In Re American Continental Corporation/Lincoln Savings and Loan Association, No. 589302 (Orange County Superior Court), the class action filed on behalf of 23,000 investors who lost approximately $300 million in the collapse of Lincoln/ACC through their purchase of now-worthless junk bonds, has also been transferred to Judge Bilby. The Department was dismissed as a named defendant in this action in May 1990. Plaintiffs' objection to the transfer to federal court (triggered by defendants' filing of cross-complaints alleging federal questions) is still on appeal in the U.S. Court of Appeals for the Ninth Circuit. The March 1991 trial date in the class action has been postponed until at least January 1992. At this writing, partial settlements totalling $40 million have been negotiated and approved by the court.

DEPARTMENT OF INSURANCE

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

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

In California, the Insurance Commissioner licenses approximately 1,450 insurance companies which carry premiums of approximately $53 billion annually. Of these, 650 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) regulates compliance with the general rating law; 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 ten 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:

Personnel Changes at DOI. DOI Commissioner John Garamendi, the first elected Insurance Commissioner in the state's history, has made a number of interesting personnel changes in the Department. The newly elected Commissioner has hired as staff or as consultants a substantial number of people who have long been active in insurance issues on behalf of consumers—including two of his election opponents.

Walter Zelman, former executive director of California Common Cause and one of Garamendi's opponents in the November 1990 election, has been hired as a special deputy on health care matters, and to advise Garamendi on methods of protecting consumer interests. San Francisco plaintiffs' attorney Ray Bourhis, also an unsuccessful candidate for Insurance Commissioner, has been appointed as a DOI consultant and special master overseeing the settlement of his lawsuit challenging the Department's enforcement practices (*see infra* for details). Steven Miller, previously of the Insurance Consumer Action Network (ICAN), was appointed as deputy commissioner in charge of rate regulation and the implementation of Proposition 103. Commissioner Garamendi also hired Carl Oshiro, San Francisco litigation director for the Center for Public Interest Law and an experienced public interest attorney previously associated with Consumers Union, to serve as a DOI administrative law judge.

In addition, former California deputy attorneys general Michael Strumwasser and Fred Woocher were hired as contract counsel to the Department, to continue their work on proposed rules to implement Proposition 103, particularly the rollback and prior approval rate review systems. Since 1989, both have taken the lead within the office of former Attorney General John Van de Kamp in defending Proposition 103 and urging its full implementation. However, in early May, new Attorney General Dan Lungren announced that his office is concerned over the possible application of "revolving door" prohibitions on the annual contract signed by Strumwasser and Woocher, in light of their prior service for the Attorney General in representing the Commissioner in a public capacity. Both Strumwasser and Woocher disputed the application of any prohibitory law to their contract, and Lungren has not pursued the matter to date. However, the Attorney General retains the discretion under law to approve outside contracts for legal services for state agencies, and is not expected to approve a subsequent contract or renewal for Strumwasser and Woocher.

Former Commissioner Roxani Gillespie, although stating in December 1989 that she would not return to the insurance industry, recently accepted employment as an attorney with the insurance specialty law firm of Buchalter, Nemur,

Fields and Younger. One of the state's largest insurance firms, it represents Farmers and the American International Group. Under California's "revolving door" prohibitions, the former Commissioner is not permitted to participate personally in matters she decided as Commissioner, including the implementation of Proposition 103.

Garamendi Creates Task Force to Settle Lawsuit, Implement Unfair Practices and Enforcement System Statutes. On May 2, Commissioner Garamendi and San Francisco attorney Ray Bourhis announced the settlement of Bourhis' class action lawsuit against the Department, which successfully contended that DOI's dismal performance in the area of enforcement against its licensees— particularly in the area of unfair claims practices—is contrary to the Commissioner's duties under the Insurance Code.

In his June 1989 lawsuit, Bourhis—a plaintiffs' attorney and then-candidate for Insurance Commissioner—presented stark data on the many thousands of complaints received annually by the Department of Insurance in relation to virtually no record of disciplinary actions taken against licensees. In November 1989, San Francisco Superior Court Judge John Dearman ruled that former Commissioner Gillespie had wholly failed to exercise her discretionary power to prosecute insurance companies which violate the law, and that she had failed to comply with Insurance Code requirements to hold hearings in cases where consumers file legitimate claims against insurers. (See CRLR Vol. 10, No. 1 (Winter 1990) p. 110 and Vol. 9, No. 4 (Fall 1989) p. 97 for background information on this case.) Gillespie appealed the ruling, and Garamendi—represented by Strumwasser and Woocher—settled the case.

The importance of the Commissioner's vigorous enforcement of unfair claims and other unlawful practices of the insurance industry is emphasized by a series of court decisions over the past several years which has eliminated tort actions against insurers for bad faith failure to pay claims (or for other related bad faith conduct). (See CRLR Vol. 10, No. 4 (Fall 1990) p. 124; Vol. 9, No. 4 (Fall 1989) p. 97; and Vol. 8, No. 4 (Fall 1988) p. 87 for discussion of the *Tricor, Zephyr Park*, and *Moradi-Shalal* cases, respectively, which eliminated both third- and first-party bad faith claims against insurers.) These cases have specifically cited the appropriateness of enforcement of unfair practice statutes through the Office of the Insurance Commissioner as the appropriate societal mechanism for relief, primarily through the discipline of licensed insurers under the broad authority of Insurance Code section 790.03 prohibiting "unfair acts."

Under the terms of the settlement agreement, Garamendi agreed to "institute a comprehensive reform program to ensure the Department's full compliance with Insurance Code sections 12921, 790.03, and 790.05." The Commissioner also agreed to establish a task force "to explore and recommend reforms in Department procedures, including the adoption of new regulations, internal training procedures, internal and external enforcement mechanisms, and proposed legislative changes, if need be." In response to Bourhis' claims that DOI routinely shreds thousands of consumer complaints every year without investigating or tracking them, Garamendi stipulated that the Department would "modify the format of its internal files so that all pertinent information can be made available for public inspection and copying...[and that] all such files shall be maintained for a period of at least three years." Finally, Garamendi agreed to the court's appointment of Bourhis as special master and monitor of the Department's compliance with the terms of the settlement agreement. In that capacity, Bourhis must be afforded access to the Department's internal operating procedures, appointed as an ex officio member and consultant to the task force, and paid at a "reasonable hourly rate" for serving as a consultant to the task force.

Also on May 2, some forty members of the Commissioner's new Consumer Complaints and Unfair Practices Task Force met for the first time in San Francisco. The Task Force includes consumer advocates, insurance industry representatives, and members of the plaintiffs' and defense bar. The Task Force is chaired by UCLA law professor Michael Asimow, an expert in administrative law, former chair of California Common Cause, and one of the state's most respected public interest advocates.

The Task Force has divided into six subcommittees: auto insurance claims, surety insurance, title insurance, health/disability/life insurance, other commercial/personal insurance, and the SB 2569 (Rosenthal) Consumer Complaint Handling subcommittee. The first five subcommittees are assisting the Commissioner in fully defining the "unfair practices" prohibited by Insurance Code section 790.03(h), within each of the various lines of insurance. The SB 2569 Consumer Complaint Handling subcommittee will assist Garamendi in implementing the legislature's *post facto* attempt to join Bourhis' effort to improve consumer response by the Commissioner. The legislation (Chapter 1375, Statutes of 1990) added sections 12921.1-.6 to the Insurance Code, which require the Commissioner to "establish a program on or before July 1, 1991, to investigate complaints and respond to inquiries from [consumers]..., and, when warranted, to bring enforcement actions against insurers." The July date is being interpreted by the Commissioner to require the initial formulation of a new system rather than its full implementation.

Legislative critics have correctly noted that SB 2569 did not add a single provision not already within the clear power of the Commissioner. The statute appears to be a belated public relations attempt by the legislature to participate in a reform effort covering problems which, before the electorate's enactment of Proposition 103, it benignly neglected.

Members of the SB 2569 Consumer Complaint Handling Subcommittee are examining the current set-up of DOI's enforcement system. Currently, the vast majority of enforcement staff (approximately 140 out of a total of 180) are assigned to receive and mediate complaints one at a time, through one of three subject-matter units (the Claims Services Bureau, the Rating Services Bureau, and the Underwriting Services Bureau). This last entity also includes 38-40 staff members who answer inquiries and receive complaints over DOI's toll-free complaint line. Last year, this line received 345,000 phone calls, from which 45,000 complaint files were opened. These complaint handlers have no access to a computer system, make no record of calls received or the company/agent complained of, and do not track whether a written complaint form was mailed to the consumer. The Department readily acknowledges that it needs major improvements in the area of automation, and that its complaint tracking system enables it to engage in little "pattern detection" or other computerized gathering of complaints or problems by carrier in order to build cases for licensure discipline.

If a complaint is generated (either through the toll-free line, a written complaint, or some other manner), one of the three bureaus attempts to resolve it and satisfy the consumer for an unspecified period of time. This process is colloquially referred to as "strong-arming" or "jaw-boning," and may or may not succeed. Among other things, bureau staff's efforts in this area are hampered by a statutory prohibition which precludes the

Department from "adjudicating a claim" (Insurance Code section 12921.4); that is, determining questions of fact and the ultimate issue—whether a company should have paid a claim and the amount thereof.

If the bureau is unsuccessful in resolving the complaint, the case may be referred to DOI's Investigations Bureau, which employs only 32 investigators statewide. In addition to investigating the thousands of consumer complaints received every year, these 32 individuals are saddled with the responsibility of investigating the background of all applicants for DOI licensure, and investigating complaints of unlicensed practice. As may be expected, DOI's Investigations Bureau is plagued with a huge backlog of cases; staff admitted that a case may sit for as long as two years without even being assigned to an investigator.

If, after investigating a case, the Investigations Bureau finds that the evidence indicates a violation which should be disciplined, the case is forwarded to the Compliance Bureau, also referred to as the "black hole." The Compliance Bureau, which is staffed by only one director, six attorneys, and one legal assistant, receives 1,300-1,400 fully investigated cases per year. As is the Investigations Bureau, the Compliance Bureau is, in the words of its director, "seriously backlogged and we have been for years." According to enforcement staff, the Department's failure to properly resource the prosecution end of its enforcement system has resulted in serious morale problems for those on the intake and investigations side; they know that even if they receive, investigate, and work up a multiple-complaint case which is causing serious injury to numerous consumers, and despite the good intentions of the staff in the Compliance Bureau, the backlog in the Compliance Bureau will usually prevent that work from resulting in disciplinary action and consumer protection.

Critics argue that such a system creates no incentive for reasonable payment of claims or other practices by insurers until or unless a call is received from the Department in an attempt to mediate. Even where mediation results in corrective action, its cost, the resulting delay, and the many cases where consumers do not pursue the DOI remedy (or give up on it) all combine to abridge consumer rights. In light of these findings, this Task Force subcommittee is expected to recommend a system allowing for the aggressive discipline and sanctioning of those who repeatedly engage in abusive trade practices, including the development of a sophisticated computerized intake system, and the shifting of personnel from complaint handling to what is hoped will be a fully-staffed, deterrence-producing enforcement unit capable of timely investigating and prosecuting consumer complaints and issuing administrative sanctions.

Zelman Report Urges DOI Structural/Policy Changes. Related to the creation of the Consumer Complaints and Unfair Practices Task Force in settlement of the *Bourhis* case discussed above is a report released in April 1991 by Walter Zelman. In *The Regulator as Consumer Advocate: Recommendations for Strengthening the Consumer Protection Capacity of the California Department of Insurance*, Zelman sets forth an array of suggestions for structural and policy change within the Department. The study was conducted by Zelman while on special assignment for the Commissioner (prior to his appointment as a special deputy on health care/consumer protection matters) and involved the interview of approximately fifty California and national consumer advocates, experts, and government officials. Although the extensive list of options included in the report may not be implemented by the Commissioner, all of them are expected to be considered. The document is expected to be a focal point of reform discussion within the Department.

The report contains 45 pages of recommendations. It includes Zelman's suggestions relevant to consumer complaint handling and unfair insurance practice response, but extends substantially beyond these subjects to include a panoply of recommendations, ranging from advisable regulatory philosophies to specific goals in the regulation of auto and health insurance—two subjects of special and direct concern to consumers. Briefly, the report's more important or creative suggestions include the following:

-In general, the Commissioner should focus less on trying to mediate individual consumer disputes with insurance firms and more on preventive and deterrence-producing strategies to ameliorate complaints at their source. (This suggestion appears consistent with those of critics of the current system (discussed above) that DOI's current system focuses on cajoling insurers into paying legitimate claims or otherwise mediating disputes, rather than on deterrence-producing discipline.)

-The Commissioner should engage in long-range planning, and reach out to other constituencies not traditionally represented in Department proceedings, particularly low-income consumers.

-The Commissioner should have an "open" administration and adopt an ethics code to help restore public confidence in the Department.

-Insurance policies should be standardized where possible to facilitate comparison shopping; free media should be more extensively used to issue warnings and notify consumers of 800 or 900 numbers for comparison shopping information.

-Insurers should be assessed some of the costs of their discipline, and fines should be increased as a deterrence- producing sanction.

-DOI should make use of aggressive "sting" operations, and coordinate with law enforcement officials who enforce California's generic unfair competition statutes.

-The Department should hold public hearings on broad problem areas.

-Any one of a number of measures to create a partially independent "public staff division" to represent policyholders in DOI should be considered.

-The Commissioner should adopt rules to prohibit, limit, or record *ex parte* contacts with DOI decisionmakers, particularly in the context of rate and other adjudicatory proceedings.

-A liberal intervenor funding system should be established to stimulate consumer representation in often costly rate and other adjudicative proceedings; one novel alternative presented is a contract between the Department and a preselected consumer advocacy entity to represent policyholders on negotiated terms (rather than on a contingency basis where compensation depends upon DOI's adoption of the positions advocated by the intervenor).

-Auto insurance policies currently discriminate against the poor, and countervailing regulatory response is required—including possible policy standardization, reduction of territorial factors in ratesetting, and the adoption of a provision reducing the number of assigned risk (CAARP) policyholders a carrier must take in return for increased policy sales in poor areas.

-No-fault insurance should be objectively studied in the jurisdictions where it is now in force, and seriously considered as a means of reducing insurance policy costs.

-The Commissioner should study whether standard policies include appropriate reductions for safety/injury prevention measures by policyholders (such as the installation of air bags).

-The Commissioner should evaluate the efficacy of driving schools, which

enable offenders to cleanse violations and retain "good driver" low rates while accounting for disproportionate claims costs.

-As with auto insurance, health insurance needs justify regulatory cross-subsidies.

-Health insurance should not be sold on a year-to-year basis, and is closer to whole life policies than auto insurance.

-Increased attention should be given to long-term care insurance, particularly as the population ages. Because the wealthy can afford long-term care and the poor are covered through Medicare, Zelman characterized this issue as a prospective "middle-class crisis."

-The Department of Insurance should increase its regulatory authority and take the lead in intervening to assure low-cost supply of insurance, especially for the individual and small business marketplace.

Auto Insurance Politics Paralyzes the Legislature. Two competing auto insurance reform measures recently enjoyed major attention in the legislature. SB 941 (Johnston) offered a no-fault system similar to the current New York model. The measure was supported by Consumers Union, numerous other consumer groups, Governor Wilson, and portions of the insurance industry. It would have provided a new $220 no-frills, no-fault policy to all good drivers, providing $15,000 per person coverage for health care and wage losses. Claims would be filed with an injured party's own carrier regardless of fault. Supporters contended that, under SB 941, approximately 80% of all accident claims which end up in court would be paid without expensive legal proceedings. Advocates contended that society's interest in deterring unsafe conduct is best addressed civilly only in cases of serious damage, or through Vehicle Code infractions and criminal sanctions already in place. The measure was opposed by Voter Revolt (the consumer organization which sponsored Proposition 103 in 1988), Ralph Nader, some ethnic/minority groups, and the politically powerful California Trial Lawyers Association (CTLA). The bill was defeated on a 5-4 vote in the Senate Judiciary Committee on May 28, and Senator Johnston announced that "it's up to others now." Johnston has carried a no-fault bill for the past two years.

CTLA is sponsoring AB 1375, a competing automobile insurance reform measure introduced by Assembly Speaker Willie Brown, which is supported by Voter Revolt and some ethnic/minority groups. The measure includes an arbitration option, but preserves the full adjudication of fault and payment based on fault determination for recovery. It focuses on the prevention of fraud, improved safety enforcement, and other measures to achieve savings. The bill has not yet suffered final defeat, but Governor Wilson has declared that he will veto it if enacted. (For a discussion of the arguments and advocacy concerning these competing measures, *see supra* reports on ACCESS TO JUSTICE FOUNDATION, CONSUMERS UNION, and PUBLIC ADVOCATES.)

One of the legislators depended upon by SB 941 proponents to vote for it, Senator Art Torres, failed to do so. However, he has introduced his own measure, SB 340 (Torres), which seeks a compromise between the two alternatives. It would create a California Auto Plan (CAP), including a limited no-fault medical insurance feature ("Medpay") of up to $1,000 to low-income drivers for $35 per year, or up to $2,500 for $55 per year for the payment of direct medical costs by an insured's own company. It would allow insurance firms contesting a claim of under $50,000 to submit the matter to binding arbitration in order to lower costs. It would also allow insurers to establish economy-of-scale contracts with auto repair facilities, giving a policyholder a choice from among three.

SB 340 includes many of the anti-fraud and safety provisions of the Brown measure, including in particular the assessment of additional fees on each policy to finance local law enforcement auto fraud investigations and prosecutions, and additional resources for DOI's Bureau of Fraudulent Claims. The legislation would allocate 55 cents per vehicle insured to the Bureau. The bill also includes the Brown proposal's bumper standards and roadside inspections by the Bureau of Automotive Repair.

The measure would reverse the *Moradi-Shalal* decision precluding civil suits against insurers for bad faith (*see supra*), cap punitive damages to 25% of actual damages, and set a maximum on attorneys' fees in damages actions. It would also prohibit "capping" in soliciting auto insurance cases.

The CAP policy would be set at a minimum of $10,000/$20,000/$3,000 (down from the existing $15,000/$30,000/$5,000), and is intended to be priced at $300, although its cost may be as high as $500. Proof of insurance would be required at point of registration.

There is some interest in the Torres compromise effort, although eligibility (a means test limiting the policy to those with poverty level income), CAP policy prices, and whether the prices are to be cross-subsidized from other policyholders are issues which have not yet been entirely resolved. In addition, the 25% punitive damage cap is very low. As a compromise effort, the draft appears to include some terms which are unacceptable to all of the contending groups. However, most interests advocating for alternative proposals admit privately that it would represent a substantial improvement over the *status quo*.

Insurance Commissioner Garamendi has offered publicly to "mediate" the dispute between CTLA/Voter Revolt on the one hand, and the insurance industry/Consumers Union on the other. The Commissioner, although criticized during the 1990 election campaign as sympathetic to no-fault, is now perceived by those involved in the current contention to be aligned with CTLA, Voter Revolt, and Nader in opposing no-fault.

The current auto insurance dispute carries with it a pre-existing dispute which fractured groups representing consumers into two camps during the 1988 insurance proposition contest. Voter Revolt and Nader supported the successful Proposition 103, while Consumers Union and numerous other consumer groups supported a rival measure, Proposition 100, which was defeated. Interestingly, although CTLA supported Proposition 100, it has made peace with the proponents of Proposition 103, while the contending consumer groups continue to oppose each other's proposals with fervor.

DOI's Health Insurance Goals. Commissioner Garamendi has expressed special interest in addressing the problems of health insurance reform, including the expansion of coverage to the substantial number of Californians employed in small enterprises who do not qualify for Medi-Cal and are not served by employer- provided health insurance. The Commissioner has assigned Walter Zelman to research and recommend health insurance policy changes, including possible rulemaking and legislative recommendations.

On June 4, Garamendi publicly outlined his health care reform goals in an address to the American Association of Preferred Providers at UCLA. He endorsed in particular AB 321 (Margolin), which would guarantee health insurance coverage for pregnant women and young children. However, this bill appears likely to become a two-year bill, given the state's budget deficit as well as a number of omissions and ambiguities in the draft extant at this writing (including a failure to clearly define the extent of coverage and precise mechanisms for

pricing, and for regulatory review of coverage and rates).

The basic principles advanced by Garamendi in his health insurance policy statements involve disavowal of price variation based on the health risks of a particular group, but rather the imposition of "community rates" applicable broadly to all citizens in an area. The Commissioner has advocated socializing medical costs, with delivery on the basis of need.

Measures such as AB 321 are termed "pay or play" measures. They require employers to either provide health insurance to specified standards, or to pay into a fund so employees (and perhaps others) may receive a state-created alternative or subsidized private insurance. "Pay or play" systems, and other alternatives, maintain the current private system of health insurance providers. The conceptual alternative is represented by SB 36 (Petris), the single payor option. This approach is modeled after the Canadian system. All citizens are issued a card entitling them to medical care; the state is then billed. Proponents argue that a single payor would cut claims procedure costs (now a major increment of health care costs), create universal health care, and limit excessive profits by the health care industry. Although SB 36 passed out of the Health and Human Services Committee by a 7-0 vote on April 10, the current fiscal situation in California makes its 1991 passage doubtful.

The Commissioner has also announced his intention to restrict unnecessary or misleading "medigap" policies purchased by the elderly, many of which simply duplicate coverage already purchased. He has also pledged to establish a task force on long- term care insurance, and to appoint a coordinator for senior citizen health care issues.

Commissioner Seizes Executive Life, First Capital. On April 11, the Department of Insurance seized the assets of Executive Life Insurance Company (ELIC) and placed it in conservatorship. The action is the largest regulatory takeover of a life insurer in the nation's history. ELIC had been the subject of a corporate "raid." It received substantial monies through the acquisition of blue-collar pension funds, which it used to purchase over $6 billion worth of junk bonds, including low-quality corporate bonds used to finance the "raid" purchase of the firms whose pension funds ELIC then acquired. In other words, the pensions of thousands of workers accrued during their productive years, and upon which they now depend for their sustenance, were not maintained by a responsible fiduciary in secure investments. Rather, they were used as a source of funds for the speculative and highly leveraged buy-out of timber and other enterprises by corporate raiders seeking billions in quick profits.

Now in conservatorship, and until rehabilitated, ELIC's 175,000 holders of life insurance and another 75,000 annuity holders will not be permitted to borrow on their policies, nor will they be able to "cash out" for surrender value. The viability of much of the pension fund assets of the company is in doubt.

The Commissioner's seizure also included a prohibition on the writing of any new business. Garamendi is attempting to find financial service companies willing to assume operations of the viable assets of Executive Life. Garamendi's efforts may be stymied by an Internal Revenue Service attempt to collect more than $640 million in taxes it claims is owed the government. The back tax assessment covers alleged delinquencies for tax years 1981, 1982, and 1983, most of which is interest and penalties ($394 million). On April 22, Garamendi issued a press release criticizing the IRS for its belated attempt to collect taxes due eight to ten years ago to the prejudice of pensioners and others seeking redress. Garamendi declared, "Wealthy investors and traders earned hundreds of millions of dollars on Executive Life transactions during the 1980s, and not a peep was heard from the tax police. Now that we have conserved the company to salvage the life savings of smaller investors, the IRS has moved with lightning speed to cannibalize the vulnerable carcass of this company."

If Executive Life is liquidated, insureds are eligible for compensation from the California Life Insurance Guarantee Fund. However, the Fund is restricted in several respects, including a maximum payout to any one company holding a group insurance policy of $5 million.

On May 10, Commissioner Garamendi ordered First Capital Life Insurance Company of San Diego (First Capital) to cease writing new business and to stop honoring requests to redeem policies. At that time, the firm had junk bond holdings of over $2 billion, 40% of its total assets. Garamendi's order prompted creditors of First Capital's parent company, First Capital Holdings Corporation (FCHC), to seek Chapter 11 bankruptcy protection for the parent company on May 13. Also on May 13, the state of Virginia seized Fidelity Bankers Live Insurance Company, a Virginia-based subsidiary of FCHC. On May 14, Garamendi seized First Capital and placed it in conservatorship. After Executive Life, First Capital is the second-largest failure of a life insurer ever. At this writing, it will continue to pay death and annuity benefits, but the state is prohibiting policy redemptions and loans on policies. The Commissioner continues to negotiate with Shearson Lehman Brothers (an American Express subsidiary), First Capital's largest shareholder, to stabilize the company and reduce its junk bond exposure.

Judicial Decision Clears the Way for Proposition 103 Rulemaking. On April 9, Los Angeles County Superior Court Judge Dzintra I. Janavs dismissed yet another attempt by the insurance industry to thwart the implementation of Proposition 103. In its latest move, a significant portion of the industry challenged the authority of Commissioner Garamendi to scrap the regulations adopted by his predecessor to implement the initiative's rollback and prior approval provisions, and to adopt his own rules in Subchapter 4.8, Chapter 5, Title 10 of the CCR. (*See infra* LITIGATION; *see also* CRLR Vol. 11, No. 2 (Spring 1991) pp. 121-22 for background information on the insurers' challenge and a discussion of the differences between the previous rules and the Garamendi rules, including extensive disallowance of expenses, and required efficiency standards for carriers.) Thus, Commissioner Garamendi noticed public hearings in Los Angeles and San Francisco throughout June on economic and actuarial issues relevant to the rate rollback and prior approval rate review provisions of the proposition.

The Garamendi efficiency standards will impute certain overhead and other costs to insurers based on the performance of others. It is the position of the Commissioner that although the California Supreme Court ruled in *CalFarm v. Deukmejian*, 48 Cal. 3d 805 (1989), that licensed insurance firms are constitutionally entitled to a fair rate of return, they are entitled to such a rate only as to "prudent" costs and "used and useful" investment; that a free market would not allow a "fair" rate of return to an inefficiently operating entrepreneur; and that there is only an obligation to provide such a return to those firms which perform efficiently. The detailed criteria to measure efficiency and the specific rules likely to be adopted are the work product of former deputy attorneys general Strumwasser and Woocher, now on retainer to the Commissioner (discussed above). Although there is support for the imposition of efficiency standards in existing case law, the approach undertaken by Commissioner Garamendi as applied to insurance is largely a matter

of first impression. Its precedential value may be significant nationally, and has led to accusations that the objections of Attorney General Lungren to the renewal of the Strumwasser/Woocher contract may be partly stimulated by insurance industry pressure to inhibit their proposals.

After the finalization of the procedural rules, company-specific hearings are expected to adjudicate possible individual variations from the generic formulae.

On another Proposition 103 front, on March 29 the Commissioner readopted as emergency regulations his auto rating factor rules in subsections 2632.1-.18, Title 10 of the CCR. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 122 for background information.) These emergency rules allow auto insurance carriers to implement immediately the altered rating factors mandated by the terms of Proposition 103. These require the diminution (if not elimination) of territory (location of the residence of the insured) as a factor in varying rates between policyholders. Rather, driving record, driving experience (*i.e.*, number of years driving), and number of miles driven per year are the priority factors, with additional criteria set forth in the rulemaking. The emergency rule implementation requires the adjustment of rates between types of policyholders to take place in a revenue- neutral setting.

Proposed Antidiscrimination Rules. On May 15, the Commissioner noticed his intent to adopt section 2646.6, Title 10 of the CCR, a rule designed to encourage the availability of insurance to "socially and economically disadvantaged communities" in California. The proposed rule, which was the subject of a petition for rulemaking filed by a minority/low-income/consumer coalition, would require each insurer to file an annual Community Service Statement, setting forth by zip code eight categories of information: number and total earned premiums in force by insurance line in that zip code during the previous year, number of offices maintained, number of agents maintaining an office, number of direct mail solicitations for insurance to addresses in that zip code, number of employees whose regular place of work was in the zip code during the previous year, number of employees who resided in the zip code during the previous year, number of employees and agents who speak a foreign language where more than 5% of those in that zip code speak that language, and the ethnic background and gender of employees and brokers.

The rule would also require the Commissioner to issue to the public and legislature a zip code listing of those communities found to be inadequately served by the insurance industry. The rule sets forth criteria for a finding of inadequate service, including proportion of uninsured motorists, businesses, and residences; access difficulties in purchasing insurance; and where two or more insurance companies have discriminated against persons in that zip code.

In addition to these measures, the Commissioner's proposed rule requires all rate applications to include a Community Service Statement and permits the Commissioner to "multiply the maximum permitted rate of return by a Community Service Factor." That factor is based on an industry average of performance in serving inadequately served communities. The factor may result in the multiplication of the generically allowed rate of return by 1.10 to 1.15 if the percentage of policies an insured has in force in inadequately served communities is 15% above the industry average; it may be multiplied by .85 to .90 where the percentage is 15% below the industry average. In addition, a .05 to .10 adjustment beyond this may be made to the multiplier if the number of offices and agents or direct mail solicitations to addresses within disadvantaged zip code areas are 15% above the industry average, or a like reduction if 15% below the industry average.

The Commissioner has scheduled a public hearing on this proposed regulation for August 19 in Los Angeles.

Proposed Flood Insurance Rules. On March 15, Commissioner Garamendi announced plans to adopt emergency rules to protect homeowners from being pressured by lenders into buying overpriced or unnecessary flood insurance. The announcement by the Commissioner was in response to a story in the *Sacramento Bee* reporting that at least 2,300 Sacramentans have been erroneously notified by their lenders that they are in flood hazard areas. The *Bee* reported that at least 1,600 homeowners are being billed at three to four times the rates offered by the federal government for the same coverage. Further, reflecting a larger problem of kickbacks among insurance providers, real estate brokers, lenders and escrow agents, the *Bee* reported "commissions" paid to lenders by insurance companies for each policy they force on homeowners, a practice appropriately called "force placing."

Commissioner Garamendi's proposed emergency rules, which will appear at sections 2692-2692.2, Title 10 of the CCR, will require consumer notification of insurance availability and rates from the federal National Flood Insurance Program. Companies not licensed in California will be restricted in flood insurance sales, and fines of up to $55,000 will be imposed on agents who negligently sell flood insurance without verifying that customers may actually need it.

LEGISLATION:

SB 1135 (Johnston), as amended May 7, is a response to the failures of Executive Life and First Capital; it would limit the ability of insurance companies to invest their assets in junk bonds and other high-risk investments. This bill was passed by the Senate on June 4 and is pending in the Assembly Insurance Committee.

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 the provisions of 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 bill was passed by the Senate on May 23 and is pending in the Assembly Insurance 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. The restructuring contained in the bill would maximize the purchasing power of the state as the single agent for health care. An administering commission would determine provider rates, control capital expenditures, and determine individual hospital budgets, similar to the health insurance system in Canada (*see supra* MAJOR PROJECTS for related discussion). This bill passed the Senate Health and Human Services Committee on April 10, and has been double-referred to the Senate Appropriations Committee and the Senate Revenue and Taxation Committee.

AB 321 (Margolin) would 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. The bill requires unification of the various state and local government programs providing services, and restructures the general obligation of counties to provide medical care to indigents by establishing a separate requirement to provide indigent perinatal and children's services in accordance with this bill. The bill further requires all insurance companies to include perinatal and children's services in their policies, and requires businesses to pay a fee, phased in for small businesses, if perinatal and children's services are not provided for employees and dependents (*see supra* MAJOR PROJECTS for related discussion). This bill is pending in the Assembly Ways and Means Committee.

SB 340 (Torres) is Senator Torres' compromise between Senator Johnston's no-fault bill and Speaker Brown's AB 1375 (*see supra* MAJOR PROJECTS; *see infra* for information on these bills). This bill passed the Senate on May 24 and is pending in the Assembly Insurance Committee.

SB 291 (Johnston). Existing law, effective January 1, 1992, requires insurers to inspect passenger automobiles prior to the issuance of collision and comprehensive coverage, except in specified circumstances. As amended May 22, this bill would make a number of revisions to these provisions. This bill would also require the Commissioner to conduct a preliminary study and submit a final report to the Governor and legislature on the cost-effectiveness of the mandatory vehicle inspection program; the bill would appropriate $150,000 from the Insurance Fund for those purposes. This bill is pending on the Senate floor.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 2 (Spring 1991) at pages 123-26:

SB 941 (Johnston), as amended May 22, would have created no-fault insurance in California, requiring each owner of a private passenger motor vehicle, other than a motorcycle, to maintain insurance that would provide personal injury protection benefits for basic economic loss of up to $15,000 actual payout per person for health care expenses, for loss of earnings up to $1,000 per month, and for other benefits, as specified, regardless of fault.

The bill would also have established procedures for claiming those benefits, including requirements for arbitration of disputes in accordance with procedures specified in the bill; provided that a tort victim has no right to recover any damages in tort for basic economic loss and, except in the case of serious injury, no right to recover noneconomic loss; and prohibited insurers from increasing premium rates for first-party benefits solely on account of prior payment of benefits or claims. SB 941 was rejected by the Senate Judiciary Committee on May 28.

AB 1375 (Brown), as amended April 29, is the Assembly Speaker's alternative to Senator Johnston's no-fault proposal. 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. 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.

This bill would 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). Among other things, AB 1375 would also establish a "fast-track" binding arbitration system for handling auto accident claims of $50,000 or less; require rates charged by the California Automobile Assigned Risk Plan (CAARP) to be actuarially sound; require drivers to present proof of minimum liability coverage before they can register their vehicles; and require all post-1994 vehicles to be equipped with antilock brakes.

AB 1375 also seeks to increase insurance fraud investigation and prosecution by, among other things, increasing resources targeted for this purpose, requiring insurers to develop a fraud investigation, and promoting the compilation and exchange of information needed to observe the utilization patterns which are evidence of fraud. This bill passed the Assembly on May 13 and is pending in the Senate Committee on Insurance, Claims and Corporations.

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 bill is pending in the Assembly Judiciary Committee.

AB 676 (Speier). Under existing law, with certain exceptions, the arbitrary cancellation of a policy of homeowners' insurance solely because the policyholder is engaged in a licensed family day care business at the insured location subjects the insurer to administrative sanctions authorized by the Insurance Code. As amended May 6, this bill would make the provisions regarding arbitrary cancellation of an existing policy applicable where the policyholder has a license to operate a family day care home, and would also subject an insurer to administrative sanctions for arbitrarily refusing to renew, accept an application for, or issue a policy of homeowners' insurance solely because the applicant has a license to operate a family day care home at the location for which insurance is sought, except as specified. This bill would exclude losses arising out of, or in connection with, the operation of a family day care home from coverage under a residential property insurance policy, unless included by a separate endorsement for which premiums have been assessed and collected. This bill passed the Assembly on May 9 and is pending in the Senate Insurance Committee on Insurance, Claims and Corporations.

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 May 6, 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 bill is pending on the Assembly floor.

AB 624 (Bane), as introduced February 20, 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. Among other things, this bill would provide that any person convicted of violating fraud

provisions with respect to a policy covering a motor vehicle shall be liable for up to ten times the amount of the fraudulent claim filed with an insurer, which amount could be awarded to the prosecuting attorney, and in some instances, up to 50% of that penalty could be awarded to persons providing leads. This bill is pending in the Assembly Public Safety Committee.

SB 1147 (Killea), as amended May 20, would provide that in any civil action against a defendant's insurance company for the recovery of damages for injury or illness based upon any act of child molestation between the defendant and a child, the defendant's intent, including his/her intent to harm, is not to be implied absent an evidentiary hearing on the merits. This bill passed the Senate on May 30 and is pending in the Assembly Judiciary Committee.

SB 921 (Committee on Insurance, Claims and Corporations), as amended April 15, 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. The bill would require each disability insurer to pay an annual fee as determined by the Commissioner, but not to exceed 15 cents, for each person covered under a plan of coverage it provides, in order to fund increased investigation and enforcement of unlawful practices. This bill passed the Senate on May 16 and is pending in the Assembly Insurance Committee.

SB 925 (Committee on Insurance, Claims and Corporations), as amended April 29, 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 bill passed the Senate on May 9 and is pending in the Assembly Insurance Committee.

AB 502 (Margolin), as introduced February 13, would require the Commissioner to study the extent of private health insurance or health coverage purchased by employers, employees, and individuals, and report to the legislature concerning specified issues by July 1, 1992; the bill would appropriate $275,000 from the Insurance Fund to pay the costs of the study and report. This bill passed the Assembly on May 9 and is pending in the Senate Committee on Insurance, Claims and Corporations.

AB 759 (Horcher), as amended May 13, would require DOI to conduct a study on the amount of personal automobile insurance written in California by nonadmitted insurers. This bill is pending in the Assembly Ways and Means Committee.

AB 2042 (Lancaster), as introduced March 8, would require the California Automobile Assigned Risk Plan (CAARP) 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 bill passed the Assembly on May 30 and is pending in the Senate 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 subject to a civil penalty. This bill would also prohibit reporting or disclosing a violation of those provisions to the DMV. This bill is pending in the Assembly Ways and Means Committee.

SB 217 (Robbins), as amended May 13, would require the Commissioner to notify a consumer who has complained to DOI about a licensee of DOI's final action on the complaint within thirty days of that action. This bill passed the Senate on April 4 and is pending in the Assembly Ways and Means Committee.

SB 364 (Robbins), as amended April 1, 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 bill passed the Senate on April 25 and is pending in the Assembly Insurance Committee.

SB 784 (Robbins), as introduced March 7, 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 bill is pending in the Senate Committee on Insurance, Claims and Corporations.

AB 966 (Peace), as amended May 15, would provide that a CAARP insurer, upon a determination that a certificate of eligibility is defective due to an immaterial omission or mistake, immediately give written notice of the defect to the insured and to the agent or broker of record that the insured has five working days from the postmark date of the notice of defect to correct the defect and postmark the correction or missing information for return to the insurer. This bill is pending in the Assembly Ways and Means Committee.

SB 894 (Committee on Insurance, Claims and Corporations), as amended May 6, would specify certain acts with respect to health care benefits which would be unlawful under the Insurance Frauds Prevention Act. This bill would also enact the Health Insurance Fraud Reporting Act, providing for the exchange of relevant information relating to health insurance fraud between disability insurers and authorized governmental agencies. This bill passed the Senate on May 24 and is pending in the Assembly Insurance Committee.

SB 889 (Committee on Insurance, Claims and Corporations), as amended May 6, would require each life insurer to annually submit the opinion of a qualified actuary as to whether the insurer's reserves and related actuarial items of policies and contracts specified by the Commissioner are computed approximately, are based on satisfactory assumptions, are consistent with prior reported amounts, and comply with applicable law. This bill would also require the Commissioner to define the specifics of the opinion by regulation. This bill passed the Senate on May 24 and is pending in the Assembly Insurance Committee.

SB 953 (Committee on Insurance, Claims and Corporations). Existing law requires insurers to pay an annual fee determined by the Commissioner in order to fund increased investigation and prosecution of fraudulent automobile insurance claims; the fee may not exceed 50 cents annually for each vehicle insured under a policy of insurance issued in this state. After incidental expenses, 40% of funds received from 30 cents of the assessment fee is directed to DOI's Bureau of Fraudulent Claims, and 60% of the funds are distributed to local district attorneys on a population basis for investigation and prosecution of automobile insurance fraud cases. The remaining 20 cents is used to implement the law dealing with the Automobile Insurance Claims Depository. As amended May 13, this bill would, among other things, instead provide that 45% of the funds from 40 cents of the assessment fee per insured vehicle shall be distributed to the Bureau and 55% to local district attorneys for those purposes; the remaining 10 cents would be used to implement the law dealing with the Automobile Insurance Claims Depository. This bill passed the Senate on May 16

and is pending in the Assembly Insurance Committee.

SB 1139 (Killea), as introduced March 8, would create a limited term task force for investigating the costs, benefits, and workability of pay-as-you-drive automobile insurance. This bill is pending in the Senate Committee on Insurance, Claims and Corporations.

SB 228 (Robbins), as amended May 22, would require that the Commissioner's annual report to the legislature and Governor include both an analysis of DOI's activities in implementing the provisions of Proposition 103 and recommendations and proposals including suggested legislation directed at furthering the purpose of Proposition 103. This bill passed the Senate on April 25 and is pending in the Assembly Insurance Committee.

SB 695 (Johnston). Existing law authorizes the Commissioner to seek a court order to act as a conservator or to liquidate insurers in violation of the law, or to serve on the insurer an order to correct deficiencies. As amended May 22, this bill would provide that if an insurer entering into contracts of life or disability insurance of annuities has exceeded its powers or committed other acts, the Commissioner may place the insurer under administrative supervision, and the insurer would be prohibited during the period of supervision from doing certain things without the approval of the Commissioner or the supervisor. This bill, which would also provide for the review of the Commissioner's orders, is pending on the Senate floor.

SB 339 (Green), as introduced February 11, would require insurers to reduce the premium and deductible for earthquake coverage, pursuant to guidelines established by the Commissioner, where there is a greater earthquake worthiness of a structure based upon a retrofit, as verified by a qualified professional engineer employed by a named insured, where the reduction is actuarially sound. This bill passed the Senate on May 9 and is pending in the Assembly Insurance Committee.

SB 35 (Robbins), as amended May 28, would authorize DMV to accept an insurer's certificate which does not cover all vehicles registered to the licensee for purposes of reinstating the driver's license of a person whose license has been revoked, suspended, or restricted pursuant to specified provisions of law. This bill is pending in the Assembly Insurance Committee.

SB 110 (Robbins), as amended April 29, would authorize the Commissioner to order a purchasing group or risk retention group to cease and desist from soliciting or selling insurance if the officers, organizers, or directors have engaged in acts for which insurance licenses may be denied, suspended, or revoked. SB 110 passed the Senate on May 24 and is pending in the Assembly Insurance Committee.

SB 122 (Robbins), as introduced December 19, would authorize DOI's Bureau of Fraudulent Claims to impose a special assessment on insurers 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 bill passed the Senate on April 4 and is pending in the Assembly Insurance Committee.

LITIGATION:

On April 9 in *Hartford Steam Boiler Inspection and Insurance Co. v. Garamendi*, No. BC023983, Los Angeles County Superior Court Judge Dzintra Janavs upheld the authority of Commissioner Garamendi to adopt his own regulations to implement the rollback and prior approval provisions of Proposition 103. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 122 for background information.) Judge Janavs ruled that there is no irreversible finality to the rules issued by the Insurance Commissioner and they may be repealed or altered in subsequent proceedings, assuming the procedural requirements of the Administrative Procedure Act and other applicable statutes are followed. Commissioner Garamendi has proceeded with his own rulemaking to implement Proposition 103, which differs markedly from that of the previous commissioner (*see supra* MAJOR PROJECTS for related discussion).

In *Belth v. Gillespie*, Professor Joseph Belth—a member of the faculty of the University of Indiana and a nationally recognized expert on insurance issues—requested a number of documents from Commissioner Gillespie in mid-1990, pertaining to the financial condition of Executive Life Insurance Company. The request was made more than one year before its seizure. The Commissioner denied the request. Represented by the Center for Public Interest Law (CPIL), Professor Belth filed suit under the California Public Records Act seeking at least one category of documents: those pertaining to an order of Commissioner Gillespie permitting Executive Life to make a payment of over $300 million to its parent company.

The Commissioner denied the request, contending that the documents were confidential. The section cited by the Commissioner justifying nondisclosure authorizes confidentiality for documents solicited by the Commissioner of a holding company seeking to register as such. The documents sought in *Belth* had nothing to do with such a registration request, and included documents issued by the Commissioner herself. Just before court hearing on the PRA request, the Commissioner informed plaintiff Belth that Executive Life had granted permission to disclose the requested documents upon request of the Commissioner. The documents were disclosed, and CPIL sought its attorneys' fees under the Public Records Act. The Act mandates such fees to a prevailing plaintiff. The Attorney General's office representing the Commissioner responded by requesting its attorneys' fees on grounds that the documents were, in fact, not subject to disclosure, that Belth had not prevailed, and that the documents were provided by the grace of Executive Life; hence, Belth's motion for fees is frivolous and he should be required to pay the fees of the Commissioner. San Francisco Superior Court Judge Ira Brown denied attorneys' fees to both parties. Belth has appealed to the First District Court of Appeal, whose decision is now pending.

On March 22 in *Amwest Surety Insurance Corp. v. Wilson*, No. C704 879, Los Angeles County Superior Court Judge Janavs denied a petition for writ of mandamus filed by Voter Revolt to prevent the legislature from amending Proposition 103. AB 3798 (Johnston) (Chapter 562, Statutes of 1990) added section 1861.135 to the Insurance Code, exempting surety companies from the rollback and prior approval provisions of Proposition 103. Voter Revolt, sponsor of Proposition 103, contended that the initiative may be amended by the legislature only if the change "furthers the purpose" of the initiative; otherwise, it must be subject to a vote of the electorate. The surety industry argued successfully that the legislature should be given deference in its determination of what does and does not advance the purpose of an initiative. This argument and its acceptance by the court would appear to vitiate any attempt to inhibit legislative reversal of electoral enactments. If exclusion of a category of insurance from coverage under a proposition "furthers its purposes" simply based on legislative decision that such is the case, it would appear that legislative exemption, waiver, or reversal of any proposition is permitted. Since the initiative power exists as a direct democracy alternative to the legislature,

and is usually resorted to based on legislative opposition or self-interest (as in legislative salaries or campaign contribution reform), the decision appears to undermine the initiative process in a fundamental way. The basis for the court's ruling is unclear, and counsel for Voter Revolt have announced their intention to appeal it.

In *Gourley v. State Farm Insurance Co.*, No. S014133 (Mar. 28, 1991), the California Supreme Court held that insurance companies are exempt from Civil Code section 3291, which requires the awarding of prejudgment interest on awards for compensatory and punitive damages. The majority reasoned that prejudgment interest should not be awarded against insurers in bad faith actions because the claim is one of "economic loss" rather than "personal injury." In a persuasive dissent, Justice Broussard contended that the holding creates a special exemption for insurance companies, eliminates a deterrent to bad faith insurance practices, and reduces the pressure on insurance company defendants to settle. The latter effect occurs since the exemption of prejudgment interest removes one incentive not to engage in dilatory litigation strategies; no interest accrues until after judgment is entered.

In *California Automobile Assigned Risk Plan v. Gillespie*, No. B050033 (Apr. 18, 1991, as modified May 14, 1991), the Second District Court of Appeal held that insurers are not entitled to make a profit—or even recover costs—on state-mandated CAARP policies; an insurer's "fair rate of return" required under Proposition 103 may be calculated with reference to the insurer's overall auto insurance rates and total revenue. This case arose after former Commissioner Gillespie denied an application for a 112% increase in CAARP rates. CAARP and Allstate petitioned for a writ of mandate challenging the decision, contending that without the increase CAARP rates would be noncompensatory, or at least fail to provide a fair rate of return on CAARP policies. The trial court agreed with the petitioners and held that the denial of the requested increase denied the insurers a "fair rate of return on their investment." (See CRLR Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) pp. 140, 144; Vol. 10, No. 1, (Winter 1990) p. 108; and Vol. 9, No. 4 (Fall 1989) p. 94 for extensive background information.)

The court of appeal reversed, holding that the "fair rate of return requirement" does not pertain to a particular aspect of business or to every customer category. Rather, it is a general protection applicable to the overall operations of the regulated enterprise. The court wrote that "the reasonable rate of return requirement does not require rates which allow insurers to break even, much less earn a profit, on assigned risk policies standing alone." The decision, consistent with the rate regulation "taking doctrine" in general, allows regulators to cross-subsidize between the customers or types of business of those regulated. Insurers may be compelled to subsidize CAARP policies from their other auto insurance policies.

The California Supreme Court is now considering a petition to review the case of *Farmers Insurance Exchange v. Superior Court (Dan Lungren)*, No. S016912. The petitioners (insurance companies) contend that where a public agency brings an action to enforce California's "Little FTC Act" (Business and Professions Code section 17200), the primary jurisdiction of the Insurance Commissioner precludes court adjudication until after all administrative remedies have been exhausted. This position implies that Insurance Code section 790.03, the unfair insurance practices statute enforced by the Department of Insurance, is not coextensive with California's unfair practice statutes applying to business generally. Since the efficacy of the general unfair practice statute depends upon immediate sanction, deference to an administrative agency and required exhaustion would undermine the basic features of the "Little FTC Act." Consumers Union and the Center for Public Interest Law will file an *amicus curiae* brief in the case, urging rejection of petitioners' position and the retention of coextensive remedies for insurance unfair practices. Should the petitioners' position be upheld in this case, both private and public remedies for insurance carrier unfair acts will be controlled or substantially influenced by the Commissioner.

DEPARTMENT OF REAL ESTATE

Acting Commissioner:
John R. Liberator
(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 July 1990, 202,408 salespersons and 98,891 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 Bulletin* is circulated quarterly as an educational service to all real estate licensees. It contains legislative and regulatory changes, commentaries and advice. In addition, it lists names of licensees against whom disciplinary action, such as license revocation or suspension, is pending. Funding for the *Bulletin* is supplied from a $2 share of license renewal fees. The paper is mailed to valid license holders.

Two industry handbooks are published by the Department. *Real Estate Law* provides relevant portions of codes affecting real estate practice. The *Reference Book* is an overview of real estate licensing, examination, requirements