AB-2154 California Insurance Guarantee Association. (2021-2022)

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Assembly Bill No. 2154

CHAPTER 408

An act to amend Section 63049.64 of the Government Code, and to amend Sections 1063.1, 1063.5, 1063.14, 1063.70, 1063.71, 1063.73, 1063.74, and 1063.75 of, to amend the heading of Article 14.26 (commencing with Section 1063.70) of Chapter 1 of Part 2 of Division 1 of, to add Section 1063.78 to, to repeal Section 1063.16 of, to repeal Article 14.25 (commencing with Section 1063.50) of Chapter 1 of Part 2 of Division 1 of, and to repeal and add Section 1063.72 of, the Insurance Code, relating to insurance.

[Approved by Governor September 18, 2022. Filed with Secretary of State September 18, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2154, Cooley. California Insurance Guarantee Association.

(1) 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 that meet specified requirements. Existing law requires CIGA to collect premium payments from its member insurers sufficient to discharge its obligations. Existing law requires CIGA to allocate its claim payments and costs to the categories of workers' compensation claims, homeowners' and automobile claims, and other claims.

Under existing law, if CIGA determines that the insolvency of one or more member insurers providing workers' compensation insurance will result in covered claim obligations for workers' compensation claims in excess of CIGA's capacity to pay from current funds, the board of CIGA may ask the California Infrastructure and Economic Development Bank to issue bonds. Under existing law, if a natural disaster results in covered claim obligations currently payable and owed to CIGA in excess of its capacity to pay from current funds and current premium assessment, the board of CIGA may ask the Department of Insurance to issue bonds. Existing law authorizes CIGA or the department, as appropriate, to levy assessments on CIGA member insurers to pay the principal and interest on the bonds, which member insurers recoup from insureds through a surcharge on applicable policies. Existing law creates the Workers' Comp Bond Fund and the Insurance Assessment Bond Fund, into which proceeds from the sale of bonds are deposited.

This bill would repeal the provisions relative to bonds issued to discharge claims after a natural disaster, and would revise the provisions relative to bonds issued to discharge workers' compensation to additionally authorize CIGA to ask the California Infrastructure and Economic Development Bank to issue bonds if CIGA determines the insolvency of member insurers writing homeowners' and automobile insurance and other insurance will result in covered claim obligations in excess of CIGA's capacity to pay from current funds. If the board of CIGA asks the California Infrastructure and Economic Development Bank to issue bonds, the bill would require the board to report specified information to the Assembly Committee on Insurance and the Senate Committee on Insurance within 60 days of the request, and annually thereafter while the bonds remain outstanding. The bill would authorize CIGA to levy an assessment on member insurers writing homeowners' and automobile insurance and other insurance to pay the principal of, and interest on, the bonds issued for that claims category, which would be recouped through a

surcharge on applicable policies, thereby imposing a tax. The bill would create the Homeowners' and Automobile Bond Fund and the Other Bond Fund into which proceeds from the sale of bonds to cover claims in those categories of insurance would be deposited. The bill would also make conforming changes.

This bill would specify that obligations under a policy issued to cover cybersecurity are covered claims, as long as CIGA's total liability does not exceed $1,000,000 or the policy limits, whichever is less.

(2) Existing law requires CIGA to adopt a plan of operation that requires a member insurer to recoup the premium charge paid by the member insurer through a surcharge on premiums charged for insurance policies in the year following the premium charge.

This bill would require the plan of operation to require a member insurer to recoup the premium charge amount, as determined by CIGA, through a surcharge on premiums, even if a premium charge has not yet been paid to CIGA because the member insurer had no direct written premium for that category of insurance for the prior year.

(3) This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $^2/_3$ of the membership of each house of the Legislature.
Vote: 2/3 Appropriation: no Fiscal Committee: yes Local Program: no

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

SECTION 1. Section 63049.64 of the Government Code is amended to read:

63049.64. (a) The bank may issue bonds pursuant to Chapter 5 (commencing with Section 63070) and may loan the proceeds thereof to the association, and deposit the proceeds into a separate account in the fund, or use the proceeds to refund bonds previously issued under this article. Bond proceeds may also be used to fund necessary reserves, capitalized interest, credit enhancement costs, or costs of issuance.

(b) Bonds issued under this article shall not be deemed to constitute a debt or liability of the state or of any political subdivision thereof, other than the bank, or a pledge of the faith and credit of the state or of any political subdivision, but shall be payable solely from the fund and other revenues and assets securing the bonds. All bonds issued under this article shall contain on the face of the bonds a statement to that effect.

(c) For purposes of this article, the term "project," as defined in subdivision (p) of Section 63010, shall include financing of the costs of claims of insolvent insurers admitted to transact insurance in at least one of the categories described in paragraph (2) of subdivision (a) of Section 1063.5 of the Insurance Code, in an amount (together with associated costs of financing) that may be determined by the association in making a request for financing to the bank.

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 or under the workers' compensation law of any state if the injured worker is a resident of this state and not otherwise entitled to coverage from an organization similar to the association in any other 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. If the individual has a covered claim that includes medical services provided by a medical facility owned in whole or in part by a state or federal agency, the association may pay that claim directly to the facility, as long as the services provided otherwise qualify as a covered claim and the claim is owned by the medical facility asserting the claim.

(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 association 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.

(14) "Covered claims" also includes all obligations arising under a policy issued to cover cybersecurity, as long as the association's total liability for all those obligations does not exceed one million dollars ($1,000,000) or the policy limits, whichever is less. Cybersecurity claims shall be covered by the account categorized pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 1063.5, unless the coverage is specifically attached to a policy that would otherwise be covered by an account categorized pursuant to subparagraph (A) or (B) of paragraph (2) of subdivision (a) of Section 1063.5.

(15) Notwithstanding any other provision in this section or Section 1063, if an insurance policy has been allocated to or assumed by a company that did not issue the policy pursuant to a state statute that provides for the division of an insurance company or the statutory assumption of designated policies by a new company, that statute provides a novation has been deemed to have occurred with respect to those policies, and that company is placed in liquidation, then to the extent a claim arising under that allocated or transferred policy would have been a covered claim had the original company been placed in liquidation before the statutory allocation or assumption, any claim arising under that same policy shall be a covered claim regardless of whether the company that allocated or assumed the policy was or was not a member at the time the policy was issued or when the insured event occurred.

(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) "Net direct written premiums" means the amount of direct written premiums in the annual financial statement on file with the commissioner, adjusted for any premiums written for any lines of insurance or types of coverages not covered by this article, plus premiums written in this state for coverage under a special excess workers' compensation policy.

(i) "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.

(j) “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 1063.5 of the Insurance Code is amended to read:

1063.5. (a) (1) To the extent necessary to secure funds for the association for payment of the administrative expenses of the association, covered claims of insolvent insurers, and for payment of reasonable costs of adjusting the claims, the association shall collect premium payments from its member insurers sufficient to discharge its obligations.

(2) The association shall allocate its claim payments and costs, incurred or estimated to be incurred, to one or more of the following categories:

(A) Workers’ compensation claims.

(B) Homeowners’ claims and automobile claims, including all of the following:

(i) Automobile material damage.

(ii) Automobile liability (both personal injury and death and property damage).

(iii) Medical payments.

(iv) Uninsured motorist claims.

(C) Claims other than workers’ compensation, homeowners’, and automobile, as defined above.

(3) Separate premium payments shall be required for each category.

(4) The premium payments for each category shall be used to pay the claims and costs allocated to that category.

(b) (1) The rate of premium charged shall be a uniform percentage of net direct written premium in the preceding calendar year applicable to that category.

(2) The rate of premium charges to each member insurer in the appropriate categories shall be based on the net direct written premium of each member insurer as shown in the latest year’s annual financial statement on file with the commissioner.

(3) In cases of a dispute as to the amount of the net direct written premium between the association and one of its member insurers, the written decision of the commissioner shall be final.

(c) Within 90 days after the filing of an annual statement, each member insurer shall file a report to the association indicating the amount of premiums not subject to the association’s premium charge and the amount of special excess workers’ compensation premiums for the preceding calendar year. The report is not required in any year in which a premium charge is not made by the association.

(d) In charging premiums to member insurers, the association shall adjust, if necessary, the net direct written premiums shown on a member insurer’s annual statement by excluding any premiums written for any lines of insurance or types of coverage not covered by this article under paragraph (3) of subdivision (c) of Section 1063.1.

(e) (1) The premium charged to any member insurer for any of the three categories or a category established by the association shall not be more than 2 percent of the net direct written premium unless there are bonds outstanding that were issued pursuant to Article 14.26 (commencing with Section 1063.70).

(2) If bonds issued pursuant to Article 14.26 (commencing with Section 1063.70) are outstanding, the premium charged to a member insurer for the category for which the bond proceeds are being used to pay claims and expenses shall not be more than 1 percent of the net direct written premium for that category.

(f) (1) The association may exempt or defer, in whole or in part, the premium charge of any member insurer, if the premium charge would cause the member insurer's financial statement to reflect an amount of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders by the company whose premium charge was deferred.

(2) Deferred premium charges shall be paid when the payment will not reduce capital or surplus below required minimums.

(g) After all covered claims of insolvent insurers and expenses of administration have been paid, any unused premiums and any reimbursements or claims dividends from liquidators remaining in any category shall be retained by the association and applied to reduce future premium charges in the appropriate category.

(h) The commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer that fails to pay a premium when due and after demand has been made.

(i) Interest at a rate equal to the current federal reserve discount rate plus $2^{1}/_{2}$ percent per annum shall be added to the premium of any member insurer that fails to submit the premium requested by the association within 30 days after the mailing request. However, in no event shall the interest rate exceed the legal maximum.

(j) This section shall apply only to premium charges paid on or after January 1, 2017.

SEC. 4. Section 1063.14 of the Insurance Code is amended to read:

1063.14. (a) (1) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain provisions whereby each member insurer is required to recoup, in the year following the premium charge, a sum calculated to recoup the premium charge paid by the member insurer under this article by way of a surcharge on premiums charged for insurance policies to which this article applies.

(2) Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

(b) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain a provision requiring a member insurer to recoup the premium charge amount, as determined by the association, through a surcharge on premiums charged for insurance policies to which this article applies, even if a premium charge was not yet paid to the association because the member insurer had no direct written premium for insurance policies to which this article applies for the prior year. All surcharges collected in this manner shall be remitted to the association within 60 days of the end of the calendar year in which the surcharge is collected.

(c) (1) The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The association shall determine the rate of the surcharge and the collection period for each category, and these shall be mandatory for all member insurers of the association who write business in those categories.

(2) Each member insurer shall file a report in accordance with the provisions of the plan of operation indicating the amount of surcharges it has collected.

(A) Member insurers who collect surcharges in excess of premium charges paid in the preceding year pursuant to Section 1063.5 shall remit the excess to the association as an additional premium within 30 days after the association has determined the amount of the excess recoupment and given notice to the member insurer of that amount. The excess shall be applied to reduce future premium charges in the appropriate category.

(B) Member insurers who report surcharge collections that are less than what they paid in the preceding year's premium charge shall receive reimbursement from the association for the shortfall in surcharge collection.

(C) Member insurers may amend their reports indicating the amount of surcharges collected for the prior five years if they discover there was an error in the original reports filed with the association.

(d) The plan of operation may permit a member insurer to omit collection of the surcharge from any of its insureds only if the expense of collecting the surcharge would exceed the amount of the surcharge, provided, however, that a member insurer is not entitled to reimbursement from the association pursuant to subparagraph (B) of paragraph (2) of subdivision (b) of any amount omitted from collection pursuant to this subdivision.

(e) This section applies only to premium charges paid on or after January 1, 2017.

SEC. 5. Section 1063.16 of the Insurance Code is repealed.

SEC. 6. Article 14.25 (commencing with Section 1063.50) of Chapter 1 of Part 2 of Division 1 of the Insurance Code is repealed.

SEC. 7. The heading of Article 14.26 (commencing with Section 1063.70) of Chapter 1 of Part 2 of Division 1 of the Insurance Code is amended to read:

Article 14.26. California Insurance Guarantee Association Bond Funds

SEC. 8. Section 1063.70 of the Insurance Code is amended to read:

1063.70. The California Insurance Guarantee Association is authorized to pay and discharge certain claims of insolvent insurers as defined in Section 1063.1 through the collection of premiums from its members, which amounts are limited by law and take time to assess and collect. This article provides for the ability of CIGA to request the issuance of bonds by the California Infrastructure and Economic Development Bank pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code to more expeditiously and effectively provide for the payment of covered claims that arise as a result of the insolvencies of insurers admitted to transact insurance in at least one of the categories described in paragraph (2) of subdivision (a) of Section 1063.5. The bonds are to be paid from the special bond assessments assessed by CIGA for those purposes and the other funds provided pursuant to Section 1063.74. Special bond assessments to repay bonds issued for payment of insurance benefits shall be assessed, to the extent necessary, for the respective category for which bonds are issued. It is a public purpose and in the best interest of the public health, safety, and general welfare of the residents of this state to provide for the issuance of bonds to pay claimants and policyholders having covered claims against insolvent insurers operating in this state.

SEC. 9. Section 1063.71 of the Insurance Code is amended to read:

1063.71. (a) The terms “member insurer,” “insolvent insurer,” and “covered claims” have the meanings assigned those terms in Section 1063.1.

(b) “Bank” means the California Infrastructure and Economic Development Bank created pursuant to Article 1 (commencing with Section 63020) of Chapter 2, Division 1 of Title 6.7 of the Government Code.

(c) “Board” means the board of governors of CIGA.

(d) “Bonds” means bonds issued by the Bank pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code to provide funds for the payment of the covered claims and the adjusting and defense expenses relating to those claims that are issued at the request of the board pursuant to Section 1063.73.

(e) “Collateral” means the special bond assessments, the right of CIGA to be paid the special bond assessments, all revenues therefrom, the separate accounts of the Workers’ Compensation Bond Fund, the Homeowners’ and Automobile Bond Fund, and the Other Bond Fund into which special bond assessments are deposited, and the proceeds thereof.

(f) “CIGA” means the California Insurance Guarantee Association, established pursuant to Article 14.2 (commencing with Section 1063).

(g) “Commissioner” means the Insurance Commissioner.

(h) “Department” means the Department of Insurance.

(i) “Homeowners’ and Automobile Bond Fund” means the fund created pursuant to subdivision (b) of Section 1063.72.

(j) “Other Bond Fund” means the fund created pursuant to subdivision (c) of Section 1063.72.

(k) “Special bond assessment” means the premiums collected by CIGA pursuant to Section 1063.74.

(l) “Workers’ Compensation Bond Fund” means the fund created pursuant to subdivision (a) of Section 1063.72.

SEC. 10. Section 1063.72 of the Insurance Code is repealed.

SEC. 11. Section 1063.72 is added to the Insurance Code, to read:

1063.72. (a) The Workers’ Compensation Bond Fund is hereby created.

(1) Proceeds from the sale of bonds with respect to the workers’ compensation category described in subparagraph (A) of paragraph (2) of subdivision (a) of Section 1063.5 shall be deposited in a separate account in the Workers’ Compensation Bond Fund. Only CIGA, and, with respect to payment of the bonds, the trustee for the bonds, shall have the ability to authorize disbursements from the separate account within the Workers’ Compensation Bond Fund.

(2) Special bond assessments levied pursuant to Section 1063.74 with respect to the workers' compensation category shall be deposited in a separate account in the Workers' Compensation Bond Fund and shall not be commingled with any other moneys. Only the trustee for the bonds shall have the ability to authorize disbursements from this separate account within the Workers' Compensation Bond Fund, and CIGA shall have no right or authority to authorize disbursements from this separate account.

(3) The Workers' Compensation Bond Fund shall be maintained with the trustee for the bonds. Following payment or provision for payment of the bonds, amounts in the Workers' Compensation Bond Fund shall be transferred to the fund that is designated in the indenture for the bonds.

(4) All money in the Workers' Compensation Bond Fund and all special bond assessments levied pursuant to Section 1063.74 with respect to the workers' compensation category shall be used by CIGA for the exclusive purpose of carrying out the purposes of this part. Notwithstanding any other law, the Workers' Compensation Bond Fund is not a state fund and shall not be subject to the rules or procedures of any fund in the State Treasury, and application of the fund shall not be subject to the supervision or budgetary approval of any officer or division of state government.

(5) CIGA and the trustee for the bonds may, as necessary or convenient to the accomplishment of any other purpose under this article, divide the Workers' Compensation Bond Fund into separate accounts.

(b) The Homeowners' and Automobile Bond Fund is hereby created.

(1) Proceeds from the sale of bonds with respect to the homeowners' and automobile category described in subparagraph (B) of paragraph (2) of subdivision (a) of Section 1063.5 shall be deposited in a separate account in the Homeowners' and Automobile Bond Fund. Only CIGA, and, with respect to payment of the bonds, the trustee for the bonds, shall have the ability to authorize disbursements from the separate account within the Homeowners' and Automobile Bond Fund.

(2) Special bond assessments levied pursuant to Section 1063.74 with respect to the homeowners' and automobile category shall be deposited in a separate account in the Homeowners' and Automobile Bond Fund and shall not be commingled with any other moneys. Only the trustee for the bonds shall have the ability to authorize disbursements from this separate account within the Homeowners' and Automobile Bond Fund, and CIGA shall have no right or authority to authorize disbursements from this separate account.

(3) The Homeowners' and Automobile Bond Fund shall be maintained with the trustee for the bonds. Following payment or provision for payment of the bonds, amounts in the Homeowners' and Automobile Bond Fund shall be transferred to the fund that is designated in the indenture for the bonds.

(4) All money in the Homeowners' and Automobile Bond Fund and all special bond assessments levied pursuant to Section 1063.74 with respect to the homeowners' and automobile category shall be used by CIGA for the exclusive purpose of carrying out the purposes of this part. Notwithstanding any other law, the Homeowners' and Automobile Bond Fund is not a state fund and shall not be subject to the rules or procedures of any fund in the State Treasury, and application of the fund shall not be subject to the supervision or budgetary approval of any officer or division of state government.

(5) CIGA and the trustee for the bonds may, as necessary or convenient to the accomplishment of any other purpose under this article, divide the Homeowners' and Automobile Bond Fund into separate accounts.

(c) The Other Bond Fund is hereby created.

(1) Proceeds from the sale of bonds with respect to the other category described in subparagraph (C) of paragraph (2) of subdivision (a) of Section 1063.5 shall be deposited in a separate account in the Other Bond Fund. Only CIGA, and, with respect to payment of the bonds, the trustee for the bonds, shall have the ability to authorize disbursements from the separate account within the Other Bond Fund.

(2) Special bond assessments levied pursuant to Section 1063.74 with respect to the other category shall be deposited in a separate account in the Other Bond Fund and shall not be commingled with any other moneys. Only the trustee for the bonds shall have the ability to authorize disbursements from this separate account within the Other Bond Fund, and CIGA shall have no right or authority to authorize disbursements from this separate account.

(3) The Other Bond Fund shall be maintained with the trustee for the bonds. Following payment or provision for payment of the bonds, amounts in the Other Bond Fund shall be transferred to the fund that is designated in the indenture for the bonds.

(4) All money in the Other Bond Fund and all special bond assessments levied pursuant to Section 1063.74 with respect to the other category shall be used by CIGA for the exclusive purpose of carrying out the purposes of this part. Notwithstanding any other law, the Other Bond Fund is not a state fund and shall not be subject to the rules or procedures of any fund in the State

Treasury, and application of the fund shall not be subject to the supervision or budgetary approval of any officer or division of state government.

(5) CIGA and the trustee for the bonds may, as necessary or convenient to the accomplishment of any other purpose under this article, divide the Other Bond Fund into separate accounts.

SEC. 12. Section 1063.73 of the Insurance Code is amended to read:

1063.73. In the event CIGA determines that the insolvency of one or more member insurers providing insurance in at least one of the categories described in paragraph (2) of subdivision (a) of Section 1063.5 will result in covered claim obligations in excess of CIGA's capacity to pay from current funds, the board, in its sole discretion, may by resolution request the Bank to issue bonds pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code to provide funds for the payment of the covered claims and the adjusting and defense expenses relating to those claims. Notwithstanding any other provision of law, CIGA is hereby authorized to borrow proceeds of the bonds to provide for those purposes. CIGA may request the Bank to issue bonds pursuant to Article 8 (commencing with Section 63049.6) of Chapter 2 of Division 1 of Title 6.7 of the Government Code. CIGA shall provide the commissioner with a copy of the request and the commissioner may, within 30 days of receipt of the request, modify, cancel, or require a delay in the requested issuance. The proceeds of bonds issued for any category of insurance benefits may be used by CIGA to reimburse funds advanced or temporarily loaned from other categories.

SEC. 13. Section 1063.74 of the Insurance Code is amended to read:

1063.74. (a) Notwithstanding any other limits on assessments, CIGA shall have the authority to levy upon member insurers special bond assessments in the amount necessary to pay the principal of and interest on the bonds, and to meet other requirements established by agreements relating to the bonds. The assessments shall be collected only from the member insurers providing insurance in the category described in paragraph (2) of subdivision (a) of Section 1063.5 for which the bonds are issued, and shall be applied in the same manner as separate premium payments are used to pay the claims and costs allocated to that category pursuant to Section 1063.5. Special bond assessments made pursuant to this section shall also be subject to the surcharge provisions in Sections 1063.14 and 1063.145.

(b) Notwithstanding any other law, after all bonds issued pursuant to this article have been redeemed, no further initial special bond assessments shall be levied or made. Any premium adjustments called for and described in Section 1063.5, as applied to special bond assessments initially charged, shall continue to be made and determined. Any credits or charges that result from the premium adjustments on the special bond assessments shall be credited or charged to the assessments called for and described in Section 1063.5.

(c) In addition to the special bond assessments provided for in this section, the board in its discretion and subject to other obligations of the association, may utilize current funds of CIGA, premium assessments made under Section 1063.5, and advances or dividends received from the liquidators of insolvent insurers to pay the principal of and interest on any bonds issued at the board's request and shall utilize, to the extent feasible, the recoveries from the liquidators of the estates of insolvent insurers in the respective category of insurance to pay bonds issued at the board's request to fund the corresponding insurance claims in that category of insurance.

SEC. 14. Section 1063.75 of the Insurance Code is amended to read:

1063.75. Bonds issued to provide funds for covered claim obligations for workers' compensation claims, homeowners' and automobile claims, as described in subparagraph (B) of paragraph (2) of subdivision (a) of Section 1063.5, and other claims, as described in subparagraph (C) of paragraph (2) of subdivision (a) of Section 1063.5, shall be issued in an aggregate principal amount outstanding for each category not to exceed at any one time one billion five hundred million dollars ($1,500,000,000) for that category. Any bonds issued or issued to refund bonds shall not have a final maturity exceeding 20 years from the date of issuance. The bonds shall be issued at the request of CIGA, shall be in the form, shall bear the date or dates, and shall mature at the time or times as the indenture authorized by the request may provide. The bonds may be issued in one or more series, as serial bonds or as term bonds, or as a combination thereof, and, notwithstanding any other provision of law, the amount of principal of, or interest on, bonds maturing at each date of maturity need not be equal. The bonds shall bear interest at the rate or rates, variable or fixed or a combination thereof, be in the denominations, be in the form, either coupon or registered, carry the registration privileges, be executed in the manner, be payable in the medium of payment at the place or places within or without the state, be subject to the terms of redemption, contain the terms and conditions, and be secured by the covenants as the indenture may provide. The indenture may provide for the proceeds of the bonds and funds securing the bonds to be invested in any securities and investments, including investment agreements, as specified therein. CIGA may enter into or authorize any ancillary obligations or derivative agreements as it determines necessary or desirable to manage interest rate risk or security features related to the bonds. The bonds shall be sold at public or private sale by the Treasurer at, above, or below the principal

amount thereof, on the terms and conditions and for the consideration in the medium of payment that the Treasurer shall determine prior to the sale.

SEC. 15. Section 1063.78 is added to the Insurance Code, to read:

1063.78. If the board requests the California Infrastructure and Economic Development Bank to issue bonds pursuant to Section 1063.70, the board shall report all of the following to the Assembly Committee on Insurance and the Senate Committee on Insurance within 60 days of the request, and annually thereafter while the bonds remain outstanding:

(a) The amount of the bonds requested.

(b) The reason for the requested bonds.

(c) Details of covered claims obligations requiring the issuance of bonds.

(d) Planned bond repayment assessments.