

Assembly Bill No. 1193

CHAPTER 253

An act to amend Section 790.03 of, and to add Section 676.10 to, the Insurance Code, relating to insurance.

[Approved by Governor September 5, 2001. Filed with Secretary of State September 5, 2001.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1193, Steinberg. Insurers: hate crimes: cancellation or refusal to renew.

(1) Existing law provides for the regulation of insurers by the Insurance Commissioner. Existing law imposes various limitations on insurers relative to cancellation or nonrenewal of policies protecting against certain residential, liability, and commercial risks.

This bill would provide that an insurer issuing policies protecting against certain residential, liability, and commercial risks may not cancel or refuse to renew a policy solely on the basis that one or more claims have been made against the policy during the preceding 60 months for a loss that is the result of a hate crime committed against the person or property of an insured, if the insured is a religious or educational organization or other nonprofit organization organized and operated for religious, charitable, or educational purposes. This bill would authorize a law enforcement agency, using specified guidelines, to determine if the action in question was a hate crime. This bill would require an insurer to report to the commissioner the cancellation or nonrenewal of a policy subject to these provisions after an insured has submitted a claim to the insurer that is the result of a hate crime.

(2) Existing law provides that certain actions are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance, and specifies certain penalties and powers of the commissioner in this regard.

This bill would provide that a violation of the bill's requirements would be subject to these provisions.

The people of the State of California do enact as follows:

SECTION 1. Section 676.10 is added to the Insurance Code, to read:
676.10. (a) This section applies to policies covered by Section 675, 675.5, or 676.5 if the insured is a religious organization described in clause (i) of subparagraph (A) of paragraph (1) of subsection (b) of



Section 170 of Title 26 of the United States Code, an educational organization described in clause (ii) of subparagraph (A) of paragraph (1) of subsection (b) of Section 170 of Title 26 of the United States Code, or other nonprofit organization described in clause (vi) of subparagraph (A) of paragraph (1) of subsection (b) of Section 170 of Title 26 of the United States Code that is organized and operated for religious, charitable, or educational purposes.

(b) No insurer issuing policies subject to this section shall cancel or refuse to renew the policy solely on the basis that one or more claims has been made against the policy during the preceding 60 months for a loss that is the result of a hate crime committed against the person or property of the insured.

(c) As it relates to this section, if determined by a law enforcement agency, a “hate crime” may include any of the following:

(1) By force or threat of force, willfully injure, intimidate, interfere with, oppress, or threaten any other person in the free exercise or enjoyment of any right or privilege secured to him or her by the Constitution or laws of this state or by the Constitution or laws of the United States because of the other person’s race, color, religion, ancestry, national origin, disability, gender, or sexual orientation, or because he or she perceives that the other person has one or more of those characteristics. However, the foregoing offense does not include speech alone, except upon a showing that the speech itself threatened violence against a specific person or group of persons and that the defendant had the apparent ability to carry out the threat.

(2) Knowingly deface, damage, or destroy the real or personal property of any other person for the purpose of intimidating or interfering with the free exercise or enjoyment of any right or privilege secured to the other person by the Constitution or laws of this state or by the Constitution or laws of the United States, because of the other person’s race, color, religion, ancestry, national origin, disability, gender, or sexual orientation, or because he or she perceives that the other person has one or more of those characteristics.

(d) Upon cancellation of or refusal to renew a policy subject to this section after an insured has submitted a claim to the insurer that is the result of a hate crime committed against the person or property of the insured, the insurer shall report the cancellation or nonrenewal to the commissioner.

(e) A violation of this section shall be an unfair practice subject to Article 6.5 (commencing with Section 790) of Chapter 1 of Division 2.

(f) Nothing in this section shall prevent an insurer subject to this section from taking any of the actions set forth in subdivision (b) on the



basis of criteria not otherwise made invalid by this section or any other act, regulation, or law.

SEC. 2. Section 790.03 of the Insurance Code is amended to read:

790.03. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his or her insurance.

(b) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

(c) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs,



or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

(f) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if those differentials are substantially supported by valid pertinent data segregated by sex, including, but not necessarily limited to, mortality data segregated by sex.

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars (\$5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars (\$5,000) or less. "Compliance date" as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.5 and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), as amended, and (2) tax sheltered annuities for employees of public schools



or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.



(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

