until January 1, 1997, is pending in the Assembly Judiciary Committee.

LITIGATION:

People of the State of California v. American Continental Corporation (ACC), the Department's civil fraud action against Charles Keating, the now-bankrupt ACC (an Arizona development company owned by Keating), and two of ACC's top officers, is still pending in federal court in Arizona under U.S. District Court Judge Richard Bilby. The Department, which authorized ACC to sell junk bonds from branch offices of its subsidiary Lincoln Savings and Loan, charges defendants with securities fraud, fraud in application for qualification, offer/sale of unauthorized securities, and unauthorized advertising. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 124–25; Vol. 10, No. 4 (Fall 1990) pp. 117–19 and 128–29; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) pp. 103 and 113–14 for extensive background information on the Lincoln/ACC scandal.)

Although the Department's case was filed in Los Angeles County Superior Court in March 1990, the defendants removed the case to federal court; it was then transferred to Judge Bilby along with numerous other civil actions concerning Keating, ACC, and Lincoln. Although the case is technically stayed due to ACC's bankruptcy, the Department has been permitted to file a motion for summary judgment in the case; after a lengthy delay, the defendants finally filed a response to the motion, and a hearing was scheduled for December 9.

Jury selection in ***People v. Keating***, the state's criminal action against Charles Keating, began on August 6 amidst increased security in response to an explosive outburst by a 72-year-old woman who grabbed Keating and shouted that he had taken all of her money. On July 26, Los Angeles County Superior Court Judge Lance A. Ito decided to sever Keating's trial from that of Judith J. Wischer, former president of ACC, after prosecutors agreed with Wischer's attorney that a joint trial might be unfair to her. Her trial is expected to follow at the conclusion of Keating's trial.

Keating and Wischer are each charged with 20 counts of securities fraud in the sale of ACC bonds to purchasers who, according to the indictment, were told by Lincoln salespersons that their investments would be insured up to $100,000 by the federal government. In fact, no such guarantee existed and more than 20,000 purchasers, including many senior citizens on fixed incomes, lost an estimated $250 million when ACC declared bankruptcy in April 1989. Keating faces up to ten years in prison if convicted on six or more of the charges.

On August 21, Judge Ito ruled that jurors will be given an aiding-and-abetting instruction, which states that in order to convict Keating, they must find that he intended to help bond salespeople make untrue statements in efforts to sell the bonds, knew bond salespeople were making untrue statements in selling the bonds, and encouraged the bond salespeople to make the untrue statements.

The trial commenced on August 29 and is expected to continue through the end of the year.

In Re American Continental Corporation/Lincoln Savings and Loan Association, the class action filed on behalf of 20,000 investors who lost an estimated $250 million in the Lincoln/ACC collapse, is also pending in U.S. District Court under Judge Bilby; plaintiffs' objection to the transfer to federal court is still on appeal in the U.S. Court of Appeals for the Ninth Circuit. The trial date has been postponed until at least January 1992; partial settlements totalling $40 million have been negotiated and approved by the court.

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 1,450 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 Cali-

fornia insurance industry asserts that it loses more than $100 million annually to such claims. Licensees currently pay an annual assessment of $1,000 to fund the Bureau's activities.

MAJOR PROJECTS:

Garamendi Endorses No-Fault Auto Insurance. On September 5, Commissioner Garamendi stunned allies and opponents alike by announcing a nine-point auto insurance reform proposal which includes a no-fault component. After maintaining neutrality on the issue during the latest legislative wars over auto insurance, and attempting to mediate the dispute between pro-no-fault (Consumers Union (CU), Governor Wilson, the insurance industry) and anti-no-fault (Voter Revolt, Ralph Nader, the California Trial Lawyers Association) factions, Garamendi stated his support for a limited no-fault program based on the New York model and SB 941 (Johnston), the CU-sponsored no-fault bill that failed in the Senate Judiciary Committee last May. (*See supra* reports on VOTER REVOLT and CONSUMERS UNION; *see also* CRLR Vol. 11, No. 3 (Summer 1991) pp. 23–24, 33, 39, and 128 for background information.)

Specifically, Garamendi's comprehensive auto insurance reform plan calls for a no-fault system with a statewide flat rate of $325 for the first year for a minimum policy which includes $15,000 in personal injury and $3,000 in property damage coverage. Claimants could sue for noneconomic (pain and suffering) damages only in cases of serious injury. The plan also includes a provision requiring motorists to show proof of insurance when registering their car in California; establishment of a voluntary auto repair shop referral system, with a guaranteed price for repairs; increased funding for the Department's Bureau of Fraudulent Claims and local law enforcement agencies to investigate and prosecute fraudulent claims; and a medical cost containment program under which the fees charged by physicians to treat auto insurance injuries would be tied to the schedule in workers' compensation cases. The Commissioner estimated that his proposal would cut premium prices for all drivers by 10%.

Garamendi attempted to discuss his plan with key legislators participating on a joint conference committee in early September. However, the conferees—which included no-fault opponents Senator Bill Lockyer and Assembly Speaker Willie Brown—abruptly cancelled a September 6 meeting and failed to return to the bargaining table before the legislature adjourned for the year.

Critics of no-fault, including Voter Revolt Chair Harvey Rosenfield, immediately assailed Garamendi's proposal. Rosenfield noted that the electorate rejected the insurance industry's no-fault initiative (Proposition 104) as recently as November 1988, while approving Proposition 103—the auto rate reform initiative which has yet to be implemented largely due to insurance industry stonewalling. No-fault proponents praised Garamendi for his leadership and predicted that a no-fault initiative will reappear on the ballot in 1992.

Commissioner's Adoption of Proposition 103 Rate Regulations Greeted by OAL Rejection, Lawsuits. On August 15, Commissioner Garamendi announced his adoption of emergency regulations implementing the rollback and prior rate approval provisions of Proposition 103. Under the new rules, the Commissioner estimated that rebates due insureds would total $2.5 billion (including interest accruing since 1989), which amounts to approximately $100 per car. Since Garamendi originally proposed them on the day after he was sworn into office, the long-awaited regulations have undergone numerous public hearings and have been promulgated in revised form three times. Once approved, the regulations will be codified at Title 10, Chapter 5, Subchapter 4.8, Articles 1 through 7 of the California Code of Regulations.

Under the new rules, a company's rollback obligation will be calculated under a maximum 10% rate of return, as contrasted with former Commissioner Roxani Gillespie's 11.2% profit margin. In addition, the rules impose 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 (using a 2–to–1 ratio of premiums collected to surplus retained). (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 129–30 and Vol. 11, No. 2 (Spring 1991) pp. 121–22 for extensive background information on the Proposition 103 regulations.)

In his statement of facts demonstrating the need for emergency action, the Commissioner noted that "[t]he delay of over two and one-half years in the implementation of Proposition 103, particularly in determining the rollback liability of insurers for 1989 policies, has led to widespread public dissatisfaction, has eroded public confidence in government, and has frustrated voters." Garamendi also blamed the insurance industry for the Department's inability to adopt the rules through the normal rulemaking process, which requires a response to each and every comment made during the public hearings: "The large scale dumping of irrelevant material by the industry into this rulemaking proceeding has created this emergency." Finally, the Commissioner argued that prompt action is required because the Department's previous Proposition 103 emergency regulations have expired; there is a backlog of insurance rate applications which cannot be processed until rate approval standards are adopted; and hundreds of California insureds who are due rebates "have moved out of state, and have died awaiting their rollback refund checks. . . . By adopting these regulations on an emergency basis, the Department of Insurance will protect the public from further loss of rollback refund benefits."

Although John Smith, then Acting Director of the Office of Administrative Law (OAL), approved a preliminary version of DOI's emergency regulations on August 14, the Department was required to submit a completed version of the rules to newly-appointed OAL Director Marz Garcia. In a surprise move on September 3, Garcia disapproved the regulations, on grounds that he found no "emergency" to justify their urgency adoption. That term is defined in Government Code section 11346.1 to mean that the regulation "is necessary for the immediate preservation of the public peace, health and safety, or public welfare." More disturbing, however, was Garcia's mention of concern over "whether the Insurance Commissioner has the rulemaking authority to adopt regulations that implement and interpret the [rollback and ratemaking] provisions of Proposition 103. . . ." (*See supra* agency report on OAL for related discussion.)

Commissioner Garamendi immediately appealed Garcia's disapproval to Governor Wilson. In his appeal, he noted that Proposition 103 expressly requires the Insurance Commissioner to preapprove certain rate increases and decreases, and pointed to the California Supreme Court's ruling in *Calfarm v. Deukmejian*, 48 Cal. 3d 805 (1989), which upheld the facial constitutionality of Proposition 103. In that decision, the court noted that "much is necessarily left to the Insurance Commissioner, who has broad discretion to adopt rules and regulations as necessary to promote the public welfare." The Governor had

until October 7 to rule on Garamendi's appeal.

Not content to wait until the regulations become effective and are ripe for review, the insurance industry commenced its latest attack on Proposition 103 on September 3. In *General Insurance Co. of America, et al. v. Garamendi*, No. BC036620 (Los Angeles County Superior Court), *Fireman's Fund Insurance Co. v. Garamendi*, No. C91-2854 (U.S.D.C., N.D. Cal.), and *United States Fidelity and Guaranty Co. v. Garamendi*, No. C91-2855 (U.S.D.C., N.D. Cal.), numerous insurance companies challenge the validity of DOI's Proposition 103 regulations as applied to their operations on a variety of constitutional grounds.

Task Force Update. Throughout the summer, the Department's Consumer Complaints and Unfair Practices Task Force continued work on its two major projects: the adoption of regulations which fully define the "unfair practices" prohibited by Insurance Code section 790.03(h), and an in-depth examination of the Department's enforcement system to determine compliance with SB 2569 (Rosenthal) (Chapter 1375, Statutes of 1990). (See CRLR Vol. 11, No. 3 (Summer 1990) pp. 126–27 for detailed background information on the creation of the Task Force and its projects.)

The importance of significant DOI improvement in both of these areas cannot be overstated. The critical need for regulations implementing Insurance Code section 790.03(h) has resulted from a series of court decisions over the past several years which has eliminated so-called "*Royal Globe*" 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 first- and third-party bad faith tort actions against insurers.) These cases have relegated consumers to the Department of Insurance as their sole mechanism for seeking relief from bad faith conduct of insurance companies.

After meeting frequently over the summer, the five Task Force subcommittees working on the section 790.03(h) regulations issued a preliminary draft of its proposed rules in late August. DOI Special Counsel and Task Force Coordinator Gary Hernandez hoped to preside over a final meeting of the five subcommittees on October 9, release the proposed regulations for a 45-day public comment by November 1, and hold public hearings during late December.

Even if the Commissioner adopts stringent bad faith regulations, they will be meaningless unless the Department has an aggressive enforcement system which routes and tracks consumer complaints, and discloses appropriate information about those complaints to inquiring consumers. The enforcement system should also be sufficiently resourced to enable quick and effective formal investigation of complaints, and legal action to revoke or suspend licenses to engage in the business of insurance, as appropriate. Such a system, in and of itself, would be a deterrent to bad faith conduct on the part of insurers. Hampered by serious legal impediments and a lack of resources, the Department's existing enforcement system does not yet approach that goal. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 126–27 for description of DOI's enforcement system.)

Although the section 790.03(h) subcommittees made progress in achieving their goals over the summer, the SB 2569 Consumer Complaint Handling Subcommittee met only twice, and Department staff missed a key deadline in its implementation of SB 2569 (codified at Insurance Code section 12921.1 *et seq.*). The bill required the Department 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 1 deadline came and went with no significant change in or improvement to the Department's enforcement system, and no report to the legislature on DOI's implementation of SB 2569. Staff correctly contends that many of the individual requirements of SB 2569 have been met; however, the overall functioning of the system has not changed.

Department Ranks Insurers. DOI satisfied one provision of SB 2569 over the summer. Among other things, SB 2569 requires the Department to establish guidelines for the dissemination of complaint and enforcement information on individual insurers to the public, including but not limited to: license status; the number and type of complaints closed within the last full calendar year (with analogous statistics from the prior two years for comparison); the number and type of violations found; the 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 the insurer that will assist the public in selecting an insurer.

On June 25, DOI released statistics ranking the state's top fifty homeowner and auto insurers, based on the number of justified consumer complaints filed against them in 1990 per $1 million in premiums. Commissioner Garamendi defined a "justified complaint" as one involving a violation of state insurance laws or a situation in which a consumer was forced to contact DOI for assistance because he/she received no response from an insurer to a question or concern. The fifty auto insurance companies rated write 89.4% of the business in California; similarly, the fifty homeowner insurance companies do 88% of the business in the state.

At a Los Angeles press conference, Garamendi stated, "For every complaint filed with the Department and found to be justified, I believe there are probably scores more instances where . . . policyholders threw up their hands in frustration." Garamendi noted that DOI handled 6,783 justified complaints in 1990 from auto insurance policyholders, and 1,355 justified complaints from homeowner insurance policyholders. He also stated that more than $4.4 million was recovered for consumers from auto insurers, and $4 million was recovered from homeowner insurers, as a result of DOI inquiries.

French Investors Make Offer on Executive Life. On August 7, the Department of Insurance announced a tentative agreement to rescue Executive Life Insurance Company of California by selling it to French investors in a deal worth $3 billion. The Department seized Executive Life's assets and placed it in conservatorship on April 11. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 129 for background information.)

The proposed deal involves a French group led by Altus Finance, a $12.4 billion investment and financial services holding company affiliated with state-owned French bank Credit Lyonnais. Under the terms of the agreement, Altus would pay $2.7 billion for Executive Life's junk bond portfolio; an additional $300 million in capital would be provided by MAAF, a Paris-based mutual insurance company with $5.3 billion in assets. This proposed agreement would cover 81 cents on the investment dollar for most policyholders. The deal would not cover $3 billion in Executive Life's municipal guaranteed investment contracts (Muni-GICs). The Commissioner considers these to be speculative investments, not traditional

insurance products. Talks between the Department and holders of $1.8 billion of the Muni-GICs have broken down; at this writing, litigation is anticipated by both parties.

Under the terms of the arrangement, the assets of Executive Life will be placed in three companies: Investco, Newco, and a liquidating trust. Executive Life's junk bond portfolio will be given to Investco, which will be owned and operated by Altus Finance. If revenues exceed certain levels, policyholders who remain during the restructuring period will be entitled to a share of the profits. Altus' $2.7 billion contribution will go to Newco, which will operate as the surviving insurance company and receive Executive Life's investment grade bonds. MAAF will operate Newco and furnish $300 million to back the company's policies. The Executive Life policies transferred to Newco will be worth about 81% of their previous value, although death benefits remain at 100%. If Newco's revenues exceed certain levels, policyholders are again entitled to a share of the profits. Newco, however, would be barred from investing more than 10% of its assets in junk bonds during the term of the deal. The remainder of Executive Life's assets would be placed in a liquidating trust subject to existing and future liabilities, such as the claims of Muni-GIC holders, the IRS, and policyholder lawsuits. Again, in the event that assets exceed liabilities, policyholders would be entitled to a share of the excess.

The plan, however, allows Newco to raise annual premiums that pay for death benefits by 15%, while simultaneously cutting the rate of return to less than 7%. The company is also authorized to increase interest rates for those that have borrowed against their policies. Exacerbating the troubles of Executive Life policyholders are the fees assessed for cashing out policies prior to the end of the five-year restructuring period; under the terms of the agreement, 40% of the cash value of the policy could be forfeited. Consumers choosing to find new coverage will be faced with traditionally costly up-front fees and commissions, leaving many Executive Life policyholders with little choice but to wait out the proposed rehabilitation plan.

On August 28, the insurance industry announced its intention to pay as much as $1 billion in coming years to make up the other 19% of the value of Executive Life's policies. The arrangement is being coordinated through the National Organization of Life and Health Insurance Guarantee Associations, the umbrella group for state-sponsored industry-financed funds that protect against policyholder losses. If this arrangement is finalized, 95% of Executive Life policyholders would receive 100% of the value of their policies. Customers who remain unprotected would be those whose policies have cash values over $100,000. Although these customers would get 100% of their policy value up to $100,000, they would be entitled to only 81% of the amount above that figure. The plan requires approval of the individual state guarantee associations, which raise money through assessments on insurers doing business in their respective states. California's guarantee association approved the plan on August 27.

However, the Commissioner noted that the proposed agreement could be derailed by several factors. First, an economic downturn could make the junk bond portfolio less attractive to Altus Finance because its bid is based on current economic conditions. Second, unanticipated hurdles in Executive Life's balance sheet could be discovered which would make the prospect of a takeover less profitable. Third, the IRS is still laying claim to $643 million in taxes it contends is owed to the government for tax years 1981, 1982, and 1983. Garamendi has publicly criticized the IRS for its delayed effort to collect these monies, which has jeopardized the funds available for consumer redress. Fourth, the bidding period may yet yield competing offers for the company. Finally, the deal requires approval by Superior Court Judge Kurt Lewin, who is overseeing the state's conservation of Executive Life. At this writing, no decision has been rendered.

Another Insurance Company Seized. On July 3, the Great Republic Insurance Company was seized by the Department as a result of financial and consumer-related problems. The court order placing control of Great Republic in the hands of the Commissioner came at a time when Great Republic's liabilities exceeded assets by $454,000. Great Republic's parent company, Nationwide, covers about 25,000 group insurance policyholders and 6,800 life insurance policyholders. Insurance investigators also revealed that Great Republic may have been adjusting claims in a manner that violates the Unfair Practices Act. Great Republic paid $55,000 in fines during 1990 for delays in processing policyholder claims.

Emergency Regulations for Flood Insurance Adopted. On June 24, the Department adopted emergency regulatory sections 2692–2692.2, Title 10 of the CCR, designed to prevent insurer abuse of federally mandated flood insurance. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 130 for background information.) In 1973, Congress enacted the Flood Disaster Protection Act. One provision of the Act requires all mortgage lenders which are insured, regulated, or financially assisted by a federal agency or instrumentality (including the Federal Reserve Board and the FDIC) to maintain flood insurance on properties which are subject to a 1% or greater chance of flooding in any given year; these are called Special Flood Hazard Areas (SFHA).

Lenders have been notified by federal agencies and instrumentalities that failure to comply will result in citations, which has prompted the lenders to accept the aid of insurance brokers and companies in determining which properties in their portfolio lie in an SFHA, and to assure that these properties are covered by flood insurance. The emergency regulations are designed to eliminate the abuses proliferated by the insurance companies in the performance of this function. These abuses include misinforming homeowners that their property is an SFHA, failing to advise homeowners that privately placed insurance might be less expensive than lender-imposed "force placed" coverage, and failing to advise homeowners that force placed coverage may be inadequate. The *Sacramento Bee* has reported that at least 2,300 Sacramentans have been erroneously notified by their lenders that they are in an SFHA. In addition, 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. In response to the allegation that insurers are inaccurately determining whether homeowners are in an SFHA, one insurer has claimed that a reasonable effort and attainment of an 85% accuracy rate is sufficient. With respect to the failure to disclose the availability of cheaper, more inclusive coverage, insurers have argued that they have no duty to disclose these facts.

The emergency regulations are intended to bring the abuses being committed by brokers and companies within the definition of various unfair practices prohibited by Insurance Code sections 790.03 and 790.06. Section 2692.1 deals with untrue, deceptive, or misleading statements, and requires that persons making or disseminating statements that a homeowner is in an SFHA use "reasonable care." This standard forces brokers and companies to use or rely upon the most accurate method feasible, without respect to cost or time, when

determining whether a homeowner is in an SFHA. In addition, a statement by an insurer informing a homeowner that a policy will be issued on his/her behalf and at his/her expense will be deemed untrue, deceptive, or misleading unless the insurer explains that flood insurance which the homeowner procures may be less expensive, that flood insurance which the homeowner procures will be less expensive (if the broker or company has reason to know this to be true), and that coverage differences exist between force placed coverage and coverage obtainable through the National Flood Insurance Program. Section 2692.2 deals with unfair acts and provides that a homeowner who has been force placed is entitled to a *pro rata* refund of the premium paid on a force placed policy if the homeowner replaces the coverage mid-term. In addition, a homeowner may contest the SFHA determination by consulting with local or county flood control officials.

Earthquake Insurance Program Delayed. A new state earthquake insurance program scheduled to start on July 1, 1991, was postponed until January 1, 1992, at the urging of Commissioner Garamendi. The postponement bill, SB 289 (Green) (Chapter 81, Statutes of 1991), is designed to allow the Department time to work out flaws in the program which had put its implementation well behind schedule. The law creating the program was initiated by former Governor Deukmejian after the October 1989 Loma Prieta earthquake, and is intended to fill the gap left by conventional earthquake insurance, which normally has a deductible of 10%. Under the program, $12–$60 in insurance premiums would be collected from homeowners who have private insurance, creating a state pool of $250 million annually. Homeowners will be eligible for up to $15,000 in coverage to offset the cost of deductibles of private insurers. After analyzing the program, however, the Commissioner stated that homeowners would be able to recover only ten to twenty cents on the dollar because the state pool would be severely underfunded. In order to adequately cover anticipated costs, Garamendi insists that the average premium charged should be $119 a year.

Department Proposes Rules to Penalize Redlining. In an effort to curb the widespread industry practice of "redlining" (the refusal to sell insurance in low-income and minority communities), DOI held an August 19 public hearing on the proposed adoption of section 2646.6, Title 10 of the CCR. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 130 for background information.) The idea behind the proposed regulation is to reward insurers who do business in low-income and minority communities and penalize those who do not. The Commissioner has stated that there is ample evidence that insurance companies actively discriminate in the sale and service of insurance policies in low-income, minority, and inner-city communities. The proposed regulations would require insurers to provide annual information to the Commissioner which will enable DOI to determine whether an insurer is adequately serving the target communities. The Commissioner would then report to both the public and the legislature those communities that are inadequately served by insurers in order to increase public awareness of the problem. In addition, the Department would allow higher rates of return on equity to companies that make it a point to serve minorities and lower-income policyholders. For example, the proposed schedule would allow a 6.5% rate of return for a company that provides "extraordinarily bad service," in contract to a 13.5% rate of return for a company that demonstrates "extraordinarily good service." At this writing, DOI is still reviewing the comments received at the public hearing, and has not yet submitted the proposed regulation to OAL for review.

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

-Preapproval of Policy and Bond Forms. On June 17, the Office of Administrative Law (OAL) approved DOI's permanent adoption of sections 2195.1–2199.1, Title 10 of the CCR. These sections establish the procedure for the Commissioner's required preapproval of policy and bond forms developed by advisory organizations. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 123; Vol. 11, No. 1 (Winter 1991) p. 101; and Vol. 10, No. 4 (Fall 1990) p. 121 for background information.)

-Intervenor Compensation Regulations. On July 18, OAL approved DOI's emergency adoption of new sections 2631.1–.6, Title 10 of the CCR, which establish procedures for payment of intervenor compensation to representatives of consumers in DOI rulemaking and other quasi-legislative proceedings. In its statement of emergency, DOI notes that it is currently conducting quasi-legislative Rate Component Determination (RCD) hearings under Proposition 103, and that Proposition 103 specifically authorizes the payment of intervenor compensation to representatives of consumers in such hearings. Consumer representatives are participating in the RCD hearings, but have threatened to withdraw because of the lack of clear and concise procedures governing compensation in such proceedings. The new sections require consumer representatives to file a request for a finding of eligibility for intervenor compensation, which includes a description of the position to be advanced and the interest to be represented. The Commissioner must make a finding of eligibility. Following the conclusion of the proceeding, the consumer representative may request intervenor compensation if he/she has made a substantial contribution to a DOI order, decision, or regulation resulting from his/her participation.

At this writing, DOI is in the process of formulating permanent, more detailed intervenor compensation regulations which will cover both quasi-legislative and adjudicatory proceedings. Department staff hopes to publish the proposed regulations before the end of the year.

-DOI seeks to add sections 2191(a)–(d) to Title 10 of the CCR, pertaining to the inspection of all private passenger vehicles prior to obtaining collision and/or comprehensive auto insurance coverage. The proposal represents an attempt to reduce the likelihood of fraudulent auto claims based on preexisting damage. Under the proposed regulations, an auto insurer would be required to complete an insured automobile inspection report, which includes information pertaining to any existing damage to the automobile body, equipment, or accessories. The form also includes vehicle identification and registration information. At least two photographs of the vehicle must accompany the report. DOI was scheduled to hold public hearings on this proposal on November 14 in San Francisco, November 15 in Los Angeles, and December 16 in Sacramento.

-On August 6, OAL rejected DOI's adoption of new section 2173, Title 10 of the CCR, which would prevent surplus line brokers from placing automobile bodily injury, property damage liability, or medical payment insurance with nonadmitted insurers unless the business has been offered to and refused by the California Automobile Assigned Risk Plan. The regulatory action would make permanent DOI's emergency adoption of section 2173 in November 1990, and emergency readoption of the section in March 1991. OAL found that the rulemaking record failed

to comply with the necessity, authority, clarity, consistency, and reference standards of Government Code section 11349.1.

LEGISLATION:

SB 389 (Johnston), as amended September 10, authorizes the Insurance Commissioner to issue an order suspending or removing an admitted insurer's director, officer, employee, or other natural person who participates in the management, direction, or control of the insurer in enumerated circumstances. This bill also provides that it is unlawful, subject to specified civil penalties, for a person against whom certain of those orders has been issued to participate in any manner in the business of an insurer without the consent of the Commissioner. The bill also enacts substantially similar provisions with respect to production agencies. SB 389 was signed by the Governor on October 9 (Chapter 771, Statutes of 1991).

SB 225 (Robbins). Existing law provides, subject to approval by the Insurance Commissioner, that all motor vehicle insurers shall disclose available discounts at the time of offering to issue or renew a policy. Insurers must also disclose the discounts to their agents and brokers, and require them to make the necessary disclosures to applicants. As amended April 1, this bill requires the disclosure to applicants to be in writing as a freestanding document which brings attention to the applicant, and makes these discount disclosure requirements applicable only to personal lines of motor vehicle insurance. This bill was signed by the Governor on July 22 (Chapter 160, Statutes of 1991).

SB 845 (Committee on Insurance, Claims and Corporations). Under existing law added by Proposition 103, affected insurers are required to reduce premiums for insurance issued or renewed on or after November 8, 1988. As amended June 19, this bill prohibits any insurer that makes refunds pursuant to that provision from requiring insurance agents or brokers to refund to the insurer any portion of their commissions which the insurer claimed, and the Commissioner allowed, as an expense in determining the insurer's actual return for purposes of computing the refund amount. This bill, which specifies that it does not affect specified policyholder refunds, was signed by the Governor on August 5 (Chapter 340, Statutes of 1991).

SB 812 (Robbins). Existing law prohibits various unfair methods of competition and unfair and deceptive acts or practices in the business of insurance, including acts and practices relating to the settlement of claims; and requires the Insurance Commissioner to adopt reasonable rules and regulations necessary to administer those and other provisions relating to unfair practices. This bill requires regulations adopted by the Commissioner which relate to the settlement of claims to take into consideration settlement practices by classes of insurers. This bill was signed by the Governor on July 27 (Chapter 233, Statutes of 1991).

SB 289 (Green), as amended February 28, delays the implementation date of the California Residential Earthquake Recovery Fund from July 1, 1991 to January 1, 1992. (*See supra* MAJOR PROJECTS.) This urgency bill was signed by the Governor on June 30 (Chapter 81, Statutes of 1991).

AB 306 (Friedman), as amended July 15, would provide that where there is reasonable cause to believe that a claim for bodily injury or property damage presented to a private passenger automobile insurer by a third party may be fraudulent, the claim shall not be paid unless the insurance carrier has first obtained positive identification of the person claiming personal injury or property damage. This two-year bill is pending in the Senate Committee on Insurance, Claims and Corporations.

The following is a status update on bills reported in detail in CRLR Vol. 11, No. 3 (Summer 1991) at pages 130–33:

SB 1135 (Johnston), as amended August 26, limits the ability of insurance companies to invest their assets in junk bonds and other high-risk investments. This bill was signed by the Governor on October 5 (Chapter 539, Statutes of 1991).

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 September 12, this bill makes a number of revisions to these provisions. This bill also requires 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 appropriates $150,000 from the Insurance Fund for those purposes. This bill was signed by the Governor on October 14 (Chapter 1056, Statutes of 1991).

AB 676 (Speier), as amended August 20, provides that the arbitrary cancellation of a homeowners' insurance policy solely because the policyholder has a license to operate a family day care home subjects the insurer to administrative sanctions authorized by the Insurance Code. This bill also subjects 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 was signed by the Governor on October 9 (Chapter 784, Statutes of 1991).

SB 1147 (Killea), as amended May 20, would have provided 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 was vetoed by the Governor on October 13.

AB 759 (Horcher), as amended June 28, requires DOI to conduct a study on the amount of personal automobile insurance written in California by nonadmitted insurers. This bill was signed by the Governor on October 5 (Chapter 565, Statutes of 1991).

SB 217 (Robbins), as amended June 27, requires 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 was signed by the Governor on July 9 (Chapter 106, Statutes of 1991).

AB 966 (Peace), as amended August 19, requires a California Automobile Assigned Risk Plan (CAARP) insurer, upon a determination that an applicant's certificate of eligibility for CAARP insurance is defective due to an immaterial omission or mistake, to immediately give written notice of the defect to the insured and to the agent or broker of record that the insured has ten days to correct the defect or missing information and return it to the insurer. This bill was signed by the Governor on October 5 (Chapter 578, Statutes of 1991).

SB 894 (Committee on Insurance, Claims and Corporations), as amended September 11, specifies certain acts with respect to health care benefits which are unlawful under the Insurance Frauds Prevention Act. This bill was signed by the Governor on October 13 (Chapter 1008, Statutes of 1991).

SB 889 (Committee on Insurance, Claims and Corporations), as amended August 26, requires each life and disability 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 also requires the Commissioner to define the specifics of the opinion by regulation. This bill was signed by the Governor on October 13 (Chapter 1005, Statutes of 1991).

SB 953 (Committee on Insurance, Claims and Corporations), as amended September 5, revises the distribution of the annual fee paid by insurers to fund increased investigation and prosecution of fraudulent automobile insurance claims. This bill was signed by the Governor on October 14 (Chapter 1222, Statutes of 1991).

SB 228 (Robbins), as amended September 10, requires 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 was signed by the Governor on October 13 (Chapter 946, Statutes of 1991).

SB 695 (Johnston). As amended July 3, this bill provides 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 may be prohibited during the period of supervision from doing certain things without the approval of the Commissioner or the supervisor. This bill was signed by the Governor on October 13 (Chapter 986, Statutes of 1991).

SB 339 (Green), as amended September 10, provides that if an insurer charges an additional earthquake premium or deductible for a dwelling which fails to comply with specified retrofitting criteria, and that dwelling is subsequently brought into compliance with certain design and retrofit requirements, the additional premium or deductible attributable to noncompliance shall not be charged. This bill was signed by the Governor on October 7 (Chapter 664, Statutes of 1991).

SB 35 (Robbins), as amended September 4, requires DMV to accept an insurer's certificate issued under prescribed liability policies and provides that these certificates satisfy the requirements of proof of financial responsibility. This bill was signed by the Governor on October 14 (Chapter 1177, Statutes of 1991).

SB 110 (Robbins), as amended September 10, authorizes 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, which also revises and recasts provisions of the Insurance Code, effective January 1, 1992, concerning the licensure of fire and casualty insurance broker-agents, was signed by the Governor on October 14 (Chapter 1040, Statutes of 1991).

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

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

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

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

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

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

AB 624 (Bane), 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. This two-year bill is pending in the Assembly Public Safety Committee.

AB 2042 (Lancaster), as introduced March 8, would require the California Automobile Assigned Risk Plan to use rates that are actuarially sound so that there is no subsidy of the plan, and require the Commissioner to approve necessary rate increases. (*See infra* LITIGATION.) This two-year bill is pending in the Senate Insurance Committee.

AB 2078 (Gotch), as amended May 6, would reenact those repealed provisions of the Robbins-McAlister Financial Responsibility Act which require drivers to provide evidence of financial responsibility; a violation of those provisions would be grounds for a civil

penalty. This two-year bill, which would also prohibit reporting or disclosing a violation of those provisions to the DMV, is pending in the Senate Insurance Committee.

SB 784 (Robbins), 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 two-year bill is pending in the Senate 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 two-year bill is pending in the Senate Insurance Committee.

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

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

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

AB 502 (Margolin), 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 two-year bill is pending in the Senate Insurance Committee.

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

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

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

LITIGATION:

On August 20, the Commissioner filed ***Garamendi v. Lungren***, No. 935731 (San Francisco Superior Court). In the lawsuit, Garamendi sought an order compelling Attorney General Dan Lungren to approve the renewal of a DOI contract for legal services with attorneys Michael Strumwasser and Fred Woocher. As special counsel to former Attorney General John Van de Kamp, Strumwasser and Woocher represented the AG's office from 1988 to late 1990 in the ongoing legal struggle to implement Proposition 103. When Van de Kamp left office in January 1991, the pair began their own law firm in Santa Monica, and entered into a contract with newly-elected Commissioner Garamendi to continue their pro-Proposition 103 advocacy on behalf of the Department. Their initial contract lasted from January 1991 to September 30, 1991. In August, however, new Attorney General Lungren, who must approve all contracts for outside legal assistance, stated that he would not approve a renewal of the Strumwasser/Woocher contract because he believed the initial contract violated the state's "revolving door" prohibition, which precludes former a state employee from performing a contract with a state agency if he/she was involved in the contract's formation or negotiation while still a state employee. (See CRLR Vol. 11, No. 3 (Summer 1991) pp. 125 and 129–30 for background information.)

On September 4, San Francisco Superior Court Judge Lucy Kelly McCabe ruled that Lungren abused his discretion in refusing to approve the renewal contract. The court noted that Van de Kamp, before leaving office, had determined that Garamendi's hiring of the two attorneys did not violate the law, and determined that the former AG's opinion is "the only sensible way to read the [law]."

On July 25 in ***Belth v. Gillespie***, No. A051541, the First District Court of Appeal ruled against the Department in an attorneys' fees issue of first impression under the Public Records Act (PRA), Government Code section 6250 *et seq.* In 1990, Joseph M. Belth, a professor of insurance at Indiana University, sought certain records pertaining to the financial condition of Executive Life Insurance Company from the Department under the PRA. Although the records were clearly disclosable, the Department refused his request. Immediately after Belth filed a PRA action, the Department turned over the requested documents. When Belth's attorney, the Center for Public Interest Law (CPIL), requested its attorneys' fees for having to file a lawsuit to compel the Department to comply with the law, the Department claimed that its sudden turnabout had nothing to do with the filing of the lawsuit, and the trial court inexplicably denied CPIL's request for fees. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 133 for background information.) The appellate court reversed, interpreting Government Code section 6295(d), which provides that "[t]he court *shall* award court costs and reasonable attorneys' fees to the plaintiff should

the plaintiff prevail in litigation pursuant to this section," as mandatory, and finding that plaintiff Belth did indeed "prevail in litigation" in that the Commissioner refused to turn over the requested documents until the PRA action was filed.

In ***Sanford v. Garamendi*** (formerly "*Sanford v. Gillespie*"), No. C006971 (Aug. 28, 1991), plaintiffs—individual insurance agents and brokers and their trade associations—sought to prohibit the Insurance Commissioner from issuing insurance agency and brokerage licenses to state banks and their subsidiaries and to rescind any such licenses already granted. The Commissioner began issuing insurer licenses to banks after the 1988 passage of Proposition 103, which expressly repealed Insurance Code section 1643. That section provided that no bank, bank holding company, subsidiary, or affiliate thereof may be licensed as or act as an insurance agent or broker in California. A January 4, 1989 "interpretive opinion" of the Superintendent of Banks concluded that Proposition 103 impliedly repealed Financial Code sections 1208 and 722(b). Section 1208 provides that a commercial bank located in a community not exceeding 5,000 in population "may act as agent for any fire, life or other insurance company authorized to do business in California" if specified conditions are met. Section 722 states in relevant part: "(a) A bank may invest in one or more corporations. (b) No such corporation may act as an insurance company, insurance agent, or insurance broker." Based on this interpretive opinion, the Insurance Commissioner announced that the Department of Insurance would not reject an application from a state-chartered bank for an insurance agency or brokerage license. (See CRLR Vol. 9, No. 2 (Spring 1989) pp. 81 and 88 for background information.)

Plaintiffs filed a writ of mandate, asking the court to declare the Superintendent's interpretive opinion legally erroneous; direct the Commissioner to rescind the insurance licenses issued to banks pursuant to the invalid interpretation; and enjoin the Commissioner from further licensing banks to engage in the general insurance agency or brokerage business. The trial court denied the requested relief, ruling that Proposition 103 impliedly repealed Financial Code sections 772(b) and 1208, thus eliminating any statutory impediments to the licensure of banks and their subsidiaries as insurance agents or brokers.

The Third District Court of Appeal agreed with the trial court's conclusion that "as a result of Proposition 103's express repeal of Insurance Code section 1643, banks may now engage in the insurance agency and brokerage business," noting that "[o]ne of the main purposes of Proposition 103 as set forth in the ballot summary was to allow banks to engage in insurance activities."

However, the Third District rejected the trial court's finding that Proposition 103 impliedly repealed Financial Code sections 1208 and 772(b). The court noted that there is "a strong presumption against the implied repeal of a statute or constitutional provision by subsequent enactment. . . . To overcome the presumption the two acts must be irreconcilable, clearly repugnant, and so inconsistent that the two cannot have concurrent operation." The court held that "there is nothing within Financial Code section 1208 which is inconsistent with the notion that all banks may now enter the insurance marketplace. Financial Code section 1208 is an express grant of authority to a limited class of banks to sell specified types of insurance. . . . It does not, merely because of its limited permissive application, impliedly prohibit all banks not described therein generally from selling insurance."

Regarding section 772(b), the Third District noted that neither Proposition 103 nor the ballot materials accompanying the initiative made any mention of bank subsidiaries, finding "no hint either in the initiative itself or in the accompanying ballot materials that Proposition 103 was designed to allow bank subsidiaries entry into the insurance business." The court thus rejected the Superintendent's conclusion that "the clear intent of the initiative was to allow both banks and their subsidiaries to enter the insurance marketplace." The court noted that Proposition 100, a competing insurance reform initiative on the November 1988 ballot, would have expressly repealed Financial Code section 722(b). "In rejecting Proposition 100 the voters rejected the express repeal of Financial Code section 722, subdivision (b). This rejection is not insignificant."

As a result, the court affirmed the trial court's decision insofar as it denied plaintiffs' request for a writ of mandate commanding the Commissioner to cease granting insurance licenses to banks and to rescind any such license previously issued to banks, and otherwise reversed the decision, directing the trial court to issue a writ of mandate commanding the Commissioner to cease granting insurance license applications to bank subsidiaries and to rescind any insurance license previously issued to any such entity.

On June 18 in ***In Re Insurance Antitrust Litigation***, No. 89-16513, the U.S. Ninth Circuit Court of Appeals reversed the district court's summary judgment in favor of 32 defendant insurers, reinsurers (both foreign and domestic), and insurance associations, and remanded the case back to the lower court for further proceedings. In 1988, then-Attorney General John Van de Kamp led the attorneys general of eighteen other states in filing an antitrust action against defendants for allegedly engaging in group boycott activity in connection with their conspiracy to force the Insurance Service Office (ISO), an industry support organization, to withdraw its standard commercial general liability (CGL) forms and replace them with ones that exclude pollution coverage and replace "occurrence" coverage (the policy covers any valid claim that arises during a certain time period) with "claims-made" coverage (the policy covers only claims reported during a specific time). Defendants filed a motion for summary judgment, claiming immunity from federal antitrust scrutiny under the McCarran-Ferguson Act, 15 U.S.C. sections 1011–1015. Although plaintiffs argued that defendants' conduct fell within the group boycott exception (found in 15 U.S.C. section 1013(b)) to the broad antitrust immunity afforded the insurance industry under the Act, the district court found otherwise and granted defendants' motion for summary judgment. (See CRLR Vol. 9, No. 4 (Fall 1989) p. 97; Vol. 9, No. 3 (Summer 1989) p. 87; and Vol. 9, No. 1 (Winter 1989) p. 76 for background information.)

On appeal, plaintiffs argued that the district court impermissibly expanded the immunity afforded by the McCarran-Ferguson Act. In its 3–0 decision, the Ninth Circuit found that for the immunity to apply, (1) the defendants must be in the business of insurance, (2) that business must be regulated by state law, and (3) the defendants must not have agreed to boycott, coerce, or intimidate, or performed an act of boycott, coercion, or intimidation. While the first condition was met, established law blocks regulation of the insurance business by one state outside the borders of that state. Moreover, regulation by the fifty states of foreign reinsurers is beyond the jurisdiction of the states. "Consequently, McCarran Act immunity does not attached to the foreign defendants . . . [and] the domestic defendants' immunity was lost when they conspired

with the foreign defendants." The appellate court also found that group boycott activity under 15 U.S.C. section 1013(b) was clearly alleged by plaintiffs and, accepting those allegations as true, summary judgment was improper.

On July 24, the California Supreme Court granted the insurance industry's petition for review of the Second District Court of Appeal's May decision in ***California Automobile Assigned Risk Plan v. Gillespie***, 229 Cal. App. 3d 514 (1991). In its decision, the Second District ruled that insurers are not entitled to make a fair rate of return off CAARP business; rather, the fair rate of return to which insurers are entitled under Proposition 103, as interpreted by the California Supreme Court in *Calfarm v. Deukmejian*, 48 Cal. 3d 805 (1989), must be calculated with reference to an insurer's overall auto insurance rates and total revenue. (See CRLR Vol. 11, No. 3 (Summer 1991) p. 134; Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) pp. 140 and 144; and Vol. 10, No. 1 (Winter 1990) p. 108 for extensive background information on this case.)

In another case relating to CAARP, the Second District Court of Appeal recently ruled that Proposition 103's procedures for determining rate increases do not apply to assigned risk policies. In ***California Automobile Assigned Risk Plan v. Garamendi***, No. B047146 (July 25, 1991) (as modified Aug. 9, 1991), the appellate court found that the assigned risk program was closely regulated by the Insurance Commissioner prior to the passage of Proposition 103, and that the initiative "was not intended to alter the procedures for establishing the uniform rate set by the Commissioner for assigned risk policies." CAARP plans to seek review by the California Supreme Court.

On June 13, Commissioner Garamendi announced the voluntary revocation of FGS Insurance Brokers' license. FGS will no longer conduct any business in California and will have its assets liquidated by an independent bankruptcy trustee. This appears to be the last chapter in a long dispute between the Department and FGS. (See CRLR Vol. 11, No. 1 (Winter 1991) pp. 102–03 and Vol. 10, No. 4 (Fall 1990) p. 124 for background information.) Garamendi noted that the Department will continue its efforts to recover FGS assets in order to pay policyholders who have outstanding claims against the company. The assets of FGS are estimated to be $6–15 million.

Also on June 13, Garamendi announced a court-approved "early-access" distribution of $107 million from the estate of failed Mission Title Insurance Company. (See CRLR Vol. 11, No. 1 (Winter 1991) p. 103; Vol. 10, No. 4 (Fall 1990) pp. 123–24; and Vol. 10, Nos. 2 & 3 (Spring/Summer 1990) p. 144 for background information.) This distribution will be made to 39 guarantee associations around the country which have paid $247 million in benefits to Mission policyholders through the end of 1990. The $107 million distribution, when added to the $78 million in statutory deposits being held by 22 states for outstanding claims against Mission, represents 78.8% of the benefits paid by the guarantee associations.

In ***ACL Technology v. Northbrook Property and Casualty Co.***, No. X-619576 (Aug. 6, 1991), Orange County Superior Court Judge Robert Jameson upheld an insurance company's owned-property exclusion clause and validated another exclusion clause that provides no coverage for pollution clean-up unless the pollution is sudden and accidental. In a case of first impression, the court was asked to decide whether costs arising from state-mandated clean-up of contaminated soil and groundwater from leaking underground storage tanks were recoverable in light of the owned-property exclusion and "sudden and accidental" clauses in the policy. In a major victory for insurance companies, the court upheld the validity of both exclusions. In refusing to recognize the corrosion of underground tanks as sudden, the court remarked that coverage would apply only to events that occurred "abruptly." The court also upheld the owned-property exclusion, which essentially relieves an insurer of liability for damages to property owned by the insured, by refusing to recognize the state-mandated clean-up as a third-party claim against the insurance policy. The exclusions addressed in the case, however, were predominantly used in policies issued prior to 1986, after which an absolute pollution exclusion clause was adopted by most insurers. The judgment is being appealed.

On July 18, the Fourth District Court of Appeal ruled that insurance companies that stonewall legitimate third-party claims may be liable for tort damages. In ***Weiner v. Fireman's Fund Insurance***, No. D011547, the court created an exception to the *Moradi-Shalal* ruling which bars civil action when an insurance company "unreasonably but in good faith" refuses to settle a third-party claim. (See CRLR Vol. 9, No. 4 (Fall 1989) p. 97 and Vol. 8, No. 43 (Fall 1988) p. 87 for background information on the *Moradi-Shalal* case.) The appellate court found that *Moradi-Shalal* contemplates that suits for intentional infliction of emotional distress could be brought against insurers under certain circumstances. The pivotal element is conduct that is "so extreme as to exceed all bounds of that usually tolerated in a civilized society." Based on the egregious record, the court stated that a cause of action for intentional infliction of emotional distress existed. The insurer plans to seek review of this decision by the California Supreme Court.

DEPARTMENT OF REAL ESTATE

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

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

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

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

In sales or leases of most residential subdivisions, the Department protects the public by requiring that a prospective buyer be given a copy of the