AMENDED IN SENATE JULY 2, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 299

Introduced by Committee on Insurance (Coto (Chair), Garrick (Vice Chair), Blakeslee, Carter, Feuer, Hayashi, Nava, Niello, and Torres)

February 17, 2009

An act to amend Sections 706.7, 730, 735.5, 736, 900.2, 942, 1170, 1182, 1197, ~~and 11580.011~~ *1215.5, 11136, 11580.011, and 12968* of, and to amend and renumber Section 10123.83 of, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 299, as amended, Committee on Insurance. Insurance.

Existing law provides that ~~annually~~ the Insurance Commissioner shall *annually* mail to every domestic insurer a report specifying the reciprocal states.

This bill would provide that every 4 years the commissioner shall mail to every domestic insurer a report specifying the reciprocal states.

Existing law provides that at specified times the commissioner may, and at specified times shall, examine the business and affairs of insurers. In conducting an examination the commissioner shall consider the results of specified data, reports, and criteria.

This bill would add other criteria that the commissioner must consider ~~as well as allowing~~ *and would allow* the consideration of any other criteria deemed appropriate by the commissioner.

Existing law provides that the commissioner may disclose the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any

other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, or to the National Association of Insurance Commissioners (NAIC), as specified.

This bill would add market analysis data to the information that the commissioner may disclose, as specified.

Existing law provides that all examinations shall be at the expense of the insurer, organization, or person examined, except that special examinations which are in addition to regular examinations may be at the expense of the state in the discretion of the commissioner.

This bill would provide that all analyses performed pursuant to the provisions discussed above authorizing examinations by the commissioner would be at the expense of the insurer, as specified.

Existing law provides that all insurers doing business in this state shall have an annual audit by an independent certified public accountant. The audit shall be conducted and the audit report prepared and filed in conformity with the Annual Audited Financial Reports instructions contained in the annual statement instructions as adopted from time to time by the NAIC. Existing law authorizes the commissioner to grant a 30-day extension of the filing date upon a showing of substantial cause. *Existing law requires an insurer to submit a request for an extension 20 days prior to the date the audit is due.*

This bill would provide that the annual audit, including required auditor and management reporting, be conducted in conformity with the standards adopted by the NAIC. The bill would instead authorize the commissioner to grant multiple 30-day extensions, as specified. *This bill would require an insurer to submit a request for an extension 10 days prior to the date the audit is due.*

Existing law provides that domestic incorporated insurers may invest in an account or accounts in one or more banks or savings and loan associations to the extent the account or accounts are insured by an agency or instrumentality of the federal government, as specified.

This bill would add credit unions to the financial institutions in which domestic incorporated insurers may invest.

Existing law provides that excess funds investments shall not be made in a loan to any one borrower, as defined, in an amount exceeding 10% of the capital stock and surplus or 1% of the admitted assets of the lending insurer, whichever amount is greater.

This bill would provide that excess fund investments shall not be made in a loan ~~or any other obligation~~ to any one borrower or obligor, as specified.

Existing law prohibits domestic insurers or commercially domiciled insurers from entering into specified transactions unless they have notified the Insurance Commissioner of their intent to enter into the transaction in advance of entering into the transaction and the commissioner fails to prohibit the transaction, as specified.

This bill would specify that tax sharing agreements are among the types of transactions for which the insurer would have to give the commissioner advanced notification of its intent to enter into the transaction, as specified.

Existing law defines a fraternal benefit society as an incorporated society or supreme lodge without capital stock conducted solely for the benefit of its members and members' beneficiaries and not for profit. Under existing law, a fraternal benefit society may issue certificates of insurance providing for the payment of life and disability insurance benefits, as specified. Existing law requires fraternal benefit societies to use, among other tables, mortality tables approved by regulation promulgated by the Insurance Commissioner for purposes of determining actuary values, as specified.

This bill would, in addition, authorize fraternal benefit societies to use mortality tables approved by bulletin issued by the commissioner for purposes of determining actuary values, as specified.

Existing law provides that every policy of automobile liability insurance, as specified, or collision coverage, as specified, shall provide coverage for replacement of a child passenger restraint system (child seat) that was in use by a child during an accident for which liability coverage under the policy is applicable due to the liability of an insured. Existing law provides that upon the filing of a claim for replacement, unless otherwise determined, an insurer shall have an obligation to ask whether a child seat was in use by a child during an accident that is covered by the policy, and must replace the child seat if it was in use by a child during the accident or reimburse the claimant for the cost of purchasing a new child seat.

This bill would provide that every policy of automobile liability insurance, as specified, shall provide coverage for replacement of a child seat that was damaged in a covered accident, and that every policy that provides collision coverage, as defined, shall include a child seat within the definition of covered property, as specified. This bill would provide that upon the filing of a claim for replacement, unless otherwise determined, an insurer would have an obligation to ask whether a child seat was in use by a child during an accident or was in the vehicle at

the time of a loss that is covered by the policy, and must replace the child seat or reimburse the claimant for the costs of buying a new child seat if it was in use by a child during the accident or if it sustained a covered loss while in the vehicle.

Existing law requires the Department of Insurance to display public pleadings, orders, or documents relating to a formal enforcement action against a licensee on its Internet Web site, as specified.

This bill would require the department to remove from its Internet Web site any displayed pleading, order, or document if the relevant enforcement action against a licensee is withdrawn, as specified.

This bill would also make changes to obsolete cross-references in insurance provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 706.7 of the Insurance Code is amended to read:

706.7. As used in this section, the term "reciprocal state" means a state the laws of which prohibit an insurer domiciled therein from insuring the lives or persons of residents of, or property or operations located in, the State of California unless it then holds a valid and subsisting certificate of authority issued by the Insurance Commissioner of this state. This prohibition may be subject to the exceptions herein set forth.

Subject to the exceptions herein set forth, a domestic insurer shall not enter into a contract of insurance upon the life or person of a resident of, or property or operations located in, a reciprocal state unless it is authorized pursuant to the laws of that state to transact such insurance therein. The commissioner shall, every four years, mail notice to every domestic insurer, specifying the reciprocal states.

The exceptions to the provisions of this section are the following:

(a) Contracts entered into where the prospective insurant is personally present in the state in which the insurer is authorized to transact insurance when he or she signs the application.

(b) The issuance of certificates under a lawfully transacted group life or group disability policy, where the master policy was entered

into in a state in which the insurer was then authorized to transact insurance.

(c) The renewal or continuance in force, with or without modification, of contracts otherwise lawful and which were not originally executed in violation of this section.

SEC. 2. Section 730 of the Insurance Code is amended to read:

730. (a) The commissioner, whenever he or she deems necessary or whenever he or she is requested by verified petition, signed by 25 persons interested as shareholders, policyholders, or creditors of any admitted insurer showing that the insurer is insolvent under this code, or upon information that any insurer has violated any provision of Article 7 (commencing with Section 800), shall examine the business and affairs of the insurer. The commissioner shall so examine every domestic insurer before issuing to it a certificate of authority other than a renewal.

(b) The commissioner may conduct an examination under this article of any company as often as the commissioner in his or her discretion deems appropriate but shall, at a minimum, conduct an examination of every insurer admitted in this state not less frequently than once every five years. In scheduling and determining the nature, scope, and frequency of the examinations, the commissioner shall consider the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, market analysis results, including consumer complaint analysis, evaluation of ongoing regulatory activities, analysis of data derived from industry surveys or interrogatories, and other criteria as set forth in the Examiner's Handbook or in the Market Regulation Handbook adopted by the National Association of Insurance Commissioners which are in effect when the commissioner exercises discretion under this section.

(c) For purposes of completing an examination of any company under this article, the commissioner may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the discretion of the commissioner, necessary or material to the examination of the company.

(d) In lieu of an examination under this article of any foreign or alien insurer admitted in this state, the commissioner may accept an examination report on the company as prepared by the insurance

department of the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, these reports may only be accepted if (1) the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioner's Financial Regulation Standards and Accreditation Program, or (2) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

SEC. 3. Section 735.5 of the Insurance Code is amended to read:

735.5. (a) Nothing contained in this article shall be construed to limit the commissioner's authority to use and, if appropriate, to make public, any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his or her discretion, deem appropriate.

(b) Nothing contained in this code shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, market analysis data, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, or to the National Association of Insurance Commissioners, provided the recipient of the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this article, unless the prior written consent of the company to which it pertains has been obtained.

(c) All working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made pursuant to this article shall be given confidential treatment and are not subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subdivision (a) or (b).

SEC. 4. Section 736 of the Insurance Code is amended to read:

736. All examinations and analyses performed pursuant to Section 730 shall be at the expense of the insurer, organization, or person examined, except that special examinations which are in addition to regular examinations may be at the expense of the state in the discretion of the commissioner. The costs and expenses of all of those examinations shall be paid from the support appropriation for the Department of Insurance current at the time of the examination but shall be charged to and collected from the insurer, organization or person examined. If any insurer, organization, or person refuses to pay those costs and expenses promptly when due, the commissioner may refuse to issue its certificate of authority, certificate of exemption, or license, as the case may be, and may revoke any existing certificate of authority, certificate of exemption, or license.

SEC. 5. Section 900.2 of the Insurance Code is amended to read:

900.2. (a) All insurers doing business in this state shall have an annual audit by an independent certified public accountant. The audit, including required auditor and management reporting, shall be conducted and the audit report prepared and filed in conformity with the standards adopted by the National Association of Insurance Commissioners.

(b) The commissioner may grant 30-day extensions of the filing date upon a showing by the insurer and its independent certified public accountant of the reasons for requesting each extension and the determination by the commissioner of substantial cause for an extension. The request for an extension shall be submitted in writing not less than 10 days prior to the due date in sufficient detail to permit the commissioner to make an informed decision on the requested extension.

(c) The commissioner may promulgate regulations to further the purposes of this section.

SEC. 6. Section 942 of the Insurance Code is amended to read:

942. The commissioner shall permit a deposit of those securities in the State Treasury, subject to the provisions of Section 11691, if applicable. The securities deposited with the Treasurer shall be maintained in electronic book entry or certificate form as security for policyholders or policyholders and creditors of the insurer to whom they respectively belong. The state is responsible for the

custody and safe return of any money or securities so deposited. The Treasurer shall deposit these moneys under the provisions of Sections 16370 and 16375 of the Government Code.

SEC. 7. Section 1170 of the Insurance Code is amended to read:

1170. Domestic incorporated insurers may invest their assets in the purchase of any of the securities specified in this article, or in loans upon such securities, if those purchases or loans conform to all the following conditions:

(a) Such securities are not in default as to principal or interest at the date of investment.

(b) In the case of a purchase, the purchase price does not exceed the market value of the securities at the date of investment.

(c) In the case of a loan not governed by the provisions of Section 1194.81, the amount loaned does not exceed eighty-five per cent of such market value at the date of investment.

SEC. 8. Section 1182 of the Insurance Code is amended to read:

1182. Domestic incorporated insurers may invest in an account or accounts in one or more banks, savings and loan associations, or credit unions to the extent the account or accounts are insured by an agency or instrumentality of the federal government. As used in this section, an account may include a certificate of deposit.

SEC. 9. Section 1197 of the Insurance Code is amended to read:

1197. Excess funds investments shall not be made in a loan to any one borrower or obligor, including all affiliates which shall be treated as one borrower or obligor, in an amount exceeding 10 percent of the capital stock and surplus or 1 percent of the admitted assets of the lending insurer, whichever amount is greater.

SEC. 10. Section 1215.5 of the Insurance Code is amended to read:

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

(1) The terms shall be fair and reasonable.

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

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

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

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

(b) The following transactions involving a domestic insurer or commercially domiciled insurer, as defined in Section 1215.13, and any person in its holding company system, may be entered into only if the insurer has notified the commissioner in writing of its intention to enter into the transaction at least 30 days prior thereto, or a shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period. The commissioner shall require the payment of one thousand eight hundred eighty-nine dollars ($1,889) as a fee for filings under this subdivision. The payment shall accompany the filing.

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

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

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

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

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

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

(3) Reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds 5 percent of the insurer's policyholder's surplus,

as of the preceding December 31st, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer.

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

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

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

(7) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in those investments, exceeds 2.5 percent of the insurer's policyholder's surplus. Direct or indirect acquisitions or investments in subsidiaries acquired

under Section 1215.1, or in nonsubsidiary insurance affiliates that are subject to the provisions of this article, or in subsidiaries acquired pursuant to Section 1199, are exempt from this requirement.

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

(c) A domestic insurer may not enter into transactions that are part of a plan or series of transactions with persons within the holding company system if the purpose of those transactions is to avoid the statutory threshold amount and thus avoid review. If the commissioner determines that separate transactions were entered into over any 12-month period to avoid review, the commissioner may exercise his or her authority under Section 1215.10.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject to by law, and the insurer shall be managed to ensure its separate operating identity consistent with the provisions of this article. However, nothing in this article shall preclude a domestic insurer from having or sharing a common

management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of subdivision (a).

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

~~SEC. 10.~~

SEC. 11. Section 10123.83 of the Insurance Code, as added by Section 2 of Chapter 839 of the Statutes of 1998, is amended and renumbered to read:

10123.835. (a) Every individual or group policy of disability insurance that covers hospital, medical, or surgical benefits that is issued, amended, or renewed on or after January 1, 1999, shall be deemed to provide coverage for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.

(b) Nothing in this section shall be construed to require an individual or group policy to cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, and combined hormonal therapy, or to prevent application of deductible or copayment provisions contained in the policy, nor shall this section be construed to require that coverage under an individual or group policy be extended to any other procedures.

(c) This section shall not apply to specified accident, specified disease, hospital indemnity, Medicare supplement, or long-term care health insurance policies.

SEC. 12. Section 11136 of the Insurance Code is amended to read:

11136. Except as otherwise provided in Section 10489.4, such valuation shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the insurance supervisory official of the state of domicile of the society, and the legal minimum standard of valuation shall be as follows:

(a) All benefits promised by certificates issued prior to September 22, 1952, and the rates therefor shall be valued in accordance with the provisions of law applicable thereto as of the date of issuance, but not lower than the standards and interest assumptions used in the calculation of rates for such benefits.

(b) The minimum standard for the valuation of all certificates issued after September 21, 1952, and prior to January 1, 1972, shall be 3 percent per annum interest; in the case of certificates issued on and after January 1, 1972, and prior to January 1, 1980, the minimum standard for the valuation of all such certificates shall be 4 percent per annum interest; and in the case of certificates issued on and after January 1, 1980, the minimum standard for the valuation of all single premium certificates shall be 5½ percent per annum interest and for the valuation of all other such certificates shall be 4½ percent per annum interest, and the following tables:

(1) For all ordinary certificates of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such certificates—the American Men Ultimate Table of Mortality, with Bowerman's or Davis' Extension thereof, or, at the option of the society, the Commissioners 1941 Standard Ordinary Mortality Table or the Commissioners 1958 Standard Ordinary Mortality Table, using actual age of the insured for male risks and an age not more than six years younger than the actual age of the insured for female risks, and for such policies issued on or after the operative date of Section 10163.2 (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, or its successor, that is approved by regulation promulgated *or bulletin issued* by the commissioner for use in determining the minimum standard of valuation for such policies.

(2) For all industrial life insurance certificates issued on the standard basis, excluding any disability and accidental death benefits in such certificates—the 1941 Standard Industrial Mortality Table, for such certificates issued prior to the operative date of Section 10163.2, and for such policies issued on or after such operative date, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, or its successor, that is approved by regulation promulgated *or bulletin issued* by the commissioner for use in determining the minimum standard of valuation for such policies.

(3) For annuity and pure endowment certificates, excluding any disability and accidental death benefits in such certificates—the 1937 Standard Annuity Mortality Table, or the Annuity Mortality Table for 1949 Ultimate, or the Individual Annuity Mortality Table for 1971, or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, or its successor, that is approved by regulation promulgated *or bulletin issued* by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of any of these tables approved by the commissioner.

(4) For disability benefits in or supplementary to ordinary certificates—Hunter's Disability Table or the Class 3 Disability Table (1926), modified to conform to the contractual waiting period, or the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries with due regard to the type of benefit, or the 1964 Commissioners Disability Table, or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, or its successor, that are approved by regulation promulgated *or bulletin issued* by the commissioner for use in determining the minimum standard of valuation for such policies. Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance certificates.

(5) For accidental death benefits in or supplementary to certificates—The Inter-Company Double Indemnity Mortality Table or the 1959 Accidental Death Benefits Table, or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, or its successor, that is approved by regulation promulgated *or bulletin issued* by the commissioner for use in determining the minimum standard of valuation for such policies. Any such table shall be combined with a mortality table permitted for calculating the reserves for life insurance certificates.

(6) For temporary accident and health benefits in or supplementary to certificates—Class 3 Disability Table (1926) with Conference Modifications or the 1964 Commissioners Disability Table, or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, or its successor, that are approved by regulation

promulgated *or bulletin issued* by the commissioner for use in determining the minimum standard of valuation for such policies.

(7) For life insurance issued upon the substandard basis and other special benefits—such tables as may be approved by the commissioner.

(c) The commissioner may, in his discretion, accept other standards for valuation if he finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed. Whenever the mortality experience under the certificates valued on the same mortality table is in excess of the expected mortality according to such table for a period of three consecutive years, the commissioner may require additional reserves when in his judgment deemed necessary on account of such certificates.

(d) Notwithstanding the provisions of subdivisions (a) and (b), any society, with the consent of the insurance supervisory official of the state of domicile of the society, and under such conditions, if any, which he may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any insured member shall not be affected thereby.

~~SEC. 11.~~

SEC. 13. Section 11580.011 of the Insurance Code is amended to read:

11580.011. (a) As used in this section, "child passenger restraint system" means a system as described in Section 27360 of the Vehicle Code.

(b) Every policy of automobile liability insurance, as described in Section 16054 of the Vehicle Code, shall provide liability coverage for replacement of a child passenger restraint system that was damaged or was in use by a child during an accident for which liability coverage under the policy is applicable due to the liability of an insured.

(c) Every policy of automobile liability insurance that provides uninsured motorist property damage coverage, as described in paragraph (2) of subdivision (a) of Section 11580.26, shall provide coverage for replacement of a child passenger restraint system that was damaged or was in use by a child during an accident for which uninsured motorist property damage coverage under the policy is applicable due to the liability of an uninsured motorist.

(d) Every policy that provides automobile collision coverage, as described in Section 660, or every policy that provides automobile physical damage coverage, as described in Section 660, shall include a child passenger restraint system within the definition of covered property, if the child passenger restraint system was in use by a child during an accident or, if the child passenger restraint system was in the vehicle and it sustained a loss covered by the policy.

(e) Upon the filing of a claim pursuant to a policy described in subdivision (b), (c), or (d), unless otherwise determined, an insurer shall have an obligation to ask whether a child passenger restraint system was in use by a child during an accident or was in the vehicle at the time of a loss that is covered by the policy, and an obligation to replace the child passenger restraint system or reimburse the claimant for the cost of purchasing a new passenger restraint system in accordance with this section if it was in use by a child during the accident or if it sustained a covered loss while in the vehicle.

(f) An insured, upon acquiring a replacement child passenger restraint system, may surrender the child passenger restraint system that was replaced to the nearest office of the Department of the California Highway Patrol.

SEC. 14. Section 12968 of the Insurance Code is amended to read:

12968. *(a)* Every pleading issued by the commissioner to initiate a formal enforcement action against a licensee under this code, and every order issued by the commissioner or a court of competent jurisdiction or other document that resolves a formal enforcement action, shall be displayed on the department's internet web site, if the document is a public record that is not exempt from disclosure to the public pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(b) Notwithstanding Section 12969, if an enforcement action against a licensee is withdrawn, then each pleading, document, or order against that licensee shall be removed from the department's Internet Web site within 30 days of the withdrawal of the action. If a pleading, document, or order contains allegations against multiple licensees, and the department withdraws all allegations against any one or more of the licensees, then the

department shall post appropriate documents that clarify that the enforcement action against that specific licensee has been withdrawn on its Internet Web site.

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