AB-1816 Insurance. (2019-2020)

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Assembly Bill No. 1816

CHAPTER 833

An act to amend Sections 678, 1063.1 and 10094.2 of the Insurance Code, relating to insurance, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor October 12, 2019. Filed with Secretary of State October 12, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1816, Daly. Insurance.

Existing law requires an insurer, at least 45 days prior to the expiration of an insurance policy, except for specified insurance policies, to deliver or mail to the named insured, an offer of renewal or a notice of nonrenewal of the policy, as specified. If the insurer fails to do so, existing law requires the existing policy, with no change in its terms and conditions, to remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured.

This bill, with respect to a notice of nonrenewal for a policy that expires on or after July 1, 2020, would require an insurer to deliver or mail the notice of nonrenewal to the named insured on or before 75 days prior to the policy expiration and, if the insurer fails to do so, would require the existing policy, with no change in its terms and conditions, to remain in effect for 75 days from the date that the notice of nonrenewal is delivered or mailed. The bill also would require, commencing on July 1, 2020, a notice of nonrenewal of a policy to contain specified contact information for the Department of Insurance.

Existing law creates the California Insurance Guarantee Association (CIGA) and requires all insurers admitted to transact specified insurance lines in this state to become members. Under existing law, CIGA pays and discharges covered claims, which are the obligations of an insolvent insurer, including the obligation for unearned premiums, that meet specified requirements. Existing law excludes the portion of a claim in excess of $500,000 from the definition of “covered claims,” except in a claim for workers’ compensation benefits.

This bill would require, with respect to a policy of residential property insurance, each claim for a loss under a different coverage category to be considered a separate covered claim. The bill would increase the limit for a covered claim for damage to, or loss of, a dwelling structure under a policy of residential property insurance to an amount that does not exceed $1,000,000 or the amount recoverable under the policy, whichever is less.

Under existing law, the California FAIR Plan Association, also known as the facility, is a joint reinsurance association formed by state insurers licensed to write and engaged in writing basic property insurance within this state to assist persons in securing basic property insurance and to formulate and administer a program and FAIR Plan for the equitable apportionment among insurers of basic property insurance. Existing law requires the FAIR Plan and any amendment to the plan to be approved by the Insurance Commissioner. Existing law requires, under the plan, each insurer to participate in the writings, expenses, and profits and losses of the association in the proportion that its premiums written bear to the aggregate premiums written by all insurers in the program, as specified, but requires the plan, pursuant to regulations adopted by the commissioner, to provide for a method for

insurers who voluntarily write basic property insurance on risks located in areas designated as brush hazard areas to be proportionately relieved of the liability to participate in the plan.

This bill would add to the insurers that are proportionately relieved of the liability to participate in the FAIR Plan those insurers voluntarily writing basic property insurance on risks in high or very high fire hazard severity zones, as determined and mapped by the Department of Forestry and Fire Protection. The bill would, for purposes of providing that proportionate relief from liability for all of those risk areas, require those areas to be designated as either a brush hazard area or a high or very high fire hazard severity zone at the beginning of the policy period. The bill would require the facility to prepare and submit a report to the Governor, the commissioner, and the insurance committees of the Senate and the Assembly identifying the credit for voluntary writings submitted by licensees in the high and very high fire hazard severity zones, as specified. The bill would require the facility to prepare and submit the report 3 times, as specified, beginning on or before July 1, 2023.

This bill would declare that it is to take effect immediately as an urgency statute.
Vote: 2/3 Appropriation: no Fiscal Committee: yes Local Program: no

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

SECTION 1. Section 678 of the Insurance Code is amended to read:

678. (a) At least 45 days before policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(1) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating each of the following:

(A) Any reduction of limits or elimination of coverage.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the renewal offer.

(2) A notice of nonrenewal of the policy. That notice shall contain all of the following:

(A) The reason or reasons for the nonrenewal.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the notice of nonrenewal.

(C) Until July 1, 2020, a brief statement indicating that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

(D) On or after July 1, 2020, a statement that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the department's internet website, www.insurance.ca.gov, the department's telephone number, (800) 927-HELP (4357), and the mailing address of the department's Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013.

(b) If an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Notwithstanding subdivisions (a) and (b), with respect to a notice of nonrenewal for a policy that expires on or after July 1, 2020, the following timelines apply:

(1) At least 75 days prior to the policy expiration, the insurer shall deliver the notice of nonrenewal to the named insured or mail the notice of nonrenewal to the named insured at the address shown in the policy. The notice shall include the information contained in paragraph (2) of subdivision (a).

(2) If an insurer fails to give the named insured a notice of nonrenewal at least 75 days prior to the policy expiration, as required by paragraph (1), the existing policy, with no change in its terms and conditions, shall remain in effect for 75 days from the date that the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the notice of nonrenewal.

(d) A policy written for a term of less than one year shall be considered as if written for a term of one year. A policy written for a term longer than one year, or a policy with no fixed expiration date, shall be considered as if written for successive policy periods

or terms of one year.

(e) This section applies only to policies of insurance specified in Section 675.

SEC. 2. Section 1063.1 of the Insurance Code is amended to read:

1063.1. As used in this article:

(a) “Member insurer” means an insurer required to be a member of the association in accordance with subdivision (a) of Section 1063, except and to the extent that the insurer is participating in an insolvency program adopted by the United States government.

(b) “Insolvent insurer” means an insurer that was a member insurer of the association, consistent with paragraph (11) of subdivision (c), either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, or, in the case of the State Compensation Insurance Fund, if a finding of insolvency is made by a duly enacted legislative measure.

(c) (1) “Covered claims” means the obligations of an insolvent insurer, including the obligation for unearned premiums, that satisfy all of the following requirements:

(A) Imposed by law and within the coverage of an insurance policy of the insolvent insurer.

(B) Which were unpaid by the insolvent insurer.

(C) Which are presented as a claim to the liquidator in the state of domicile of the insolvent insurer or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings.

(D) Which were incurred before the date coverage under the policy terminated and before, on, or within 30 days after the date the liquidator was appointed.

(E) For which the assets of the insolvent insurer are insufficient to discharge in full.

(F) In the case of a policy of workers’ compensation insurance, to provide workers’ compensation benefits under the workers’ compensation law of this state.

(G) In the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

(2) “Covered claims” also includes the obligations assumed by an assuming insurer from a ceding insurer when the assuming insurer subsequently becomes an insolvent insurer if, at the time of the insolvency of the assuming insurer, the ceding insurer is no longer admitted to transact business in this state. Both the assuming insurer and the ceding insurer shall have been member insurers at the time the assumption was made. “Covered claims” under this paragraph shall satisfy the requirements of subparagraphs (A) to (G), inclusive, of paragraph (1), except for the requirement that the claims be against policies of the insolvent insurer. The association has a right to recover a deposit, bond, or other assets that may have been required to be posted by the ceding company to the extent of covered claim payments and shall be subrogated to any rights the policyholders may have against the ceding insurer.

(3) “Covered claims” does not include obligations arising from the following:

(A) Life, annuity, health, or disability insurance.

(B) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(C) Fidelity or surety insurance including fidelity or surety bonds, or any other bonding obligations.

(D) Credit insurance.

(E) Title insurance.

(F) Ocean marine insurance or ocean marine coverage under an insurance policy, including claims arising from the following: the Jones Act (46 U.S.C. Secs. 30104 and 30105), the Longshore and Harbor Workers’ Compensation Act (33 U.S.C. Sec. 901 et seq.), or any other similar federal statutory enactment, or an endorsement or policy affording protection and indemnity coverage.

(G) A claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers’ compensation policy issued pursuant to subdivision (c) of Section 3702.8 of the Labor Code that

covers all or any part of workers' compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.

(4) "Covered claims" does not include an obligation of the insolvent insurer arising out of a reinsurance contract, an obligation incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured, canceled at the insured's request, or canceled by the liquidator, or an obligation to a state or to the federal government.

(5) (A) "Covered claims" does not include an obligation to insurers, insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

(B) An insurer, insurance pool, or underwriting association may not maintain, in its own name or in the name of its insured, a claim or legal action against the insured of the insolvent insurer for contribution, indemnity, or by way of subrogation, except insofar as, and to the extent only, that the claim exceeds the policy limits of the insolvent insurer's policy. In those claims or legal actions, the insured of the insolvent insurer is entitled to a credit or setoff in the amount of the policy limits of the insolvent insurer's policy, or in the amount of the limits remaining, when those limits have been diminished by the payment of other claims.

(6) "Covered claims," except in cases involving a claim for workers' compensation benefits or for unearned premiums, does not include a claim in an amount of one hundred dollars ($100) or less or the portion of a claim that is in excess of the applicable limits provided in the insurance policy issued by the insolvent insurer.

(7) (A) "Covered claims" does not include that portion of a claim, other than a claim for workers' compensation benefits, that is in excess of five hundred thousand dollars ($500,000).

(B) For purposes of subparagraph (A), with respect to a policy of residential property insurance, each claim for a loss under a different coverage category shall be considered a separate covered claim.

(C) Notwithstanding subparagraph (A), a claim for damage to, or loss of, a dwelling structure under a policy of residential property insurance shall not exceed one million dollars ($1,000,000) or the amount recoverable under the policy, whichever is less.

(8) "Covered claims" does not include an amount awarded as punitive or exemplary damages, or an amount awarded by the Workers' Compensation Appeals Board pursuant to Section 5814 or 5814.5 of the Labor Code because payment of compensation was unreasonably delayed or refused by the insolvent insurer.

(9) "Covered claims" does not include either of the following:

(A) A claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured.

(B) A claim by a person other than the original claimant under the insurance policy in the claimant's own name, the claimant's assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into before insolvency, or the claimant's executor, administrator, guardian, or other personal representative or trustee in bankruptcy, and does not include a claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

(10) "Covered claims" does not include an obligation arising out of the issuance of an insurance policy written by the separate division of the State Compensation Insurance Fund pursuant to Sections 11802 and 11803.

(11) "Covered claims" does not include an obligation of the insolvent insurer arising from a policy or contract of insurance issued or renewed before the insolvent insurer's admission to transact insurance in the State of California.

(12) "Covered claims" does not include surplus deposits of subscribers as defined in Section 1374.1.

(13) "Covered claims" shall also include an obligation arising under an insurance policy written to indemnify a permissibly self-insured employer pursuant to subdivision (b) or (c) of Section 3700 of the Labor Code for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention. However, for purposes of this article, those claims shall not be considered workers' compensation claims and therefore are subject to the per-claim limit in paragraph (7), and any payments and expenses related thereto shall be allocated to category (c) for claims other than workers' compensation, homeowners, and automobile, as provided in Section 1063.5.

These provisions shall apply to obligations arising under a policy as described herein issued to a permissibly self-insured employer or group of self-insured employers pursuant to Section 3700 of the Labor Code and notwithstanding any other provision of this code, those obligations shall be governed by this provision in the event that the Self-Insurers' Security Fund is ordered to

assume the liabilities of a permissibly self-insured employer or group of self-insured employers pursuant to Section 3701.5 of the Labor Code. This paragraph applies only to insurance policies written to indemnify a permissibly self-insured employer or group of self-insured employers under subdivision (b) or (c) of Section 3700 of the Labor Code, for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention, and this paragraph does not apply to special excess workers' compensation insurance policies unless issued pursuant to authority granted in subdivision (c) of Section 3702.8 of the Labor Code, and as provided for in subparagraph (G) of paragraph (3). In addition, this paragraph does not apply to a claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses as are excluded in subparagraph (G) of paragraph (3).

A permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall, to the extent required by the Labor Code, be responsible for paying, adjusting, and defending each claim arising under policies of insurance covered under this section, unless the benefits paid on a claim exceed the specific or aggregate retention, in which case:

(A) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy requires the insurer to defend and adjust the claim, the California Insurance Guarantee Association (CIGA) shall be solely responsible for adjusting and defending the claim, and shall make all payments due under the claim, subject to the limitations and exclusions of this article with regard to covered claims. As to each claim subject to this paragraph, notwithstanding any other provisions of this code or the Labor Code, and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(B) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy does not require the insurer to defend and adjust the claim, the permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall not have any further payment obligations with respect to the claim, but shall continue defending and adjusting the claim, and shall have the right, but not the obligation, in a proceeding to assert all applicable statutory limitations and exclusions as contained in this article with regard to the covered claim. CIGA shall have the right, but not the obligation, to intervene in a proceeding in which the self-insured employer, group of self-insured employers, or the Self-Insurers' Security Fund is defending a claim and shall be permitted to raise the appropriate statutory limitations and exclusions as contained in this article with respect to covered claims. Regardless of whether the self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, asserts the applicable statutory limitations and exclusions, or whether CIGA intervenes in a proceeding, CIGA shall be solely responsible for paying all benefits due on the claim, subject to the exclusions and limitations of this article with respect to covered claims. As to each claim subject to this paragraph, notwithstanding any other provision of this code or the Labor Code and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund, shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(C) In the event that the benefits paid on the covered claim exceed the per-claim limit in paragraph (7), the responsibility for paying, adjusting, and defending the claim shall be returned to the permissibly self-insured employer or group of employers, or the Self-Insurers' Security Fund.

These provisions shall apply to all pending and future insolvencies. For purposes of this paragraph, a pending insolvency is one involving a company that is currently receiving benefits from the guarantee association.

(d) "Admitted to transact insurance in this state" means an insurer possessing a valid certificate of authority issued by the department.

(e) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(f) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing that control does not in fact exist.

(g) "Claimant" means an insured making a first party claim or a person instituting a liability claim. However, no person who is an affiliate of the insolvent insurer may be a claimant.

(h) “Ocean marine insurance” includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, that are usually insured against by traditional marine insurance such as hull and machinery, marine builders’ risks, and marine protection and indemnity. Those perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of a vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person.

(i) “Unearned premium” means that portion of a premium as calculated by the liquidator that had not been earned because of the cancellation of the insolvent insurer’s policy and is that premium remaining for the unexpired term of the insolvent insurer’s policy. “Unearned premium” does not include an amount sought as return of a premium under a policy providing retroactive insurance of a known loss or return of a premium under a retrospectively rated policy or a policy subject to a contingent surcharge or a policy in which the final determination of the premium cost is computed after expiration of the policy and is calculated on the basis of actual loss experienced during the policy period.

SEC. 3. Section 10094.2 of the Insurance Code is amended to read:

10094.2. (a) Notwithstanding subdivision (c) of Section 10095, the facility shall, pursuant to regulations adopted by the commissioner, provide for a method whereby insurers who voluntarily write basic property insurance on risks located in areas designated at the beginning of the policy period as brush hazard areas by the Insurance Services Office (ISO) or designated at the beginning of the policy period as high or very high fire hazard severity zones as determined and mapped by the Department of Forestry and Fire Protection, or very high fire hazard severity zones as determined and mapped by the Department of Forestry and Fire Protection pursuant to Section 51178 of the Government Code will, to that extent, be proportionately relieved of the liability to participate in a plan adopted pursuant to this chapter. The facility shall, pursuant to regulations adopted by the commissioner, provide for a method whereby insurers who voluntarily write basic property insurance or business owners package insurance on risks located in areas designated as inner-city areas by the commissioner will, to that extent, be proportionately relieved of the liability to participate in a plan adopted pursuant to this chapter. This chapter does not preclude adoption of a plan or plans to allow proportionate credit for voluntary writings in other areas or for other classes of insurance.

(b) (1) The facility shall prepare and submit a report to the Governor, the commissioner, and the committees of the Senate and the Assembly having jurisdiction over insurance, identifying the credit for voluntary writings submitted by licensees in the high and very high fire hazard severity zones as determined and mapped by the Department of Forestry and Fire Protection, and the very high fire hazard severity zones as determined and mapped by the Department of Forestry and Fire Protection pursuant to Section 51178 of the Government Code, in order to determine whether or not the designations are sufficient to effectuate the purposes of this section.

(2) The facility shall prepare and submit the report required by this subdivision three times, with the first report due on or before July 1, 2023, the second report due on or before July 1, 2025, and the third report due on or before July 1, 2027.

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to provide assistance as soon as possible to homeowners in high and very high fire hazard severity zones, including assistance to homeowners who are having difficulty obtaining insurance, it is necessary that this act take effect immediately.