

CALIFORNIA DEPARTMENT OF INSURANCE
2006 ANNUAL REPORT
OF THE INSURANCE COMMISSIONER





STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
OFFICE OF THE COMMISSIONER

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July 31, 2007

The Honorable Arnold Schwarzenegger
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Schwarzenegger:

I am pleased to present you the 2006 Annual Report of the Insurance Commissioner as required by California Insurance Code ("CIC") section 12922.

Although this report reviews the activities of calendar year 2006, prior to my assuming office, it was produced under my watch. With an eye toward benefiting California's insurance consumers, I have collected and analyzed as much information as possible. Accordingly, this Annual Report includes more mandated information than ever before.

Consistent with the requirements of various CIC statutes, following information is included:

- | | |
|-----------------|---|
| §1060 | Insurer insolvency and delinquency proceedings; |
| §1872.83(h) | Workers' compensation fraud-fighting efforts and results; |
| §1872.9 | Activities undertaken to reduce fraud under the Insurance Frauds Prevention Act; |
| §1874.8(f) | Results of the Organized Automobile Fraud Activity Interdiction Program; |
| §10089.83(a) | Program statistics about the Department's mediation of claims disputes; |
| §12921.1(a)(10) | Information about the Department's investigations of consumer complaints about claims handling by insurers; |
| §12962 | Analysis of programs to: ensure the availability of liability insurance, prevent arbitrary rates and practices, and reduce the number of uninsured motorists; |
| §12967(e) | Progress in resolution of the insurance claims of Holocaust survivors and their beneficiaries. |

Finally, the report presents synopses of various reports filed with the Department and a summary of California's insurance industry and interests.

Sincerely,

STEVE POIZNER
Insurance Commissioner

**STATE OF CALIFORNIA DEPARTMENT OF INSURANCE
2006 ORGANIZATIONAL CHART**

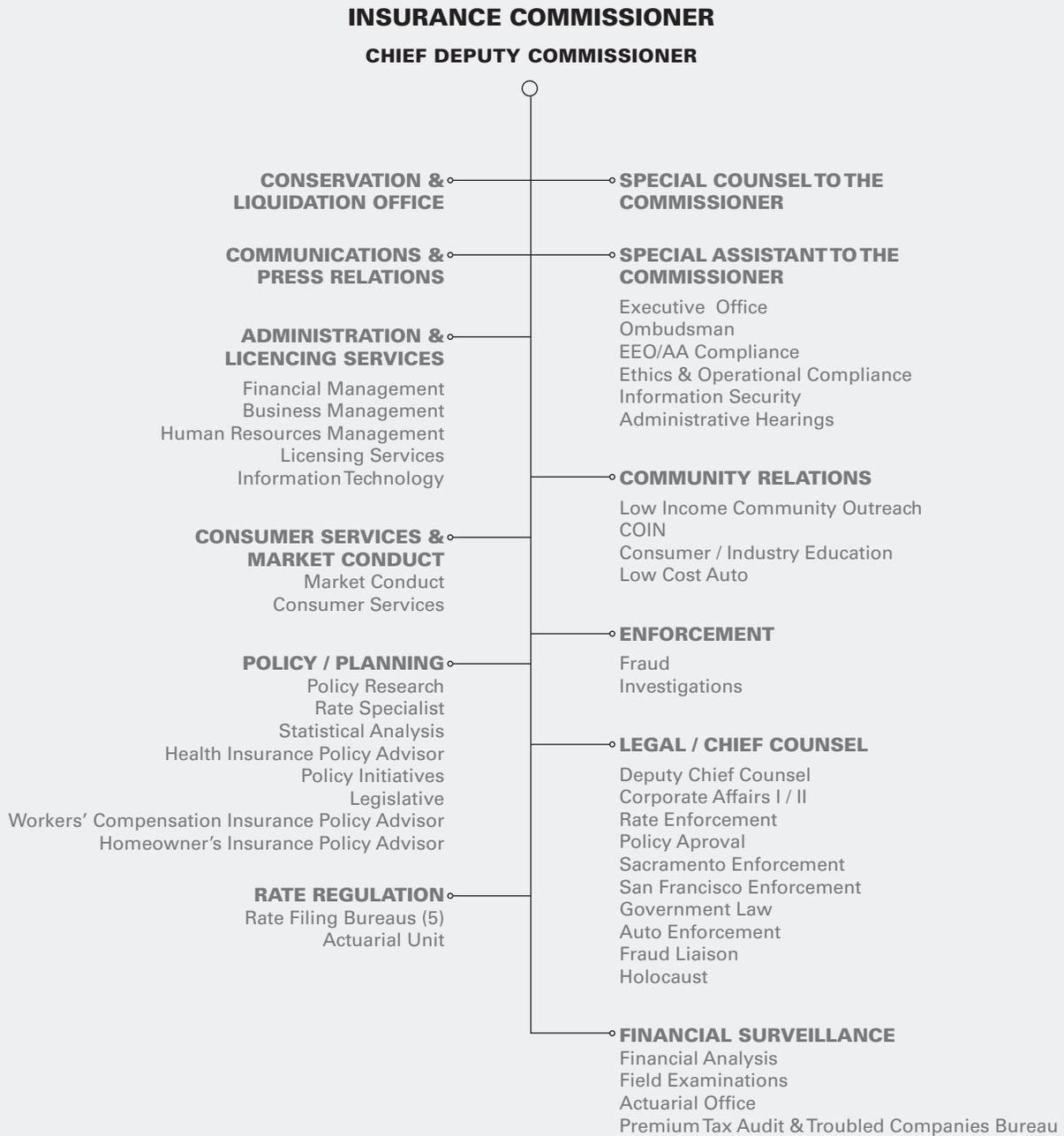




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CALIFORNIA DEPARTMENT OF INSURANCE
2006 ANNUAL REPORT
OF THE INSURANCE COMMISSIONER

CONSERVATION & LIQUIDATION OFFICE

The following table summarizes the activity of the Conservation & Liquidation Office (CLO), (also interchangeably referred to in this report as “the Commissioner” and “the Liquidator”). The CLO acts on behalf of the Insurance Commissioner regarding insurance companies or agencies under the Commissioner’s direction and control as

Conservator or Liquidator, and shows Estates opened and closed during 2006, and Estates open at December 31, 2006. Following the tabulations are summary paragraphs describing the status of each Estate. Financial information presented below the summary paragraphs includes Estate total assets; total estimated liabilities; administrative expenses (legal, consulting & professional fees, salaries, office and depreciation); and 2006 distribution amounts.

Conservation or Liquidation Estates Opened During the Year 2006

Estate Name	Conservation	Liquidation
Municipal Mutual Insurance Company	N/A	10/31/06

Conservation or Liquidation Estates Closed During the Year 2006

Estate Name	Conservation	Liquidation
Domestic: Premier Alliance Insurance Company Closed: 07/06/06	02/18/94	08/02/94
Foreign: None		

California Insurers – Estates in Liquidation or Conservation as of December 31, 2006

Estate Name	Date Conserved	Date Liquidated
Alistar Insurance Company	04/11/02	10/24/02
California Compensation Ins. Co.	03/06/00	09/26/00
Citation General Insurance Company	07/21/95	08/24/95
Combined Benefits Ins. Co.	03/06/00	09/26/00
Commercial Compensation Cas. Co.	06/09/00	09/26/00
Executive Life Insurance Company	04/11/91	12/06/91

California Insurers—Estates in Liquidation or Conservation as of December 31, 2006 (Continued)

Estate Name	Date Conserved	Date Liquidated
Fremont Indemnity Company	06/04/03	07/02/03
Frontier Pacific Insurance Company	09/07/01	11/30/01
Golden Eagle Insurance Company	01/31/97	02/01/98
Great States Insurance Company	03/30/01	05/08/01
HIH America Comp. & Liab. Ins. Co.	03/30/01	05/08/01
Mission Insurance Company	10/31/85	02/24/87
Mission National Insurance Company	11/26/85	02/24/87
Municipal Mutual Insurance Company	*	10/31/06
National Automobile Casualty Ins. Co.	03/15/02	04/23/02
Pacific National Ins. Co.	05/14/03	08/05/03
Paula Insurance Company	04/26/02	06/21/02
S&H Insurance Company	01/28/85	04/16/85
Sable Insurance Company	05/10/01	07/17/01
Superior National Ins. Co.	03/06/00	09/26/00
Superior Pacific Casualty Co.	03/06/00	09/26/00
Western Employers Insurance Company	04/02/91	04/19/91
Western Employers Ins. Co. of America	04/25/91	05/07/91
Western Growers Ins. Co.	*	01/17/03
Western International Insurance Company	08/10/92	09/09/92

**Insurers Domiciled In Foreign States – Estates in Liquidation or Conservation
as of December 31, 2006**

None

* No Conservation Order obtained

Status of California Estates

Alistar Insurance Company

Conservation Order: April 11, 2002

Liquidation Order: October 24, 2002

2006 Report

Alistar Insurance Company was a non-standard Automobile and Workers' Compensation insurance company that was domiciled and wrote business in California. Alistar also wrote Bail Bond business which was sold to Lincoln General Insurance prior to liquidation. The "Claims Bar Date", or the final date to submit a claim against the Estate, was July 31, 2003. The Estate's immediate goal is to resolve all Non-Class 2 liability and determine final IGA/Class 2 liability by second quarter 2007. Additionally, the Estate seeks to collect all remaining reinsurance assets and make a final distribution by year-end 2007.

Total Assets:	\$15,315,000
Total Estimated Liabilities:	\$27,827,000
Net Assets (deficiency):	(\$12,512,000)
2006 Administrative Expenses:	\$ 504,000
2006 Distributions:	—
POCs Outstanding	2

Citation General Insurance Company

Conservation Order: July 21, 1995

Liquidation Order: August 24, 1995

2006 Report

Citation General Insurance Company was the successor to Canadian Insurance Company and Canadian Insurance Company of California via an Assumption Agreement dated February 13, 1986. This company wrote primarily Medical Malpractice, Workers' Compensation and Healthcare insurance. Citation also wrote Contractors' General Liability policies covering construction defects and other losses. Citation

was licensed to conduct business in California; Nevada; Arizona; South Dakota; and Washington. The Estate's immediate goal is to quantify the total Estate liability focusing on approximately \$14 million in potential Class 5 liability. Thereafter, the Estate's primary objective will be to complete reinsurance collections.

Total Assets:	\$17,901,000
Total Estimated Liabilities:	\$15,357,000
Net Assets (deficiency):	\$2,544,000
2006 Administrative Expenses:	\$370,000
POCs Outstanding	65

Executive Life Insurance Company

Conservation Order: April 11, 1991

Liquidation Order: December 6, 1991

2006 Report

Executive Life Insurance Company (ELIC) was placed into conservation in April 1991 primarily as a result of significant value declines in its high-yield investment portfolio. A comprehensive Rehabilitation Plan was adopted, heavily litigated and ultimately confirmed by the Court in September 1993. As part of the Plan, ELIC policyholders could elect to either accept new coverage (Opt-In) from Aurora National Life Assurance Company (Aurora), or to "Opt-out" and surrender their policies for cash. Over the years, enhancement trusts were established to collect ELIC assets for distribution to policyholders that opted out, or to Aurora to enhance the policy values of the ELIC policyholders that opted in.

In February 1999, the Commissioner commenced a lawsuit entitled Insurance Commissioner v. Altus Finance S.A. The suit alleged that the defendants intentionally deceived the Commissioner in order to gain control of ELIC's junk bonds and insurance policies. The suit seeks disgorgement of all profits gained by the defendants and recovery for all

damages caused by their deceit. Recoveries from the lawsuit (Altus Proceeds) would go to ELIC policyholders.

After prevailing in the litigation, and prior to distribution of the Altus Proceeds, the National Organization of Life and Health Guaranty Associations (NOLGHA) entered arbitration with the Commissioner over the proper method by which to distribute the funds. NOLGHA argued they should receive approximately 50% of all available Altus Proceeds, while the Commissioner sought to have the greater share of the distribution be paid to the Opt-in policyholders. In December 2006 the Arbitration Panel rendered an interim decision in favor of the Commissioner.

The Bureau of State Auditors (BSA) completed Phase 1 of the legislative audit and submitted their report in October 2006.

The Estate's primary objective is to resolve pending litigation and asset recovery. The closure of some secondary trusts and resolution to the Estate's escheatment requirements are goals for second and third quarters of 2007. The ELIC Estate acts as a pure funding mechanism to distribute legal proceeds.

Executive Life Insurance Company

Total Assets:	\$360,581,000
Total Estimated Liabilities:	\$2,793,150,000
Net Assets (deficiency):	(\$2,432,569,000)
2006 Administrative Expenses:	\$8,227,000
2006 Distributions:	\$139,730,000

Executive Life Opt-Out Trust

Total Assets:	\$11,326,566
Total Estimated Liabilities:	(\$77,530,771)
Net Assets (deficiency):	\$88,857,336
2006 Administrative Expenses:	\$1,004,000
2006 Distributions:	\$205,749,000

Executive Life FEC Litigation Trust

Total Assets:	\$1,903,046
Total Estimated Liabilities:	\$1,829,901
Net Assets (deficiency):	\$73,146
2006 Administrative Expenses:	—

Fremont Indemnity Company

Conservation Order:	June 04, 2003
Liquidation Order:	July 02, 2003

2006 Report

Fremont Indemnity Company (Fremont) was placed into conservation on June 4, 2003. The Commissioner filed a Consolidated Application for Liquidation and Fremont was ordered into liquidation on July 2, 2003. Fremont was authorized as a Multi-line Property & Casualty insurer, but operated as a "monoline" Workers' Compensation insurer writing only Workers' Compensation and Employer Liability coverage both within and outside of California. Fremont wrote business in 48 states. Fremont is the successor by merger of six affiliate insurers that were under the common ownership of Fremont Compensation Insurance Group, Inc. (FCIG), Fremont's immediate parent company. FCIG is wholly-owned by a publicly traded holding company, Fremont General Corporation (FGC). Approximately 65% of Fremont's workers' compensation claims are attributable to business written in California. The claims bar date was set as of June 30, 2004.

The Estate's immediate objectives are to conclude two legal appeals and return both cases (against Parent) to trial court by the first quarter 2007; aggressively pursue certain Directors & Officers (D&O) for breach of fiduciary duty claims; position the Estate for a complete 4th Early Access Distribution in 2007; and estimate the Estate's non-covered liability by second quarter 2007.



Lost or missing underwriting files continue to delay production and advancement of various legal actions. D&O defendants and FGC show no apparent desire to pursue global settlement terms at this time.

Total Assets:	\$642,552,000
Total Estimated Liabilities:	\$2,085,962,000
Net Assets (deficiency):	(\$1,443,410,000)
2006 Administrative Expenses:	\$8,090,000
2006 Distributions:	\$182,323,000
POCs Outstanding	7,867

Frontier Pacific Insurance Company

Conservation Order: September 7, 2001

Liquidation Order: November 30, 2001

2006 Report

Frontier Pacific Insurance Company ("FPIC"), a California-domiciled Property and Casualty company, was conserved by the Commissioner on September 7, 2001. In August 2001, FPIC's parent company, Frontier Insurance Company ("FIC") of New York, voluntarily entered rehabilitation under the control of the New York Insurance Department. As a result of the rehabilitation, certain reinsurance recoverables due to FPIC from the parent were not received and could therefore no longer be carried on the books of FPIC. An examination by the California Department of Insurance's Financial Analysis Division found that the disallowance of the FIC reinsurance credit in the amount of \$12,842,609 resulted in a negative surplus of \$5,289,000.

Following the conservation, the Commissioner determined that FPIC's financial rehabilitation was futile and the Order of Liquidation was entered on November 30, 2001. The Liquidator is continuing negotiations with the New York Liquidation Bureau (NYLB) regarding the disposition of collateral which secures joint obligations of FPIC and FIC. The Liquidator is collaborating with

NYLB to reconcile and collect on many group reinsurance programs that were historically maintained by FIC, as well as amounts due from FPIC's largest reinsurer, NICO (Berkshire Hathaway).

The Estate is positioned to either participate with the NYLB in the sale of the book of business as a component of the rehabilitation of FIC, or to pursue final asset recoveries and position the Estate for closure in 2008.

Total Assets:	\$69,553,000
Total Estimated Liabilities:	\$81,418,000
Net Assets (deficiency):	(\$11,865,000)
2006 Administrative Expenses:	\$1,015,000
POCs Outstanding	453

Golden Eagle Insurance Company

Conservation Order: January 31, 1997

Rehabilitation/Liquidation

Plan Approved: August 4, 1997

Liquidation Order: February 13, 1998

2006 Report

The Court-sanctioned Golden Eagle Insurance Company Liquidating Trust (The Trust) manages the liquidation of Golden Eagle Insurance Company. The Trust was created as of the entry of the Liquidation Order. The Liquidation Order does not contain a formal finding of insolvency, and thus the California Insurance Guaranty Association has not been triggered.

The Commissioner is the Trustee of the Trust and three Deputy Trustees manage the day-to-day operations. The Trust is responsible for the management of third-party claim administrators and reinsurers (affiliates of Liberty Mutual Insurance Company) who are responsible for the adjustment and payment of covered policyholder claims. The Trust also manages the residual assets of the liquidated Estate and administers proofs of claims filed by general creditors. The original

duration of the Trust was five years from its inception in February 1998. The Commissioner and the Deputy Trustees have agreed to a series of court-approved extensions, the most recent of which continued the duration of the Trust through June 30, 2006. The claims bar date for the Trust was February 27, 1998.

During 2006, the Deputy Trustees purchased sufficient reinsurance coverage to cover the remaining insurance exposures and implemented a final closing plan that transferred the remaining affairs to the CLO. The Trust Closing Plan was completed, approved by the Court, and closed on November 30, 2006. The Golden Eagle Trust is officially closed and terminated subject to a final accounting to be filed in February 2007. All remaining liquidation responsibilities have been transferred into CLO.

Total Assets:	\$182,025,589
Total Estimated Liabilities:	\$180,009,838
Net Assets (deficiency):	\$2,015,751
2006 Administrative Expenses:	\$50,000
POCs Outstanding:	*See note below

***All POCs are processed and paid by Liberty Mutual in accordance with a reinsurance agreement; therefore, no distributions are planned.**

HIH America Comp. & Liab. Ins. Co.
Conservation Order: March 30, 2001
Liquidation Order: May 8, 2001

2006 Report

HIH America Compensation Liability Insurance Company (“HIH”) was domiciled in California and licensed to transact business in 31 states. HIH wrote only Workers’ Compensation insurance. The principal states where HIH conducted business were California; Illinois; Michigan; Hawaii; Nevada; Colorado; and Wisconsin. In 2006, the HIH Estate released \$136 million in court-approved early access distributions to participating

IGAs. The Estate collected approximately \$676,000 in legal and reinsurance recoveries.

The Estate’s immediate goals are to resolve various inter-company collection matters with the Hawaii affiliate and the Australia parent company. Two legal disputes remain and are expected to be resolved by fourth quarter 2007. The Estate will seek closure by the fourth quarter 2008 if no significant impediments or appeals are encountered.

Total Assets:	\$68,964,000
Total Estimated Liabilities:	\$358,959,000
Net Assets (deficiency):	(\$289,995,000)
2006 Administrative Expenses:	\$605,000
2006 Distributions:	\$136,060,000

Great States Insurance Company
Conservation Order: March 30, 2001
Liquidation Order: May 8, 2001

2006 Report

Great States Insurance Company was domiciled in California and was licensed to transact business in 14 states. Great States wrote only Workers’ Compensation insurance and concentrated in Arizona, Colorado, and Nevada, with minimal writings in California and Illinois. In 2006, the Great States Estate released \$10 million in court-approved early access distributions to participating IGAs. The Estate has completed actuarial work in preparation to commute the remaining reinsurance contracts. The Estate continues to bill and collect amounts due under a surety bond posted for the benefit of policyholders. All surety bond collections inure to CIGA.

Total Assets:	\$19,297,000
Total Estimated Liabilities:	\$72,920,000
Net Assets (deficiency):	(\$53,623,000)
2006 Administrative Expenses:	\$236,000
2006 Distributions:	\$10,000,000

Mission Insurance Company

Conservation Order: October 31, 1985

Liquidation Order: February 24, 1987

Mission National Insurance Company

Conservation Order: November 26, 1985

Liquidation Order: February 24, 1987

Enterprise Insurance Company

Conservation Order: November 26, 1985

Liquidation Order: February 24, 1987

2006 Report

Mission Insurance Company and Mission National Insurance Company

The insolvency of Mission Insurance Company and affiliated insurers was the largest Property and Casualty insurer failure at the time of conservation. The Mission companies wrote complicated Primary, Excess, and Surplus insurance and reinsurance, much of which is long-tail in nature.

The Mission group of companies consisted of five affiliates: Mission Insurance Company (“MIC”), Mission National Insurance Company (“MNIC”) and Enterprise Insurance Company (“EIC”) which are California-domiciled companies and wrote primarily P&C business. Holland-America Insurance Company (“HAIC”) and Mission Reinsurance Corporation (“MRC”) are domiciled in Missouri. HAIC wrote P&C business while MRC reinsured P&C business. These companies are direct or indirect subsidiaries of the Mission Insurance Group, Inc. which was later renamed as Danielson Holding Corporation (“DHC”), now known as Covanta Holding Corporation.

The Mission Insurance Companies insolvency proceedings began with a court-ordered conservation on October 31, 1985 due to their hazardous financial condition. Efforts to rehabilitate the companies did not succeed and on February 24, 1987, the companies were

ordered into liquidation. Ancillary proceedings in California for HAIC and MRC were initiated concurrent with the Missouri Insurance Director’s obtaining a receivership order.

The Commissioner entered into an Agreement of Reorganization, Rehabilitation, and Restructuring in 1989 which was approved by the Court on August 15, 1990. This agreement resulted in the transfer of assets and liabilities of the Mission Companies into individual liquidating trusts. The effect was to legally separate the assets and liabilities from their corporate charters and licenses which preserved certain tax advantages inuring to the benefit of claimants.

In an effort to accelerate the closure of the Estate, the Commissioner adopted an Amended Final Liquidation Dividend Plan which required claimants, who had previously filed timely contingent and un-liquidated claims, to file amended proofs of claim quantifying their claims by August 18, 1995. The Commissioner’s Amended Final Liquidation Dividend Plan was approved on January 9, 1997 and affirmed upon appeal in 1998. A comprehensive plan was developed for closing the Mission companies and was filed with the Los Angeles Superior Court on August 2, 2002.

On June 25, 2004, the Commissioner filed a motion with the Los Angeles Superior Court to set a Section 1025 date for the Liquidation of General Creditors and other non-policyholder claims for final distribution. The Court approved the motion and set August 2, 2004 as the cut-off date.

As of December 31, 2005, six Early Access and five Interim distributions have been made for MIC and MNIC.

On January 24, 2006, the court approved the Commissioner’s Motion to Approve Rehabilitation Plan and Implementation Agreement and Motion

for Approval of the Final Distribution and Accounting. It is expected that these Estates will be reopened in the future to distribute the remainder of reserved assets and any large collections from insolvent reinsurers that may materialize in the coming years.

The Mission and Mission National Final Distributions completed in March 2006 totaled in excess of \$509 million. The Liquidator filed a Declaration of Compliance to conditionally close these two estates for closures on July 24, 2006. The Court heard the Commissioner’s Status Report and Summary of the case for Mission Insurance Company Trust and the Mission National Insurance Company Trust on December 1, 2006. The Estate’s goal is to efficiently monitor “post-closing” collections and distribute available funds and stock assets in accordance with the Closing Plan.

Enterprise Insurance Company

Enterprise Insurance Company (EIC) was a California-domiciled company affiliate of Mission Insurance Company. The liquidation of Enterprise was administered in connection with the Mission Insurance Company Trusts (Trusts).

The Commissioner sought and received court approval of the Motion to Re-open Proceedings on EIC and the Motion to Approve Reconciliation of Distributions to the California Insurance Guarantee Association. Also, the Estate completed its final distribution on August 4, 2006 in the amount of \$46.4 million, and the Declaration of Compliance was filed with the court on December 29, 2006 for the Estate re-closure. The Estate’s goal is to efficiently monitor “post-closing” collections and distribute available funds and stock assets in accordance with the Closing Plan.

Mission Insurance Company

Total Assets: \$214,271,000

Total Estimated Liabilities: \$394,099,000
 Net Assets (deficiency): (\$179,828,000)
 2006 Administrative Expenses: \$1,145,000
 2006 Distributions: \$388,123,000

Mission National Insurance Company

Total Assets: \$66,835,000
 Total Estimated Liabilities: \$15,953,000
 Net Assets (deficiency): \$50,882,000
 2006 Administrative Expenses: \$320,000
 2006 Distributions: \$125,554,000

Enterprise Insurance Company

Total Assets: \$5,056,000
 Total Estimated Liabilities: \$36,623,000
 Net Assets (deficiency): (\$31,567,000)
 2006 Administrative Expenses: \$110,000
 2006 Distributions: \$46,409,000

Municipal Mutual Insurance Company

Supervision Agreement Date: August 18, 2003

Liquidation Order: October 31, 2006

2006 Report

Municipal Mutual Insurance Company, a Liability and Workers’ Compensation insurance company, was placed in informal administrative supervision in August of 2003. The company ceased writing business in April 2003 and was liquidated on October 31, 2006. All claims were transferred to CIGA for handling.

In an effort to manage the Estate more efficiently, the Commissioner filed a motion to transfer the liquidation venue to San Francisco, and plans to file a motion to limit the Proof of Claim process to only the GL policies issued by Municipal Mutual. The Estate remains open for the collection of reinsurance. We have initiated proposals to commute all remaining reinsurance treaties. If unsuccessful with commutation, we will explore alternative methods of concluding the reinsurance collections and will close the Estate.



Total Assets:	\$1,368,411
Total Estimated Liabilities:	\$2,723,593
Net Assets (deficiency):	(\$1,505,182)
2006 Administrative Expenses:	\$110,000

**National Automobile &
Casualty Insurance Company**

Conservation Order:	March 15, 2002
Liquidation Order:	April 23, 2002

2006 Report

National Automobile & Casualty Insurance Company (NACIC) specialized in Private Passenger Automobile Liability and Physical Damage insurance and Homeowner insurance, and also wrote Fire, Liability, Common Carrier Liability, Surety and other miscellaneous classes of insurance. NACIC was licensed to write business in eight states. Since liquidation, all guaranty associations continue to pay and report on covered claims. The CLO has commenced plans to settle the Estate's remaining reinsurance contracts. The Estate has completed claims valuation agreements with three IGAs. Additionally, the Estate completed the court-approved sale of the Estate's shell (charter and license).

The Estate's immediate goal is to determine the total Estate liability, research certain assets for collectibility, and recover all remaining assets by September 2007. Thereafter, the Estate will seek to complete a final distribution by year-end 2007.

Total Assets:	\$28,347,000
Total Estimated Liabilities:	\$27,894,000
Net Assets (deficiency):	\$453,000
2006 Administrative Expenses:	\$223,000
POCs Outstanding	18

**Pacific National Ins. Co./Pacific Automobile
Ins. Co.**

Conservation Order:	May 14, 2003
Liquidation Order:	August 5, 2003

2006 Report

Pacific National Insurance Company (PNIC) is a subsidiary of the Highlands Insurance Group. PNIC's principal business lines included Workers' Compensation;

Commercial Multiple-Peril; General Liability; and Commercial Automobile insurance. PNIC was licensed to write business in California and Ohio.

In October 2002, Highlands Insurance Group and five of its non-insurance subsidiaries commenced Chapter 11 bankruptcy proceedings with the U.S. Bankruptcy Court in the District of Delaware.

On May 14, 2003, the Commissioner was appointed as Conservator of PNIC, and on August 5, 2003, the Superior Court appointed the Commissioner as Liquidator of PNIC. Upon liquidation, covered claims were transferred to the appropriate insurance guaranty associations. PNIC's assets consist primarily of cash assets and reinsurance receivables.

Highlands Insurance Company (HIC) in New Jersey, a subsidiary of Highlands Insurance Group, continues to handle routine administrative services for PNIC under an inter-company agreement. HIC has been placed in conservation by the Texas receiver in November 2003. The CLO continues to work with the Texas receiver on data transfer and reinsurance collections.

The Estate's immediate goal is to resolve claims data issues in support of asset recovery. The Estate's ultimate objective is to resolve all asset collections in 2007 and position the Estate for a final distribution in 2008.

Total Assets:	\$18,018,000
Total Estimated Liabilities:	\$77,168,000
Net Assets (deficiency):	(\$59,150,000)
2006 Administrative Expenses:	\$418,000
2006 Distributions:	—
POCs Outstanding	3

Paula Insurance Company

Conservation Order: April 26, 2002

Liquidation Order: June 21, 2002

2006 Report

Paula Insurance Company, a wholly-owned subsidiary of Paula Financial, wrote Workers' Compensation coverage for labor-intensive agribusinesses located in eight states. All Paula policies were cancelled as of July 21, 2002. In September 2003, a secured loan for the amount of \$500,000 was advanced to the Alaska Insurance Guaranty Association to avoid an interruption in benefit payments. By year-end 2005, the loan was repaid in full, with interest. The Estate's ultimate goal is to collect final asset recoveries and position the Estate for a final distribution and closure in 2008. The Estate's immediate objective is to prepare and release an EAD/Interim by first quarter 2007.

Total Assets:	\$67,091,000
Total Estimated Liabilities:	\$231,716,000
Net Assets (deficiency):	(\$164,625,000)
2006 Administrative Expenses:	\$815,000
2006 Distributions:	\$689,000
POCs Outstanding	616

Premier Alliance Insurance Company

Conservation Order: February 18, 1994

Liquidation Order: August 2, 1994

2006 Report

Premier Alliance Insurance Company wrote primarily Medical Malpractice, Workers' Compensation and Hospital Liability insurance. All claims and reinsurance Proof of Claims have been fully adjudicated.

The Commissioner completed a final distribution of approximately \$42 million on December 15, 2005, and was discharged as Liquidator upon the filing of a Declaration of Compliance on July 7, 2006.

Total Assets:	—
Total Estimated Liabilities:	—
Net Assets (deficiency):	—
2006 Administrative Expenses:	\$45,000

S & H Insurance Company

Conservation Order: January 28, 1985

Liquidation Order: April 16, 1985

2006 Report

S & H Insurance Company wrote Surety and Property/Casualty insurance. S&H became insolvent when the company's former president won a judgment against S&H in the amount of \$8 million, resulting in a substantial decrease in the capital of the company.

The Estate has resolved a final Order to Show Cause and settled its tax liability to its parent. The Estate completed its final distribution in September 2006. A Final Report and Account closing the Estate will be filed with the Court in 2007.

Total Assets:	\$481,000
Total Estimated Liabilities:	(\$5,266,000)
Net Assets (deficiency):	\$5,747,000
2006 Administrative Expenses:	\$231,000
2006 Distributions:	\$19,663,000

Sable Insurance Company

Conservation Order: May 10, 2001

Liquidation Order: July 17, 2001

2006 Report

Sable Insurance Company is a California-domiciled wholly-owned subsidiary of Sable Insurance Holding Company. Sable Insurance Company wrote Workers' Compensation and Property and Casualty insurance and was licensed to write business in California.

A significant portion of Sable's assets consists of reinsurance receivables which are not immediately

collectible due to the insolvency of Reliance, Sable's primary reinsurer. The CLO initiated final settlement discussion with the participating IGAs in 2006 with a primary objective of resolving all reinsurance recoveries and to determine the Estate's ultimate liability for a final distribution in 2008.

Total Assets:	\$18,750,000
Total Estimated Liabilities:	\$51,151,000
Net Assets (deficiency):	(\$32,401,000)
2006 Administrative Expenses:	\$195,000
POCs Outstanding	5

Superior National Insurance Companies In Liquidation (SNICIL)

(California Compensation Insurance Company; Combined Benefits Insurance Company; Commercial Compensation Casualty Company; Superior National Insurance Company; and Superior Pacific Casualty Company)

Conservation Order: March 6, 2000
Liquidation Order: September 26, 2000

2006 Report

On March 6, 2000, the Los Angeles Superior Court appointed the Commissioner as Conservator of Superior National Insurance Company; Superior Pacific Casualty Company; California Compensation Insurance Company; and Combined Benefits Insurance Company. On June 9, 2000, the Court appointed the Commissioner as Conservator of Commercial Compensation Casualty Company. On September 26, 2000, the Court appointed the Commissioner as Liquidator for these five insurance companies (collectively, the "Superior National Insurance Companies in Liquidation" or "SNICIL"). The value of the property and assets of the SNICIL entities at the time of liquidation exceeded \$1.4 billion.

On August 17, 2000, the Commissioner and

Lumbermen's Mutual Casualty Company, an Illinois corporation doing business as Kemper Insurance Companies ("Kemper"), among other parties, entered into the Superior National Insurance Companies Rehabilitation Agreement ("Rehabilitation Agreement"). On September 26, 2000, the Los Angeles County Superior Court issued the Final Order Approving the Rehabilitation Plan. All remaining operations were consolidated into the CLO on September 30, 2003.

Under the most optimistic estimates, SNICIL will not have sufficient assets to fully pay the Class 2 policyholder claims. Consequently, once asset recoveries and liabilities are determined, the Estate will seek court approval to reject all potential claims below Class 2.

After several years of arbitration in the U.S. Life matter, a panel of arbitrators issued a final award. After consideration for the reformation of the contract (an earlier phase of the arbitration had reduced the collectible amount under the contract by 10%), the award produced a net billing to U.S. Life of \$443 million. U.S. Life immediately moved to vacate the award in U.S. District Court. Simultaneously, we moved to confirm the award in the same court. The Court will consider the competing motions in 2007. In another protracted reinsurance arbitration matter, the Estate also reached agreement with Hanover Re which settled its obligation to the Estate. It is anticipated that a fifth Early Access Distribution to IGAs of approximately \$50 million will be made in the third quarter of 2007.

The Estate is working to determine all non-guaranty association liability by June 2007. Once the Estate has resolved the remaining reinsurance programs (including the U.S. Life Treaty), the team will work to position the Estate for closure in 2009.

California Compensation Insurance Company

Total Assets:	\$501,876,000
Total Estimated Liabilities:	\$1,438,905,000
Net Assets (deficiency):	(\$937,029,000)
2006 Administrative Expenses:	\$3,402,000
2006 Distributions:	\$105,000

Combined Benefits Insurance Company

Total Assets:	\$15,801,000
Total Estimated Liabilities:	\$21,777,000
Net Assets (deficiency):	(\$5,976,000)
2006 Administrative Expenses:	\$141,714
2006 Distributions:	—

Superior National Insurance Company

Total Assets:	\$300,007,000
Total Estimated Liabilities:	\$784,035,000
Net Assets (deficiency):	(\$484,028,000)
2006 Administrative Expenses:	\$1,927,000
2006 Distributions:	\$7,000

Superior Pacific Casualty Company

Total Assets:	\$54,796,000
Total Estimated Liabilities:	\$192,160,000
Net Assets (deficiency):	(\$137,364,000)
2006 Administrative Expenses:	\$430,000
2006 Distributions:	\$16,000

Commercial Compensation Casualty Company

Total Assets:	\$89,171,000
Total Estimated Liabilities:	\$141,145,000
Net Assets (deficiency):	(\$51,974,000)
2006 Administrative Expenses:	\$808,000
2006 Distributions:	\$327,000
POCs Outstanding	9

Western Employers Insurance Company

Conservation Order: April 2, 1991
Liquidation Order: April 19, 1991

Western Employers Insurance Company of America

Conservation Order: April 25, 1991
Liquidation Order: May 7, 1991

2006 Report

Western Employers Insurance Company (WEIC) was a New York-domiciled insurer known as Letherby Insurance Company and was re-domesticated to California in the late 1970's. The company was licensed in 38 states and wrote primarily Workers' Compensation and Multi-Peril insurance. After four years of self-liquidation, WEIC determined it could no longer continue liquidation without the assistance of the California Department of Insurance.

Western Employers Insurance Company of America (WEICA) is a wholly-owned subsidiary of WEIC. WEICA was licensed in eight states, with its principal place of business located in Fullerton, California. The company wrote only Workers' Compensation insurance. WEICA was included in its parent company's self-liquidation process.

Both the WEIC and WEICA Estates are in the process of determining the Estate's ultimate liability.

Reinsurance billings are issued monthly and collections are current. Continuing efforts to commute the largest treaty with General Reinsurance have been unsuccessful. A lack of reliable data is contributing to delays in resolving all open reinsurance treaties. The Estate's primary objective will be to resolve all asset recoveries, determine final Estate liability and position the Estate for closure by 2008.

A significant requirement to meet that objective is to determine how to quantify the remaining long-tail exposure. The Estate will seek court approval to establish a new claims-bar date after which no new claims will be honored.

Western Employers Insurance Company

Total Assets:	\$129,177,000
Total Estimated Liabilities:	\$55,065,000
Net Assets (deficiency):	\$74,112,000
2006 Administrative Expenses:	\$652,000
2006 Distributions:	—

Western Employers Insurance Company of America

Total Assets:	\$10,809,000
Total Estimated Liabilities:	\$10,583,000
Net Assets (deficiency):	\$226,000
2006 Administrative Expenses:	\$45,000
2006 Distributions:	—
POCs Outstanding	3,155

Western Growers Insurance Company**Liquidation Order: January 17, 2003***2006 Report*

On January 17, 2003, the Orange County Superior Court entered an Order of Liquidation for Western Growers Insurance Company. WGIC wrote Workers' Compensation business in California and Arizona.

In 2004, the Commissioner obtained a court order to forego the comprehensive Proof of Claim process saving the Estate significant cost, yet still protecting all recovery rights of the two participating guaranty associations. The Liquidator continues to bill, collect, and seek commutation of remaining reinsurance coverage.

In 2006, the Estate continued its aggressive plan to commute the remaining reinsurance contracts and schedule a final distribution for year-end 2007. Prior to a final distribution, the Estate will seek to recover excess funds held by the Arizona regulator.

Total Assets:	\$11,028,000
Total Estimated Liabilities:	\$50,845,000

Net Assets (deficiency):	(\$39,817,000)
2006 Administrative Expenses:	\$323,000
2006 Distributions:	—
POCs Outstanding	2

Western International Insurance Company**Conservation Order: August 10, 1992****Liquidation Order: September 9, 1992***2006 Report*

Western International Insurance Company ("WIIC") was domiciled and licensed in California. The company wrote primarily Property and Casualty insurance. WIIC was conserved on August 10, 1992 and placed into liquidation on September 9, 1992. CIGA is the only guaranty association affected. All CIGA claims and CLO in-house claims have been adjusted. There are sufficient funds to pay Class 1 & 2 claims, and General Creditor claimants have been advised there are no available funds to pay claims past Class 2. The Estate's primary focus is to complete the settlement and collection of disputed reinsurance receivables.

Significant progress has been made in collecting reinsurance funds due on this Estate. The Estate is pursuing resolution of all reinsurance recoverables and will continue to assert arbitration demands on reinsurers unwilling to honor valid billings.

The Estate's goal is to resolve all remaining asset recoveries and position the Estate for a final distribution in 2008.

Total Assets:	\$11,845,000
Total Estimated Liabilities:	\$43,143,000
Net Assets (deficiency):	(\$31,298,000)
2006 Administrative Expenses:	\$357,000

THE OFFICE OF SPECIAL COUNSEL TO THE COMMISSIONER

The Special Counsel serves the Commissioner and the Chief Deputy Commissioner, providing leadership and advice on a range of high priority policy issues that affect both the internal functioning of the Department and insurance regulation more broadly.

Some of these internal issues include such matters as management of the regulation development process, review of Administrative Hearing Bureau decisions, and coordination of Department participation in the National Association of Insurance Commissioners.

The Special Counsel coordinated Department comment on federal legislation affecting insurance regulation, lead the Seniors Task Force and the Life and Annuity Consumer Protection Program and actively participated in the national debate on federal catastrophe insurance legislation.

Special Counsel to the Commissioner 2006 Priorities

Life and Annuity Consumer Protection Program (LACPP)/ SENIORS

The Special Counsel oversees the LACPP, created by Assembly Bill 2316 (Chan), which in 2006 granted approximately \$500,000 to four District Attorney's Offices to prosecute financial abuse cases. Additionally, the Special Counsel wrote a script for a video, to be produced in 2007, that will inform consumers how to protect themselves from common annuity scams and pressure tactics.

Additionally, in a related activity, the Special Counsel produced the report "A Suitable Match: Best Practices in Annuity Sales." The result of a year-long investigation into the methods insurers currently

use to ensure the sale of suitable annuities to their customers, this report culls the best practices in use now and recommends a system for insurers to follow.

Legislation to address some of the problems with long term care insurance, including closed blocks of policies, was initially drafted by the Special Counsel, and was enacted.

Regulations

During 2006, thirty-six regulation development projects were completed and two were abandoned. While new regulation development projects were introduced over the course of the year, the backlog of long-standing regulation development projects was significantly reduced. At the inception of the management process, in April of 2005, the number of regulation development projects stood at 43.

National Catastrophe Insurance

The Special Counsel represented the Insurance Commissioner at many special events over the course of 2006, to bring to the table the notion of national catastrophe insurance. Among these events were Congressional hearings in Washington, D.C., and the Centennial events marking the 1906 San Francisco earthquake.

THE COMMUNICATIONS/PRESS RELATIONS OFFICE

The Communications/Press Relations Office coordinates and disseminates the Department's message and objectives to consumers, the industry, media and CDI staff. The effective delivery of this information, through a variety of tools and methods, ensures that all Department efforts contribute to the ultimate goal of creating the best consumer protection agency in the nation.

The role of the Communications Office is to inform the state of California of the undertakings within the Department, as the Office studies trends, conducts research and identifies media issues which need to be addressed. The Communications Office fosters relationships with important stakeholders, the insurance industry, state legislators, the Governor's Office, consumers and also with CDI staff.

The Communications/Press Relations Office also collaborates with the Community Relations Branch in performing a myriad of outreach campaigns regarding the Department's consumer programs and services. The Communications Office plays an integral role by serving as a positive liaison with the press (television, newspaper, internet and radio media) via press releases, phone calls, emails and press events. Importantly, the Communications staff key responsibility is to deliver information which is vital in representing the message of the Insurance Commissioner and the Department.

2006 ANNUAL REPORT
EXECUTIVE PROGRAMS
BRANCH

EXECUTIVE PROGRAMS BRANCH

Reporting directly to the Insurance Commissioner, the Executive Programs Branch provides a wide range of services to the Commissioner, the Executive staff, Department personnel, and the public. The branch is comprised of the Administrative Hearing Bureau, the Office of Ethics and Operational Compliance, the Information Security Office, the Equal Employment Opportunity Office, and the Office of the Ombudsman. Branch personnel perform critical functions, including: responding to the public inquires: conducting Administrative Law Hearings and writing proposed decisions on the Commissioner's behalf; reviewing and documenting the effectiveness and efficiency of all program areas within the Department; and providing an equitable working environment for all employees.

2006 ANNUAL REPORT OF THE ADMINISTRATIVE HEARING BUREAU

The Insurance Commissioner is authorized by statute to fulfill a regulatory role and an adjudicatory role. The Administrative Hearing Bureau ("AHB") supports the Insurance Commissioner in his adjudicatory role. Pursuant to the Insurance Code, the Insurance Commissioner is authorized to conduct evidentiary hearings at the AHB on various insurance matters identified below.

The AHB supplies administrative law judges ("ALJ") for many of the hearings provided for by the Insurance Code. In 2006, the AHB employed five full-time ALJs, one part-time ALJ, two legal secretaries, one office technician and one part-time calendar clerk. As directed by a particular statute, the ALJs conduct formal or informal hearings under the Administrative Procedure Act ("APA")

as well as non-APA hearings provided for by regulation. The ALJs submit proposed decisions to the Commissioner for adoption, modification or rejection. Upon written agreement, the ALJs also will mediate disputes thereby avoiding the necessity of an evidentiary hearing.

The cases filed with the AHB involve not only disputed rate change applications in Proposition 103 lines of insurance (Ins. Code § 1861.05), but also:

- + workers' compensation insurance rating system disputes between employers and the Workers' compensation Insurance Rating Bureau or an insurance carrier (Ins. Code §§ 11737 and 11753.1),
- + appeals regarding the plan of operations of the California Automobile Assigned Risk Plan (CAARP) (Cal. Code of Regs., title 10, section 2498.6),
- + allegations of noncompliance with the Insurance Code (Ins. Code §§ 1851.1 and 1851.2),
- + allegations of conducting business in a manner hazardous to policyholders, creditors or the public (Ins. Code §§ 10651.1, 1065.2 and 1756.1(g),
- + reviews of the Commissioner's denial of consent for a prohibited person to be licensed (Cal. Code of Regs., title 10, section 2175.1 et seq.).

In 2006, the AHB opened 81 cases and closed 134 cases. The statistics by subject matter are as follows:

Case Type	Opened	Closed
CAARP	1	0
Cease and Desist	1	1
FPA	1	0
CIGA	3	2
Non-Compliance	2	2

Prior Approval	7	5
Prohibited Persons	0	0
Workers Compensation Appeals	66	125

¹ Effective January 1, 2007, the AHB employs 3 ALJ-I and 1 ALJ-II Supervisor. The staff consists of 2 Legal Secretaries and 1 Office Technician. The ALJ positions are down by 1 _ after 1 full-time ALJ (serving on a limited term basis) and 1 part-time ALJ (retired annuitant) separated from CDI service on December 30, 2006. In addition, the AHB staff is down by _ position after the part-time calendar clerk (retired annuitant) separated from CDI service in December 2006.

In 2006, 1 writ of administrative mandamus was filed in superior court from an Order adopting an AHB proposed decision in a workers' compensation appeal. To date, all proposed decisions written by the ALJs arising out of AHB matters have been upheld on writ and appellate review. The CDI's legal department provides the AHB with quarterly reports on the progress of all matters on writ and appellate review so that the ALJs' decisions are consistent with current law.

ETHICS AND OPERATIONAL COMPLIANCE

The Ethics and Operational Compliance Office (EOCO) provides management of the Department with independent, objective, accurate and timely information necessary to make policy decisions. The EOCO assists management in their efforts to increase operational and program efficiency and effectiveness by providing them with analysis, appraisals, recommendations and technical assistance.

The EOCO is independent and team-oriented, committed to providing timely, professional and objective services to satisfy customer needs. The EOCO takes personal responsibility for its work by meeting the standards of professional competence.

The EOCO is composed of three distinct functions with six staff members reporting to the

Special Assistant to the Commissioner:

- + Internal Audits Unit
- + Curriculum Compliance Audits Unit
- + Ethics Office

Internal Audits Unit

The Internal Audits Unit was established in 1994 to ensure compliance with management's goals and objectives and adherence to federal, state, and departmental mandates, policies and procedures. The professional audit staff conducts internal audits and special projects for the Department and for the Conservation and Liquidation Office according to standards established by the Institute of Internal Auditors.

The audit staff assists executive management by conducting performance audits and program effectiveness and efficiency reviews. The staff also performs a variety of special projects that include: research and fact finding, project consultation, post-implementation evaluations, reviews of automated -projects, reviews of proposed changes to policies and procedures, and participation in various workgroups.

We owe a responsibility to management to provide information about the adequacy and effectiveness of the Department's system of internal control and quality of performance.

Curriculum Compliance Audits Unit

The Curriculum Compliance Audits Unit conducts reviews of insurance education providers' pre-licensing and continuing education courses to ensure the curriculum and provider operations adhere to California's Insurance Code and Code of Regulations. The audit findings are intended for use by the Licensing Services Division to assist them in reviewing the quality of education to ensure adequate training for the licensing and

continuing education requirements of insurance agents and brokers.

The auditor also reports quarterly to the Curriculum Board on the progress of the audit function, audit production plans and common audit findings. Any significant fraudulent or criminal activity discovered during an audit would be referred to the Enforcement Branch for further review and investigation.

Ethics Office

The Ethics Office was created in 2000 to provide private, secure and confidential communications and investigations. The Ethics Office receives and researches complaints regarding employees' conflicts with the Political Reform Act and the Department's Incompatible Activities Statements such as misuse of state property, inappropriate acceptance of gifts, and abuse of authority.

This is an independent office where the Department's employees can confidentially obtain answers to questions regarding proper conduct and report improper governmental activities by telephone, letter or e-mail. The Ethics Office investigates claims of suspicious activities as required by State Administrative Manual Section 20080. It oversees ethics orientation training for the Department's employees and advises them of their rights and responsibilities under the Whistleblowers' Protection Act.

INFORMATION SECURITY OFFICE

The Information Security Office (ISO) provides oversight to ensure that the Department's data is protected against unauthorized use, modifications and deletions. The ISO's functions and specific activities are varied and diversified.

Each state agency that uses, receives or provides

information technology services designates an Information Security Officer with responsibility for implementing state policies and standards regarding the confidentiality and security of information. The statewide policies and standards include, but are not limited to, strict controls to prevent unauthorized access to data maintained in computer files, program documentation, data processing systems and data processing equipment physically located in the agency.

The Information Security Officer has oversight responsibility for the Department's compliance with these state-wide requirements as listed in State Administrative Manual Section 4841:

- Oversight responsibility for ensuring the integrity and security of automated information that is produced and used in the Department's operations.
- Oversight responsibility for the security of information technology facilities, software and equipment that is utilized for automated information processing.
- Oversight of compliance with state audit and reporting requirements relating to the integrity of information assets.
- Oversight of the development and maintenance of the Department's Operational Recovery Plan (ORP).
- Oversight responsibility for the Department's information technology risk management program.
- Oversight of IT Security Incident Reporting requirements
- Coordination and assistance in the development and maintenance of the Department's Business Continuity Plan.

- Coordination and assistance in the development and maintenance of the Department's Privacy Protection Program.

THE OFFICE OF THE OMBUDSMAN

The Office of the Ombudsman responds to inquiries and requests for assistance from consumers, agents and brokers, and elected officials inquiring on behalf of constituents. When consumers request it, Ombudsman officers conduct second reviews of cases handled elsewhere in the Department to assure that all available consumer protections have been considered. Inquiries are received by mail and telephone and, increasingly, by email. In 2006, Ombudsman staff responded to over 1300 inquiries, about half of them referrals from legislators and the governor. The unit also coordinates the Commissioner's appointments to 9 boards and committees and conducts other special projects as requested by Executive Staff.

EQUAL EMPLOYMENT OPPORTUNITY OFFICE

The Equal Employment Opportunity Office's (EEO) objective is to ensure the Department of Insurance is in compliance with Title VII of the Civil Rights Act of 1964, as amended, and the Fair Employment and Housing Act prohibiting discrimination and harassment of employees and applicants for employment on the basis of their protected status. To achieve this objective, the EEO Office monitors the Department's policies, practices in employment, development and treatment of its employees, to ensure decisions are not based on non-job related factors that are discriminatory. Below are some of the activities that describe how this is accomplished:

- Development and dissemination of the Department's EEO policies to all employees,

- Provides EEO related training to all employees, supervisors and managers,
- Development and dissemination of the Department's discrimination complaint procedure which allows employees to complain of conduct they suspect are in violation of those policies,
- Conducting investigations into complaints of discrimination, harassment and retaliation and making recommendations for appropriate corrective action when policy violations occur.

Eliminating the distractions of discrimination, harassment and retaliation allows department employees to focus on the mission of the Department to be the single best consumer service protection agency in the nation.



2006 ANNUAL REPORT
ADMINISTRATION & LICENSING
SERVICES BRANCH

ADMINISTRATION & LICENSING SERVICES BRANCH

The mission of the Administration and Licensing Services Branch is to protect insurance consumers and maintain the integrity of the insurance industry by assisting with the implementation and enforcement of insurance licensing laws, and by providing professional, quality support services to each of the California Department of Insurance's (CDI) programs.

This Branch consists of the Business Management Bureau, the Human Resources Management Division, the Information Technology Division, the Licensing Services Division and the Financial Management Division.

BUSINESS MANAGEMENT BUREAU (BMB)

The Business Management Bureau is a multidisciplinary team consisting of 28 employees (18 in Sacramento, six in Los Angeles, and four in San Francisco) who are responsible for carrying out the following responsibilities:

- Preparation, coordination and processing of all contracts and purchase documents in accordance with State law, policies and procedures (Sacramento BMB).
- Providing mail services and supplies at the three largest CDI work-sites: Sacramento, San Francisco, and Los Angeles.
- Overseeing and managing all facilities projects, issues and leases at each of the 16 CDI addresses and locations.
- Managing records retention, fixed assets, forms, transportation, Conflict of Interest, and reproduction programs/processes.
- Providing record, equipment, and file storage for the Department and Licensing Services Division in the West Sacramento warehouse.

- Coordinating the development and implementation of CDI's Disaster Management Plan Program. The plan includes CDI's Emergency Assessment and Evacuation, Communications, Departmental Disaster Recovery and Resumption, and the Department's External role in response and recovery efforts to a State declared emergency.

Accomplishments in 2006

- The completion of the relocation of the Fresno Fraud Regional Office.
- The completion of the development of the Red Beam fixed asset tracking system of the department's equipment.
- The completion of the department's Disaster Recovery and Resumption Plan.
- The reorganization of the department's material handling facilities in West Sacramento and in Los Angeles.

HUMAN RESOURCES MANAGEMENT DIVISION (HRMD)

The Human Resources Management Division consists of four units: the Labor Relations/Health Management Unit; the Selection, Training and Merit Issues Unit; the Personnel Transactions Unit, and the Personnel Operations Unit.

- The Labor Relations/Health Management Unit is responsible for labor contract implementation issues, including grievance processing, updating emergency evacuation plans and teams and providing evacuation and safety training, responding to reasonable accommodation requests, administering the return to work program, providing information and advice on ergonomic compliance, providing information on a variety of wellness topics, and managing Workers' Compensation claims filed by CDI employees.

- The Selection, Training, and Merit Issues Unit administers civil service exams, coordinates training for departmental employees, investigates merit issue complaints and appeals, and manages the various departmental awards programs.
- The Personnel Transactions Unit is responsible for issues related to payroll, employee benefits, leave balances, and access to employee personnel files.
- The Personnel Operations Unit provides departmental managers and supervisors with consultative services and assistance with various human resources related subject areas including but not limited to hiring, employee discipline, classification and compensation, recruitment, employee assistance, the Family and Medical Leave Act, bilingual services and employee performance.

INFORMATION TECHNOLOGY DIVISION (ITD)

The Information Technology Division consists of three bureaus: the Statewide Network Support Bureau (SNS), the Application Development and Maintenance Bureau (ADAM), and the Project Coordination and Administrative Support Bureau (PCAS). ITD employs 86 employees (62 in Sacramento, 16 in Los Angeles, and eight in San Francisco) who carry out the following responsibilities:

- The SNS Bureau provides departmental support for the technology infrastructure. Support provided consists of telecommunication services, Local Area Network (LAN), Wide Area Network (WAN), Internet, Intranet, hardware/software installation, and maintenance for personal computers.
- The ADAM Bureau provides custom software development including the Integrated Database, the Fraud Integrated Database system, Internet/

Intranet development, and custom interfaces. ADAM monitors and maintains the Oracle Internet Application Server, commonly referred to as the 'middle tier', and works with Data Administrators at the Department of Technology Services where CDI's department data is stored.

- The PCAS Bureau includes a Project Management Office (PMO) and an Administrative Support Office (ASO). The PMO provides Project Management Methodology and Project Management for information technology (IT) projects. The ASO facilitates information technology related purchases and tracks requests for technology services and is responsible for Control Agency programs such as the Software Management Program and the Desktop and Mobile Computing Policy.

Major Technology Accomplishments In 2006

Infrastructure

ITD developed a plan, established a baseline budget, and replaced the end-of-life personal computer cabling in the Los Angeles Ronald Reagan Building. This project supports the CDI's direction toward VoIP and higher speed applications.

Telecommunications

The Department of General Services approved CDI's Request for Proposal (RFP) to replace the current end-of-life telephone system with a voice over Internet protocol (VoIP) solution. This will be the first large scale implementation of VoIP for the State of California and will serve as the State's pilot for further deployments of the technology. This project is supported by the California Performance Review Report and the California State Strategic Plan dated November 2005.

The Los Angeles Call Center (Consumer Hotline) telephone system was upgraded in April 2005. This upgrade improves reporting capabilities of Call Center activities and replaces an outdated and non-upgradeable system. The Telecommunication Infrastructure Replacement Project (TIRP) is currently in progress and expected to complete by March 2008.

Automation Projects

On Line Renewals/Address Changes

This project allows agents and brokers the ability to renew and pay for license renewals via credit card on line and, allow address changes on line.

Benefits:

- + Reduction in PLB staff needed to process deficient renewals and address changes.
- + Provide a method to allow credit card payment for license renewals.
- + Licensed agents and brokers will be able to change their address via the CDI website.

Rate Filing Document Imaging

Allows the RFB in LA and SF to scan rate filing documents, store them electronically, retrieve them via search/query, and provide public access to the document images.

Benefits:

- + Ensures compliance with CIC 1292.1.
- + Savings on costs for office space.
- + Improves efficiencies for storing and retrieving documents.
- + Improves public service.

District Attorney Program Report/Online Entry

Provides an online report, accessed through the CDI website, to allow the district attorney's office to input statistical information as it relates to

their specific grant program(s). This enhancement will allow the district attorney offices to report statistical information, as required by the Insurance Code and regulations, on a timely basis in a format that is easily accessible to both the reporting district attorney office and the Fraud Division.

Benefits:

- + Reduce staff time needed to compile the statistical information needed to assist the grant review panel.
- + Definitive categories for reporting purposes.
- + Online reporting by the district attorneys.
- + Accurate and timely reporting by the district attorneys.

COIN Web Development

Created a COIN website that would provide better insurer access to community development investment opportunities benefiting California's low-to-moderate income communities. This website would also provide Community Development Organizations the ability to search and identify Investor contacts to allow them to market investment opportunities directly to Insurers.

Benefits:

- + Increase Insurers awareness of community development investment opportunities; allow community development organizations the ability to promote opportunities to investors.

Legal Case/Matter Management & Activity Tracking Project

This project will replace an existing case/matter management system used by the Legal staff. The system has reached end of life and a replacement is needed. The project was formally implemented in September and is complex with interfaces into COSMOS, e-mail, and DM web publishing

systems. The project is currently in progress and expected to complete by May 2007.

Enterprise Information Portal Project

This system will provide access to enterprise information to support executive and management decision making. The project is currently in progress and expected to complete by March 2007.

LICENSING SERVICES DIVISION (LSD)

The Licensing Services Division (LSD), under the authority of the California Insurance Code, protects insurance consumers and maintains the integrity of the insurance industry by determining the qualifications and eligibility of applicants for licenses. The Division consists of three Bureaus: the Producer Licensing Bureau, the Licensing Background Bureau and the Licensing Compliance and Business Process Bureau.

- The Producer Licensing Bureau (PLB) is primarily responsible for issuing, maintaining and updating records of all insurance producer licenses; preparing and administering written qualifying insurance examinations; and the review and approval of education courses submitted by insurance companies, educational institutions, and others.
- The Licensing Background Bureau (LBB) is responsible for obtaining information and documentary evidence regarding criminal convictions and other adverse actions in the backgrounds of insurance producers, licensing applicants, and organizations seeking authority to transact insurance in California. The LBB analyzes the evidence and recommends a course of action against the licensee/applicant.
- The Licensing Compliance and Business Process Bureau (LCB) was formed during the summer of 2006. Its primary function is to assist the

Enforcement Branch's Investigation Division with the review and analysis of case files received from the Investigation Division's Complaint Intake Unit. The Bureau consists of three units: the Licensing Compliance Unit, the Business Process Reengineering Unit and the Surplus Line Filing Unit.

Major Accomplishments in 2006

Producer Licensing Bureau (PLB)

During 2006, the PLB completed projects encompassing both e-government initiatives and implementing new legislation.

Agent Endorsement Service for Insurance Agencies

During 2006, the department developed an online service for insurance agencies to submit their agent endorsements to the PLB through the department's website. This service allows licensed insurance agencies to endorse licensed individual agents to transact specified lines of insurance on the agency's behalf.

The department estimates that 20 percent of all agent endorsements sent to the PLB through the mail are deficient, most common errors being that the correct fees are not submitted, the individual agent endorsed has an inactive or suspended license and the insurance agency endorsement authority for a particular line of insurance is incorrect.

The online service ensures that all required information and payment of fees are included prior to sending the information electronically to the department. The licensing records shown on the department's website for both the individual and agency licensees are updated immediately after a successful transmission. The service accepts payment for the endorsements by credit card. There is no additional charge to use the service.

New Online Insurance Agency Application Service

During 2006, the department developed an online application service specifically intended for applicants applying for an insurance agency license. It will become operational in the Spring of 2007. This online service allows insurance agency license applicants to apply for licensure through the department's website.

The department estimates that 90 percent of all insurance agency license applications sent to the PLB through the mail are deficient, most common errors relating to information about the agency's officers and directors and the approved name of the insurance agency.

The online service provides for quicker issuance of the license, reduces processing errors, and eliminates the need for a business name reservation. It also results in timelier fund deposits from the online transactions, as the fees are paid by credit card. There is no additional charge for using the service.

Increased Usage of the Department's On-line Application Service

The Fast Licensing Application Service is Here (FLASH) was introduced in 2003 and continued to grow in popularity with the insurance industry during 2006. This "no cost" service allows applicants for individual insurance agent and broker licenses to apply for such licenses through the department's website.

During 2006, more than 47,667 or 83 percent of all license applicants eligible to apply on-line were received from applicants using the FLASH on-line service. FLASH provides for quicker issuance, reduction of processing errors, immediate update of license records, and lower operating costs for insurance companies and agencies. It also

results in timelier fund deposits from the online transactions, as the fees are paid by credit card. Even with the reduction of several staff, the PLB's processing backlog of all work continues to be reduced as a result of this service.

Legislation

New Ethics Training Regulations

The PLB successfully implemented new regulations that became effective June 24, 2006 which require both Fire and Casualty broker-agents and Life agents to complete four hours of ethics continuing education every license term. The regulations also require Personal Lines broker-agents to complete two hours of ethics continuing education every license term.

The PLB sent notices to the industry, notices with each affected agent and broker's renewal notices and provided information on the department's website regarding this new CE requirement.

New Law regarding Cheating on the Agent and Broker Examination

In January 2006, the PLB successfully implemented new legislation (AB 729) which made cheating on the insurance agent examination a punishable crime. Specifically, with this new legislation, the willful cheating or subverting of a license examination is punishable by a fine up to \$10,000 or imprisonment not to exceed one year per Section 1681.5 of the California Insurance Code. Additionally, the commissioner shall bar any candidate caught willfully cheating from taking any license examination and from holding an active insurance agent or broker license for a period of five years.

The PLB sent notices to the industry, placed large signs in its Examination Centers to notify examinees of the new law and provided information on the department's website.

Financial Security Requirements for Limited Liability Companies

In January 2006, the PLB also successfully implemented another element of AB 729. Specifically, Section 1647.5 of the California Insurance Code was amended. This section regarding limited liability company security requirements was clarified so that insurance agency applicants who classify themselves as such will understand what is required of them to provide to the PLB so that the department may ensure that these agencies have adequate errors and omissions coverage.

The PLB sent notices to the industry and provided information on the department's website regarding the amended limited liability company security requirements.

Public Adjuster Requirements

In January 2006, the PLB successfully implemented new legislation (SB 518) which made changes affecting public insurance adjusters. Among several changes, the surety bond requirement for public insurance adjusters was increased from \$5,000 to \$20,000 and the time that an expired public insurance adjuster license may be renewed was reduced from five years to one year.

The PLB sent notices to the industry and provided information on the department's website regarding the new licensing requirements for public insurance adjusters.

Statistics

The chart below compares key workload statistics between calendar years 2005 and 2006.

Statistic	2005*	2006*	Change
License Applications Received	63,240	71,886	+ 14%
License Examinations Scheduled	60,218	61,892	+ 3%
New Licenses Issued	44,734	51,277	+ 15%
Licenses Renewed	113,837	116,715	+ 3%
Insurance Company Appointments and Terminations	467,995	464,538	- 1%
Bonds Processed	7,482	8,676	+ 16%
Telephone Calls Handled by Producer Licensing Staff	204,366	212,424	+ 4%

* Calendar year workload totals

*Major Accomplishments in 2006***Licensing Background Bureau (LBB)**

During 2006, the LBB completed projects that both improved the integrity of the licensing background process and implemented new legislation.

Licensing Background Triage Meetings

In 2006, the LBB began meeting on a weekly basis with attorneys from the department's Legal Enforcement Bureau. In "Triage," LBB analysts present pending cases to department attorneys for which legal action is being considered. Presenting cases in these triage meetings allows for immediate feedback on any proposed decision. The files are also assigned to attorneys at the meetings for review of the legal documents, which have been prepared. Prior to instituting the triage meetings, the time needed to approve proposed decisions and review the legal documents was between two and three weeks. This time has now been cut to just one to two days as a direct result of these meetings.

Prompt Reply to Insurance Commissioner's Inquiries

In 2006, the Licensing Background Bureau successfully implemented yet another element of

AB 729. Specifically Section 1736.5 was added to the California Insurance Code requiring every agent, broker and applicant for such a license, to reply to inquiries from the commissioner within 21 days after the date the inquiry was mailed. If no response is received, the commissioner may revoke, suspend or refuse to issue or renew a license.

The LBB sent notices to the industry and provided information on the department's website regarding the new reporting requirements.

Statistics

The chart below compares key workload statistics between calendar years 2005 and 2006.

Casework

LBB's casework is derived from these sources:

- The PLB refers license applications wherein the applicant has answered affirmatively to a background question in the license application.
- The DOJ provides on-going criminal history information on license applicants and current licensees based on fingerprints submitted during the initial licensing process.
- The department's Legal Branch requires background reviews of persons serving as an

Statistic	2005*	2006*	Change
Background Reviews Completed	3,731	3,095	- 17%
Cases Referred to Legal Division for Formal Disciplinary Action	352	287	- 18%
Cases Concluded Under the Alternative Resolution Program	673	648	- 4%

* Calendar year workload totals

officer or controlling person of an insurance company doing or proposing to do business in this state.

- The National Association of Insurance Commissioners provides daily reports on out-of-state disciplinary actions through its Regulatory Information Retrieval System.

Alternative Resolution Program

The LBB handles many of its cases under the department's Alternative Resolution Program, which consists of having LBB analysts, rather than attorneys, offer sanctions with subjects and prepare the necessary legal documents to impose discipline. The Alternative Resolution Program saves thousands of hours of valuable attorney time and enables department attorneys to focus their attention to more serious types of cases. The Alternative Resolution Program also helps expedite the licensing process for applicants.

Certain criminal convictions and previous regulatory actions have a direct bearing on the qualification of persons applying for licenses. Violent crimes and serious economic crimes, such as assault, rape, forgery, embezzlement, and theft, are of particular concern; and, are grounds for the Commissioner to deny or revoke a license. The background information collected by the LBB is used to evaluate an applicant's background and, when appropriate, to present as evidence in legal proceedings to deny or revoke a license.

Significant Accomplishments In 2006

Licensing Compliance & Business Process Bureau (LCB)

The Licensing Compliance and Business Process Bureau (LCB) was formed during the summer of 2006. During 2006, the LCB completed staff hiring and training, wrote procedures and guidelines for the functions of the new bureau and successfully

assumed several duties from other bureaus within the LSD. The LCB consists of the following three units:

Licensing Compliance Unit

The Licensing Compliance Unit is responsible for reviewing minor violations of the California Insurance Code committed by insurance producers with authority to transact insurance in California. Suspected minor violations are referred to the unit by the department's Investigation Division. These referrals include the use of unapproved fictitious names, improper or no license and improper or misleading advertising. The Unit's primary goal is to bring those in violation into compliance. In cases in which the subject will not cooperate, or in cases of repeated non-compliance, this unit will either refer the case back to the Investigation Division for further review or initiate formal legal action through the department's Alternative Resolution program.

Business Process Reengineering Unit

The Business Process Reengineering Unit identifies and implements changes to the division's processes to improve the efficiency and effectiveness of the Division's operations, makes recommendations to management on procedures, policies and program alternatives, and works closely with the Information Technology Division on various projects.

Surplus Line Filing Unit

The Surplus Line Filing Unit assists in processing the applications of non-admitted insurers applying to be added to the department's List of Eligible Surplus Lines Insurers (LESLI). This unit coordinates with the department's Legal and Financial Analysis divisions and the Surplus Line Association of California.

Financial Management Division (FMD)

The Financial Management Division consists of two bureaus and one unit: the Accounting Services Bureau, the Budget and Revenue Management Bureau, and the Administrative Systems Unit.

- The Accounting Services Bureau (ASB) is responsible for a full range of accounting functions including payables, receivables, revolving fund, cashiering, general ledger, security deposits and gross premium and surplus line tax collection. Approximately \$2.1 billion in tax revenue was collected for Fiscal Year 2005/06 to support the State's General Fund. The ASB maintains centralized records of the CDI's appropriations, financial activities, and cash flow to ensure effective management of the CDI's financial affairs and to provide accurate financial reports to state control agencies.
- The Budget and Revenue Management Bureau (BRMB) develops CDI's Annual Budget including the preparation and submission of all Supplementary Schedules required by the Department of Finance (DOF) for creation of the Governor's Budget. The CDI's Fiscal Year 2006-07 proposed budget is \$208 million and supports 1,271 positions. BRMB also coordinates and prepares a mid-year and a 3rd quarter fiscal analysis. The analysis includes the reconciliation of allotments to authorized appropriations, the monitoring of program allotments and their comparison to the actual levels of expenditure, the distribution of monthly expenditure data, and the projection of expenditures for the remainder of the current Fiscal Year.
- The Administrative Systems Unit is responsible for overseeing the operations of the CDI's Time Activity Reporting System (TARS), providing TARS training and technical assistance to all CDI staff, providing technical financial support

to users of various fiscal systems including CALSTARS, establishing of new program cost accounts, updating of cost allocation plan, and developing specialized financial related management reports.

Tax Collection

One of the Financial Management Division's (FMD) functions is to ensure the timely processing of tax returns filed by insurers and surplus line brokers and the timely collection and reporting of all appropriate taxes. The timeframes for remitting tax payments to the CDI are monthly, quarterly, or annually depending upon the tax liability of each insurer/surplus line broker.

Pursuant to California Insurance Code Section 1775.1, every surplus line broker whose annual tax for the preceding calendar year was Five Thousand Dollars (\$5,000) or more shall make monthly installment payments on account of the annual tax on business done during the calendar year.

Pursuant to California Revenue and Taxation Code Section 12251, insurers transacting insurance in this state and whose annual tax for the preceding calendar year was Five Thousand Dollars (\$5,000) or more shall make quarterly prepayments of the annual tax for the current calendar year.

For the tax year 2005, the Accounting Services Bureau processed a total of 3,070 tax returns during 2006.

CDI Budget

CDI's budget consists of the following five programs:

- *Regulation of Insurance Companies and Insurance Producers (Program 10)*—\$64,216,000 of the FY 2005/06 budget was expended by this program which aims to prevent losses to policyholders, beneficiaries or the public due to the insolvency

Insurance Type	Tax Returns*	Tax Rate	Law Reference
Surplus Line	1,124	3%	CI Code 1775.5
Property & Casualty	868	2.35%	CR&T Code 12202
Ocean Marine	563	5%	CR&T Code 12101
Life	482	2.35% or 0.5%	CR&T Code 12202
Title	22	2.35%	CR&T Code 12202
Home	11	2.35%	CR&T Code 12202
Total	3,070		

* Number of annual tax returns

CR&T – California Revenue & Taxation
 CI – California Insurance

**California Department of Insurance
 5-year Summary of Premium
 and Surplus Lines**

Taxes collected by the Department of Insurance
 for the State of California

Fiscal Year Ending June 30

2001	\$1,584,295,000
2002	\$1,767,842,000
2003	\$1,949,975,000
2004	\$2,056,524,000
2005	\$2,124,097,000

Collection as of March 31, 2007

of insurers, and to prevent unlawful or unfair practices by insurers and producers.

+ *Consumer Protection (Program 12)*—\$45,454,000 of the FY 2005/06 budget was spent by the program to provide direct service to California consumers by protecting insurance policy holders and other parties involved in insurance transactions against unfair or illegal practices with respect to claims handling, rating or underwriting by insurers; and to protect consumers from illegal and fraudulent practices in the sale of insurance.

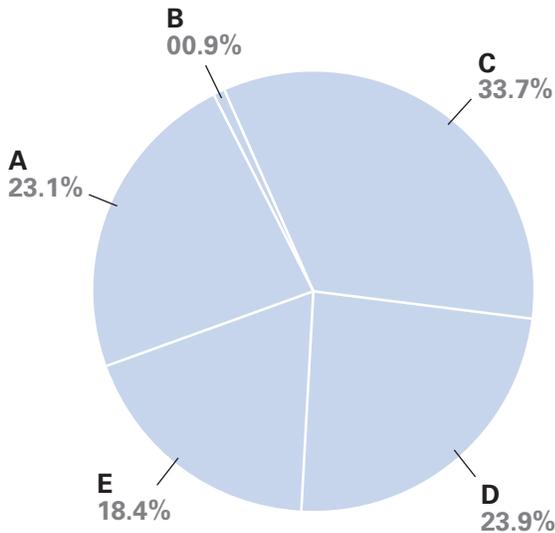
+ *Fraud Control (Program 20)*—\$35,118,000 was spent for state operations and \$44,006,000 for local assistance in FY 2005/06. The program protects the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and to reduce the overall incidence of insurance fraud through anti-fraud outreach to the public, private and governmental sectors. For local assistance, as an example, district attorneys receive funding to implement

the Organized Automobile Fraud Activity Interdiction program.

- *Tax Collections and Audits (Program 30)*—\$1,736,000 was spent in FY 2005/06 performing tax collection, accounting and tax audits of insurance companies and surplus line brokers. This program collects approximately \$2 billion for the State’s General Fund.

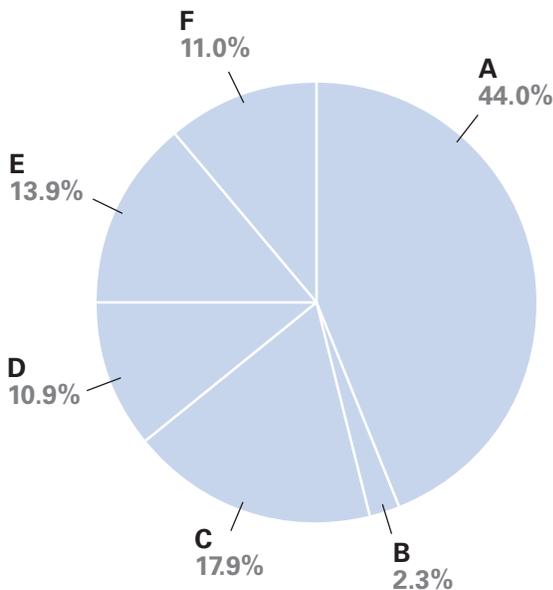
Revenues

In Fiscal Year 2005/06, the CDI received 100 percent of its revenue from the Insurance Fund. Insurance Fund receipts are generally received from the insurance companies and producers that the CDI services and regulates. Both insurers and producers pay license, filing, and other fees. Insurance companies pay assessments for Proposition 103, Workers’ Compensation



**California Department of Insurance
Total Expenditures by Program Fiscal Year 2005/2006
\$190,530,00**

- A** Fraud Control (Local Assistance) \$44,006,000—23.1%
- B** Tax Collection and Audits \$1,736,00—00.9%
- C** Regulation of Insurance Companies and Insurance Producers \$44,006,000—33.7%
- D** Consumer Protection \$45,454,000—23.9%
- E** Fraud Control (State Operations) \$35,118,000—18.4%



**California Department of Insurance
Insurance Fund Fiscal Year 2005/2006
\$189,765,00**

- A** Insurance Fraud \$83,473,00—44.0%
- B** Miscellaneous \$33,898,00—2.3%
- C** License Fees and Penalties \$33,898,000—17.9%
- D** Fees, Examination \$20,594,000—10.9%
- E** Fees, Proposition 103 \$26,439,000—13.9%
- F** Fees, General \$20,900,000—11.0%

Fraud, Auto Fraud and General Fraud. Insurance companies also pay for periodic examinations to determine the financial stability of the company, and to evaluate insurance practices and market conduct.

- † *License Fees and Penalties*—This is revenue collected to cover the cost of licensing and regulating licensees of CDI. All insurers and insurance producers doing business in the State of California must be licensed.
- † *Examination Fees*—This is revenue collected to recover the cost of performing examinations to ensure that insurers are financially stable and operating in compliance with the insurance code.
- † *Proposition 103*—This is a voter-approved initiative that requires the CDI to review and approve certain insurance rates. An annual assessment is levied to recover the actual costs of administering Proposition 103.
- † *Filing and Other Fees, General*—These fees include Action Notices, Policy Approval, Insurer Certifications, Annual Statements and Worker's Compensation Rate Filings.
- † *Fraud Assessment*—This revenue is derived from the following assessments:

- 1 Worker's Compensation assessment is determined by the Fraud Assessment Commission and is levied by the Department of Industrial Relations on insurers and self-insured employers.
 - 2 Fraud auto assessment is an annual fee of \$1.80 that an insurer has to pay for each vehicle it insures. Part of the assessment collected is distributed to the California Highway Patrol and to county District Attorneys. \$0.30 of the auto assessment fee is allocated to maintaining and improving the consumer functions of the department related to automobile insurance.
 - 3 Fraud general assessment is the annual billing of \$1,300 to each insurer doing business in the state.
 - 4 Fraud health and disability assessment is an annual fee of \$0.10 that an insurer must pay for each person insured under a health or disability policy.
- † *Miscellaneous*—This includes charges for services that the Department provides to the public, such as, photo copying, microfilm, first class mail, computer listing of agents and admitted companies and penalties for unauthorized use of

Types of Revenue	Amount	% to Total
License Fees and Penalties	\$33,898,000	17.9%
Fees, Examination	\$20,594,000	10.9%
Fees, Proposition 103	\$26,439,000	13.9%
Fees, General	\$20,900,000	11.0%
Insurance Fraud Assessment	\$83,473,000	44.0%
Miscellaneous	\$4,461,000	2.3%
Total Insurance Fund Revenue	\$189,765,000	100.00%

forms. The department also recovers the cost of assisting the Conservation and Liquidation Office in Legal and other administrative matters. It also includes revenues from restitution in enforcement cases.

Disbursements

The chart below illustrates the CDI's disbursements by category for FY 2005-06.

+ *Personal Services*—These are payments made for services performed by CDI staff to implement

government programs. This includes salaries and wages, and staff benefits.

+ *Operating Expenses and Equipment (OE&E)*—This includes costs of goods and services (other than personal services previously defined) that are used by the CDI to support its programs.

+ *Local Assistance*—Local assistance includes funds provided to local entities (e.g., counties, cities, municipalities, special districts, etc.) in support of the CDI's programs.

Category	Disbursement
Personal Services	\$96,770,000
Operating Expense and Equipment	\$49,754,000
Local Assistance	\$44,006,000
Total Distributed	\$190,530,000

2006 ANNUAL REPORT
COMMUNITY RELATIONS
BRANCH

COMMUNITY RELATIONS BRANCH

The Community Relations Branch (CRB) is the lead organization connecting the California Department of Insurance with California communities and consumers. To achieve this mission, CRB creates and sustains collaborative partnerships with community groups, consumer organizations, small businesses, nonprofits, insurance industry organizations and individuals, and government agencies to facilitate the dissemination of consumer information on the Department's programs and consumer protection resources. Two programs in the Community Relations Branch are the California Organized Investment Network and the California Low Cost Auto Program.

CALIFORNIA ORGANIZED INVESTMENT NETWORK

The mission of the California Organized Investment Network (COIN) is to provide leadership in increasing the level of insurance industry capital in safe and sound investments that provide fair returns to investors and social and economic benefits to traditionally underserved communities. COIN carries out this mission through two distinct programs.

- 1 *The COIN Program*—COIN facilitates and encourages the insurance industry to maximize their voluntary investments benefiting California's low-to-moderate income people and communities.
- 2 *The California Community Development Financial Institution (CDFI) Certification and Tax Credit Program*—As provided under California law, COIN certifies tax credits to California taxpayers making investments meeting certain specifications in financial institutions that COIN

has determined meet California's requirements to be designated as a CDFI.

The COIN Program

Established in 1997, the COIN Program is a first-in-the-nation collaborative effort among the insurance industry, the state department regulating the industry and the various stakeholders involved with community development investment in traditionally underserved communities. COIN serves as a liaison between insurers and community organizations, as a facilitator, and as a clearinghouse of California community development investment information. By working with nonprofit organizations, community economic development agencies, affordable housing groups, and local governments, COIN seeks to maximize insurer awareness of the widest possible choice of community development investment opportunities.

The COIN Advisory Board provides policy advice to the Commissioner. The board also provides a valuable forum for exchange of information as well as assisting COIN in disseminating information and removing obstacles that might hinder increased insurance industry investing. The board is made up of legislators, insurance industry representatives, consumer advocates, and practitioners in affordable housing and community economic development throughout the State of California.

The rewards of increased industry community development investing are economically healthy communities where the insurers who have made a difference will have established profitable partnerships and earned significant good will. These translate directly into new, profitable business opportunities, while achieving significant social benefit for underserved communities.

One way COIN assists community development organizations that are seeking insurer investment capital is working with them to develop COIN Investment Opportunity Bulletins. In order to maximize insurer awareness of these investment choices, COIN seeks out various opportunities for disseminating the bulletins, including mailing and emailing them to insurers, making them available at insurance industry trade association meetings, and posting them on the COIN Web site: <http://www.insurance.ca.gov/0250-industry/0700-coin/>

Another way COIN carries out its roles as liaison and facilitator is by promoting the COIN Program at various events throughout the year.

2006 COIN Program Highlights

• On September 12, 2006, launched two new Internet searchable databases with user-friendly simple and advanced search screens accessible on the COIN Web site.

1 Search for Investment Opportunity Bulletins–

This user-friendly search function provides prospective insurer investors with information about COIN Investment Opportunity Bulletins developed in cooperation with community development organizations. All bulletins can be viewed, or the search can be narrowed based on, for example, the kind of investment, where projects are located, and the resulting type and extent of social benefits to California low-to-moderate income families and communities.

2 Search for Insurers as Community Development

Investors–This user-friendly search function provides community development organizations seeking investment capital with information about insurance companies as community development investors. Information on over 1300 companies is included. The search for Insurance companies to be viewed

can be narrowed by selecting, for example, the kinds of California community development investments they have reported, the regions where they have invested, and the type and extent of social benefit provided by the investments they have made. In addition, the information for a specific insurance company or group of companies can be found by identifying the company or group by name or by NAIC number. Insurer contact information collected by COIN is also provided.

- Over 5000 investments were reported in response to the 2005 Community Development Investment Data Call. After extensive analysis, COIN found that about 2500 totaling \$7.8 billion qualified as California community development investments. After duplicates with previously reported investments were eliminated, over \$6 billion in COIN qualifying investments were added to the Insurers as Community Development Investors database and incorporated into the insurer investment reports published on the COIN Web site.
- On September 25, 2006, Insurance Code Sections 926.1 and 926.2 requiring insurers to report California community development investments was added by Chapter 456, Statutes of 2006 (AB 925, Ridley-Thomas). The new law required insurers who had not already responded voluntarily to the 2005 Data Call to respond by February 28, 2007. Updated reports from insurers are required by May 31, 2007 and again by May 31, 2009. In the future, the new law requires the Department to post on its Web site the aggregate investments reported by insurers and to identify “Insurers that make investments that are innovative, responsive to community needs, not routinely provided by insurers, or have a high degree of positive impact on the economic welfare of low-income or moderate-income

individuals, families, or communities in urban or rural California.” Pursuant to other provisions, the Department will also biennially aggregate and post information insurers report to the NAIC on California public debt purchased and other identified California investments.

The California CDFI Certification and Tax Credit Program.

COIN reviews applications and designates qualifying applicants as California CDFIs. To qualify for certification, CDFIs must be private financial institutions - such as community development banks, loan funds, credit unions, microenterprise funds, corporation-based lenders, or venture funds - that are specifically dedicated to and whose core purpose is to provide financial products and services to people and communities underserved by traditional financial markets.

COIN also certifies the tax credits under this program. The tax credits are not restricted to insurers. Any California taxpayer of Personal Income Tax, Bank and Corporation Tax, or Insurance Gross Premium Tax is eligible to receive tax credits for qualifying investments in certified California CDFIs. The tax credit amount is 20% of the investment amount and is to be taken for the year the investment is made.

COIN reviews applications for tax credits submitted by the CDFIs on behalf of their investors. To qualify, investments must be zero interest deposits or loans, equity investments, or equity-like debt instruments of \$50,000 or more invested for a minimum of 60 months in California certified CDFIs. After determining that the investments qualify, COIN provides the taxpayers with tax credit certificates and annually reports the year’s tax credits to the Franchise Tax Board and the Board of Equalization.

2006 California CDFI Tax Credit Program Highlights

- + Certified 32 investments from 17 investors totaling \$10 million.
- + On September 28, 2006, legislation was enacted (AB 2831 Ridley-Thomas, Chapter 580, Statutes of 2006) to continue the program, which would have sunset in 2006, until 2012. The new law modifies the program to encourage more insurers to invest and ensures a broad range of small to large CDFIs will benefit from the program.

THE CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM

The California Low Cost Automobile Insurance program (CLCA) was created by the California Legislature in 1999 in an effort to provide an affordable insurance option for low-income good drivers. The program was implemented as a pilot-program in Los Angeles County and the City and County of San Francisco July 2000, to comply with California’s financial responsibility laws (SB 171, Escutia and SB 527, Speier).

Subsequent legislation, (SB 1427, Escutia), modified and enhanced the program in 2002. Among other things, SB 1427 established the requirement for an annual report to the Senate and Assembly Committees on Insurance and the Senate and Assembly Committees on Transportation, detailing the Insurance Commissioner’s plan to inform the public about the availability of the CLCA program.

In 2004, SB 1500 (Speier) added further requirements to report on the Commissioner’s determination of success of the program, based on specified criteria. The Department of Motor Vehicles (DMV) implemented SB 1500 in October 2006.

SB 1500 (Speier) requires insurance companies:

- Electronically report to the DMV all motor vehicle liability insurance policies issued, within 30 days of the effective date of the coverage
- Electronically report policy terminations to the DMV within 45 days of the date of termination

SB 1500 (Speier) requires the DMV:

- Suspend, cancel, or revoke the vehicle registration upon notification by an insurance company that required coverage has been canceled. Prior to suspending vehicle registration the DMV must notify the vehicle owner of its intent to suspend and provides the vehicle owner 45 days to provide evidence of financial responsibility.

SB 1500 also required that the DMV provide information on the availability of the Low Cost Automobile Insurance Program within the 45 day notice.

In 2005, SB 20 (Escutia) extended the sunset date to January 1, 2011, modified eligibility criteria, mandated that the program become available in six enumerated counties on April 1, 2006, and authorized expansion of the program to all counties in California, based upon the Commissioner's determination of need. AB 1183 (Vargas) allocated funds to publicize the existence of the Low Cost Automobile Insurance Program, subject to budget approval.

Insurance Commissioner Steve Poizner is committed to reducing the number of uninsured drivers on California roads. With the passage of SB 1500, which requires the Department of Motor Vehicles to suspend or revoke the registration of a vehicle without proof of financial responsibility, Commissioner Poizner firmly believes the best way to encourage Californians to willfully abide by the law is to make insurance affordable and available to all consumers. To that end, the Commissioner

has made the California Low Cost Automobile Insurance program a key component of his priorities and seeks to expand the program to additional underserved communities throughout the state of California.

This auto insurance initiative is one in a series of Department of Insurance programs and public education activities that focus on improving access to and the availability of insurance services throughout the state.

Program and Policy Overview

The California Low Cost Automobile Insurance Program (CLCA) provides an affordable auto insurance option for low-income, good drivers. As of March 30, 2007 the program is now available in 22 counties: in Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Merced, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Sonoma, Stanislaus, Tulare and Ventura Counties.

As authorized by SB 20 (Escutia), the Commissioner may expand the program to all other counties in California, based on his determination of need.

The California Automobile Assigned Risk Plan (CAARP) administers the CLCA program. CAARP assigns CLCA applications to licensed auto insurers based on each insurer's share of the California voluntary auto insurance market. Only producers (agents/brokers) certified by CAARP are authorized to submit program applications. Currently, there are approximately 7,500 producers certified by CAARP.

Policy Premiums

The Insurance Code specifies that rates shall be sufficient to cover losses and expenses incurred by policies issued under the program. Rate-setting

standards also require that rates shall be set so as to result in no projected subsidy of the program or subsidy of policyholders in one county by policyholders in any other county. Consistent with these standards, the program rates in 2006 generated sufficient premiums to cover losses and expenses incurred by CLCA policies issued under each respective county program. In determining any adjustment to rates, the Commissioner holds a public hearing to consider a rate recommendation by the California Automobile Assigned Risk Plan, as required each year by statute.

Premiums in 2006 were as follows:

County	Rate
Alameda	\$322.00
Contra Costa	\$317.00
Fresno	\$299.00
Imperial	\$210.00
Kern	\$239.00
Los Angeles	\$355.00
Orange	\$312.00
Riverside	\$246.00
Sacramento	\$383.00
San Bernardino	\$283.00
San Diego	\$268.00
San Francisco	\$322.00
San Joaquin	\$295.00
San Mateo	\$307.00
Santa Clara	\$290.00
Stanislaus	\$359.00

Policy Features

The basic CLCA liability policy limits, as prescribed by state law, are \$10,000 for bodily injury or death per person in an accident, \$20,000 for bodily injury or death per accident, and \$3,000 property damage for each accident.

The annual premium rate for a CLCA liability policy varies by county (see Rate Chart). There is a 25 percent surcharge for unmarried male drivers ages 19 through 24. Several installment options are available, with a down payment as low as 15 percent of the total cost.

Two optional coverages, providing first-party benefits, are also available at additional cost. An insured may purchase medical payments coverage with \$1,000 limits and uninsured motorist bodily injury coverage, with the same limits as the underlying liability policy. Current premiums for these optional coverages vary by county (see Rate Chart). Premiums for expansion counties will be set in accordance with statutory rate-setting standards.

Eligibility Requirements

- + By statute, the applicant’s annual household income may not exceed 250 percent of the federal poverty level. Currently, the annual gross income threshold is \$25,525 for a one person household and \$51,625 for a four-person household (2007 Income Eligibility) Figures).
- + An applicant must be a “good driver,” defined as having no more than one at-fault property damage accident, or no more than one “point” for a moving violation, but not both, no at-fault accident involving bodily injury or death in the past three years; and no felony or misdemeanor conviction for a violation of the California Vehicle Code.
- + An applicant must be at least 19 years of age and a resident of an eligible county.
- + The applicant must have been continuously licensed to drive for the previous three years. In meeting the three year standard, up to 18 months of foreign licensure is acceptable, providing the

applicant was licensed to drive in the United States or Canada for the preceding 18 months.

- The value of the vehicle to be insured shall not exceed \$20,000.
- No more than two low-cost policies per person are permitted.
- A CLCA policyholder shall not purchase a non-CLCA liability policy for any vehicle in the household.

2006—The Year in Review

The most important event in 2006 was the expansion of the program to 14 new counties. To implement the expansion, the 2006 Consumer Education and Outreach Plan incorporated and expanded upon successful activities in 2005 that focused on a grassroots effort in partnership with other agencies and community based organizations. In 2006, the Department focused outreach efforts on five major goals:

Continue and enhance consumer education and outreach event activities in collaboration with government agencies and community based organizations in CLCA eligible counties

- Promote the program through community based advertising
- Develop and distribute targeted consumer education materials
- Implement program expansion into additional counties
- Conduct an analysis of need for the CLCA program in additional counties throughout the state and coordinate public meetings

The primary focus of the Department's 2006 outreach activities was to continue to raise consumer awareness and increase the volume

of program inquiries. This was accomplished in partnership with various community-based organizations, faith-based organizations, and state and local government agencies that serve those eligible for the program.

Consumer Education and Outreach Activities

Consumer education and outreach activities in 2006 focused on the development and distribution of easy-to-understand outreach materials and increased collaboration with government agencies and community based organizations. The department participated in over 100 events hosted by partner organizations. Advertising concentrated on community based and ethnic specialty press to reach low-income communities in the most economic way. Department staff educated producers on program particulars and sought to increase their participation in the program. A more detailed description of the Department's 2006 outreach activities is provided below.

Consumer Education and Outreach Materials Development and Distribution

In 2006, over 500,000 brochures and outreach materials in English, Spanish, and Chinese were distributed to more than 2,500 government agencies and community based organizations in the sixteen eligible counties. The Consumer Federation of California and Consumer Action were valuable partners in 2006. These organizations dramatically increased consumer program awareness in the newly eligible Northern California counties. Materials were also distributed to over 250 faith-based organizations serving low-income and inner-city communities. Distribution to organizations was repeated periodically throughout the year and upon request.

New materials in various languages were developed including:

- Posters
- Mailing inserts were translated into eight languages for distribution by the LADPSS and various other agencies
- New English and Spanish print advertisements were created for use in community and ethnic publications

Governmental Agency Collaboration

Efforts to integrate the CLCA program with other state and local governmental agencies that serve low-income residents continued. These efforts focused on the LADPSS, the California Department of Motor Vehicles (DMV), Head Start Centers, the Women Infants and Children (WIC) program, Housing Authorities, and Workforce Development programs in the sixteen eligible counties. Specific Inter-governmental activities included:

Department of Motor Vehicles (DMV)

The DMV distributed CLCA materials in each of the eligible county field offices. Additionally, Department staff trained DMV staff on program eligibility details and encouraged their assistance in referring uninsured consumers to the CAARP hotline for further information on the program.

In October 2006, the DMV implemented SB 1500 (Speier), which requires that the DMV send a notice to affected registered vehicle owners of intent to suspend or revoke registration without proof of insurance submitted within a specified time period. Notification letters sent to vehicle owners residing in one of the sixteen eligible counties also include information on the availability of the CLCA program and CAARP's toll-free hotline number.

Workforce Development Agencies

Department staff provided training to One-Stop and CalWorks staff, providing management

and frontline workers with an overview of the CLCA program and informational materials for distribution.

Los Angeles County Department of Public and Social Services (LADPSS)

Specific materials were developed to accommodate a targeted mailing to over 100,000 LADPSS households. Department staff presented educational programs at LADPSS staff meetings and participated in the 2006 Case Workers Conference in Long Beach.

Community Based Organizations

Throughout 2006, the Department continued to develop relationships and partnerships with numerous community based organizations in each of the eligible counties. Partner organizations ranged from Senior Centers to Head Start Centers. Department staff participated in a wide variety of events hosted by partner organizations. Materials and other program materials were distributed to over 700 community based organizations in the sixteen eligible counties, more than twice as many organizations as in 2005.

Department staff also participated in over 130 community and government agency events in 2006. These events provided the opportunity for Department staff to provide on-site program education and distribute outreach materials.

Administrative Modifications and Operational Improvements

In the fall 2006, CAARP launched a new automated-interactive phone system to handle CLCA program inquiries and track referral sources. The new system fully automates the program eligibility test with telephone prompts. The system also allows eligible consumers to leave their contact information after hours, which has improved consumer access to the program. The

Department and CAARP are monitoring the new system for any necessary refinements to ensure ease of use.

Community Based Advertising Campaign

The consumer education and outreach plan utilized community based and ethnic-specialty press, public service announcements and paid radio advertisements to advertise the CLCA program. The primary advertising goal was to select affordable publications and radio programs that targeted low-income communities within eligible counties.

Print Advertising

In an effort to reach the largest audience within eligible communities in the most cost-effective manner, the Department elected to advertise in community based and ethnic-specialty press. These ads enabled the Department to promote consumer awareness across a broad spectrum of communities and to amplify consumer education and outreach efforts. The print advertising campaign was delivered in English and Spanish via publications in each of the sixteen eligible counties. The Department placed ads in the 51 community publications, with the assistance of its consulting public relations firm.

Radio Advertising

The Department contracted with Metro Networks for delivery of a CLCA “radio-billboard” advertising program. The program targeted a wide array of Metro Networks radio stations in Los Angeles, San Francisco and the Bay Area. The Metro Networks contract began in June 1, 2005 and concluded May 31, 2006, providing one week of “radio-billboard” advertising each month for the twelve month term. In addition, the Department provided public service announcement scripts and participated in on-air radio interviews.

In addition, the department ran PSA spots

on select community radio stations in targeted communities.

To evaluate the effectiveness of print and radio advertisements, the Department reviews “referral-source” statistics collected by CAARP each month. Based on these statistics, the Department, working with its public relations firm, adjusts print and radio advertising purchases.

Cable Television

Although Cable TV advertising is usually beyond the program budget, CLCA was invited to participate in several free cable television opportunities. Senator Margett and Assembly member Lynn Daucher invited the Department to discuss the program on their constituent cable shows. The hosts dedicated the entire 30 minutes of programming to constituent education on the CLCA program.

Expansion to Additional Counties

As authorized by SB 20 (Escutia) the Department expanded the program to fourteen additional counties in 2006, bringing the total to 16 operational counties. In addition, effective March 30, 2007 the program has been expanded to Merced, Monterey, Santa Barbara, Sonoma, Tulare and Ventura Counties. The Department will continue work to make the program available in additional counties throughout 2007.

- + *April 1, 2006*
Alameda, Fresno, Orange, Riverside,
San Bernardino and San Diego Counties
- + *June 1, 2006*
Contra Costa, Imperial, Kern, Sacramento,
San Joaquin, San Mateo, Santa Clara and
Stanislaus Counties
- + *March 30, 2007*
Merced, Monterey, Santa Barbara, Sonoma,
Tulare and Ventura Counties



Program Statutory Rate-Setting Standards

In 2006, CAARP submitted its statutorily mandated rate proposal and updated loss and expense data. Based on loss experience in the program, the Commissioner determined, after public hearing, that a slight overall decrease in 2007 rates was consistent with rate-setting standards and also determined to maintain the surcharge for certain drivers.

The Commissioner has established the following rates, effective January 15, 2007:

County	Rate
Alameda	\$318.00
Contra Costa	\$313.00
Fresno	\$295.00
Imperial	\$208.00
Kern	\$236.00
Los Angeles	\$350.00
Orange	\$308.00
Riverside	\$243.00
Sacramento	\$378.00
San Bernardino	\$280.00
San Diego	\$265.00
San Francisco	\$336.00
San Joaquin	\$292.00
San Mateo	\$303.00
Santa Clara	\$286.00
Stanislaus	\$354.00

Effective March 30, 2007 the Commissioner established the following rates, for the six new counties:

County	Rate
Merced	\$267
Monterey	\$210
Santa Barbara	\$220
Sonoma	\$270

Tulare	\$222
Ventura	\$280

As loss experience warrants, the Commissioner will make necessary rate adjustments, consistent with the rate-setting standards and procedures of California Insurance Code section 11629.72(c).

Recent legislation (Statutes 2005, chapter 435) authorized the expansion of the program to all counties in California, based upon a determination of need made by the Commissioner.

To implement the expansion of the program to additional counties, the Commissioner, in consultation with CAARP, will set premiums for each of the expansion counties so that each county program will generate sufficient premiums to meet statutory rate-setting standards.

Performance Measures and Statistics

2006 Calendar Year Program Statistics

- + Applications Assigned: 5,991
- + Applications Received: 7,493
- + Percentage of applications eligible for assignment: 80%
- + Policies In Force: 8,695
- + Hotline Inquiries: 37,351, compared to 14,236 in 2005
- + 2006 Average Number of Policies Assigned by Month: 499
- + Retention Rate: 50%
- + Assignments with Uninsured Motorist Bodily Injury Coverage (UMBI): 2415 (40%)
- + Assignments with Medical Payments Coverage: 1608 (27%)
- + Assignments with both UMBI and Medical Coverages: 1535 (26%)

- Applicants with Income of \$20,000 or Less: 4859 (81%)
- Predominant Age Group: 40-59 (44%)
- Predominant Vehicle Value: \$2,000–\$5,000 (40%)
- % Applicants Without Insurance at Time of Assignment: 81%

Program Statistics–2000 Implementation through 2006

- Policies Assigned: 29,010
- Applications Received: 37,203
- Percentage of Applications Assigned: 78.0%
- Hotline Inquiries: 135,290
- Assignments with Uninsured Motorist Bodily Injury Coverage (UMBI) Since March 2003: 9,606 (39%)
- Assignments with Medical Payment Coverage Since March 2003: 5,729 (23%)
- Assignments with both UMBI and Medical Coverages Since March 2003: 5,537 (22%)
- % Applicants Without Insurance at Time of Assignment: 85%
- % Applicants with Income of \$20,000 or Less: 84%
- Predominant Age Group: 40-59 (44%)
- Predominant Household Income Group: \$0–\$10,000 (44%)
- Predominant Vehicle Value: \$2,000–\$5,000 (38%)

Conclusion

Insurance Commissioner Steve Poizner considers the California Low Cost Automobile Insurance program a key component to making automobile

insurance affordable and available to all California consumers. He believes the CLCA program shows promise in helping reduce the number of uninsured drivers on California roads. In an effort to achieve these goals the Commissioner is committed to the program's success and expansion.

The Commissioner is committed to making the California Low Cost Automobile Insurance program a model for the nation.



2006 ANNUAL REPORT
CONSUMER SERVICES & MARKET
CONDUCT BRANCH

CONSUMER SERVICES & MARKET CONDUCT BRANCH

The Consumer Services and Market Conduct Branch's (CSMCB) focus is consumer protection, and it accomplishes this by educating consumers, mediating consumer complaints, and enforcing applicable insurance laws. CSMCB enforces applicable insurance laws during the investigation of individual consumer complaints against insurers and through on-site examinations of insurer claims and underwriting files.

CSMCB consists of two divisions and six bureaus:

Consumer Services Division (CSD)

- + Consumer Communications Bureau (CCB)
- + Consumer Education and Outreach Bureau (CEOB)

- + Claims Services Bureau (CSB)
- + Rating and Underwriting Services Bureau (RUSB)

Market Conduct Division (MCD)

- + Field Claims Bureau (FCB)
- + Field Rating and Underwriting Bureau (FRUB)

CONSUMER SERVICES DIVISION

The Consumer Services Division (CSD) is responsible for responding to consumer inquiries and complaints regarding insurance company or producer activities. CSD maintains separate bureaus to handle telephone inquiries, respond to consumer complaints on claims handling practices, respond to rating and underwriting based consumer complaints, and to provide education

Calendar Year 2006 Results

Consumer Services Division (CSD)

Consumer Telephone Calls Received	276,419
Cases Opened	33,054
Cases Closed	32,940
Total Amount of Consumer Dollars Recovered	\$31,526,079

Market Conduct Division (MCD)

Number of Exams Adopted by the Commissioner	271
Total Amount of Claims Dollars Recovered or Premium Returned to Consumers	\$46,359,051
Penalties Resulting from Legal Actions in 2006	\$1,227,000

CSMCB Grand Total Amount

\$79,112,130

(Consumer Dollars Recovered, Claims Dollars Recovered or Premium Returned to Consumers, and Penalties Resulting from Legal Actions in 2006)





to the public on insurance issues. The goal of CSD is primarily to protect California insurance consumers through enforcement of the California Insurance Code and related laws and regulations.

Consumer Communications Bureau

Cases Opened	6,283
Cases Closed	6,285
Telephone Calls Received.....	276,419
Consumer Dollars Recovered	\$69,719
(not including Mediation)	
Mediation Dollars Recovered	\$132,270

The Consumer Communications Bureau (CCB) Consumer Hotline is often referred to as the Commissioner’s “eyes & ears” on the issues and concerns that affect California’s insurance consumer. CCB officers respond to phone calls received through The California Department of Insurance’s (CDI) statewide toll-free Consumer Hotline 800- 927-HELP (4357) to provide callers with immediate access to constantly updated information on insurance related issues. The Hotline is staffed by knowledgeable insurance professionals whose years of expertise, combined with their dedication to consumers, enables them to provide immediate assistance on time sensitive issues. CCB also responds to inquiries received through the Consumer “Contact Us” Web site; coordinates responses to inquiries addressed to the Commissioner through its Commissioner’s Correspondence Unit; responds to “walk-in” inquiries at the Department’s Los Angeles public counter; leads the CSD Health Triage Team; chairs the CSD Inter-Agency Health Team; analyzes and provides input on proposed legislation; and leads or participates in various task forces.

Additionally, CCB administers the Department’s Residential Property, Earthquake Claims, and Automobile Physical Damage Mediation Program. The program was enacted in 1995 in

response to earthquake claims resulting from the Northridge Earthquake of January 17, 2004. The legislature has since expanded to program to include automobile physical damage and residential property disputes subject to specific guidelines. In accordance with CIC 10089.83, the following is a report of the results of the program for the calendar year 2006:

Residential Mediation:

Number of mediation cases eligible:.....	2
Number settled within 28 day settlement period:	2
Number sent to mediation:	0
Number of cases rejected by insurer:	0
Number accepted by insurer:.....	0
Number of cases closed:.....	7
(includes previous year)	
Number of settlements rejected within 3 day waiting period:.....	0
Amount initially claimed:.....	\$128,524
Amount of settlements:	\$106,233

Automobile Mediation:

Number of mediation cases eligible:.....	2
Number settled within 28 day settlement period:	0
Number sent to mediation:	2
Number of cases rejected by insurer:	1
Number of cases accepted by insurer:	1
Number of cases closed:.....	3
(includes previous year)	
Number of settlements rejected within 3 day waiting period:.....	0
Amount initially claimed:.....	\$45,508
Amount of settlements:	\$26,037

There were no claims or recoveries received for earthquake claims mediation in 2006. For Calendar Year 2006, the Mediation Program had a



total of \$132,270 in recoveries. Since this program's inception in 1996 through December 31, 2006, CCB has recovered a total of \$14,763,946 for consumers.

Consumer Education & Outreach Bureau

The Consumer Education and Outreach Bureau (CEOB) was created for the purpose of educating consumers on important insurance issues through the development and distribution of informational guides and the coordination and participation in educational and outreach events. By becoming more informed on insurance issues, the public is better able to purchase insurance products product that meet their needs, or evaluate existing insurance products that have been purchased to better protect themselves from unfair insurance practices. CEOB is also responsible for participation in disaster outreach events in coordination with the Office of Emergency Services. Under the direction of the CSD office, CEOB also maintains and updates the External Disaster Management Plan that has been designed to establish consumer services for the Department in the event of a disaster. CEOB is involved in the establishment of town hall meetings and CDI hearings for the Insurance Commissioner.

Comprised of insurance professionals, the CEOB has enhanced the Department's efforts to educate the public and find new and exciting ways for Californians to learn about the ever-changing insurance industry. The CEOB handles a variety of events throughout the state often in partnership with civic, community, educational, law enforcement organizations, and other state agencies. Some of those partnerships include the Contractors State License Board, California Association of Area Agencies on Aging, Los Angeles County Department of Consumer Affairs, Los Angeles County Commission on Aging, CHP, LAPD, City of Los Angeles, Senator

Richard Alarcon's office, Cal-Bear Credit Union and others. CEOB also provides presentations on a variety of insurance issues, conducts workshops, health forums, town hall meetings, seminars, and participates on educational panels. In 2006, the CEOB coordinated or participated in more than 190 outreach events throughout the state and distributed over 127,000 insurance related information guides in over 5 different languages.

CEOB is responsible for the publication and updating of all consumer insurance information guides for the Department. These guides have been developed as a result of consumer need or because of statutory provisions.

Claims Services Bureau

Cases Opened	18,382
Cases Closed	18,179
Consumer Dollars Recovered	\$20,076,054

The Claims Services Bureau (CSB) investigates consumer allegations of improper claims handling by insurers. These written requests for assistance include, but are not limited to, wrongful denial of claims, payments less than amounts claimed, and delays in claims handling.

CSB has actively participated in CDI task forces on proposed amendments to California Insurance Code (CIC) Section 790.03 --Fair Claims Settlement Practices Regulations (this includes participation in several hearings in connection with the proposed amendments). Most recently, CSB has implemented SB 367, the program for mediating provider complaints, effective 7/1/06. CSB has also implemented a program in which it investigates complaints submitted by auto body repair shops alleging insurers are engaged in underpaying claims and improperly referring customers to contracted repair facilities. CSB continues to participate in the development of current legislative proposals and proposed new

insurance legislation in a variety of consumer insurance areas, including the participation in inter and intra agency meetings involving health insurance issues. CSB also administers the Department’s Independent Medical Review program (IMR) as required under Insurance Code Section 10169. In 2006, 143 medical necessity disputes were referred to the IMR program, with 68 denied cases overturned in favor of the consumer.

Rating & Underwriting Services Bureau

Cases Opened	8,389
Cases Closed	8,476
Consumer Dollars Recovered	\$11,380,306

The Rating and Underwriting Services Bureau (RUSB) investigates consumer complaints of improper or inequitable rating and underwriting transactions performed by insurance companies and agent-brokers. RUSB works with the affected parties to clarify issues and reach a resolution. If its investigation shows that an insurance violation or a policy breach has occurred, RUSB enforces the code or policy contract and requires the reinstatement of coverage and the refunding of premiums and broker fees, when applicable.

In addition to assisting consumers with a variety of issues involving all lines of insurance, RUSB also performs other functions. RUSB participates on the Senior Issues Task Force and the Disability Advisory Committee, and RUSB assists people impacted by wildfires and other catastrophic events at local assistance centers. RUSB produces detailed trend and hot topics reports on insurance company and agent-broker violations that RUSB has identified from its review of consumer complaint files, and CSMCB and others within the Department have found these reports valuable for identifying and monitoring non-compliant activity by licensees. RUSB proposes legislation,

including a refund accountability bill that clarifies California Insurance Code Section 481.5 and requires insurance companies to give an accounting of premium refunds upon request, and RUSB participates in the development of laws such as California Insurance Code Section 677.4, which increased the number of days’ advance notice that insurance companies must give named insureds when canceling their homeowners insurance policies. RUSB also collaborated with the Department’s Legal Branch in the development of regulations that required insurance brokers to disclose their broker fees and that prohibited the charging of broker fees under certain conditions.

MARKET CONDUCT DIVISION

The Market Conduct Division (MCD) is responsible for the examination of insurance company practices on behalf of the California Insurance Department. There are over 1400 insurance companies and advisory organizations subject to market conduct examination in California. MCD maintains separate bureaus to conduct claims handling practices exams and rating and underwriting exams, a reflection of a division of operations in the insurance industry and in the laws regulating claims from sales practices. The goal of any market conduct examination is to reduce the frequency and severity of insurance practices that are unfair to policyholders and claimants, and to evaluate compliance with statutes and regulations relative to the business of insurance.

The following is a summary of MCD’s accomplishments for the year 2006. The list covers different areas of accomplishment, including exams completed, dollars returned to consumers, industry and community interactions, and legal actions taken.

The Market Conduct Division (Joel Laucher, Chief) is a member of the Consumer Services and

Market Conduct Branch (Woody Girion, Deputy Commissioner).

Field Claims Bureau

Number of Exams Adopted by the Commissioner133*
 Amount of Claims Recovered for Consumers \$2,257,221

The Field Claims Bureau (FCB) conducts market conduct examinations of the claims practices of all licensed California insurers. These examinations are generally based on a fixed schedule of examinations, scheduled re-examinations and reviews of consumer complaint data. The focus is on compliance with the California Insurance Code and the California Fair Claims Settlement Practices regulations. FCB seeks to ensure equitable treatment of policyholders and claimants in accordance with insurance contracts and California law. The California Insurance Code

sections cited in FCB examinations vary by line of insurance. However, those that are common to both life & disability and property & casualty insurance involve delay, documentation, and improper handling, which may include improper settlement, failure to pursue investigation, and improper denial. FCB obtains thousands of remedial claim actions from insurers each year as a result of the examinations it conducts. Many of the issues which lead to these actions are displayed in our reports which are published in the Department’s website. These bureau reports include the total number of citations made for a claim sample. From the more than 14,601 files reviewed, a total of 5,611 citations were issued by the FCB in the reports filed in 2006.

***Number of Exams Adopted by the Commissioner” is the total number of examinations that have been adopted during the reporting period. These adopted examinations may have been opened during the reporting period or carried over from the prior reporting period.**



Market Conduct Division Results for 2006

Examination Results	Field Claims Bureau	Field Rating & Underwriting Bureaus	MCD Totals
Number of Exams Adopted by the Commissioner	133	138	271
Amount of Claims Dollars Recovered or Premium Returned to Consumers	\$2,257,221	\$44,101,830	\$46,359,051
Legal Actions & Penalties	Field Claims Bureau	Field Rating & Underwriting Bureaus	MCD Totals
Number of Actions Finalized by Legal Branch due to MCD Exam Findings	9	1	10
Penalties Resulting from Legal Branch Actions in 2006	\$927,000	\$300,000	\$1,227,000

Field Rating & Underwriting Bureau

Number of Exams Adopted by the Commissioner	138*
Amount of Premium Returned to Consumers due to FRUB Exams	\$44,101,830

The Field Rating and Underwriting Bureau (FRUB) conducts market conduct examinations of insurer rating and underwriting practices. FRUB reviews the advertising, marketing, risk selection and declination, underwriting, pricing, and policy termination practices of life, health, property, and casualty insurers. This review seeks to ensure that all California consumers are treated fairly, and that insurers are selling and servicing policies in compliance with law. The market conduct examinations conducted by FRUB advance the availability and affordability of insurance in the marketplace.

FRUB examinations focus on compliance with rate filing requirements, consistency within the insurer’s adopted rating processes, and overall conformity of rating and underwriting with California law. FRUB examiners verify that the insurer’s adopted rates have been filed and approved, and are applied consistently. This requires that underwriting be adequately documented and not unfairly discriminatory. Exams are generally conducted in the insurer’s offices, located nationwide.

***Number of Exams Adopted by the Commissioner” is the total number of examinations that have been adopted during the reporting period. These adopted examinations may have been opened during the reporting period or carried over from the prior reporting period.**



2006 ANNUAL REPORT
ENFORCEMENT
BRANCH

ENFORCEMENT BRANCH

The California Department of Insurance, Enforcement Branch, respectfully submits its Annual Report to the Governor as required by California Insurance Code Sections 1872.9, 1872.96, 1874.8, and 1872.83. The information contained in the attached report represents the receipts, expenditures, and activities of the Fraud Division and Investigation Division for Fiscal Year 2005-06. The report covers the Fraud Division's Workers' Compensation, Automobile, Organized Automobile Fraud Activity Interdiction (Urban Automobile), Disability and Healthcare, and Property/Casualty programs and the Investigation Division's programs for investigating complaints against agents, brokers, public adjusters, bail agents and other individuals and entities involved in the insurance industry (including premium theft, senior abuse, phony insurance companies, and others) and the Life and Annuity Consumer Protection Program.

Branch Overview

The Enforcement Branch is comprised of two divisions: Fraud and Investigation. The Branch investigates criminal and regulatory violations starting with point-of-sale transactions through the claims process.

Branch Mission Statement

"To protect the public from economic loss and distress by actively investigating, arresting, and referring, for prosecution or other adjudication, those who commit insurance fraud and other violations of law; to reduce the overall incidence of insurance fraud and consumer abuse through anti-fraud outreach and training to the public, private, and governmental sectors."

Branch Organization

Branch Management—The Enforcement Branch Management consists of the Deputy Commissioner, one CEA II (Investigation Division), three Bureau Chiefs (Fraud Division), one Supervising Insurance Investigator (Investigation Division), one Staff Services Manager II (Fraud Division), one Supervising Fraud Investigator II (Fraud Division), and an Executive Assistant.

Branch Headquarters—The Staff Services Manager II is responsible for the operation of the Branch Headquarters Office in support of the Enforcement Branch Deputy Commissioner. This position works closely with other units within the Department, most notably Human Resources Management Division, Budget and Revenue Management Bureau, Accounting Services Bureau, and Business Management Bureau.

Internal Affairs/Backgrounds—The Supervising Fraud Investigator II oversees all internal affairs investigations for the Department and pre-employment background investigations for the Branch.

Computer Forensic Team—The Supervising Fraud Investigator I coordinates the efforts of the Computer Forensic Team that supports statewide investigative efforts through technical expert forensic examinations of computer data seized during investigations.

FRAUD DIVISION

The CDI's Fraud Division has the responsibility of ensuring the provisions outlined in Chapter 12 of the California Insurance Code, "The Insurance Frauds Prevention Act," and Penal Code Section 550 are enforced throughout the State of California.

The mission statement of the Fraud Division is “To protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and to reduce the overall incidence of insurance fraud through anti-fraud outreach to the public, private and governmental sectors.”

Budget and Staffing (See chart below)

Fraud Division (Administration & Operations)

The Fraud Division has nine regional offices serving all 58 counties. The Division’s Headquarters office supports all regional office

operations, including those activities related to the management of the statewide grant programs, as well as centralized support of investigations in the Automobile, Organized Automobile Fraud Interdiction Program, Workers’ Compensation, Disability & Healthcare, and Property & Casualty Fraud Programs.

Fraud Division headquarters has eight major sub-units performing the following: receiving, cataloging, and processing Suspected Fraudulent Claim (SFC); processing seized computer evidence; auditing insurance companies’ Special Investigative Units for compliance with applicable



Budget and Staffing	
Fiscal Year 2005-06 Fraud Division Budgeted/Revenue/Expenditures by Program and Fiscal Year Staffing level:	
Fraud Auto Revenues ¹ :	\$33,551,579
Insurance Fraud Assessment, Automobile (includes Assembly Bill 1050)	
Budgeted Levels:	\$40,159,000
District Attorneys’ Auto Distribution:	\$21,337,000
State Operations Auto Expenditures:	\$15,401,000
Insurance Fraud Assessment, Workers’ Compensation	
Budgeted Levels:	\$39,027,000
District Attorneys’ Workers’ Compensation Distribution:	\$21,369,000
State Operations Workers’ Compensation Expenditures:	\$15,714,000
Insurance Fraud Assessment, Disability and Healthcare	
Budgeted Levels:	\$2,735,000
District Attorneys’ Disability and Healthcare Distribution:	\$1,300,000
State Operations Disability and Healthcare Expenditures:	\$2,059,000
Insurance Fraud Assessment, General Budgeted Levels:	\$2,063,000
State Operations General Assessment Expenditures:	\$1,944,000
Fiscal Year 2005-06 Fraud Division Positions:	285.4

¹Auto revenues exclude the \$0.30 assessment per SB 940 which is not used for Fraud Division programs.

laws and regulations; providing grant funding to participating district attorneys; auditing grant funds awarded to district attorneys; collecting and analyzing Fraud Division statistical data; and training Fraud Division employees.

Automobile Insurance Fraud

The Fraud Division coordinates automobile insurance fraud investigations statewide, provides assistance to law enforcement agencies, and presents prosecutable automobile fraud cases to district attorney's offices and the US Attorney General's Office. Fraud Division criminal investigators enforce the provisions of California Insurance Code Section 1871.4 and California Penal Code Sections 549 and 550. The Fraud Division continues to focus on five major categories of automobile insurance fraud activities: economic medical mills, organized crime, staged accident rings, false claim filing, and organized economic car theft enterprises. Organized criminal elements have and continue to use these types of schemes.

During Fiscal Year 2005-06, the Fraud Division identified and reported 14,714 SFCs, assigned 445 new cases and made 309 arrests and submitted 349 submissions to prosecuting authorities. Potential² Loss amounted to \$144,492,355.

District Attorneys' Automobile Insurance Fraud Program

During Fiscal Year 2005-06, 34 counties received funding totaling \$12,853,045 through the Department's Auto Insurance Grant Program. The amount of financial support funded to each county revolved around three variables: county population, the number of SFCs reported, and the county's plan.

For Fiscal Year 2005-06, the district attorneys initiated 1,860 investigations and made 1,066

arrests, culminating in 935 convictions. Chargeable fraud³ amounted to \$11,883,663, with \$1,800,076 in restitution ordered by the courts.

2 Potential Loss is the dollar loss/exposure for the claim if the fraud had gone undiscovered.

3 Chargeable Fraud is the total amount of fraud that would result from all counts that are actually charged.

Organized Automobile Fraud Activity Interdiction

The California State Legislature finds that organized automobile fraud activity operating in the major urban centers of the state represents a significant portion of all individual fraud-related automobile insurance cases. These cases result in artificially higher insurance premiums for core urban areas and low-income areas of the state than for other areas of the state. Only a focused, coordinated effort by all appropriate agencies and organizations can effectively deal with this problem. With the passage of Assembly Bill 1050 (Wright), the Organized Automobile Fraud Activity Interdiction ("Urban Grant") Program was created in Fiscal Year 2000-01. The California Insurance Code Section 1874.8 mandates the Insurance Commissioner award three to 10 grants for a coordinated program targeted at the successful prosecution and elimination of organized automobile fraud activity. The primary focus of the program is directed at the organized criminal activity that occurs in urban areas and which often involves the staging of automobile accidents and the filing of fraudulent automobile accident or damage claims. Traditionally, legal and medical professionals or their associates mastermind these cases. In recent years, highly sophisticated groups have captured the attention of the Fraud Division, prosecutors and allied law enforcement.

During Fiscal Year 2005-06, the Fraud Division assigned 388 new cases and made 256 arrests

with 257 submissions to prosecuting authorities. Potential Loss amounted to \$11,244,760.

District Attorneys' Organized Automobile Fraud Activity Interdiction Program

During Fiscal year 2005-06, nine counties were awarded grant funding totaling \$8,483,632. The grant-awarded district attorneys reported 348 arrests, which also included many of the Fraud Division arrests. District attorneys prosecuted 283 cases involving 540 defendants with chargeable fraud totaling \$19,489,482. District attorney outcomes totaled 272 convictions.

Disability And Healthcare Fraud

Funding for the Disability and Healthcare Fraud Program is derived from an annual assessment of 10 cents annually for each insured under an individual or group insurance policy issued in the state. This funding supports criminal investigations by the Fraud Division and prosecution by District Attorneys of suspected fraud involving disability and healthcare fraud. The program started in the beginning of fiscal year 2004-05 and a task force comprised of two fraud investigator teams was established in Los Angeles and Orange Counties.

During Fiscal Year 2005-06, the Fraud Division identified and reported 782 SFCs, assigned 52 new cases and made 9 arrests with 14 submissions to prosecuting authorities. Potential Loss amounted to \$21,985,783.

District Attorneys' Disability and Healthcare Program

In Fiscal Year 2005-06, three counties received funding totaling \$1,200,000 through the Department's Disability and Healthcare Fraud Grant Program. For Fiscal Year 2005-06, the district attorneys reported 71 investigations, 13 arrests, and 15 convictions, which also included

a majority of Fraud Division arrests. Chargeable fraud amounted to \$104,622,996, with \$8,607,815 in restitution ordered by the courts.

Workers' Compensation

During the 1920s, most states, including California, accepted a new social insurance program known as workers' compensation. In California, workers' compensation insurance is a no-fault system. Injured employees need not prove the injury was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury. The National Insurance Crime Bureau estimated in the year 2000, workers' compensation insurance fraud was the fastest-growing insurance scam in the nation, costing the industry \$5 billion per year by what many people consider a victimless crime. Often white-collar criminals, including doctors and lawyers, dupe the system through fraudulent activity and insurance companies "pick up the tab," passing the cost onto policyholders, taxpayers and the general public.

The Workers' Compensation Fraud Program was established in 1991 through the passage of Senate Bill 1218 (Chapter 116). The law made workers' compensation fraud a felony, required insurers to report suspected fraud, and established a mechanism for funding enforcement and prosecution activities. Senate Bill 1218 also established the Fraud Assessment Commission to determine the level of assessments to fund investigation and prosecution of workers' compensation insurance fraud. The funding comes from California employers who are legally required to be insured or self-insured.

During Fiscal Year 2005-06, the Fraud Division received 8,509 SFCs, assigned 572 new cases, made 299 arrests and referred 319 submissions to prosecuting authorities. Potential Loss amounted to \$240,670,133.

The investigation of Workers' Compensation Fraud very often involves difficult and lengthy investigations. These investigations have resulted in convictions and the reduction of a number of medical and/or legal workers' compensation mills. Since Fiscal Year 2003-04, the CDI has participated as a member of the "Underground Economy Strike Force," per Assembly Bill 202. The Fraud Division continues to focus its efforts in that area of the Underground Economy known as employer misrepresentation or Premium Fraud. Participation on the Strike Force helps the Fraud Division and district attorneys investigate and prosecute the premium fraud cases which most significantly impact the California economy and business climate.

Evidence suggests that the aggressive anti-fraud campaign by the Department, the district attorneys, the insurance industry and California employers continues to play a substantial role in reducing crime and helps lower workers' compensation premiums for employers statewide.

District Attorneys' Workers' Compensation Program

In Fiscal Year 2005-06, the district attorneys reported a total of 574 arrests, which also included the majority of Fraud Division arrests. During the same time frame, district attorneys prosecuted 946 cases with 1,066 suspects, resulting in 465 convictions. Restitution of \$16,380,416 was ordered in connection with these convictions and \$6,313,435 was collected during F/Y 05-06. The total chargeable fraud was \$190,858,814, representing only a small portion of actual fraud since many fraudulent activities had not been identified or investigated.

Property, Life And Casualty Fraud

Funding for the Property and Casualty Fraud Program is derived from an annual assessment

of \$1,300 per licensed insurance company. This funding supports criminal investigations by the Fraud Division of all suspect fraudulent claims involving life, property (including arson), all other non-automobile, non-workers' compensation, and non-Health and Disability cases. This program area includes suspected fraudulent claims involving commercial/residential burglaries; arson for profit; natural claims to real property; slip and falls; internal embezzlements; life insurance fraud, including murder for profit; food contamination; agricultural/livestock; and property thefts from vehicles.

During Fiscal Year 2005-06, the Fraud Division identified and reported 2,930 SFCs, assigned 129 new cases, made 35 arrests and referred 38 submissions to prosecuting authorities. Potential Loss amounted to \$316,084,619.

Special Investigative Unit—Compliance Review Office

The primary responsibility of the Fraud Division, Special Investigative Unit (SIU) Compliance Review Office, is to inspect insurance companies to ensure regulatory compliance with regard to the establishment, staffing and operation of the insurer's SIU. The Office also is responsible for updating, distributing, reviewing, monitoring and tracking the annual SIU compliance reports filed by approximately 1,300 insurance companies each year.

The majority of California licensed insurers are required by California Insurance Code Section 1875.20-24 and California Code of Regulations, Title 10, Section 2698.30-43 to establish and maintain Special Investigative Units. Regulation also requires each insurance company to submit an annual compliance report to the Fraud Division, SIU Compliance Review Office. The SIU annual reports must provide adequate information and

documentation regarding the insurer's anti-fraud operations, policies and procedures, and anti-fraud training. The SIU Compliance Review Office provides the format and instruction for submission of the reports and reviews, monitors and evaluates the completeness and timeliness of the reports filed annually.

After completion of a review and rating of the insurers' reports filed annually, the SIU Compliance Review Office considers various risk-based criteria for proper selection of insurers for SIU review. The risk-based criteria include, but are not limited to:

- † Prior SIU review history, including follow-up of audit findings and implemented recommendations.
- † Possible deficiencies or areas of non-compliance identified during examination of annual SIU compliance reports.
- † Quantity and quality of suspected insurance fraud (FD-1 and eFD-1) submissions.
- † Insurance that is risky and susceptible to fraud, thus negatively impacting consumers, producers and insurers.
- † Volume and nature of complaints received for a particular insurance company.
- † Market share of the insurance carrier.

During Fiscal Year 2005-06, the SIU Compliance Review Office conducted 14 audits of primary insurance companies, which included 41 subsidiary companies, for a total of 55 companies. Of the 55 companies reviewed, 34 were licensed to write, and are currently writing, workers' compensation insurance in California. Of the 14 primary companies reviewed, five were out-of-state and nine were in-state.

The purpose of the SIU compliance review is to identify areas of regulatory non-compliance or operational weaknesses of an insurer's SIU and provide recommendations for improvement and to provide technical assistance to the insurer's SIU management.

Common findings were:

- † Lack of ongoing existence of an SIU.
- † Lack of referrals to the CDI Fraud Division and District Attorneys.
- † Outdated or incomplete suspected fraud referral forms (FD-1 and eFD-1 forms).
- † Lack of adequate written SIU policies and procedures.
- † Lack of adequate SIU anti-fraud training plan.
- † SIU staff were not adequately trained.
- † New anti-fraud personnel not properly trained within 90 days of commencing duties.
- † Training records were incomplete or did not exist.
- † SIU annual compliance report lacked adequate information.
- † SIU annual compliance report submitted after the required due date.
- † Lack of monitoring procedures for contracted SIU.

Upon completion of an SIU compliance review, a preliminary report, or Exit Review Report, is issued to the company, identifying proposed findings and recommendations. The insurer is given 30 days to respond to the Exit Review Report and provide supplemental information. Once the 30 days has passed, a Final Report of Findings, which indicates whether or not the findings have been resolved, is issued to the company and to the Deputy Commissioner of the Enforcement Branch. The findings reported

regarding the Final Report of Findings are subject to the hearing process and possible fines and penalties.

Anti-fraud Outreach

One component of the Fraud Division's mission statement is to provide anti-fraud outreach and training to the public, private and governmental sectors. The following are examples of Fraud Division's outreach activities:

Public

Posting Convictions on Web Site—Consistent with the requirements of AB 2866, which went into effect January 1, 2005, the Department continues to post on its website for five years from the date of conviction or until it is notified in writing that the conviction has been reversed or expunged, the following information concerning convictions in workers' compensation insurance fraud cases:

- the name, case number, county or court, and other identifying information with respect to the case.
- the full name of the defendant.
- the city and county of the defendant's last known residence or business address.
- the date of conviction.
- a description of the offense.
- the amount of money alleged to have been defrauded.
- a description of the punishment imposed, including the length of any sentence of imprisonment and the amount of any fine imposed.

Community Forums—The Fraud Division participates in community-sponsored events, such as town hall meetings, public hearings, and underground economy seminars. These forums give the Division

opportunities to hear directly from consumers regarding their insurance concerns, and provide information communities can use to protect themselves from insurance fraud.

Media/Public Service Announcements—The Fraud Division participates with local, state, and national broadcasting outlets to educate the public about insurance fraud in California. One example is the workers' compensation medical provider video produced by the Employer Fraud Task Force.

Industry Liaison

The Fraud Division maintains ongoing liaison with the insurance industry by interacting with a variety of organizations, including the International Association of Special Investigation Units; Workers' Compensation Advisory Committee; Insurance Fraud Advisory Board; National Insurance Crime Bureau Regional Advisory Committee; Health Fraud Task Force; Underground Economy Task Forces; California Coalition on Workers' Compensation; California Workers' Compensation Institute; Northern California Fraud Investigators Association; and the Southern California Fraud Investigators Association.

Governmental Liaison

The Division maintains a routine and specific liaison with the following State agencies or entities on matters of overlapping jurisdiction or mutual concern: California Peace Officer's Association; California Peace Officers Standards and Training; Instructor Standards Counsel; California Highway Patrol; Employment Development Department; Department of Industrial Relations – Division of Workers' Compensation and Division of Labor Standards Enforcement; Department of Consumer Affairs, Bureau of Automotive Repair, California Contractors State License Board, and the Cemetery and Funeral Bureau; Department of

Justice; Department of Corporations; Franchise Tax Board; California Board of Chiropractic Examiners; California District Attorneys Association; National Association of Insurance Commissioners; Statewide Vehicle Task Force; Advisory Committee on Automobile Insurance Fraud; Department of Rehabilitation and Corrections; Department of Alcoholic Beverage Control; and Regional Auto Theft Task Forces.

Internet

The CDI Internet public website contains information on the following subjects: Insurance Fraud Reporting Forms; What is Insurance Fraud; Where to Report; Fraud Division Regional Offices; Workers’ Compensation Fraud Conviction Data; Automobile Fraud; Property, Life and Casualty; Health and Disability; Workers’ Compensation Fraud; Insurer Special Investigative Units; and Fraud Newsletters.

Fraud Division’s Supplemental Report – Insurance Code § 1872.9

The number of cases reported to the Fraud Division:

The source of leads for investigations initiated by the Fraud Division is the Suspected Fraudulent Claim (SFC), also known as a FD1 or eFD-1. A suspected fraud referral can be as simple as a telephone call from a citizen or as complex as a “documented referral” with supporting evidence submitted by an insurance carrier. All referrals submitted to the Fraud Division, regardless of the reporting party and supporting evidentiary information, are assigned a case tracking number, placed in the Fraud Integrated Database (FIDB), and forwarded to supervisors in the regional office with jurisdiction over the allegations. The Fraud Division, like all other law enforcement agencies, must track and make a determination

on whether further action, if any, is to be taken on all reports filed under its mandate. All reports will be reviewed, although the majority will not be assigned for further investigation.

Suspected Fraudulent Claims:

Auto and Urban Auto	14,714
Property Casualty	2,930
Workers’ Compensation	8,509
Health	782
Total	26,935

The number of cases rejected by the Fraud Division due to insufficient evidence or any other reason:

SFCs unassigned due to insufficient evidence:	16,768
SFCs unassigned due to other reasons:	8,685

The vast majority of SFCs are generated by the insurance industry. The standard for referring an SFC is codified by a number of statutes within the Insurance Code. The fact that there are five different statutes, offering various standards for when to refer, often results in referrals that fail to rise to the level necessary to result in a criminal conviction. The variations in the Insurance Code for the standard to refer range from when the carrier “believes” or has “reason to believe” to “has reason to suspect” that insurance fraud has occurred. As a result, different interpretations have demonstrated inconsistencies regarding the referral process. Some SFCs make allegations of abuse, which does not rise to the level of fraud. It should also be pointed out that the referrals submitted by the insurance industry contain errors and misinformation.

Supervisors use standard criteria when determining case assignments in the various fraud programs, including:





- † Public Safety.
- † Consideration of the Insurance Commissioner’s strategic initiatives.
- † The quality of the evidence presented.
- † The priority level of the suspected fraud referral.
- † The availability of investigative resources.
- † The jurisdiction for prosecution, especially if the district attorney is receiving grant funds.
- † If the arrest and conviction of suspects would make an impact on the problem within the county and /or State.
- † Allegations are abuse rather than fraud.
- † Insufficient resources, the statute of limitations, discussion with a district attorney regarding facts of the SFC resulted in rejection, or referral to another agency.

The number and kind of cases prosecuted as a result of funding received under Insurance Code § 1872.7:
Insurance Code Section 1872.7 assesses funding for use in property/casualty fraud, which can

include false and bogus death claims, arson in order to receive life insurance policy payout, murder for profit in order to obtain life insurance benefits, inflated/faked homeowner claims, false boat claims, arson for profit, and so forth.

Caseload (open and newly assigned)396
Arrests.35
Suspect Submissions to District Attorneys. . . 38

An estimate of the economic value of insurance fraud by type of insurance fraud:

The chart below reflects the total amount of fraud reported in all programs.

Recommendations On Ways Insurance Fraud May Be Reduced:

To reduce insurance fraud, the Department continues to implement the following:

- † A systematic effort to measure the extent and nature of fraud in the system and the types of fraudulent activities most responsible for driving up the insurance premium.

	Premium	Amount Paid ¹	Suspected Fraudulent Loss ²	Potential Loss ³
Automobile	\$0	\$51,615,737	\$39,707,235	\$144,492,355
“Urban Auto”	\$0	\$1,365,053	\$3,290,362	\$11,244,760
Property Casualty	\$0	\$24,196,853	\$43,334,735	\$316,084,619
Workers’ Compensation	\$29,918,754	\$142,167,193	\$85,129,227	\$240,670,133
Health	\$0	\$5,916,308	\$17,061,782	\$21,985,783
Totals	\$29,918,754	\$225,261,144	\$188,523,341	\$734,477,650

1 Amount paid on claim to date.
2 Amount paid that is suspected as being fraudulently claimed.
3 Amount of loss/exposure if fraud had gone undiscovered.

- An overall strategy for combating fraud based on goals, objectives, priorities and measurable targets.
- A means to periodically evaluate the effectiveness of the efforts to reduce the occurrence of those types of fraud.

The goal of the Fraud Division is to produce quality, cost-effective investigations which result in successful enforcement actions. The Fraud Division, in partnership with local district attorneys, selects those cases which will have the most significant impact on the insurance fraud problem in their area of expertise. All open case assignments are coordinated in a joint effort between the Fraud Division and local district attorneys, particularly those receiving grant funding.

Four critical elements have been identified to achieve successful outcomes: an aggressive outreach program, partnership with key stakeholders, effective trend analysis, and a balanced caseload. To that end, the Fraud Division continues to implement performance measures to gauge productivity and efficiency. This is done to measure the overall return on investment and to maximize the impact on insurance fraud. Successful outcomes that can have a positive impact on insurance fraud have been measured by three methods of enforcement actions:

- *Criminal*—A completed investigation and aggressive prosecution resulting in convictions, restitution, jail/prison, penalties and fines. This type of enforcement produces the best results, including deterrence of further criminal activity.
- *Civil*—The successful disruption and termination of a criminal enterprise or activity, whether it is a single suspect or an organized ring, have been accomplished by civil actions. A single victim, a collective group of individuals or an insurance

carrier has followed up with civil actions resulting in termination of the criminal enterprise and stipulating civil fines and restitution. Additionally, the Fraud Division has worked closely with district attorneys involving unfair business practices and related actions.

- *Investigative Inquiry*—Potential fraud activity or abuse have been stopped and deterred by initial contact from the Fraud Division or district attorney's office. The preliminary investigative steps taken in these cases often halt or deter activity that does not rise to the level of a full criminal investigation.

A summary of the Fraud Division's activities with respect to pursuing a reduction of fraud

An effective partnership with allied agencies is another critical element needed to achieve positive outcomes. The Fraud Division continues its interagency coordination efforts and participates in the following intergovernmental anti-fraud task forces:

Public

Posting Convictions on Web Site—Consistent with the requirements of AB 2866, which went into effect January 1, 2005, the Department continues to post on its web site for five (5) years from the date of conviction or until it is notified in writing that the conviction has been reversed or expunged, the following information concerning convictions in workers' compensation insurance fraud cases:

- the name, case number, county or court, and other identifying information with respect to the case.
- the full name of the defendant.
- the city and county of the defendant's last known residence or business address.
- the date of conviction.

- a description of the offense.
- the amount of money alleged to have been defrauded.
- a description of the punishment imposed, including the length of any sentence of imprisonment and the amount of any fine imposed.

Community Forums—Fraud Division participates in community-sponsored events, such as town hall meetings, public hearings, and underground economy seminars. These forums give the Division opportunities to hear directly from consumers regarding their insurance concerns, and provide information communities can use to protect themselves from insurance fraud.

Media/Public Service Announcements—The Fraud Division participates with local, state, and national broadcasting outlets to educate the public about insurance fraud in California. An example is the workers' compensation medical provider video produced by the Employer Fraud Task Force.

Industry Liaison

The Fraud Division maintains an ongoing liaison with the insurance industry by interacting with the following organizations: International Association of Special Investigation Units; Workers' Compensation Advisory Committee; Insurance Fraud Advisory Board; National Insurance Crime Bureau Regional Advisory Committee; Health Fraud Task Force; Underground Economy Task Forces; California Coalition on Workers' Compensation; California Workers' Compensation Institute; Northern California Fraud Investigators Association; and the Southern California Fraud Investigators Association.

Governmental Liaison

The Division maintains a routine and specific liaison with the following State agencies or

entities on matters of overlapping jurisdiction or mutual concern: California Peace Officers' Association; California Highway Patrol; Employment Development Department; Department of Industrial Relations, Division of Workers' Compensation, and Division of Labor Standards Enforcement; Department of Consumer Affairs, Bureau of Automotive Repair, California Contractors State License Board and the Cemetery and Funeral Bureau; Department of Justice; Department of Corporations; Franchise Tax Board; California Board of Chiropractic Examiners; California District Attorneys Association; National Association of Insurance Commissioners; Statewide Vehicle Task Force; Advisory Committee on Automobile Insurance Fraud; Department of Rehabilitation and Corrections; Department of Alcoholic Beverage Control; Underground Economy; California Joint Underground Economy Task Force; Orange County Investigation and Premium Fraud Underground Economy Team; Employment Enforcement Task Force; Bay Area Premium Fraud Coalition; Riverside County Uninsured Employer Task Force; Premium Fraud Task Force; Ventura County Underground Economy/Employer Fraud Task Force; Central Valley Premium Fraud Task Force; Northern California Underground Economy Task Force; Central Valley Underground Economy Task Force; Los Angeles County Workers' Compensation Interdiction Program; CDI and Department of Industrial Relations Committee on Professional Employer Organizations; Health Care Task Force; Department of Health Services Fraud and Abuse Steering Committee; High Tech Crimes Task Force; California Department of Justice RX-NET; CDI Disaster Fraud Task Force; CDI Urban Grant Task Forces (8); Cargo Theft Interdiction Program; Orange County Auto Theft Task Force; Los Angeles County Task Force for Regional



Auto Theft Prevention; Riverside Auto Theft Task Force; San Diego Auto Theft Task Force; Sierra/Sacramento Arson Task Force; California Anti-Terrorism Information Center; and the San Bernardino Auto Theft Task Force.

Internet

The CDI Internet public web site contains information on the following subjects: Insurance Fraud Reporting Forms; What is Insurance Fraud; Where to Report; Fraud Division Regional Offices; Workers' Compensation Fraud Conviction Data; Automobile Fraud; Property, Life and Casualty; Health and Disability; Workers' Compensation Fraud; Insurer Special Investigative Units; and Fraud Newsletters.

Basic claims information, including trends of payments by type of claim and other claim information that is generally provided in a closed claim study

Although basic claims information and closed claim studies are not available, the Fraud Division collaborates with the National Insurance Crime Bureau (NICB) on emerging issues and trends in the investigation of insurance fraud crimes. A critical component of this partnership is that Fraud Division has access to the NICB database as well as the Insurance Service Organization database, which has been used for trend analysis. The Fraud Division continues to explore other sources of information that will enhance its ability to identify emerging trends in all programs.

A summary of the Fraud Division's activities with respect to the reduction of fraudulent denials and payments of compensation, pursuant to § 1871.4 (veiw chart below)

The number and types of cases investigated and prosecuted with funds specified in Insurance Code § 1872.83:

Workers' compensation fraud is committed to obtain workers' compensation benefits to which a claimant is not entitled. Suspects make false statements to doctors, employers, and insurance carriers regarding work-related injuries, work while receiving benefits, and fake injuries.

Caseload	1,415
(open and newly assigned)	
Arrests	294

*** Cases**

INVESTIGATION DIVISION

The Investigation Division is charged with enforcing applicable provisions of the California Insurance Code under authority granted by Section 12921 and to certify crimes, of which the Commissioner has knowledge, to a prosecuting authority pursuant to Insurance Code Sections 12928 and 12930. The Investigation Division pursues prosecutions of offenders through both regulatory and criminal justice systems. Investigation Division investigators are empowered by Penal Code § 830.11, to exercise the powers of arrest and to serve warrants during the course and scope of their employment.

Fiscal Year 2005–2006: Restitutions	Ordered	Collected
Workers' Compensation	\$16,380,416	\$6,313,435
Automobile	\$1,800,076	\$786,669
Organized Auto Interdiction.	\$10,181,021	\$1,448,376

The mission statement of the Investigation Division is “To protect the public from economic loss and distress by actively investigating and referring for administrative and/or criminal prosecution those who have committed violations of the California Insurance Code (CIC).”

The Insurance Commissioner, as part of the Enforcement Branch, charged the Investigation Division with the responsibility and authority to take steps to protect California policyholders from insurance-related crimes committed by businesses and individuals.

The public and the insurance industry are both safeguarded when the Investigation Division investigates crimes and violations and seeks criminal prosecutions and disciplinary actions when warranted by the evidence. In this way, those who break the law can be disciplined or removed from the industry and future crimes and violations will be deterred.

The Insurance Commissioner has established case handling priorities for the Investigation Division, which includes premium theft; senior citizen abuse; bogus insurance companies; viatical settlement fraud; deceptive sales practices by insurance companies; and consumer abuse by automobile insurance agents, title insurance rebates, public adjusters, insider fraud, and bail agents.

Overall funding sources for the Investigation Division are Insurer Fees and Licenses, Producer Fees and Licenses, automobile policy assessments and life insurance and annuity products assessment.

Budget And Staffing

During the period of July 2005 through June 2006, the Investigation Division’s expenditures totaled

\$8,307,164, in support of an authorized staff of 89.3 positions.

Administration & Operations

Division Chief

Under the general direction of the Deputy Commissioner, the Division Chief oversees a statewide consumer protection and law enforcement unit consisting of regional offices and administrative staff.

Division Headquarters

The Division Headquarters is responsible for administering statewide programs, such as the Life and Annuity Consumer Protection Program, and providing administrative services to the regional Chief Investigators and their staff. An Administrative Chief Investigator oversees the Division Headquarters functions and is also responsible for division intake and inquiries, equipment, human resource functions, training, unit, statistical analysis and E-government systems.

Division Case Intake and Inquiry Unit

A newly created Division Case Intake and Inquiry Unit was established within Division Headquarters. This unit receives and reviews information from the public, governmental agencies, the insurance industry, law enforcement agencies, and the Department. All reports of suspected violations are entered into the Investigation Division Database for tracking and intelligence purposes. Reports of suspected violations are assigned to regional offices to conduct the investigation. The unit further processes all Division inquiries and requests from consumers, other CDI branches and other governmental agencies.

Investigation Division Regional Offices

There are seven regional offices located throughout California. Each regional office is managed by a Chief Investigator and consists of first-line supervisors, investigators, and support staff.

Investigation Division Violations

The following categories identify the priority types of violations investigated by the Division:

- ♦ *Premium Theft*—Identified by the Investigation Division staff as the single most prevalent type of misconduct seen in the insurer producer area. Instances can range from a single theft of minimal amounts to multi-million dollar scams causing the insurance industry and competitive businesses to become the unwitting victims of financial loss.
- ♦ *Senior Citizen Abuse*—Particular agents and insurers target their marketing efforts to senior citizens. Certain agents and insurers abuse the senior citizen by over selling, misrepresenting an insurance product, and selling unneeded or even inappropriate insurance products to them. At times, the misconduct is criminal, involving theft, false documents, and confidence games. The current product lines used to abuse seniors are the single premium annuity and long term care insurance.
- ♦ *Viatical and Viatical Settlement Fraud*—This involves complex schemes that induce investors to purchase, at present value, the right to collect a death benefit on life insurance issued to a person who allegedly is terminally ill. The investment and insurance transactions are manipulated against the interests of the insurer, insured, policy owner, and investor. Because of the securities nature of the investment component, these cases are worked in cooperation with the Department of Corporations.
- ♦ *Insurance Company Deceptive Practices/Condoning Sales Force Misconduct*—Insurers may fail to properly monitor and control their sales forces, in part because they are seen as independent contractors. The failure, in extreme cases, may involve ignoring complaints and other evidence of sales force misconduct or even training and encouraging misconduct.
- ♦ *Phony Insurance Companies*—This type of fraud involves selling falsified papers that appear to be insurance policies or contracts. This includes everything from phony insurance cards sold in Department of Motor Vehicle parking lots to fully-operational offshore insurance companies issuing policies they have no intention of honoring.
- ♦ *Private Passenger Auto Insurance Consumer Abuse*—Certain high-volume private passenger automobile agencies concentrate on the less desirable auto insurance risks. These include people with bad driving records, young drivers, people who have never had insurance before, and people who cannot afford insurance. Some agencies focus on consumer abuse.
- ♦ *Public Adjuster Misconduct*—Public adjusters can represent insurance claimants in conflict with their insurance companies. This specialty has, in the past, had a high incidence of contested practices, including high-pressure sales, overcharging, conflict of interest with vendors, and failure to account for claims proceeds.
- ♦ *Title Company Bribery and Kickback Activity*—These matters represent problems associated with a remote purchaser of insurance. The title insurer sells a policy needed for closing a real estate transaction. The property buyer pays for it, but the realtor selects the insurer. The problem is that the title companies engage in kickbacks and commercial bribery to induce business from

the realtors. This adds to the cost, but not the commercial value of the insurance.

- * *Bail Agent Activity*—A bail agent is a person permitted to solicit, negotiate, and transact undertakings of bail on behalf of any pointed surety insurer. An unscrupulous bail agent may fail to return collateral, aid and abet unlicensed bail agents and fail to remit premium to insurer.

In addition to these priority types, the Division investigates all other complaints and alleged violations of laws as provided within the California Insurance Code, California Business and Professions Code, California Code of Regulations, California Penal Code, and Title 18 of the United States Code, related to individuals and entities conducting the business of insurance within the State of California.

Division-wide Investigations

During this fiscal year, 1,770 complaints were received from consumers, other CDI units, law enforcement agencies and other agencies. In addition, over 1,500 inquiries about individuals and entities transacting insurance were processed. This resulted in cases being opened during the fiscal year involving 835 different individuals and/or entities.

An additional 256 complaints were consolidated within the investigation of the 835 investigations, which were opened.

Cases opened against 997 different individuals and/or entities were completed during Fiscal Year 05/06.

772 Cases were still in progress as of June 30, 2006.
(Criminal Cases 497)
(Regulatory/Administrative Cases 275)

380 Reports of Suspected Violation⁴ were pending as of June 30, 2006.

(Criminal Cases 139)

(Regulatory/Administrative Cases 241)

⁴ **Any initial allegation that is found sufficient to warrant investigation, but which has not yet been assigned to an investigator. It is intended to represent matters that are potential future investigations.**

**Economic Impact, Losses and Recoveries
(Closed Cases)**

Monetary Loss:	\$126,896,130.09
Losses Recovered.	\$4,212,862.44

Criminal Prosecution Cases

Assisted Law Enforcement Agencies	77
Referred to Prosecutor	53
Prosecutor Rejected	9
Filing/Arrests/Indictments	103
Search Warrants Served	38
Convictions/Sentencing.	73

Regulatory Prosecution Cases

Cases Referred for Regulatory Prosecution	154
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Specially Funded Investigations

Most investigations conducted by the Investigation Division are compensated by revenues generated from fees and licenses charged to the insurance industry. Two areas of investigations which are specially funded are investigations related to automobile insurance and investigations related to Life and Annuity Consumer Protection Programs.

Investigations Related to Automobile Insurance

Effective July 1, 2000, the Investigation Division, Legal Branch’s Compliance Bureau and Consumer Services and Market Conduct Branch’s Consumer Services Bureau were charged with implementing Senate Bill 940 (SB 940). This legislation, which established Section 1872.81 of the Insurance Code,





requires each insurer doing business in California to pay to the Insurance Commissioner an annual fee of \$0.30 for each insured vehicle under an insurance policy it issues in the state.

SB 940 limits the expenditure of this revenue to maintaining and improving consumer service functions of the department that are related to automobile insurance. The legislation specifically requires that the highest priority for use of these revenues shall be to eliminate the backlog of consumer complaints relative to automobile insurance and the insurers, agents and brokers selling those policies. Revenues are divided between Investigation Division, Legal Branch's Compliance Bureau and Consumer Services and Market Conduct Branch.

Auto Insurance Investigations⁵

Opened	204
Completed	231
In progress as of June 30, 2006	178
Reports of Suspected Violation.	39

⁵This data is included in the overall Division case information shown on the top of this page.

Investigations Related to Life Insurance and Annuity Products

Effective July 1, 2005, the Investigation Division was charged with implementing Assembly Bill 2316 (AB 2316). AB 2316 (Chapter 835, Statutes of 2004) adds Section 10127.17 to the California Insurance Code, which creates and establishes the Life and Annuity Consumer Protection Fund. Monies from this fund are dedicated to protecting consumers of life insurance and annuity products. Revenue generated pursuant to this program is divided between the Department of Insurance and Local Assistance Grants to various County District Attorney Offices.

It allows levying a \$1.00 fee against insurers for each new individual life insurance and annuity product worth \$15,000 or more and requires that the monies be deposited into the new fund. The fund will be used to protect consumers of life insurance and annuity products from financial abuse. The bill allows an insurer to charge this fee to the policyholders, but requires that the insurer charge it separately from other premiums or other fees. Monies collected will be equally divided between the Department and district attorneys (DAs) for investigating and prosecuting violators and for other projects beneficial to insurance consumers. This bill provides that the Commissioner may develop guidelines and issue regulations for implementing these provisions.

The Investigation Division is currently reviewing each complaint that has been received through its Case Intake Unit. This is necessary to identify the complaints that are within the scope of AB 2316.

Recommendations On Ways To Reduce Producer Fraud

To reduce incidents involving producer fraud, the Department is implementing the following:

- + Improve coordination with other CDI Branches to identify suspicious patterns of activities by insurance producers and entities.
- + Develop a central intake and inquiry point for complaints and reports of suspected violations. Establish a complaint intake system which allows complaints to come from consumers, other CDI units, prosecutors and law enforcement agencies, either in written, facsimile, telephonic or electronic (through the Internet) methods.
- + Improve Investigation Division Database to include better identification of suspects of investigations and complaints handled by the Division.

- Improve Investigation Division Database to include additional loss information, economic impact information and other factors, which would assist in identifying and preventing patterns of non-compliance by individuals and entities involved in the transaction of insurance.
- Develop stronger liaisons with county prosecutors, local law enforcement agencies, consumer groups and industry organizations to identify investigative issues and develop the exchange of information as appropriate.
- Focus investigative efforts to decrease the time expended on individual cases.
- Reduce the backlog of investigative cases and streamline prosecutorial efforts.
- Develop contacts with insurance industry representatives and improve communication regarding agents and brokers involved in violations of the laws related to insurance transactions; and identify and close unlicensed transactors and companies illegally selling insurance within the State of California.

A Summary Of The Investigation Division's Activities With Respect To Reducing Illegal Activities Of Producers

Within the Department:

The Investigation Division has increased efforts to streamline investigative efforts, reduce backlog of cases and improve the quality and quantity of investigations produced. We have entered into interagency partnerships with other Branches and Units to better focus resources into a stronger consumer protection agency by identifying trends, violators and illegal practices.

Consumer Outreach:

The Investigation Division has begun to send representatives to various industry and consumer

organization meetings including:

- Agent Broker Association Group
- California Medicare Coalition
- Workers' Compensation Interagency Work Group
- California District Attorneys Association (Training Conferences)
- Attendance and Participation with Various Senior and Consumer Group Meetings
- Information kiosks at multiple County Fairs
- Insurance Fraud Advisory Board
- Various service and professional organization seminars and programs

During Fiscal Year 05/06, the Investigation Division has continued to provide the best consumer protection investigative services in the nation as demonstrated by high conviction rates (99 percent), restitution orders awarded to consumers, reduction in the numbers of bogus insurance companies, and the significant sentences imposed upon violators.

2006 ANNUAL REPORT
POLICY
& PLANNING

POLICY & PLANNING

The Policy & Planning Branch in 2006 included the Statistical Analysis Division, the Rate Specialist Bureau, the Policy Research Division, the Legislative Division, the Policy Initiatives Office and the Life Insurance and Annuity consumer Protection Fund program.

The Statistical Analysis Division responds to all data collection and reporting required by the California Insurance Code and the California Code of Regulations.

The Rate Specialist Bureau provides technical advice and support to the Insurance Commissioner, Executive Staff, and other Branch Managers regarding insurance underwriting, rating, and data collection and analysis issues.

The Policy Research Division conducts statistical research and studies of public policies affecting the Department of Insurance, consumers, and the insurance industry.

The Legislative Division sponsors key legislation to support the Commissioner's Policy agenda. The Legislative division also monitors and responds appropriately to legislation affecting the Commissioner's policies.

The Policy Initiatives Office supports and advances the Commissioner's policy ideas and initiatives.

The Life Insurance and Annuity Consumer Protection Fund program protects buyers of life insurance and annuities in California from financial abuse.

POLICY RESEARCH DIVISION

The Policy Research Division produces studies of proposed and existing public policies affecting the Department of Insurance, consumers and the insurance industry. The Division conducts long-term insurance policy and statistical research,

including specialized economic studies that may guide the Department's regulatory and legislative agenda. These analyses provide the Department with a strong factual foundation that supports the decision-making process.

In 2006, the Policy Research Division's most important activities included:

- technical support for the RH03029826 proceeding, the venue for the Department to change the auto rating factor regulations (Title 10, Section 2632.8)
- Collaborative work with the Policy Initiatives Office for a health insurance portal on the CDI website
- A report on annual mileage data used for auto insurance rating, titled "Errors in Self-Reported Mileage for California Vehicles (available on the CDI website)."

RATE SPECIALIST BUREAU (RSB)

The Rate Specialist Bureau (RSB) provides technical advice and support to the Insurance Commissioner, executive staff, and other CDI Branch Managers with regard to underwriting, rating, data collection, statistical analysis, profitability, and rate-of-return issues. In October 2004, RSB was transferred from the Rate Regulation Branch to the Policy and Planning Branch. Hence, RSB's duties and responsibilities expanded from the previous property and casualty areas to all lines of insurance. The following is a list of the projects and duties handled in 2006.

- 1 During 2006, RSB worked with the Title Insurance Working Group in drafting the proposed Title Insurance regulation.
- 2 RSB continued to assist the Prior Approval Working Group with regard to the preparation of key rate components for the prior-approval regulations. In support of the regulation, RSB

- promulgated supporting data and reports that were used by the CDI and the rate analysts in the review of rate filings for Proposition 103 lines of insurance. Report topics included: Efficiency Standards; Leverage Factors by line; Reserve-to-Earned premiums Ratios; industry Rate-of>Returns; Projected Yields; Investment Income; CPI Index for expense trend factors; the Federal Income Tax rate on investment income; California and Countrywide Profitability; and Risk Based Capital.
- 3 RSB compiled: California Market Share Reports for Property & Casualty insurance, for Life & Annuity insurance, for Title insurance, and for Home Warranty; a Directory of all California licensed insurers and their Annual Statement state page data; summaries of the Investment Schedules for California licensed P&C insurers; and the Supplemental Executive Compensation Exhibits data.
 - 4 RSB completed various projects in relation to workers' compensation insurance such as preparing market share reports and historical premium, loss and dividend comparisons, and compiling the Workers' Compensation Insurance Rate Comparison for CDI's website.
 - 5 RSB promulgated the Proposition 103 Administration Fees for property & casualty companies, and the workers' compensation filing fee charges for the Accounting Division.
 - 6 RSB collected, compiled, and analyzed data as required by various sections of the California Insurance Code (i.e. child care liability, medical & legal professional liability). RSB also continued to collect the loss and experience data of credit property and credit unemployment insurance pursuant to (CIC §779.36, amended by Statute 199, Chapter 413, Section 1), to reflect 2004 to 2006 experience. The due date for the Child Care Report is May 1; the due date for the Legal and Medical Professional Liability Reports and the Credit reports is July 1. Consequently, the results included in this report are for 2005 data.
 - 7 RSB continued to collect and compile earthquake probable maximum loss (PML) data via the annual data calls which are due by June 30 from primary carriers and August 31 from reinsurers. An updated "California Earthquake Zoning and Probable Maximum Loss Evaluation Program" report for 2002-2005 will be released in 2007. RSB also collected and compiled the annual Earthquake Premium & Policy Count data call.
 - 8 RSB assisted the Statistical Analysis Division (SAD) in the review and compilation of their private passenger motor vehicle physical damage data call.
 - 9 During 2006, RSB continued to work with the staff of the State Controller's Office (SCO) with regard to the unclaimed Proposition 103 rollbacks that were escheated to the SCO. RSB provided information and clarification with regard to the rollbacks. To date, all rollback cases have been settled, except for one rollback settlement that is being contested and is awaiting the courts' decision. Total refunds including interest for 149 companies/groups amounted to approximately \$1.43 billion.
 - 10 RSB continued to review Insurance Services Office (ISO) and National Association of Independent Insurers (NAII) submitted Fast Track data, and promulgated private passenger automobile and homeowners' insurance trend factors. RSB also compiled the commercial line fast track historical data, and was involved in other rate component determination research.
 - 11 RSB acted as liaison to the California FAIR Plan Association. RSB's staff participated

in the California FAIR Plan's rating and underwriting appeals proceedings and attended its Governing Committee meetings.

RSB is also responsible for reporting data under the following California Insurance Code (CIC) Sections:

CIC §674.5 & 674.6

Companies ceasing to offer a particular line of coverage

CIC §1857.9

Special data call on classes of insurance designated by the Insurance Commissioner as unavailable or unaffordable.

CIC §1864

Child Care Liability Insurance

CIC §11555.2

Malpractice Insurance—Dental, Medical, and Legal

CIC §12963

Public Entity Liability Insurance

CIC §674.5 & §674.6

Companies Ceasing to Offer a Particular Line of Coverage

Under CIC §674.5, an insurer ceasing to offer any particular class of commercial liability insurance must provide prior notification of its intent to the commissioner. Likewise, under CIC §674.6, an insurer offering policies of commercial liability and most types of property/casualty insurance, must provide prior notification to the commissioner of its intent to withdraw wholly or substantially from the specified line of insurance.

The following is the list of notifications that the Department received:

**Prior Withdrawal & Cease-writing Notices:
Received By The Insurance Commissioner During 2006**

Company Name	Group No.	Group Name	Request Date	Effective Date	Proposed Action by Company
American Travelers Assurance Company	0	American Travelers Assurance Co		03/10/2006	Withdrew as an insurer.
Financial Indemnity Company	215	Unitrin Grp	01/25/2006	03/25/2006	Withdrew from writing Personal Watercraft insurance.
National Union Fire Insurance Company of Pittsburgh, PA	12	American Intrnl Grp	01/31/2006	03/31/2006	Nonrenewed Direct Agents Errors & Omissions Policies
ALEA North America Insurance Company	1325	Rhine Re Group	02/10/2006	04/10/2006	Discontinued writing the following lines of business: Coml Multiple, Workers' Compensation, Other Coml Liability, and Coml Physical Damage.

Prior Withdrawal & Cease-writing Notices (Continued)

Company Name	Group No.	Group Name	Request Date	Effective Date	Proposed Action by Company
Royal Indemnity Company	553	Royal & Sun Alliance USA	04/18/2006	06/18/2006	Withdrew from Homeowners' & Property Lines of Insurance.
Security Insurance Company of Hartford	553	Royal & Sun Alliance USA	04/18/2006	06/18/2006	Withdrew from Homeowners' & Property Lines of Insurance.
Church Mutual Insurance Company	0	Church Mutual Ins. Co.	04/24/2006	07/01/2006	Withdrew their Dwelling Program.
Valley Insurance Company	215	Unitrin Group	06/02/2006	08/02/2006	Ceased offering personal lines covg. & withdrew from most of its personal lines business in CA. Valley Ins. Co. policyholders offered a policy through Kemper Independence Ins. Co.
Galway Insurance Company	218	CNA Insurance Grp	07/17/2006	07/01/2006	Withdrew from California. Galway's obligations have been assumed by Continental.
Quadrant Indemnity Company	38	Chubb & Son Inc.	10/02/2006	01/02/2007	Transferred business from Quadrant to Chubb National Ins. Co. (not a withdrawal action)
Sompo Japan Insurance Company of America	3219	Sompo Japan Ins. Grp.	10/19/2006	03/01/2007	Intended to withdraw wholly from the personal homeowners' and umbrella lines of business.
Boston Old Colony Insurance Company (The)	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (surviving company)
Buckeye Union Insurance Company (The)	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (surviving company)
Commercial Insurance Company of Newark, NJ	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (surviving company)



Prior Withdrawal & Cease-writing Notices (Continued)

Company Name	Group No.	Group Name	Request Date	Effective Date	Proposed Action by Company
Continental Reinsurance Corp.	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Fidelity and Casualty Company of New York (The)	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Fireman's Insurance Company of Newark, NJ	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Glen Falls Insurance Company (The)	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Kansas City Fire & Marine Insurance Company	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Mayflower Insurance Company, Ltd. (The)	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
National-Ben Franklin Insurance Company of Illinois	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Niagara Fire Insurance Company	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)
Pacific Insurance Company	218	CNA Ins. Group	10/20/2006	12/31/2006	Planned merger with and into Continental Ins. Co. (NAIC# 35289) (suiving company)

CIC §1857.9: Special Data Call on Classes of Insurance Designated by The Commissioner as Unavailable or Unaffordable in California

The Insurance Commissioner did not designate any classes of insurance in 2006.

CIC §1864: Child Care Liability Insurance (2005 report revised 12/12/06)

Section 1864 was added to the Insurance Code as of January 1, 1986. This section requires that on or before May 1 of each year, each insurer

engaged in writing child care liability insurance in California submits a report of its child care liability premium and loss experience for the preceding calendar year. A call for the prescribed statistics is sent to all insurers licensed to transact liability insurance in California, and the reports are categorized by licensed Family Day Care (FDC) Homes and licensed Child Care (CC) Centers. FDC Home business is further broken into Small FDC Homes (licensed for 1 to 6 children) and Large FDC Homes (licensed for 7 to 12 children). The following is an aggregate summary of the data submitted for calendar years 2004 and 2005. The 2005 report has been revised to add in data from 1 insurer. The 2006 data will be provided in the 2007 Commissioner's Report since the due date for the child care reports was May 1, 2007, and the data was not available at the time of the compilation of this report.

For calendar year 2005, 26 property-casualty companies/groups admitted to do business in California submitted data under CIC §1864 requirements. Of the 26 insurers, 16 insurers submitted data for FDC Homes insured either on a separate liability policy or as an endorsement to the homeowners' policy. Nineteen (19) insurers submitted data for licensed CC Centers.

Policy Writing Activity For Family Day Care Homes

Of the 16 companies/groups reporting data for FDC Homes in 2005, 6 insurers had direct written premium exceeding \$100,000. These 6 insurers provided coverage for 13,824 FDC Home providers, approximately 94.00% of all the FDC business insured. Of these 16 insurers: 5 carriers insured from 0 to 10 providers each; 4 carriers insured between 11 and 100 providers each; 0

Insurers Reporting Data For Family Day Care Homes: Part 1

Range: Insured Count	# of Companies Writing		# of FDC Homes (Providers) Insured		
	2004	2005	2004	2005	% of Total
From 0–10 providers	4	5	17	14	0.09%
From 11–100 providers	5	4	149	163	1.11%
From 100–450 providers	0	0	0	0	0.00%
Over 450 providers	6	7	13,490	14,529	98.80%
Total	15	16	13,656	14,706	100.00%

Insurers Reporting Data For Family Day Care Homes: Part 2

Range: Insured Count	# of Cos. Writing		# of FDC Homes (Providers) Insured			
	2004	2005	2004	2005	2004	2005
Small FDC Homes (1–6 children)	13	15	8,546	62.58%	10,734	72.99%
Large FDC Homes (7–12 children)	6	7	5,110	37.42%	3,972	27.01%
Total Insurers Providing Coverage	15	16	13,656	100.00%	14,706	100.00%

carrier insured between 101 to 450 providers; and 7 carriers insured over 450 providers each.

Of the 16 insurers that wrote child care liability insurance for FDC Homes in 2005, 15 insurers wrote coverage for Small FDC Homes (licensed for 1 to 6 children) and 7 wrote coverage for Large FDC Homes (licensed for 7 to 12 children). Of the 15 Small FDC Home insurers, 4 insurers had direct written premium exceeding \$100,000. They insured approximately 90.71% of all Small FDC Homes. Of the 7 Large FDC Home insurers, 3 insurers had direct written premium exceeding \$100,000. They insured about 98.11% of all Large FDC Homes.

Policy Writing Activity for Child Care Centers

Of the 19 companies/groups which submitted data for licensed Child Care Centers in 2005, 10 insurers had direct written premium exceeding \$100,000. These 10 carriers insured approximately 90.18% of the CC Center business.

Of the 19 insurers submitting data: 5 carriers insured from 0 to 10 CC Centers each; 3 carriers insured between 11 and 50 Centers; 2 carriers insured between 51 and 200 Centers; and 9 insurers wrote more than 200 CC Centers in 2005.

Insurers' Activity In 2005

From the information provided for calendar year 2005, there was an increase in the overall total of child care providers insured, even though the number of carriers reporting data decreased slightly from that in the previous year. The number of FDC Homes insured increased, while the number of CC Centers insured decreased. However, the majority of the coverage being written in California is still being provided by the same handful of insurers, particularly with regards to FDC Homes. The following exhibits were developed from the data provided by the insurers.

Insurers Reporting Data For Child Care Centers

Range: Insured Count	# of Cos. Writing		# of Child Care Centers (Providers) Insured			
	2004	2005	2004	2005	2004	2005
0-10	6	5	15	0.42%	15	0.45%
11-50	3	3	107	3.02%	87	2.58%
51-200	4	2	523	14.77%	115	3.41%
201 + providers	7	9	2,897	81.79%	3,154	93.56%
Total	20	19	3,542	100.00%	3,371	100.00%

Exhibit I: Comparison Of Insurers' Participation in the Child Care Liability Insurance Market

	Family Day Care Homes		Child Care Centers	
	2004	2005	2004	2005
# of Insurers Reporting Data	15	16	20	19
# of Policies In-Force at Beginning of Year	12,654	13,622	3,351	2,993
# of Policies In-Force at End of Year	11,466	16,906	3,115	3,904
Change in # Policies In-Force at End of Year	-9.39%	24.11%	-7.04%	30.44%
# Insurers w/ No Policies In-Force at End of Year	1	1	1	1

Exhibit II: Breakdown of Form and Coverage Types Written During 2004 and 2005

Family Day Care Homes (Licensed for 1-6 children or 7-12 children) 15 insurers reported data for 2004; 16 insurers reported data for calendar year 2005

Form Type:	# of Companies Writing	
	2004	2005
Occurrence Policy	13	15
Claims-Made Policy	1	1
Both Occurrence & Claims-Made Policy	0	0
Not Specified	1	0
Coverage/limits:		
100K/300K limit, OL&T	0	0
300K CSL, OL&T	0	0
Endorsement to Homeowners Policy	7	7
Both Liability Policies & HO Endorsement	0	0
From 100K/100K to 500K/500K	1	1
Up to \$1 Million + CSL	5	6
1Mil / All Other	1	1
Various Limits (from 100K to 500K CSL)	1	0
Various Limits - not specified	0	1

Child Care Centers (Licensed for 13+ children) 20 insurers reported data for 2004;
19 insurers reported data for calendar year 2005:

Form Type:	# of Companies Writing	
	2004	2005
Occurrence Policy	17	17
Claims-Made Policy	1	1
Both Occurrence & Claims-Made	2	1
Coverage/limits:		
100K/300K limit, OL&T.	1	0
300K CSL, OL&T	1	2
Various Limits (below \$1 Million)	2	1
Various Limits (up to & above \$1 Mil+ CSL	9	8
Various (\$1M/\$1M; \$1M/All other; higher)	6	6
Various - Not Specified	1	2

Exhibit III: Insurers Reporting Child Care Data for Calendar Year 2004 vs. 2005 per CIC §1864

Insurers Reporting:	2004		2005		Notes	Policy Type
	FDCH	CCC	FDCH	CCC		
Allstate Insurance Group	X	—	X	—		OC
American Alternative Insurance Corp	—	X	—	X		OC
Armed Forces Insurance Exchange	—	—	X	—		OC
California Casualty Insurance Cos.	X	—	X	—		OC
Church Mutual Insurance Co.	X	X	X	X		OC
Country Ins & Financial Service	X	—	—	—		
Farmers Insurance Group	X	—	X	—		OC
Fireman's Fund Insurance Cos.	—	X	—	X		CL/OC
Grange Insurance Group	X	—	X	—		OC
Great American Insurance Group	—	X	—	X		CL/OC
Great Divide Insurance Co.	—	X	—	X		OC
GuideOne Insurance Group	X	X	X	X		OC
Markel Insurance Co.	X	X	X	X		OC
Mitsui Sumitomo Ins. Co.	—	X	—	X		OC
Mitsui Sumitomo Ins. Co. USA Inc.	—	X	—	X		OC
Pacific Property & Casualty Co.	X	—	X	—		OC

Penn-America Ins. Co.	X	X	X	X		OC
Philadelphia Indemnity Ins. Co.	—	X	X	X		OC
Riverport Insurance Co. of CA	—	X	—	X		OC
SAFECO Insurance Group	X	X	X	X		CL
State Farm Insurance Cos.	X	X	X	X		OC
St. Paul Travelers Group	—	X	—	X	*1	OC
St. Paul Travelers Company	—	X	—	—	*2	OC
Stonington Insurance Co.	X	X	X	X		OC
TIG Insurance Group	—	X	—	X		OC
TOPA Insurance Company	X	X	X	X		OC
Unigard Insurance Group	X	—	X	—		OC
Zurich American Ins. Group	—	X	—	X		OC
# of Insurers Submitting Data	15	20	16	19		
Total # of Insurers Submitting Data		27		26		

FDCH Family Day Care Homes
 CCC Child Care Centers

*1 St. Paul Travelers Group was formerly St. Paul Insurance Group, before its merger with Travelers Group.

*2 St. Paul Travelers Company was formerly Travelers Property and Casualty Group—the two groups filed separately.

Exhibit IV: California Child Care Providers Liability Insurance Report
Licensed Family Day Care Homes & Child Care Centers

	Family Day Care Homes Lic. 1–6 / 7–12 Children		Child Care Centers Lic. 13 + Children		Combined Data FDCH & CCC	
	2004	2005	2004	2005	2004	2005
# Insurers Reporting Data	15	16	20	19	27	26
1) Premiums Earned	\$3,406,273	\$3,564,608	\$5,381,719	\$5,270,726	\$8,787,992	\$8,835,334
2) Premiums Written	\$3,368,139	\$3,841,463	\$5,493,683	\$5,621,568	\$8,861,822	\$9,463,031
Number of Claims:						
3) Outstanding at Beginning of Yr	80	59	120	96	200	155
4) New - During Reporting Period	67	131	111	160	178	291
5) Closed During Reporting Period	52	112	118	175	170	287
6) Outstanding at End of Year	95	78	113	81	208	159
7) Total Losses Incurred	\$1,142,929	\$1,599,438	\$5,277,397	\$1,039,522	\$6,420,326	\$2,638,960
8) Loss Ratio (7)/(1)	33.55%	44.87%	98.06%	19.72%	73.06%	29.87%
9) Loss Adjustment Exps (LAE)	\$492,445	\$201,793	\$444,155	\$517,568	\$936,600	\$719,361
10) Total Losses Incurred + LAE	\$1,635,374	\$1,801,231	\$5,721,552	\$1,557,090	\$7,356,926	\$3,358,321
11) Loss & LAE Ratio (10)/(1)	48.01%	50.53%	106.31%	29.54%	83.72%	38.01%
Number of Policies:						
12) In-Force at Beginning of Yr	12,654	13,622	3,351	2,993	16,005	16,615
13) Written During the Year	5,756	9,028	977 (*2)	1,464	6,733	10,492
14) Cancelled During the Year	1,012	1,168	284	434	1,296	1,602
15) NonRenwd During the Year	5,932	4,576	929	119	6,861	4,695
16) In-Force at End of Year	11,466	16,906	3,115	3,904	14,581	20,810
17) Allocation of Expenses:						
a. Commissions	\$672,844	\$646,968	\$1,021,986	\$769,414	\$1,694,830	\$1,416,382
b. Other Acquisition Costs	\$142,372	\$149,987	\$231,398	\$253,664	\$373,770	\$403,650
c. General Expenses	\$160,221	\$157,634	\$256,140	\$218,280	\$416,361	\$375,894
d. Taxes, Licenses, Fees	\$98,813	\$94,751	\$145,784	\$142,767	\$244,597	\$237,518
18) Total Underwriting Expenses	\$1,074,250	\$1,049,340	\$1,655,308	\$1,384,105	\$2,729,558	\$2,433,445
Total Expns Ratio [(18)/(1)]	31.54%	29.44%	30.76%	26.26%	31.06%	27.54%
19) Combined Lss & Exp Ratio	79.55%	79.97%	137.07%	55.80%	114.78%	65.55%
20) Net Underwriting Gain or (Loss) [(1)-(10)-(18)]	\$696,649	\$714,037	(\$1,995,141)	\$2,329,531	(\$1,298,492)	\$3,043,568
21) Allocated Investment Income/(Loss)	\$175,449	\$231,121	\$266,564	\$320,997	\$442,013	\$552,117
22) Net Income/(Loss) after Investment [(20)+(21)]	\$872,098	\$945,158	(\$1,728,577)	\$2,650,528	(\$856,479)	\$3,595,686

FDCH Family Day Care Homes
 CCC Child Care Centers

*2 Data not available from 2 companies

Exhibit V: California Child Care Providers Liability Insurance Report
Data Reported For Licensed Family Day Care Homes

	Small Family Day Care Homes		Large Family Day Care Homes	
	2004	2005	2004	2005
# of Insurers Reporting FDC Info.	13	15	6	7
1) Premiums Earned	\$1,092,035	\$1,736,347	\$2,314,238	\$1,828,261
2) Premiums Written	\$1,167,417	\$1,795,889	\$2,200,722	\$2,045,574
Number of Claims:				
3) Outstanding at Beginning of Year	14	30	66	29
4) New - During Reporting Period	9	62	58	69
5) Closed During Reporting Period	13	49	39	63
6) Outstanding at End of Year	10	43	85	35
7) Total Losses Incurred	(\$85,386)	\$946,753	\$1,228,315	\$652,685
8) Loss Ratio (7)/(1)	-7.82%	54.53%	53.08%	35.70%
9) Loss Adjustment Expenses (LAE)	\$61,071	\$112,512	\$431,374	\$89,281
10) Total Losses Incurred + LAE	(\$24,315)	\$1,059,265	\$1,659,689	\$741,966
11) Loss & LAE Ratio (10)/(1)	-2.23%	61.01%	71.72%	40.58%
Number of Policies:				
12) In-Force at Beginning of Year	7,949	9,961	4,705	3,661
13) Written During the Year	3,611	5,790	2,145	3,238
14) Cancelled During the Year	675	857	337	311
15) NonRenewed During the Year	4,458	3,771	1,474	805
16) In-Force at End of Year	6,427	11,123	5,039	5,783
17) Allocation of Expenses:				
a. Commissions	\$147,282	\$280,380	\$525,562	\$366,588
b. Other Acquisition Costs	\$81,455	\$94,278	\$60,917	\$55,709
c. General Expenses	\$47,394	\$75,742	\$112,827	\$81,892
d. Taxes, Licenses, Fees	\$27,647	\$44,651	\$71,167	\$50,101
18) Total Underwriting Expenses	\$303,778	\$495,051	\$770,473	\$554,289
Total Expense Ratio [(18)/(1)]	27.82%	28.51%	33.29%	30.32%
19) Combined Loss & Expense Ratio	25.59%	89.52%	105.01%	70.90%
20) Net Underwriting Gain or (Loss) [(1)-(10)-(18)]	\$812,572	\$182,031	(\$115,924)	\$532,006
21) Allocated Investment Income/(Loss)	\$76,998	\$115,939	\$98,451	\$115,181
22) Net Income/(Loss) after Invstment [(20)+(21)]	\$889,570	\$297,971	(\$17,473)	\$647,187

Average Written Premium Per Policy

The rates that an insurer charges for a child care liability insurance policy or a homeowners' endorsement are not required to be filed under this section of the Insurance Code. Subsequently, we are able to calculate only a rough estimate of the average written premium (AWP) per policy written based on the information submitted.

Exhibit VI summarizes the AWP for a FDC Home (Small and Large) policy and for a CC Center policy, based on available data from 1995 to 2005. The AWP's were calculated after removing the direct written premium for insurers that could not provide a policy written count.

Note for Child Care Centers:

- 1995:** The AWP was calculated without the premium from 3 insurers that did not provide a policies written count. Data were from 25 of 28 insurers, with direct written premium (DWP) of \$6,746,194 and policies written of 1,036.
- 1996:** AWP was calculated based on data from 20 of 23 insurers with DWP of \$4,859,034 and policies written of 1,296.
- 1997:** AWP was calculated based on data from 23 of 24 insurers with DWP of \$4,741,919 and policies written of 876.
- 1998:** AWP was calculated based on data from 22 of 24 insurers with DWP of \$4,299,031 and policies written of 1,462.
- 1999:** AWP was calculated based on data from 26 of 27 insurers with DWP of \$4,050,351 and policies written of 931.
- 2000:** AWP was calculated based on data from 26 of 27 insurers with DWP of \$4,104,022 and policies written of 1,479.

**Exhibit VI: Estimated Average Written Premium
Family Day Care Homes & Child Care Centers**

Year	Small FDC Homes	Larg FDC Homes	Combined FDC Homes	Child Care Centers
1995	\$316.01	\$474.64	\$357.11	\$6,511.77
1996	\$340.03	\$479.12	\$383.54	\$3,749.25
1997	\$134.05	\$9,822.00	\$140.51	\$5,413.13
1998	\$210.11	\$1,212.69	\$309.20	\$2,940.58
1999	\$228.40	\$1,910.40	\$232.46	\$4,350.53
2000 *	\$212.11	\$490.75	\$298.47	\$2,775.13
2001 *	\$227.75	\$764.92	\$242.08	\$2,093.76
2002	\$319.16	\$1,054.67	\$521.95	\$3,036.13
2003	\$318.57	\$1,034.42	\$554.94	\$4,297.50
2004	\$323.29	\$1,025.98	\$585.15	\$5,624.15
2005	\$310.17	\$631.74	\$425.51	\$3,839.75

* Missing 1 insurer's data in 2001—possibly 2000 also.

2001: AWP was calculated based on data from 24 of 25 insurers with DWP of \$4,380,155 and policies written of 2,092.

2002: AWP was calculated based on data from 19 of 20 insurers with DWP of \$5,319,299 and policies written of 1,752.

2003: AWP was calculated based on data from 16 of 18 insurers with DWP of \$6,270,046 and policies written of 1,459.

2004: AWP was calculated based on data from 16 of 20 insurers with DWP of \$5,494,796 and policies written of 977.

2005: AWP was calculated based on data from 18 of 19 insurers with DWP of \$5,621,390 and policies written of 1,464.

CIC §11555.2: Malpractice Insurance—Dental, Medical, and Legal

CIC §12963: Public Entity Liability Insurance

Under CIC §11555.2, insurers transacting insurance covering liability for malpractice of any person licensed under the Dental Practice Act, the Medical Practice Act, or the State Bar Act, shall report specified statistics to the commissioner, by profession and by medical specialty, upon request of the commissioner. Likewise, under CIC §12963, each insurer transacting insurance covering liability for any public entity shall report specified data to the commissioner by type of claim, upon request of the commissioner. For 2005 and 2006, data calls were issued for California Legal and

Medical Professional Liability Insurance. A data call was “not” requested for Public Entity Liability Insurance.

California Legal Professional Liability Insurance Report—2005

In October 2001, the Department resumed collecting the California Legal Professional Liability Insurance Report. CIC §11555.2 requires each insurer transacting insurance covering liability for malpractice of any person licensed under the State Bar Act (Chapter 4 [commencing with Section 6000] of Division 3 of the Business and Professions Code) to file this report. The amounts reported reflect only direct business written in California and are filed on a group basis. Since the due date for the 2006 reports is July 1, 2007, at the time this Commissioner’s Report was prepared, the 2006 data was not yet submitted. The 2006 summary will be available in next year’s report. For 2005, 19 companies/groups reported data under this section. Sixteen (16) insurers reported writing claims-made policies, 2 wrote occurrence policies, and 1 wrote both.

The following exhibit shows the top 10 legal professional liability insurers that reported data for calendar year 2005.

Group / Company Name	Written Premium	Earned Premium	Incurred Losses	Loss Ratio
2005: 19 Insurers Reporting *	\$167,213,948	\$167,069,401	\$70,158,058	41.99%
2004: 18 Insurers Reporting	\$178,484,970	\$168,611,866	\$90,195,202	53.49%

* following up with 1 company for 2005 data

California Legal Professional Liability Insurance: Top 10 Writers—2005

Goup/Company Name	Market Share	Written Premium	Earned Premium	Incurred Losses	Loss Ratio
1) Lawyers' Mutual Ins. Co.	32.65%	\$54,600,000	\$53,720,000	\$15,120,000	28.15%
2) CNA Insurance Group	18.24%	\$30,496,433	\$30,810,091	\$9,637,913	31.28%
3) Carolina Casualty Ins. Co.	14.89%	\$24,894,297	\$30,257,791	\$16,582,120	54.80%
4) Zurich-U.S. Ins. Group	9.72%	\$16,247,246	\$16,712,395	\$11,401,522	68.22%
5) Chubb Group	7.52%	\$12,580,164	\$10,110,149	\$8,851,340	87.55%
6) Great American Ins. Co.	6.14%	\$10,261,586	\$9,673,741	\$5,373,908	55.55%
7) NCMIC Ins. Co.	4.53%	\$7,569,842	\$6,651,434	\$2,144,873	32.25%
8) Hartford Group (The)	4.14%	\$6,919,651	\$6,668,747	\$0	0.00%
9) State National Ins. Co., Inc	0.91%	\$1,523,237	\$236,272	\$0	0.00%
10) AIG Group (American Intl Grp)	0.90%	\$1,500,000	\$1,500,000	(\$854,648)	-56.98%
2005: Top 10 Insurers	99.63%	\$166,592,456	\$166,340,620	\$68,257,028	41.03%

2005 Legal Professional Liability Report: Summary of Premiums and Expenses

Year	# Lawyers Written (*1) in 2005	Direct Premium Written	Direct Premium Earned	Direct Losses Incurred	Loss Ratio	Defns & Cst Containmnt Expsn Incrrd	Incrd Loss & DCCE Ratio
2005	46,487	\$167,213,948	\$167,069,401	\$70,158,058	41.99%	\$35,543,068	63.27%
2004	54,180	\$174,458,737	\$167,979,019	\$87,715,347	52.22%	\$35,920,627	73.60%
2003	48,926	\$172,698,056	\$152,894,597	\$76,407,927	49.97%	\$31,066,726	70.29%

Year	Adjusting & Other Expsn. Incurred	Commission & Brokerage Expsn. Incurred	Tax, Lic Fees Incurred	Other Acqstn Fld Suprvsn Clctn Exp	General Expenses Incurred	Total Underwriting Expenses	Combined Loss + Exp Ratio
2005	\$6,545,216	\$17,937,321	\$3,309,598	\$4,644,637	\$16,676,045	\$49,112,816	92.66%
2004	\$10,129,934	\$15,894,830	\$3,179,759	\$2,170,434	\$9,780,642	\$41,155,597	98.10%
2003	\$8,304,136	\$19,167,989	\$3,434,974	\$1,337,658	\$9,306,164	\$41,550,920	97.47%

*1: # of lawyers for 2004 & 2005 "Not Available" from 2 insurers.

Summary of: Claims Closed In 2005**Direct Payments**

Indemnity Claim Size Interval	Number of Claims	Total Indemnity Paid for Claims in Interval	Total DCCE Paid for Claims in Interval
\$0 *	638	\$0	\$481,727
\$0 *	224	\$0	\$7,553,007
\$1–9,999	43	\$113,327	\$307,592
\$10,000–49,999	108	\$2,187,986	\$3,360,587
\$50,000–99,999	69	\$3,873,313	\$2,450,941
\$100,000–249,999	69	\$6,360,614	\$2,330,698
\$250,000–499,999	46	\$6,653,820	\$1,912,430
\$500,000–749,999	16	\$4,016,031	\$902,263
\$750,000–999,999	10	\$5,794,396	\$181,274
\$1,000,000 and over	6	\$13,220,494	\$1,650,151
Total	1,229	\$42,219,981	\$21,130,671

Claims Closed with Payment to the Claimant During 2005

Occurrence Year	# of Claims	Total Monetary Amount Paid	Avg. Claim Payment	Defense & Cost Contnmt Expns Pd	Loss + DCCE Paid	Avg Loss & DCCE Paid
Pre 1997	5	\$228,611	\$45,722	\$1,168,000	\$1,396,611	\$279,322
1997	5	\$457,445	\$91,489	\$220,000	\$677,445	\$135,489
1998	2	\$242,500	\$121,250	\$178,295	\$420,795	\$210,398
1999	14	\$1,786,218	\$127,587	\$1,025,851	\$2,812,069	\$200,862
2000	21	\$3,823,940	\$182,092	\$2,187,704	\$6,011,644	\$286,269
2001	58	\$16,349,415	\$281,886	\$5,547,526	\$21,896,941	\$377,533
2002	84	\$14,437,462	\$171,875	\$6,651,418	\$21,088,880	\$251,058
2003	81	\$10,116,429	\$124,894	\$2,251,443	\$12,367,872	\$152,690
2004	84	\$6,452,529	\$76,816	\$2,400,810	\$8,853,339	\$105,397
2005	14	\$876,829	\$62,631	\$36,000	\$912,829	\$65,202
Total	368	\$54,771,378	\$148,835	\$21,667,048	\$76,438,426	\$207,713

* The claims closed in 2005, without indemnity payment, should be broken down in two categories : Claims with Defense and Cost Containment Expenses Paid and Claims without Defense and Cost Containment Expenses Paid.

Claims Closed Without Payment to the Claimant During 2005

Occurrence Year	# of Claims	Defens & Cost Contnmt Expenses Pd	Average DCCE Paid	Avg Claim Payments for All Claims Combined
Pre 1997	25	\$508,879	\$20,355	\$63,516
1997	5	-\$98,672	-\$19,734	\$57,877
1998	10	\$704,699	\$70,470	\$93,791
1999	20	\$1,645,301	\$82,265	\$131,099
2000	31	\$1,203,342	\$38,817	\$138,750
2001	67	\$2,471,169	\$36,883	\$194,945
2002	97	\$1,131,272	\$11,663	\$122,763
2003	153	\$853,174	\$5,576	\$56,500
2004	311	\$491,196	\$1,579	\$23,657
2005	147	\$30,375	\$207	\$5,858
Total	866	\$8,940,735	\$10,324	\$69,189

Claims Reported:
First time & ReopenedMonetary Amount Paid
on Claims During 2005

Occmc Year	# 1st Time Claim Reports	# Claims Re-Open	Occmc Year	Monetary Amount Paid on Claims	Defense & Cost Contnmt Paid
Pre 1997	15	—	Pre 1997	\$127,133	\$757,195
1997	10	1	1997	\$285,661	\$298,226
1998	6	2	1998	\$207,912	\$460,900
1999	9	4	1999	\$2,881,868	\$1,903,014
2000	21	7	2000	\$2,024,281	\$1,888,866
2001	29	12	2001	\$9,166,660	\$3,942,090
2002	56	24	2002	\$10,625,447	\$7,201,858
2003	96	15	2003	\$9,556,258	\$4,527,247
2004	225	21	2004	\$11,318,365	\$5,466,787
2005	616	13	2005	\$1,195,477	\$813,308
Total	1,083	99	Total	\$47,389,062	\$27,259,490

of Claims info N/A from 1 insurer

Claims Outstanding as of 12/31/2005

Occrnc Year	# of Claims Outstdng	Dir Amount Resrvd for Loss on Rprtd Claims	Dir Amount Resrvd for DCCE on Rprtd Claims	Amount of IBNR Rsrv for Loss & DCCE*
Pre 1997	51	\$2,517,010	\$2,483,263	\$553,237
1997	16	\$505,016	\$730,852	\$79,365
1998	22	\$1,535,246	\$1,033,960	\$1,603,195
1999	64	\$1,701,114	\$2,375,433	\$1,084,999
2000	136	\$2,204,008	\$1,680,710	\$1,658,296
2001	168	\$12,737,202	\$3,666,081	\$4,283,101
2002	161	\$9,126,187	\$3,909,579	\$6,314,345
2003	206	\$10,051,211	\$4,418,394	\$11,252,434
2004	365	\$19,555,151	\$6,040,475	\$36,735,448
2005	491	\$16,395,000	\$4,189,786	\$43,975,463
Total	1,680	\$76,327,145	\$30,528,533	\$171,333,884

of Claims info N/A from 1 insurer

* Include Bulk Reserve for Adverse Development on Case Reserves.

California Medical Professional Liability Insurance Report: 2005

In June 2003, the Department resumed collecting the California Medical Professional Liability Insurance Report. CIC §11555.2 requires each insurer transacting insurance covering liability for malpractice of any person licensed under the Dental Practice Act (Chapter 4 [commencing with Section 1600] of Division 2 of the Business and Professions Code) or under the Medical Practice Act (Chapter 5 [commencing with Section 2000] of Division 2 of the Business and Professions Code) to file this report. The amounts reported reflect only business written in California and are filed on a group basis. All amounts reported are direct liability with no deduction for reinsurance.

A separate report is required for the following designated type of health care providers as defined in Supplement A to Schedule T of the Annual Statement:

- a Physicians—including Surgeons and Osteopaths;
- b Hospitals;
- c Other Health Care Professionals - including Dentists; and
- d Other Health Care Facilities.

Since the deadline for the 2006 reports is July 1, 2007, at the time this Commissioner's Report was prepared, the 2006 data was still being submitted. The 2006 summary will be available in next year's report.

California Medical Professional Liability Insurance: Report Year 2005

Summary of Premiums and Expenses

All types of health care providers combined—39 insurers reporting data

	2003	2004	2005
# of Providers/ Beds Insured *	561,369	209,433	207,039
Direct Premiums Written	\$724,479,649	\$707,316,974	\$710,699,653
Direct Premiums Earned (EP)	\$710,426,151	\$707,020,320	\$703,228,230
Direct Losses Incurred (IL)	\$319,536,414	\$247,392,740	\$243,871,307
Loss Ratio [IL/EP]	44.98%	34.99%	34.68%
Defns & Cost Contnmt Exp (DCCE)	\$235,823,729	\$205,936,140	\$211,654,212
IL+DCCE Ratio [(IL+DCCE)/EP]	78.17%	64.12%	64.78%
Adjusting & Other Exp Incurred	\$52,780,016	\$53,860,326	\$74,246,128
Commsns & Brokrg Exp Inc'd	\$40,324,788	\$37,787,415	\$39,191,294
Taxes, Licenses & Fees Inc'd	\$19,825,415	\$18,912,625	\$17,698,216
Othr Acq, Fld Supvsn Exp Inc'd	\$20,954,478	\$26,183,958	\$19,784,398
General Expenses Incrd	\$56,976,863	\$44,493,879	\$55,788,213
Underwriting Expense	\$190,861,560	\$181,238,203	\$206,708,249
Combined Ratio = (Loss+Exp) / EP	105.04%	89.75%	94.17%

California Medical Professional Liability Insurance: Report Year 2005

Physicians

	2003	2004	2005
# of Insurers Reporting Data	19	25	26
# Insurers Rprtng w/ DWP > \$0	15	21	18
# of Providers/ Beds Insured *	*1 39,416	*1 40,092	*0 43,003
Direct Premiums Written	\$548,908,509	\$566,113,337	\$582,250,996
Direct Premiums Earned	\$532,699,306	\$552,585,866	\$570,019,864
Direct Losses Incurred	\$275,512,443	\$232,479,218	\$188,480,016
Loss Ratio	51.72%	42.07%	33.07%
Defns & Cost Contnmt Exp Inc'd	\$186,465,333	\$169,584,200	\$161,811,140
IL+DCCE Ratio	86.72%	72.76%	61.45%
Adjusting & Other Exp Incurred	\$41,836,210	\$44,491,828	\$51,685,955
Commsns & Brokrg Exp Inc'd	\$20,957,945	\$20,628,506	\$22,496,593
Taxes, Licenses & Fees Inc'd	\$14,223,639	\$15,250,613	\$14,236,910
Othr Acq, Fld Supvsn Exp Inc'd	\$15,297,288	\$21,137,198	\$16,660,573
General Expenses Incrd	\$42,061,391	\$40,188,531	\$43,674,289
Underwriting Expense	\$134,376,472	\$141,696,676	\$148,754,321
Combined Ratio = (Loss+Exp) / EP	111.95%	98.40%	87.55%

* Not all insurers were able to provide "# of beds / providers insured"

California Medical Professional Liability Insurance: Report Year 2005 Other Health Care Professionals

	2003	2004	2005
# of Insurers Reporting Data	19	19	17
# Insurers Rprtng w/ DWP > \$0	17	17	15
# of Providers/ Beds Insured *	*2 506,479	*1 161,059	*1 162,313
Direct Premiums Written	\$85,725,879	\$91,588,738	\$88,319,530
Direct Premiums Earned	\$81,199,389	\$89,738,293	\$88,461,492
Direct Losses Incurred	\$13,741,563	\$14,749,335	\$28,536,325
Loss Ratio	16.92%	16.44%	32.26%
Defns & Cost Contnmt Exp Inc'd	\$32,914,758	\$20,603,224	\$22,489,998
IL+DCCE Ratio	57.46%	39.40%	57.68%
Adjusting & Other Exp Incurred	\$5,809,980	\$4,549,225	\$8,601,835
Commsns & Brokrg Exp Inc'd	\$12,872,290	\$13,656,353	\$13,110,077
Taxes, Licenses & Fees Inc'd	\$3,080,591	\$2,230,417	\$2,439,593
Othr Acq, Fld Supvsn Exp Inc'd	\$1,121,488	\$1,561,038	\$1,497,970
General Expenses Incrd	\$9,817,326	\$10,049,970	\$9,232,485
Underwriting Expense	\$32,701,676	\$32,047,003	\$34,881,959
Combined Ratio = (Loss+Exp) / EP	97.73%	75.11%	97.11%

California Medical Professional Liability Insurance: Report Year 2005 Hospitals

	2003	2004	2005
# of Insurers Reporting Data	16	16	15
# Insurers Rprtng w/ DWP > \$0	8	7	9
# of Providers/ Beds Insured *	*2 655	*1 2,698	*2 340
Direct Premiums Written	\$60,318,482	\$34,347,337	\$26,938,203
Direct Premiums Earned	\$68,600,675	\$45,570,768	\$29,461,840
Direct Losses Incurred	\$33,893,998	(\$227,886)	\$25,942,870
Loss Ratio	49.41%	-0.50%	88.06%
Defns & Cost Contnmt Exp Inc'd	\$9,788,283	\$15,369,435	\$25,328,962
IL+DCCE Ratio	63.68%	33.23%	174.03%
Adjusting & Other Exp Incurred	\$3,397,311	\$3,895,660	\$13,175,313
Commsns & Brokrg Exp Inc'd	\$3,732,445	\$2,477,549	\$2,299,872
Taxes, Licenses & Fees Inc'd	\$1,406,070	\$973,740	\$714,672
Othr Acq, Fld Supvsn Exp Inc'd	\$3,449,090	\$2,183,546	\$758,775
General Expenses Incrd	\$4,120,349	(\$6,547,491)	\$1,737,746
Underwriting Expense	\$16,105,265	\$2,983,004	\$18,686,378
Combined Ratio = (Loss+Exp) / EP	87.15%	39.77%	237.45%

* Not all insurers were able to provide "# of beds / providers insured"

California Medical Professional Liability Insurance: Report Year 2005 Other Health Care Facilities

	2003	2004	2005
# of Insurers Reporting Data	13	15	16
# Insurers Rprtng w/ DWP > \$0	*4 13	*1 10	*1 8
# of Providers/ Beds Insured *	14,819	5,584	1,383
Direct Premiums Written	\$29,526,779	\$15,267,562	\$13,190,924
Direct Premiums Earned	\$27,926,781	\$19,125,393	\$15,285,034
Direct Losses Incurred	(\$3,611,590)	\$392,073	\$912,096
Loss Ratio	-12.93%	2.05%	5.97%
Defns & Cost Contnmt Exp Inc'd	\$6,655,355	\$379,281	\$2,024,111
IL+DCCE Ratio	10.90%	4.03%	19.21%
Adjusting & Other Exp Incurred	\$1,736,513	\$923,612	\$783,025
Commsns & Brokrg Exp Inc'd	\$2,762,108	\$1,025,006	\$1,284,752
Taxes, Licenses & Fees Inc'd	\$1,115,115	\$457,855	\$307,040
Othr Acq, Fld Supvsn Exp Inc'd	\$1,086,613	\$1,302,177	\$867,081
General Expenses Incrd	\$977,797	\$802,870	\$1,143,693
Underwriting Expense	\$7,678,146	\$4,511,520	\$4,385,590
Combined Ratio = (Loss+Exp) / EP	38.39%	27.62%	47.90%

* Not all insurers were able to provide "# of beds / providers insured"

The following exhibits show the total premiums and losses as reported by the insurers in their Annual Statements to the NAIC database under Line 11 – Medical Malpractice. For 2006, 97 California licensed companies had reported data under this line, although of this amount, only 38 companies

had written premium greater than \$0. Of these 38 companies, 15 had direct written premium greater than \$5,000,000. The top 10 insurers for 2006 wrote approximately 92% of all California medical malpractice business written by admitted insurers.

California Medical Malpractice Liability Insurance

(source: NAIC Database, as of 04/17/07)

# of Companies (Cos.) Reporting 2006	Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Dir Defense & Cost Cntnmy Expns Incrrd	DLI + DCC Incrrd Ratio
38 Cos. w/ DWP > \$0	\$664,637,166	\$648,877,456	\$199,268,300	30.71%	\$175,711,965	57.79%
Total Reporting: 97 Cos.	\$664,630,504	\$649,301,799	\$192,999,174	29.72%	\$176,616,688	56.93%
2005						
45 Cos. w/ DWP > \$0	\$677,741,527	\$676,935,900	\$240,827,939	35.58%	\$194,897,804	64.37%
Total Reporting: 105 Cos.	\$677,526,218	\$677,048,843	\$233,847,954	34.54%	\$209,870,866	65.54%

Top 10 Medical Professional Liability Writers in California: Year 2006

Source: NAIC Database (as of 4/18/07)

Company (Co.) Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Dir Defense & Cost Cntnmy Expns Incrrd	DLI + DCC Incrrd Ratio
1 Norcal Mutual Ins. Co.	\$187,490,871	28.21%	\$171,167,392	\$43,096,050	25.18%	\$66,545,004	64.05%
2 Doctors Co. an Interins Exchange	\$151,233,161	22.75%	\$149,783,157	\$43,279,255	28.89%	\$28,087,022	47.65%
3 SCPIE Indemnity Co.	\$98,594,980	14.83%	\$98,688,909	\$28,252,859	28.63%	\$24,048,231	53.00%
4 Medical Ins. Exchnng of CA	\$37,808,325	5.69%	\$38,202,926	\$19,156,495	50.14%	\$11,505,326	80.26%
5 American Healthcare Ind. Co.	\$31,144,824	4.69%	\$31,018,460	\$8,127,285	26.20%	\$8,040,990	52.12%
6 Medical Protective Co.	\$28,419,834	4.28%	\$28,352,139	\$14,383,812	50.73%	\$10,831,292	88.94%
7 Dentists Insurance Co.	\$25,923,558	3.90%	\$25,576,893	\$4,361,769	17.05%	\$4,731,626	35.55%
8 Professional Undrwtrs Liab. Ins. Co.	\$20,085,353	3.02%	\$23,051,463	\$2,247,313	9.75%	\$1,005,921	14.11%
9 American Insurance Co.	\$18,309,646	2.75%	\$16,840,462	\$5,120,125	30.40%	\$3,803,273	52.99%
10 American Cas Co. of Reading PA	\$13,337,091	2.01%	\$12,587,315	\$3,652,380	29.02%	\$2,220,145	46.65%
Top 10 Med Mal Writers	\$612,347,643	92.13%	\$595,269,116	\$171,677,343	28.84%	\$160,818,830	55.86%

Top 10 Medical Professional Liability Writers in California: Year 2005

Source: NAIC Database (as of 4/18/07)

Company (Co.) Name	Direct Premiums Written	Market Share	Direct Premiums Earned	Direct Losses Incurred	Loss Ratio	Dir Defense & Cost Cntnmy Expns Incrrd	DLI + DCC Incrrd Ratio
1 Norcal Mutual Ins. Co.	\$182,961,839	27.00%	\$177,364,883	\$56,965,354	32.12%	\$60,861,142	66.43%
2 Doctors Co., an Interins Exchnng	\$153,785,194	22.69%	\$151,626,079	\$62,938,038	41.51%	\$37,898,642	66.50%
3 SCPIE Indemnity Co.	\$106,511,989	15.72%	\$107,032,692	\$29,095,077	27.18%	\$26,583,315	52.02%
4 Medical Ins. Exchnng of CA	\$37,248,339	5.50%	\$36,289,747	\$14,934,059	41.15%	\$12,888,334	76.67%
5 Professional Undrwtrs Liab Ins. Co.	\$31,702,898	4.68%	\$33,673,419	\$2,220,123	6.59%	\$3,037,980	15.61%
6 American Healthcare Ind. Co.	\$31,132,772	4.59%	\$29,497,364	\$9,128,378	30.95%	\$9,811,695	64.21%
7 Medical Protective Co.	\$28,882,647	4.26%	\$28,572,079	\$15,817,512	55.36%	\$13,340,529	102.05%
8 Dentists Insurance Co.	\$25,227,394	3.72%	\$24,843,988	(\$1,586,587)	-6.39%	\$8,103,017	26.23%
9 American Insurance Co.	\$15,965,890	2.36%	\$15,801,917	\$7,199,801	45.56%	\$2,228,431	59.67%
10 American Cas Co. of Reading PA	\$11,830,223	1.75%	\$11,482,642	\$5,487,601	47.79%	\$2,048,543	65.63%
Top 10 Med Mal Writers	\$625,249,185	92.25%	\$616,184,810	\$202,199,356	32.81%	\$176,801,628	61.51%

Distribution by Size of Payment for Claims Closed During 2005 All Health Care Providers Combined

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims in Interval	Total DCCE Paid for Claims in Interval
\$0 (1)	5,877	\$0	\$101,833,932
\$0 (1)	3,828	\$0	\$0
\$1–9,999	418	\$1,628,995	\$3,495,292
\$10,000–49,999	603	\$14,914,525	\$18,621,931
\$50,000–99,999	257	\$14,360,900	\$10,513,994
\$100,000–249,999	290	\$40,762,575	\$15,450,940
\$250,000–499,999	151	\$50,053,492	\$12,111,280
\$500,000–749,999	26	\$14,624,404	\$2,506,191
\$750,000–999,999	33	\$28,416,890	\$3,455,491
\$1,000,000 and over	50	\$55,744,039	\$7,559,344
Total	11,533	\$220,505,818	\$175,548,394

Distribution by Size of Payment for Claims Closed During 2005 Physicians

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims in Interval	Total DCCE Paid for Claims in Interval
\$0 (1)	4,953	\$0	\$89,577,803
\$0 (1)	2,601	\$0	\$0
\$1–9,999	103	\$499,900	\$1,669,381
\$10,000–49,999	383	\$9,134,894	\$13,174,387
\$50,000–99,999	140	\$8,173,729	\$7,100,663
\$100,000–249,999	208	\$30,352,711	\$11,512,398
\$250,000–499,999	121	\$40,750,038	\$9,511,785
\$500,000–749,999	22	\$12,283,676	\$2,321,530
\$750,000–999,999	26	\$21,902,451	\$2,476,235
\$1,000,000 and over	46	\$51,684,287	\$6,918,094
Total	8,603	\$174,781,685	\$144,262,276

1 The claims closed during 2005, without indemnity payment, should be broken down in two categories: "Claims with Defense & Cost Containment Expenses Paid" and "Claims without Defense and Cost Containment Expenses Paid."

Distribution by Size of Payment for Claims Closed During 2005 Other Health Care Professionals

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims in Interval	Total DCCE Paid for Claims in Interval
\$0 (1)	676	\$0	\$7,919,472
\$0 (1)	410	\$0	\$0
\$1–9,999	192	\$943,723	\$1,657,601
\$10,000–49,999	157	\$4,273,907	\$3,000,078
\$50,000–99,999	94	\$4,596,770	\$2,598,296
\$100,000–249,999	51	\$5,822,839	\$2,099,540
\$250,000–499,999	13	\$3,310,482	\$659,595
\$500,000–749,999	0	\$0	\$0
\$750,000–999,999	4	\$3,725,000	\$313,701
\$1,000,000 and over	2	\$2,059,752	\$550,828
Total	1,599	\$24,732,473	\$18,799,111

Distribution by Size of Payment for Claims Closed During 2005 Hospitals

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims in Interval	Total DCCE Paid for Claims in Interval
\$0 (1)	136	\$0	\$2,796,333
\$0 (1)	735	\$0	\$0
\$1–9,999	114	\$168,494	\$96,934
\$10,000–49,999	38	\$884,004	\$1,711,761
\$50,000–99,999	8	\$565,101	\$401,810
\$100,000–249,999	19	\$2,694,991	\$1,253,241
\$250,000–499,999	8	\$3,046,693	\$1,446,610
\$500,000–749,999	4	\$2,340,728	\$184,661
\$750,000–999,999	2	\$1,789,478	\$23,639
\$1,000,000 and over	0	\$0	\$0
Total	1,064	\$11,489,489	\$7,914,989

* The claims closed in 2005, without indemnity payment, should be broken down in two categories: "Claims with Defense & Cost Containment Expenses Paid" and "Claims without Defense & Cost Containment Expenses Paid."

Distribution by Size of Payment for Claims Closed During 2005 Other Health Care Facilities

Claim Payment Size Interval	Number of Claims	Total Amount Paid for Claims in Interval	Total DCCE Paid for Claims in Interval
\$0 (1)	112	\$0	\$1,540,324
\$0 (1)	82	\$0	\$0
\$1–9,999	9	\$16,878	\$71,376
\$10,000–49,999	25	\$621,720	\$735,705
\$50,000–99,999	15	\$1,025,300	\$413,225
\$100,000–249,999	12	\$1,892,034	\$585,760
\$250,000–499,999	9	\$2,946,279	\$493,290
\$500,000–749,999	0	\$0	\$0
\$750,000–999,999	1	\$999,961	\$641,916
\$1,000,000 and over	2	\$2,000,000	\$90,422
Total	267	\$9,502,172	\$4,572,018

2005 Claims Data: All Health Care Providers Combined

Claims Closed With Payment to the Claimant During 2005

Occurrence Year	# of Claims	Total Monetary Amount Paid	Average Claim Payment	Defense & Cost Contnmt Expns Paid	Loss + Defns & Cost Contnmt Expns Paid	Average Loss + DCCE Paid
Pre 1997	36	\$8,889,720	\$246,937	\$2,526,126	\$11,415,846	\$317,107
1997	25	\$2,608,731	\$104,349	\$1,817,527	\$4,426,259	\$177,050
1998	30	\$5,784,754	\$192,825	\$2,275,053	\$8,059,807	\$268,660
1999	45	\$8,985,063	\$199,668	\$3,817,045	\$12,802,108	\$284,491
2000	86	\$17,168,635	\$199,635	\$6,981,083	\$24,149,718	\$280,811
2001	216	\$36,144,118	\$167,334	\$14,273,130	\$50,417,247	\$233,413
2002	460	\$62,566,523	\$136,014	\$24,249,892	\$86,816,415	\$188,731
2003	516	\$62,174,342	\$120,493	\$15,838,215	\$78,012,556	\$151,187
2004	285	\$14,732,774	\$51,694	\$1,632,351	\$16,365,125	\$57,421
2005	146	\$1,451,162	\$9,939	\$274,601	\$1,725,763	\$11,820
Total	1,845	\$220,505,822	\$119,515	\$73,685,024	\$294,190,846	\$159,453

2005 Claims Data: All Health Care Providers Combined

Claims Closed Without Payment
to Claimant During 2005

Occurrence Year	# of Claims	Defns & Cost Containment Expns Paid	Average DCCE Paid
Pre 1997	271	\$2,496,598	\$9,213
1997	150	\$1,153,049	\$7,687
1998	139	\$2,717,420	\$19,550
1999	211	\$4,763,909	\$22,578
2000	417	\$11,264,991	\$27,014
2001	799	\$20,185,118	\$25,263
2002	1,629	\$28,865,048	\$17,719
2003	2,924	\$23,896,507	\$8,173
2004	2,686	\$5,012,028	\$1,866
2005	463	\$1,508,644	\$3,258
Total	9,689	\$101,863,311	\$10,513

All Claims
Combined

Occmc Year	Avg Claim Payment for All Claims
Pre 1997	\$45,317
1997	\$31,882
1998	\$63,771
1999	\$68,617
2000	\$70,407
2001	\$69,559
2002	\$55,376
2003	\$29,625
2004	\$7,195
2005	\$5,311
Total	\$34,338

Lawsuits

Info. "not available" from 1 insurer

Occmc Year	# Laysuits Filed Agnst Insurer's Insureds	# of Doctors Included Therein
Pre 1997	80	77
1997	29	30
1998	28	33
1999	58	55
2000	105	98
2001	177	206
2002	354	421
2003	883	1,092
2004	1,098	1,358
2005	210	218
Total	3,022	3,588

Claims Reported for First Time &
Claims Reopened In 2005

Occmc Year	# 1st Time Claims Reported	# Claims Re-Open
Pre 1997	87	11
1997	61	7
1998	33	3
1999	81	14
2000	140	37
2001	269	73
2002	576	104
2003	1,402	148
2004	3,705	151
2005	2,102	24
Total	8,456	572

2005 Claims Data: All Health Care Providers Combined

Claims Outstanding as of
12/31/2005

Occurrence Year	# of Claims Outstanding	Direct Amount Resrvd for Loss on Reprtd Clms (Cases)	Dir Amt Resrvd for DCCE on Reprtd Clms (Cases)	Amount of IBNR Reserve for Loss & DCCE*
Pre 1997	663	\$18,605,549	\$27,845,938	\$9,513,912
1997	291	\$7,622,463	\$3,487,377	\$4,341,757
1998	158	\$12,356,593	\$2,228,817	\$8,996,086
1999	226	\$15,487,380	\$4,165,932	\$14,614,823
2000	382	\$33,194,758	\$5,172,030	\$26,838,721
2001	630	\$36,478,778	\$7,144,491	\$29,383,174
2002	1,088	\$61,663,924	\$11,541,559	\$69,792,968
2003	2,308	\$119,457,837	\$24,545,384	\$143,037,148
2004	3,732	\$109,103,790	\$25,737,391	\$203,821,565
2005	2,333	\$31,842,478	\$9,583,055	\$161,942,561
Total	11,811	\$445,813,549	\$121,451,973	\$672,282,717

Monetary Amount Paid
on Claims During 2005

Occrnc Year	Monetary Amount Paid on Claims	Defense & Cost Contnmt Paid
Pre 1997	\$7,509,676	\$3,732,270
1997	\$1,700,509	\$2,233,276
1998	\$5,183,387	\$2,510,499
1999	\$6,287,234	\$5,950,915
2000	\$12,156,946	\$10,386,302
2001	\$25,083,025	\$22,050,202
2002	\$76,719,170	\$45,560,238
2003	\$78,541,780	\$63,255,059
2004	\$13,387,934	\$24,284,915
2005	\$1,143,686	\$15,415,765
Total	\$227,713,347	\$195,379,441

* Include Bulk Reserve for Adverse Development on Case Reserves

2005 Claims Data: By Type of Health Care Provider

Claims Closed With Payment to the Claimant During 2005

All Years Combined	# of Claims	Total Monetary Amount Paid	Average Claim Payment	Defense & Cost Contnmt Expns Paid	Loss + Defns & Cost Contnmt Expns Paid	Average Loss + DCCE Paid
Physicians	1,054	\$174,781,686	\$165,827	\$54,858,031	\$229,639,717	\$217,874
Other Prof	525	\$24,732,475	\$47,109	\$10,676,644	\$35,409,119	\$67,446
Hospitals	193	\$11,489,489	\$59,531	\$5,118,655	\$16,608,144	\$86,053
Other Fac	73	\$9,502,172	\$130,167	\$3,031,694	\$12,533,866	\$171,697
Combined	1,845	\$220,505,822	\$119,515	\$73,685,024	\$294,190,846	\$159,453

Claims Closed Without Payment to Claimant During 2005

All Years Combined	# of Claims	Defns & Cost Containment Expns Paid	Average DCCE Paid
Physicians	7,549	\$89,404,186	\$11,843
Other Prof	1,075	\$8,122,466	\$7,556
Hospitals	871	\$2,796,335	\$3,210
Other Fac	194	\$1,540,324	\$7,940
Combined	9,689	\$101,863,311	\$10,513

All Claims Combined

All Years Combined	Avg Claim Payment for All Claims
Physicians	\$37,085
Other Prof	\$27,207
Hospitals	\$18,237
Other Fac	\$52,712
Combined	\$34,338

Lawsuits

Info. "not available" from 1 insurer

All Years Combined	# Lawsuits Filed Agnst Insurer's Insureds	# of Doctors Included Therein
Physicians	2,485	3,144
Other Prof	388	325
Hospitals	95	74
Other Fac	54	45
Combined	3,022	3,588

Claims Reported for First Time & Claims Reopened In 2005

All Years Combined	# 1st Time Claims Reported	# Claims Re-Open
Physicians	6,377	396
Other Prof	1,594	124
Hospitals	371	30
Other Fac	114	22
Combined	8,456	572

2005 Claims Data: By Type of Health Care Provider

Claims Outstanding as of 12/31/2005

All Years Combined	# of Claims Outstanding	Direct Amount Resrvd for Loss on Reprtd Clms (Cases)	Dir Amt Resrvd for DCCE on Reprtd Clms (Cases)	Amount of IBNR Reserve for Loss & DCCE*
Physicians	9,551	\$371,925,770	\$89,395,392	\$573,882,183
Other Prof	1,335	\$32,768,138	\$6,401,878	\$50,528,534
Hospitals	783	\$30,583,508	\$23,410,958	\$30,413,188
Other Fac	142	\$10,536,132	\$2,243,746	\$17,458,812
Combined	11,811	\$445,813,549	\$121,451,973	\$672,282,717

Monetary Amount Paid on Claims During 2005

Occrnc Year	Monetary Amount Paid on Claims	Defense & Cost Contnmt Paid
Physicians	\$187,263,540	\$143,408,368
Other Prof	\$21,106,028	\$24,148,769
Hospitals	\$11,518,974	\$22,962,081
Other Fac	\$7,824,805	\$4,860,223
Combined	\$227,713,347	\$195,379,441

Notes:

1. Defense and Cost Containment Expenses (DCCE) were formerly known as Allocated Loss Adjustment Expenses (ALAE).
2. Adjusting and Other Expenses (AOE) were formerly known as Unallocated Loss Adjustment Expenses (ULAE).
3. LAE = DCCE + AOE (formerly LAE = ALAE + ULAE).

* Include Bulk Reserve for Adverse Development on Case Reserves

STATISTICAL ANALYSIS DIVISION

The Statistical Analysis Division (SAD) is based in Los Angeles and is responsible for responding to all data collection & reporting requirements set forth in the California Insurance Code and the California Code of Regulations. The data, analysis and reports developed by SAD help the Insurance Commissioner and the Department support a healthy insurance marketplace and provide California's consumers with information to help them make important insurance decisions.

The SAD maintains databases on a variety of insurance lines. On an annual basis, SAD

conducts in-depth analysis on thousands of data elements submitted by the insurance industry and other sources. SAD evaluates, compares and interprets massive raw data and statistics in order to maintain annual and semi-annual reports based on that data. In addition, SAD analyzes and develops legislation related to the collection of data by the Department

SAD has provided data and related research assistance to virtually every unit in the California Department of Insurance - Actuarial Division, Consumer Services, Financial Analysis, Fraud, Legal, Licensing, Press Office and Rate Regulation.

In addition to CDI internal units, SAD's data and reports are used by the public, consumer groups, industry, the Legislature, the media, university students, teachers, and the Department's management team and employees.

1) During 2006, The SAD Performed Extensive Analysis of:

- † Private Passenger Automobile Liability and Physical Damage Experience by Zip Code, as required by California Insurance Code Section 11628(a).
- † Annual Private Passenger Automobile and Homeowners Premium Comparison surveys in accordance with California Insurance Code Section 12959.
- † Annual Consumer Complaint Ratio Study, in accordance with California Insurance Code Section 12921.1.
- † Insurance policies for the Slavery Era Insurance Policy Registry, as required by California Insurance Codes sections 13810-13813.
- † Annual Long Term Care Insurance Consumer Rate & History Guide, as required by California Insurance Code Section 10234.6.
- † Annual Long Term Care Insurance Experience Survey, in accordance with California Insurance Code Sections 10232.3 (h), 10234.86, 10234.95 (l), 10235.9.
- † Medicare Supplement Insurance Consumer Rate Guide, in accordance with California Insurance Code Section 10192.20.
- † Commissioner's Report of Underserved Communities, in accordance with California Code of Regulations 2646.6.
- † Automobile Body Repair Inspection Data Call, as required by California Insurance Code Sections 1874.85 & 1874.86.
- † Accident & Health Covered Lives Data Call, conducted under the Insurance Commissioner's general examination authority.
- † California Seismic Assessment Project, as required by California Insurance Code 12975.9.
- † Long Term Care Facilities Data Call, as required by California Insurance Code Section 674.9 (b).
- † Health Assessment Table & Report Development, in accordance with California Insurance Code Section 1872.85.
- † Health Assessment Table & Report Development, in accordance with CCR 2218.62 (AB1996).
- † Long Term Care Insurance Agents Data Call (Semi-annual), as required by California Insurance Code Section 10234.93(a)(3).
- † Developed a list of insurance companies currently offering health insurance coverage in accordance with California Insurance Code Section 10133.66.
- † Personal Property Coverage and Limits in accordance California Insurance Code 1857, 1857.4, 12926, 16014(b) and 16016.

The SAD conducted several management-requested data collections during the year which supported long-term insurance data trend analysis. In addition, SAD provided Private Passenger Automobile and Personal Property information to the National Association of Insurance Commissioners (NAIC) for their annual report.

2) Special Projects Requested By Executive Staff/Commissioner:

In addition to annual data calls, the SAD also conducts research and data collection for special projects. These special projects are a result of "hot topic" policy issues that the CDI executive staff faces throughout the year.

- † *California Uninsured Motorist Rate Report & Website*—At the request of CDI Executive Staff. Calculated uninsured motorist rate by county and developed consumer website to distribute data & information.
- † *Disability Income Insurance Policy Provisions*—At the request of CDI Executive Staff and Legal Division. Collected information on Disability Income Insurance Policy forms, riders and endorsements to determine if certain policy provisions are legal and appropriate for sale in California.
- † *Automobile Rating Factor and Low Cost Automobile*—Provided the Commissioner with reports showing rate comparison data for selected counties and their variance between ZIP codes with the county.
- † *Long-Term Care Closed Blocks of Business Analysis*—At the request of CDI Executive Staff and Legal Division. SAD collected data and conducted analysis & reports on all closed blocks of business in Long-Term Care Insurance by company and policy form.

3) Research Consultation/Database Development:

At various times throughout the year, the SAD provides technical assistance in developing databases or assistance in conducting analyses of data for CDI internal branches as well as other state agencies. The following is a list of the SAD's research consultation/database development activities during 2006:

- † *1998–2005 Long Term Care Insurance Experience data*—Responded to a request for data from the California Dept of Health Services (Partnership for LTC Division).
- † *Automobile Rating Factors*—Continued to provide data from our private passenger automobile liability data base to CDI Policy Research

Division, working with outside consultants to conduct a study for the development of new automobile rating factors to comply with Prop 103.

- † *Low Cost Auto*—Continued to provide data from our private passenger automobile liability database to CDI Rate Regulation Actuaries for research and development of rates for the California Low Cost Auto Program in newly approved counties.
- † *Fraud Vehicle Assessment*—Provide CDI Accounting staff with private passenger automobile exposure database for audit purposes in regards to the Fraud Vehicle Assessment payments from insurers (California Insurance Code 1872.8).
- † *Claims Frequency*—Provided CDI Fraud Unit with private passenger automobile claims frequency database by county to assist with determining funding to county District Attorneys (California Insurance Code 1874.8)
- † *Project & Special Event Tracking System for Consumer Education & Outreach Bureau (CEOB)*—Developed a database to help track special events and staff resource usage for CEOB's annual workload.

4) Request for Data/Consumer Inquiries Received From CDI Consumer Hotline:

At various times throughout the year, the SAD is requested to provide data by the public and handles inquiries received by the CDI's Consumer Hotline. With respect to data requests, the SAD fields requests for data from a wide spectrum of the public – from individual consumers, to other state and federal agencies, to university students and professors.

LEGISLATIVE DIVISION

The California Department of Insurance is increasing its efforts to fight fraud in all parts of the insurance industry. AB 1401 (*Aghazarian*) is

CDI's highest priority this year. The bill would nearly triple what insurers pay to fund CDI's general fraud operations. This will allow CDI's Fraud Division to fill vacant positions, and investigate and prosecute an even greater array of fraudulent activities that raise insurance costs for all Californians.

AB 1271 (Carter) is part of CDI's larger project to provide greater consumer protections for seniors, who are often the target of unscrupulous schemes. Many modern insurance products, including annuities, are extremely complicated financial instruments, and CDI has found cases where seniors were targeted for abuse. When seniors replace one annuity with another, agents are required to assure that the new product will provide the senior with a financial benefit. However, this is not always done. This bill would help agents fulfill the existing law by requiring a comparison of key elements of the old and new annuities, in order to assure that the new one meets the current legal requirement.

Commissioner Poizner is committed to making the office of Insurance Commissioner a model of government accountability. One of the most prominent problems that has arisen with electing commissioners in California is the partisan pressure that candidates and elected Insurance Commissioners may feel. The Commissioner's focus should be on consumers and the insurance industry, not partisan politics. *AB 1653 (Horton)* would have made the Commissioner a non-partisan office, along with judges and the state Superintendent of Public Instruction. However, that bill did not make it out of committee—and the vote was along partisan lines.

In addition, CDI is pursuing a number of other bills to clean up some problems related to agents, and to make CDI operations more effective and efficient. These include *AB 1639* and *SB 1038*.

Full summaries of CDI sponsored bills, as of 5/14/07

Assembly Bill 1401 (Aghazarian)—Fight Against Insurance Fraud and Abuse

Location: Assembly Appropriations Committee

This bill would allow the Insurance Commissioner to collect revenue that would match the annual appropriations currently authorized by the Legislature in the Budget Act, in an effort to fight insurance fraud. Currently, the California Department of Insurance (CDI) funds the Fraud Division through various assessments. However, the revenue generated from the existing rate is insufficient to fully fund the state automobile and health/disability fraud prevention programs. As a result, the Department is unable to fill all authorized positions or fully fund base operation costs.

This bill would increase the Fraud General assessment from \$1,300 to \$5,100 per insurer. That incremental change would increase the annual revenue collected by an amount that would fully fund the operation costs for CDI's Fraud Division. The bill also includes an accountability provision that would require the Fraud Division to post on the Department's Web site investigative program performance outcomes. CDI's Fraud Division is one of our most hard-working and success-oriented units, and this is a way for us to make sure the public knows how well we are doing in our fight against insurance fraud.

As the regulator of a \$115 billion a year insurance industry, the Insurance Commissioner has made it a top priority to fight against fraud in this state—a toll of approximately \$15 billion a year. The cost of fraud shows up in higher premiums for homeowners, automobile and health insurance, and is also reflected in the prices charged by businesses for their products. In California, we must protect

consumers who ultimately pick up the tab for insurance crimes.

Assembly Bill 1271 (Carter)—Replacement Life Insurance and Annuity Products

Location: Assembly Insurance Committee (interim hearing) (2-Year Bill)

This measure assures that consumers who are replacing a life insurance or annuity policy receive the most complete information upon which to make a decision in his or her own best interest, as well as reduces the opportunity for misrepresentation and incomplete disclosures about the replacement policy provisions.

Assembly Bill 1639 (Duvall)—Insurance Licensing Issues

Location: Assembly Appropriations Committee

Assembly Bill 1639 remedies three important insurance broker-agent issues – (1) streamlines the name approval guidelines for insurance adjusters to be the same as the naming guidelines set forth for other insurance producer applicants and licensees; (2) requires California residents who are selling surplus line/special lines’ surplus line insurance to be individually licensed by the Department of Insurance, instead of being licensed under, or on behalf of, a business entity. Surplus line producers are currently having difficulty obtaining licensure in other states because they do not have their individual license in California. Further, this bill reduces the licensing fees for such applicants; and (3) prohibits a licensed insurance agent, who is also licensed to teach self-study (non-contact or correspondence) continuing education courses, from applying credits obtained through their own self-study course toward their personal continuing education requirement for continued licensure.

Assembly Bill 1653 (Horton)—Non-Partisan Office of the Insurance Commissioner

Location: Assembly Elections and Redistricting Committee (2-Year Bill)

Assembly Bill 1653 would make the office of Insurance Commissioner non-partisan. This bill would ensure that the responsibilities of the Insurance Commissioner in the regulation of the \$115 billion insurance industry remain separate from partisan politics. This was an important issue in my campaign for California Insurance Commissioner and it received strong support from voters and newspapers across the state. As a chief watchdog for all consumers in California, the Insurance Commissioner should never make decisions based on partisan considerations. This measure would help protect against politicizing the office.

Senate Bill 1038 (Senate Banking, Finance and Insurance Committee)

Location: Senate Floor

This is the CDI’s annual “technical cleanup bill”, which makes corrections to references in the Insurance Code, and streamlines the deadline for district attorneys to submit their applications to participate in the Automobile Insurance Fraud Program.

POLICY INITIATIVES OFFICE

The Policy Initiatives Office (“PIO”) supports the Commissioner’s Executive Team by researching and analyzing emerging and existing insurance issues which impact policy. The PIO implements the Commissioner’s policy initiatives by coordinating department-wide task forces and working groups. In addition to facilitating the daily efforts to advance the Commissioner’s policy initiatives, the PIO in 2006:

- 1 Coordinated the Department's work and communication with the National Association of Insurance Commissioners;
- 2 Acted as the liaison between the Policy and Planning Branch and Department's Budget Office;
- 3 Made sure the Department's chartered legislation was implemented by monitoring the completion of workplans;
- 4 Provided the foundation research and analysis to assist the Department formulate positions on: i) regulations to increase the health insurer minimum medical loss ratio from 50% to 70%, ii) insurer deliverables remaining from the mega-mergers between Anthem-WellPoint and UnitedHealth-PacifiCare, and iii) regulation of companies selling Medicare Part D plans.
- 5 Coordinated the Department's Seniors' Task Force;
- 6 Developed and maintained the health and seniors issues webpages on the Department's public website;
- 7 Coordinated the publishing of the *Priced Out* and *A Suitable Match: Best Practices for Annuity Sales* reports.

In July 2006, approximately half a million dollars was distributed in the form of grants to four District Attorneys offices. The Department will make additional grants in July 2007.

LIFE AND ANNUITY CONSUMER PROTECTION FUND PROGRAM

CIC §10127.17 established the Life and Annuity Consumer Protection Fund (LACPF) program. Pursuant to this program insurers pay a small fee per life/annuity policy. This money funds grants to District Attorneys offices throughout the state as well as the Department's own investigations and education and outreach efforts. The LACPF is exclusively dedicated to protecting consumers of life insurance and annuity products in California.



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GOVERNMENT LAW BUREAU

The Government Law Bureau in the Legal Branch is responsible for legal support to the Legislative Office, is the Custodian of Records for the Department and is responsible for the Department's rulemaking program. Data regarding legislative accomplishments is provided by the Legislative Office elsewhere in this report.

Rulemaking Projects in 2006

The GLB oversees the scores of regulation projects that are ongoing or prospective in the Department at any given time. Currently, the Department is in the process of promulgating over fifteen (15) separate sets of regulations; additionally, over twenty (20) prospective rulemaking projects are in the evaluation and planning stages. The GLB tracks the progress of each project, from inception

through filing with the Secretary of State of permanent regulations for publication in the California Code of Regulations (CCR).

FRAUD LIAISON BUREAU

The Fraud Liaison Bureau (FLB) provides legal support to the Department's Fraud Division (FD), a division of the Enforcement Branch. The FD maintains ten (10) regional offices throughout the state. It has 236 sworn officers and 46 support personnel. Legal support is provided in the areas of Division management and oversight of regional offices pertaining to the operation of the FD's various anti-fraud programs to suppress the overall incidence of insurance fraud within the state. This includes legislative support, the promulgation of regulations, and legal advice arising from the implementation of program objectives and services.

Rulemaking Projects

1 Completed Rulemaking Projects	37
a) Permanent Regulations	32
b) Emergency Regulations	5
2 Current Rulemaking Projects as of December 31, 2004	19
a) Permanent Regulations	17
b) Emergency Regulations	2
3 Prospective Rulemaking Projects as of December 31, 2004	21

Custodian of Records	Opened	Closed
Public Records Act Requests	785	706
Subpoenas	260	292
Services of Process	43	47
Litigation Matters		
Appeals/Writ	7	2
Defense/Other (SOC)	19	34
Qui Tam	19	5

Legal Support to Fraud Division Executive and Regional Offices:

Legal support is provided to the Deputy Commissioner in charge of the Fraud Division. Legal participates in weekly senior management conferences on a variety of matters related to the operation of the anti-fraud programs maintained and enforced throughout the state. Support includes the drafting of pending legislation, the promulgation of proposed regulations, the pleading of administrative enforcement actions, and general day to day legal issues that arise in operational matters.

Attorney of the Week: Staff attorneys handle all informal requests for routine legal assistance arising out of the division's executive branch, or regional offices.

Legal Support to Fraud Division Programs:

1 **Workers' Compensation Insurance Fraud Program.** FD receives mandated funding through the Fraud Assessment Commission (FAC). The FAC is a legislatively created state body involved in assessing and administering a special fund dedicated to the investigation and prosecution of California workers' compensation fraud (WCF). The FAC, along with the Insurance Commissioner and another, independent state body, the FAC Review Panel, are responsible for managing the WCF program, including productivity supervision, promulgation of regulations, testifying before legislative oversight committees and related matters.

Funding (approximately \$40 million during fiscal year 2006/07) is split between the FD and District Attorneys: FD approximately \$18 million; DAs approximately \$22.5 million. Thirty-nine counties within the state participated in this program. Funding requires a consensus amongst the FAC Review Panel,

the body that reviews applications and audits, and the FAC, that needs to lend its advice and consent to the final funding recommendations, and the Insurance Commissioner, authorized to independently recommend funding distribution levels. Annual audits of the services rendered by each D.A. office are conducted by FD, with legal support.

The FLB has assigned one full time staff counsel to act as counsel to perform the functions of a general counsel to the program area, including review of numerous documents, legal advice on a variety of issues, audit support, and the promulgation of regulations to support the program. Combined FAC, FAC Review Panel, and FD all day conferences are held throughout the year.

- 2 **Automobile Insurance Fraud Section 1872.8 CIC-**The FD coordinates automobile insurance fraud investigations statewide, provides assistance to law enforcement agencies, and presents prosecutable automobile fraud cases to district attorney's offices and the United States Attorneys office. Fraudulent activity includes medical mills, organized crime staged accident rings, paper accidents, and organized cart theft conspiracies, as some of the enforcement targets pursued.
- 3 **Organized Automobile Insurance Fraud Activity Interdiction Program-** Legislative findings confirm that organized automobile fraud activity operating in major urban centers of the state represents a significant portion of all individual fraud-related automobile insurance cases. Task forces have been established throughout the state comprised of FD personnel, CHP, district attorneys offices and allied agencies.
- 4 **Underground Economy Task Force-**The Task Force has the general purpose of coordinating

enforcement activities and sharing information for combating tax evasion problems and the failure to pay wages that are legally due. It is comprised of representatives from the Employment Development Department, Department of Consumer Affairs, DIR, and Office of Criminal Justice Planning, and other prospective agencies.

- 5 Property/Casualty/Life Program-This program includes all criminal cases of fraudulent claims arising from all lines of insurance other than auto and workers' compensation. The programs criminal cases are presented to both state and federal prosecutors. This includes the Disability Insurance Fraud Assessment Program covering Life and Disability Health Insurance.

Legal Services for Program Funding and Support: Legal support and funding for all the above programs arise out of assessments upon various lines of insurance policies sold within the state by the insurance industry. The assessment process upon the insurance industry requires the promulgation and implementation of various sets of regulations through the Office of Administrative Law (OAL). FLB attorneys are assigned full time with the responsibility of reviewing, consulting, and drafting the regulations in conjunction with the programs as requested that pertain to the funding of this program, or legal support to the program such as opinions, statutory review, and responses to outside counsel. They also provide general legal advice, attend public hearings, review pending legislation, and provide audit support.

- 6 Special Investigation Unit Program: The insurance code requires that all insurers doing business within the state maintain "special investigative units" within the insurance company to detect and report suspected fraudulent claims and activity within all lines of

insurance written by the company to the Fraud Division. The insurance company's maintenance of such a unit is governed by regulations, which are periodically updated. An FLB attorney is assigned to review, consult, and draft the proposed regulations working with program personnel, attend public hearings, and process the projects up to the OAL for review and approval. They also provide legal opinions, and bring administrative compliance actions before the Office of Administrative Hearings (OAH) when requested by the program.

- 7 Internal Affairs: The FLB provides legal advice & support to the FD Internal Affairs Unit which conducts confidential investigations of department employees allegedly engaged in some form of impermissible conduct during the course of their employment, or outside their employment which violates department policies, etc.

Legal Services: Qui Tam matters, Civil litigation, Legal Services Requests, Subpoenas:

- 1 Number of Qui Tam (whistleblower civil litigation lawsuits) matters
 - a) Pending on 01/0640
 - b) Opened in 200619
 - c) Intervened in 2006: 0
 - d) Closed in 200613
- 2 Civil Litigation other than qui tam matters in 2006
 - a) Pending on 01/6 5
 - b) Opened in 2006 2
 - c) Closed in 2006 2
- 2 Number of Legal Service Requests during 2006
 - a) Pending (as of 01/01/06) 3
 - b) Opened 34

c) Closed.....	28
d) Pending (as of 12/31/06)	9
3 Informal Requests for Legal Services during 2006	
a) Pending (as of 01/01/06)	0
b) Opened	27
c) Closed.....	20
4 Subpoenas	
a) Opened	33
b) Closed	33

Fraud Liaison Bureau Rulemaking Projects in 2006:

1 Completed Rulemaking	
Projects Year 2006	4
a) Permanent Regulations	3
b) Emergency Regulations.....	1
2 Current Rulemaking Projects as of Dec. 31, 2006.....	2
a) Permanent Regulations	2
b) Emergency.....	0

Legislative Analysis and Review:

Number of bills requiring legal support in the promulgation of legislative bills, attendance at hearings, redrafting of proposed language, etc.:	5
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ENFORCEMENT BUREAU – SACRAMENTO

New cases received	1,050
Closed/disposed	854
Consent	234
Cease and Desist	7
Order for Monetary Penalty and or/eimbursement.....	7
Order of Immediate Suspension.....	1

Order Removing Restrictions	61
Miscellaneous Orders	29
Order of Dismissal/Application Withdrawn.....	1
Order for Monetary Penalty in Lieu of Suspension.....	1
Order of Denial.....	52
Order of Denial/Issuance of Restricted License.....	52
Order of Revocation.....	12
Order of Revocation/Issuance of Restricted License.....	8
Order of Dismissal/Surrender of License	0
Order of Dismissal	3
Default	36
Order of Revocation	21
Order of Denial.....	15
Hearing	74
Order of Approval/Issuance	7
Miscellaneous.....	0
Order of Denial.....	38
Order of Denial/Issuance of Restricted License.....	15
Order of Revocation	10
Order of Revocation/Issuance of Restricted License.....	4
Order of Dismissal	0
Informal Action	86
Warning	7
Voluntary Withdrawal of Application	0
Voluntary Surrender of License	1
No Disciplinary Action Warranted/ Out of License.....	3

No Disciplinary Action Warranted	15
No AR Action/Referred to Discip.	56

Summary 300

Order of Summary Denial.	140
Order of Summary Denial/ Issuance of Restricted License.	83
Order of Summary Revocation.	68
Order of Summary Revocation/ Issuance of Restricted License.	9

Legal Opinion

Closed cases	16
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ENFORCEMENT BUREAU—SAN FRANCISCO

During the year, 220 cases were received and action was completed on 228 cases.

Order of Revocation	32
Order of Revocation/Issuance of Restricted License.	15
Order of Denial.	10
Order of Denial/Issuance of Restricted License.	9
Order of immediate Suspension	0
Order of Suspension.	0
Order for Monetary Penalty &/ or Reimbursement.	0
Order of Monetary Penalty in Lieu of Suspension	2
Order of Dismissal	1
Order of Dismissal/Application Withdrawn.	0
Order removing Restrictions.	0
Miscellaneous Orders	1
License Suspension.	2
No Disciplinary Action Warranted	10

No Disciplinary Action Warranted/ Out of License.	0
Voluntary Withdrawal of Application	0

Rejected

Order of Summary Revocation.	8
Order of Approval/Issuance	0
Order to Cease & Desist	2
Order of Stipulation/Issue Restricted License	0
Order of License Surrender for Cancellation	1
Order Adopting Stipulation and Settlement Agreement	1

Enforcement Actions:

Unfair Practices Act Violations:	0
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Title Insurance Violations:

Commonwealth Land Title Insurance Company	\$1,725,000
Lawyers Title Insurance Corporation Transnation Title Insurance Company	

Noncompliance:

Universal Underwriters Insurance Company	\$200,000
Mercury Insurance Group	\$300,000

Cease and Desist Orders:

Homeward Bound Services, Inc. Homeward Bound Services of North America, Inc. T.L.C. Services, Inc. Sinclair Insurance Company LTD N.M. SIM Management LTD Prompt Insurance Agency, LLC. Brendon Christopher Knight	
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AUTO ENFORCEMENT BUREAU

The Auto Enforcement Bureau (AEB) litigates enforcement actions against insurance companies and Broker-Agents (producers). As an Enforcement bureau, AEB protects policyholders, prospective policyholders, consumers, and the California insurance marketplace by ensuring that insurance producers and insurers comply with the Insurance Code and other laws and regulations that apply to the business of insurance.

In addition to automobile issues, AEB also handles all aspects of litigation and enforcement previously known as “compliance” cases. AEB attorneys prepare and file pleadings and represent the Commissioner in administrative court in disciplinary actions against both licensed and unlicensed insurers and producers, including the revocation or denial of licenses and imposing fines for unfair claims practices by insurers.

Beyond its core function of an enforcement litigation bureau, AEB also provides legal opinions to the Commissioner and to the various divisions of the Department; provides support for investigations of producers and examinations of insurers; promulgates regulations; and represents the Department in employee adverse actions.

Auto Enforcement Bureau Statistics: 2006

In 2006 the Auto Enforcement Bureau conducted twenty-seven (27) administrative hearings to conclusion.

Monetary penalties and costs obtained through negotiated settlements and/or hearings totaled approximately \$976,018.75.

The categories of cases handled by AEB in 2006 are described below.

Matter Type	Matters Opened	Matters Closed	Matters Concluded
Disciplinary	121	66	27
Vehicle Service Contract	3	3	0
Unfair Practices Act	12	12	0
Legal Opinion	1	3	0
Legislative Analysis (pending bill)	1	0	0
Miscellaneous	5	0	0
Human Resources	5	0	0
Regulations	0	0	0
Cease & Desist Orders	3	1	0
Non-Compliance	2	0	0
Litigation	2	0	0
Subpoena	2	0	0
Order to Show Cause	1	1	0
Total	158	86	27

Significant matters worked in 2006

Marsh

Auto Enforcement Bureau Staff Counsel, working with the General Counsel, negotiated a settlement with the country's largest broker and wrote a precedent decision that established that producers owe fiduciary duties and what those duties are.

An AEB attorney researched and wrote a 20-page private advisory letter reciting authority for the fiduciary duties of producers;

American Reliable

AEB Staff Counsel negotiated and wrote a precedent decision reciting factors that establish that a producer is a de facto agent and therefore not permitted to charge fees in addition to premium at the approved rate.

IBAWest Petition re American Reliable

IBA West challenged the Department's authority to establish the American Reliable decision as precedent. Staff Counsel from Auto Enforcement wrote the Department brief on why a precedent decision adopted pursuant to a settlement was not an underground regulation under the A.P.A... Issues remain pending.

Cases against ULR insurers

Along with the General Counsel, AEB worked with outside counsel to settle civil suits against Unum-Provident, Hartford, Prudential, and Met Life, requiring them to disclose compensation paid to insured's broker. Some of these matters remain pending.

General Agent fee cases

AEB Staff Counsel used subpoenas to obtain evidence against, and drafted pleadings against, General Agents and insurers re G.A.'s charging fees while acting as insurer's agent (e.g., Superior Access, Hartford). Matters on these issues remain pending.

NAIC Broker Activities Task Force

Along with the General Counsel, AEB Staff Counsel participated in NAIC Task Force sub-group working on multi-state settlements against large brokers and insurers re compensation disclosure and steering. CDI participation on these issues continues.

Safe-Guard / AutoNation

Subpoenaed records of and filed action against unlicensed insurer re sales of limited auto policies covering damage to tires and wheels from road hazards. The matter remains pending.

Mercury

Continued prosecution of one of the State's largest auto insurers seeking multi-million dollar fine for permitting its agents to charge broker fees.

Regulations

Bail prelicensing and continuing education

- work is ongoing (15-day notice mailed the week of April 23, 2007).

Regulations for noncompliance hearings

- regulations providing the procedural framework for noncompliance hearings in the Administrative Hearing Bureau.

Earthquake mediation regulations

- regulations adding certain automobile and homeowners claims to the existing earthquake mediation regulations, allowing for mediation of certain automobile/homeowner claims.

Auto Body Labor Rate Survey Regulations

- This was an amendment to CCR section 2698.91 to further clarify the language of CIC section 758(c) and implement the section.

The amendments provided additional information on what data had to be included in any survey submitted to the Department if the insurer

intended to rely on the survey to adjust the labor rate on auto body estimates it wrote. The amendments also specifically defined what each geographic area included and excluded the use of negotiated rates to determine the prevailing rate in a geographic area.

The package was submitted to OAL on Nov. 14 and disapproved. The Department has been given until August 8 to resubmit the package for reconsideration.

CORPORATE AFFAIRS BUREAUS

The mission of the Corporate Affairs Bureaus (CAB) is to protect California consumers by effectively exercising licensing, oversight and enforcement functions such that insurers remain solvent and conduct their affairs in accordance with the law. Program areas handled by CAB include corporate applications, troubled companies, surplus lines, company compliance, risk retention and risk purchasing groups, conservation and liquidation of insurance companies, and providing essential legal advice and assistance in support of the Financial Surveillance Branch's regulatory programs.

CAB seeks to ensure that licenses are issued to qualified applicants who demonstrate compliance with the insurance Code and regulations, and who have the competence, character, integrity, experience and financial wherewithal to transact an insurance business in this State. In addition, the demands of insurers' businesses periodically necessitate corporate transactions such as mergers, stock issuances or bulk reinsurance agreements, which require departmental approval. Additionally, the law requires that domestic (California companies) insurers obtain prior approval of all transactions with affiliates and most changes in ownership structure.

Breakdown of Closed Matters (2006)

Amended Certificate of Authority	71
Certificate of Authority	42
Certificate of Authority as a Grants & Annuities Society	30
Certificate of Authority as a Grants and Annuity Society-Amended.	04
Certificate of Authority as a Status Filing CIC 700C	09
Custody Agreement	05
Failure to Make Required Filing	34
Holding Company Acquisition	07
1215.2(f) Exemption from Form A filing	19
1215.4(f) Ordinary Dividend	101
1215.4(l) Disclaimer of Affiliation	16
1215.5(b)(1) Sales, Purchases Loans, etc.	11
1215.5(b)(3) Reinsurance.	54
1215.5(b)(4) Mtg. Service/ Cost Sharing Agreements	100
1215.5(g) Extraordinary dividend.	09
Misc. Holding Co. Filings	03
Mergers	28
Miscellaneous Filings	61
Motor Club License/ Service Contract	07
Name Approval Reservation	151
Reinsurance Sale & Purchase, Transfer & Assumption	23
Reinsurer Accreditation	24
Risk Purchasing Group	29
Risk Purchasing Group Renewal	239
Risk Retention Group	06
Risk Retention Group Renewal	67

Stock Permit/Amended Stock Permit	04
Surplus Line/LESLI	77
Underwritten Title Company License-Amended	12
Underwritten Title Company Permit/ Org. Permit	02
Underwritten Title Company Shares-Transfer	10
Withdrawal	09
Workers' Compensation Depository Agreement	17
Total	1281

POLICY APPROVAL BUREAU

The Policy Approval Bureau performs most of the legal functions involving life, disability (accident and health), and workers' compensation insurance products. PAB review policy forms of those lines of insurance when provided by law. It advises the public, other government and CDI personnel and legislators on statutes and regulations pertaining to life, disability and workers' compensation insurance. It develops and administers CDI regulations and bulletins on life and disability insurance product design, advertising and administration. View products below.

Product	Matters Opened	Matters Closed
Disciplinary	121	66
Group Non-Health	317	320
Supplemental Life Insurance	176	155
Variable Contracts	335	359
Group & Individual Health Insurance	536	562
Medicare Supplement	282	345
Unclassified	66	51
Individual Non-Health	70	73
Individual & Group Credit Insurance	37	41
Long Term Care Ins.	226	272
Workers' Compensation	166	146
Variable Product Qualifications	1	4
Variable Annuity Qualifications	1	3
Amended Variable Annuity	160	190
Amended Variable Life	77	87
Modified Guarantee Annuity Qualification	0	0
Other Activities		
Regulations	2	3
Legal Opinions	2	5
Legislation	7	10
Total	2,461	2,626

RATE ENFORCEMENT BUREAU

The Rate Enforcement Bureau oversees and enforces the provisions of Proposition 103 and other laws pertaining to the availability and affordability of insurance and to rating and underwriting practices. This includes prior approval rate hearings

Rate Enforcement Bureau Actions

Prior Approval

Petitions for Hearing Received	1
Petitions for Hearing Granted.	0
Petitions for Hearing Denied	2
Notices of Hearing Issued	6
Matters Resolved Without Hearing.	4
Matters Pending	1
Variance Requested.	0
Variance Requests Concluded.	1

Rollback

Administrative Cases Pending.	1
Rollback Litigation Pending	1

Noncompliance

Matters Received.	1
Matters Concluded	4

Vehicle Service Contract

Applications Received.	135
Applications Concluded.	101

Regulations

Regulation Matters Opened	12
Regulations Approved	15

Civil Litigation

Matters Opened	5
Matters Concluded	6

CAARP

Appeals Opened	4
Appeals Resolved.	4

Producer Peer Review Decisions Issued.	4
Producer Peer Review Matters Opened.	4
Servicing Carrier Applications Received	4
Servicing Carrier Applications Approved	3
Servicing Carrier Applications Disapproved.	1

Section 674.6 Notices

Matters Opened	3
Matters Concluded	6

Legal Opinions

Opinions Requested	10
Opinions Drafted	13

Legislative Analyses

Matters Opened	1
Matters Concluded	7

HOLOCAUST ERA INSURANCE

The Department's Holocaust era insurance project has been responsible, since 1998, for advocating on behalf of Holocaust survivors, their families and heirs in their efforts to collect on life insurance policies issued before the war and never paid.

California Insurance Code Section 12967 directs the Department to advocate for these claimants. The Department has done so through its work on the International Commission on Holocaust Era Insurance Claims (ICHEIC - formed in 1997 to work out a way to fund, evaluate and pay claims and also to distribute humanitarian funds), the National Association of Insurance Commissioners (NAIC) Holocaust Task Force and through its own outreach and claimant advocacy and assistance work. The Insurance Commissioner has had a seat on ICHEIC and has been a strong claimant advocate. ICHEIC was comprised of European insurers, U.S. and European regulators, survivor organizations, and the State of Israel. ICHEIC accepted claims up until December 31, 2003 and closed its operation in March 2007. At

the conclusion of the ICHEIC process, ICHEIC insurers made offers on claims worldwide totaling \$306.24 million. (Almost \$26 Million of that money went to California claimants). ICHEIC put an additional \$165 million into Humanitarian projects (in home services for survivors worldwide, education on Jewish heritage for citizens of the former Soviet Union, as well as training for European Holocaust educators through a Yad Vashem program). ICHEIC's lifetime budget for administering the project was \$95 million. The bulk of ICHEIC's papers will be available to the public and researchers on its website (www.icheic.org) and also at the United States Holocaust Memorial Museum (www.ushmm.org). In order to protect claimants' privacy, ICHEIC will retain claims and appeals files until 2082, at which time they will be made available through the USHMM.

In June 2003, the Holocaust Victims Insurance Relief Act of 1999 (California Insurance Code Section 13800 et. seq.), which would have required insurers to provide the Department with information regarding policies they wrote to persons in Europe between 1920 and 1945, was found unconstitutional by the United States Supreme Court.

In calendar year 2006 the Department spent \$520,604.41 on Holocaust era insurance claims activities. The bulk of that money was spent for outside counsel working on the lawsuit referenced above (even though the law was found unconstitutional in 2003 the lawsuit continued, as the insurers wanted the Department to reimburse their legal expenses). The remaining funds went to fund staff working with ICHEIC and assisting claimants, as well as travel expenses and actuarial assistance with ICHEIC related projects.

Armenian Genocide

California Code of Civil Procedure Section 354.4 permits venue in California for suits brought by heirs of relatives of victims of the Armenian Genocide and extends that statute of limitations to 2010. In February 2004, the United States District Court approved plaintiffs' \$20 million settlement against New York Life Insurance Company of approximately 2,400 potential claims on unpaid insurance policies. As of December 2006, the claims process was complete with payments of approximately \$8 Million. An additional \$3.9 Million humanitarian fund (over and above the \$3 Million in humanitarian monies that was distributed to charities two years ago) will be distributed to charities that help Armenians. Plaintiffs' aim is to give small amounts to as many charities as possible.

Slavery Era Insurance

Prior to 1865 it was not uncommon for American slave owners to take out life insurance on the lives of their African slaves. California Insurance Code Section 13810 et. seq. (September 2000) directs insurers licensed to do business in California to submit to the Department all documents having to do with slavery era insurance together with the names of all slaves and slaveholders found in those documents. The Department has made public the database of slave and slaveholder names, together with a summary of the documents received in its May 2002 Report to the California Legislature. All of the documents received are publicly available at the Department's Public Viewing Rooms in Los Angeles and San Francisco. They were also sent to the California State Library as well as to selected University of California and county libraries across the state.

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RATE REGULATION
BRANCH



RATE REGULATION BRANCH

The Rate Regulation Branch (RRB) analyzes filings submitted by property and casualty insurers and other insurance organizations under California's prior approval statutes for most property and casualty lines of business. In addition, the RRB analyzes filings submitted by property and casualty insurers and other insurance organizations under California's file and use statutes for a limited number of property and casualty lines of business. The passage of Proposition 103 in 1988 required the RRB to begin reviewing rates for most property and casualty lines of business before property and casualty companies could use them. This process, mandated by the California Insurance Code (CIC) Section 1861.05, requires the RRB to ensure that the rates contained in an insurer's filing are not excessive, inadequate or unfairly discriminatory prior to those rates being approved for use by the insurer.

RATE FILING BUREAUS

The Rate Regulation Branch has five (5) filing bureaus (two in San Francisco and three in Los Angeles) that receive and review filings from over seven hundred fifty (750) property and casualty companies licensed in the state. The Intake Unit in the San Francisco office is responsible for processing all filing applications except for Workers Compensation and Title companies and providing copies of all filings to the Public Viewing Rooms maintained in San Francisco and Los Angeles for public access.

In conjunction with the National Association of Insurance Commissioners (NAIC), Rate Regulation is actively promoting its participation in the System for Electronic Rate and Form Filings (SERFF) project. This system is designed

to enable companies to send and states to receive, comment on, approve or reject insurance industry rate and form filings. The electronic aspects of this project will help increase the efficiency and facilitate communication between the Rate Filing Bureaus and insurers. The percentage of filings received via SERFF continues to increase each year. During 2006, the percentage of total filings received through SERFF increased to thirty three percent (33%).

In addition to prior approval filing applications, the Rate Filing Bureaus are responsible for the review of other required filings as follows:

Private Passenger Auto Class Plans

California Department of Insurance regulations require all insurance companies writing private passenger automobile insurance to submit a Classification Plan (Class Plans). Class Plans provide the Department with the rating methodology each company will develop or adopt in order to comply with the provisions of Proposition 103 that mandates the use of certain specific rating factors.

Advisory Organizations

California Insurance Code Section 1855.5 requires that all policy or bond forms intended for use by members of an advisory organization must first be filed with the Commissioner for review and approval prior to being used by member insurance companies.

Workers Compensation

In 1993 and 1994, the workers compensation minimum rate law was replaced with a competitive rating system which took effect in 1995. Under the competitive rating law, codified in California Insurance Code Section 11735, insurers are free to develop their own rates based on advisory pure premiums (loss costs) and company developed

loss cost multipliers. However, all company rates, rating plans, and rating rules must be filed with the Rate Regulation Branch prior to use. In 2006, five hundred seventy (570) workers' compensation rate filings were reviewed.

Title Insurance

California Insurance Code Section 12401.1 requires title insurers and underwritten title companies to file their title and escrow rates with the Department prior to their use. In 2006, ninety-five (95) title insurance rate filings were reviewed.

Types of Filings Received During 2006

Private Passenger Automobile	951
Homeowner	194
Other Personal Lines Products	224
Title	95
Workers' Compensation	570
Medical Malpractice	41
Other Commercial Lines Products	5456
Total	7531



2006 ANNUAL REPORT
FINANCIAL SURVEILLANCE
BRANCH

FINANCIAL SURVEILLANCE BRANCH

The Financial Surveillance Branch (FSB) is responsible for monitoring the financial condition of the insurance industry to ensure it can provide the benefits and protection promised to California citizens. FSB's function is to assure that all insurers licensed to do business in California (as well as those insurers operating on a non-admitted or surplus lines basis) maintain the financial stability and viability necessary to provide the benefits and protection they have promised their California policyholders. The Department is accredited by the National Association of Insurance Commissioners (NAIC) and undergoes an accreditation review every 5 years. The accreditation review ensures that the Department meets all the national standards and requirements as adopted by the NAIC.

FSB is composed of the Financial Analysis Division (FAD), the Field Examination Division (FED), the Actuarial Office (AO), the Troubled Companies Unit (TCU), and the Premium Tax Audit Bureau (PTAB).

FAD evaluates and monitors the financial condition of insurance companies to identify financially distressed companies and takes corrective actions or recommends regulatory actions to assure insurer solvency for the protection of California consumers.

FED is responsible for conducting comprehensive financial examinations of California's domiciled insurance companies and other insurance organizations to determine their financial solvency and capacity to meet policyholder obligations. The examinations also serve to protect policyholder interests by including a review of insurance management, operations, investments and advertising.

The AO formulates actuarial policy within the CDI and assists in the drafting of legislation and regulations.

TCU is responsible for overseeing those insurers identified by the CDI's Early Warning System (EWS) as being financially troubled.

PTAB is responsible for auditing all premium tax returns filed by insurers and surplus lines brokers.

FSB developed an Early Warning System (EWS) to track all significant findings that may affect the operations of a company. The primary purpose of EWS is to facilitate early detection of potential insolvency problems with admitted (authorized or licensed) insurance companies.

FINANCIAL ANALYSIS DIVISION

FAD analyzes and maintains ongoing surveillance of admitted insurers, fraternal benefit associations, grants and annuities societies, underwritten title companies, home protection companies, motor clubs, risk retention groups, surplus line insurers and Lloyd's syndicates. The purpose is to identify companies in or approaching hazardous financial condition and to recommend corrective action when necessary. FAD analyzes holding company transactions and acquisitions pursuant to the Insurance Holding Company System Regulatory Act. In addition, FAD assists the CDI Legal Branch by providing financial analysis of applications for certificates of authority, amended certificates of authority, securities permits, variable contract qualifications, underwritten title company licenses and various other corporate affairs matters. FAD assists in the development of reinsurance regulatory policy. FAD also provides information and assistance to other divisions relative to reinsurance practices and procedures, surplus line insurers, captive insurers and risk retention groups.

The workload performed by the FAD is distributed among three bureaus: FAD 1 (Property and Casualty Bureau I), FAD 2 (Property and Casualty Bureau II) and FAD 3 (Life Bureau). Listed below are workload statistics of FAD:

Workload Performed for the Year 2005

Financial Statements Analysis	Annual
Life and Property & Casualty	687
Other Entities	511
Surplus Lines	102
Financial Statements Analysis	Quarterly
Life and Property & Casualty	1,193
Other Entities	233
Surplus Lines	306
Corporate Affairs Applications	
Certificate of Authority	65
Holding Company Matters	297
All Others	167

FIELD EXAMINATION DIVISION

Under the provisions of Section 730, 733, 734.1 and 736 of the California Insurance Code, the Insurance Commissioner must examine the business and affairs of every admitted insurer, whenever deemed necessary, to determine its financial condition and compliance with applicable laws. Unless financial or other conditions warrant an immediate examination, domestic insurers are usually examined triennially and foreign insurers are usually examined in accordance with the NAIC's Association Plan of Examination. FED also performs financial examinations of underwritten title companies, home warranty companies and other entities as necessary.

It is the responsibility of FED to determine the financial condition of insurance companies in accordance with California Insurance Code legal

requirements and prescribed accounting practices as promulgated by the NAIC. In addition, FED provides financial and actuarial support to other divisions.

Various types of examinations initiated and completed by FED in 2006 are presented as follows:

Type of Examination	Initi	Comp
Domestic Companies	46	36
Underwritten Title Companies	11	7
Foreign Companies	5	1
Qualifying Exams	2	4
Statutory Exams	1	3
Limited-Scope Exams	2	1
Total:	67	52

Initi = Initiated Comp = Completed

ACTUARIAL OFFICE

The AO is responsible for formulating actuarial policy and providing technical assistance within the FSB. The AO monitors reserves established by life and health insurance companies; drafts new legislation, regulations, and bulletins regarding actuarial matters; review life insurance and annuity policy forms; and reviews Medicare supplement and other accident & health insurance rate filings. Listed below are workload statistics of the AO:

Actuarial Reviews	# Reviewed
Reinsurance Agreements	32
Health Rate Filings	282
Asset Adequacy Analysis Memoranda	77
Regulatory Asset Adequacy Issues Summaries	264

TROUBLED COMPANIES UNIT

Staffed by three seasoned analysts, TCU is responsible for overseeing those insurers identified by the CDI's Early Warning System as being

financially troubled. Whereas the number of companies under review does vary, as does the level of complexity each presents, on average 45 companies are assigned to TCU at any given time.

TCU personnel carefully monitor the financial status of assigned companies and make recommendations to the Early Warning Team. The Early Warning Team has ultimate responsibility for monitoring insurers determined to be in financial difficulty or troubled. TCU also provides other technical and administrative support for the Early Warning Team.

PREMIUM TAX AUDIT BUREAU

Insurance Taxes

Insurance taxes assessed in 2006 on business done during 2005, other than retaliatory and surplus line taxes, amounted to \$1,991,489,498. Refunds of \$79,733,625 were granted during the year.

Additional assessments proposed by the Insurance Commissioner to the Board of Equalization and the State Controller's Office totaled \$16,005,631.

Basis of Tax

The basis of tax is the amount of "gross premiums" received, less return premiums, upon business done in the State, with the exception of title insurance and ocean marine insurance. Insurers transacting title insurance are taxed upon all income received in this State, with the exception of income arising out of investments. Ocean marine insurers are taxed upon underwriting profits.

Rate of Tax

A tax rate of 2.35 percent is imposed on "gross premiums" received, with the exception that a lower rate of 0.50 percent is applied to premiums received under pension and profit sharing plan contracts which are "qualified" under certain sections of the United States Internal Revenue

Code. Title insurers are taxed at a rate of 2.35 percent of "income". Ocean marine insurers are taxed at a rate of 5 percent of underwriting profits.

Retaliatory Taxes

Insurers domiciled in states with a higher tax rate than California pay a "retaliatory tax" to California equal to the difference in the tax rate of their state of domicile and the tax rate of the State of California.

Retaliatory taxes assessed and collected in 2006 on business done during 2005 totaled \$2,925,090.

Surplus Line Taxes

The surplus line tax rate is 3 percent and is assessed on surplus line premiums pursuant to California Insurance Code Section 1775.5. Surplus line taxes collected during 2006 for calendar year 2005 totaled \$171,963,088.

