

**Assembly Bill No. 1309**

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Passed the Assembly    September 7, 1999

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*Chief Clerk of the Assembly*

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Passed the Senate    September 7, 1999

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*Secretary of the Senate*

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This bill was received by the Governor this \_\_\_\_\_ day  
of \_\_\_\_\_, 1999, at \_\_\_\_\_ o'clock \_\_\_\_M.

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*Private Secretary of the Governor*

Corrected 9-9-99



## CHAPTER \_\_\_\_\_

An act to amend Sections 2870 and 2871 of the Civil Code, to amend Section 1063.1 of, and to add Section 1872.91 to, the Insurance Code, and to amend Section 3702.8 of the Labor Code, relating to insurance.

## LEGISLATIVE COUNSEL'S DIGEST

AB 1309, Scott. Insurance.

(1) Existing law requires employers that elect to be self-insured for workers' compensation liabilities to obtain a certificate of consent to self-insure from the Director of Industrial Relations, as specified. Existing law also requires private employers that cease to be self-insured to discharge their continuing obligations to secure the payment of workers' compensation that accrued during the period of self-insurance by complying with various procedures, including the deposit and maintenance of a security deposit with the director for accrued liability. Under these provisions, an employer that ceases to be self-insured may alternatively discharge this obligation by purchasing a special excess workers' compensation insurance policy, and an employer that does so must maintain the required security deposit for a period of 3 years after the policy is issued, unless the insurer issuing the policy posts a financial guarantee bond with the director.

This bill would provide that certain of the provisions relating to an employer that ceases to be a self-insured employer also apply to public employers. It would provide that any employer, who is currently self-insured or who has ceased to be self-insured, may choose to discharge, without recourse or liability to the Self-Insurers Security Fund, its continuing obligations as a self-insurer, by purchasing a special excess workers' compensation insurance policy, in accordance with existing provisions of law regarding the transfer of liability to insurers and subject to certain approvals and rate filing requirements, as specified. The bill would



provide that the provisions relating to the security deposit only apply to private self-insured employers. The bill would also delete provisions relating to the issuance of a financial guarantee bond and instead provide that in order for the special excess workers' compensation policy to discharge the obligation of a private employer to maintain a security deposit with the director, the policy shall provide coverage for all claims arising out of that liability for the applicable period, and to the extent the policy does not provide coverage for all claims, the employer shall maintain with the director the required security deposit for a period of 3 years after the issuance date of the policy. This bill would require the director to adopt regulations reasonably necessary to implement these provisions.

(2) Existing law prohibits insurers from engaging in unfair claims settlement practices, and provides for sanctions against insurers who engage in unfair claims settlement practices with respect to coverage under a policy of liability insurance by means of administrative sanctions against the insurer. SB 1237 of the 1999–2000 Regular Session, the Fair Insurance Responsibility Act of 2000 or “FAIR,” would provide that an insurer shall act in good faith toward and deal fairly with 3rd-party claimants. It would provide that if an insurer engages in unfair claims settlement practices with respect to a 3rd-party claimant, the 3rd-party claimant would generally have the right, upon meeting certain conditions, to assert a cause of action against the insurer, except as specified. It would permit binding arbitration for specified personal injury claims.

This bill would make changes to the provisions of SB 1237 if SB 1237 becomes operative. Among those changes would be the elimination of the use of verdict amounts as evidence of insurer bad faith; restricting 3rd-party bad faith actions to individuals for bodily injury, as defined, wrongful death, or property damage resulting from an incident involving a motor vehicle; providing for a defense, as specified; limiting the prospective effect of that bill's new 3rd-party rights as to prior accidents,



events, occurrences, or losses; and revising the presumption regarding insurer good faith and fair dealing arising from the submission of relevant claims to arbitration.

The bill would require the State Auditor to study the effects of FAIR, and to deliver his or her report to the Governor and the Legislature on or before January 1, 2005.

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

SECTION 1. The Legislature finds that public employers are liable for the payment of workers' compensation benefits in substantial amounts. These amounts are owed to current or former county employees who have previously been injured on the job, and to others in accordance with applicable law. The Legislature finds that new liabilities are created every year, as additional persons become eligible for workers' compensation benefits.

SEC. 2. Section 2870 of the Civil Code, as added by Senate Bill 1237 of the 1999–2000 Regular Session, is amended to read:

2870. (a) For purposes of this title, the following definitions shall apply:

(1) "Third-party claimant" or "claimant" shall mean each individual seeking recovery against an insured under a liability insurance policy or a self-funded liability protection program, fund, or plan, for bodily injury; wrongful death; or property damage resulting from an incident involving a motor vehicle; including, without limitation, damages resulting from loss of consortium or loss of care, comfort, society and the like resulting from wrongful death.

(2) "Insured" shall mean a natural person or entity named as an insured in a liability insurance policy or a private self-funded liability protection program, fund, or plan; a natural person or entity who is identified as an additional insured under a liability insurance policy or a private self-funded liability protection program, fund, or



plan; a natural person or entity who is an additional insured under the definitions of insured persons set forth in a liability insurance policy or a private self-funded liability protection program, fund, or plan; a natural person or entity who is defined, by law, as an insured under a liability insurance policy or a private self-funded liability protection program, fund, or plan; or cooperative corporations or interindemnity arrangements provided for under Section 1280.7 of the Insurance Code.

(3) “Insurer” shall mean any insurer licensed pursuant to, or subject to regulation under, the Insurance Code which provides liability insurance to an insured against whom a third-party claimant makes a claim for bodily injury, or for property damage resulting from an incident involving a motor vehicle, and the third-party administrator of any private self-funded liability protection program, fund, or plan; or cooperative corporations or interindemnity arrangements provided for under Section 1280.7 of the Insurance Code. However, “insurer” does not include the self-funded liability protection program, fund, or plan, itself, an insurer named as the insurer under a policy of workers’ compensation insurance, nor a self-insured public entity, a private administrator for a public entity, or a public entity insured by a private insurer or carrier. For purposes of this section, “public entity” has the meaning set forth in Section 811.2 of the Government Code.

(4) “Liability insurance” shall mean that portion of a personal or commercial insurance policy or a private self-funded liability protection program, fund or plan, which provides liability coverage for bodily injury, or for property damage resulting from an incident involving a motor vehicle.

(5) “Bodily injury” shall mean actual physical injury, sickness, or disease sustained by a person, including death therefrom. “Bodily injury” shall not mean (a) emotional distress, of any kind, resulting from economic loss, or (b) emotional distress resulting from a cause other than economic loss unless accompanied by actual physical manifestations of such emotional distress.



SEC. 3. Section 2871 of the Civil Code, as added by Senate Bill 1237 of the 1999–2000 Regular Session, is amended to read:

2871. (a) (1) Every insurer, as defined in paragraph (3) of subdivision (a) of Section 2870, doing business in the State of California shall act in good faith toward and deal fairly with third-party claimants. A third-party claimant may bring an action against an insurer doing business in the State of California to recover damages, including general, special, and exemplary damages, for commission of any unfair claims settlement practice specified in paragraph (1), (2), (3), (5), (8), (9), (10), (11), (12), (13), (14), or (15) of subdivision (h) of Section 790.03 of the Insurance Code as it relates to a third-party claimant.

(2) (A) In considering a third-party claim an insurer shall make an honest, intelligent and knowledgeable evaluation of the claim on its merits. However, an insurer shall not be considered to have violated its obligation to act in good faith and deal fairly with a third-party claimant because of the insurer's honest mistake in judgment in connection with the settlement of a claim.

(B) The fact that an insurer did not settle a claim is not necessarily proof of bad faith.

(b) A third-party claimant shall not be entitled to assert the remedies set forth in subdivision (a) unless the third-party claimant (1) obtains in the underlying action a final judgment after trial, a judgment after default, or an arbitration award arising from a contractual predispute binding arbitration clause or agreement, and (2) the third-party claimant makes a written demand by certified mail to settle the claim in the underlying action, and the claimant's judgment or arbitration award in that prior proceeding exceeded the amount of the final written demand on all claims by the third-party claimant made before the trial, entry of default or arbitration listed above. The final written demand sent by certified mail may not exceed the applicable policy limits and shall be deemed rejected if not responded to within 30 days of receipt of the final written demand.



(c) The remedies set forth in this title shall apply to any insurer who violates the standards set forth in subdivision (a) in its handling, processing, or settlement of the claims made by a third-party claimant under the insured's insurance protection.

(d) A professional liability insurer for medical, health care, or legal malpractice is not liable under this title if both of the following conditions apply:

(1) The consent of the policyholder to settlement is a prerequisite to settlement.

(2) The policyholder withholds consent to settlement.

(e) A person injured in an accident arising out of the operation or use of a motor vehicle, who at the time of the accident was operating a motor vehicle in violation of Section 23152 or 23153 of the Vehicle Code, and was convicted of that offense, may not assert a cause of action under this section.

(f) Any time period within which an action must be commenced pursuant to any applicable statute of limitations shall not begin until the underlying claim has been resolved through a final judgment. In the event of an appeal by either party, resolution of the appeal shall be a prerequisite to a claim under this title.

(g) Nothing in this title shall abrogate or limit any theory of liability or remedy otherwise available at law including, but not limited to, tort remedies for the breach of implied covenant and fair dealing or any theory of liability or remedy based on *Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654 or *Crisci v. Security Ins. Co.* (1967) 66 Cal.2d 425.

(h) The provisions of this title are prospective and are only applicable as follows:

(1) To accidents, events, occurrences, or losses that occur on or after January 1, 2000.

(2) To conduct by any insurer, its agents or employees concerning accidents, events, occurrences, or losses that occur on or after January 1, 2000.

SEC. 4. Section 1778 of the Code of Civil Procedure, as added by Senate Bill 1237 of the 1999–2000 Regular Session, is amended to read:



1778. If the insurer requests or agrees to submit a claim to arbitration under Section 1777 the insurer shall be conclusively presumed to have complied with the duties under subdivision (a) of Section 2871 of the Civil Code.

SEC. 5. Section 1063.1 of the Insurance Code is amended to read:

1063.1. As used in this article:

(a) “Member insurer” means an insurer required to be a member of the association in accordance with subdivision (a) of Section 1063, except and to the extent that the insurer is participating in an insolvency program adopted by the United States government.

(b) “Insolvent insurer” means a member insurer against which an order of liquidation or receivership with a finding of insolvency has been entered by a court of competent jurisdiction.

(c) (1) “Covered claims” means the obligations of an insolvent insurer, including the obligation for unearned premiums, (i) imposed by law and within the coverage of an insurance policy of the insolvent insurer; (ii) which were unpaid by the insolvent insurer; (iii) which are presented as a claim to the liquidator in this state or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings; (iv) which were incurred prior to the date coverage under the policy terminated and prior to, on, or within 30 days after the date the liquidator was appointed; (v) for which the assets of the insolvent insurer are insufficient to discharge in full; (vi) in the case of a policy of workers’ compensation insurance, to provide workers’ compensation benefits under the workers’ compensation law of this state; and (vii) in the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

(2) “Covered claims” also include the obligations assumed by an assuming insurer from a ceding insurer where the assuming insurer subsequently becomes an



insolvent insurer if, at the time of the insolvency of the assuming insurer, the ceding insurer is no longer admitted to transact business in this state. Both the assuming insurer and the ceding insurer shall have been member insurers at the time the assumption was made. “Covered claims” under this paragraph shall be required to satisfy the requirements of subparagraphs (i) to (vii), inclusive, of paragraph (1), except for the requirement that the claims be against policies of the insolvent insurer. The association shall have a right to recover any deposit, bond, or other assets that may have been required to be posted by the ceding company to the extent of covered claim payments and shall be subrogated to any rights the policyholders may have against the ceding insurer.

(3) “Covered claims” does not include obligations arising from the following:

(i) Life, annuity, health, or disability insurance.

(ii) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(iii) Fidelity or surety insurance including fidelity or surety bonds, or any other bonding obligations.

(iv) Credit insurance.

(v) Title insurance.

(vi) Ocean marine insurance or ocean marine coverage under any insurance policy including claims arising from the following: the Jones Act (46 U.S.C.A. Sec. 688), the Longshore and Harbor Workers’ Compensation Act (33 U.S.C.A. Sec. 901 et seq.), or any other similar federal statutory enactment, or any endorsement or policy affording protection and indemnity coverage.

(vii) Any claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers’ compensation policy issued pursuant to subdivision (c) of Section 3702.8 of the Labor Code that covers all or any part of workers’ compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.



(4) “Covered claims” does not include any obligations of the insolvent insurer arising out of any reinsurance contracts, nor any obligations incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured or canceled at the insured’s request, or after the insurance policy has been canceled by the association as provided in this chapter, or after the insurance policy has been canceled by the liquidator, nor any obligations to any state or to the federal government.

(5) “Covered claims” does not include any obligations to insurers, insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

An insurer, insurance pool, or underwriting association may not maintain, in its own name or in the name of its insured, any claim or legal action against the insured of the insolvent insurer for contribution, indemnity or by way of subrogation, except insofar as, and to the extent only, that the claim exceeds the policy limits of the insolvent insurer’s policy. In those claims or legal actions, the insured of the insolvent insurer is entitled to a credit or setoff in the amount of the policy limits of the insolvent insurer’s policy, or in the amount of the limits remaining, where those limits have been diminished by the payment of other claims.

(6) “Covered claims,” except in cases involving a claim for workers’ compensation benefits or for unearned premiums, does not include any claim in an amount of one hundred dollars (\$100) or less, nor that portion of any claim that is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer.

(7) “Covered claims” does not include that portion of any claim, other than a claim for workers’ compensation benefits, that is in excess of five hundred thousand dollars (\$500,000).

(8) “Covered claims” does not include any amount awarded as punitive or exemplary damages.



(9) “Covered claims” does not include (i) any claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured nor (ii) any claim by any person other than the original claimant under the insurance policy in his or her own name, his or her assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into prior to insolvency, his or her executor, administrator, guardian or other personal representative or trustee in bankruptcy and does not include any claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

(10) “Covered claims” does not include any obligations arising out of the issuance of an insurance policy written by the separate division of the State Compensation Insurance Fund pursuant to Sections 11802 and 11803.

(11) “Covered claims” does not include any obligations of the insolvent insurer arising from any policy or contract of insurance issued or renewed prior to the insolvent insurer’s admission to transact insurance in the State of California.

(12) “Covered claims” does not include surplus deposits of subscribers as defined in Section 1374.1.

(d) “Admitted to transact insurance in this state” means an insurer possessing a valid certificate of authority issued by the department.

(e) “Affiliate” means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(f) “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an



official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing that control does not in fact exist.

(g) “Claimant” means any insured making a first party claim or any person instituting a liability claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(h) “Ocean marine insurance” includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, which are usually insured against by traditional marine insurance such as hull and machinery, marine builders’ risks, and marine protection and indemnity. Those perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person.

(i) “Unearned premium” means that portion of a premium that had not been earned because of the cancellation of the insolvent insurer’s policy and is that premium remaining for the unexpired term of the insolvent insurer’s policy. “Unearned premium” does not include any amount sought as return of a premium under any policy providing retroactive insurance of a known loss or return of a premium under any retrospectively rated policy or a policy subject to a contingent surcharge or any policy in which the final determination of the premium cost is computed after expiration of the policy



and is calculated on the basis of actual loss experience during the policy period.

SEC. 6. Section 1872.91 is added to the Insurance Code, to read:

1872.91. (a) The State Auditor shall prepare a report analyzing and evaluating the effect of the Fair Insurance Responsibility Act of 2000 (FAIR) on California insurance claims practices and rates. The report shall identify changes in claim practices and patterns caused by the enactment of FAIR. The report shall be delivered to the Governor and the Legislature on or before January 1, 2005. The report shall be funded from existing resources of the State Auditor. The report shall include, but not be limited to, an analysis of the following:

(1) The number of complaints to the Department of Insurance regarding unfair claims settlement practices.

(2) The number and type of actions taken by the Department of Insurance in response to those complaints.

(3) The number of cases in which the parties enter into voluntary binding arbitration under Title 11.65 (commencing with Section 1776) of Part 3 of the Code of Civil Procedure, and the disposition of those cases, including whether the use of retired judges as arbitrators has provided an adequate pool of arbitrators.

(4) The number of cases that proceed to trial and the disposition of these cases, including appeals.

(5) The number of actions filed under Title 13.7 (commencing with Section 2870) of Part 4 of Division 3 of the Civil Code, and the disposition of these cases, including appeals.

(6) An analysis of the disposition of cases of third-party claimants who are not eligible to file a bad faith action and whether these claimants have been subject to unfair claims settlement practices.

(b) As part of the study, the State Auditor shall conduct a statistical closed claim study to compare auto insurance claims closed in 1999 and 2003. The study shall provide at least the same kinds of information as the August 1990 study, "Automobile Claims, A study of Closed



Claim Payments Patterns in California,” prepared by the Statistical Analysis Bureau. The Insurance Commissioner shall cooperate with the State Auditor in this study, and shall provide information requested by the State Auditor. The study shall identify the component costs of claims, including, but not limited to, the items listed in subdivision (c) by coverage for major settlement methods, including each of the following:

- (1) Closed without payment, no litigation.
  - (2) Closed with payment, no litigation.
  - (3) Closed without payment, litigated.
  - (4) Closed with payment after mediation.
  - (5) Closed with payment after judicial arbitration.
  - (6) Closed with payment after voluntary binding arbitration.
  - (7) Closed with payment after trial, including appeals.
- (c) The part of the study required in subdivision (b) shall include the following items, shown separately by coverage:

- (1) Number of claims.
- (2) Amount of losses or claim payouts, including both economic damages shown separately by category and noneconomic damages.
- (3) Punitive damages or bad faith awards, when applicable.
- (4) Defense costs.
- (5) Other claim or loss adjustment expenses.
- (6) Time period between filing of claim and final settlement.

SEC. 7. Section 3702.8 of the Labor Code is amended to read:

3702.8. (a) Employers who have ceased to be self-insured employers shall discharge their continuing obligations to secure the payment of workers' compensation that accrued during the period of self-insurance, for purposes of Sections 3700, 3700.5, 3706, and 3715, and shall comply with all of the following obligations of current certificate holders:

- (1) Filing annual reports as deemed necessary by the director to carry out the requirements of this chapter.



(2) In the case of a private employer, depositing and maintaining a security deposit for accrued liability for the payment of any workers' compensation that may become due, pursuant to subdivision (b) of Section 3700 and Section 3701, except as provided in subdivision (c).

(3) Paying within 30 days all assessments of which notice is sent, pursuant to subdivision (b) of Section 3745, within 36 months from the last day the employer's certificate of self-insurance was in effect. Assessments shall be based on the benefits paid by the employer during the last full calendar year of self-insurance on claims incurred during that year.

(b) In addition to proceedings to establish liabilities and penalties otherwise provided, a failure to comply may be the subject of a proceeding before the director. An appeal from the director's determination shall be taken to the appropriate superior court by petition for writ of mandate.

(c) Notwithstanding subdivision (a), any employer who is currently self-insured or who has ceased to be self-insured may purchase a special excess workers' compensation policy to discharge any or all of the employer's continuing obligations as a self-insurer to pay compensation or to secure the payment of compensation.

(1) The special excess workers' compensation insurance policy shall be issued by an insurer authorized to transact workers' compensation insurance in this state.

(2) Each carrier's special excess workers' compensation policy shall be approved as to form and substance by the Insurance Commissioner, and rates for special excess workers' compensation insurance shall be subject to the filing requirements set forth in Section 11735 of the Insurance Code.

(3) Each special excess workers' compensation insurance policy shall be submitted by the employer to the director. The director shall adopt and publish minimum insurer financial rating standards for companies issuing special excess workers' compensation policies.



(4) Upon acceptance by the director, a special excess workers' compensation policy shall provide coverage for all or any portion of the purchasing employer's claims for compensation arising out of injuries occurring during the period the employer was self-insured in accordance with Sections 3755, 3756, and 3757 of the Labor Code and Sections 11651 and 11654 of the Insurance Code. The director's acceptance shall discharge the Self-Insurer's Security Fund, without recourse or liability to the Self-Insurer's Security Fund, of any continuing liability for the claims covered by the special excess workers' compensation insurance policy.

(5) For public employers, no security deposit or financial guarantee bond or other security shall be required. The director shall set minimum financial rating standards for insurers issuing special excess workers' compensation policies for public employers.

(d) (1) In order for the special excess workers' compensation insurance policy to discharge the full obligations of a private employer to maintain a security deposit with the director for the payment of self-insured claims, applicable to the period to be covered by the policy, the special excess policy shall provide coverage for all claims for compensation arising out of that liability. The employer shall maintain the required deposit for the period covered by the policy with the director for a period of three years after the issuance date of the special excess policy.

(2) If the special workers' compensation insurance policy does not provide coverage for all of the continuing obligations for which the private self-insured employer is liable, to the extent the employer's obligations are not covered by the policy a private employer shall maintain the required deposit with the director. In addition, the employer shall maintain with the director the required deposit for the period covered by the policy for a period of three years after the issuance date of the special excess policy.

(e) The director shall adopt regulations pursuant to Section 3702.10 that are reasonably necessary to



implement this section in order to reasonably protect injured workers, employers, the Self-Insurers' Security Fund, and the California Insurance Guarantee Association.

(f) The posting of a special excess workers' compensation insurance policy with the director shall discharge the obligation of the Self-Insurer's Security Fund pursuant to Section 3744 to pay claims in the event of an insolvency of a private employer to the extent of coverage of compensation liabilities under the special excess workers' compensation insurance policy. The California Insurance Guarantee Association shall be advised by the director whenever a special excess workers' compensation insurance policy is posted.

SEC. 8. The provisions of Sections 2, 3, and 5 of this act, the provisions of Title 13.7 (commencing with Section 2870) of Part 4 of Division 3 of the Civil Code, and the provisions of Title 11.65 (commencing with Section 1776) of Part 3 of the Code of Civil Procedure, are severable. If any of those provisions or any of their applications is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 9. Sections 2, 3, 5, and 7 of this act shall not become operative unless Senate Bill 1237 of the 1999–2000 Regular Session is enacted, becomes operative, and this act is chaptered after Senate Bill 1237.



Approved \_\_\_\_\_, 1999

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*Governor*

