AB-2884 Insurance. (2015-2016)

Assembly Bill No. 2884

CHAPTER 304

An act to amend Sections 660, 789, 1215.5, 1669, 1681, 1726, 1807.5, 10168.6, 10234.6, 10234.95, 10236.1, 10236.13, 10236.14, 10236.15, 11520.5, 11691, and 12921.1 of, to repeal Section 736.5 of, and to repeal and add Section 1682 of, the Insurance Code, relating to insurance.

[Approved by Governor September 12, 2016. Filed with Secretary of State September 12, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2884, Committee on Insurance. Insurance.

(1) Existing law authorizes the Insurance Commissioner, under specified circumstances, to examine the business and affairs of an insurer. That examination is required to be at the expense of the insurer, organization, or person examined by the commissioner, as specified.

Existing law prohibits the revenue raised from the examination of insurers in the 1996–97 fiscal year from exceeding the examination fee revenue estimate for the 1996–97 Governor's Budget by more than $2,000,000.

This bill would, among other things, make technical and nonsubstantive changes. The bill would also delete the provision relating to revenue raised during the 1996–97 fiscal year.

(2) The Insurance Holding Company System Regulatory Act requires each insurer that is authorized to do business in this state and that is a member of an insurance holding company system to register with the commissioner and to file a registration statement containing specified information, including the capital structure and general financial condition of the insurer and specified transactions between the insurer and its affiliates.

The act provides that the transactions by registered insurers with their affiliates are subject to various standards, including the requirement that the terms be fair and reasonable.

The act provides that any insurer or any director, officer, employee, or agent of the insurer that commits a willful violation of the act is subject to criminal proceedings.

This bill would require that the terms also be consistent with the current version of the NAIC Insurance Holding Company System Model Regulation.

Because a willful violation of this provision would be subject to criminal proceedings, the bill would create a state-mandated local program.

(3) Existing law prohibits a person from soliciting, negotiating, or effecting contracts of insurance, or acting in the capacity of various types of insurance agents, unless the person holds a valid license from the Insurance Commissioner authorizing the

person to act in that capacity. Existing law authorizes the commissioner to deny an application for a license for various reasons including if the applicant committed a felony or a misdemeanor as shown by a plea of guilty or nolo contendere. Existing law also requires an applicant to pass the qualifying examination for the license prior to receiving a permanent license and allows the applicant to retake the qualifying examination subject to reasonable time limits limiting when a person who has failed the examination may retake.

This bill would add that the commissioner may deny an application for a license if the applicant has been convicted of a felony or misdemeanor, as specified. The bill would also prohibit a person who has failed any license qualification examination 10 times within the previous 12-month period from enrolling in any further license qualification examinations for a period of 12 months.

(4) Existing law requires a person who is licensed in this state as an insurance agent or broker, advertises insurance on the Internet, and transacts insurance in this state, to identify certain information on the Internet, regardless of whether the insurance agent or broker maintains his or her Internet presence or if the presence is maintained on his or her behalf. The required information includes, but is not limited to, his or her name as it appears on his or her license, and any fictitious name approved by the commissioner.

This bill would instead require that the person provide his or her name as filed with the commissioner that has not been disapproved pursuant to the provisions regarding the use of fictitious names.

(5) Existing law prohibits an insurer from executing an undertaking of bail except by and through a person holding a bail license, as provided. Existing law also prohibits the commissioner from suspending or revoking any license, issued as specified, without first granting a hearing, as specified.

This bill would prohibit the commissioner from denying a license to an applicant without first granting a hearing, as specified.

(6) Existing law provides that for the purpose of determining certain benefits, that in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election is permitted by the contract.

This bill would add that in the case of annuity contracts under which the fixed maturity date is later than the later of the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, the maturity date shall be deemed to be the later of the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract.

(7) Existing law requires the commissioner to annually prepare a consumer rate guide for long-term care insurance and to include specified information, including a history of the rates of all policies issued in California for the current year and for the 4 preceding years.

This bill would require the history of the rates of all policies issued in California to be listed for the 9 preceding years.

(8) Existing law provides for the regulation of insurers, including insurers issuing policies of long-term care insurance, by the Insurance Commissioner. Existing law prohibits an insurer from increasing the premium for an individual or group long-term care insurance policy or certificate approved for sale unless the insurer has received prior approval for the increase from the commissioner and requires the insurer to submit to the commissioner for approval all premium rate schedule increases, as specified. Existing law further requires that approval of all premium rate schedule increases, and approved premium rate schedule increases be subject to various requirements, including filing updated projections annually for the next 3 years, as specified.

This bill would require that for the above-described rate schedules, the lifetime expected loss ratio be calculated as specified. The bill would also modify the requirements that approved premium rate schedule increases are subject to by requiring the insurer to file composite rate projections if it is necessary to maintain consistent premium rates for new certificates receiving a rate increase.

(9) Existing law requires an insurer, in order to be admitted in this state to transact specified workers' compensation transactions, among other things, to deposit cash instruments or approved interest-bearing securities or approved stocks readily convertible into cash, investment certificates, or share accounts issued by a savings and loan association doing business in this state and insured by the Federal Deposit Insurance Corporation, certificates of deposit, or savings deposits in a bank licensed to do business in this state that is either domiciled in and with its principal place of business in this state or that is a national banking association with a trust office located in this state.

This bill would instead include a bank licensed to do business in this state, or a trust company, licensed to do business and located in this state that is either domiciled in and with its principal place of business in this state or that is a national banking association with a trust office located in this state.

(10) Existing law requires the Insurance Commissioner to establish a program to investigate complaints and respond to inquiries received regarding the handling of insurance claims and, when warranted, to bring enforcement actions against insurers or production agencies. Existing law requires the commissioner to promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer or production agency.

This bill would authorize the commissioner to establish an Internet-accessible complaint response system to distribute and receive complaint information, as specified.

(11) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 660 of the Insurance Code is amended to read:

660. As used in this chapter:

(a) “Policy” means an automobile liability, automobile physical damage, or automobile collision policy, or any combination thereof, delivered or issued for delivery in this state, insuring a single individual or individuals residing in the same household, as named insured, and under which the insured vehicles therein designated are of the following types only:

(1) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others; or

(2) Any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less; provided, however, that this chapter shall not apply to any of the following:

(A) Any policy issued under an automobile assigned risk plan.

(B) Any policy insuring more than four automobiles.

(C) Any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(3) A motorcycle.

(b) “Automobile liability coverage” includes only coverage of bodily injury and property damage liability, medical payments, and uninsured motorists coverage.

(c) “Automobile physical damage coverage” includes all coverage of loss or damage to an automobile insured under the policy except loss or damage resulting from collision or upset.

(d) “Automobile collision coverage” includes all coverage of loss or damage to an automobile insured under the policy resulting from collision or upset.

(e) “Renewal” or “to renew” means to continue coverage with either the insurer which issued the policy or an affiliated insurer, as defined in Section 1215, for an additional policy period upon expiration of the current policy period of a policy, provided that if coverage is continued with an affiliated insurer, it shall be the same or broader coverage as provided by the present insurer, and the insured shall be notified in writing at least 20 days prior to expiration of the current policy period of all of the following:

(1) That the insurer has determined that it will not offer renewal of the policy with the present insurer.

(2) That it is offering replacement in an affiliated insurer.

(3) That the insured may obtain in writing the reasons for the change in insurers if he or she requests in writing not later than one month following the expiration of the policy period the reason or reasons for the change in insurers. Any policy with a policy period or term of six months or less, whether or not made continuous for successive terms upon the payment of additional premiums, shall, for the purpose of this chapter be considered as if written for a policy period or term of six months. Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall for the purpose of this chapter, be considered as if written for successive policy periods or terms of one year.

(f) “Nonpayment of premium” means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

(g) “Cancellation” means termination of coverage by an insurer (other than termination at the request of the insured) during a policy period.

(h) “Nonrenewal” means a notice by the insurer to the named insured that the insurer is unwilling to renew a policy.

(i) “Expiration” means termination of coverage by reason of the policy having reached the end of the term for which it was issued or the end of the period for which a premium has been paid.

SEC. 2. Section 736.5 of the Insurance Code is repealed.

SEC. 3. Section 789 of the Insurance Code is amended to read:

789. (a) The commissioner shall have the administrative authority to assess penalties against insurers, brokers, agents, and other entities engaged in the transaction of insurance or any other person or entity for violations of this article.

(b) Upon a showing of a violation of this article in any civil action, a court may also assess the penalties prescribed in this article.

(c) Whenever the commissioner has reasonable cause to believe or determines after a public hearing that any insurer, agent, broker, or other person or entity engaged in the transaction of insurance, has violated this article the commissioner shall make and serve upon the insurer, broker, agent, or other person or entity a notice of hearing. The notice shall state the commissioner’s intent to assess the administrative penalties, the time and place of the hearing, and the conduct, condition, or ground upon which the commissioner is holding the hearing, and assessing the penalties. The hearing shall occur within 30 days after the notice is served. Within 30 days after the hearing the commissioner shall issue an order specifying the amount of the penalties to be paid. The penalties resulting from the hearing shall be paid to the Insurance Fund.

(d) The powers vested in the commissioner by this section shall be in addition to any and all powers and remedies vested in the commissioner by law.

(e) Actions for injunctive relief, penalties specified in Section 789.3, damages, restitution, and all other remedies in law, may be brought in superior court by the Attorney General, district attorney, or city attorney on behalf of the people of California. The court shall award reasonable attorney’s fees and court costs to the prevailing plaintiff who establishes a violation of this article.

SEC. 4. Section 1215.5 of the Insurance Code is amended to read:

1215.5. (a) Transactions by registered insurers with their affiliates are subject to the following standards:

(1) The terms shall be fair and reasonable and consistent with the current version of Section 19 of the NAIC Insurance Holding Company System Model Regulation, subject to the requirements of this article.

(2) Charges or fees for services performed shall be reasonable.

(3) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(4) The books, accounts, and records of each party to all transactions shall be so maintained as to clearly and accurately disclose the precise nature and details of the transactions, including accounting information that is necessary to support the reasonableness of the charges or fees to the parties.

(5) The insurer’s policyholder’s surplus following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer’s outstanding liabilities and adequate to its financial needs.

(b) The following transactions involving a domestic insurer or commercially domiciled insurer, as defined in Section 1215.14, and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, may be entered into only if the insurer has notified the commissioner in writing of its intention to enter into the transaction at least 30 days prior thereto, or a shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer or commercially domiciled insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any. The commissioner shall require the payment of one thousand eight hundred eighty-nine dollars ($1,889) as a fee for filings pursuant to this subdivision, and the filings shall be on a form and in a format prescribed by the NAIC. The payment shall accompany the filing.

(1) Sales, purchases, exchanges, loans, extensions of credit, or investments, if the transactions are equal to or exceed:

(A) For a nonlife insurer, the lesser of 3 percent of the insurer's admitted assets or 25 percent of the policyholder's surplus as of the preceding December 31st.

(B) For a life insurer, 3 percent of the insurer's admitted assets as of the preceding December 31st.

(2) Loans or extensions of credit to a person who is not an affiliate, if made with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer, if the transactions are equal to or exceed:

(A) For a nonlife insurer, the lesser of 3 percent of the insurer's admitted assets or 25 percent of the policyholder's surplus as of the preceding December 31st.

(B) For a life insurer, 3 percent of the insurer's admitted assets as of the preceding December 31st.

(3) Reinsurance agreements and pooling agreements and modifications thereto in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds 5 percent of the insurer's policyholder's surplus, as of the preceding December 31st, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

(4) All management agreements, service contracts, tax sharing agreements, and cost-sharing arrangements. However, subscription agreements or powers of attorney executed by subscribers of a reciprocal or interinsurance exchange are not required to be reported pursuant to this section if the form of the agreement was in use before 1943 and was not amended in any way to modify payments, fees, or waivers of fees or otherwise substantially amended after 1943. Payment or waiver of fees or other amounts due under subscription agreements or powers of attorney forms that were in use before 1943 and that have not been amended in any way to modify payments, fees, or waiver of fees, or otherwise substantially amended after 1943 shall not be subject to regulation pursuant to paragraph (2) of subdivision (a).

(5) Guarantees when initiated or made by a domestic or commercially domiciled insurer, provided that a guarantee that is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of 1 percent of the insurer's admitted assets or 10 percent of surplus as regards policyholders as of the 31st day of December next preceding. Further, all guarantees that are not quantifiable as to amount are subject to the notice requirements of this paragraph.

(6) Derivative transactions or series of derivative transactions. The written filing to the commissioner shall include the type or types of derivative transactions, the affiliate or affiliates engaging with the insurer in the derivative transactions, the objective and the rationale for the derivative transaction or series of derivative transactions, the maximum maturity and economic effect of the derivative transactions, and any other information required by the commissioner. Derivative transactions entered into pursuant to this subdivision shall comply with the provisions of Section 1211.

(7) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in those investments, exceeds 2.5 percent of the insurer's policyholder's surplus. Direct or indirect acquisitions or investments in subsidiaries acquired under Section 1215.1, or in nonsubsidiary insurance affiliates that are subject to the provisions of this article, or in subsidiaries acquired pursuant to Section 1199, are exempt from this requirement.

(8) Any material transactions, specified by regulation, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

(c) A domestic insurer may not enter into transactions that are part of a plan or series of transactions with persons within the holding company system if the purpose of those transactions is to avoid the statutory threshold amount and thus avoid review. If the commissioner determines that separate transactions were entered into over any 12-month period to avoid review, the commissioner may exercise his or her authority under Section 1215.11.

(d) The commissioner, in reviewing transactions under subdivision (b), shall consider whether the transactions comply with the standards set forth in subdivision (a) and whether they may adversely affect the interests of policyholders.

(e) The commissioner shall be notified within 30 days of any investment by the insurer in any one corporation if the total investment in the corporation by the insurance holding company system exceeds 10 percent of the corporation's voting securities.

(f) For purposes of this article, in determining whether an insurer's policyholder's surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

(2) The extent to which the insurer's business is diversified among the several lines of insurance.

(3) The number and size of risks insured in each line of business.

(4) The extent of the geographical dispersion of the insurer's insured risks.

(5) The nature and extent of the insurer's reinsurance program.

(6) The quality, diversification, and liquidity of the insurer's investment portfolio.

(7) The recent past and projected future trend in the size of the insurer's investment portfolio.

(8) The recent past and projected future trend in the size of the insurer's surplus, and the policyholder's surplus maintained by other comparable insurers.

(9) The adequacy of the insurer's reserves.

(10) The quality and liquidity of investments in subsidiaries made under Section 1215.1. The commissioner may treat those investments as a disallowed asset for purposes of determining the adequacy of the policyholder's surplus whenever, in his or her judgment, the investment so warrants.

(11) The quality of the company's earnings and the extent to which the reported earnings include extraordinary accounting items.

(g) No insurer subject to registration under Section 1215.4 shall pay any extraordinary dividend or make any other extraordinary distribution to its stockholders until 30 days after the commissioner has received notice of the declaration thereof and has approved the payment or has not, within the 30-day period, disapproved the payment.

For purposes of this section, an extraordinary dividend or distribution is any dividend or distribution which, together with other dividends or distributions made within the preceding 12 months, exceeds the greater of (1) 10 percent of the insurer's policyholder's surplus as of the preceding December 31st, or (2) the net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, for the 12-month period ending the preceding December 31st.

Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution that is conditional upon the commissioner's approval. The declaration confers no rights upon stockholders until the commissioner has approved the payment of the dividend or distribution or until the commissioner has not disapproved the payment within the 30-day period referred to in this subdivision.

(h) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject to by law, and the insurer shall be managed to ensure its separate operating identity consistent with the provisions of this article. However, nothing in this article shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of subdivision (a).

(i) The provisions of this section do not apply to any insurer, information, or transaction exempted by the commissioner.

SEC. 5. Section 1669 of the Insurance Code is amended to read:

1669. The commissioner may, without hearing, deny an application if the applicant has done one or more of the following:

(a) (1) Been convicted of a felony.

(2) Been convicted of a misdemeanor denounced by this code or by other laws regulating insurance.

(3) A judgment, plea, or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this subdivision.

(b) Had a previous application for a professional, occupational, or vocational license denied for cause by any licensing authority, within five years of the date of the filing of the application to be acted upon, on grounds that should preclude the granting of a license by the commissioner under this chapter.

(c) Had a previously issued professional, occupational, or vocational license suspended or revoked for cause by any licensing authority, within five years of the date of the filing of the application to be acted upon, on grounds that should preclude the granting of a license by the commissioner under this chapter.

In the event the commissioner issues an order based on a plea that does not at any time result in a judgment of conviction, the commissioner shall vacate the order upon petition by the applicant.

SEC. 6. Section 1681 of the Insurance Code is amended to read:

1681. If an applicant fails the qualifying examination, he or she may, subject to the provisions of Section 1682, retake a qualifying examination.

SEC. 7. Section 1682 of the Insurance Code is repealed.

SEC. 8. Section 1682 is added to the Insurance Code, to read:

1682. (a) A person who has failed any license qualification examination 10 times within the previous 12-month period shall not be permitted to enroll in any further license qualification examinations for a period of 12 months, beginning from the date of the 10th license qualification examination failure.

(b) For the purpose of this section, “license qualification examination” includes examinations for all types of licenses issued by the commissioner pursuant to this chapter, Chapter 7 (commencing with Section 1800) and Chapter 8 (commencing with Section 1831), and Chapter 1 (commencing with Section 14000) and Chapter 2 (commencing with Section 15000) of Division 5.

SEC. 9. Section 1726 of the Insurance Code is amended to read:

1726. (a) A person who is licensed in this state as an insurance agent or broker, advertises insurance on the Internet, and transacts insurance in this state, shall identify all of the following information on the Internet, regardless of whether the insurance agent or broker maintains his or her Internet presence or if the presence is maintained on his or her behalf:

(1) His or her name as filed with the commissioner that has not been disapproved pursuant to Section 1724.5.

(2) The state of his or her domicile and principal place of business.

(3) His or her license number.

(b) A person shall be deemed to be transacting insurance in this state when the person advertises on the Internet, regardless of whether the insurance agent or broker maintains his or her Internet presence or if it is maintained on his or her behalf, and does any of the following:

(1) Provides an insurance premium quote to a California resident.

(2) Accepts an application for coverage from a California resident.

(3) Communicates with a California resident regarding one or more terms of an agreement to provide insurance or an insurance policy.

SEC. 10. Section 1807.5 of the Insurance Code is amended to read:

1807.5. Except as provided in Sections 1669 and 1738, the commissioner shall not deny, suspend, or revoke any license, issued under this article, without first granting a hearing, upon reasonable notice to the applicant or licensee, except that he may temporarily suspend a license for a period not exceeding 15 days pending the hearing. Where a hearing is held under this section the proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted pursuant to that chapter.

SEC. 11. Section 10168.6 of the Insurance Code is amended to read:

10168.6. For the purpose of determining the benefits calculated under Sections 10168.4 and 10168.5, the following apply:

(a) In the case of annuity contracts under which the fixed maturity date is later than the later of the anniversary of the contract next following the annuitant’s 70th birthday or the 10th anniversary of the contract, the maturity date shall be deemed to be the later of the anniversary of the contract next following the annuitant’s 70th birthday or the 10th anniversary of the contract.

(b) In the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

SEC. 12. Section 10234.6 of the Insurance Code is amended to read:

10234.6. (a) The commissioner shall, by June 1 of each year, jointly design the format and content of a consumer rate guide for long-term care insurance with a working group that includes representatives of the Health Insurance Counseling and Advocacy Program, the insurance industry, and insurance agents. The commissioner shall annually prepare the consumer rate guide for long-term care insurance that shall include, but not be limited to, the following information:

(1) A comparison of the different types of long-term care insurance and coverages available to California consumers and a specimen outline of coverage for each product currently marketed by each insurer listed in the rate guide.

(2) A premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in California.

(b) The consumer rate guide to be prepared by the commissioner shall consist of two parts: a history of the rates for all policies issued in California for the current year and for nine preceding years, and a comparison of the policies, benefits, and sample premiums for all policies currently being issued for delivery in California.

(1) For the rate history portion of the rate guide required by this section, the department shall collect, and each insurer shall provide to the department, all of the following information for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in California for the current year and for nine preceding years:

(A) Company name.

(B) Policy type.

(C) Policy form identification.

(D) Dates sold.

(E) Date acquired (if applicable).

(F) Premium rate increases requested.

(G) Premium rate increases approved.

(H) Dates of premium rate increase approvals.

(I) Any other information requested by the department.

(2) For the policy comparison portion of the rate guide required by this section, the department shall collect, and each insurer shall provide to the department, the information needed to complete the following form, along with any other information requested by the department, for each long-term care policy currently issued for delivery in California, including all policies, whether issued by the insurer or purchased or acquired from another insurer:

PRINTER PLEASE NOTE: TIP-IN MATERIAL TO BE INSERTED

If an insurer does not offer a policy for sale that fits the criteria set forth in the sample premium portion of the policy comparison section of the rate guide, the department shall include in that section of the form for that policy a statement explaining that a policy fitting that criteria is not offered by the insurer and that the consumer may seek, from an agent, sample premium information for the insurer's policy that most closely resembles the policy in the sample.

The department shall use the format set forth in this section for the policy comparison portion of the rate guide, unless the working group convened pursuant to subdivision (a) designs an alternative format and agrees that it should be used instead.

In compiling the policy comparison portion of the rate guide, the department shall separate the group policies from the individual policies available for sale so that group policies for all insurers appear together in the guide and individual policies for all insurers appear together in the guide.

The policy comparison portion of the rate guide shall contain a cross-reference for each policy form listed indicating the page in the rate guide where rate information on the policy form can be found.

(c) The department shall publish, on the department's Internet Web site, a premium history of each insurer that writes long-term care policies for all the types of long-term care insurance and coverages issued by the insurer in each state. Each insurer shall provide to the department all of the information listed in paragraph (1) of subdivision (b) for each long-term care policy, including all policies, whether issued by the insurer or purchased or acquired from another insurer, issued in the United States for the current year and for the nine preceding years.

(d) Insurers shall provide the information required pursuant to subdivisions (b) and (c) no later than July 31 of each year, commencing in 2000.

(e) The consumer rate guide shall be published no later than December 1 of each year commencing in 2000, and shall be distributed using all of the following methods:

(1) Through Health Insurance Counseling and Advocacy Program (HICAP) offices.

(2) By telephone using the department's consumer toll-free telephone number.

(3) On the department's Internet Web site.

(4) A notice in the Long-Term Care Insurance Personal Worksheet required by Section 10234.95.

(f) Notwithstanding any other provision of law, the data submitted by insurers to the department pursuant to this section are public records, and shall be open to inspection by members of the public pursuant to the procedures of the California Public Records Act. However, a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, is not subject to this subdivision.

SEC. 13. Section 10234.95 of the Insurance Code is amended to read:

10234.95. (a) Every insurer or other entity marketing long-term care insurance shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(2) Train its agents in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(b) The agent and insurer shall develop procedures that take into consideration, when determining whether the applicant meets the standards developed by the insurer, the following:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(3) The value, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(c) (1) The issuer, and where an agent is involved, the agent, shall make reasonable efforts to obtain the information set out in subdivision (b). The efforts shall include presentation to the applicant, at or prior to application, of the "Long-Term Care Insurance Personal Worksheet," contained in the Long-Term Care Insurance Model Regulations of the National Association of Insurance Commissioners. The personal worksheet used by the insurer shall contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type. The insurer may request the applicant to provide additional information to comply with its suitability standards.

(2) In the premium section of the personal worksheet, the insurer shall disclose all rate increases and rate increase requests for all policies, whether issued by the insurer or purchased or acquired from another insurer, in the United States for the current year and for nine preceding years.

(3) The premium section shall include a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, for the current year and for the nine preceding years. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov)." If the personal worksheet is approved prior to the availability of the rate guide, the worksheet shall indicate that the rate guide will be available beginning December 1, 2000.

(4) A copy of the issuer's personal worksheet shall be filed and approved by the commissioner. A new personal worksheet shall be filed and approved by the commissioner each time a rate is increased in California and each time a new policy is filed for approval by the commissioner. The new personal worksheet shall disclose the amount of the rate increase in California and all prior rate increases for the nine preceding years in California as well as all prior rate increases and rate increase requests or filings in any other state for the nine preceding years. The new personal worksheet shall be used by the insurer within 60 days of approval by the commissioner in place of the previously approved personal worksheet.

(d) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sale of employer group long-term care insurance to employees and their spouses and dependents.

(e) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited.

(f) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(g) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(h) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. Alternatively, the issuers shall send the applicant a letter similar to the "Long-Term Care Insurance Suitability Letter" contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(i) The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter.

(j) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

SEC. 14. Section 10236.1 of the Insurance Code is amended to read:

10236.1. (a) Benefits under individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11 shall be deemed reasonable in relation to premiums if the expected loss ratio is at least 60 percent, calculated in a manner that provides for adequate reserving of the long-term care insurance risk.

(b) (1) For individual long-term care insurance policies issued before new premium rate schedules are approved under Section 10236.11, and for which rate revisions are filed on or after January 1, 2010, benefits shall be deemed reasonable in relation to the premium if the premium rate schedules have a lifetime expected loss ratio of at least 60 percent of the premium scale in effect on December 31, 2009, plus 70 percent of premium increases filed on or after January 1, 2010, calculated in a manner that provides for adequate reserving of the long-term care insurance risk. The lifetime expected loss ratio shall be calculated using the discount rate defined in paragraph (9) of subdivision (c).

(2) However, if the premiums in any rate revision filing calculated in the manner provided in paragraph (1) produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for this policy form in the initial filing or that for requested premium rates in any filing made after January 1, 2013, the insurer shall reduce the premiums in the filing so that the current lifetime expected loss ratio is equal to or greater than the highest initially filed loss ratio or that for requested premium rates filed after January 1, 2013. In the determination of a lifetime expected loss ratio, a margin may reflect changes in the manner in which risks are shared between the insurer and a block of policies due to changes in this law effective January 1, 2013, and that margin shall not be increased unless the manner in which risks are shared between the insurer and the block of policies is changed further by law or regulation. The determination of the lifetime expected loss ratio shall be based on the actual distribution of policies in force at the time of the first filing after January 1, 2013, and not any prior assumed distribution.

(c) In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including the following:

(1) Statistical credibility of incurred claims experience and earned premiums.

(2) The period for which rates are computed to provide coverage.

(3) Experienced and projected trends.

(4) Concentration of experience within early policy duration.

(5) Expected claim fluctuation.

(6) Experience refunds, adjustments, or dividends.

(7) Renewability features.

(8) All appropriate expense factors.

(9) The discount rate used in the calculation of lifetime expected loss ratios. All present and accumulated values used to determine rate increases should use the maximum valuation interest rate for contract reserves. If one rate increase filing includes policy forms with different discount rates, separate projections for each discount rate should be prepared and then combined to create the total projection for the filings.

(10) Experimental nature of the coverage.

(11) Policy reserves.

(12) Mix of business by risk classification.

(13) Product features, such as long elimination periods, high deductibles, and high maximum limits.

(d) Asset investment yield rate changes may not be used to justify a rate increase unless the insurer can demonstrate that its return on investments is lower than the maximum valuation interest rate for contract reserves for those policies or the commissioner determines that a change in interest rates is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state.

(e) The experience on all similar long-term care policy forms issued in this state by an insurer and its affiliates and retained within the affiliated group shall be pooled together and the combined experience shall be used as the basis for assumptions that satisfy the requirements in subdivisions (a) and (b). Those assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms shall be classified into one of the following benefit classifications: nursing facility and residential care facility only, home care only, or comprehensive long-term care benefits.

(f) Notwithstanding any other provision of this section, for rate revisions filed on or after January 1, 2010, the commissioner may approve an application for a rate revision based on less than a 70 percent loss ratio, but not less than a 60 percent loss ratio, for the portion attributable to the rate increase if an insurer can demonstrate that the rates are necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(g) This section applies only to long-term care insurance policies issued before the approval of rate schedules under Section 10236.11.

SEC. 15. Section 10236.13 of the Insurance Code is amended to read:

10236.13. No insurer may increase the premium for an individual or group long-term care insurance policy or certificate approved for sale under this chapter unless the insurer has received prior approval for the increase from the commissioner.

The insurer shall submit to the commissioner for approval all proposed premium rate schedule increases, including at least all of the following information:

(a) Certification by an actuary, who is a member of the American Academy of Actuaries and who meets the qualification standards of that organization, that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated.

(2) The premium rate filing is in compliance with the provisions of this section.

(b) An actuarial memorandum justifying the rate schedule change request that includes all of the following:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase, and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(A) Annual values for the five years preceding and the three years following the valuation date shall be provided separately.

(B) The projections shall include the development of the lifetime loss ratio. The lifetime expected loss ratio shall be calculated using the discount rate provided by subdivision (c) of Section 10236.14.

(C) For policies issued with premium rate schedules approved under Section 10236.11, the projections shall demonstrate compliance with subdivision (a) of Section 10236.14. For all other policies, the projections shall demonstrate compliance with Section 10236.1.

(D) If the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, then:

(i) The projected experience should be limited to the increases in claims expenses attributable to the changes in law or regulations.

(ii) If the commissioner determines that potential offsets to higher claims costs may exist, the insurer shall be required to use appropriate net projected experience.

(2) Disclosure of how reserves have been incorporated in this rate increase.

(3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary.

(4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration.

(5) A statement that asset investment yield rate changes have not been used to justify the rate increase unless the insurer can demonstrate that its return on investments is lower than the maximum valuation interest rate for contract reserves for those policies or the commissioner determines that a change in interest rates is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state.

(6) If it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer shall file composite rates reflecting projections of new certificates.

(c) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner.

(d) Sufficient information for approval of the premium rate schedule increase by the commissioner.

(e) (1) The insurer, at its discretion, may request a premium rate schedule increase that is lower than the rate increase necessary to provide the certification required by subdivision (a) or a series of premium rate schedule increases with a present value of not more than the rate increase necessary to provide the certification required by subdivision (a). The commissioner may accept the premium rate schedule increase or series of increases without submission of the certification required by subdivision (a) if all of the following apply:

(A) In the opinion of the commissioner, accepting the lower premium rate schedule increase or increases is in the best interest of California policyholders.

(B) The actuarial memorandum discloses to the commissioner the rate increase necessary to provide the certification required by subdivision (a).

(C) The rate increase filing satisfies all other requirements of this section.

(D) The insurer discloses to policyholders affected by the approved increases the filed increase, the approved premium rate schedule increase or increases, and the amount and timing of any subsequent rate schedule increases included in the rate increase filing whether those subsequent rate schedule increases are approved or not approved by the commissioner.

(2) The commissioner may approve a lower requested premium rate schedule increase and may approve the initial increase or more than just the initial increase requested pursuant to paragraph (1).

(3) If the amount of increase after all increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner, triggers the contingent benefit upon lapse, the commissioner shall require the administration by an insurer of the contingent benefit upon lapse as a condition of approval of a premium rate schedule increase that is lower than the amount necessary to provide the certification required by paragraph (1) of subdivision (a) or with the initial increase and each subsequent increase in a series of premium rate schedule increases. The commissioner may waive this condition of approval if an insurer demonstrates that the waiver is necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(4) For purposes of paragraph (2) of subdivision (a) of Section 10236.14, the loss ratio calculation shall assume future premiums are based on the total filed rate schedule increase or series of increases disclosed pursuant to subparagraph (D) of paragraph (1), whether the increase or increases are approved or not approved by the commissioner.

(5) Premium rate schedule increases requested pursuant to paragraph (1) or approved as described in paragraph (2) shall comply with the provisions of Sections 10234.6 and 10234.95.

(f) The provisions of this section are applicable to all individual and group policies issued in this state on or after July 1, 2002.

SEC. 16. Section 10236.14 of the Insurance Code is amended to read:

10236.14. Approval of all premium rate schedule increases shall be subject to the following requirements:

(a) (1) Premium rate schedule increases shall demonstrate that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times the maximum of both of the following:

(i) 58 percent.

(ii) The lifetime expected loss ratio calculated using the initial pricing assumption, actual distribution of policies issued, and the discount rate provided by subdivision (c).

(B) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis.

(C) The present value of future projected initial earned premiums times the maximum of both of the following:

(i) 58 percent.

(ii) The lifetime expected loss ratio calculated using the initial pricing assumption, actual distribution of policies issued, and the discount rate provided by subdivision (c).

(D) Eighty-five percent of the present value of future projected premiums not in subparagraph (C) on an earned basis.

(2) However, if the premiums in any rate revision filing calculated in this manner produce a lifetime expected loss ratio that is less than the highest lifetime expected loss ratio for this policy form in the initial filing or that for requested premium rates in any filing made after January 1, 2013, the insurer shall reduce the premiums in the filing so that the current lifetime expected loss ratio is equal to or greater than the highest initially filed loss ratio or that for requested premium rates filed after January 1, 2013. In the determination of a lifetime expected loss ratio, the margin for moderately adverse experience shall be reflected and shall not be increased unless the manner in which risks are shared between the insurer and block of policies has been changed by this law or any future law or regulation. The determination of the lifetime expected loss ratio shall be based on the actual distribution of policies issued and not any assumed distribution prior to actual sales.

(b) In the event the commissioner determines that a premium rate increase is justified due to changes in laws or regulations that are retroactively applicable to long-term care insurance previously sold in this state, a premium rate schedule increase may be approved if the increase provides that 70 percent of the present value of projected additional premiums shall be returned to policyholders in benefits and the other requirements applicable to other premium rate schedule increases are met.

(c) All present and accumulated values used to determine rate increases should use the maximum valuation interest rate for contract reserves. If one rate increase filing includes policy forms with different discount rates, separate projections for each discount rate should be prepared and then combined to create the total projection for the filing.

(d) No request for a rate increase on any policy form approved under Section 10236.11 shall be approved by the commissioner except as follows: the experience on all similar long-term care policy forms issued in this state by the insurer and its affiliates and retained by the affiliated group that have been approved either prior to approval under, or pursuant to, Section 10236.11 shall be pooled together and the combined experience shall be used as the basis for assumptions that satisfy the requirements in subdivision (a). Those assumptions and requested rate increases may vary by policy form if actuarially appropriate. Similar long-term care policy forms shall be classified into one of the following benefit classifications: nursing facility and residential care facility only, home care only, or comprehensive long-term care benefits. An insurer is not precluded from filing requests for premium rate schedule increases on all of its policy forms if the combined experiences after pooling all applicable policy forms satisfies the requirements of subdivision (a).

(e) Notwithstanding any other provision of this section, for applications for rate revisions filed on or after January 1, 2013, the commissioner may approve the application if an insurer demonstrates that the rates are necessary to protect the financial condition of the insurer, including avoidance of further reductions in capital and surplus.

(f) The provisions of this section are applicable to all individual and group policies issued in this state on or after July 1, 2002.

SEC. 17. Section 10236.15 of the Insurance Code is amended to read:

10236.15. Premium rate schedule increases that have been approved shall be subject to the following:

(a) For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in paragraph (1) of subdivision (b) of Section 10236.13, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years.

(b) (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subdivision (a), the commissioner may require the insurer to implement any of the following:

(A) Premium rate schedule adjustments.

(B) Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph (6) of subdivision (b) of Section 10236.13, if applicable.

(c) If the commissioner demonstrates, based upon credible evidence, that an insurer has engaged in a persistent practice of filing inadequate premium schedules, the commissioner may, in addition to any other authority of the commissioner under this chapter, and after the insurer is afforded proper notice and due process, prohibit the insurer from filing and marketing comparable coverage for a period of up to five years or from offering all other similar coverages, and may limit marketing of new applications to the products subject to recent premium rate schedule increases.

(d) This section shall not apply to life insurance policies and certificates that accelerate benefits for long-term care.

(e) The provisions of this section are applicable to all individual and group policies issued in this state on or after July 1, 2002.

SEC. 18. Section 11520.5 of the Insurance Code is amended to read:

11520.5. No person shall transact in this state the business described in this chapter without first procuring a certificate of authority from the commissioner for such purpose. Application for such certificate shall be made on a form prescribed by the commissioner accompanied by a filing fee of one thousand seven hundred seventy dollars ($1,770). The certificate shall not be granted until the applicant conforms to the requirements of this chapter and the laws of this state prerequisite to its issue. After such issue the holder shall continue to comply with the requirements of this chapter and the laws of this state. When a hearing is held under this section the proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all of the powers granted therein.

Subject to the annual fee provisions herein, every certificate of authority issued or held under this chapter shall be for an indefinite term and, unless sooner revoked by the commissioner, shall terminate upon occurrence of any of the following:

(a) Upon the holder’s ceasing to exist as a separate entity.

(b) Upon the winding up or dissolution, or expiration or forfeiture of the corporate existence of a corporate holder thereof.

(c) Upon winding up or dissolution of a holder not a corporation.

(d) In any event upon surrender by the holder of its certificate of authority and cancellation of the same by the commissioner.

The commissioner shall not cancel a surrendered certificate of authority until he or she is satisfied by examination, or otherwise, that the former holder has discharged its annuity liabilities to residents of this state or satisfactorily reinsured the same.

Notwithstanding the preceding provisions for a certificate of authority of indefinite term, each holder of a certificate of authority under this chapter shall owe and pay in advance to the commissioner in lawful money of the United States an annual fee of fifty-eight dollars ($58) on account of a certificate of authority until its final termination or revocation. The fee shall be for annual periods commencing on July 1st of each year and ending on June 30th of each year and shall be due on each March 1st and shall be delinquent on and after each April 1st.

Each holder of a certificate of authority shall also be subject to the payment in advance of the following fees, as appropriate:

(1) One hundred eighteen dollars ($118) for each amended certificate of authority caused by a change of the name of the holder.

(2) Eighty-nine dollars ($89) for the services and expenses of the commissioner in connection with the filing of amended articles by a holder.

(3) Three hundred fifty-four dollars ($354) for all services and expenses of the commissioner in connection with the withdrawal of a holder of a certificate of authority under this chapter.

(e) Upon the receipt of a notice of filing of a petition by or against a certificate holder under the United States Bankruptcy Code for bankruptcy or reorganization, the commissioner shall cease imposing, billing, or collecting the annual fees due under this chapter and this section to the certificate holder.

(f) Upon notice of the suspension of the corporate status of the certificate holder for a period of 12 months by the Secretary of State, the commissioner shall terminate the certificate of authority and shall deem the certificate to be terminated.

SEC. 19. Section 11691 of the Insurance Code is amended to read:

11691. (a) (1) In order to provide protection to the workers of this state in the event that the insurers issuing workers' compensation insurance to employers fail to pay compensable workers' compensation claims when due, except in the case of the State Compensation Insurance Fund, every insurer desiring admission to transact workers' compensation insurance, or workers' compensation reinsurance business, or desiring to reinsure the injury, disablement, or death portions of policies of workers' compensation insurance under the class of disability insurance shall, as a prerequisite to admission, or ability to reinsure the injury, disablement, or death portion of policies of workers' compensation insurance under the class of disability insurance, deposit cash instruments or approved interest-bearing securities or approved stocks readily convertible into cash, investment certificates, or share accounts issued by a savings and loan association doing business in this state and insured by the Federal Deposit Insurance Corporation, certificates of deposit, or savings deposits in a bank licensed to do business in this state, or approved letters of credit that perform in material respects as any other security allowable as a form of deposit for purposes of a workers' compensation deposit and that meet the standard set forth in Section 922.5, or approved securities registered with a qualified depository located in a reciprocal state as defined in Section 1104.9, with that deposit to be in an amount and subject to any exceptions as set forth in this article. The deposit shall be made from time to time as demanded by the commissioner and may be made with the Treasurer, or a bank or savings and loan association authorized to engage in the trust business pursuant to Division 1 (commencing with Section 99) or Division 2 (commencing with Section 5000) of the Financial Code, or a trust company. A deposit of securities registered with a qualified depository located in a reciprocal state as defined in Section 1104.9 may only be made in a bank or savings and loan association authorized to engage in the trust business pursuant to Division 1 (commencing with Section 99) or Division 2 (commencing with Section 5000) of the Financial Code, or a trust company, licensed to do business and located in this state that is either domiciled in and has a principal place of business in this state, or is a national bank association with a trust office located in this state, that is a qualified custodian as defined in paragraph (1) of subdivision (a) of Section 1104.9, and that maintains deposits of at least seven hundred fifty million dollars ($750,000,000). The deposit shall be made subject to the approval of the commissioner under those rules and regulations that he or she shall promulgate. The deposit shall be maintained at a deposit value specified by the commissioner, but in any event no less than one hundred thousand dollars ($100,000), nor less than the reserves required of the insurer to be maintained under any of the provisions of Article 1 (commencing with Section 11550) of Chapter 1, relating to loss reserves on workers' compensation business of the insurer in this state, nor less than the sum of the amounts specified in subdivision (a) of Section 11693, whichever is greater. The deposit shall be for the purpose of paying compensable workers' compensation claims under policies issued by the insurer or reinsured by the admitted reinsurer and expenses as provided in Section 11698.02, in the event the insurer or reinsurer fails to pay those claims when they come due. If the insurer providing the deposit is domiciled in a state where a state statute, regulation, or court decision provides that, with respect to covered claims within the deductible amount that are paid by a guarantee association after the entry of an order of liquidation under large deductible workers' compensation policies, any part of the reimbursement proceeds, other than the reasonable expenses of the receiver related to treatment of deductible policy arrangements of insurance companies in liquidation, owed by insureds on those deductible amounts, whether paid directly or through a draw of collateral, are general assets of the estate, then the amount of the insurer's deposit pursuant to this article shall be calculated based on the gross amount of that insurer's liabilities for loss and loss adjustment expenses under those policies without regard to the deductible, and those reserves shall not be reduced by any collateral or reimbursement obligations insureds were required to provide under those policies.

(2) This section does not require that the deposit be calculated based on gross amounts of liabilities described above if the domiciliary state does not have an existing statute, regulation, or court decision providing that the reimbursement proceeds described above are general assets of the estate.

(b) Each insurer or reinsurer desiring to have the ability to reinsure the injury, disablement, or death portions of policies of workers' compensation under the class of disability insurance shall provide prior notice to the commissioner, in the manner and form prescribed by the commissioner of its intent to reinsure that insurance. In the event of late notice, a late filing fee shall be imposed on the reinsurer pursuant to Section 924 for failure to notify the commissioner of its intent to reinsure workers' compensation insurance.

(c) If the deposit required by this section is not made with the Treasurer, then the depositor shall execute a trust agreement in a form approved by the commissioner between the insurer, the institution in which the deposit is made or, where applicable, the qualified custodian of the deposit, and the commissioner, that grants to the commissioner the authority to withdraw the deposit as set forth in Sections 11691.2, 11696, 11698, and 11698.3. The insurer shall also execute and deliver in duplicate to the commissioner a power of attorney in favor of the commissioner for the purposes specified herein, supported by a resolution of the depositor's board of directors. The power of attorney and director's resolution shall be on forms approved by the commissioner, shall provide that the power of attorney cannot be revoked or withdrawn without the consent of the commissioner, and shall be acknowledged as required by law.

(d) (1) The commissioner shall require payment in advance of fees for the initial filing of a trust agreement with a bank, savings and loan association, or trust company on deposits made pursuant to subdivision (a); for each amendment, supplement, or other change to the deposit agreement; for receiving and processing deposit schedules pursuant to this section; and for each withdrawal, substitution, or any other change in the deposit. The fees shall be set forth in the department's Schedule of Fees and Charges.

(2) The commissioner shall require payment in advance of a fee for the initial filing of each letter of credit utilized pursuant to subdivision (a). In addition, the commissioner shall require payment in advance of a fee for each amendment of a letter of credit. The fees shall be set forth in the department's Schedule of Fees and Charges.

(e) Any workers' compensation insurer that deposits cash or cash equivalents pursuant to this section shall be entitled to a prompt refund of those deposits in excess of the amount determined by the commissioner pursuant to subdivision (a). The commissioner shall cause to be refunded any deposits determined by the commissioner to be in excess of the amount required by subdivision (a) within 30 days of that determination. In the alternative, an insurer may use any excess deposit funds to offset a demand by the commissioner to increase its deposit due to the failure of a reinsurer to make a deposit pursuant to this section.

(f) (1) An admitted insurer reinsuring business covered in this article (hereafter referred to as reinsurer) shall identify to the commissioner, in a form prescribed by the commissioner, amounts deposited for credit in the name of each ceding insurer.

(2) All reinsurance agreements covering claims and obligations under business covered by this article, and allowable for purposes of granting a ceding carrier a deposit credit, shall include a provision granting the commissioner, in the event of a delinquency proceeding, receivership, or insolvency of a ceding insurer, any sums from a reinsurer's deposit that are necessary for the commissioner to pay those reinsured claims and obligations, or to ensure their payment by the California Insurance Guarantee Association, deemed by the commissioner due under the reinsurance agreement, upon failure of the reinsurer for any reason to make payments under the policy of reinsurance. The commissioner shall give 30 days' notice prior to drawing upon these funds of an intent to do so. Notwithstanding the commissioner's right to draw on these funds, the reinsurer shall otherwise retain its right to determine the validity of those claims and obligations and to contest their payment under the reinsurance agreement. Prior to a reinsurer's deposit being drawn upon, in whole or in part, by the department, the department shall provide a reinsurer with an explanation of procedures that a reinsurer may use to explain to the department why the use of the reinsurer's deposit may not be appropriate under the reinsurance agreement.

(3) A reinsurer entering into a contract identified in paragraph (2), beginning on or after January 1, 2005, may not cede claims or obligations assumed from a ceding insurer unless the deposit securing the ceded claims or obligations is governed by paragraph (2) or, upon approval of the commissioner, would secure the ceded claims or obligations in all material respects and in the same manner as a deposit identified in paragraph (2) above.

(4) All sums received from the reinsurer by the commissioner for those claims paid by the California Insurance Guarantee Association shall be held separate and apart from and not included in the general assets of the insolvent insurer, and shall be transferred to the California Insurance Guarantee Association upon receipt by the commissioner. In the event of a final judgment or settlement adverse to the drawing of funds by the commissioner pursuant to paragraph (2) or (3), the California Insurance Guarantee Association shall repay funds it obtained to pay covered claims and shall, if necessary, either levy a surcharge as needed or seek legislative approval to levy the surcharge if the California Insurance Guarantee Association is already levying the maximum surcharge permissible under law.

(g) If a reinsurer has not maintained deposits as required by subdivision (a) in amounts equal to the amounts of deposit credits claimed by its ceding insurers, the commissioner, after notifying the reinsurer and its ceding insurers of the deposit shortfall and allowing 15 days from the date of the notice for the deposit shortfall to be corrected, may disallow all or a portion of the reserve credits claimed by the ceding insurers. A ceding insurer disallowed a reserve credit pursuant to this provision shall immediately make the deposit required by this section.

(h) For interest-bearing securities that are debt securities and include principal payment features prior to maturity that are utilized pursuant to subdivision (a), all principal payments received shall be retained as part of the deposit.

(i) Withdrawal of any amount of the deposit required under subdivision (a) that results in a reduction of the required amount of the deposit may only occur with the prior written consent of the commissioner.

SEC. 20. Section 12921.1 of the Insurance Code is amended to read:

12921.1. (a) The commissioner shall establish a program on or before July 1, 1991, to investigate complaints and respond to inquiries received pursuant to Section 12921.3, to comply with Section 12921.4, and, when warranted, to bring enforcement actions against insurers or production agencies, as those terms are defined in subdivision (a) of Section 1748.5. The program shall include, but not be limited to, the following:

(1) A toll-free telephone number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries.

(2) Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department.

(3) A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked.

(4) Retention of records on complaints for at least three years after the complaint has been closed.

(5) Guidelines to disseminate complaint and enforcement information on individual insurers to the public, that shall include, but not be limited to, the following:

(A) License status.

(B) Number and type of complaints closed within the last full calendar year, with analogous statistics from the prior two years for comparison. The proportion of those complaints determined by the department to require that corrective action be taken against the insurer, or leading to insurer compromise, or other remedy for the complainant, as compared to those that are found to be without merit. This information shall be disseminated in a fashion that will facilitate identification of meritless complaints and discourage their consideration by consumers and others interested in the records of insurers.

(C) Number and type of violations found, by reference to the line of insurance and the law violated. For the purposes of this subparagraph, the department shall separately report this information for health insurers.

(D) Number and type of enforcement actions taken.

(E) Ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. Private passenger automobile insurance ratios shall be calculated as the number of complaints received to total car years earned in the period studied.

(F) Any other information the department deems is appropriate public information regarding the complaint record of the insurer that will assist the public in selecting an insurer. However, nothing in this section shall be construed to permit disclosure of information or documents in the possession of the department to the extent that the information and those documents are protected from disclosure under any other provision of law.

(6) Procedures and average processing times for each step of complaint mediation, investigation, and enforcement. These procedures shall be consistent with those in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 for complaints within the purview of that article, consistent with those in Article 7 (commencing with Section 1858) of Chapter 9 of Part 2 of Division 1 for complaints within the purview of that article, and consistent with any other provisions of law requiring certain procedures to be followed by the department in investigating or prosecuting complaints against insurers or production agencies.

(7) A list of criteria to determine which violations should be pursued through enforcement action, and enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

(8) Referral of complaints not within the department's jurisdiction to appropriate public and private agencies.

(9) Complaint handling goals that can be tested against surveys carried out pursuant to subdivision (a) of Section 12921.4.

(10) Inclusion in its annual report to the Governor, required by Section 12922, detailed information regarding the program required by this section, that shall include, but not be limited to: a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the department pursuant to

complaints if further enforcement is deemed necessary to ensure proper compliance by insurers or production agencies with the law.

(b) The commissioner shall promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer or production agency.

(c) The commissioner shall provide to the insurer or production agency a description of any complaint against the insurer or production agency that the commissioner has received and has deemed to be justified at least 30 days prior to public release of a report summarizing the information required by this section. This description shall include all of the following:

(1) The name of the complainant.

(2) The date the complaint was filed.

(3) A succinct description of the facts of the complaint.

(4) A statement of the department's rationale for determining that the complaint was justified that applies the department's criteria to the facts of the complaint.

(d) An insurer shall provide to the department the name, mailing address, telephone number, and facsimile number of a person whom the insurer designates as the recipient of all notices, correspondence, and other contacts from the department concerning complaints described in this section. The insurer may change the designation at any time by providing written notice to the Consumer Services Division of the department.

(e) The commissioner may establish an Internet-accessible complaints response system to distribute and receive complaint information as described in subdivisions (a) and (c). Insurers shall be required to submit and receive complaint information, including, but not limited to, requested claim files, underwriting files, correspondence, and other supporting documents, using any system established by the commissioner pursuant to this subdivision.

(f) For the purposes of this section, notices, correspondence, and other contacts with the designated person shall be deemed contact with the insurer.

SEC. 21. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.