

Assembly Bill No. 1985

Passed the Assembly August 20, 2002

Chief Clerk of the Assembly

Passed the Senate August 14, 2002

Secretary of the Senate

This bill was received by the Governor this _____ day of
_____, 2002, at _____ o'clock __M.

Private Secretary of the Governor



CHAPTER _____

An act to amend Sections 739, 11732, 11733, 11735, 11737, and 11753.1 of the Insurance Code, relating to workers' compensation insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 1985, Calderon. Insurance: workers' compensation: state rate supervision.

Existing law requires property and casualty insurers to file an annual risk-based capital report concerning various risks to the insurer's assets. Existing law requires that all insurers, including property and casualty insurers, take certain actions based on the report, and, in some instances authorizes the Insurance Commissioner to take action. Property and casualty insurer is defined for purposes of these provisions.

This bill would revise the definition of property and casualty insurer to include, among other things, workers' compensation insurance.

Existing law provides for the payment of workers' compensation benefits to employees injured in the course of employment.

Existing law regulates workers' compensation insurance rates, and among other things, provides for minimum rates. Existing law prohibits the use of rates that impair or threaten the solvency of an insurer or tend to create a monopoly in the market.

This bill would revise these workers' compensation insurance rate provisions to delete the prohibition against the use of rates that impair or threaten the solvency of an insurer and to require, instead, that rates be adequate to cover an insurer's losses and expenses. The bill would make conforming changes.

Existing law requires an insurer to file all rates, rating plans, and supplementary rate information with the commissioner. Existing law authorizes the commissioner, after a hearing and finding that an insurer's rates require closer supervision due to the insurer's financial condition, to require the insurer to file additional rates and information.

This bill would delete reference to rating plans. The bill would delete the authority of the commissioner, described above, to have



a hearing based on the insurer's financial condition and require an insurer to file additional rates and information.

Existing law authorizes the commissioner to disapprove a rate if certain determinations are made, and specifies procedures for a hearing prior to the disapproval of rates, for the discontinuance of a disapproved rate, and for the use of an interim rate.

This bill would modify the basis upon which a rate is disapproved, and would revise the various procedures described above.

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

SECTION 1. Section 739 of the Insurance Code is amended to read:

739. As used in this article, these terms shall have the following meanings:

(a) "Adjusted RBC Report" means a Risk-Based Capital (RBC) report that has been adjusted by the commissioner in accordance with subdivision (c) of Section 739.2.

(b) "Corrective Order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(c) "Domestic insurer" means any life or health insurer or property and casualty insurer organized in this state.

(d) "Foreign insurer" means any life or health insurer or property and casualty insurer that is licensed to do business in this state but is not domiciled in this state.

(e) "Life or health insurer" means any admitted insurer issuing insurance subject to Part 2 (commencing with Section 10110) of Division 2, or a licensed property and casualty insurer writing only disability insurance.

(f) "NAIC" means the National Association of Insurance Commissioners.

(g) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the RBC Instructions defined in subdivision (i).

(h) "Property and casualty insurer" means any admitted insurer writing insurance as described in Section 102, 103, 105, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 118, 119.5, 119.6,



or 120, but does not include monoline mortgage guaranty insurers, financial guaranty insurers, or title insurers.

(i) “RBC Instructions” means the RBC Report, including risk-based capital instructions adopted by the NAIC, and as the RBC Instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(j) “RBC Level” means an insurer’s Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

(1) “Company Action Level RBC” means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC.

(2) “Regulatory Action Level RBC” means the product of 1.5 and its Authorized Control Level RBC.

(3) “Authorized Control Level RBC” means the number determined under the risk-based capital formula in accordance with the RBC Instructions.

(4) “Mandatory Control Level RBC” means the product of .70 and the Authorized Control Level RBC.

(k) “RBC Plan” means a comprehensive financial plan containing the elements specified in subdivision (b) of Section 739.3. If the commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the commissioner’s recommendation, the plan shall be called the “Revised RBC Plan.”

(l) “RBC Report” means the report required in Section 739.2.

(m) “Total Adjusted Capital” means the sum of:

(1) An insurer’s statutory capital and surplus.

(2) Other items, if any, that the RBC Instructions may provide.

SEC. 2. Section 11732 of the Insurance Code is amended to read:

11732. Rates shall be adequate to cover an insurer’s losses and expenses. Rates shall not tend to create a monopoly in the market. For the purpose of this section, the rates of any individual insurer, other than the State Compensation Insurance Fund, are presumed to create a monopoly in the market if the insurer has a market share, based on a percentage of statewide workers’ compensation premium, equivalent to 20 percent or more of the premium written by all insurers other than the State Compensation Insurance Fund.

SEC. 3. Section 11733 of the Insurance Code is amended to read:



11733. In determining whether rates comply with Section 11732, the following criteria shall apply:

(a) Due consideration may be given to past and prospective loss and expenses experience within this state, to catastrophe hazards and contingencies, to events or trends within this state, to loadings for leveling premium rates over time or for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers, and to all other relevant factors, including judgment.

(b) The expense provisions included in the rates to be used by an insurer shall reflect the operating methods of the insurer and, so far as is credible, its own actual and anticipated expense experience.

(c) The rates may contain a provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of profit, consideration shall be given to all investment income attributable to premiums and the reserves associated with those premiums.

SEC. 4. Section 11735 of the Insurance Code is amended to read:

11735. (a) Every insurer shall file with the commissioner all rates and supplementary rate information that are to be used in this state. The rates and supplementary rate information shall be filed not later than 30 days prior to the effective date. Upon application by the filer, the commissioner may authorize an earlier effective date. To the extent possible, rates and supplementary rate information shall be based upon supporting information derived from the experience or data of the insurer, rating organization, advisory organization, or other insurers. For the purposes of this subdivision, “rating organization” shall have the same meaning as set forth in subdivision (b) of Section 11750.1, and “advisory organization” shall have the same meaning as set forth in subdivision (e) of that section.

(b) Rates filed pursuant to this section shall be filed in the form and manner prescribed by the commissioner. All rates, supplementary rate information, and any supporting information for rates filed under this article, as soon as filed, shall be open to public inspection at any reasonable time. Copies may be obtained by any person upon request and the payment of a reasonable charge.



(c) Upon the written application of the insurer and insured, stating its reasons therefor, filed with the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(d) Notwithstanding Section 679.70, no rating organization may issue, nor may any insurer use, any classification system or rate, as applied or used, that violates Section 679.71 or 679.72 or that violates the Unruh Civil Rights Act.

(e) Notwithstanding Sections 11657 to 11660, inclusive, supplementary rate information filed with the commissioner for purposes of offering deductibles to policyholders for all or part of benefits payable under the policy shall be deemed complete if the filing contains all of the following:

(1) A copy of the deductible endorsement that is to be attached to the policy to effectuate deductible coverage.

(2) Endorsement language that protects the rights of injured workers and ensures that benefits are paid by the insurer without regard to any deductible. The endorsement shall specify that the nonpayment of deductible amounts by the policyholder shall not relieve the insurer from the payment of compensation for injuries sustained by the employee during the period of time the endorsed policy was in effect. The endorsement shall provide that deductible policies for workers' compensation insurance coverage shall not be terminated retroactively for the nonpayment of deductible amounts.

(3) The endorsement shall provide that notwithstanding the deductible, the insurer shall pay all of the obligations of the employer for workers' compensation benefits for injuries occurring during the policy period. Payment by the insurer of any amounts within the deductible shall be treated as an advancement of funds by the insurer to the employer and shall create a legal obligation for reimbursements, and may be secured by appropriate security.

(4) The endorsement shall specify whether loss adjustment expenses are to be treated as advancements within the deductible to be reimbursed by the employer.

(5) An explanation of premium reductions reflecting the type and level of the deductible shall be clearly set forth for the policyholder.



(6) The filing shall provide that premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount, and the premium reductions reflect the type and level of deductible consistent with accepted actuarial standards.

(7) The filing shall provide that the nonpayment of deductible amounts by the insured employer to its insurer, or the failure to comply with any security-related terms of the policy, shall be treated under the policy in the same manner as the payment or nonpayment of the premium pursuant to paragraph (1) of subdivision (b) of Section 676.8.

(f) The insurer shall report and record losses subject to the deductible as losses for purposes of ratemaking and application of an experience rating plan on the same basis as losses under policies providing first dollar coverage.

SEC. 5. Section 11737 of the Insurance Code, as amended by Chapter 6 of the Statutes of 2002, is amended to read:

11737. (a) The commissioner may disapprove a rate if the insurer fails to comply with the filing requirements under Section 11735.

(b) The commissioner may disapprove rates if the commissioner determines that premiums charged, in the aggregate, resulting from the use of the rates or the rates as modified by any supplementary rate information, would be inadequate to cover an insurer's losses and expenses, unfairly discriminatory, or tend to create a monopoly in the market pursuant to Section 11732, 11732.5, or 11733.

(c) The commissioner shall disapprove rates if the commissioner determines that premiums charged, in the aggregate, resulting from the use of the rates or the rates as modified by any supplementary rate information would, if continued in use, tend to impair or threaten the solvency of an insurer. In determining whether the premium charged in the aggregate would, if continued in use, tend to impair or threaten the solvency of the insurer, the commissioner shall consider the insurer's experience in other states.

(d) If the commissioner intends to disapprove rates pursuant to subdivision (a) or (b), the commissioner shall serve notice on the insurer of the intent to disapprove and shall schedule a hearing to commence within 60 days of the date of the notice.



(e) If the commissioner disapproves rates pursuant to subdivision (c), the commissioner shall immediately serve notice on the insurer of the disapproval. An insurer whose rates have been disapproved pursuant to that subdivision may, within 20 days of the date of the notice of disapproval, request a hearing, and the commissioner shall hold a hearing within 60 days of the date of the notice of disapproval.

(f) Every insurer or rating organization shall provide within this state reasonable means whereby any person aggrieved by the application of its filings may be heard by the insurer or rating organization on written request to review the manner in which the rating system has been applied in connection with the insurance afforded or offered. If the insurer or rating organization fails to grant or reject the request within 30 days, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the insurer or rating organization on the request may appeal, within 30 days after written notice of the action, to the commissioner who, after a hearing held within 60 days from the date on which the party requests the appeal, or longer upon agreement of the parties and not less than 10 days' written notice to the appellant and to the insurer or rating organization, may affirm, modify, or reverse that action. If the commissioner has information on the subject from which the appeal is taken and believes that a reasonable basis for the appeal does not exist or that the appeal is not made in good faith, the commissioner may deny the appeal without a hearing. The denial shall be in writing, set forth the basis for the denial, and be served on all parties.

(g) If the commissioner disapproves a rate, the commissioner shall issue an order specifying in what respects the rate fails to meet the requirements of this article and stating when, within a reasonable period thereafter, that rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within 20 days after the notice prescribed in subdivision (e) is served. If a hearing is held pursuant to subdivision (d) or (e), the order shall be issued, instead, within 30 days after the close of the hearing. The order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on that date.



(h) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall specify interim rates for the insurer that protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds of less than ten dollars (\$10) per policyholder shall not be required. However, if the commissioner has disapproved rates pursuant to subdivision (c), the commissioner shall order the insurer in the interim to use, at a minimum, the approved advisory pure premium rates pursuant to subdivision (b) of Section 11750, as modified by the uniform experience rating plan established pursuant to subdivision (c) of Section 11734, without any deviations on account of any supplementary rate information and reflecting the actual expenses of the insurer, until the time that a final determination of rates is adjudicated and ordered through a hearing.

(i) Notwithstanding any other provision of law, an insurer may increase rates on policies with inception dates prior to January 1, 2003, in an amount no greater than the pure premium rate increase approved by the commissioner reflecting the cost of the change in benefit levels authorized by the act adding this subdivision.

SEC. 6. Section 11753.1 of the Insurance Code is amended to read:

11753.1. (a) Any person aggrieved by any decision, action, or omission to act of a rating organization may request that the rating organization reconsider the decision, action, or omission. If the request for reconsideration is rejected or is not acted upon within 30 days by the rating organization, the person requesting reconsideration may, within a reasonable time, appeal from the decision, action, or omission of the rating organization. The appeal shall be made to the commissioner by filing a written complaint and request for a hearing specifying the grounds relied upon. If the commissioner has information on the subject appealed from and believes that probable cause for the appeal does not exist or that the appeal is not made in good faith, the commissioner may deny the appeal without a hearing. The commissioner shall otherwise hold



a hearing to consider and determine the matter presented by the appeal.

(b) Any insurer adopting a change in the classification assignment of an employer that results in an increased premium shall notify the employer in writing, or if the insurance was transacted through an insurance agent or broker, the insurer shall notify the agent or broker who shall notify the employer in writing of the change and the reasons for the change. Any employer receiving this notice shall have the right to request reconsideration and appeal the reclassification pursuant to this section. The notice required by this section shall inform the employer of his or her rights pursuant to this section. No notification shall be required when the change is a result of a regulation adopted by the Department of Insurance or other action by or under the authority of the commissioner.

An insurer shall provide written notification of the revised classification assignment to an employer within 30 days after adoption.



Approved _____, 2002

Governor

