AMENDED IN ASSEMBLY AUGUST 2, 2010

AMENDED IN ASSEMBLY JUNE 29, 2010

AMENDED IN ASSEMBLY JUNE 1, 2010

SENATE BILL No. 1408

Introduced by Committee on Banking, Finance and Insurance (Senators Calderon (Chair), Cogdill, Correa, Cox, Florez, Kehoe, Liu, Lowenthal, Padilla, Price, and Runner)

February 19, 2010

An act to amend Sections 1025.5, 1067.02, 1067.03, 1067.04, 1067.05, 1067.055, 1067.07, 1067.08, 1067.09, 1067.10, 1067.11, 1067.12, 1067.13, 1067.16, and 1067.17 of the Insurance Code, relating to insurance, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 1408, as amended, Committee on Banking, Finance and Insurance. Insurance: California Life and Health Insurance Guarantee Association Act.

Existing law requires the formation of the California Life and Health Insurance Guarantee Association to provide coverage for persons for direct, nongroup life, health, annuity, and supplemental policies or contracts of insurance, except as specified, in case of failure in the performance of contractual obligations under policies and contracts because of the impairment or insolvency of the member insurer that issued the policies or contracts.

This bill would revise and recast provisions of the act, including, but not limited to, the powers and duties of the association, coverage eligibility, the conditions and procedures for payment of a claim,

association reporting requirements, and other related changes. The bill would also make various technical and conforming changes.

This bill would provide that the amendments made to the California Life and Health Insurance Guarantee Association Act by this act shall not apply to any member insurer that, before the effective date of this act, has been placed under an order of liquidation with a finding of insolvency.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 1025.5 of the Insurance Code is amended to read:

1025.5. Notwithstanding the provisions of Sections 1021 to 1025, inclusive, the commissioner may, in lieu of requiring claimants to file separate claims:

(a) File a claim himself or herself on behalf of all claimants for return premiums.

(b) Permit any assignee of the right of the insured to a return premium by virtue of a valid assignment, as security or otherwise, made prior to an order under Section 1011 or a seizure under Section 1013, whichever is earlier in time in the particular case, to file one claim as assignee on behalf of all insureds having assigned rights to the assignee, which shall set forth such information as may be required under Section 1023.

(c) Permit the California Insurance Guarantee Association under subdivision (b) of Section 1063.4, or the California Life and Health Insurance Guarantee Association under paragraph (1) of subdivision (k) of Section 1067.07 to file one claim, for its association, combining all assigned claims and setting forth the information that the commissioner may require under Section 1023.

SEC. 2. Section 1067.02 of the Insurance Code is amended to read:

1067.02. (a) This article shall provide coverage for the policies and contracts specified in subdivision (b) to all of the following:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees of the persons covered under paragraph (2).

(2) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who either:

(A) Are residents of this state.

(B) Are not residents, but only under all of the following conditions:

(i) The insurer that issued the policies or contracts is domiciled in this state.

(ii) The states in which the persons reside have associations similar to the association created by this article.

(iii) The persons are not eligible for coverage by the association in their resident state due to the fact that the insurer was not licensed in that state at the time specified in that state's guaranty association law.

(3) For structured settlement annuities specified in subdivision (b), paragraphs (1) and (2) of this subdivision shall not apply, and this article shall, except as provided in paragraphs (4) and (5) of this subdivision, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee is either:

(A) A resident of this state, regardless of where the contract owner resides.

(B) Not a resident, but only if both of the following conditions are satisfied:

(i) The contract owner of the structured settlement annuity is a resident, or the contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this article.

(ii) Neither the payee, or beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This article shall not provide coverage to a person who is a payee, or beneficiary, of a contract owner resident of this state, if

the payee, or beneficiary, is afforded coverage by the association of another state.

(5) This article is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this article is provided coverage under the laws of any other state, the person shall not be provided coverage under this article. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this article shall be construed in conjunction with other state laws to result in coverage by only one association.

(b) (1) This article shall provide coverage to the persons specified in subdivision (a) for direct, nongroup life, health, or annuity policies or contracts, and supplemental contracts to any of these, and for certificates under direct group policies and contracts, except as limited by this article. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts. The health policies and contracts covered under this article include, but are not limited to, basic hospital, medical, and surgical insurance, major medical insurance, disability income insurance, disability insurance, including insurance appertaining to injury, disablement, or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness, and long-term care insurance, including any net cash surrender and net cash withdrawal values.

(2) This article shall not provide coverage for any of the following:

(A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy owner or contract owner.

(B) Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract.

(C) A portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by the use of an index or other external

reference which is stated in the policy or contract and employed in calculating returns or changes in value does both of the following:

(i) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this article exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for the lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this article, not to go below a minimum of 0 percent.

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this article exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available, not to go below a minimum of 0 percent.

(D) An unallocated annuity contract.

(E) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under any of the following:

(i) A multiple employer welfare arrangement as defined in Section 1144 of Title 29 of the United States Code.

(ii) A minimum premium group insurance plan.

(iii) A stop-loss group insurance plan.

(iv) An administrative services only contract.

(F) A portion of a policy or contract to the extent that it provides for any of the following:

(i) Dividends or experience rating credits.

(ii) Voting rights.

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract.

(G) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state.

(H) Any annuity issued by a charitable organization that is duly qualified as such under applicable provisions of the Internal

Revenue Code, and that is not engaged in the business of insurance as its primary business.

(I) A portion of a policy or contract to the extent that the assessments required by Section 1067.08 with respect to the policy or contract are preempted or otherwise not permitted by federal or state law.

(J) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation, any of the following:

(i) Claims based on marketing materials.

(ii) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements.

(iii) Misrepresentations of, or regarding, policy benefits.

(iv) Extracontractual claims.

(v) A claim for penalties or consequential or incidental damages.

(K) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

(L) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture pursuant to this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture.

(M) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C

of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-21 et seq.) or Part D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), commonly known as Medicare Parts C and D, or any regulations issued pursuant thereto.

(c) The benefits for which the association may become liable for life insurance and annuity policies shall in no event exceed the lesser of the following:

(1) Eighty percent of the contractual obligations for each policy or contract as modified pursuant to subparagraph (C) of paragraph (2) of subdivision (b), for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer.

(2) (A) With respect to any one life, regardless of the number of policies or contracts:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance.

(ii) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) With respect to each payee of a structured settlement annuity, or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values.

(C) Notwithstanding subparagraphs (A) and (B), in no event shall the association be obligated to cover more than an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one life under subparagraphs (A) and (B).

(D) Notwithstanding subparagraphs (A), (B), and (C), with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, in no event shall the association be obligated to cover more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner.

(d) The health insurance benefits for which the association may become liable shall in no event exceed the lesser of the following:

(1) The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer.

(2) With respect to any one individual receiving health care benefits, regardless of the number of policies or contracts, two hundred thousand dollars ($200,000) in health insurance benefits; an amount that shall increase or decrease based upon changes in the health care cost component of the consumer price index from January 1, 1991, to the date on which the insurer becomes an insolvent insurer.

(e) The limitations set forth in subdivisions (c) and (d) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this article may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(f) In performing its obligations to provide coverage under Section 1067.07, the association shall not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

SEC. 3. Section 1067.03 of the Insurance Code is amended to read:

1067.03. This article shall be liberally construed to effect the purpose under Section 1067.01.

SEC. 4. Section 1067.04 of the Insurance Code is amended to read:

1067.04. As used in this article:

(a) "Account" means either of the two accounts created under Section 1067.05.

(b) "Association" means the California Life and Health Insurance Guarantee Association created pursuant to Section 1067.05.

(c) "Authorized assessment" means an assessment, to be called immediately or in the future from member insurers for a specified

amount, that is authorized by a resolution of the board of directors. "Authorized," when used in the context of assessments, means authorized by a resolution of the board of directors. An assessment is authorized when this resolution is passed.

(d) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(e) "Called assessment" means an assessment as to which a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within a timeframe set forth in the notice. "Called," when used in the context of assessments, means required by notice to be paid by member insurers. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Commissioner" means the Insurance Commissioner.

(g) "Contractual obligation" means any obligation under a policy or contract, or certificate under a group policy or contract, or portion thereof, for which coverage is provided under Section 1067.02.

(h) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 1067.02.

(i) "Extracontractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney's fees and costs.

(j) "Impaired insurer" means a member insurer which, after the effective date of this article, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(k) "Insolvent insurer" means a member insurer that, after October 1, 1990, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(*l*) "Member insurer" means any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 1067.02 and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include any of the following:

(1) A hospital or medical service organization, whether for profit or nonprofit.

(2) A health maintenance organization.

(3) A fraternal benefit society.

(4) A mandatory state pooling plan.

(5) A mutual assessment company or other person that operates on an assessment basis.

(6) An insurance exchange.

(7) An organization that has a certificate or license limited to the issuance of charitable gift annuities.

(8) A grants and annuities society holding a certificate of authority under Section 11520.

(9) An entity similar to any of the above.

(m) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(n) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(o) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(p) "Plan sponsor" means any of the following:

(1) The employer in the case of a benefit plan established or maintained by a single employer.

(2) The employee organization in the case of a benefit plan established or maintained by an employee organization.

(3) In a case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(q) (1) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits.

(2) "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under subdivision (b) of Section 1067.02, except that assessable premium shall not be reduced on account of subparagraph (C) of paragraph (2) of subdivision (b) of Section 1067.02 relating to interest limitations and paragraph (2) of subdivision (c) of Section 1067.02 relating to limitations with respect to one individual, one participant, and one contract owner.

(3) "Premiums" does not include any of the following:

(A) Premiums on an unallocated annuity contract.

(B) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(r) (1) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering all the following factors:

(A) The state in which the primary executive and administrative headquarters of the entity are located.

(B) The state in which the principal office of the chief executive officer of the entity is located.

(C) The state in which the board of directors, or similar governing persons, of the entity conducts the majority of its meetings.

(D) The state in which the executive or management committee of the board of directors, or similar governing persons, of the entity conducts the majority of its meetings.

(E) The state from which the management of the overall operations of the entity is directed.

(F) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However,

in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(2) The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(s) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(t) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States who are either residents of foreign countries, or residents of United States' possessions, territories, or protectorates that do not have an association similar to the association created by this article shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(u) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(v) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for, or with respect to, personal injury suffered by the plaintiff or other claimant.

(w) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

(x) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits

guaranteed to an individual by an insurer under the contract or certificate.

SEC. 5. Section 1067.05 of the Insurance Code is amended to read:

1067.05. (a) A nonprofit legal entity to be known as the California Life and Health Insurance Guarantee Association shall exist as a result of the merger of the Seastrand Health Insurance Guaranty Association with and into the California Life Insurance Guaranty Association pursuant to Section 1067.055. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Section 1067.09 and shall exercise its powers through a board of directors established under Section 1067.06. For purposes of administration and assessment, the association shall maintain the following two accounts:

(1) The life insurance and annuity account which includes both of the following subaccounts:

(A) The life insurance account.

(B) The annuity account, which shall include annuity contracts owned by a governmental retirement plan, or its trustee, established under Section 401, 403(b), or 457 of the Internal Revenue Code.

(2) The health insurance account.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

SEC. 6. Section 1067.055 of the Insurance Code is amended to read:

1067.055. In order to provide for the merger of the Seastrand Health Insurance Guaranty Association with and into the California Life Insurance Guaranty Association, the following shall apply:

(a) Notwithstanding the repeal of the California Life Insurance Guaranty Association Act and the Seastrand Health Insurance Guaranty Association Act, the Seastrand Health Insurance Guaranty Association shall, effective immediately prior to that repeal, be merged with and into the California Life Insurance Guaranty Association, which shall then be known as the California Life and Health Insurance Guarantee Association.

(b) Notwithstanding the repeal of the California Life Insurance Guaranty Association Act and the Seastrand Health Insurance Guaranty Association Act, but subject to the last sentence of this subdivision, all of the following shall apply:

(1) The association shall succeed, without other transfer, to all the rights, powers, privileges, assets, and property of each of the California Life Insurance Guaranty Association and the Seastrand Health Insurance Guaranty Association, which for the purposes of this section shall be referred collectively as the merging associations. The association shall be subject to all debts, obligations, and liabilities of each merging association in the same manner as if the association had itself incurred them, in each case under the law in effect prior to the effective date of this article, as those rights, powers, privileges, obligations, debts, and liabilities may be amended and restated in this article, and in each case with respect to member insurers that became impaired insurers or insolvent insurers prior to the effective date of this article and after October 1, 1990. Without limiting the generality of the foregoing, the association shall succeed to (A) all collected, uncollected, or unbilled assessments of the merging associations, (B) all cash, bank accounts, and accrued interest of the merging associations, (C) all rights, powers, privileges, and obligations of the merging associations under any contracts or commitments of the merging association, (D) all subrogations, assignments, and creditor rights and interests of the merging associations, and (E) all rights, powers, privileges, and obligations of each of the trusts established on December 31, 1993, by each of the merging associations as settlor.

(2) All rights of creditors and all liens upon the property of each of the merging associations shall be preserved unimpaired, provided that the liens upon property of a merging association shall be limited to the property affected thereby immediately prior to the effective date of this article.

(3) Any action or proceeding pending by or against a merging association may be prosecuted to judgment, which shall bind the association, or the association may be proceeded against or be substituted in its place.

Notwithstanding the other provisions of this subdivision, all debts, obligations, and liabilities of a merging association that were to be paid out of a specified account of the merging association shall be paid solely out of the assets of that merging association

that were available to that merging association to pay those debts and liabilities, including, without limitation, collected, uncollected, or unbilled assessments, and any and all subrogation, assignment, and creditor rights, or out of assets in the same type of account of the association.

(c) Notwithstanding any other provision to the contrary in this article:

(1) It is the intent of this section to preserve rights, powers, privileges, assets, property, debts, obligations, and liabilities of each of the merging associations, and not to provide contract owners and policy owners, or their respective payees, beneficiaries, or assignees, with duplicative rights, powers, privileges, assets, or property.

(2) Accordingly, no contract owner and policy owner, and no contract owner's or policy owner's payee, beneficiary, or assignee, shall be entitled to (A) a recovery from the association that is duplicative of a previous recovery from either of the merging associations, or the trust established by either merging association, or (B) a recovery from the association on account of a claim against either of the merging associations where the association is liable with respect to a claim under the same policy or contract under this article.

SEC. 7. Section 1067.07 of the Insurance Code is amended to read:

1067.07. (a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner, do any of the following:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer.

(2) Provide moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate paragraph (1) and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (1).

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either do those things described in paragraph (1) or in paragraph (2):

(1) (A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(C) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties.

(2) Provide benefits and coverages in accordance with the following provisions:

(A) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts.

(ii) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts.

(B) Make diligent efforts to provide all known insureds or annuitants, for nongroup policies and contracts, or group policy owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to subparagraph (A), of the benefits provided.

(C) With respect to nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (D), if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which

the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(D) (i) In providing the substitute coverage required under subparagraph (C), the association may offer either to reissue the terminated coverage or to issue an alternative policy and shall consider obtaining coverage for a medically uninsurable person from the program established under Part 6.5 (commencing with Section 12700) of Division 2.

(ii) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(iii) The association may reinsure any alternative or reissued policy.

(E) (i) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(G) The association’s obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage

or policy is replaced by another similar policy by the policy owner, the insured, or the association.

(H) When proceeding under this paragraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subparagraph (C) of paragraph (2) of subdivision (b) of Section 1067.02.

(c) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this article with respect to that policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of that order.

(e) The protection provided by this article shall not apply where any guarantee protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(f) In carrying out its duties under subdivision (b), the association may, subject to approval by a court of competent jurisdiction, do either of the following:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association's duties under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy or contract liens, to be in the public interest.

(2) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash

values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subdivision. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(h) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subdivision (b), the commissioner shall have the powers and duties of the association under this article with respect to the insolvent insurer.

(i) The association may render assistance and advice to the commissioner, upon his or her request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(j) The association shall have standing to appear or intervene before a court or agency engaged in an adjudication in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise.

Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise.

(k) (1) Any person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of those rights and cause of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon that person.

(2) The subrogation rights of the association under this subdivision shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.

(3) In addition to paragraphs (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code.

(4) If the preceding provisions of this subdivision are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subdivision, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(*l*) In addition to the rights and powers elsewhere in this article, the association may do any of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this article.

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 1067.08 and to settle claims or potential claims against it.

(3) Borrow money to effect the purposes of this article. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(4) Employ or retain an executive director and other persons to handle the financial transactions of the association, and to perform other functions necessary or proper under this article, provided that the executive director shall be subject to the approval of the commissioner.

(5) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims.

(6) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this article.

(7) Organize itself as a corporation or in another legal form permitted by the laws of the state.

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its

obligations under this article with respect to the person, and the person shall promptly comply with the request.

(9) Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its powers under this article.

(m) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(n) There shall be no liability on the part of and no cause of action shall arise against the association or against any transferee from the association in connection with the transfer by reinsurance or otherwise of all or any part of an impaired or insolvent insurer's business by reason of any action taken or any failure to take any action by the impaired or insolvent insurer at any time.

(o) With respect to covered policies for which the association becomes obligated after an entry of an order or liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(p) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

(q) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association's obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(r) The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this article.

(s) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subdivision (a)

or (b), the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with all of the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value.

(2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract.

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

SEC. 8. Section 1067.08 of the Insurance Code is amended to read:

1067.08. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at the time and for the amounts as the board finds necessary. Assessments shall be due not more than 30 days after prior written notice to the member insurers and shall accrue interest at the rate of 10 percent per annum on and after the due date.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of subdivision (e) of Section 1067.11. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 1067.07 with regard to an impaired or an insolvent insurer.

(c) (1) The amount of any class A assessment shall be determined at the discretion of the board of directors and such assessments shall be authorized and called on a non pro rata basis.

The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to premiums received on business in this state for those calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized and called until necessary to implement the purposes of this article. Classification of assessments under subdivision (b) and computation of assessments under this subdivision shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which that assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e) (1) (A) Subject to the provisions of subparagraph (B), the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one calendar

year exceed 2 percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(B) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (A) shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(C) If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(g) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article.

(h) The association shall issue to each insurer paying an assessment under this article, other than class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All

outstanding certificates shall be of equal dignity and priority without reference to amounts or date of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in the form and for the amount, if any, and period of time as the commissioner may approve.

(i) (1) Subject to the provisions of paragraph (3), the plan of operation adopted pursuant to Section 1067.09 shall contain provisions whereby each member insurer may recoup over a reasonable length of time a sum reasonably calculated to recoup the assessments with respect to the health insurance account paid by the member insurer under this article by way of a surcharge on premiums charged for health insurance policies to which this article applies. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agent's commission.

(2) Member insurers who collect surcharges in excess of assessments paid pursuant to this section for an insolvent insurer shall remit the excess to the association as an additional assessment within 120 days after the end of the collection period as determined by the association. The excess shall be applied to reduce future health insurance account assessments for that insurer.

(3) The plan of operation may permit a member insurer to omit the collection of the surcharge from its insureds when it determines the amount of the surcharge collectible from each insured would be unreasonably small in relation to the potential confusion of or objection by the insureds even if the aggregate surcharges collectible from all insureds exceeds the expense of collection.

(j) Any statement of the amount of surcharge provided by the association shall include a description of, and purpose for, the California Life and Health Insurance Guarantee Association, as follows:

"Companies writing health insurance business in California are required to participate in the California Life and Health Insurance Guarantee Association. If a company writing health insurance becomes insolvent, the California Life and Health Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share."

"California law allows all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA

Surcharge" with an amount will be displayed on your premium notice."

(k) (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within 60 days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(*l*) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with a request.

SEC. 9. Section 1067.09 of the Insurance Code is amended to read:

1067.09. (a) (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the

commissioner's written approval or unless he or she has not disapproved it within 30 days.

(2) If the association fails to submit a suitable plan of operation within 120 days following the effective date of this article or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate those reasonable rules as are necessary or advisable to effectuate the provisions of this article. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this article, do all of the following:

(1) Establish procedures for handling the assets of the association.

(2) Establish the amount and method of reimbursing members of the board of directors under Section 1067.06.

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(5) Establish the procedure whereby selections for the board of directors will be made and submitted to the commissioner.

(6) Establish any additional procedures for assessments under Section 1067.08.

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(8) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer.

(9) Require the board of directors to establish a policy and procedures for addressing conflicts of interests.

(d) The plan of operation may provide that any or all powers and duties of the association, including its administration, except those under paragraph (3) of subdivision (*l*) of Section 1067.07 and Section 1067.08, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more

states. That corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subdivision shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this article.

SEC. 10. Section 1067.10 of the Insurance Code is amended to read:

1067.10. In addition to the duties and powers enumerated elsewhere in this article:

(a) The commissioner shall do all of the following:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this article.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture shall not exceed 5 percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(c) A final action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken within 60 days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(d) The liquidator, rehabilitator, or conservator of any impaired insurer or insolvent insurer may notify all interested persons of the effect of this article.

SEC. 11. Section 1067.11 of the Insurance Code is amended to read:

1067.11. To aid in the detection and prevention of insurer insolvencies or impairments:

(a) It shall be the duty of the commissioner to do the following:

(1) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when he or she takes any of the following actions against a member insurer:

(A) Revocation of license.

(B) Suspension of license.

(C) Makes any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

The notice shall be mailed to all commissioners within 30 days following the action taken or the date on which the action occurs.

(2) To report to the board of directors, the Legislature, and the Governor when he or she has taken any of the actions set forth in paragraph (1) or has received a report from any other commissioner indicating that any action has been taken in another state. The report to the board of directors, the Legislature, and the Governor shall contain all significant details of the action taken on the report received from another commissioner.

(3) To report to the board of directors when he or she has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until that time as it is made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his or her duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Those reports and recommendations shall not be considered public documents.

(d) The board of directors shall, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(e) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within 30 days of the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by persons that the commissioner designates. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subdivision (a).

The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) Reports, information, and recommendations from the board to the commissioner and from the commissioner to the board under this section shall be treated as confidential and shall not be considered public documents except as otherwise specifically

provided in this section or by specific action of the board or commissioner.

SEC. 12. Section 1067.12 of the Insurance Code is amended to read:

1067.12. (a) This article shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 1067.07. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed to the public prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subdivision shall limit the duty of the association to render a report of its activities under Section 1067.13.

(c) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Section 1067.07. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subdivision, are that proportion of the assets which the reserves that should have been established for those policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subdivision (c) and consistent with Section 1035.5, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this article. If the liquidator has not, within 120 days of an order directing the liquidation of the business of an insolvent insurer or a final determination of insolvency of an insurer by the receivership court,

made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e) (1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In the determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Section 1067.07 with respect to the insurer have been fully recovered by the association.

(f) (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) to (4), inclusive.

(2) No such distribution shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he or she received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he or she would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subdivision shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (3) is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

SEC. 13. Section 1067.13 of the Insurance Code is amended to read:

1067.13. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, the Governor, and the Legislature each year, not later than 120 days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

SEC. 14. Section 1067.16 of the Insurance Code is amended to read:

1067.16. All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed not less than 180 days from the date an order of liquidation, rehabilitation, or conservation is final, to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

SEC. 15. Section 1067.17 of the Insurance Code is amended to read:

1067.17. (a) No person, including an insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the California Life and Health Insurance Guarantee

Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the California Life and Health Insurance Guarantee Association Act. Provided, however, that this section shall not apply to the California Life and Health Insurance Guarantee Association or any other entity which does not sell or solicit insurance.

(b) (1) The association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subdivision (c). This document shall be submitted to the commissioner for approval. Sixty days after receiving approval, no insurer may deliver a policy or contract described in paragraph (1) of subdivision (b) of Section 1067.02 to a policyholder or contractholder unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except if subdivision (d) applies. The document should also be available upon request by the policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the article may require. Failure to receive this document does not give the policyholder, contractholder, certificate holder, or insured any greater rights than those stated in this article. This paragraph shall remain operative only until paragraph (2) becomes operative.

(2) Within 180 days of the effective date of the act that amended this section in the 2009–10 Regular Session, the association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subdivision (c). This document shall be submitted to the commissioner for approval. At the expiration of the 60th day after the date on which the commissioner approves the document, an insurer may not deliver a policy or contract described in paragraph (1) of subdivision (b) of Section 1067.02 to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner. The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract

or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association, as amendments to the article may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, or insured any greater rights than those stated in this article.

(c) The document prepared under subdivision (b) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall do all of the following:

(1) State the name and address of the life and health insurance guarantee association and insurance department.

(2) Prominently warn the policy owner or contract owner that the California Life and Health Insurance Guarantee Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state.

(3) State that the insurer and its agents are prohibited by law from using the existence of the California Life and Health Insurance Guarantee Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance.

(4) State that the policy owner or contract owner should not rely on coverage under the California Life and Health Insurance Guarantee Association when selecting an insurer.

(5) Provide other information as directed by the commissioner.

SEC. 16. The amendments made to the California Life and Health Insurance Guarantee Association Act (Article 14.7 (commencing with Section 1067) of Chapter 1 of Part 2 of Division 1 of the Insurance Code) by this act during the 2009–10 Regular Session of the Legislature shall not apply to any member insurer that, before the effective date of this act, has been placed under an order of liquidation with a finding of insolvency.

~~SEC. 16.~~

SEC. 17. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to increase benefits payable to consumers in the event of the insolvency of a life or health insurance company as soon as possible, to make California's insurance regulatory statutes

governing the administration of an insolvency of a life or health insurance company more consistent with those in other states, and to resolve any possible gaps in coverage, it is necessary that this act take effect immediately.

O