California State Auditor

BUREAU OF STATE AUDITS

Department of Insurance:

Recent Settlement and Enforcement Practices Raise Serious Concerns About Its Regulation of Insurance Companies

October 2000
2000-123

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October 19, 2000 2000-123

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning our review of the Department of Insurance's (department) settlement practices. This report concludes that former insurance commissioner Chuck Quackenbush abused his authority when he required insurers to pay $12.3 million in settlement outreach payments directly to nonprofit organizations and vendors for purposes not specifically related to his regulatory responsibilities. Also, while it appears that his instructions to insurers to make another $16.5 million in settlement payments directly to nonprofit organizations and vendors may have been within his discretion because the funds were intended for purposes ostensibly related to his regulatory responsibilities, we believe it was imprudent to direct those moneys outside of the State's control. In fact, the entire $28.8 million was not subject to the State's fiscal controls or legislative oversight. We also found that insurers that have violated the Insurance Code may go unpunished because the department does not effectively manage its enforcement actions and that departmental controls for receiving and depositing settlement funds are inadequate.

Respectfully submitted,

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SUMMARY

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Our review of the settlement practices at the Department of Insurance (department) revealed that:

- ☑ *The former commissioner abused his authority by requiring companies to make "off-the-book" payments directly to third parties that were unrelated to the enforcement activities that led to the payments.*
- ☑ *Other settlement payments made directly to third parties, while apparently legal, were imprudent because they were not subject to state purchasing and expenditure controls.*
- ☑ *Many settlements failed to include any monetary penalties against insurance companies that violated the law.*
- ☑ *The department deprived consumers of important information regarding insurance companies because settlement agreements omitted details of the insurers' illegal activities.*
- ☑ *Insurers that violate the law may go unpunished because the department does not effectively manage its enforcement activities.*

RESULTS IN BRIEF

The recent settlement practices of the Department of Insurance (department) and its management of enforcement activities, unless changed, raise concerns about its ability to carry out its mission: to regulate insurance companies and protect consumers. The insurance commissioner has the discretion to settle enforcement actions against insurance companies when he or she believes that a settlement will satisfactorily address violations of the Insurance Code and avoid protracted legal proceedings. However, the former commissioner abused this discretion by requiring companies to make "off-the-book" payments, known as outreach payments, directly to nonprofit organizations and vendors. During the former commissioner's tenure, the department levied outreach payments totaling $28.8 million without posting them to the department's accounting records. Ultimately, many of these outreach payments were used for purposes completely unrelated to the regulatory responsibility of the department.

According to a recent opinion of the attorney general, settlement payments directed to third parties are legal only when used for activities related to the regulatory issues that prompted them. For example, the department might require an insurer accused of discrimination against minority neighborhoods to direct settlement payments to community groups in those neighborhoods to fund programs that enhance safety and quality of life, thus helping to reduce insurable risks in those neighborhoods. Using the attorney general's opinion as criteria, we concluded the former commissioner overstepped his authority when he ordered insurers to make outreach payments to nonprofit organizations and vendors totaling $12.3 million. The terms in each of these settlements were for vague and ambiguous purposes that failed to establish the relationship between the regulatory issues that culminated in the settlements and the outreach payments ordered.

Although the terms in the settlements for the remaining $16.5 million in outreach payments directed to third parties appear to have met the attorney general's threshold for legality, we believe such payments are imprudent because they are not

subject to state purchasing and expenditure controls. This practice limits the department's ability to ensure that outreach payments were made in accordance with the terms of the agreements and used in ways that relate to the regulatory issues involved in the settlement. Moreover, it usurps the authority of the Legislature to oversee and direct expenditure of the funds through the budget process. Absent these fiscal controls, outreach payments were spent for questionable purposes. For example, one nonprofit organization that received outreach payments donated more than $500,000 to the Sacramento Urban League to construct a new building and made an additional $263,000 donation to an athletic foundation that operates youth football camps. Neither of these purposes even remotely relates to the department's regulatory activities.

Furthermore, many settlements failed to include any monetary penalties against insurance companies found to have violated certain provisions of the Insurance Code and the Unfair Practices Act such as handling claims in bad faith or receiving illegal monetary benefits on amounts deposited in escrow accounts. The department also omitted critical enforcement provisions from settlement agreements, thereby further eroding the department's ability to effectively regulate insurers. For instance, in some settlement agreements, the department did not include specific provisions requiring the insurers to cease activities that were in violation of the law and failed to impose fines, making it appear that it had absolved them of misconduct. Additionally, the department sometimes concealed the specifics of outreach payments by including the amount or nature of the payments in separate letters. The department then kept these letters confidential, rather than including such information in the public settlement agreements. When the settlements did not include monetary penalties or orders to cease illegal activities, the insurers' violations were not reported to the National Association of Insurance Commissioners. Therefore, by reaching settlement agreements that require outreach payments rather than imposing penalties, the department limited the amount of information available to other states' insurance regulators and increased the risk of continued violations. The department also deprived consumers of important information on how insurance companies conduct themselves because the public settlement agreements involving outreach payments frequently omitted details of the insurers' illegal activities and the original examinations that identified the insurers' violations of the law are deemed confidential according to current statutes.

Finally, because the department has not managed its enforcement activities effectively, insurers that break the law may go unpunished. The department's legal division does not promptly resolve cases that other bureaus refer to it, even though some are designated as high priority. The department's bureaus also cannot effectively track the status of a referred case because they lack an integrated monitoring system that includes such standard information as the case number, identification of violations, and the outcome of the legal division's review. Further, the department currently tracks enforcement activities using five systems that do not share data. As a result, it cannot readily determine the number and status of open and closed cases, thereby depriving management of information needed to assess the department's ability to effectively regulate the industry. The department's poor controls over payments for fines, cost reimbursements, and outreach activities also inhibit its ability to ensure that it receives and deposits these payments promptly and that the funds are used to further its regulatory purposes.

RECOMMENDATIONS

To ensure that all activities and expenditures funded by settlement payments are what the department intended and that they adhere to state fiscal controls, it should require insurers to direct all payments to the department. If necessary, it can then contract for activities that clearly relate to the regulatory issues that originally prompted the payments. This practice would allow the department to maintain direct control over expenditures made for outreach and education and ensure that they clearly enhance its regulatory role and are legal.

Additionally, the Legislature should consider a change to the Insurance Code that would forbid the insurance commissioner from specifying that payments go directly to nonprofit organizations, foundations, or vendors as part of a settlement agreement.

In those instances in which egregious violations have been identified, the department should require the insurer to pay an appropriate penalty. Further, the department should clearly state the amount of the penalty, the date each type of payment is due, and all other settlement terms in the public settlement agreement, along with a listing of the violations and an order to cease and desist the activities.

Finally, to improve the effectiveness of its enforcement activities, the department should take the following actions:

- Develop an integrated system for tracking enforcement activities.
- Periodically review open enforcement cases.
- Promptly assign and resolve the backlog of open cases in the legal division.
- Instruct insurers to remit settlement payments directly to the accounting division or establish cashiering units within the enforcement bureaus and the legal division. Once a settlement agreement is reached, the legal division should also immediately communicate the terms to the accounting division.
- Strengthen accounting controls to ensure settlement payments are collected promptly and deposited in the appropriate state funds.

AGENCY COMMENTS

The new insurance commissioner believes our findings present a convincing case for organizational improvement and change and he is committed to implementing our recommendations during his tenure. ■

INTRODUCTION

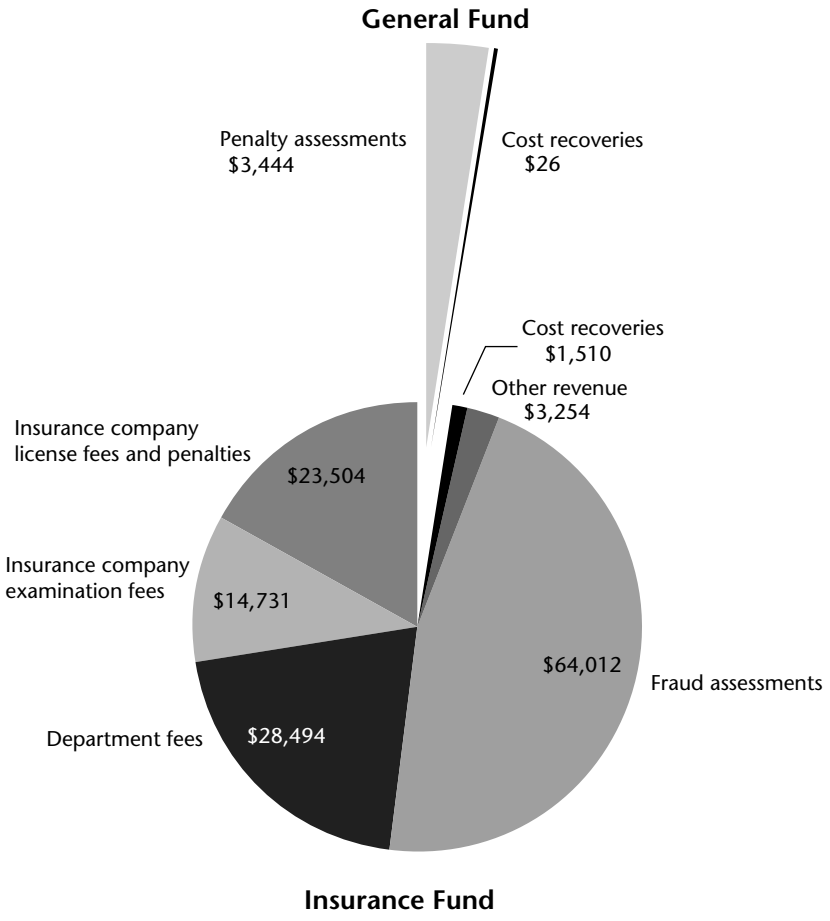
BACKGROUND

The primary responsibility of the Department of Insurance (department) is to protect California's insurance policyholders by regulating the insurance industry within the State. To fulfill this responsibility, the department administers programs designed to protect policyholders, beneficiaries, and the public from the insolvency of insurance companies and to prevent unlawful, deceptive, and unfair practices by insurers, agents, and brokers. The department is also responsible for protecting the general public and policyholders from discriminatory, unlawful, or fraudulent practices related to the sale of insurance. The department performs these duties by conducting on-site examinations of insurance companies; performing desk reviews of insurance company information; and using various other analytical techniques, including trend reviews and reviews of financial reports filed by insurers and other state regulators. The department also investigates and mediates consumer complaints regarding insurer practices. In its investigations of complaints and market conduct examinations, the department verifies that insurers are complying with the Insurance Code and department regulations. Four branches of the department are primarily responsible for monitoring and investigating the various types of insurer activity: consumer services and market conduct, financial surveillance, fraud, and enforcement.

The department receives the majority of its funding from the Insurance Fund, which is supported in part by the department's ability to charge specific regulatory costs, including the cost of certain enforcement activities, to the insurers, in accordance with the Insurance Code. In addition, the code requires fines and penalties levied against insurers as a result of enforcement activities to be deposited in the State's General Fund. Figure 1 depicts the various sources of revenue for the department in fiscal year 1999-2000, that in total amount to approximately $139 million.

FIGURE 1

Revenues* Generated From Department Activities in Fiscal Year 1999-2000 (in Thousands)



* The department also collects $1.3 billion of gross premium and surplus line brokers taxes that are unrelated to its regulatory activities. These tax amounts are reflected in the state controller's general fund accounts.

Enforcement actions taken against insurance companies, agents, and brokers can include issuing orders to cease and desist unlawful activities, levying fines, and suspending or revoking their ability to transact business in the State. However, to avoid the time and expense of pursuing enforcement actions through the courts, the department usually negotiates with insurers what corrective actions they must take. These negotiations result in settlement agreements, which the department reaches with insurance companies in one of two ways. In some cases, the departmental branch that initiated and confirmed the wrongful activity can take direct enforcement action, with the legal division's review

and approval. In a more formal process, the branch that identified the illegal activity refers the case to the legal division, which develops and negotiates the settlement agreement.

The purpose of direct enforcement actions is to take legal action against an insurer with minimal support from the legal division. Activities that result in enforcement actions are generally initiated by any of four branches within the department. In a direct enforcement action, branch staff negotiate the settlement agreement as a swifter alternative to having attorneys from the legal division perform this function. As a result, the legal division is able to focus on higher-profile issues. Direct enforcement actions are not generally used for cases that involve industry-wide issues or those that concern insurers that are among the top 10 in terms of the volume of premiums written in California. These types of cases are referred to the legal division, as are cases that branch staff are unable to settle.

Consumer Services and Market Conduct Branch

Four bureaus within the consumer services and market conduct branch—market conduct, claims services, rating and underwriting, and field rating and underwriting—conduct activities that can lead to enforcement actions that are either determined by the court or negotiated through settlement processes. Generally, the bureaus can choose to resolve problems involving noncompliance by insurers through direct enforcement actions or through referrals to the legal division. In addition, the bureaus sometimes refer cases to other bureaus for enforcement action.

Some bureaus interact directly with consumers in mediating complaints against insurers. Other bureaus enforce regulations concerning fair claims settlements by examining the claims-handling practices of insurers. These regulations establish minimum standards for the prompt, efficient, and equitable settlement of claims. Knowingly violating these regulations, whether on a single occasion or with such frequency as to indicate a general business practice, constitutes unfair claims settlement practices as defined by the Insurance Code.

Financial Surveillance Branch

The financial surveillance branch monitors the solvency of insurance companies by conducting field examinations to determine their financial condition and methods of operation. The branch also analyzes the financial information that insurers

are required to file with the department and creates projections based on this information to detect and correct any potential financial problems before they become more serious. This branch only occasionally negotiates settlement agreements, more often assessing late filing fees against insurers for failing to submit required reports on time.

Fraud Branch and Enforcement Branch

The department's fraud and enforcement branches also perform activities that may result in settlement agreements. The fraud branch protects consumers by investigating fraudulent claims, while the enforcement branch investigates alleged violations of the law by agents, brokers, or insurance companies.

Legal Division

The primary duty of the legal division is to enforce compliance with the Insurance Code by all persons and organizations engaging in the insurance business in California. The division provides legal review and analysis of enforcement actions, approves policy, and promulgates regulations, among other tasks. The legal division also determines whether it will negotiate settlement agreements for referred cases or take them to administrative hearings.

This division consists of six bureaus; however, enforcement actions are generally limited to the compliance, rate enforcement, and administrative law bureaus. The compliance bureau is responsible for providing legal opinions to other bureaus in the department. Staff of the legal division's compliance bureau also prepare and file pleadings in connection with enforcement cases that involve large insurance companies and egregious or industry-wide violations. The rate enforcement bureau enforces the provisions of Proposition 103 and other laws pertaining to the availability and affordability of insurance and rating and underwriting practices. The administrative law bureau conducts hearings to adjudicate a variety of issues, including determining whether companies subject to the insurance commissioner's regulatory powers are conducting their business in a manner hazardous to policyholders or the public.

Recent Events Affecting the Department

The recent controversy surrounding the department's settlement practices and the resulting legislative inquiry led to the resignation of the former commissioner and several deputy commissioners. On July 31, 2000, the governor nominated a new commissioner, who was sworn in by the Legislature on September 18, 2000. Additionally, the Legislature introduced a series of bills prompted by the department's settlement practices. Appendix C briefly describes the content and current status of each bill.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (committee) asked the Bureau of State Audits to perform an audit of the department's settlement practices. Specifically, the committee asked us to determine how many settlement agreements the department reached between January 1996 and the end of May 2000. The committee also asked us to track any payments ordered by settlement agreements to determine if and when insurers made such payments. Further, we were asked to evaluate the department's record keeping to determine whether it is adequate to ensure appropriate and prompt payment of settlement agreements.

To familiarize ourselves with the department's policies, procedures, and practices, we interviewed executives and management staff in branches and bureaus throughout the department. We also familiarized ourselves with laws, rules, regulations, and guidelines related to the department and its settlement process.

Since multiple branches and bureaus entered into settlement agreements during this time, we spoke with department executives and management staff in each one to identify the number of settlement agreements reached and to better understand the process that each branch and bureau went through to arrive at settlement agreements. We also obtained and analyzed information from the case-tracking databases that each branch or bureau uses to deduce the total number of cases that the department opened during this period. To ensure that we identified all settlement agreements, we obtained and reconciled lists of cases that each bureau referred to other bureaus and determined whether such cases had been closed or otherwise resolved in

settlement agreements. Using sequential record numbers assigned by the legal division, we identified missing numbers and attempted to document the resolution of each one.

To track the payments that insurers made as a result of settlement agreements executed from January 1996 through May 2000, we used data obtained from the department's financial records system and reconciled it with our list of settlement agreements and cases. In addition, we interviewed the accounting and administrative staff involved in processing payments and maintaining financial records. Finally, we obtained information from nonprofit organizations that were frequent recipients of outreach payments regarding how they used the funds and the amount and timing of payments made by insurers per the terms of the settlement agreements. We coordinated our efforts to gather this information with similar efforts ongoing at the Department of Justice. In accordance with government auditing standards, we limited our reporting of matters to those that would not compromise any civil or criminal proceedings initiated by the Department of Justice.

To evaluate the department's record keeping and tracking of cases, we interviewed department executives and management staff in each branch and bureau that performed work that could result in a settlement agreement. We also traced a sample of settlement payments to verify if and when the department received and deposited the payments into its accounts. ■

AUDIT RESULTS

THE DEPARTMENT IS RESPONSIBLE FOR REGULATING THE INSURANCE INDUSTRY IN AN OPEN AND EQUITABLE MANNER

The primary responsibility of the Department of Insurance (department) and the insurance commissioner is to protect California's policyholders by enforcing the Insurance Code. According to the department's November 1999 Report of Accomplishments, the commissioner's mission is to "ensure that consumers are protected against unfair practices, excessive or discriminatory insurance rates, and insurer financial instability; that laws are enforced with equal diligence; that all consumers are served in the most efficient, responsive manner; and that the regulatory process is open, fair, and equitable." In other words, the activities of the department and the commissioner should benefit the consumer and fairly and equitably regulate the industry. In the report, the former insurance commissioner identified several critical duties that the department must perform to ensure that it regulates insurance companies effectively and protects California consumers against abusive insurance practices. These duties include providing greater access to information about insurance companies; ensuring better protection against unfair and illegal insurance practices; and collecting fees, reimbursements, fines, and penalties from the insurance industry.

Duties Identified by the Former Commissioner as Critical to Effective Regulation of the Insurance Industry

- Focus on aggressive enforcement of insurance laws, and punish violators.
- Provide consumers with information on enforcement actions.
- Provide protection against unfair and illegal insurance practices.
- Improve efficiency and effectiveness of department operations.
- Fulfill legislative mandates and public responsibilities.
- Provide a stable, well-regulated insurance market without excessive government involvement.
- Provide a "level playing field" for the insurance industry.
- Collect fees, reimbursements, fines, and penalties from the insurance industry.
- Provide information to the public and media about the department's mission to protect California consumers.
- Participate in the National Association of Insurance Commissioners.

The Legislature has given the department the authority to examine or investigate the claims-handling and underwriting practices of insurance companies and to pursue enforcement actions based on those examinations. The department's authority to regulate the insurance industry is found in both the Insurance Code and the Government Code, through the Administrative Procedures Act (APA).

The Insurance Code gives the commissioner the power to deny, suspend, or revoke an insurer's ability to transact insurance business in California. In lieu of suspension, the commissioner can assess a monetary penalty when an insurer violates the law and recoup certain enforcement costs. Whenever the commissioner believes that an insurance company has engaged in an unfair method of competition or an unfair or deceptive act or practice, he or she has the authority to serve the company with an "order to show cause." In answer to this order, the company must demonstrate that the charges outlined in the order are unfounded. If the company cannot do so and the department finds the charges to be justified, the commissioner must order the insurer to cease and desist those methods, acts, or practices and give notice of an administrative hearing.

The department conducts administrative hearings pursuant to the APA, which specifically recognizes that an agency can issue a decision on a pending matter by negotiating a settlement. Moreover, the settlement can include any terms that the parties determine are appropriate and sanctions that the agency would otherwise lack the power to impose.

The attorney general recently opined that the commissioner lacks authority to require outreach payments if the activities to be funded are not related to the violations that gave rise to the settlements.

This discretionary ability was recently confirmed by the state attorney general, who, in an opinion issued in July 2000, stated that the commissioner can require an insurer to contribute to a nonprofit corporation as one of the terms of a settlement agreement. However, the opinion also stated that such a payment cannot be for a purpose unrelated to the regulatory duties of the department in the proceeding. The attorney general also opined that the commissioner lacks the authority to require the contribution if the activities to be funded are unrelated to the violation that gave rise to the settlement. The Legislative Counsel had another view based on the commissioner's authority to impose sanctions. In two opinions issued in late April and early May 2000, the Legislative Counsel concluded that the former insurance commissioner did not have the legal authority to require an insurer to contribute money to a nonprofit organization as part of a settlement agreement, reasoning that such a contribution is not a sanction as defined by law.

Although these apparently conflicting views raise questions about the insurance commissioner's authority to require outreach payments in settlements, we have relied on the attorney general's opinion in assessing whether outreach payments were within the former commissioner's legal authority for two reasons.

First, the attorney general's opinion speaks to the insurance commissioner's legal authority in a broad context, while the Legislative Counsel opinions were limited to a particular settlement agreement. Second, the attorney general is designated as the attorney for executive branch agencies such as the Department of Insurance, so the department can be expected to rely on this opinion.

In enacting the APA, the Legislature provided the commissioner with broad authority to settle pending enforcement actions. In fact, it is not unprecedented for a settlement agreement to contain provisions ordering the insurer to make payment directly to a third party. For example, in March 1993, the department examined the rating and underwriting practices of an insurance group and its constituent companies (hereafter collectively referred to as the insurers). The examination found that the insurers had been using a highlighted street map of the city of San Francisco as an underwriting tool, declining to write insurance policies in areas that the map identified as being predominantly minority, gay and lesbian, and low-income communities. This practice was in violation of the Insurance Code. As a result, former commissioner John Garamendi (who held this position from January 1, 1991, until January 1, 1995) entered into a public settlement agreement in August 1993, listing all of the insurers' violations of the Insurance Code and requiring them to contribute $100,000 to a San Francisco foundation.

An August 1993 settlement agreement requiring an insurer to make an outreach payment to a third party appeared to further the enforcement activities that led to the settlement.

The foundation was to distribute the funds to minority and gay and lesbian community organizations located within the city to reward them for their participation in community improvement, crime prevention, and safety education activities—activities that arguably serve to reduce insurable risks. The settlement agreement also called for a $400,000 fine and instructed the insurers to exert their best efforts to increase the amount of insurance premiums written in the "underserved areas" in California by $3 million to $4 million within approximately four years of the settlement date. The underserved areas referred to in the settlement presumably would include the groups the department had found were unfairly denied insurance by the insurers' underwriting practices. Finally, the insurers were ordered to cease engaging in the rating and underwriting practices that the department found had violated the Insurance Code.

While the Garamendi settlement appeared to further the department's enforcement responsibilities at issue, many of the settlements of former commissioner Quackenbush (who held

this position from January 2, 1995, until his resignation on July 10, 2000) did not. For example, in a case settled in April 1999 with State Farm Fire and Casualty Company (State Farm), the public settlement agreement contained no listing of the violations the department found in its examination of the company, assessed no fine or penalty, and included no order to cease and desist any unfair or illegal practices. The agreement also failed to include any mention of a $2 million "voluntary contribution" that State Farm agreed to make to a "public earthquake study/education fund" to be established by a nonprofit public benefit corporation. The information about the outreach payment was included in a side agreement that was not made a part of the public settlement agreement.

THE FORMER INSURANCE COMMISSIONER ABUSED HIS DISCRETIONARY AUTHORITY IN THE SETTLEMENT OF ENFORCEMENT ACTIONS

Between January 1, 1996, and May 31, 2000, former commissioner Quackenbush entered into 96 settlement agreements requiring some form of monetary payment on the part of the insurance companies for various violations of the Insurance Code. In the early part of this period, some of the agreements included fines for noncompliance with the Insurance Code and cease and desist orders, as well as outreach payments. These earlier agreements also generally identified the violations committed by the insurer. However, beginning in 1997, the department began a trend of negotiating away its enforcement powers on particular cases. Moreover, it increased the use of outreach payments while at the same time reducing the imposition of fines.

Key State Fiscal Controls

- Reconciling receipts deposited in the state treasury system with the state controller's accounting records.
- Competitive bidding for contracts.
- Approval of payments by individuals that do not order or receive the goods and services.
- Legislative oversight of spending through the budget process.
- Conflict-of-interest requirements to prevent self-dealing.

Millions of Dollars in Outreach Payments Did Not Relate to the Department's Regulatory Responsibilities

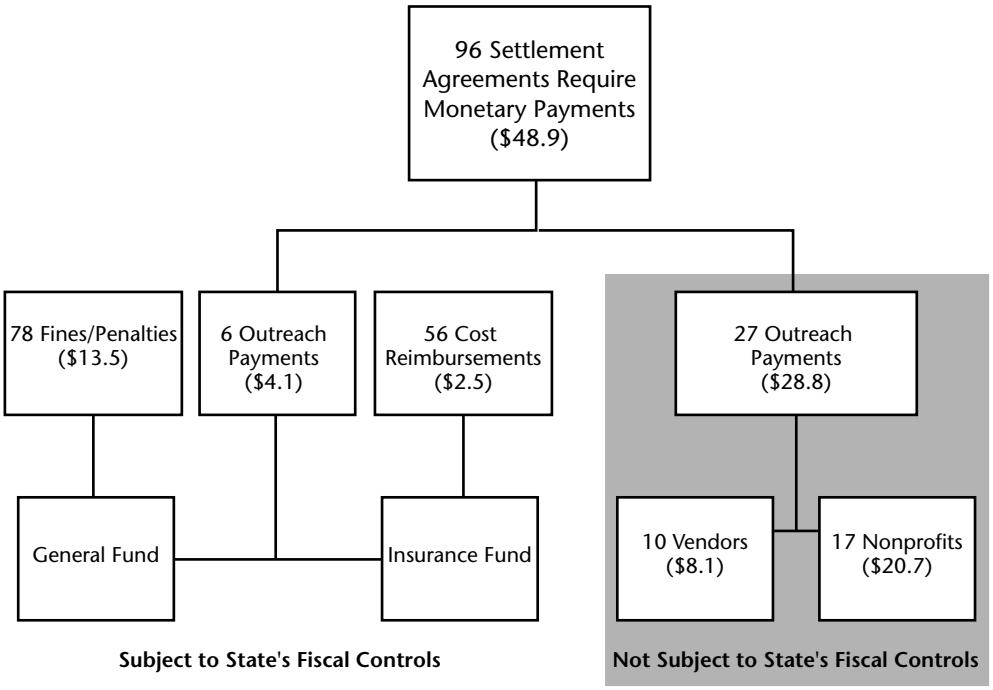
The former insurance commissioner abused his authority by requiring insurance companies to make $12.3 million in outreach payments directly to vendors and nonprofit organizations when such payments did not relate to the regulatory activities that gave rise to them. These funds were not subject to the State's system of fiscal controls and were outside the oversight of the Legislature. These settlement agreements established by the former commissioner ambiguously defined the purposes of the outreach payments, therefore, we

question how the department established a relationship between its regulatory responsibilities and the funneling of $12.3 million in settlement payments to entities outside the State's control. According to a recent attorney general's opinion, to be legal, an outreach payment to a third party must be related to the enforcement responsibilities of the department that led to the settlement agreement.

Of the 96 settlements we reviewed, 27 (28 percent) required insurance companies to make outreach payments in the form of contributions to nonprofit organizations or payments to vendors that the former commissioner would later select to provide services. As shown in Figure 2, $28.8 million, or 59 percent of the total monetary payments required by settlement agreements, was in outreach payments not subject to the State's fiscal controls. On the other hand, although 78 cases (81 percent) exacted fines or penalties, the total paid was only $13.5 million, or 28 percent of the total settlement payments. (For a complete list of all the settlements made during the period and their terms, see Appendix A.)

FIGURE 2

Where Funds Were Directed in Settlements Made From January 1, 1996, Through May 31, 2000 (Dollars in Millions)



As shown in Figure 2, settlement fines and penalties, which are defined as charges imposed by the department for wrongdoing, are deposited in the General Fund. Cost reimbursements, representing costs incurred by the department during the course of enforcement activities that the department can recoup from the insurer, are deposited in the Insurance Fund. The figure also shows $4.1 million in outreach payments that were subject to state control. These payments were made directly to the department rather than to a nonprofit organization or vendor. Not shown in Figure 2 are amounts for consumer restitution, which can take the form of direct insurer payments to affected policyholders or insurer rebates of future premiums and are the result of self-audits or reexamination of records conducted by insurers as part of the terms of settlement agreements. Of the 96 settlements we reviewed,13 contained provisions requiring the insurers to make restitution to their respective policyholders.

The Department Omitted Critical Enforcement Provisions From Settlement Agreements

The former commissioner may have thwarted the law's intent when he failed to impose penalties and issue cease and desist orders against insurers that violated the Insurance Code.

Beginning with the Prudential Insurance Company of America (Prudential) in 1997 and, to a greater extent, the subsequent Northridge earthquake settlements, the department omitted certain enforcement provisions from its settlement agreements. In some cases, the department departed from its usual practice and permitted insurance companies to draft some settlements. Further, the former commissioner may have thwarted the intent of the law when he failed to impose penalties and issue cease and desist orders against insurance companies engaging in unfair or deceptive business practices—practices that had been substantiated by the department's examinations.

The Insurance Code specifically states that if charges against a company are found to be justified, the commissioner must issue an order requiring the company to pay a penalty and to cease and desist those practices found to be unfair or deceptive. Failure to assess penalties gives the appearance that no improper conduct occurred. Cease and desist orders are also an important part of a settlement agreement because any future findings of noncompliance with the applicable codes would be considered willful violations of the law, subjecting the insurer to harsher penalties.

In February 1997, the department executed a settlement agreement with Prudential resulting from substantiated allegations of improper sales and marketing practices. The terms of the agreement required Prudential to pay a fine of $5.5 million and

reimburse the department $1.4 million for the costs associated with the investigation. Prudential was also required to invest $5.5 million in the California Organized Investment Network (COIN)—a program created by former commissioner Quackenbush to increase the level of investment by the insurance industry in low-income and rural communities—and to pay the department $3 million for "future customer services and outreach." However, despite substantiated violations of the Insurance Code, the department did not include a cease and desist order in the settlement agreement.

The omission of enforcement provisions from the Northridge settlement agreements is even more troubling. Between April 1999 and July 1999, the department reached settlement agreements with four insurance companies and their affiliates related to their handling of Northridge earthquake claims. The insurance companies that executed these settlements were Allstate Insurance Company (Allstate), Farmers Home Group, State Farm, and 20th Century Insurance. Prior to entering into these agreements, the department performed a market conduct examination of each company. The purpose of a market conduct examination is to evaluate the insurer's compliance with contractual obligations, its own procedures, the Insurance Code, and other applicable legal requirements as they relate to the handling of claims.

The department's examinations of the four insurance companies identified numerous irregularities in claims-handling practices. However, none of the settlement agreements ordered any of the insurance companies to cease and desist the activities identified as violations in the market conduct examinations, and only one assessed a fine. For example, in its examination of State Farm, the department identified more than 1,300 violations of the Insurance Code, including inadequate investigation and scoping of damages, low claim settlement offers, and unsupported depreciation reductions. Despite the seriousness of these findings, the department did not include a cease and desist clause in its settlement agreement with State Farm, nor did it require the company to pay any fine related to its handling of earthquake claims. In fact, the only monetary provision contained in the public settlement agreement was an order to pay the department $5,000 for costs related to its review of claim files. However, in a separate, nonpublic agreement, the department ordered State Farm to make a "contribution" of $2 million to the California Research and Assistance Fund (CRAF), a nonprofit organization.

Although one insurer reportedly violated more than 1,300 provisions of the Insurance Code, the department neither fined the insurer nor issued a cease and desist order.

In addition, these agreements did not include provisions that would allow the department to reexamine the companies' business practices with regard to claims arising from the Northridge earthquake. Such reexaminations are important because they allow the department to verify whether insurers have made corrective changes in their handling of claims. In fact, the agreement with 20th Century Insurance included a provision stating that the settlement resolved all matters relating to the company's handling of claims arising out of the Northridge earthquake and covered by the market conduct examination. The former commissioner further agreed not to issue a statement of charges or accusations against the company. As a result, the nature of the company's violations and their impact on policyholders were not publicly disclosed.

In exchange for contributions to nonprofit organizations totaling $1.55 million, the department agreed not to perform future market conduct examinations of two insurers related to their handling of Northridge earthquake claims—even though neither insurers' earthquake claims had been examined.

In an even more alarming concession of its enforcement powers, the department agreed not to conduct any future market conduct examinations of the Fireman's Fund Insurance Company (Fireman's Fund) and Farmers Insurance Exchange (Farmers Exchange) related to their handling of Northridge earthquake claims. In return, Fireman's Fund and Farmers Exchange agreed to contribute $550,000 and $1 million, respectively, to two different nonprofit organizations, to be used at the discretion of the organizations' administrators. However, the department made this concession without having conducted any examination of these companies' claims-handling practices related to the earthquake.

Settlement Agreements Established by the Former Commissioner Did Not Foster Open and Equitable Regulation of the Industry

Based on a November 1997 memorandum from the department's former chief counsel and another staff counsel to the former general counsel, it appears that the increased use of outreach payments was a deliberate attempt to circumvent the State's fiscal controls. In the memo, counsel cautioned that any funding mechanism that appeared to use a statutory loophole probably would not withstand legislative scrutiny. As evidence, they referred to the Insurance Code, Section 12975.7, which states that all moneys received by the commissioner in fines and penalties must be deposited in the General Fund and that all payments received for lawful fees and cost reimbursements must be deposited in the Insurance Fund. More importantly, they cited Section 13332.18(a) of the Government Code, which states that revenues derived from the assessment of fines and penalties

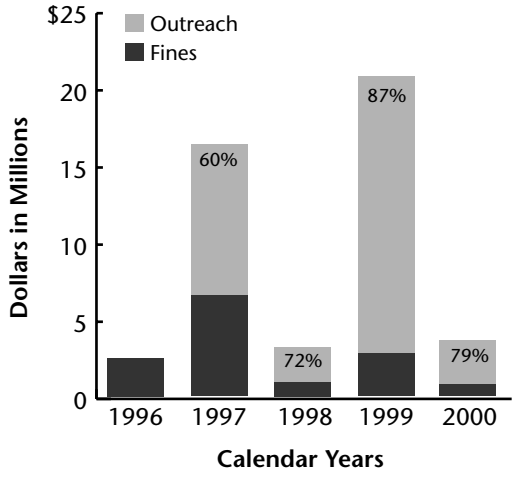
The department's use of outreach payments was a deliberate attempt to circumvent the State's fiscal controls.

must not be spent unless the Legislature specifically provides authority for the expenditure of these funds. The memo further states that these code sections, taken together, express a legislative intent that the department cannot expend funds derived from reimbursements, fines, and penalties without legislative approval. However, in a recommendation that ultimately served as a model for subsequent settlements, the counsel proposed having the settlement document require the insurer to fund outreach programs directly. Another alternative that they considered less desirable was to establish a fund for the restitution of victims of the conduct for which the fine or penalty was imposed or, if applicable, for repairing damage to the environment caused by the conduct. However, the counsel noted that this alternative would involve informing the public of the availability of the restitution fund, and therefore they recommended that insurers instead fund outreach programs by making payments directly to third parties.

As shown in Figure 3, the amount of outreach payments required of insurers generally increased in proportion to the amount of fines and penalties assessed to insurers during the 4.5-year period we examined. For example, in calendar year 1997, outreach payments were $9.8 million and represented 60 percent of the combined total for outreach and fines. However, 2 years later, the proportion of required outreach contributions increased to 87 percent of the combined total for outreach and fines.

FIGURE 3

Outreach Payments Versus Fines Imposed From January 1, 1996, Through May 31, 2000



Insurance Companies Involved in Northridge Earthquake Settlements

- Allstate
- State Farm
- Farmers Home Group
- 20th Century Insurance
- Fireman's Fund
- Farmers Exchange

Settlement negotiations with the insurers handling Northridge earthquake claims illustrate the department's move to replace fines with outreach payments subsequent to the 1997 memorandum. Beginning in June 1996, the department's market conduct bureau performed market conduct examinations of four insurance companies, focusing on their handling of claims resulting from the 1994 Northridge earthquake. The market conduct bureau identified numerous irregularities in the claims handling practices on the part of all of these companies. As a result, the department notified the four insurance companies that it intended to pursue enforcement through the administrative process. Fireman's Fund and Farmers Exchange were later added to the process, although the department had not performed market conduct examinations for these companies.

In March 1999, a team consisting of legal division attorneys, the former chief of the enforcement branch, the former chief of the consumer services and market conduct branch, the former general counsel, and other senior staff began settlement negotiations with the insurers. Prior to these negotiations, the department team estimated the amount of the fine that could be levied against each of the four examined insurers by projecting the number of violations identified during the market conduct examinations to the entire population of earthquake claims handled by each insurer. It then multiplied the projected number of violations by $10,000, the maximum fine allowed by law for each violation, to arrive at a potential total fine of $3.4 billion for the four insurers. However, the settlements reached with these companies required only one company—20th Century Insurance—to pay a fine, which amounted to $100,000. In lieu of heavy fines, the four insurers were collectively required to make outreach payments totaling $10.9 million.

Total fines imposed on insurance companies handling Northridge earthquake claims amounted to only $100,000.

While the $3.4 billion in estimated fines was most likely a maximum sanction from which to negotiate settlements with these four insurers, when compared to the single $100,000 fine and $10.9 million of combined outreach payments that were eventually assessed, it is clear that the department decided to obtain outreach funds rather than fine insurers for violations of the Insurance Code. Because the outreach payments were made to entities outside the State's system of fiscal controls, none of the money directed to these entities was recorded in the department's accounting records. Moreover, the department did

not require the four insurers to provide evidence that they had made the outreach payments. As a result, the department could not properly track the payments to ensure that they were promptly received or that the funds were used as directed in the settlement agreements. In fact, one nonprofit ultimately spent more than $1.4 million for purposes clearly unrelated to the regulation of the insurance industry.

The Department Sometimes Masked the Purpose of Outreach Payments by Omitting Specific Information From Public Settlement Agreements

Settlement agreements that included an outreach component did not always stipulate the exact amount that was to be paid to the nonprofit organization or vendor. In these cases, the payment amount was specified in a separate letter, which the department agreed to keep confidential. In addition, settlement agreements did not always specify how the funds were to be used. Rather, the terms of the agreements were vague and ambiguous. For example, 11 settlement agreements contained provisions requiring only that outreach funds be used for the general benefit of the public or to educate consumers about basic insurance issues. Moreover, the former commissioner frequently failed to include orders to show cause and statements of charges—lists of alleged wrongdoing by the insurer—as part of the public settlement agreement.

The department prevented policyholders and consumers from obtaining information about insurers' business practices by keeping some settlement terms confidential and omitting others.

Besides being inconsistent with the commissioner's regulatory role, these practices misled the public. Specifically, by electing to keep some settlement terms confidential and exclude code violations, the department prevented policyholders and consumers from obtaining critical information about the business practices of insurers. California citizens also had no way of determining whether appropriate actions had been taken to correct violations identified by the department. These practices contradicted the department's mission of ensuring that the regulatory process is open, fair, and equitable. Moreover, the Government Code requires that, unless specifically exempted from disclosure, all documents executed by state departments be available for public viewing. There is no question that all the terms of a settlement agreement are public record, yet the former commissioner agreed to keep some of them confidential. Therefore, in addition to misleading the public, the former commissioner may also have violated state law.

By omitting portions of settlement agreements from the public records, the department also allowed insurance companies to avoid having their violations reported to the National Association of Insurance Commissioners (NAIC). The NAIC was created as a voluntary means for state insurance commissioners to coordinate the regulation of multistate insurers. As part of these coordination efforts, the NAIC created the Regulatory Information Retrieval System (RIRS), which contains regulatory actions taken by participating state insurance departments against insurance agents, brokers, companies, and other entities engaged in the business of insurance. When the department negotiated settlement agreements that did not impose fines or penalties, insurance commissioners in other states were not made aware of unfair practices or other code violations committed by these companies, which may do business in their states.

Even when the department does impose a fine or penalty on an insurance company that violates the Insurance Code, it does not consistently report regulatory actions taken against California insurers. We identified 78 settlement agreements that included fines and penalties for the period January 1, 1996, through May 31, 2000, however, the department only reported four of these to the NAIC, even though it voluntarily participates in the association and has a mechanism to report violations. By failing to consistently report the fines and penalties it does impose, the department removes an effective deterrent against further violations and increases the risk that insurers will continue to break the law.

The department fined insurers 78 times during a 4½ year period but only reported four of these fines to the NAIC.

The Department Entered Some Settlements Without Conducting Examinations

We also found that only four of the six Northridge earthquake settlement agreements were based on the department's examinations of the companies' records. Although it reached settlement agreements with Fireman's Fund and Farmers Exchange, the department had not performed market conduct examinations of them as it did the others. Unlike the other settlements we reviewed, which were written by the department, attorneys for each of the two insurers prepared these settlement agreements. Both agreements were labeled confidential and contained several similar provisions. For example, both insurers agreed to survey policyholders that had submitted Northridge earthquake claims to measure their satisfaction with the insurers' claims-handling practices. The survey was limited to claims that were not subject to litigation and did not involve representation by counsel.

Based on the survey results, the two insurers agreed to review and reevaluate all claims that policyholders were dissatisfied with and determine what, if any, additional payments might be due. As a prerequisite to making any additional payments, both insurers reserved the right to require that affected policyholders waive their ability to sue the insurers regarding their claims. Both insurers agreed to submit reports to the former commissioner confirming their compliance with these terms and acknowledged his right to verify the information in the reports by reviewing the actions the insurers took to comply. However, the settlement agreement of one insurer states that this verification is not a market conduct examination and that its purpose is not to assess fault or serve as the basis for other regulatory measures by the former commissioner. Finally, one insurer agreed to make a contribution of $1 million to one nonprofit organization while the other insurer agreed to contribute $550,000 to a different nonprofit organization.

In exchange for these concessions on the part of Fireman's Fund and Farmers Exchange, the former commissioner agreed to conclude any pending market conduct examinations and forego any future market conduct examinations of the Northridge earthquake claims of these two insurers. He also agreed not to take any regulatory actions, including fines or other penalties, relative to such claims. By making these agreements, the former commissioner effectively bargained away his right to examine or sanction these insurers in the future for any violations they may have committed in their handling of claims arising from the Northridge earthquake.

While the Department Settled Code Violation Cases With Some Title Insurers, It Has Not Yet Settled With Others for the Same Practices

The department has alleged that 20 title companies violated laws related to earnings credits, but has executed settlement agreements with only 5.

The department did not take prompt and consistent enforcement action with insurers that committed identical violations of the Insurance Code. For example, although the department had examined 20 title companies and alleged that each had violated the law, it had executed settlement agreements with only 5 as of the end of August 2000. In 1999, the department determined that earnings credits were widely used throughout the title insurance industry, and it confirmed their use through limited-scope examinations. Earnings credits are in-kind compensation, such as reductions in bank or vendor service charges, that banks and other financial institutions offer to title companies to encourage them to maintain escrow account balances. The

department subsequently concluded that the accumulation and use of earnings credits violated the Insurance Code because title companies were receiving monetary benefits as a result of depositing policyholders' funds without always informing policyholders of this practice or obtaining their written consent to continue receiving the credits.

According to the deputy commissioner for the financial surveillance branch, staff from his branch and a consulting law firm performed examinations of 20 title companies to determine the extent and nature of their use of accumulated earnings credits. The department discussed with the Office of the Attorney General which companies it would examine and the scope of the examinations, because the attorney general would use the results in support of a lawsuit against one of the title companies. The companies that the department and its consultant examined accounted for approximately 80 percent of California's escrow business, as determined by the volume of their average escrow balances for calendar year 1998. Based on these examinations, the department determined that all 20 title companies had accumulated and used earnings credits in apparent violation of the Insurance Code. However, rather than having the financial surveillance branch negotiate a separate settlement agreement with each company in proportion to the severity of its violation of the law, the former commissioner instructed the branch to use a lump-sum settlement figure based on the amount needed to fund an outreach program. Moreover, even though the department determined that all 20 title companies had violated the law, as of the end of August 2000, it had executed settlement agreements with only 5.

The former commissioner based the total settlement amount for the 20 companies on the funding needed for a public outreach program.

According to the deputy commissioner, in November 1999, the former commissioner directed that the cases with the title companies be settled. The department prioritized the order in which cases were settled with title companies based on market share. The first 5 companies that the department reached settlements with were: First American Title, Fidelity National Title, Chicago Title, American Title, and Old Republic Title. The deputy commissioner stated that negotiations had been initiated with other companies, but none had been finalized. He told us that the settlements with the remaining 15 title companies are still pending the new insurance commissioner's decision on how to proceed.

The deputy commissioner also stated that the former commissioner instructed him to settle the title company cases for a total of $4 million. The $4 million was a "global amount" suggested to the former commissioner by a former deputy commissioner as the amount needed to fund a public outreach program concerning title insurance and escrow business to be administered and directed by a nonprofit foundation. According to the deputy commissioner, the $4 million settlement amount was subsequently reduced to $3 million based on the belief that $1.25 million was already available to fund the outreach program as the result of a prior settlement agreement reached with First American Title for paying illegal rebates to real estate licensees. Given this directive, the deputy commissioner determined the outreach payments for each of the 20 title companies by devising a formula based on market share, as measured by the average escrow balance maintained by each company during calendar year 1998. The deputy commissioner stated that his rationale for the formula was that those companies with the highest average escrow balances had received the greatest financial benefit from earnings credits and thus should pay the highest settlement amounts. The five settlements the department finalized contained a total of $2.3 million in outreach payments, as well as $140,000 in combined cost recovery for settlement and hearing preparation costs. Old Republic Title was the only company to receive a fine, but the settlement agreement called the $55,000 fine an "administrative fee." All five title companies also agreed not to oppose the enactment of a clarifying regulation proposed by the department to eliminate confusion in the law regarding earnings credits.

THE PURPOSES OF OUTREACH PAYMENTS MADE TO ENTITIES OUTSIDE STATE CONTROL WERE OFTEN QUESTIONABLE

Settlement outreach payments totaling $16.5 million directed to third parties outside the State's fiscal controls appear to be legal but we believe this practice is imprudent.

Although the attorney general concluded that the practice of directing settlement funds outside the State's control is legal if the payments are used in ways that relate to the regulatory issues that prompted the payments, we believe that this practice is imprudent. According to the attorney general's criteria, the settlement terms directing a total of $16.5 million in outreach payments to third parties appear to be legal, but in some instances the subsequent use of these funds was questionable. Further, because many of the settlement agreements specify the purposes of outreach payments in vague and ambiguous terms,

we question the appropriateness of payments directed to nonprofit organizations and vendors totaling $12.3 million. (For a listing of the companies directed to make outreach payments and a description of how such funds were used, see Appendix B.)

Settlement payments deposited in the state treasury system are subject to various fiscal controls and legislative oversight.

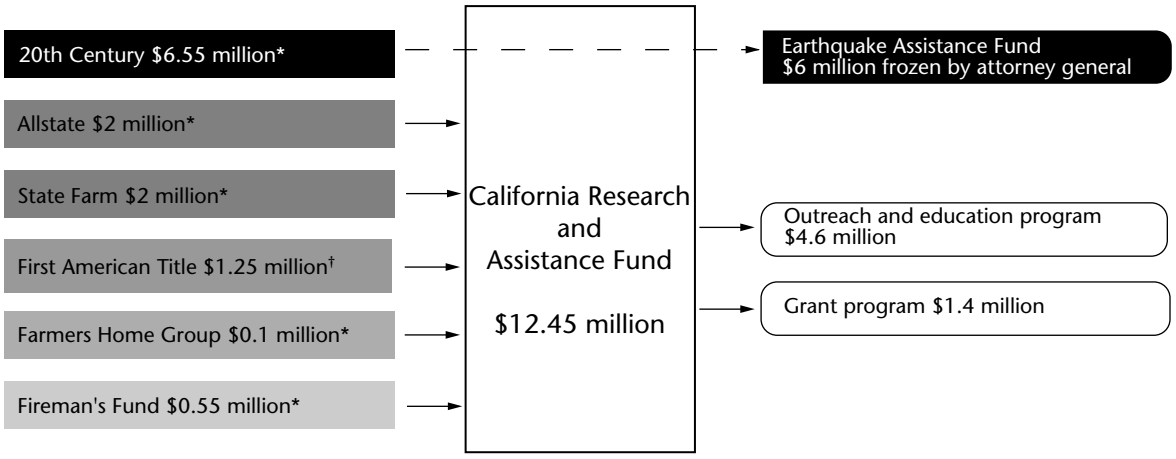
It is with good reason that the Insurance Code requires that the fines and reimbursements the commissioner receives through settlement agreements or by order of an administrative law judge be deposited in the General Fund and Insurance Fund of the state treasury system. Such requirements enable the department to better track insurers' adherence to settlement provisions. In addition, funds deposited in this manner are subject to state purchasing and expenditure controls, and their disbursement must be reviewed and approved according to state laws and regulations. The funds must also be included in the department's budget process, which allows for legislative oversight and public disclosure. Absent these fiscal controls, more than $1.4 million in settlement funds directed to one nonprofit organization were spent for purposes wholly unrelated to the department's regulatory responsibilities.

One Nonprofit's Use of Outreach Payments Illustrates the Potential Effect of Eliminating State Fiscal Controls

CRAF received approximately $11.2 million in contributions from Northridge earthquake settlement agreements with five insurance companies and another $1.25 million from a settlement with a title insurance company. CRAF is a nonprofit organization incorporated in April 1999 by the former general counsel of the department. According to its Articles of Incorporation, CRAF was organized solely for the purpose of promoting social welfare. The articles further state that no person should personally gain from the activities of CRAF. Figure 4 shows CRAF's sources of funding and the general purposes for which the funds were used.

FIGURE 4

Sources of Contributions Made to CRAF and How Funds Were Used



* Northridge earthquake settlement

† Title rebate settlement

Of the $11.2 million CRAF received from the earthquake settlements, more than half ($6.55 million) came from the department's settlement agreement with 20th Century Insurance. According to the terms of this agreement, CRAF would set aside $6 million in an Earthquake Assistance Fund to provide limited financial assistance to homeowners whose claims exceeded the amount covered by their earthquake insurance and for assisting underinsured nonprofit organizations that suffered earthquake damage. A fund manager suggested by 20th Century Insurance and approved by the former commissioner would administer the fund, with full authority to decide who was eligible for assistance from the fund and the amount given to each applicant. The agreement also stated that any amounts remaining in the fund after all payments of financial assistance and expenses of winding down and dissolving the fund had been made should be used for the general purposes of CRAF, as determined by its board. It also required 20th Century Insurance to pay CRAF $550,000 to be used for its general purposes. However, the agreement did not define "general purposes" or place any restrictions on the use of these funds. As a result, CRAF and its fund manager had full discretion over how these funds were to be used. Although the settlement with 20th Century Insurance was executed in April 1999, the insurer did not provide any funding for the Earthquake Assistance Fund until May 9, 2000. The attorney

general had already frozen all of CRAF's assets a few days earlier, however, so that when it received the $6 million earmarked for assisting earthquake victims, those funds were frozen as well. Therefore, no assistance to earthquake victims was ever provided by the Earthquake Assistance Fund.

The earthquake settlement agreements with the other four insurance companies required outreach contributions totaling $4.65 million and contained equally vague terms about how the funds were to be used. For example, in its settlement with the department, Fireman's Fund agreed to contribute $550,000 to a nonprofit education project, later identified as CRAF. The agreement further stated that the project administrators should use their discretion concerning the use of the funds. Because of the broad discretion given to these administrators and the elimination of any state controls, more than $1.4 million of the funds were spent by CRAF for activities that clearly did not relate to the department's regulatory function or the enforcement responsibilities that led to the insurers' contributions.

After receiving $263,000 in donations from CRAF, the foundation paid a former deputy commissioner for the department at least $90,000—reportedly to reimburse him for equipment purchases and rendering services for the foundation.

For example, during a five-month period from July 1999 through November 1999, CRAF provided grant funds totaling $263,000 to Skillz Athletic Foundation, an organization that runs youth football camps in Sacramento. The foundation used a portion of the grant funds to pay at least $90,000 to a former deputy commissioner for the department, reportedly to reimburse him for the purchase of equipment and for running some programs. CRAF also contributed $500,000 to build a new building for the Sacramento Urban League, an organization for which the former commissioner was a board member. Table 1 lists all the nonprofit organizations that received funding from CRAF and how they used the money. Clearly the purposes are far removed from the regulatory responsibilities of the department that initially prompted the outreach payments—and thereby fail the test that the attorney general concluded must be met for the use of these funds to be considered legal.

TABLE 1

Earthquake Settlement Funds Used for Purposes Unrelated to the Department's Regulatory Requirements

Organization	Amount of Funding	Purpose of Donation or Grant
Sacramento Urban League	$501,500	Construct new building ($500,000). Tickets for fund-raiser dinner ($1,500).
Skillz Athletic Foundation	263,000	Educate, coach, counsel, and guide student athletes.
100 Black Men Bay Area Inc.	200,000	Fund scholarships for youth and for general purposes.
Athletes & Entertainers for Kids	190,000	Televised charity sporting event ($70,000). General purposes ($120,000).
Freedom Foundation	100,000	General purposes. The purpose of the organization is to reclaim blighted urban areas and develop inner-city commercial ventures.
9-1-1 4 Kids Foundation	45,000	Classroom kits to teach children how to use 9-1-1.
Oakland Mentoring Center	40,000	General purposes. This organization serves as a regional mentoring think tank providing technical assistance, consultation, and youth-mentoring training.
Meadowview Community Action	25,000	Fund programs for low-income individuals to become more self-sufficient.
National Latinos Peace Officers Association	12,000	General purposes. This organization's purpose is to increase the recruitment, hiring, training, retention, and promotion of Latinos in the field of law enforcement.
Black Filmmakers Hall of Fame	10,000	Screen a film and fund an art exhibit honoring the contributions of African-American soldiers.
Northern California Reinvestment Consortium	10,000	General purposes. This organization advocates the creation of loan pools, products, and services to revitalize disadvantaged areas and provide economic opportunities for low-income people.
Second District Education and Policy Foundation	10,000	Sponsor an event for foster children.
Total Payments	**$1,406,500**	

Moreover, the lack of fiscal controls was apparent in CRAF's contracting practices. Since its incorporation in April 1999, CRAF has entered into several consulting agreements, none of which were competitively bid to ensure that the organization received the best services for the lowest cost. As of the end of March 2000, CRAF had paid its consultants $4.6 million, most of which went for services such as planning and producing a media campaign featuring earthquake preparedness. One consultant agreement awarded $18,000 to Community Connections, a sole proprietorship owned by one member of the CRAF board—the same board that approved the contract. Although there was a provision in the agreement concerning conflict of interest, apparently the board did not consider the provision when awarding the contract to one of its members.

One of CRAF's board members approved an $18,000 contract for himself.

The Outreach Provisions of Many Settlement Agreements Raise Questions About Their Legality

Many settlement agreements also contained vague and ambiguous language describing how insurer outreach payments to nonprofit organizations should be used, rather than identifying the specific objectives and projects to be funded. For example, through its investigation, the department determined that the First American Title Company had illegally offered rebates to real estate licensees in the form of free computer software and hardware, gift certificates, sales retreats, ski trips, training unrelated to the title insurance business, and holiday parties, among other benefits. First American Title subsequently settled with the department in an agreement reached in October 1999. The settlement agreement ordered the insurer to pay a combination fine and cost reimbursement to the department totaling $1.25 million to be allocated as the former commissioner deemed appropriate and to make an outreach payment of another $1.25 million. The outreach payment was to be made to a nonprofit charitable corporation established by the former commissioner "to provide funding for the purpose of educating the people of California about general insurance issues." The agreement goes on to state that the former commissioner would have sole discretion as to how these funds were spent. Likewise, in its Northridge earthquake settlement agreement with Farmers Exchange, the department required the company to contribute $1 million to a nonprofit foundation to be established by the former commissioner; however, the agreement did not specify the intended use for the donated funds. The general requirements in these and similar agreements call into question whether

Vague and ambiguous settlement terms call into question whether $12.3 million in settlement payments directed to nonprofits and vendors related to the enforcement actions that prompted the payments.

$4.2 million in outreach payments directed to nonprofit organizations met the legal requirement that any such funds be used in a way that relates to the enforcement responsibilities that prompted the payment.

The 10 settlements requiring insurers to pay vendors directly contained language that was equally vague. In each agreement, the insurer was instructed to pay an unnamed vendor to be identified by the former commissioner at some unspecified future time. Based on the lack of specificity in these settlements, there is no way to determine how all 10 payments to vendors totaling $8.1 million related to the department's regulatory functions that elicited such requests.

THE DEPARTMENT DOES NOT EFFECTIVELY MANAGE ITS ENFORCEMENT ACTIVITIES

Insurers that have committed Insurance Code violations may go unpunished because the department does not effectively manage its enforcement activities. The department is unable to compel insurance companies to correct identified violations promptly because of significant delays by the legal division in resolving cases. Additionally, bureaus that have initiated enforcement actions cannot quickly determine the status of cases referred to the legal division because the department's systems for monitoring cases are not integrated. Current systems also do not always contain standardized information such as case numbers and resolution information, making it difficult for managers to evaluate the effectiveness of enforcement activities. Finally, poor controls over the remittance of fines, reimbursements for the costs of enforcement activity, and outreach payments do not ensure the prompt receipt and deposit of funds or the appropriate use of settlement payments.

The Legal Division Does Not Resolve Enforcement Cases Efficiently

The department's legal division does not always act promptly on cases referred by the other bureaus that initiate enforcement actions, resulting in a considerable backlog of cases awaiting resolution. For example, one case that was initially referred to the legal division in April 1986 was finally closed 11 years later in November 1997 without the division taking any enforcement

action. By failing to resolve outstanding cases promptly, the legal division risks allowing insurance companies to continue committing the same violations, which may have an adverse effect on policyholders.

The July 2000 case summary report for the consumer services and market conduct branch identified 65 open, or unresolved, cases. Twenty-two of these cases had been referred to the legal division more than a year ago, and another 11 had been referred to the division more than two years ago. Although some of these cases were limited to requests for opinions on specific insurance claims practices, many involved documented violations of the Insurance Code, including claims-handling violations, inadequate assistance to claimants, and illegal nonrenewal of policies. One case involving numerous violations has been submitted to the legal division several times since September 1997 and still remains unresolved. Furthermore, according to the legal division's tracking system, as of April 2000, 183 (33 percent) of the 554 open cases in the legal division's compliance bureau have yet to be assigned to an attorney for resolution. Thirty-seven of these cases have been open for more than one year, even though several are designated as high priority.

As of April 2000, the legal division's compliance bureau had a backlog of 183 cases waiting to be assigned to an attorney, including 37 that had been open more than one year.

According to the assistant chief counsel of the legal division's rate enforcement bureau, the division recognizes the need to quickly resolve compliance issues and is aware of the significant backlog of pending cases. However, the assistant chief counsel told us that because of staffing shortages, the division is unable to promptly address all of the cases referred by the bureaus for further regulatory actions. According to the department's records, as of June 30, 2000, the legal division's six bureaus were authorized 118.5 positions, but only 93.5 of those positions were filled. A further problem, according to the assistant chief counsel, is that many cases submitted to the division required approvals from the former insurance commissioner that were never obtained. For instance, the former commissioner rejected an administrative law judge's January 1997 decision that would have forced an insurance company to pay $14.8 million in restitution to its customers. The Government Code gives the commissioner the authority to adopt, modify, or reject an administrative law judge's proposed decision. Although the former commissioner stated that he would decide the matter himself, he failed to do so for more than three years, and the matter remains unresolved. In another instance, an administrative law judge ordered the department to give certain documents to an insurance company that was seeking information concerning

the analysis, litigation, and settlement of rate rollback cases. The department appealed the decision to the former commissioner in July 1997, but he failed to act on the appeal prior to his resignation.

Systems for Tracking Enforcement Cases Are Not Integrated and Omit Critical Information

The department lacks a central case-tracking system and, as a result, cannot readily determine the status and results of its enforcement activities. The various bureaus that perform enforcement activities and the legal division, which ultimately approves enforcement actions, currently use different systems that are not integrated. Further, the bureaus and the legal division have no protocol for recording key information about enforcement activities, even though some of the tracking systems are capable of capturing this information. For example, neither the bureaus nor the legal division have a process for tracking insurer compliance with nonmonetary settlement terms, such as reexamining their claim files and making any necessary restitution to policyholders. Because of these weaknesses, the department cannot rely on the current systems to provide accurate, timely, and easy-to-use management information about enforcement activities. Moreover, the department is wasting resources by having staff enter the same information into multiple systems. Additional resources are also wasted in the legal and accounting divisions because staff are unable to efficiently locate documents to determine the status of enforcement cases or to see whether fines and penalties assessed against insurers have been received and deposited in the correct state funds. Finally, except in the conservation and liquidation bureau, the legal division does not use any method that allows it to track the amount of time it spends on a particular case. Therefore, the division has no means of accurately recording time for which it could legally seek reimbursement from insurers.

Resources in the legal and accounting divisions are being wasted because staff cannot efficiently locate documents.

The department is aware of many of the deficiencies in its case-tracking capabilities. In March 2000, the department issued a report identifying numerous weaknesses in its case management processes and criticizing efforts to fully implement or upgrade the current automated systems. In its report, the department recognized that it is not taking full advantage of technology for information sharing and operational duties. For example, although the department developed an integrated database in 1991, it has never been fully implemented and is not consistently used by all bureaus throughout the department. The report

further states that even though the department's many bureaus focus on different aspects of regulation, all are ultimately working with the same customers: insurance companies, producers, and policyholders. However, information developed by one bureau that might be of value to other bureaus is often not available for their use. Instead, the bureaus operate independently and currently use different case management databases and applications that cannot share information.

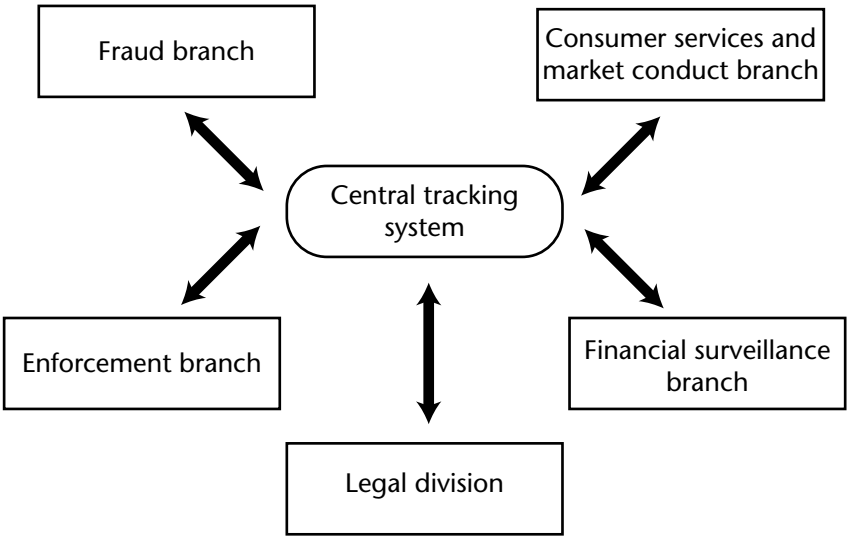
Data about enforcement cases must be rekeyed into multiple systems because the systems are not integrated and cannot share information.

This problem was confirmed during our review. Specifically, we identified at least five separate systems—the department's integrated database, the legal division's LawPack database, an Access database, a stand-alone Excel spreadsheet, and one other stand-alone system used by the investigations branch—all used by the department to track the status of enforcement activities. Although the department's report notes that considerable time and resources have been invested in developing an integrated database, there currently is no central system to store and make easily accessible all the regulatory information necessary to carry out the department's mission. Because these disparate systems are not integrated, when an enforcement case is referred from one bureau to various other bureaus or to the legal division, the data must be rekeyed into the system receiving the case.

As shown in Figure 5, a central tracking system would help ensure that the department maintained consistent data on all enforcement activities and would allow department-wide monitoring of those activities. A central tracking system would also eliminate the unnecessary duplication of data entry. For instance, bureaus that initiate enforcement actions could create records within the database by entering standard data into the central tracking system for all enforcement activities. The legal division could build on those records by completing additional fields for cases that are subsequently referred to it.

FIGURE 5

Proposed Central Tracking System



Furthermore, the department is not recording essential data about enforcement cases despite the ability of its existing systems to capture this data. For example, the legal division's LawPack database, which came online in January 1999, is able to capture information on the types of violations and the amounts of fines imposed for enforcement cases. However, the division is not consistently recording this information in the database. For instance, a March 2000 settlement agreement required the Old Republic Title Company to pay $179,200 in fines and cost reimbursements to the department, but the legal division did not record this information in LawPack. Omitting this information from the tracking system makes it difficult to identify insurers that have been assessed fines or cost reimbursements—information that is critical to the department's accounting division in establishing and collecting receivables.

We also identified several records that were deleted from the LawPack system; however, the legal division could not explain satisfactorily why these records were deleted, and it did not maintain documentation to justify these actions. The LawPack system uses sequential numbers for record entry, so deletions from the system result in a skip in the number sequence. We reviewed various LawPack reports and identified 78 instances in which one or more numbers had been skipped. According to the LawPack administrator, deletions can occur when a record is

erroneously entered into the database twice or when staff enter a "dummy" record to test modifications to the system. Although this explanation seems reasonable, we could not verify the reasons for the deletions or the nature of the records that were removed because the division did not maintain any evidence of why so many records were removed from the system during the 20-month period since the LawPack system came online in January 1999.

Finally, the legal division's record-keeping system hinders its ability to operate efficiently and to effectively manage the division. Using LawPack reports of closed cases and reports provided by the consumer services and market conduct branch of cases referred to the legal division during the period January 1, 1996, through May 31, 2000, we compiled a list of 595 cases. We submitted the list to the legal division on August 2, 2000, and asked them to provide settlement agreements or other documentation showing the status or final resolution of the cases. As of September 12, 2000, more than six weeks after our request, the legal division was not able to document the status or final resolution of 68 of the cases. The division responded that the files for 41 of the cases were no longer in the division and may have been archived or returned to the referring bureaus. As for the remaining 27 cases, the division could provide no explanation for the status or resolution of 23. While we recognize the division's extensive effort in attempting to determine the status or final resolution of these cases, its assertion regarding their whereabouts and status underscores the need for a more effective method of tracking the flow of enforcement cases.

The legal division could not document the status or resolution of 68 cases because of its inefficient record-keeping system.

If a centralized tracking system had been in place and consistently updated, the division could have quickly identified the status or final resolution of these cases, as well as the location of the respective files. Moreover, for 3 of the cases with an undetermined status or resolution, we observed notations made in the LawPack system indicating that enforcement orders had been signed. However, the division was not able to provide any copies of the signed orders. Also, based on information provided by the division or notations made in the LawPack system, settlement agreements were negotiated for 4 other cases. Again, the division was not able to provide us with copies of any of the 4 agreements. For example, according to comments made in LawPack, as of August 5, 1998, the department was awaiting payment from an insurer, but the division was not able to provide a copy of the settlement agreement or evidence that the department ever received a payment.

The Process for Remitting Settlement Funds Needs Improvement

Departmental controls for receiving and depositing settlement funds are inadequate, resulting in misdirected payments, late collection of fines and cost reimbursements, and delays in depositing settlement funds. There is also no mechanism to track settlement payments directed outside the department, such as insurer payments made to nonprofit organizations and payments made directly to vendors. The relatively high risk associated with transactions involving cash or negotiable instruments such as checks demands a strong system of controls. However, the department has no formal policy for the receipt and deposit of settlement payments, increasing the risk that these payments could be misused.

Rather than remitting payments for fines and cost reimbursements to the accounting division, insurance companies currently send them directly to the bureaus that initiated the direct enforcement actions or to the legal division for settlements negotiated by that division. Moreover, because all approved settlement agreements, including those for direct enforcement actions, are maintained by the legal division, fines and cost reimbursement payments remitted to bureaus are first forwarded to the legal division for reconciliation before being submitted to the accounting division. Given the geographic organization of the department, a check from an insurance company could be remitted to a bureau in Los Angeles, sent to the legal division in San Francisco for reconciliation, and then forwarded to the accounting division in Sacramento before being restrictively endorsed and deposited. We found four instances in which checks for $10,000, $22,500, $25,000, and $47,100 followed such a path. A memorandum attached to each check from the claims services bureau chief stated that he was not sure who was to get the check and asked the legal division to forward each one to the correct person in the department.

The accounting division seldom establishes accounts receivables for settlement payments, increasing the likelihood of lost or late payments.

In many instances, the accounting division receives funds from the legal division with no forewarning. As a result, it cannot properly establish the funds in its listing of accounts receivable, increasing the likelihood of lost, late, or misdirected payments and delaying deposits. We noted one instance when the department apparently lost a $10,000 check submitted by the Gateway Title Company for the payment of penalties. The check, dated July 1999, was initially sent to the enforcement

branch. However, the check was reportedly misplaced before it could be deposited. The title company subsequently remitted a second check in June 2000, 11 months later.

Because most outreach payments are submitted directly to nonprofit organizations or vendors that are outside the State's accounting and budget system, the accounting division is not informed of the payment; therefore, it does not record the payment as being receivable. As a result, the department has no way to effectively monitor these types of payments to determine if or when they were made or whether the correct amounts were paid. Likewise, the department cannot ensure that outreach funds were ever used for their intended purposes.

A total of $4.2 million in outreach payments intended to aid California victims of the holocaust has not been paid.

For example, the accounting division did not make any record of the amounts owed by three insurance companies for World War II holocaust agreements. In November 1999, the department entered into agreements with ING Financial Services, Fortis Incorporated, and AEGON Insurance Group, requiring these companies to pay a total of $4.2 million to a "humanitarian fund" to be established by the department to aid California victims of the holocaust. Additionally, on November 30 and December 1, 1999, the former commissioner issued press releases publicly announcing these "landmark agreements." However, according to the head of the legal division's holocaust bureau, as of September 2000, none of the $4.2 million had been paid. She stated that, while the insurers are prepared to pay the required amounts, the department has postponed collecting the funds since the departure of the former commissioner until it is certain it has a legal method for handling the money. The department's position is understandable given the recent controversy surrounding the use of outreach payments. However, because the department's use of outreach payments was not a subject of legislative inquiry until April 27, 2000 (five months after these agreements were executed), it does not adequately explain why no efforts were made to collect the funds before that date. As with other outreach payments, the accounting division neither established receivables for the payments nor subjected them to the collection procedures used for other amounts owed to the department. Therefore, the $4.2 million in outreach meant to aid California victims of the holocaust remains unpaid.

In another instance, in an e-mail sent to the former general counsel, the former chief of financial planning stated that he was aware of a settlement with Levitz/General Electric Capital Assurance Company (Levitz) for $675,000 as well as a settlement

with John Hancock Mutual Life Insurance (John Hancock). However, he had received no information on whether the settlement amounts were for fines, reimbursement of costs, or outreach. In his responding e-mail, the former general counsel stated that a settlement had been reached with John Hancock for $750,000. Of this amount, $200,000 represented reimbursement of department costs, and the remaining $550,000 was for outreach that the company agreed to pay directly to vendors selected by the former commissioner; however, he did not indicate the final recipients of the outreach portion. Ultimately, the accounting division did not record or maintain any documentation on the outreach payment, making it impossible to monitor the receipt and use of the $550,000. The former general counsel also stated that the Levitz settlement required that a third-party administrator hold the $675,000 directed for outreach. Again, the accounting division did not record or track the receipt or use of these funds, thereby relinquishing control over their use.

The accounting division has also failed to maintain sufficient documentation to establish that settlement payments were received and properly recorded in the accounting records. On August 21, 2000, we asked the accounting division for documentation to verify that payments related to 48 settlements were received and recorded in the department's accounting records. Because some of the settlements contained provisions for installment payments, a total of 52 payments were required for these 48 settlements. However, as of September 13, 2000, more than three weeks after our initial request, the accounting division was only able to provide evidence that 24 (46 percent) of the 52 payments were received and deposited in the state treasury system.

The accounting division could not provide any evidence that 13 of 52 settlement payments were ever received and deposited by the department.

While the division was able to provide documentation showing 15 of the remaining 28 payments were received, it could not demonstrate that these payments were actually deposited. The division was unable to provide any evidence that the other 13 payments were ever made by the insurers. For example, one of the items we requested information on related to a settlement agreement with American Banker's Life Assurance Company. Under the terms of the settlement agreement, the insurer was required to pay the department $500,000 in fines and $239,600 in cost reimbursements. According to a December 1998 letter sent by the insurer's market conduct manager to the former deputy commissioner of administration, the company enclosed a check for the $239,600 cost reimbursement portion of the settlement

along with the letter. In February 1999, the department requested that the insurer make full payment of the $500,000 fine no later than March 5, 1999. However, the accounting division has not been able to provide evidence that the department had ever received and deposited any of the $739,600.

Moreover, the process for remitting settlement payments has resulted in delays in receiving and depositing funds. Specifically, eight of the payments the department received were made more than 20 days after the due date required by the settlement. Furthermore, three payments were deposited more than 45 days after the accounting division received the payment. In one example, a payment for $13,000 was deposited 230 days after it was received. Because of its poor record-keeping procedures, the department has no effective means to verify that insurers remit payments when required under the terms of settlement agreements or that payments are promptly deposited.

RECOMMENDATIONS

To ensure that all activities and expenditures funded by settlement payments relate to the department's regulatory responsibilities that prompted the payments and adhere to the State's fiscal controls, the department should require insurers to direct all payments to it. The department should then deposit these funds in the state treasury system. After depositing such funds, the department could either conduct outreach activities itself or contract for these activities so as to increase its direct control over the expenditures made for outreach and ensure that they clearly relate to the regulatory responsibilities that initiated the payments.

Additionally, the Legislature should consider a change to the Insurance Code that would forbid the insurance commissioner to require that payments be made to nonprofit organizations, foundations, or vendors as part of a settlement agreement.

While it is necessary for the department to have flexibility when settling enforcement actions, it should consider the effect on its mission to protect consumers when entering into these agreements. Specifically, penalties should be a public component

of the settlement in all instances involving egregious violations in which a penalty is justified. Public settlement agreements should also include the date each type of payment is due, provisions listing the alleged violations of the law, and an order to cease and desist from such activities, as well as all other terms of the agreements. Finally, the department should report all penalties assessed against insurers to the National Association of Insurance Commissioners. These actions would ensure the appropriate public disclosure of the nature of the violations and provide the department with more enforcement power should repeat violations occur.

To improve the effectiveness of its enforcement activities, the department should take the following steps:

- Develop an integrated system for tracking enforcement activities and protocols for the consistent recording of key information.
- Periodically review open enforcement cases.
- Determine why the legal division is taking so long to resolve the cases referred to it and correct the situation.
- Instruct insurance companies to remit settlement payments directly to the accounting division or establish cashiering units in the bureaus initiating enforcement actions and the legal division to better safeguard these funds.
- Communicate settlement terms to the accounting division upon approval of settlement agreements so that appropriate accounts receivable can be established to track and monitor payments.
- Strengthen controls in the accounting division to ensure that all settlement payments are collected promptly and deposited in the appropriate state funds.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: October 19, 2000

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APPENDIX A

Payments Imposed on Insurers in Settlement Agreements

The Department of Insurance (department) executed 96 settlement agreements with insurance companies between January 1, 1996, through May 31, 2000. The settlement agreements required insurers to pay fines for various violations of the Insurance Code and reimburse the department for the costs of enforcement activities. Additionally, many of the agreements required insurers to make outreach payments to the department, nonprofit organizations, and vendors. Table 2 identifies the insurer and the payments required for each of the 96 settlements.

TABLE 2

Payments Ordered for Settlements Reached From January 1, 1996, Through May 31, 2000*

Company Name	Fine	Cost Recovery	Outreach	Totals
Calendar Year 1996				
Indemnity Company of California	$1,000,000	$30,000		$1,030,000
Fremont General Corporation	900,000†			900,000†
Sutter Insurance Company	360,000			360,000
St. Paul Fire & Marine Insurance Company	104,176	5,824		110,000
Camden Fire Insurance Association, General Accident Insurance Company, and Pennsylvania General Insurance Company	57,500			57,500
Primerica Life Insurance Company	28,000			28,000
Anthem Life Insurance Company	20,000			20,000
Mercury Casualty Company	15,000			15,000
Yosemite Insurance Company	8,680	1,320		10,000
1996 Subtotals	**$2,493,356**	**$37,144**		**$2,530,500**
Calendar Year 1997				
Prudential Insurance Company of America	$5,500,000	$1,400,000	$8,500,000	$15,400,000
John Hancock Mutual Life Insurance Company		200,000	550,000	750,000
Levitz and General Electric Capital Assurance Company		25,000	675,000	700,000

* Listing excludes Proposition 103 and low-dollar amount settlements that involve insurance agents or brokers.

† This amount represents a late filing fee resolved through a settlement agreement.

(continued on next page)

Company Name	Cost Fine	Recovery	Outreach	Totals
Chubb Group of Insurance Companies	$600,000			$600,000
Eastwood Insurance Services	300,000	25,000		325,000
North American Title Insurance Company	57,120	4,800	38,080	100,000
Stewart Title Insurance Company	40,000	4,000	25,000	69,000
Foundation Health Life Insurance Company	50,000			50,000
Coast National Insurance Company	22,472	22,528		45,000
Massachusetts General Life Insurance Company	15,000	5,000		20,000
Principal Mutual Life Insurance Company	2,500	5,000		7,500
Equitable Life Assurance Society	2,500			2,500
1997 Subtotals	**$6,589,592**	**$1,691,328**	**$9,788,080**	**$18,069,000**
Calendar Year 1998				
American Bankers Life Assurance Company of Florida	$500,000	$239,634	$800,000	$1,539,634
Surety Company of the Pacific			1,000,000	1,000,000
Pacific Life Insurance Company		5,000	300,000	305,000
Progressive Title Company	50,000	4,000	31,000	85,000
Foundation Health National Life Insurance Company	84,690			84,690
Sutter Preferred Health and Life Insurance Company	40,000		40,000	80,000
Republic Western Insurance Company	75,000			75,000
Sun Assurance Company of Canada	36,192	3,808	35,000	75,000
Dayton Hudson Corporation, Retailers Bank, and Mervyn's	5,000	10,000	42,500	57,500
Pacific Professional Insurance Inc.	4,300	45,700		50,000
Chicago Insurance Company	25,000	18,090		43,090
Maxicare Life and Health Insurance Company			40,000	40,000
Superior Insurance Company	30,000			30,000
National Union Fire Insurance Company of Pittsburgh, Commerce & Industry Insurance Company, and New Hampshire Insurance Company	20,000	5,000		25,000
Calvert Insurance Company	20,000			20,000
Federal Insurance Company	15,355			15,355
First Financial Insurance Company	5,815			5,815
Progressive Casualty Insurance Company	1,500			1,500
1998 Subtotals	**$912,852**	**$331,232**	**$2,288,500**	**$3,532,584**

* Listing excludes Proposition 103 and low-dollar amount settlements that involve insurance agents or brokers.

(continued on next page)

Company Name	Fine	Cost Recovery	Outreach	Totals
Calendar Year 1999				
20th Century Insurance Company	$100,000		$6,750,000	$6,850,000
First American Title Company	1,188,618	61,382	1,250,000	2,500,000
State Farm Fire & Casualty and State Farm General Insurance Company		5,000	2,000,000	2,005,000
Allstate Insurance Company			2,000,000	2,000,000
ING Financial Services			2,000,000	2,000,000
AEGON Insurance Group			1,200,000	1,200,000
Farmers Insurance Exchange			1,000,000	1,000,000
Fortis Incorporated			1,000,000	1,000,000
Fireman's Fund Insurance Company			550,000	550,000
Foundation Health National Life Insurance Company	256,885			256,885
Aetna Life Insurance Company and Aetna Life	250,000			250,000
Chicago Title Company	146,875		88,125	235,000
United States Fidelity and Guaranty Insurance Group	210,000			210,000
The Manufacturers Life Insurance Company	150,000	3,000		153,000
Benchmark Services Inc.	93,525	27,332		120,857
Commonwealth Land Title Company	70,844	4,156	45,000	120,000
Farmers Home Group		2,500	100,000	102,500
Aetna Life Insurance Company	50,000			50,000
Clarendon National Insurance Company	40,000	10,000		50,000
Prudential Insurance Company of America	39,000	5,100		44,100
Hartford Underwriters Insurance Company	30,000	4,085		34,085
Viking Insurance Company of Wisconsin	25,000	5,610		30,610
Lyndon Property Insurance Company	20,000	2,550		22,550
Omni Insurance Company	20,000	2,500		22,500
Amex Assurance Company	17,500	3,550		21,050
American International Insurance Company of California	16,000	1,080		17,080
Reliance Insurance Company	8,500	3,060		11,560
National Alliance Insurance Company	10,000	1,020		11,020
Gateway Title Company	10,000			10,000

* Listing excludes Proposition 103 and low-dollar amount settlements that involve insurance agents or brokers.

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Company Name	Fine	Cost Recovery	Outreach	Totals
Colonial Penn Insurance Company	$3,000	$6,120		$9,120
Reliance National Insurance Company	8,200	765		8,965
Jefferson Insurance Company of New York	6,000	1,020		7,020
Reliastar Life Insurance Company of New York	5,000	425		5,425
Liberty Mutual Fire Insurance Company	2,000	2,000		4,000
Western Mutual Insurance Company	2,750	510		3,260
Alistar Insurance Company	1,500			1,500
Fidelity Security Life Insurance Company	1,030	170		1,200
1999 Subtotals	**$2,782,227**	**$152,935**	**$17,983,125**	**$20,918,287**
Calendar Year 2000 (through May 31)				
Fidelity National Title Insurance Company	$492,500	$115,000	$492,500	$1,100,000
First American Title Company		4,500	840,000	844,500
Chicago Title Company		4,500	650,000	654,500
Old Republic Title Company	55,000	124,231	334,268	513,499
Fidelity National Title Insurance Company		4,500	425,000	429,500
American Home Assurance Company	100,000			100,000
American Title Company		2,500	85,000	87,500
Investors Title Company		20,000	55,000	75,000
Millers Mutual Fire Insurance Company	20,000	5,000		25,000
New Hampshire Insurance Company	10,000	9,500		19,500
TravCal Secure Insurance Company	14,000	1,020		15,020
Harleysville Mutual Insurance Company	11,000	1,020		12,020
Century-National Insurance Company	5,000	5,000		10,000
Electric Insurance Company	10,000			10,000
Jackson National Life Insurance Company	10,000			10,000
Pennsylvania General Insurance Company	6,930			6,930
Beneficial Life Insurance Company	5,000			5,000
Sun Life Assurance Company of Canada	5,000			5,000
West Coast Life Insurance Company	5,000			5,000
Progressive Casualty Insurance Company	500	1,500		2,000
2000 Subtotals	**$749,930**	**$298,271**	**$2,881,768**	**$3,929,969**
Grand Totals	**$13,527,957**	**$2,510,910**	**$32,941,473**	**$48,980,340**

* Listing excludes Proposition 103 and low-dollar amount settlements that involve insurance agents or brokers.

APPENDIX B

Amounts, Dates, and Purposes of Outreach Payments Directed to Non-State Entities

The terms of many settlement agreements required insurance companies to make outreach payments directly to nonprofit organizations and vendors. Some of these agreements also required insurers to remit payment by a certain date. Table 3 shows the amount and date of outreach payments made by each insurer and the entity that received the funds. The table also identifies how the nonprofit organizations and vendors used the funds, if known.

TABLE 3

Outreach Payments to Nonprofit Organizations and Vendors
January 1, 1996, Through May 31, 2000

Company Name	Payment Due	Amount Received	Date Payment Due	Date Payment Received	Entity That Received Outreach Funds	How Funds Were Used
Calendar Year 1997						
Prudential Insurance Company of America	$5,500,000	$5,500,000	Not Specified	4/14/97	Community Reinvestment Fund	Investment in low-income housing projects
					Enterprise Social Investment Corporation-Angelina Apartments, L.P.	
					HUD National Tax Credit Investment-New Economics for Women	
Levitz and General Electric Capital Assurance Company	675,000	675,000	10/19/97	10/16/97	Insurance Education Fund	Vendors spent on media campaign
John Hancock Mutual Life Insurance Company	550,000	550,000	Not specified	12/4/97	Target Enterprises	Vendor spent on media campaign
North American Title Insurance Company	38,080	0	Not specified	Amount not paid	N/A	N/A
1997 Subtotals	**$6,763,080**	**$6,725,000**				

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Company Name	Payment Due	Amount Received	Date Payment Due	Date Payment Received	Entity That Received Outreach Funds	How Funds Were Used
Calendar Year 1998						
American Bankers Life Assurance Company of Florida	$800,000	$0	Not specified	No evidence of payment*	N/A	N/A
Pacific Life Insurance Company	300,000	286,000	Not specified	6/30/99	California Insurance Education Project	Adminstrative, consulting, and legal fees
		14,000	6/30/99	6/25/99	California Alliance for Consumer Education	Outreach activities to underserved areas
Dayton Hudson Corporation, Retailers Bank, and Mervyn's	42,500	42,500	Not specified	8/25/98	Target Enterprises	Vendor spent on media campaign
Progressive Title Company	31,000	31,000	3/12/99	3/10/99	California Alliance for Consumer Education	Outreach activities to underserved areas
1998 Subtotals	**$1,173,500**	**$373,500**				
Calendar Year 1999						
20th Century Insurance Company	$6,750,000	$6,343,000	Not specified	5/9/00	California Research & Assistance Fund	Earthquake Assistance Fund, media campaign, contributions to charitable organizations, legal fees, and general expenses
		207,000	Not specified	10/18/99	California Research & Assistance Fund	
Allstate Insurance Company	2,000,000	2,000,000	Not specified	9/7/99	California Research & Assistance Fund	Media campaign, contributions to charitable organizations, legal fees, and general expenses
ING Financial Services	2,000,000	0	Not specified	Amount not paid	N/A	N/A
State Farm Fire & Casualty, and State Farm General Insurance Company	2,000,000	2,000,000	Not specified	6/2/99	California Research & Assistance Fund	Media campaign, contributions to charitable organizations, legal fees, and general expenses
First American Title Company	1,250,000	1,250,000	10/22/99	11/2/99	California Research & Assistance Fund	Media campaign, contributions to charitable organizations, legal fees, and general expenses
AEGON Insurance Group	1,200,000	0	Not specified	Amount not paid	N/A	N/A
Farmers Insurance Exchange	1,000,000	1,000,000	7/22/99	7/21/99	California Insurance Education Project	Adminstrative, consulting, and legal fees

*An official from the insurance company asserted that the amount has been paid, however, no evidence was provided to verify this assertion.

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Company Name	Payment Due	Amount Received	Date Payment Due	Date Payment Received	Entity That Received Outreach Funds	How Funds Were Used
Fortis Incorporated	$1,000,000	$0	Not specified	Amount not paid	N/A	N/A
Fireman's Fund Insurance Company	550,000	550,000	8/3/99	7/6/99	California Research & Assistance Fund	Media campaign, contributions to charitable organizations, legal fees, and general expenses
Farmers Home Group	100,000	100,000	Not specified	6/1/99	California Research & Assistance Fund	Media campaign, contributions to charitable organizations, legal fees, and general expenses
Chicago Title Company	88,125	9,000	5/20/99	7/7/99	California Land Title Association	Unknown
Commonwealth Land Title Company	45,000	0	Not specified	Amount not paid	N/A	N/A
1999 Subtotals	**$17,983,125**	**$13,459,000**				
Calendar Year 2000 (through May 31)						
First American Title Company	$840,000	$0	Not specified	Insurer stopped payment on original check; no replacement check issued.	N/A	N/A
Chicago Title Company	650,000	650,000	Not specified	3/9/00	Title & Escrow Consumer Education & Outreach Corporation	Start-up costs, legal fees
Fidelity National Title Insurance Company	492,500	492,500	3/21/00	3/21/00	Title & Escrow Consumer Education & Outreach Corporation	Start-up costs, legal fees
Fidelity National Title Insurance Company	425,000	425,000	Not specified	2/3/00	Title & Escrow Consumer Education & Outreach Corporation	Start-up costs, legal fees
Old Republic Title Company	334,268	334,268	4/12/00	3/24/00	Title & Escrow Consumer Education & Outreach Corporation	Start-up costs, legal fees
American Title Company	85,000	85,000	4/14/00	3/7/00	Title & Escrow Consumer Education & Outreach Corporation	Start-up costs, legal fees
Investors Title Company	55,000	55,000	Not specified	Unknown	Title & Escrow Consumer Education & Outreach Corporation	Start-up costs, legal fees
2000 Subtotals	**$2,881,768**	**$2,041,768**				
Grand Totals	**$28,801,473**	**$22,599,268**				

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APPENDIX C

Bills Introduced During the 1999-2000 Legislative Session Arising From Department Settlement Practices

TABLE 4

Bill Number	Author(s)	General Description/Purpose	Status of Bill
SB 1524	Figueroa	Requires fines, penalties, fees, and costs resulting from any enforcement activity to be deposited in the appropriate fund as required by law. Provides that funds ordered or allocated for outreach efforts: • May not be expended for purposes that use the commissioner's voice, name, or likeness without court approval. • Must be expended for purposes relevant to the issues raised in the enforcement or compliance action. • May only be expended for purposes approved by a court.	Chapter 1089, Statutes of 2000
SB 1805	Escutia	The Bureau of State Audits must audit examinations of claims practices that are suspended or terminated by the department. The commissioner must make the following publicly available and must post on the Web site: • Final examination reports of unfair or deceptive business practices. • All executed stipulations, settlements, orders, and other forms of agreement resolving market conduct examinations—whether the examinations are final, suspended, or terminated.	Chapter 997, Statutes of 2000
AB 481	Scott, Keeley, McClintock, Shelley, Steinberg, and Villaraigosa	Requires the insurance commissioner to give first priority to policyholder concerns in settlement agreements related to alleged unfair or deceptive acts or practices and authorizes the commissioner to provide for policyholder remediation, restitution, or both in such settlements. • Authorizes the commissioner to order or allocate funds in a settlement for education or outreach relating to the alleged wrongdoing. • Requires such funds to be deposited in the Insurance Fund. • Requires Budget Act authorization before those funds may be spent.	Vetoed by the Governor

Bill Number	Author(s)	General Description/Purpose	Status of Bill
SB 1899	Burton	Revives claims for policyholders whose Northridge earthquake claims were denied because they were time-barred and grants them an additional year to file claims beginning January 1, 2001.	Chapter 1090, Statutes of 2000
SB 2107	Speier	Permits the commissioner to delegate the power to negotiate settlements but not the power to approve them. Unless specifically authorized by law, prohibits the commissioner from agreeing that: • An insurer, agent, or broker will contribute to a nonprofit entity, or direct funds outside the state treasury system. • Funds will be directed to another person or entity. • Settlement proceeds will be used to produce materials using the commissioner's name, voice, or likeness. Permits settlement payments only to those who may be due payment as a result of the wrongdoer's violations. Requires all fines, penalties, assessments, costs, and sanctions be deposited in the state treasury.	Chapter 1091, Statutes of 2000
SB 953	Speier	Places limits on the amounts insurers may contribute to candidates for the office of insurance commissioner when the insurer has a matter pending before the department. Limits the campaign contributions a candidate for the office of insurance commissioner may accept from the insurance industry. Places campaign contribution and voluntary campaign expenditure limits on the insurance commissioner and candidates for the Office of the Insurance Commissioner.	Failed to pass

Agency's comments provided as text only.

Department of Insurance
Honorable Harry W. Low, Insurance Commissioner
300 Capitol Mall, Suite 1700
Sacramento, Ca 95814

October 4, 2000

Elaine M. Howle
State Auditor
555 Capitol Mall, Suite 300
Sacramento, California 95814

Dear Ms. Howle:

From the perspective of a newly-appointed Insurance Commissioner who is responsible for restoring trust in the Department of Insurance, the timing of your September 2000 audit report, *Department of Insurance: Recent Settlement and Enforcement Practices Raise Serious Concerns About Its Regulation of Insurance Companies*, could not have been better. The report is especially useful to my new administration since it goes beyond an analysis of the questionable settlement practices engaged in by former Commissioner Quackenbush to include documentation of which I consider to be very serious gaps in the Department's internal management and control systems.

The report essentially confirms in disturbing detail former Acting Insurance Commissioner Clark Kelso's assessment, which he conveyed to the Senate Insurance Committee in testimony on August 9, 2000, that the Department has been seriously mismanaged or, as he now likes to say, "unmanaged,". Moreover, the type of mismanagement which your report identifies – a lack of appropriate checks and balances within the Department – creates precisely the sort of risk of abuse of power that occurred in the settlements with six Northridge earthquake insurers.

I have decided to respond primarily to the "recommendations" section of the audit report because, while I might not agree with the details of all of the report's factual findings, the general sweep of those findings presents a convincing case for substantial organizational improvement and change, and I am committed to making those improvements happen during my tenure. Following the outline of the report's recommendations, I have divided the remainder of this response into two parts: first, a response to recommendations on settlements, and second, a response to recommendations on enforcement.

Settlements

The report recommends that when the Department settles an enforcement matter, all payments resulting from the settlement should be directed to the Department and deposited in the state treasury system. I am in complete agreement with this recommendation for the reasons given in your report. The diversion of settlement payments elsewhere avoids the constitutional checks and balances that are inherent in the budget process, and I believe it is important for those checks and balances to be observed. I have therefore directed my staff that settlements entered into during my tenure will not provide for payments to be made to any entity or person other than the Department.

On the same topic, the report recommends that the Legislature should consider changing the Insurance Code to forbid settlement payments going to nonprofit organizations, foundations or vendors, a statutory change that would codify my directive to staff described above. SB 2107 [(Speier) Chapter 1091, Statutes 2000] is in accord with this recommendation. It would seem appropriate that the Legislature should consider new legislation that would apply this law toward all state agencies, since the same constitutional checks and balances should apply to all executive agencies, not just the Department of Insurance.

The report makes several recommendations regarding specific terms for settlement agreements, and I generally concur in those recommendations with the caveat that, as the report itself quite properly recognizes, “it is necessary for the department to have flexibility when settling enforcement actions.” For example, I agree that penalties, fines or sanctions should be a public component of a settlement when the Department is convinced there is reason to believe egregious violations have occurred which justify a penalty. Of course, as I am sure you recognize, not all settlements involve egregious violations, and the Department may have varying levels of confidence in particular allegations. These and many other factors may affect the Department’s settlement posture and the final terms of settlement agreements, and I am sure you do not intend by your recommendations to tie the Department’s hands in resolving complex enforcement actions.

As for the Northridge earthquake settlements themselves, as you know, the Department of Insurance and the Department of Justice is engaged in discussions with the six insurance companies to effect a modification or rescission of those settlements so that the Department could conduct a fresh evaluation of how well policyholders were treated and whether policyholders were prejudiced by any unfair insurance practices. If those negotiations are unsuccessful, the Department will join the Department of Justice in seeking a judicial declaration that those settlements are unenforceable.

Enforcement

I concur entirely with the six enforcement activity recommendations, and the Department has already taken substantial steps to address the problems the report identifies.

The report recommends developing an integrated system for tracking enforcement activities and protocols for the consistent recording of key information. Former Acting Insurance Commissioner Clark Kelso, who is a state and national leader in promoting integrated information systems in the courts and justice system, made the same observations and recommendations regarding the Department's information technology systems in July. To put us in a better position to respond to information technology challenges, I have created at the executive staff level the position of Deputy Commissioner for E-Government & Technology Solutions. This new deputy commissioner will be responsible for fully implementing, among other things, the LawPack and Docs Open systems. Legal staff has been informed that as soon as certain updates, expansions and improvements have been completed to the Department's computer network and there has been proper training, use of those systems will become mandatory, and the legal staff is itself eager to have such systems up and operational.

The report recommends a periodic review of open enforcement cases to ensure that cases do not become stale and that decisions are made in a timely manner. In part, the integrated system for tracking will address this problem, but even without the integrated system, there is no excuse for not having appropriate tickler systems in place. As part of my October 2, 2000, reorganization of the Department, I have placed what formerly was the enforcement division under a newly-named Criminal Investigations division that encompasses both criminal fraud and civil investigations under the leadership of Deputy Commissioner Dick Ross. Deputy Commissioner Ross has been instrumental in the Department in improving the practices and procedures of what formerly was called the fraud division, and I have directed Deputy Commissioner Ross aggressively to address the backlog problem in enforcement.

The report recommends that the Department determine why the legal division is taking so long to resolve cases referred to it and to correct the situation. The present administration is well aware of the necessity to improve the responsiveness of the Legal Division, including but not limited to erasing the backlog of matters which have been referred for action by other branches of the Department. A significant part of the problem is related to the abuses under the Quackenbush administration which are so well documented in your report and in the Legislature's two reports on the Department of Insurance. One of the key individuals identified in the Assembly report as responsible for abusive practices, William Palmer, was former Commissioner Quackenbush's top lawyer in the Department. Although not reflected in your report, the Legal Division suffered for many years under this management and leadership which resulted in a precipitous decline in morale in significant resignations of experienced Department attorneys, and in an inability to recruit new attorneys effectively. From the first day of former Acting Insurance Commissioner Clark Kelso's appointment to the job to the present, we have been working day and night to improve the situation in the Legal Division. Morale has definitely improved, and we are engaged in studious efforts to hire new attorneys and install effective Legal Division management so that the division can promptly and effectively provide legal services to the Department. I will be reevaluating our progress continually.

The final three recommendations deal with establishing appropriate checks and balances between the Legal Division and accounting to ensure proper follow-up on settlements of regulatory enforcement actions. I agree with each of these specific recommendations, and I would go further by stating that, as of the time former Acting Insurance Commissioner Clark Kelso was appointed, the administrative, accounting and auditing practices within the Department had serious deficiencies. We have begun addressing these problems by, among other things, the appointment of Loren Suter, a twenty-five year veteran of state service, as Deputy Commissioner for Administration & Licensing Services, who has been directed to clean up our administrative, accounting and financial practices, and by moving the Department's internal audits function out of the administration division so that internal audits will report directly to me.

Conclusion

The problems your report identifies in the operation of the Department of Insurance did not arise overnight, and they are not neatly attributable to any one person. I am committed to changing the Department's culture and practices so that it will be recognized as the best Department of insurance in the nation and as one of the best executive agencies in California state government. I look forward to your continued oversight and assistance in this challenging endeavor.

Sincerely,

(Signed by: Harry W. Low)

Harry W. Low
Insurance Commissioner

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press