **SB 1630 (Leonard)**, which would have provided that workers' compensation premium rates shall not be excessive, inadequate, or unfairly discriminatory, and required the Insurance Commissioner to approve or issue, as adequate for all admitted workers' compensation insurers, a classification of risks and minimum premium rates relating to California workers' compensation insurance; **SB 1923 (Marks)**, which would have revised existing law regarding unfair practices in the business of insurance to specifically include, as an unfair practice, discrimination based on an individual's race, religion, national origin, marital status, or sexual orientation in the rates charged for any contract of insurance or in other benefits payable or in any other of the terms and conditions of the contract; **AB 3176 (Lempert)**, which would have—among other things—required that the mandatory orientation that applicants for a child day care license must attend prior to licensure disclose that insurers offering commercial and homeowners insurance are required to offer liability insurance for family day care homes; **SB 2060 (Hill)**, a reintroduction of SB 941 (Johnston), a no-fault auto insurance bill killed by the legislature in 1991; **AB 1375 (Brown)**, which would have eliminated liability for vehicular property damage in most cases (and allowed those claims to be handled on a no-fault basis), but left the current fault-based tort system largely intact for personal injury claims; **SB 340 (Torres)**, Senator Torres' compromise between SB 941 (Johnston) and AB 1375 (Brown); **AB 744 (Moore)**, which would have imposed 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, and would have required DOI's Bureau of Fraudulent Claims to establish a pilot project in Los Angeles County to combat automobile insurance fraud, with the additional assessment being used exclusively for that purpose; **SB 36 (Petris)** and **SB 308 (Petris)**, which would have dramatically restructured California's health care delivery system by establishing the state as the principal payor of medical care, and shifting financing from an employer-based system to a tax-based system; the bill would have extended basic health benefits, including long-term care, to every resident of California; **AB 321 (Margolin)**, which would have enacted the California Family Health Plan Act and created 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; and **SB 364 (Robbins)**, which would have required all companies providing specified insurance in this state and all nonprofit hospital plans doing business in this state to establish a toll-free telephone number to receive telephone calls regarding claims, complaints, questions, or other inquiries.

LITIGATION

The writ trial in ***20th Century Insurance Company v. Garamendi***, No. BS016789 (Los Angeles County Superior Court), was scheduled to commence on November 30. This case represents the long-awaited "as applied" constitutional challenge to Proposition 103's rate rollback provision and the regulations adopted by Commissioner Garamendi to implement it. The rollback provision requires companies to scale back their rates to November 1987 levels minus 20%, and to refund that amount on a pro rata basis to policyholders. In 1991, Commissioner Garamendi ruled that 20th Century must rebate $106 million to its auto, homeowner, and business insurance policyholders. Following that decision, the company exhausted its administrative remedies by requesting and receiving an hearing before a DOI administrative law judge. Last May, ALJ Elizabeth LaPorte substantially upheld the Commissioner's decision, recommending that the company refund $101.8 million to its policyholders; Commissioner Garamendi adopted her recommendation on May 8. *[12:2&3 CRLR 170–71]*

In November 1988, on the day after Proposition 103 passed, the insurance industry filed *Calfarm v. Deukmejian*, its challenge to the facial constitutionality of all aspects of the initiative; on May 4, 1989, the California Supreme Court upheld the vast majority of the measure [48 Cal. 3d 805 (1989)]. While the court had problems with Insurance Code section 1861.01(b)'s "insolvency standard" (which provides for relief from rate reduction requirements only for insurance companies which are "substantially threatened with insolvency"), it interpreted the provision to require the state to permit the insurers a fair rate of return on their investment. *[9:3 CRLR 86–87]* Thus, the 1987-rates-minus-20% rollback requirement may be imposed only to the extent that insurance company owners are afforded a fair rate of return.

In its lawsuit, 20th Century challenges the authority of the Commissioner to regulate an insurer's rate of return as opposed to premium rates. The company alleges that the Commissioner's sole authority is to disapprove rates that are shown to be excessive, inadequate, or discriminatory. The company also challenges the generic regulations adopted by Commissioner Garamendi to implement the rollback provision. Among other things, these regulations impose a 10% rate of return; set tough, industrywide efficiency standards; exclude entire categories of expenses, including political contributions, lobbying, and fines and penalties for unfair and discriminatory conduct; impose stringent caps on executive salaries paid for by premiums; and establish standards for permissible company reserves. *[11:3 CRLR 129–30; 11:2 CRLR 121–22]*

In the lawsuit, Commissioner Garamendi is represented by Fredric D. Woocher and Michael J. Strumwasser, private attorneys who work on contract for the Commissioner and who have defended Proposition 103 and its implementation since the day it was passed. 20th Century is represented by Gary L. Fontana of the San Francisco law firm of Thelen, Marrin, Johnson & Bridges. Proposition 103 spon-

sor Voter Revolt and Allstate Insurance Company have intervened in the case, and a multitude of insurers are participating as *amici curiae*. Judge Dzintra I. Janavs is presiding; since mid-1990, she has handled all cases related to Proposition 103 under a consolidation order by the state Judicial Council.

In a separate case, ***Hartford Steamboiler Inspection and Insurance Co. v. Garamendi***, No. BC023983 (Los Angeles County Superior Court), Hartford and 142 other companies challenge the facial validity of Commissioner Garamendi's rollback regulations. *[12:1 CRLR 124]* Although this case is being kept separate from the *20th Century* case, the *Hartford* plaintiffs have intervened in *20th Century* on the issue of the validity of the Commissioner's "leverage factor" regulations, which is the generic method of computing a company's capital for purposes of the rollback. *[11:2 CRLR 121–22]*

In other Proposition 103-related litigation, the insurers have appealed Judge Janavs' dismissal of ***General Insurance Co. of American v. Garamendi***, No. BC036620, and ***California State Automobile Association Inter-Insurance Bureau v. Garamendi***, No. BC044991. In those cases, Judge Janavs upheld the authority of Commissioner Garamendi to substitute new rollback regulations for those adopted by his predecessor. The insurers are also appealing the decision of U.S. District Court Judge Charles A. Legge to dismiss ***Fireman's Fund v. Garamendi***, No. C91-2854, and ***United States Fidelity and Guaranty v. Garamendi***, No. C91-2855, on ripeness grounds and the federal abstention doctrine. Finally, the California Supreme Court denied the insurers' petition for review in ***Wilshire Insurance Co. v. Gillespie***, No. S026820 (July 9, 1992). In that case, the Second District Court of Appeal unanimously upheld Judge Janavs' September 1990 ruling that 400 insurance companies are not exempt from Proposition 103's rollback provision because former Commissioner Roxani Gillespie failed to schedule administrative hearings on their demands for exemptions within 60 days of the demands. *[12:2&3 CRLR 179]*

In ***California State Automobile Association Inter-Insurance Bureau v. Garamendi (California Automobile Assigned Risk Plan (CAARP), Real Party in Interest)***, No. A049887 (May 29, 1992), the Second District Court of Appeal unanimously affirmed orders of the San Francisco Superior Court and the Insurance Commissioner which required the appellant insurer to accept assignment of automobile insurance risks on a statewide basis, and created a special Urban Credit Program for risk assignments in certain urban areas. Under the CAARP scheme, all auto insurers writing business in California must write their fair share of policies to drivers with poor records; the Insurance Commissioner is responsible for developing a "reasonable plan for the equitable apportionment" of assigned risks among insurers, based upon a ratio or quota derived from the percentage of voluntary policies they write in the state.

In 1987, due to an increasing number of assigned risks in southern California and some insurers' refusal to accept risks from that area, former Commissioner Gillespie instituted a new method of statewide, random risk assignment; she also created (and later abandoned) the Urban Credit Program to encourage insurers to write policies in heavily urbanized areas which appear "exceptionally undesirable to automobile insurers as a result of the nature of the risks involved and the alleged inadequacy of the rates which insurers are allowed to charge for coverage in those areas."

Prior to these actions, California State Automobile Association Inter-Insurance Bureau (Bureau) had traditionally accept assignments of risks from the northern and central areas of California, its preferred areas of operations. As a result of Gillespie's new programs, it was required to accept risk assignments from southern California, and it was unable to fully benefit from the Urban Credit Program since it did not voluntarily write policies in the urban areas of southern California. According to the court, "[t]he interaction of the Urban Credit Program and the statewide random assignment of risks approved by the Commissioner...caused the Bureau, which had previously limited its business to the northerly portions of the state, to suddenly begin to receive large numbers of assignments from actuarially undesirable urban portions of Southern California. The Bureau contends that it thereby suffered an actuarial loss in the tens of millions of dollars."

During the early stages of this case, Commissioner Gillespie suspended the Urban Credit Program; however, the Bureau pressed its claims as to both programs. The trial court ruled against the Bureau on both issues, and the Second District affirmed, finding that both programs were consistent with the Commissioner's statutory mandate, not arbitrary or capricious, and supported by substantial evidence. While finding that the Urban Credit Program presented particularly "troubling" issues, the court noted that "the Legislature has obviously given the Commissioner great discretion in fashioning a specific response to the problems encountered in fulfilling the overall goals of the assigned risk laws." The court even declined to interfere with Commissioner Gillespie's policy decision not to relieve the Bureau of its already accrued obligations under the Urban Credit Program after its suspension, finding that the Commissioner exercised her discretion pursuant to an expansive delegation of authority by the legislature. "It is not to the courts that the Legislature granted this discretion and power. Rather, where as here the discretion in issue resides in the administrative agency, 'mandate will not lie to compel the exercise of such discretion in a particular manner.' A writ of mandate 'is not a writ of right to be freely issued whenever a court disagrees with the policy of the administrative action'" (citations omitted).

In ***Bank of the West v. Superior Court***, 2 Cal. 4th 1254 (July 30, 1992), the California Supreme Court ruled that an "advertising injury," although defined as "unfair competition" in the coverage of most standard comprehensive general liability (CGL) policies, is limited to advertising. It does not embody the entire panoply of "unfair competition" offenses covered by California's "Little FTC Act," Business and Professions Code section 17200, which prohibits "unfair" acts in competition. *[12:2&3 CRLR 180; 11:2 CRLR 126, 186]* This decision dashed the hopes of many who were looking to CGL policies to pay multimillion-dollar claims against failed savings and loan associations for a wide spectrum of "unfair" competition acts. Although the appellate court held that the standard CGL policy must be broadly interpreted and that any ambiguity must be construed against the insurer, the Supreme Court ruled that courts must first attempt to discern and effectuate the mutual intention of the parties. The court also held that the "'advertising injury' must have a causal connection with the insured's 'advertising activities' before there can be coverage"; in this case, the court found that the acts underlying the claims did not occur in the course of the bank's advertising activities within the meaning of the CGL policy.

In ***Federal Trade Commission v. Ticor Title Insurance Company***, 112 S. Ct. 2169, No. 91-72 (June 12, 1992), the FTC filed an administrative complaint against six of the nation's largest title insurance companies, alleging horizontal price fixing in their fees for title searches and examinations. Among other things, the companies asserted the defense of state

action immunity, on grounds their state insurance departments are authorized to regulate rates. The FTC rejected the defense, but the court of appeals reversed.

The U.S. Supreme Court reviewed the findings of the FTC's administrative law judge with regard to the insurance regulatory schemes in four states (Arizona, Montana, Connecticut, and Wisconsin), and the two-pronged test for state action immunity under *Parker v. Brown*, 317 U.S. 341 (1943), and its progeny: The state must articulate a clear and affirmative policy to allow the challenged anticompetitive conduct, and the state must provide active supervision of anticompetitive conduct undertaken by private actors. The Court held that the regulatory schemes in Wisconsin and Montana failed to afford active state supervision because, in those states, private rating bureaus establish title insurance rates and file them with the insurance regulator. Both states use a "negative option" system to approve rate filings; that is, the rating bureau files the rates, and they become effective unless the regulator rejects them within a specified time period. According to the Court, "[a]lthough the negative option system provides a theoretical mechanism for substantive review, the ALJ determined, after making detailed findings regarding the operation of each regulatory regime, that the rate filings were subject to minimal scrutiny by state regulators."

In this context, the 6–3 majority rejected the state action defense asserted by the insurance companies. "This case involves horizontal price fixing under a vague imprimatur in form and agency inaction in fact. No antitrust offense is more pernicious than price fixing. In this context, we decline to formulate a rule that would lead to a finding of active state supervision where in fact there was none" (citation omitted).

The dissent argued that the decision gives too much power to the federal courts interpreting broad antitrust concepts and judging what is and is not adequate state supervision where states authorize restraints of trade. However, the majority—in upholding the better rule—held that state authorization of serious restraints of trade allowing private parties to form cartels, fix prices, or otherwise replace or subvert the marketplace must be supervised in some minimally effective manner by a state agency substituting for the absent marketplace as appropriate.

DEPARTMENT OF REAL ESTATE

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

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

DRE primarily regulates two aspects of the real estate industry: licensees (as of September 1992, 260,133 salespersons and 115,613 brokers, including corporate officers) and subdivisions.

License examinations require a fee of $25 per salesperson applicant and $50 per broker applicant. Exam passage rates averaged 56% for salespersons and 48% for brokers (including retakes) during the 1991–92 fiscal year. License fees for salespersons and brokers are $120 and $165, respectively. Original licensees are fingerprinted and license renewal is required every four years.

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

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

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

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

MAJOR PROJECTS

Office of Real Estate Appraisers Update. The federal Financial Institutions Reform, Recovery and Enforcement Act of 1989 requires all states to institute a licensing and certification program for real estate appraisers who engage in federally-related appraisal activity, which is estimated to comprise nearly 95% of all transactions. In response to the federal mandate, California enacted AB 527 (Hannigan) (Chapter 491, Statutes of 1990), which created the Office of Real Estate Appraisers (OREA) within the Business, Transportation and Housing Agency; OREA is not affiliated with or located within DRE. *[12:2&3 CRLR 181]* Although the original effective date of the program was July 1, 1991, subsequent extensions moved the effective date to July 1, 1992. Further, SB 1958 (Presley)