AMENDED IN SENATE AUGUST 19, 2013

AMENDED IN SENATE JUNE 27, 2013

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AMENDED IN ASSEMBLY APRIL 11, 2013

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1391

Introduced by Committee on Insurance

March 4, 2013

An act to amend Sections 131, 662, 739, 739.3, 985, 1011, 1011.1, 1012, 1016, 1070.6, 1216.1, 1624, 1675, 1749.3, 1749.31, 1749.32, 1749.33, 1749.8, 1758.3, 1872.87, 10234.93, 10785, 11620, 12414.25, and 14090.1 of, to add Sections 1758.681 and 12389.7 to, and to repeal Section 668.5 of, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 1391, as amended, Committee on Insurance. Insurance: omnibus.

(1) Existing law requires an entity seeking to be licensed as a risk retention group to be organized under California law and licensed as a liability insurance company. A risk retention group is a corporation, public entity, or other limited liability association that meets certain criteria, including that its primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members. Existing law also exempts risk retention groups from the Business Transacted with Producer Controlled Insurer Act, which regulates controlled insurers, as prescribed.

This bill would require, on and after January 1, 2015, a risk retention group to comply with specified corporate governance requirements at the time of licensure, including that the board of directors have a majority of independent directors, as defined, that the term of any material service provider contract with a risk retention group not exceed 5 years, and that the risk retention group have an audit committee composed of at least 3 independent board members. The bill would also delete the risk retention group exemption from the Business Transacted with Producer Controlled Insurer Act.

(2) Existing law provides that no cancellation of a motor vehicle insurance policy, not subject to certain cancellation protections because it has been in effect less than 60 days, is effective unless a notice of cancellation, subject to certain notice provisions, is mailed or delivered by the insurer to the named insured not later than the 59th day following the effective date and at least 10 days prior to the effective date of cancellation. Existing law also provides no notice of cancellation of a motor vehicle insurance policy, where the cancellation is based on, among other things, nonpayment of premium, is effective unless mailed or delivered by the insurer to the named insured, lienholder, or additional interest at least 20 days prior to the effective date of cancellation, except as specified.

This bill would delete the requirements for cancellation of a motor vehicle insurance policy less than 60 days old, and would apply the requirements regarding notice of cancellation for nonpayment of premiums, and other specified reasons, to all cancellation circumstances.

(3) Existing law defines the term “Adjusted RBC Report” as a Risk-Based Capital (RBC) report that has been adjusted by the Insurance Commissioner in accordance with specified provisions governing the determination of a property and casualty insurer’s RBC.

This bill would revise that definition to also include an RBC report that has been adjusted by the commissioner in accordance with specified provisions governing the determination of a life or health insurer’s RBC.

(4) Existing law provides for continuing education requirements, prior to license renewals, for specified insurance agents and broker-agents, including personal lines broker-agents and limited lines automobile insurance agents.

This bill would require that those continuing education requirements include 3 hours of ethics.

(5) Existing law requires every life agent who sells annuities to satisfactorily complete 8 hours of training prior to soliciting individual consumers, and requires every life agent who sells annuities to satisfactorily complete 4 hours of training prior to each license renewal.

This bill would clarify the completion of an 8-hour training requirement to initially procure a license to sell annuities does not satisfy the requirement to complete a 4-hour training course in order to renew the annuity license.

(6) Existing law prohibits the Insurance Commissioner from granting authority to transact variable contracts unless the life agent or applicant furnishes proof that he or she is registered to sell securities in accordance with the rules of the United States Securities and Exchange Commission or the Financial Industry Regulatory Authority.

This bill would make clear that the life agent or applicant is required to furnish proof that he or she is registered to sell securities in California in accordance with the rules of the United States Securities and Exchange Commission or the Financial Industry Regulatory Authority.

(7) Existing law requires an individual holding an insurance adjuster license, not otherwise exempt, to complete a minimum of 24 hours of continuing education courses, as specified.

This bill would authorize an exemption from the continuing education requirements for an individual licensed as an insurance adjuster and as a property or casualty broker-agent who has met other specified continuing education requirements.

(8) Existing law defines an insurance solicitor as a natural person employed to aid an insurance agent or insurance broker in transacting insurance other than life.

This bill would redefine an insurance solicitor to mean a natural person employed to aid a property and casualty broker-agent acting as an insurance agent or insurance broker in transacting insurance other than life, disability, or health.

(9) Existing law provides that a nonresident licensee who applies for a property broker-agent, casualty broker-agent, personal lines broker-agent, or life agent resident license in this state, and who is currently licensed for the same lines of authority in the state of his or her current resident license, is not required to complete an examination. The application for examination is required to be received within 90 days of the cancellation of the applicant's resident license and the producer database records, maintained by the National Association of

Insurance Commissioners, are required to indicate that the producer is licensed in good standing for the line of authority requested.

This bill would provide that upon issuance of the California resident license, the examination waiver also applies to adding additional lines of authority to the California resident license provided that the individual was previously licensed in good standing for the requested additional lines of authority, and the application is received within 12 months of the cancellation of the applicant's previous resident license in another state.

(10) Existing law regulates the sale of portable electronics insurance policies and requires all portable electronics vendors offering that insurance to be licensed, as specified.

This bill would authorize an insurer to terminate or otherwise change the terms and conditions of a policy of portable electronics insurance, as provided.

(11) Existing law requires the commissioner, after a public hearing held in accordance with the rulemaking provisions of the Administrative Procedure Act, to approve or issue a reasonable plan, or reasonable amendments to the plan, for the equitable apportionment, among insurers admitted to transact liability insurance, of those applicants for automobile bodily injury and property damage liability insurance who are in good faith entitled to, but are unable to procure, that insurance through ordinary methods. Existing law provides for judicial review of the proceedings held to revise automobile insurance rates.

This bill would additionally require that the reasonable amendments to the plan be approved by the plan's advisory committee. The bill would delete the requirement that the public hearings be held in accordance with the rulemaking provisions of the Administrative Procedure Act, and provide, with exceptions, that the plan and any amendments not be subject to those provisions. The bill would instead require the commissioner to provide 45 days' notice of a public hearing by publishing the notice in the California Regulatory Notice Register, mailing the notice to the parties on the Department of Insurance's regulations mailing list, and posting the notice on the department's public Internet Web site. The bill would authorize interested parties to make oral or written comments and require the commissioner to consider all comments received before adopting any amendments to the plan, as provided. The bill would also provide for judicial review of a change to the plan.

(12) Existing law authorizes an underwritten title company to engage in the business of preparing title searches, title reports, title examinations, or certificates or abstracts of title, upon the basis of which a title insurer writes title policies. Existing law authorizes any insurer, upon payment of the fees and costs and surrender to the commissioner of its certificate of authority, to apply to withdraw from this state, as provided.

This bill would authorize underwritten title companies to apply to withdraw from the California insurance market.

(13) This bill would make technical, conforming, and clarifying changes, and delete obsolete provisions.

(14) This bill would incorporate additional changes to Section 10785 of the Insurance Code proposed by AB 1180, that would become operative only if AB 1180 and this bill are both chaptered and become effective on or before January 1, 2014, and this bill is chaptered last.

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 131 of the Insurance Code is amended to read:

131. (a) An entity seeking to be licensed in this state as a risk retention group shall be organized under the laws of this state and licensed as a liability insurance company pursuant to Article 3 (commencing with Section 699) of Chapter 1 of Part 2.

(b) An entity that has not completed its chartering and licensing as a risk retention group in its domiciliary state is subject to the requirements of Article 8 (commencing with Section 820) of Chapter 1 of Part 2.

(c) In addition to the requirements of Article 3 (commencing with Section 699) of Chapter 1 of Part 2, a risk retention group licensed in this state shall submit to the commissioner a feasibility study or plan of operations and all other documentation required by the federal Liability Risk Retention Act of 1986 (15 U.S.C. Sec. 3901 et seq.) to be submitted by a risk retention group to a nonchartering state.

(d) In addition to the requirements of Article 3 (commencing with Section 699) of Chapter 1 of Part 2, a risk retention group

licensed in this state shall comply with all of the following at the time of licensure, and thereafter:

(1) (A) The "board of directors" or "board," as used in this section, means the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions.

(B) "Director," as used in this section, means a natural person designated in the articles of the risk retention group, or designated, elected, or appointed by any other manner, name, or title to act as a director.

(2) (A) The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal risk retention group, the attorney-in-fact shall be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors and subscribers' advisory committee under these standards, and, to the extent permissible under this state's laws, service providers of a reciprocal risk retention group shall contract with the risk retention group and not the attorney-in-fact.

(B) No director qualifies as "independent" unless the board of directors affirmatively determines that the director has no "material relationship" with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator, at least annually. For this purpose, any person that is a direct or indirect owner of, or subscriber in, the risk retention group, or is an officer, director, or employee, or all three, of an owner and insured, as contemplated by 15 U.S.C. Section 3901(a)(4)(E)(ii) of the federal Liability Risk Retention Act of 1986, is considered to be "independent," unless some other position of that officer, director, or employee constitutes a "material relationship."

(C) "Material relationship" of a person with the risk retention group includes, but is not limited to, any of the following:

(i) The receipt in any one 12-month period of compensation or payment of any other item of value by that person, a member of that person's immediate family, or any business with which that person is affiliated from the risk retention group or a consultant or service provider to the risk retention group that is greater than, or equal to, 5 percent of the risk retention group's gross written

premium for that 12-month period or 2 percent of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in a 12-month period. The person or immediate family member of that person is not independent until one year after his or her compensation from the risk retention group falls below the threshold.

(ii) A relationship with an auditor as follows: a director or an immediate family member of a director who is affiliated with, or employed in, a professional capacity by a present or former internal or external auditor of the risk retention group is not independent until one year after the end of the affiliation, employment, or auditing relationship.

(iii) A relationship with a related entity as follows: a director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of that service or the employment relationship.

(3) The term of any material service provider contract with the risk retention group shall not exceed five years. Any contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit, or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for that contract is greater than, or equal to, 5 percent of the risk retention group's annual gross written premium or 2 percent of its surplus, whichever is greater.

(A) For purposes of this standard, "service providers" shall include captive managers, auditors, accountants, actuaries, investment advisers, attorneys, and managing general underwriters or any other party responsible for underwriting, determination of rates, collection of premium, adjusting and settling claims, or the preparation of financial statements. Any reference to "attorneys" does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to those attorneys are "material" as referenced in this paragraph.

(B) A service provider contract meeting the definition of "material relationship" pursuant to paragraph (2) shall not be

entered into unless the risk retention group has notified the commissioner in writing of its intention to enter into the transaction at least 30 days prior thereto, and the commissioner has not disapproved the transaction within that period.

(4) The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to do all of the following:

(A) Ensure that all owners or insureds, or both, of the risk retention group receive evidence of ownership interest.

(B) Develop a set of governance standards applicable to the risk retention group.

(C) Oversee the evaluation of the risk retention group's management, including, but not limited to, the performance of the captive manager, managing general underwriter, or other parties responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims, or the preparation of financial statements.

(D) Review and approve the amount to be paid for all material service providers.

(E) Review and approve, at least annually, all of the following:

(i) The risk retention group's goals and objectives relevant to the compensation of officers and service providers.

(ii) The officers' and service providers' performance in light of those goals and objectives.

(iii) The continued engagement of the officers and material service providers.

(5) The risk retention group shall have an audit committee composed of at least three independent board members as defined in paragraph (2). A nonindependent board member may participate in the activities of the audit committee, if invited by the members, but cannot be a member of that committee.

(A) The audit committee shall have a written charter that defines the committee's purpose, which, at a minimum, shall be to do all of the following:

(i) Assist in board oversight of the integrity of the financial statements, the compliance with legal and regulatory requirements, and the qualifications, independence, and performance of the independent auditor and actuary.

(ii) Discuss the annual audited financial statements and quarterly financial statements with management.

(iii) Discuss the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor.

(iv) Discuss policies with respect to risk assessment and risk management.

(v) Meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors.

(vi) Review with the independent auditor any audit problems or difficulties and management's response.

(vii) Set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor.

(viii) Require the external auditor to rotate the lead or coordinating audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit, so that neither individual performs audit services for more than five consecutive fiscal years.

(ix) Report regularly to the board of directors.

(B) If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

(6) The board of directors shall adopt and disclose governance standards by making the information available through electronic means, such as posting the information on the risk retention group's Internet Web site, or other means, and providing that information to members and insureds upon request. The information shall include all of the following:

(A) A process by which the directors are elected by the owners, insureds, or both.

(B) Director qualification standards.

(C) Director responsibilities.

(D) Director access to management and, as necessary and appropriate, independent advisers.

(E) Director compensation.

(F) Director orientation and continuing education.

(G) The policies and procedures that are followed for management succession.

(H) The policies and procedures that are followed for the annual performance evaluation of the board.

(7) The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers, and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, including all of the following topics:

(A) Conflicts of interest.

(B) Matters covered under the corporate opportunity doctrine under the state of domicile.

(C) Confidentiality.

(D) Fair dealing.

(E) Protection and proper use of risk retention group assets.

(F) Compliance with all applicable laws, rules, and regulations.

(G) Requiring the reporting of any illegal or unethical behavior that affects the operation of the risk retention group.

(8) The captive manager, president, or chief executive officer of the risk retention group shall promptly notify the domestic regulator, in writing, if he or she becomes aware of any material noncompliance with any of these governance standards.

(e) Domestic risk retention groups, licensed as of December 31, 2013, shall be governed by subdivision (d) on and after January 1, 2015.

SEC. 2. Section 662 of the Insurance Code is amended to read:

662. (a) A notice of cancellation of a policy shall not be effective unless mailed or delivered by the insurer to the named insured, lienholder, or additional interest at least 20 days prior to the effective date of cancellation; provided, however, that where cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason for the cancellation shall be given. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than 15 days prior to the effective date of cancellation, the insurer will specify the reason for the cancellation.

(b) This section shall not apply to nonrenewal.

(c) Notices made to lienholders pursuant to this section may be done electronically with the consent of the lienholder.

SEC. 3. Section 668.5 of the Insurance Code is repealed.

SEC. 4. 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 (b) or (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. 5. Section 739.3 of the Insurance Code is amended to read:

739.3. (a) "Company Action Level Event" means any of the following events:

(1) The filing of an RBC Report by an insurer that indicates any of the following:

(A) The insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC.

(B) If a life or health insurer, the insurer has Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 2.5, and has a negative trend.

(C) If a property and casualty insurer, the insurer has Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions.

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided that the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges, under Section 739.7, an Adjusted RBC Report that indicates the event in paragraph (1), the

notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the commissioner a comprehensive financial plan that shall do all of the following:

(1) Identify the conditions in the insurer that contribute to the Company Action Level Event.

(2) Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event.

(3) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, or surplus, or a combination. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions.

(5) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

(c) The RBC Plan shall be submitted as follows:

(1) Within 45 days of the Company Action Level Event.

(2) If the insurer challenges an Adjusted RBC Report pursuant to Section 739.7, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC Plan to the commissioner, the commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines that the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions that will render the RBC Plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a

Revised RBC Plan, which may incorporate by reference revisions proposed by the commissioner, and shall submit the Revised RBC Plan to the commissioner as follows:

(1) Within 45 days after the notification from the commissioner.

(2) If the insurer challenges the notification from the commissioner under Section 739.7, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the commissioner may, at his or her discretion, subject to the insurer's right to a hearing under Section 739.7, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(f) Every domestic insurer that files an RBC Plan or Revised RBC Plan with the commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if both of the following apply:

(1) That state has an RBC provision substantially similar to subdivision (a) of Section 739.8.

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state.

(B) The date on which the RBC Plan or Revised RBC Plan is filed under subdivision (c) of Section 739.7.

SEC. 6. Section 985 of the Insurance Code is amended to read:

985. (a) On or after January 1, 1970, as used in this article and in subdivision (i) of Section 1011, "insolvency" means either of the following:

(1) Any impairment of minimum "paid-in capital" or "capital paid in," as defined in Section 36, required in the aggregate of an insurer by the provisions of this code for the class, or classes, of insurance that it transacts anywhere.

(2) An inability of the insurer to meet its financial obligations when they are due.

(b) On or after January 1, 1970, an insurer cannot escape the condition of insolvency by being able to provide for all its liabilities and for reinsurance of all outstanding risks. An insurer must also be possessed of additional assets equivalent to the aggregate "paid-in capital" or "capital paid in" required by this code after making provision for all those liabilities and for that reinsurance.

(c) On or after October 1, 1967, as used in this code provision for reinsurance of all outstanding risks and "gross premiums without any deduction, received and receivable upon all unexpired risks" means the greater of: (1) the aggregate amount of actual unearned premiums, or (2) the amount reasonably estimated as being required to reinsure in a solvent admitted insurer the unexpired terms of the risks represented by all outstanding policies.

(d) On or after October 1, 1967, an insurer shall make provision for reinsurance of the outstanding risk on policies that provide premiums that are fully earned at inception and on policies that for any other reason do not provide for a return premium to the insured on cancellation prior to expiration.

(e) On or after October 1, 1967, the commissioner shall prescribe standards for reasonably estimating the amount required to reinsure that will provide adequate safeguards for the policyholders, creditors, and the public.

(f) On or after October 1, 1967, this section shall not be applicable to life, title, mortgage, or mortgage guaranty insurers.

(g) In the application of this section to disability insurance, as defined in Section 106, reserves for unearned premiums and amounts reasonably estimated as required to reinsure outstanding risks shall be determined in accordance with the provisions of Section 997.

SEC. 7. Section 1011 of the Insurance Code is amended to read:

1011. The superior court of the county in which the principal office of a person described in Section 1010 is located, upon the filing by the commissioner of the verified application showing any of the conditions in this subdivision exist, or a filing by the Federal Deposit Insurance Corporation of the verified application showing that the conditions enumerated in subdivision (j) exist and the conditions set forth in Section 5383(e)(3) of Title 12 of the United States Code having been satisfied, shall issue its order vesting title to all of the assets of that person, wheresoever situated, in the

commissioner or his or her successor in office, in his or her official capacity, and direct the commissioner forthwith to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business of the person, or so much thereof as to the commissioner may seem appropriate, and enjoining the person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until any of the following further order of the court:

(a) That the person has refused to submit its books, papers, accounts, or affairs to the reasonable inspection of the commissioner or his or her deputy or examiner.

(b) That the person has neglected or refused to observe an order of the commissioner to make good within the time prescribed by law any deficiency in its capital if it is a stock corporation, or in its reserve if it is a mutual insurer.

(c) That the person, without first obtaining the consent in writing of the commissioner, has transferred, or attempted to transfer, substantially its entire property or business or, without consent, has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(d) That the person is found, after an examination, to be in a condition that makes its further transaction of business hazardous to its policyholders, or creditors, or to the public.

(e) That the person has violated its charter or any law of the state.

(f) That any officer of the person refuses to be examined under oath, touching its affairs.

(g) That any officer or attorney in fact of the person has embezzled, sequestered, or wrongfully diverted any of the assets of the person.

(h) That a domestic insurer does not comply with the requirements for the issuance to it of a certificate of authority, or that its certificate of authority has been revoked.

(i) That the last report of examination of any person to whom the provisions of this article apply shows the person to be insolvent within the meaning of Article 13 (commencing with Section 980) of Chapter 1 of Part 2 of Division 1; or if a reciprocal or interinsurance exchange, within the applicable provisions of

Section 1370.2, 1370.4, 1371, or 1372; or if a life insurer, within the applicable provisions of Sections 10510 and 10511.

(j) Notification is given by the United States Secretary of the Treasury that a determination has been made by the secretary, in accordance with and satisfying the provisions of Section 5383(b) of Title 12 of the United States Code, as to a person described in Section 1010 that is an insurance company as defined in Section 5381(a)(13) of Title 12 of the United States Code, and one of the following:

(1) The board of directors, or body performing similar functions, of the person acquiesces or consents to the appointment of a receiver as provided for in Section 5832(a)(1)(A)(i) of Title 12 of the United States Code, with that consent to be considered to be consent to issuance of an order under this section.

(2) The United States District Court for the District of Columbia issued an order for the appointment of a receiver of the person as provided for in Section 5382(a)(1)(A)(iv)(I) of Title 12 of the United States Code, without regard to whether an appeal of the order is pending.

(3) A petition by the United States Secretary of the Treasury for appointment of a receiver was made to the United States District Court for the District of Columbia and was granted by operation of the law as provided for in Section 5382(a)(1)(A)(v) of Title 12 of the United States Code, without regard to whether an appeal of the order is pending.

SEC. 8. Section 1011.1 of the Insurance Code is amended to read:

1011.1. If a verified application is filed pursuant to Section 1011 that shows that the conditions set forth in subdivision (j) of Section 1011 exist and upon a showing that notice was provided to the person that is the subject of the verification application, all of the following apply:

(a) A superior court hearing shall be held in which the person may oppose the verified application solely on the grounds that the conditions set forth in subdivision (j) of Section 1101 do not exist. The hearing shall be completed within 24 hours after the verified application is filed with the court.

(b) The superior court shall issue an order as provided for in Section 1011 within 24 hours after the verified application was filed with the court.

(c) If the superior court does not issue an order within 24 hours as provided for in subdivision (b), then an order described in Section 1011 shall be deemed granted by operation of law upon expiration of the 24-hour period, without further notice.

(d) An order entered by the superior court pursuant to subdivision (b) or entered by operation of law pursuant to subdivision (c) shall not be subject to any stay or injunction pending appeal.

SEC. 9. Section 1012 of the Insurance Code is amended to read:

1012. Except in the case of an order issued based on a verified application showing the conditions in subdivision (j) of Section 1011 to exist, the order shall continue in force and effect until, on the application either of the commissioner or of that person, it shall, after a full hearing, appear to the court that the ground for the order directing the commissioner to take title and possession does not exist or has been removed and that the person can properly resume title and possession of its property and the conduct of its business.

SEC. 10. Section 1016 of the Insurance Code is amended to read:

1016. (a) If at any time after the issuance of an order under Section 1011, or if at the time of instituting any proceeding under this article, including under Section 1011, it shall appear to the commissioner that it would be futile to proceed as conservator with the conduct of the business of that person, he or she may apply to the court for an order to liquidate and wind up the business of the person. Upon a full hearing of that application, the court may make an order directing the winding up and liquidation of the business of that person by the commissioner, as liquidator, for the purpose of carrying out the order to liquidate and wind up the business of that person.

(b) Notwithstanding subdivision (a), the court may issue an order to liquidate and wind up the business of a person as to whom a verified application is filed pursuant to subdivision (j) of Section 1011 based solely on the verified application and hearing as provided for in subdivision (a) of Section 1011.1, without further hearing, or may issue an order to liquidate and wind up the business of the person upon application by the commissioner after the issuance of an order under Section 1011. The court’s order may

direct the winding up and liquidation of the business of the person by the commissioner, as liquidator, for the purpose of carrying out the order to liquidate and wind up the business of the person.

SEC. 11. Section 1070.6 of the Insurance Code is amended to read:

1070.6. The withdrawal procedure and fees prescribed by this article shall not be required of a nonsurviving admitted constituent to a merger or consolidation into another admitted insurer in accordance with the applicable statutes and the commissioner's prior written consent given pursuant to subdivision (c) of Section 1011, provided the commissioner is satisfied by documents, authenticated so as to be admissible in evidence over objection, filed with him or her, that:

(a) The constituent has discharged all of its liabilities to residents of this state in the manner provided by Section 1071.5;

(b) There will be an admitted insurer directly available to the constituent's policyholders: (1) to obtain policy changes and endorsements, (2) to receive payment of premiums and refund unearned premiums, (3) to serve notice of claim, proof of loss, summons, process, and other papers, and (4) for purposes of suit;

(c) The constituent shall timely file with the commissioner appropriate financial statements reporting its insurance business done in this state during the calendar year of the merger or consolidation and all appropriate tax returns required by law for the period, and shall timely pay all taxes found to be due on account of the business; and

(d) The constituent has surrendered its current California certificate of authority to the commissioner for cancellation as of the effective date of the merger.

The withdrawal procedure and fees prescribed by this article shall not be required of an insurer that has been liquidated by a final order of a court of record of this or any sister state provided a certified copy of the order reciting the fact of liquidation and discharge of all obligations has been filed with the commissioner.

SEC. 12. Section 1216.1 of the Insurance Code is amended to read:

1216.1. As used in this article, the following terms have the following meanings:

(a) "Accredited state" means a state in which the insurance department or regulatory agency having jurisdiction over the

business of insurance has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners' (NAIC) Financial Regulation Standards and Accreditation Program.

(b) "Control" or "controlled" has the meaning ascribed in Section 1215.

(c) "Controlled insurer" means an admitted insurer which is controlled, directly or indirectly, by a producer.

(d) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(e) "Admitted insurer" or "insurer" means any person, firm, association, or corporation admitted to transact any property or casualty insurance business in this state. The following are not insurers for the purposes of this article:

(1) All residual market pools and joint underwriting authorities or associations.

(2) All captive insurers, other than risk retention groups as defined in the federal Superfund Amendments Reauthorization Act of 1986 (42 U.S.C. Sec. 9671), the federal Liability Risk Retention Act of 1986 (15 U.S.C. Sec. 3901 et seq.), and the California Risk Retention Act of 1991 (Chapter 1.5 (commencing with Section 125) of Part 1). For the purposes of this article, captive insurers are either insurance companies which are owned by another organization and whose exclusive purpose is to insure risks of the parent organization and affiliated companies, or in the case of groups and associations, insurance organizations which are owned by the insureds and whose exclusive purpose is to insure risks of member organizations and group or association members and their affiliates.

(f) "Producer" means a fire and casualty licensee or licensees or any other person, firm, association, or corporation, when, for any compensation, commission, or other thing of value, the person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association, or corporation.

SEC. 13. Section 1624 of the Insurance Code is amended to read:

1624. "Insurance solicitor" means a natural person employed to aid a property and casualty broker-agent acting as an insurance agent or insurance broker in transacting insurance other than life, disability, or health.

SEC. 14. Section 1675 of the Insurance Code is amended to read:

1675. The following applicants who have theretofore been licensed under this code are exempt from the requirements of this article:

(a) An applicant for a license to act as a property broker-agent or a casualty broker-agent who has been licensed as a property broker-agent, casualty broker-agent, or surplus line broker during any part of the license year in which the application is filed or the immediately preceding license year.

(b) An applicant for a license to act as a life-only agent who has been licensed as a life-only agent during any part of the license year in which the application is filed or the immediately preceding license year.

(c) An applicant for a license to act as an accident and health agent who has been licensed as an accident and health agent during any part of the license year in which the application is filed or the immediately preceding license year.

(d) An applicant for a license to act as a travel insurance agent.

(e) An applicant specifically exempted from the particular qualifying examination requirement by other provisions of this code.

(f) (1) A nonresident licensee who applies for a property broker-agent, casualty broker-agent, personal lines broker-agent, or life agent resident license in this state, and who is currently licensed for the same lines of authority in the state of his or her current resident license, shall not be required to complete an examination. The application shall be received within 90 days of the cancellation of the applicant's resident license and the producer database records, maintained by the National Association of Insurance Commissioners, shall indicate that the producer is licensed in good standing for the line of authority requested.

(2) Upon issuance of the California resident license, the examination waiver also applies to adding additional lines of authority to the California resident license provided that the individual was previously licensed in good standing for the

requested additional lines of authority, and the application is received within 12 months of the cancellation of the applicant's previous resident license in another state.

SEC. 15. Section 1749.3 of the Insurance Code is amended to read:

1749.3. An individual licensed as a life-only agent or an accident and health agent and also licensed as a property or casualty broker-agent, or an individual only licensed as a property or casualty broker-agent, shall complete those courses, programs of instruction, or seminars approved by the commissioner for the type of license held. Completion of specified product training required in subdivision (d) of Section 1749.33, subdivision (b) of Section 1749.8, and paragraph (4) of subdivision (a) of Section 10234.93 may result in the completion of more than the minimum of required continuing education hours. The minimum number of hours required is as follows:

(a) Any licensee, as specified in this section, shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(b) An individual licensed as a property broker-agent or casualty broker-agent and as a life-only agent or an accident and health agent shall satisfy the requirements of this section by demonstrating completion of the courses, programs of instruction, or seminars approved by the commissioner for any of the license types listed in this section.

(c) A licensee shall not be required to comply with the requirements of this article if the licensee submits proof satisfactory to the commissioner that he or she has been a licensee in good standing for 30 continuous years in this state and is 70 years of age or older. This exemption shall not apply to those individuals licensed for the first time on or after January 1, 2010.

SEC. 16. Section 1749.31 of the Insurance Code is amended to read:

1749.31. (a) An individual licensed as a personal lines broker-agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The personal lines broker-agent shall complete 24 hours, of which three hours shall be in ethics, during each two-year license term as defined in subdivision (d) of Section 1625.5.

(b) An individual licensed as a personal lines broker-agent and as a life-only agent or accident and health agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 17. Section 1749.32 of the Insurance Code is amended to read:

1749.32. (a) An individual licensed as a limited lines automobile insurance agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The minimum number of hours required is 20 hours, of which three hours shall be in ethics, per license term prior to the renewal of the license.

(b) An individual licensed as a limited automobile insurance agent and as a life-only agent or accident and health agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 18. Section 1749.33 of the Insurance Code is amended to read:

1749.33. (a) A life-only agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(b) An accident and health agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(c) An agent licensed as both a life-only agent and as an accident and health agent shall satisfactorily complete a total of 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(d) Any accident and health agent who wishes to sell 24-hour care coverage, as defined in Section 1749.02, shall complete a course, program of instruction, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability, which shall be completed by examination approved by the commissioner as part of the continuing education course, program of instruction, or seminar prior to selling this coverage. The required number of instruction hours shall be equal to but no greater than that required by the

curriculum board for the prelicensing requirements of a property broker-agent or a casualty broker-agent on these subjects. For resident licensees, this requirement shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section. Nothing in this section shall be deemed to allow an accident and health agent to satisfy the obligations set forth in this section by other than a proctored examination administered or approved by the department.

SEC. 19. Section 1749.8 of the Insurance Code is amended to read:

1749.8. (a) Every life agent who sells annuities shall satisfactorily complete eight hours of training prior to soliciting individual consumers in order to sell annuities.

(b) Every life agent who sells annuities shall satisfactorily complete four hours of training prior to each license renewal. Completion of the eight-hour annuity training required by subdivision (a) does not satisfy the four-hour annuity training required by this subdivision. For resident licensees, this requirement shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section.

(c) The training required by this section shall be approved by the commissioner and shall consist of topics related to annuities, and California law, regulations, and requirements related to annuities, prohibited sales practices, the recognition of indicators that a prospective insured may lack the short-term memory or judgment to knowingly purchase an insurance product, and fraudulent and unfair trade practices. Subject matter determined by the commissioner to be primarily intended to promote the sale or marketing of annuities shall not qualify for credit toward the training requirement. Any course or seminar that is disapproved under the provisions of this section shall be presumed invalid for credit toward the training requirement of this section unless it is approved in writing by the commissioner.

(d) The training requirements set forth in this section shall not apply to nonresident agents representing an insurer that is a direct response provider.

For the purposes of this section, "direct response provider" means an insurer that meets each of the following criteria:

(1) The insurer does not initiate telephone contact with insureds or prospective insureds.

(2) Agents of the insurer speak with insureds and prospective insureds only by telephone, and at the request of the insureds or prospective insureds.

(3) Agents of the insurer are assigned to speak with insureds or prospective insureds on a random basis, when contacted.

(4) Agents of the insurer are salaried and do not receive commissions for sales or referrals.

SEC. 20. Section 1758.3 of the Insurance Code is amended to read:

1758.3. The commissioner shall not grant authority to transact variable contracts unless the life agent or applicant furnishes proof that he or she is registered to sell securities in California in accordance with the rules of the United States Securities and Exchange Commission or the Financial Industry Regulatory Authority. Any authority granted to a life agent to transact variable contracts shall immediately terminate upon the life agent no longer being registered to sell securities in accordance with the rules of the United States Securities and Exchange Commission or the Financial Industry Regulatory Authority.

SEC. 21. Section 1758.681 is added to the Insurance Code, to read:

1758.681. Notwithstanding any other law:

(a) As used in this section, "portable electronics vendor policyholder" means a portable electronics insurance agent licensee pursuant to subdivision (f) of Section 1758.69.

(b) An insurer may terminate a portable electronics insurance policy or otherwise change the terms and conditions of a portable electronics insurance policy only upon providing the portable electronics vendor policyholder and enrolled customers with at least 30 calendar days' written notice.

(c) If the insurer changes the terms and conditions of a policy of portable electronics insurance, the insurer shall provide the portable electronics vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating that

a change in the terms and conditions has occurred and a summary of those changes.

(d) Notwithstanding subdivision (b), an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 calendar days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the policy.

(e) Notwithstanding subdivision (b), an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy without prior notice for any of the following:

(1) For nonpayment of premium.

(2) If the enrolled customer ceases to have an active service with the vendor of portable electronics.

(3) If the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not sent within 30 calendar days, enrollment shall continue notwithstanding the aggregate limit of liability until 30 calendar days from the date the insurer sends notice of termination to the enrolled customer.

(f) If a portable electronics insurance policy is terminated by a portable electronics vendor policyholder, the portable electronics vendor policyholder shall mail or deliver a written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered by the portable electronics vendor policyholder to the enrolled customer at least 30 days prior to the termination. However, if the notice is not sent within 30 calendar days, enrollment shall continue until 30 calendar days from the date the portable electronics vendor policyholder sends notice of termination to the enrolled customer or until a new portable electronics insurance policy is in effect.

(g) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this section, it shall be in writing and sent within the notice period required pursuant to this section. Notices and correspondence shall be sent to the portable electronics vendor policyholder at the portable electronics vendor policyholder's mailing address specified for

that purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer or the portable electronics vendor policyholder. The insurer or portable electronics vendor policyholder shall maintain proof that the notice or correspondence was sent for not less than three years after that notice or correspondence was sent.

SEC. 22. Section 1872.87 of the Insurance Code is amended to read:

1872.87. (a) Each insurer required to pay special purpose assessments pursuant to Sections 1872.8, 1872.81, 1872.85, 1874.8, or subdivision (a) of Section 1872.86 may, over a reasonable length of time, but in no event later than the calendar year in which the assessment is paid, recoup the special purpose assessments by way of a surcharge on premiums charged for the insurance policies to which those sections apply or by including the assessments within the insurer's rates. Amounts recouped shall not be considered premiums for any purpose, including the computation of gross premium tax or agents' commission.

(b) The amount of the surcharge shall be separately stated on either a billing or policy declaration sent to an insured.

SEC. 23. Section 10234.93 of the Insurance Code is amended to read:

10234.93. (a) Every insurer of long-term care in California shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Submit to the commissioner within six months of the effective date of this act, a list of all agents or other insurer representatives authorized to solicit individual consumers for the sale of long-term care insurance. These submissions shall be updated at least semiannually.

(4) Provide the following training and require that each agent or other insurer representative authorized to solicit individual consumers for the sale of long-term care insurance shall satisfactorily complete the following training requirements that, for resident licensees, shall count toward the licensee's continuing education requirement, but may still result in completing more

than the minimum number of continuing education hours set forth in this section:

(A) For licensees issued a license after January 1, 1992, eight hours of training in each of the first four 12-month periods beginning from the date of original license issuance and thereafter eight hours of training prior to each license renewal.

(B) For licensees issued a license before January 1, 1992, eight hours of training prior to each license renewal.

(C) For nonresident licensees that are not otherwise subject to the continuing education requirements set forth in Section 1749.3, the evidence of training required by this section shall be filed with and approved by the commissioner as provided in subdivision (g) of Section 1749.4.

Licensees shall complete the initial training requirements of this section prior to being authorized to solicit individual consumers for the sale of long-term care insurance.

The training required by this section shall consist of topics related to long-term care services and long-term care insurance, including, but not limited to, California regulations and requirements, available long-term care services and facilities, changes or improvements in services or facilities, and alternatives to the purchase of private long-term care insurance. On or before July 1, 1998, the following additional training topics shall be required: differences in eligibility for benefits and tax treatment between policies intended to be federally qualified and those not intended to be federally qualified, the effect of inflation in eroding the value of benefits and the importance of inflation protection, and NAIC consumer suitability standards and guidelines.

(5) Display prominently on page one of the policy or certificate and the outline of coverage: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(6) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

(7) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subdivision.

(8) Every insurer shall provide to a prospective applicant, at the time of solicitation, written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge. Every agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP number, 1-800-434-0222.

(9) Provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each prospective applicant prior to the presentation of an application or enrollment form for insurance.

(10) Clearly post on its Internet Web site and provide written notice at the time of solicitation that a specimen individual policy form or group master policy and certificate form for each policy form offered in this state is available to a prospective applicant upon request. The individual specimen policy form or group master policy and certificate form shall be provided to a requesting party within 15 calendar days of receipt of a request.

(b) In addition to other unfair trade practices, including those identified in this code, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation, incomplete, or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

SEC. 24. Section 10785 of the Insurance Code is amended to read:

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as

defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every disability insurer that covers hospital, medical, or surgical expenses shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A disability insurer shall offer the following health benefit plans under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter

if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.

(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health benefits plans offered by a disability insurer in the individual market in the same manner as it applies to an insurer in connection with a group health benefit plan policy or group health benefit plan contract.

(h) A disability insurer shall compensate an accident and health agent or a life and accident and health agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates accident and health agents or life and accident and health agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.

(i) Every disability insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the federal Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No disability insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(*l*) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 24.5. Section 10785 of the Insurance Code is amended to read:

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the

individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every disability insurer that covers hospital, medical, or surgical expenses shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A disability insurer shall offer the following health benefit plans under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.

(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health benefits plans offered by a disability insurer in the individual market in the same manner as it applies to an insurer in connection with a group health benefit plan policy or group health benefit plan contract.

(h) A disability insurer shall compensate ~~a life agent, property broker-agent, or casualty broker-agent~~ *an accident and health agent or a life and accident and health agent* whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates ~~life agents, property broker-agents, or casualty broker-agents~~ *accident and health agents or life and accident and health agents* for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.

(i) Every disability insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the *federal* Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No disability insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(*l*) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

(m) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 25. Section 11620 of the Insurance Code is amended to read:

11620. (a) The commissioner, after a public hearing, shall approve or issue a reasonable plan for the equitable apportionment, among insurers admitted to transact liability insurance, of those applicants for automobile bodily injury and property damage liability insurance who are in good faith entitled to but are unable to procure that insurance through ordinary methods. The commissioner shall require the payment of five hundred ninety dollars ($590), in advance, as a fee for the filing of amendments to the plan with the commissioner. The commissioner may approve or issue reasonable amendments to the plan that are approved by the plan's advisory committee, if he or she first holds a public hearing to determine whether the amendments are in keeping with the intent and purpose of this section. All those insurers shall subscribe to the plan and its amendments and participate in the plan.

(b) Judicial review of a change to the plan, including rate revision proceedings, shall be in accordance with Section 1858.6.

(c) The adoption of the plan referenced in subdivision (a), and any amendments thereto, is not subject to the requirements of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), unless written or oral comments submitted pursuant to subdivision (e) raise regulatory standards set forth in subdivisions (a), (b), (c), (d), (e), and (f) of Section 11349 of the Government Code.

(d) The commissioner shall provide notice of any hearing pursuant to subdivision (a) by doing all of the following at least 45 days prior to the hearing:

(1) Publishing the notice in the California Regulatory Notice Register.

(2) Mailing the notice to the parties on the department's regulations mailing list.

(3) Posting the notice on the department's public Internet Web site.

(e) Interested parties may present written or oral comments at the hearing, or may submit written comments to the contact person identified in the hearing notice by the date and time posted in the notice. Before adopting any amendments to the plan, the commissioner shall consider all comments received on or before the day of the hearing.

SEC. 26. Section 12389.7 is added to the Insurance Code, to read:

12389.7. (a) Sections 1070, 1070.5, 1070.6, 1071.5, 1072, and 1076 shall be applicable to underwritten title companies.

(b) The following terms from Sections 1070, 1070.5, 1070.6, 1071.5, 1072, and 1076 shall be applicable to underwritten title companies as follows:

(1) "Certificate of Authority" shall mean an underwritten title company license.

(2) "Insurer" shall mean an underwritten title company.

(3) "Reinsurer" shall mean a title underwriter or another underwritten title company.

(c) For the purposes of this section, Sections 1070, 1070.5, 1070.6, 1071.5, 1072, and 1076 shall be construed in accordance with the nature of underwritten title companies and the business of title insurance.

SEC. 27. Section 12414.25 of the Insurance Code is amended to read:

12414.25. (a) Any person, title insurer, underwritten title company, or controlled escrow company who fails to comply with a final order of the commissioner under this chapter shall be liable to the state in an amount not exceeding one hundred dollars ($100), but if that failure is willful he, she, or it shall be liable to the state in an amount not exceeding five thousand dollars ($5,000) for that failure. The commissioner shall collect the amount so payable and may bring an action in the name of the people of the State of California to enforce collection. Those penalties may be in addition to any other penalties provided by law.

(b) (1) A willful violation of the provisions of this chapter is a misdemeanor.

(2) This subdivision is not applicable to Section 12389.7.

SEC. 28. Section 14090.1 of the Insurance Code is amended to read:

14090.1. (a) An individual who holds an insurance adjuster license and who is not exempt under subdivision (b) shall satisfactorily complete a minimum of 24 hours, of which three hours are to be in ethics, of continuing education courses pertinent to the duties and responsibilities of an insurance adjuster license reported to the insurance commissioner on a biennial basis in conjunction with his or her license renewal cycle.

(b) This section does not apply to any of the following:

(1) A licensee not licensed for one full year prior to the end of the applicable continuing education biennium.

(2) A licensee holding a nonresident insurance adjuster license who has met the continuing education requirements of his or her designated resident state.

(3) An individual licensed as an insurance adjuster and as a property or casualty broker-agent, pursuant to Section 1625, who has met the continuing education requirements specified in Section 1749.3.

SEC. 29. Section 24.5 of this bill incorporates amendments to Section 10785 of the Insurance Code proposed by both this bill and Assembly Bill 1180. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2014, (2) each bill amends Section 10785 of the Insurance Code, and (3) this bill is enacted after Assembly Bill 1180, in which case Section 24 of this bill shall not become operative.

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