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Insurance

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Insurance; California Insurance Guarantee Association

Insurance Code §§ 1063.1, 1063.2, 1063.5, 1063.14 (amended).
SB 1581 (Maddy); 1992 STAT. Ch. 227

Existing law provides that the California Insurance Guarantee Association (CIGA)[1] must pay and discharge covered claims[2] of insolvent insurers[3] who are members of the CIGA.[4] Existing law excludes from the definition of a covered claim any claim by any person other than the original claimant under an insurance policy in his or her own name.[5] Chapter 227 adds to this exclusion any claim

1. *See* CAL. INS. CODE §§ 1063-1063.15 (West 1988, Supp. 1992 & amended by Chapter 227) (stating the powers and duties of the California Insurance Guarantee Association).

2. *See id.* § 1063.1(c) (amended by Chapter 227) (defining covered claims as the obligations of an insolvent insurer, including the obligation for unearned premiums that are: (1) Imposed by law and within the coverage of an insurance policy of the insolvent insurer; (2) which were unpaid by the insolvent insurer; (3) 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; (4) 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; (5) for which the assets of the insolvent insurer are insufficient to discharge in full; (6) in the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state; and (7) 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).

3. *See id.* § 1063.1(b) (amended by Chapter 227) (defining insolvent insurer).

4. *Id.* § 1063.2 (amended by Chapter 227); *see* Ross v. Canadian Indem. Ins. Co., 142 Cal. App. 3d 396, 404, 191 Cal. Rptr. 99, 104 (1983) (holding that when a secondary insurer is available in the event the primary insurer becomes insolvent, the secondary insurer should be responsible for the coverage of the loss, not the CIGA). *See generally* Roger F. Cox, *Protecting Against Insurer Insolvency*, 13 PA. L. 29 (May 1991) (discussing the problem of insolvent insurers, and offering advice for the insurance purchaser); Davis J. Howard, *Standing to Sue a Carrier's Killers*, 17 PEPP. L. REV. 311 (January 1990) (discussing the right to sue those responsible for the insurance carrier's financial failure); David P. Schack, Comment, *Reinsurance and Insurer Insolvency: The Problem of Direct Recovery by the Original Insured or Injured Claimant*, 29 UCLA L. REV. 872, 882-84 (1982) (providing the historical background and functions of guaranty associations).

5. CAL. INS. CODE § 1063.1(c)(9) (amended by Chapter 227).

by an assignee who is entitled to that claim under a premium finance agreement[6] entered into before the insurer became insolvent.[7]

Existing law requires premium payments from member insurers in order to pay off the covered claims of insolvent insurers.[8] Chapter 227 allows an insurer to collect a refund on any excess premium payments paid, based upon an adjusted assessment, when the insurer has become insolvent or has departed from the state and has turned in its certificate of authority.[9]

CPH

Insurance; company solvency and examinations

Insurance Code § 3080 (repealed); §§ 729, 734.1, 735.5, 737, 928, 1215.16, 1216, 1216.1, 1216.2, 1216.3, 1216.4, 1216.5 (new); §§ 730, 733, 734, 900.2, 923, 1215.10 (amended). SB 1666 (Johnston); 1992 STAT. Ch. 614

Existing law authorizes the Insurance Commissioner (Commissioner)[1] to examine the business activities of insurers.[2]

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6. *See* CAL. FIN. CODE § 18564 (West 1989) (defining premium finance agreement as a loan, contract, note, agreement or obligation by which an insured agrees to pay to a company in installments the principal amount advanced by the company to an insurer or producer in payment of premium on an insurance contract, plus charges, with the assignment as security therefor of the unearned premiums, accrued dividends or loss payments, the final installment due date of the agreement not to extend beyond the term of the insurance contract included in the agreement having the latest expiration date).

7. CAL. INS. CODE § 1063.1(c)(9) (amended by Chapter 227). Chapter 227 also requires the computation of covered claims for unearned premiums by lenders under premium finance agreements at the earliest date of cancellation of the policy. *Id.* § 1063.2(h) (amended by Chapter 227).

8. *Id.* § 1063.5 (amended by Chapter 227).

9. *Id.*; *see id.* § 700 (West Supp. 1992) (requiring a certificate of authority before a person may transact insurance business in the state).

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1. *See* CAL. INS. CODE §§ 12900-12940 (West 1988 & Supp. 1992) (setting forth the powers and duties of the Insurance Commissioner).

2. *Id.* § 730(b) (amended by Chapter 614); *see id* § 23 (West 1972) (defining insurer as the person who undertakes to indemnify another by insurance); *see also* Delta Mfg. Co. v. Jones, 69 Cal. App. 3d 428, 431-32, 138 Cal. Rptr. 40, 42 (1977) (defining an insurer as one who undertakes a contractual obligation to indemnify another from loss, damage, or liability from a contingent or

Chapter 614 authorizes the Commissioner to investigate any company[3] as often as is deemed necessary, but every insurer must be examined at least once every five years.[4] Chapter 614 allows the Commissioner to retain attorneys, appraisers, independent certified public accountants and other specialists as examiners[5], with the cost of these services to be borne by the company subject to examination.[6]

Furthermore, Chapter 614 mandates that no cause of action may arise against the Commissioner, the Commissioner's authorized representatives, or any examiner for any statements made or conduct performed in good faith while carrying out the examination duties.[7] Chapter 614 provides that persons serving in the aforementioned capacities are entitled to an award of attorney fees and costs if they are the prevailing parties in a civil cause of action for libel, slander, or any other relevant tort arising out of activities engaged in while carrying out their duties and the party bringing the action was not substantially justified in bringing the action.[8] Chapter 614 additionally states that an insurer may not accept any single risk or

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unknown act).

3. *See* CAL. INS. CODE § 729(a) (enacted by Chapter 614) (defining company).

4. *Id.* § 730(b) (amended by Chapter 614); *see* People v. United Nat'l Life Ins. Co., 66 Cal. 2d 577, 589, 427 P.2d 199, 207, 58 Cal. Rptr. 599, 607 (1967) (holding that California can constitutionally regulate insurance transactions of foreign insurance companies that do business with California residents by mail from outside California as long as the companies have sufficient contact with the state); *cf.* GA. CODE ANN. § 33-39-15 (1990); NEV. REV. STAT. § 679B.240 (1991); TENN. CODE ANN. § 56-5-315 (1989) (providing similar authority to the insurance commissioners to conduct examinations of insurers).

5. *See* CAL. INS. CODE § 729(b) (enacted by Chapter 614) (defining examiner).

6. *Id.* § 733(g) (amended by Chapter 614). Chapter 614 also provides that while conducting an examination of an insurer the Commissioner must: (1) Have free access to all the books and papers of the company; (2) inspect and examine all its affairs; (3) ascertain its condition and ability to fulfill its obligations; (4) ascertain if it has complied with all laws applicable to its insurance transactions; (5) observe the guidelines and procedures set forth in the Examiner's Handbook adopted by the National Association of Insurance Commissioners). *Id.* § 733(a)-(f) (amended by Chapter 614).

7. *Id.* § 737(a) (enacted by Chapter 614).

8. *Id.* § 737(d) (enacted by Chapter 614). A proceeding is substantially justified if it has a reasonable basis in law or fact at the time it is initiated. *Id.*

reinsurance[9] on any single risk when its liability exceeds 10% of its capital and surplus.[10]

Existing law provides penalties for an insurer or for an individual who willfully violates insurance holding company laws.[11] Chapter 614 provides, in addition to the fines, that any insurer who files a required document late will be subject to late filing fees.[12] Chapter 614 also provides that any officer or director of an insurance holding company who knowingly violates holding company laws will be subject to a civil forfeiture of no more than $50,000 per violation after notice and a hearing before the Commissioner.[13]

Chapter 614 provides that a receiver who has been appointed under an order for liquidation or rehabilitation has the right to recover distributions and payments on behalf of the insurer.[14] Chapter 614 further mandates that a controlling insurer[15]must not accept business from a controlling producer,[16]and a controlling producer must not place business with a controlled insurer unless there is a written contract between the producer and the insurer.[17] Chapter 614 requires the contract to specify the responsibilities of each party, and to meet the approval by the board of directors of the insurer.[18]

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9. *See id.* § 620 (West 1972) (defining a reinsurance contract as a contract between an insurer and a third person to insure the insurer against loss or liability by reason of such original insurance).

10. *Id.* § 928(a) (enacted by Chapter 614). Chapter 614 provides that life, title, surety, mortgage guarantee, or financial guaranty insurance is exempt from this requirement. *Id.* § 928(b)(1)-(5) (enacted by Chapter 614).

11. *Id.* § 1215.10(d) (amended by Chapter 614); *see id.* §§ 1215-1215.15 (West 1988) (regulating holding companies); *cf.* 18 U.S.C. § 656 (1992) (regulating holding companies and providing penalties for misuse of funds).

12. CAL. INS. CODE § 1215.10(a) (amended by Chapter 614); *see id.* § 924 (West Supp. 1992) (providing the procedure for and the amount of late filing fees).

13. *Id.* § 1215.10(b) (amended by Chapter 614). The Commissioner can also order an insurer to cease and desist any unauthorized activity. *Id.* § 1215.10(c) (amended by Chapter 614). Any fraud committed willfully by an individual against the Commissioner shall be punished by a fine or imprisonment in the state prison, or both. *Id.* § 1215.10(e) (amended by Chapter 614).

14. *Id.* § 1215.16(a) (enacted by Chapter 614).

15. *See id.* § 1216.1(c) (enacted by Chapter 614) (defining controlled insurer as an admitted insurer which is controlled, directly or indirectly, by a producer).

16. *See id.* § 1216.1(d) (enacted by Chapter 614) (defining controlling producer as a producer who, directly or indirectly, controls an insurer).

17. *Id.* § 1216.3(b) (enacted by Chapter 614).

18. *Id.*; *see id.* § 1216.3(b)(1)-(11) (enacted by Chapter 614) (providing the minimum provisions that must be contained in the contract).

Chapter 614 requires every controlled insurer to have an audit committee of the board of directors composed of independent directors to review the adequacy of the insurer's loss reserves.[19] Chapter 614 also requires the controlled insurer to annually report to the Commissioner the amount of commissions paid to the producer, the percentage the amount represents of the net premiums written and comparable amounts and percentages paid to noncontrolling producers for placements of the same kinds of insurance.[20] Chapter 614 also requires the controlling producer to deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer.[21]

Chapter 614 empowers the Commissioner to order a controlling producer to cease placing business with the controlled insurer if the Commissioner believes that the controlling producer has not complied with any applicable laws or regulations and the controlling producer has been given notice and an opportunity to be heard.[22] Chapter 614 also authorizes the Commissioner to bring a civil action or intervene in an action brought by or on behalf of the insurer or policyholder if the Commissioner finds that a controlling producer has not complied with applicable provisions.[23] Further, a receiver appointed under an order for liquidation or rehabilitation is authorized to maintain a civil action for recovery of damages if the receiver believes that the controlling producer has not materially

19. *Id.* § 1216.3(c) (enacted by Chapter 614); *see id.* § 923.5 (West Supp. 1992) (requiring every insurer transacting business in this state to provide reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims for which the insurer may be liable, and to provide for the expense of adjustment or settlement of losses and claims). Chapter 614 requires the controlled insurer to annually file with the Commissioner an opinion of an independent financial actuary, or other independent loss reserve specialist, acceptable to the Commissioner. *Id.* § 1216.3(d)(1) (enacted by Chapter 614). The opinion must report loss ratios for each line of business written and attest to the adequacy of loss reserves established for losses incurred and outstanding as of the year's end, including incurred but not reported losses, on business placed by the producer. *Id.*

20. *Id.* § 1216.3(d)(2) (enacted by Chapter 614).

21. *Id.* § 1216.4 (enacted by Chapter 614).

22. *Id.* § 1216.5(a)(1) (enacted by Chapter 614).

23. *Id.* § 1216.5(a)(2) (enacted by Chapter 614).

complied with applicable laws or regulations, and the insurer suffered loss or damage as a result.[24]

CPH

Insurance; coverage of FDA approved prescription drugs for nonapproved uses

Health and Safety Code § 1367.21 (new);
Insurance Code §§ 10123.195, 11512.182 (new).
AB 1985 (Speier); 1992 STAT. Ch. 1268

Under Chapter 1268, group and individual disability insurance policies, nonprofit hospital service plans, and health care service plans may not be issued if they limit or exclude coverage for the use of a drug that is different from the use for which that drug was approved for marketing by the federal Food and Drug Administration (FDA).[1] The nonprescribed use, however, must be in accord with recognized medical practices.[2] Chapter 1268 further provides that its

24. *Id.* § 1216.5(b) (enacted by Chapter 614).

1. CAL. INS. CODE § 10123.195(a) (enacted by Chapter 1268); *id.* § 11512.182(a) (enacted by Chapter 1268); CAL. HEALTH & SAFETY CODE § 1367.21 (enacted by Chapter 1268); *see* 21 U.S.C. § 355(a) (1990) (stating that no person shall introduce or deliver for introduction into interstate commerce any new drug unless an approval of an application is granted and filed); *cf.* MICH. COMP. LAWS ANN. §§ 333.21054b, 500.3406e, 500.3616a, 550.1416a (West Supp. 1992) (providing that in antineoplastic therapy, coverage shall be provided regardless of whether the specific neoplasm used is the specific neoplasm approved for the use permitted by the FDA, so long as specified conditions are met). In the case of health care service plans and group or individual nonprofit hospital service plans, health care service plans contracting for delivery of Medi-Cal Services under the Waxman-Duffy Prepaid Health Plan Act are exempt from the requirements of sections 1367.21(a) and 11512.182(a). CAL. HEALTH & SAFETY CODE § 1367.21(g) (enacted by Chapter 1268); CAL. INS. CODE § 11512.182(g) (enacted by Chapter 1268).

2. CAL. HEALTH & SAFETY CODE § 1367.21(a)(1)-(3) (enacted by Chapter 1268); CAL. INS. CODE §§ 10123.195(a)(1)-(3), 11512.182(a)(1)-(3) (enacted by Chapter 1268) (stating that to be in accord with recognized medical practice, the nonprescribed use of the drug prescribed must be approved by the FDA, prescribed by a participating licensed health care professional for the treatment of a life-threatening condition, and must have been recognized for treatment by the American Medical Association Drug Evaluation, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia dispensing Information, Volume 1, "Drug Information for the Health

provisions do not apply to disability insurance policies issued outside California to an employer whose principle place of business is located outside California.[3]

COMMENT

Chapter 1268 was apparently enacted in response to a growing health care crisis.[4] Physicians and patients have expressed dissatisfaction with the present ability of insurers and health care providers to exclude coverage of nonlabel uses for FDA approved prescription drugs.[5] Chapter 1268 will codify the FDA's apparent informal acquiescence in allowing doctors to use their discretion in prescribing FDA approved drugs for nonapproved uses.[6] There is some indication, however, that the FDA may be reluctant to continue

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Care Professional"). Chapter 1268 also requires that the nonlabel use be supported by two articles from major peer reviewed medical journals as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal. CAL. HEALTH & SAFETY CODE § 1367.21(a)(3)(D) (enacted by Chapter 1268); CAL. INS. CODE §§ 10123.195(a)(3)(D), 11512.182(a)(3)(D) (enacted by Chapter 1268).

3. CAL. INS. CODE § 10123.195(f) (enacted by Chapter 1268).

4. *See* Constance Matthiessen, *When Illness Strikes and Health Insurance Won't Pay,* WASH. POST, June 26, 1990, at Z12 (describing how increasing numbers of health insurance providers have been forced to exist the field because of increasing medical costs, the growing number of elderly, and increasingly burdensome state mandated coverage); Hugh McIntosh, *Off Label Drug Coverage Tackled By States,* J. NAT'L. CANCER INST., July 18, 1990, at 1176-77 (describing the efforts of some states to enact legislation to cover nonlabel uses, and the opposition to such efforts); Linda Schwab, *New York Legislation Mandates Some Off-Label Drug Coverage,* J. NAT'L. CANCER INST., May 1, 1991, at 602-03 (describing New York's enactment of AB 10660, Michigan's efforts at legislating coverage for nonlabel uses, California's efforts to pass Chapter 1268, and the difficulties oncologists have in obtaining reimbursement for nonlabel uses from insurance companies).

5. *See* Charles G. Moertel, M.D., *Off-Label Drug Use for Cancer Therapy and National Health Care Priorities,* JAMA, Dec. 4, 1991 at 3031-32. Dr. Moertel describes the custom of reliance on nonlabelled uses for FDA approved drugs because there are frequently long delays for FDA approval, manufacturers of the drugs often do not apply for a new label indication, and testing of the drug on extremely rare tumors would be nearly impossible. *Id. See also* Elisabeth Rosenthal, *Rules on Approved Uses of Drugs Could Bar Help for Some Patients,* N.Y. TIMES, Aug. 11, 1991, § 1, at 1. Ms. Rosenthal demonstrates that nearly 60% of legitimate chemotherapy falls outside of the uses recognized by the FDA. *Id.* The oncology community reportedly knows the results of research six months before its placement into medical literature, two years before its acceptance by the three compendia, *see supra* note 3, and five years before it is officially labelled by the FDA. *Id.*

6. *See* Teri Randall, *FDA Scrutinizes "Off-Label" Promotions,* JAMA, July 3, 1991, at 11 (stating that it is a long-standing policy of the FDA to permit practicing physicians to use their own discretion in prescribing drugs for nonlabel uses).

such a policy in light of increasing misuses of FDA approved drugs, placing the rationale of Chapter 1268 on questionable ground.[7]

BED

Insurance; disclosures--residential property insurance

Insurance Code §§ 10101, 10102, 10103, 10104, 10105, 10106, 10107 (new).
SB 1854 (Petris); 1992 STAT. Ch. 1089

Existing law requires the use of a standard form fire insurance[1] policy which provides compensation for losses equivalent to the actual cash value[2] of the property at the time of loss,[3] subject to any policy limits on the amount payable.[4] No allowance is made in the

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7. *Id.* Experts have testified that thousands of adverse reactions, including death, deformity, and disability have resulted from nonlabelled use of liquid injectable silicone, tretinoin, and injectable collagen. *Id.*

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1. *See* CAL. INS. CODE § 102 (West 1972) (defining fire insurance); *cf. id.* §§ 5001(d), 10087 (West Supp. 1992) (defining residential property insurance and policy of residential property insurance). Chapter 1089 utilizes the definition of a policy of residential property insurance found in section 10087. *Id.* § 10104(a) (enacted by Chapter 1089).

2. *See id.* § 2071 (West 1972) (requiring that all disputes concerning actual cash value be settled by using appraisers appointed by the insured and insurer, with differences settled by an umpire); *see also* Jefferson Ins. Co. of New York v. Superior Court, 3 Cal. 3d 398, 402, 90 Cal. Rptr. 608, 610, 475 P.2d 880, 882 (1970) (holding that actual cash value is synonymous with fair market value, not with replacement cost less depreciation). *See generally* Barry Zalma, *Actual Cash Value Should not be Synonymous With Market Value in California,* 21 U. WEST L.A. L. REV. 51 (1990) (criticizing the definition of actual cash value recognized in California, and suggesting an alternative definition).

3. *See* Maples v. Aetna Casualty & Surety Co., 83 Cal. App. 3d 641, 644, 148 Cal. Rptr. 80, 82 (1978) (defining the time of loss as the time the party was actually damaged, not the time the harmful act occurred).

4. CAL. INS. CODE § 2071 (West 1972); *see id.* § 2070 (West 1972) (requiring use of the standard form laid out in section 2071 for all fire insurance policies covering property in California); *see also id.* § 2083 (West 1972) (making it a misdemeanor for any insurer or agent to sign or issue a fire policy on property located in California which varies from the standard form, but which makes the policy binding on the insurer nevertheless); *cf.* ARIZ. REV. STAT. ANN. § 20-1503(a) (West 1990); HAW. REV. STAT. § 431:10-210 (1987); N.Y. INS. LAW § 3404 (McKinney 1985 & Supp. 1992); OR. REV. STAT. § 742.202 (Supp. 1992) (requiring the use of, and laying out, standard form fire insurance policies).

standard form for increased costs to comply with any ordinance or law regulating construction or repair.[5]

Under Chapter 1089, no policy of residential property insurance may be issued or initially renewed unless the named insured is provided a copy of the California Residential Property Insurance Disclosure.[6] Chapter 1089 requires the agent[7] or insurer[8] to indicate on the disclosure the type of coverage[9] the applicant or insured selected or purchased.[10] Within ten working days of the date of the

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5. CAL. INS. CODE § 2071 (West 1972); *see* McCorkle v. State Farm Ins. Co., 221 Cal. App. 3d 610, 614, 270 Cal. Rptr. 492, 494-45 (1990) (holding that the standard form fire insurance policy used in California did not require the insurer to provide insured with a more valuable building than that destroyed, even though improvements were necessary to bring the new structure into compliance with changed building codes). *McCorkle* involved a garage with a wooden floor, which was destroyed by fire. *Id.* at 613, 270 Cal. Rptr. 492, 493-94. A building code passed after the garage was built but before it was destroyed required that the floor be made of cement. *Id.* The cost of replacing the garage with a cement floor was $58,448. *Id.* The insurer agreed to pay $29,350, the cost of replacing the garage with a wood floor. *Id.* The trial court and appellate court rejected the insured's misrepresentation claims, even though the agent assured the clients that the policy provided full coverage. *Id.; see also* Breshears v. Indiana Lumbermens M.I. Co. of Indianapolis, 256 Cal. App. 2d 245, 248, 63 Cal. Rptr. 879, 883 (1967) (upholding the constitutionality of statutory provision which eliminates insurers' responsibility to pay for code upgrades). *See generally* Garry Chandler, *Oakland Fire Sparks Replacement Costs Debate*, PROPERTY & CASUALTY, Feb. 17, 1992, at 11 (Risk and Benefits Management Edition), *available in* LEXIS, Nexis Library, (reporting on the problems created after the Oakland/Berkely Hills fire by the *McCorkle/Breshears* line of precedent absolving insurers from the obligation to cover the costs associated with code upgrade); Robert Wainess & Charles Ehrlich, *Ashes From Ashes; Recent Precedent May Bar East Bay Fire Victims From Sufficient Recovery on Their Insurance Policies to Meet Code Requirements When Rebuilding Their Homes*, THE RECORDER, Dec. 6, 1991, at 8 (criticizing the *McCorkle* and *Breshears* cases, and providing arguments against application of the precedent to various factual situations); *Insurer's Liability as Affected by Refusal of Public Authorities to Permit Reconstruction or Repair After Fire*, 90 A.L.R. 2d 790, 799-802 (1963 & Supp. 1992) (annotating cases involving claims by insureds for increased costs occasioned by building regulations).

6. CAL. INS. CODE § 10101 (enacted by Chapter 1089); *see id.* § 10102(a) (enacted by Chapter 1089) (outlining the language of the California Residential Property Insurance Disclosure). The Insurance Commissioner has only the power to modify the disclosure statement to ensure clarity, accuracy and brevity. *Id.* § 10106 (enacted by Chapter 1089).

7. *See id.* § 31 (West Supp. 1992) (defining insurance agent).

8. *See id.* § 10091(g) (West 1972) (defining insurer). Chapter 1089 utilizes the definition of insurer found in section 10091(g). *Id.* § 10104(b) (enacted by Chapter 1089).

9. *See id.* § 10101 (enacted by Chapter 1089) (requiring that the purchaser of or applicant for insurance be notified of and be given a description of the following types of coverage available for dwellings: (1) Guaranteed replacement cost coverage with full building code upgrade; (2) guaranteed replacement cost coverage with limited or no building code upgrade; (3) extended replacement cost coverage; (4) replacement cost coverage; (5) actual cash value coverage; and (6) building code upgrade).

10. *Id.* § 10102(b) (enacted by Chapter 1089).

application, the insurer must obtain the applicant's signature acknowledging receipt of the disclosure.[11] If the disclosure is mailed,[12] it must be sent to the mailing address shown on the policy or to the address requested by the applicant.[13]

Chapter 1089 also prohibits any policy of residential property insurance from being issued or renewed unless the insured is provided notice indicating any limits on liability for the structure and for personal property.[14] The insured must also be notified of any deductible[15] and, if the policy does not cover costs associated with complying with new building codes or ordinances, the insurer must so notify the insured.[16] No policy of residential property insurance which purports to guarantee replacement cost coverage may be issued or renewed on or after January 1, 1993 if the policy contains any maximum limitation of coverage based on set dollar limits, percentage amounts, construction cost limits, indexing, or any other preset maximum limitation.[17]

JSP

Insurance; good driver discount policies

Insurance Code § 658 (new); §§ 11624, 11624.08, 11624.09 (amended).
AB 2605 (Peace); 1992 STAT. Ch. 1255

Existing law requires motor vehicle liability[1] insurers[2] to offer

11. *Id.* § 10102(a) (enacted by Chapter 1089). Chapter 1089 creates a conclusive presumption that the insurer provided the required notice if the applicant or the insured signed the disclosure. *Id.* No signature is required for renewals. *Id.*

12. *See id.* (providing that first class mail is adequate to establish proof of mailing). The burden is on the insurer to establish mailing. *Id.*

13. *Id.*

14. *Id.* § 10103(a), (b) (enacted by Chapter 1089).

15. *Id.* § 10103(c) (enacted by Chapter 1089).

16. *Id.* § 10103(d) (enacted by Chapter 1089).

17. *Id.* § 10102(d), (e) (enacted by Chapter 1089).

1. *See* CAL. VEH. CODE § 16450 (West Supp. 1992) (defining motor vehicle liability policy).

and sell good driver discount policies to good drivers.[3] Under Chapter 1255, any insurer that refuses to accept an applicant[4] for a good driver discount policy or refuses to issue such a policy when a written application has been made and where the applicant meets the criteria for purchase of a good driver discount policy, must furnish the applicant, within ten days, a written statement explaining the reasons for denying coverage.[5]

Existing law requires California Assigned Risk Program (CAARP)[6] applicants, applying for motor vehicle liability insurance, to submit with the application, a certification of eligibility[7] for coverage under CAARP.[8] Chapter 1255 requires an applicant who meets the criteria of a good driver discount to include, in addition to the certification of eligibility, a letter showing that he or she was denied coverage by a private insurer.[9]

BAB

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2. *See* CAL. INS. CODE § 11627 (West 1988) (defining insurer).

3. *Id.* § 1861.02(b)(1) (West Supp. 1992); *see id.* § 1861.025 (West Supp 1992) (describing the criteria for qualification for the good driver discount); *id.* § 1861.02(b)(2) (West Supp. 1992) (requiring insurers to charge at least 20% less for a good driver discount policy then would otherwise be charged for the same policy).

4. *See id.* § 791.02(d) (West Supp. 1992) (defining applicant).

5. *Id.* § 658 (enacted by Chapter 1255); *cf. id.* § 657 (West Supp. 1992) (requiring an insurer or agent who refuses to accept or to issue an automobile liability insurance policy to provide, upon request, a written statement describing the reasons for denial).

6. *See id.* §§ 11620-11627.5 (West 1988 & Supp. 1992) (outlining procedures and duties associated with CAARP). The purpose of the plan is to enable normally unqualified persons to obtain liability insurance. Fireman's Fund American Ins. Co. v. Escobedo, 80 Cal. App. 3d 610, 616, 145 Cal. Rptr. 785, 787 (1978). *See generally Review of Selected 1990 California Legislation,* 22 PAC. L.J. 621 (1991) (explaining CAARP as the equitable apportionment among liability insurers of automobile bodily injury and property damage insurance for those applicants unable to obtain such insurance through normal avenues). *Cf.* FLA. STAT. ANN. ch. 627.351(1) (Harrison 1991); N.Y. INS. LAW § 5301-5304 (McKinney 1985); TEX. INS. CODE ANN. § 5.06-1 (West Supp. 1992) (promulgating auto assigned risk plans).

7. *See* CAL. INS. CODE § 11624(a)(1)-(5) (amended by Chapter 1255) (allowing CAARP to consider: (1) Any criminal conviction record; (2) any record of revocation or suspension of a driver's license; (3) any accident record; (4) age and mental, physical, and moral characteristics pertaining to the applicant's ability to operate a motor vehicle; and (5) the condition or use of the applicant's automobile); *see* CAL. CODE REGS. tit. 10, § 2430 (1992) (outlining the eligibility requirements for coverage under CAARP).

8. CAL. INS. CODE § 11624.08 (amended by Chapter 1255).

9. *Id.* Chapter 1255 further requires that the letter of refusal, denying purchase of a good driver discount policy, be dated no earlier than sixty days prior to the making of the application. *Id.*

Insurance; group disability insurance--mental disorders

Insurance Code § 10123.15 (amended).
AB 306 (Bronzan); 1991 STAT. Ch. 462

Existing law requires that each group disability insurance policy[1] which offers coverage for disorders of the brain, must additionally offer coverage for certain biologically based severe mental disorders.[2] Under existing law, an insurer[3] may reserve the right to confirm the diagnosis and review specific treatment plans.[4] Under Chapter 462, the insurer may reserve the right to confirm the diagnosis and review specific treatment plans in order to ensure that

1. *See* CAL. INS. CODE § 12671 (West 1988) (defining group policy as a group disability insurance policy providing medical coverage by an insurer, a group contract issued by a hospital service corporation, or other medical coverage provided by a policyholder for its employee).

2. *Id.* § 10123.15 (amended by Chapter 462); *see* CAL. HEALTH & SAFETY CODE § 50684 (West 1986) (defining mentally disordered and stating that biologically based severe emotional disorders of the brain include schizophrenia, schizo-affective disorders, bipolar and delusional depressions); *see also* Martin Minkowitz, *WC is Key in Merger Assessment of U.S. Firms,* Oct. 14, 1991, THE NATIONAL UNDERWRITER COMPANY at 13, *available in* LEXIS, Nexis Library, Current File (citing mental claims as being a primary cause of the tremendous increase in the cost of medical care).

3. *See* CAL. INS. CODE § 23 (West 1972) (defining insurer as a person who undertakes to indemnify another by insurance); *see also* Vaughn v. C. and J. Lynch & Co., 69 Cal. App. 3d 428, 431, 130 Cal. Rptr. 48, 42 (1977) (explaining that to be an insurer, one must enter into a contract to indemnify another for loss, damage, or liability from a contingent unknown event).

4. CAL. INS. CODE § 10123.15 (amended by Chapter 462). Existing law gives the insurer the right to confirm the diagnosis and review the treatment plans in order to ensure that the intent of section 10123.15 is met. *Id.*

coverage under this section is provided only for those services which are medically necessary.[5]

DCHIV

Insurance; health care plans--children's benefits

Health and Safety Code § 1367.5 (new); § 1367.3 (amended); Insurance Code §§ 10123.55, 11512.173 (new); §§ 10123.5, 11512.17 (amended).
SB 371 (Thompson); 1992 STAT. Ch. 1134

5. *Id.* § 10123.15 (amended by Chapter 462); *see* Sarchett v. Blue Shield of Cal., 43 Cal. 3d 1, 4 n.2, 6, 729 P.2d 267, 269 n.2, 270-71, 233 Cal. Rptr. 76, 78 n.2, 79-80 (1987) (discussing the language of an insurance policy using the term medically necessary). Chapter 462 clarifies ambiguous language in existing law by specifying a "medically necessary" standard which provides physicians with clear guidelines. CAL. SENATE COMM. ON CLAIMS AND CORPS., ANALYSIS OF AB 306, at 1 (March 18, 1992); *cf.* CAL. WELF. & INST. CODE § 14059.5 (West 1991) (defining medically necessary for the purposes of public social services); 75 PA. CONS. STAT. § 1797 (1990) (establishing a peer review plan for challenges by insurers to reasonableness and necessity of medical treatment given to victims of auto accidents); 1992 HAW. SESS. LAWS § 123(J) (allowing a no fault insurer to challenge a bill for medical treatment or rehabilitative services). *See generally* Cynthia Crosson, *Mental Disorders Top DI Claims*, December 17, 1990, THE NATIONAL UNDERWRITER COMPANY at 13, *available in* LEXIS, Nexis Library, Current File (stating that mental and nervous disorders are more difficult to administer because they are so subjective).

Existing law requires health care service plans,[1] insurers[2], and nonprofit hospital service plans[3] to make benefits[4] available for the comprehensive preventive care of children.[5]

Chapter 1134 provides that every health care service plan, group disability insurer, and nonprofit health service plan which covers hospital, medical, or surgical expenses must offer benefits to children who are seventeen and eighteen years of age.[6] Chapter 1134 also requires every health care service plan, group disability insurer, and

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1. *See* CAL. HEALTH & SAFETY CODE § 1345(f) (West Supp. 1992) (defining a health care plan as a plan that provides health care services to subscribers or enrollees or provides for the payment of or reimbursement of any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees).

2. *See* CAL. INS. CODE § 23 (West 1972) (defining insurer as one who undertakes to indemnify another by insurance).

3. *See id.* § 11493(a)-(c) (West 1988) (defining hospital services as: (1) Maintenance and care in the hospital, including but not limited to nursing care, drugs, medicines, supplies, physiotherapy, transportation, and use of facilities and appliances; (2) reimbursement of the beneficiary or subscriber for, but without requiring that he first pay, expenses incurred for any of the items included in (1); and (3) reimbursement of the beneficiary or subscriber for, but without requiring that he first pay, the costs and expenses incurred for professional medical services rendered during hospitalization).

4. *See* CAL. HEALTH & SAFETY CODE § 1367.3(b) (amended by Chapter 1134) (stating the benefits to be provided as: (1) Physician services for routine physical examinations; (2) immunizations; (3) laboratory services in connection with routine physical examinations; and (4) screening for blood lead levels in children at risk for lead poisoning, when the screening is prescribed by a physician and surgeon affiliated with the health care service plan); *see also id.* § 1367.5(b) (enacted by Chapter 1134); CAL. INS. CODE §§ 10123.5(b), 11512.17(b) (amended by Chapter 1134); §§ 10123.55(b), 11512.173(b) (enacted by Chapter 1134) (stating the same three benefits as Health and Safety Code section 1367.3(b), but omitting the screening for blood lead levels).

5. CAL. HEALTH & SAFETY CODE § 1367.3(a) (amended by Chapter 1134); CAL. INS. CODE § 10123.5(a) (amended by Chapter 1134); *Id.* § 11512.17(a) (amended by Chapter 1134). *See generally* Sabin Russell, *Number of Uninsured Californians Likely to Rise 40%*, S.F. CHRON., Sept. 7, 1992, at A21; Birt Harvey, *Children's Needs*, S.F. CHRON., Aug. 6, 1992, at A25 (discussing current problems relating to health care and insurance for children).

6. CAL. HEALTH & SAFETY CODE § 1367.3(a) (amended by Chapter 1134); CAL. INS. CODE § 10123.55 (enacted by Chapter 1134); *id.* § 11512.173(a) (enacted by Chapter 1134).

nonprofit health service plan to offer benefits for the comprehensive preventive care of children sixteen years of age or under.[7]

CPH

Insurance; health insurance reimbursement

Health and Safety Code §§ 1371, 1371.1 (amended).
AB 2656 (Frizzelle); 1992 STAT. Ch. 747

Existing law mandates that all health care service plans[1] and nonprofit hospital service plans[2] covering hospital, medical, or surgical expenses must reimburse claims no later than thirty working days after receipt of the claim, or no more than forty-five working days if the service plan is a health maintenance organization.[3] Under

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7. CAL. HEALTH & SAFETY CODE § 1367.5(a) (enacted by Chapter 1134); CAL. INS. CODE § 10123.5 (amended by Chapter 1134); *id.* § 11512.17 (amended by Chapter 1134); *cf.* ARK. CODE ANN. § 23-79-141 (Michie 1992) (requiring every disability insurer, hospital or medical service corporation, health maintenance organization, fraternal benefit society and self-insured plan to provide similar benefits); MICH. COMP. LAWS ANN. § 550.1438 (West 1992) (providing the basic health care benefits that a health care corporation must provide to children); R.I. GEN. LAWS § 27-38.1-2 (1989) (providing the coverage required for pediatric preventive care). *See generally* Lawrence D. Brown, *The Medically Uninsured: Problems, Policies, and Politics*, 15 J. HEALTH POL. POL'Y & L. 413 (1990); Alice Sardell, *Child Health Policy in the U.S.: The Paradox of Consensus*, 15 J. HEALTH POL. POL'Y & L. 271 (1990) (discussing current issues in the field of health services for children).

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1. *See* CAL. HEALTH & SAFETY CODE § 1345(f) (West Supp. 1992) (defining health care service plan); *see also* People v. California Mut. Ass'n, 68 Cal. 2d 677, 683, 441 P.2d 97, 101, 68 Cal. Rptr. 585, 589 (1968) (holding that the test of whether a medical plan is an "insurer" or a "health care service plan" involved balancing the indemnification features of the plan with the direct service of the business).

2. *See* CAL. INS. CODE § 11495 (West 1988) (describing corporations eligible to operate nonprofit hospital service plans); *id.* §§ 11512-11516.5 (West 1988 & Supp. 1992) (regulating the provisions of a hospital service contract).

3. CAL. HEALTH & SAFETY CODE § 1371 (amended by Chapter 747); CAL. INS. CODE § 11512.180 (West Supp. 1992). If the claim is contested by the plan, notice must be given to the claimant within 30 working days or 45 working days if the claimant is a health maintenance organization. CAL. HEALTH & SAFETY CODE § 1371 (amended by Chapter 747); CAL. INS. CODE § 11512.180 (West'Supp 1992). Failure to make reimbursement of an uncontested claim within the applicable time frame results in the accrual of interest at 10% per year starting on the first day after the time period. CAL. HEALTH & SAFETY CODE § 1371 (amended by Chapter 747); CAL. INS. CODE § 11512.180 (West Supp. 1992); *cf.* ILL. ADMIN. CODE tit. 50, §§ 6501-6501.90 (1988) (providing

existing law, all individual or group disability insurance plans[4] covering hospital, medical, or surgical expenses must reimburse claims within thirty working days of receipt of the claim.[5] If an overpayment of a claim has occurred under any of these plans, existing law requires the overpaid party to reimburse the health care plan within thirty working days of receiving the notice of the overpayment.[6] Chapter 747 extends these requirements to all specialized health care service plans.[7]

DHT

Insurance; long-term care insurance

Insurance Code §§ 10230, 10230.2, 10230.4, 10232.3, 10232.6, 10233.8, 10235.6, 10235.12 (repealed); §§ 10231.2, 10232.3, 10232.8, 10234.4, 10234.5, 10234.9 (repealed and new); §§ 10232.1, 10233.3, 10234.2, 10234.3, 10234.93, 10234.95, 10234.97, 10235.17, 10236, 10236.5, 10236.8 (new); §§ 10231.6, 10232, 10233.2, 10233.5, 10233.6, 10235.14, 10235.16 (amended).
SB 1943 (Mello); 1992 STAT. Ch. 1132

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regulations for the reimbursement of health care insurance claims).

4. *See* CAL. INS. CODE § 106 (West 1972) (defining disability insurance).

5. *Id.* § 10123.13 (West Supp. 1992).

6. CAL. HEALTH & SAFETY CODE § 1371.1 (amended by Chapter 747); CAL. INS. CODE §§ 10123.145, 11512.181 (West Supp. 1992). If the overpaid party fails to reimburse the health insurer, interest will begin to accrue at 10% per year starting on the next day after the 30 working day time period. CAL. HEALTH & SAFETY CODE § 1371.1 (amended by Chapter 747); CAL. INS. CODE §§ 10123.145, 11512.181 (West Supp. 1992); *see* Viegas v. Workers' Compensation Appeals Bd., 148 Cal. App. 3d 423, 427, 196 Cal. Rptr. 10, 13 (1983) (holding that under the statute providing for assessment of 10% penalty on late workers' compensation payments, a person is entitled to two penalties against a tardy insurer for both the cost of claimant's medical treatment and for physical therapy expenses before and after the date payment was due).

7. CAL. HEALTH & SAFETY CODE § 1371 (amended by Chapter 747); *see id.* § 1345(n) (West Supp. 1992) (defining specialized health care service plans).

Existing law provides for the regulation of long-term care insurance.[1] Chapter 1132 changes the definition of long-term care to include policies for under twelve months that purport to have long-term care benefits.[2]

Chapter 1132 requires all applications for long-term care insurance to contain a warning stating that the insurer may have the right to deny benefits or rescind coverage for misstated or untrue answers on an application.[3] Chapter 1132 provides that if an insurer does not complete medical underwriting and resolve all questions arising from information submitted on or with an application before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant.[4] Chapter 1132 further provides that the contestability period for long-term insurance is two years.[5]

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1. CAL. INS. CODE §§ 10231.2-10236.8 (West Supp. 1992); *see id.* § 10231.2 (repealed and enacted by Chapter 1132) (defining long-term care insurance as any insurance policy, certificate or rider advertised, marketed, solicited, or designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services which are provided in a setting other than an acute care unit of a hospital); *cf.* ARIZ. REV. STAT. ANN. §§ 20-1691 to 20-1691.07 (1990 & Supp. 1992); FLA. STAT. ANN. §§ 651.011-651.134 (West 1984 & Supp. 1922); ILL. ANN. STAT. ch. 73, paras. 963A-1 to 963A-11 (Smith-Hurd Supp. 1992) (defining long-term insurance, and providing for the regulation of long-term or continuing care insurance).

2. CAL. INS. CODE § 10231.2 (repealed & enacted by Chapter 1132). *See generally The Traps in Long Term Care Insurance*, CONSUMER REPORTS, June 1991, at 425-42; Nancy Weaver, *Complex Insurance Policies Can Leave Elderly Open to Abuse*, SACRAMENTO BEE, May 14, 1992, at D1, 6 (discussing the problems associated with long-term care insurance).

3. CAL. INS. CODE § 10232.3(b) (repealed and enacted by Chapter 1132); *see* Taylor v. Sentry Life Ins. Co., 729 F.2d 652, 655 (9th Cir. 1984) (holding that the insurer was justified in rescinding a certificate of insurance issued on the basis of material misrepresentations by an insured regarding her medical condition).

4. CAL. INS. CODE § 10232.3(c) (repealed and enacted by Chapter 1132). Chapter 1132 provides that the evidence must: (1) Pertain to the condition for which benefits are sought; (2) involve a chronic condition or involve dates of treatment before the date of application; and (3) be material to the acceptance for coverage. *Id.* § 10232.3(c)(1)-(3) (repealed and enacted by Chapter 1132).

5. *Id.* § 10232.3(e) (repealed and enacted by Chapter 1132); *see id.* § 10350.2(b) (West 1972) (defining contestability period as the three year period from the date of issue of a policy during which the insurer may reduce or deny a claim for loss incurred or disability on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the policy).

Existing law prohibits long-term care insurance from limiting or excluding home health care[6] benefits on specified grounds.[7] In addition, Chapter 1132 requires every long-term care policy or certificate that provides benefits of home care or community based services to provide the following benefits or services: (1) Home health care; (2) adult day care; (3) personal care; (4) homemaker services; (5) hospice services; and (6) respite care.[8] Chapter 1132 also prohibits the use of the words "usual and customary," "reasonable and customary," or similar words when describing the standards upon which benefits are based.[9]

Under prior law, continuation,[10] conversion,[11] or replacement coverage provided after group coverage was discontinued could not contain preexisting condition exclusions if the conditions had been satisfied under the prior policy.[12] Chapter 1132 requires the replacing insurer to waive any time periods relating to preexisting condition exclusions and probationary periods to the extent that

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6. *See id.* § 10232.8(b)(1) (repealed and enacted by Chapter 1132) (defining home health care as skilled nursing or other professional services in the residence).

7. *Id.* § 10232.8(e)(1)-(7) (repealed and enacted by Chapter 1132). Chapter 1132 provides that home health care benefits shall not be limited or excluded by any of the following: (1) Requiring a need for care in a nursing home if home care services are not provided; (2) requiring that skilled nursing or therapeutic services be used before or with unskilled services; (3) requiring the existence of an acute condition; (4) limiting benefits to services provided by Medicare-certified providers or agencies; (5) limiting benefits to those provided by licensed or skilled personnel when other providers could provide the service, except where prior certification or licensure is required by state law; (6) defining an eligible provider in a manner that is more restrictive than that used to license that provider by the state where the service is provided; (7) requiring "medical necessity" or similar standard as a criteria for benefits. *Id.*

8. *Id.* § 10232.8(a)(1)-(6) (repealed and enacted by Chapter 1132). Chapter 1132 provides that the threshold establishing eligibility for home care benefits must be at least as permissive as a provision that the insured will qualify if there is impairment in either of two activities of daily living or impairment of cognitive ability. *Id.* § 10232.8(c)(1)-(2) (repealed and enacted by Chapter 1132).

9. *Id.* § 10233.2(e) (amended by Chapter 1132).

10. *Id.* § 10236.5(b) (enacted by Chapter 1132) (defining continuation coverage as the maintenance of coverage under an existing group policy when that coverage would be or has been terminated and which is subject only to continued timely payment of the premium).

11. *See id.* § 10236.5(c) (enacted by Chapter 1132) (defining conversion coverage as an individual policy of long-term care insurance, issued by the insurer of the terminating group coverage, without considering insurability, containing benefits which are identical, or which have determined by the Commissioner to be at least substantially equivalent, to the group coverage which would be or has been terminated for any reason).

12. 1990 Cal. Legis. Serv. ch. 530, sec. 1, at 2464 (West) (amending CAL. INS. CODE § 10235.12).

similar exclusions have been satisfied under the policy or certificate being replaced.[13] Furthermore, Chapter 1132 requires agents to make reasonable efforts to determine whether a purchase or replacement of any long-term care insurance that they recommend is appropriate.[14]

Chapter 1132 requires every certificate of group insurance issued or delivered in California to provide for continuation or conversion coverage for the certificate holder if the group coverage terminates.[15] Chapter 1132 also requires a long-term care policy, if it is replaced by another policy to the same master policyholder, to provide benefits that are identical or substantially equivalent to the terminating coverage.[16]

Chapter 1132 requires every long-term care policy issued to an individual to contain a renewal provision that is either guaranteed renewable[17] or noncancelable.[18] Chapter 1132 requires every long-term care policy and certificate to contain an appropriately captioned

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13. CAL. INS. CODE § 10233.3 (enacted by Chapter 1132).

14. *Id.* § 10234.95 (enacted by Chapter 1132); *see* Saunders v. Cariss, 224 Cal. App. 3d 905, 909, 274 Cal. Rptr. 186, 189 (1990) (stating that, as a general proposition, agents will be liable in tort when they fail to act with reasonable care, or act intentionally when obtaining or managing their client's insurance and this results in damage to the client); Hernandez v. General Adjustment Bureau, 199 Cal. App. 3d 999, 1007, 245 Cal. Rptr. 288, 292-93 (1988) (holding that the appellant's allegations that the insurance adjuster knew of her susceptibility to mental distress and of her attempts at suicide and intentionally delayed payment of approved benefits were sufficient to state a cause of action for intentional infliction of emotional distress).

15. CAL. INS. CODE § 10236.5(a) (enacted by Chapter 1132). Chapter 1132 provides the following exceptions to this provision: (1) Where the termination of group coverage resulted from the insured's failure to make any required payment of premium or contribution; (2) where the termination coverage is replaced not later than 31 days after termination by new group coverage effective on the day following the termination and the replacement coverage meets the criteria in § 10236.8. *Id.* § 10236.5(a)(1)-(2) (enacted by Chapter 1132).

16. *Id.* § 10236.8(a) (enacted by Chapter 1132); *cf. id.* § 10128.3(b) (West Supp. 1992) (requiring the level of benefits under a succeeding carrier's group insurance policy to be no lower than the benefits provided under the prior carrier's policy reduced by the amount of benefits paid by the prior carrier).

17. *See id.* § 10236(a) (enacted by Chapter 1132) (defining guaranteed renewable as the right of the insured to continue coverage in force if premiums are timely paid during which period the insurer may not unilaterally change the terms of coverage or decline to renew, except that the insurer may, in accordance with provisions in the policy, change the premium rates to all insureds in the same class).

18. *Id.* § 10236 (enacted by Chapter 1132); *see id.* § 10236(b) (enacted by Chapter 1132) (defining noncancelable as the right of the insured to continue the coverage in force if premiums are timely paid during which period the insurer may not unilaterally change the terms of coverage, decline to renew, or change the premium rate).

renewability provision on page one, which must clearly describe the initial term of coverage, the conditions for renewal and if guaranteed renewable, a description of the class and of each circumstance under which the insurer may change the premium amount.[19]

Existing law authorizes the Insurance Commissioner to impose penalties for violations related to long-term care insurance.[20] Chapter 1132, in addition to providing for penalties, provides for a hearing before the Administrative Law Bureau of the Department of Insurance if ordered by the Commissioner or requested by the person charged with the violation.[21]

CPH

Insurance; nonresident agents

Insurance Code § 1707.51 (new); §§ 1639, 1749.3 (amended).
AB 1689 (Filante); 1992 STAT. Ch. 26
(Effective April 1, 1992)

Under prior law, a nonresident[1] could not obtain a license[2] as a life agent[3] or fire and casualty agent-broker[4] in this state unless the

19. *Id.* § 10236(c) (enacted by Chapter 1132).

20. *Id.* § 10234.2(a) (repealed and enacted by Chapter 1132) (granting the Commissioner the power to assess penalties against insurers, brokers, agents, and other entities which have been determined by the Commissioner to be engaged in the business of insurance).

21. *Id.* § 10234.5(a),(c) (repealed and enacted by Chapter 1132).

1. *See* CAL. INS. CODE § 30 (West 1972) (defining nonresident).

2. *See id.* § 1627 (West Supp. 1992) (defining license); *see also id.* § 1633 (West 1972) (making it a misdemeanor for any person to transact insurance without a license). *But see* Arley v. Chaney, 496 P.2d 202, 207 (Or. 1972) (reaffirming a general rule that statutes requiring licensing of insurance agents do not change the agents' powers to bind their principals).

3. *See* CAL. INS. CODE § 32 (West 1972) (defining life agent as an insurance agent authorized to transact life, disability or life and disability insurance); *see also id.* § 1626 (West Supp. 1992) (defining life license); *id.* § 1639(b) (amended by Chapter 26) (requiring that nonresidents be licensed in their state of residence to transact life insurance and disability insurance to be eligible for a nonresident life agent license in California).

individual was a resident of a jurisdiction that required continuing education of insurance salespersons.[5] Under prior law, the jurisdiction also had to recognize on a reciprocal basis compliance with California's continuing education requirements[6] for insurance salespersons for eligibility for nonresident licenses in that jurisdiction.[7]

Chapter 26 eliminates the requirement that the nonresident be from a jurisdiction which has continuing education requirements for insurance salespersons[8] and the requirement that the jurisdiction recognize California's continuing education requirements for eligibility for nonresident licenses in that jurisdiction.[9] However, a nonresident licensed to transact insurance in a jurisdiction with no continuing education requirements must comply with California's

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4. *See id.* § 33.5 (West Supp 1992) (defining fire and casualty broker-agent); *see also id.* § 1625 (West Supp. 1992) (defining fire and casualty license); *id.* § 1639(a) (amended by Chapter 26) (requiring that nonresidents be licensed to transact more than one class of insurance, other than life and disability, in their state or province of residence to be eligible for a nonresident fire and casualty broker-agent license in California).

5. 1990 Cal. Legis. Serv. ch. 1420, sec. 11, at 5523 (West) (amending CAL. INS. CODE § 1639); *see* Carole King, *Nagging Questions on Continuing Ed*, LIFE AND HEALTH, Apr. 1, 1991, at 39 (Financial Services Edition) *available in* LEXIS, Nexis Library (dealing generally with continuing education requirements for insurance salespersons); *LIMRA Revises Continuing Education Tracking Program, Includes Vendor Listing of Programs*, LIFE AND HEALTH, Jan. 28, 1991, at 20 (Financial Services Edition) *available in* LEXIS, Nexis Library (concerning availability of information about state and Canadian continuing education requirements and about a listing of certified course offerings). Other states have adopted various continuing education schemes. *See, e.g.*, DEL. CODE ANN. tit. 18 § 1725 (1989); FLA. STAT. ANN. § 626.815 (West Supp. 1992); IND. CODE ANN. § 27-1-15.5-7.1(b)-(j) (West Supp. 1991); LA. REV. STAT. ANN. § 22:1193 (West Supp. 1992); ME. REV. STAT. ANN. tit. 24-A, § 1877 (West Supp. 1991); MINN. STAT. ANN. § 60A.1701 (West Supp. 1992); N.M. STAT.ANN. § 59A-12-26 (Michie 1988); OR. REV. STAT. § 744.665 (1989); UTAH CODE ANN. § 31-A-23-206 (Michie 1991); WASH. REV. CODE ANN. § 48.17.150 (West Supp. 1992). *See generally* Colleen Mulcahy, *Agent, Insurer Continuing Education on the Rise*, PROPERTY AND CASUALTY, Oct. 21, 1991, at 17 (Risk and Benefits Management Edition) *available in* LEXIS, Nexis Library (reporting that 34 states have continuing education requirements for insurance salespersons, and a number of other states are considering continuing education legislation).

6. *See* CAL. INS. CODE § 1749.3(a)-(c) (amended by Chapter 26) (requiring a minimum number of hours of continuing education as a prerequisite to renewal of life agent and fire and casualty broker-agent licenses).

7. 1990 Cal. Legis. Serv. ch. 1420, sec. 11, at 5523 (West) (amending CAL. INS. CODE § 1639).

8. CAL. INS. CODE § 1639 (amended by Chapter 26).

9. *Id.*

continuing education requirements to be eligible for a nonresident license.[10]

Prior law required any person who held a license prior to January 1, 1992, or who had complied with section 1749.3(a) of the California Insurance Code, to complete fifteen classroom hours of instruction prior to application for renewal of her or his license to transact insurance.[11] Chapter 26 will increase the required hours of classroom instruction to thirty hours.[12]

JSP

Insurance; surplus line brokers

Insurance Code § 1763 (amended).
AB 2608 (Friedman); 1992 STAT. Ch. 1205

Under existing law, a person[1] may not purchase insurance[2] from a nonadmitted[3] insurer[4], except through a surplus line broker.[5] Prior

10. *Id.* § 1639(c) (amended by Chapter 26). A nonresident who has completed a continuing education course in his or her jurisdiction need not comply with California's continuing education requirements. *Id.*

11. 1990 Cal. Legis. Serv. ch. 1420, sec. 65, at 5536 (West) (amended by Chapter 26).

12. CAL. INS. CODE § 1749.3(b) (amended by Chapter 26).

1. *See* CAL. INS. CODE § 19 (West 1972) (defining person as any person, association, organization, partnership, business trust, or corporation).

2. *See id.* § 22 (West 1972) (defining insurance as a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event).

3. *See id.* § 25 (West 1972) (defining nonadmitted as not entitled to transact business in California, whether by failure to comply with specified conditions or by inability to comply); *see also id.* § 1063.1(d) (West Supp. 1992) (defining admitted to transact insurance in this state).

4. *See id.* § 23 (West 1972) (defining insurer); *see also* Delta Mfg. Co. v. Jones, 69 Cal. App. 3d 428, 431, 138 Cal. Rptr. 40, 42 (1977) (explaining that to be an insurer, one must enter into a contract to indemnify another for loss, damage or liability from a contingent or unknown event).

5. CAL. INS. CODE § 1761 (West 1972). California citizens may also purchase property insurance directly from nonadmitted insurers. *Id.* § 1760 (West 1972); *see also* Robertson v. California, 328 U.S. 440, 455 n.20 (1946) (noting that section 1760 relates only to property insurance); 4 CALIFORNIA INSURANCE LAW & PRACTICE § 62.04[2] (1992) (suggesting that section 1760 and *Robertson* refer to "true property" insurance, and not liability insurance); *id.* § 62.01 (explaining that surplus line brokers are specially licensed brokers who make insurance transaction with nonadmitted insurers to obtain insurance that is not available through admitted insurers); Nowlon

law allowed such a purchase only if the desired insurance could not be obtained from a majority of admitted insurers, and the policy was not placed with the nonadmitted insurer for the purpose of receiving a lower rate than the lowest rate accepted by an admitted insurer.[6]

Under Chapter 1205, a surplus line broker may solicit and place insurance with a nonadmitted insurer only if the desired insurance cannot be procured from an admitted insurer.[7] Chapter 1205 further requires a surplus line broker to ensure that a diligent search has been made of admitted insurers who write the desired type of insurance in this state before procuring insurance from a nonadmitted insurer.[8] Chapter 1205 additionally mandates that each surplus line broker must file a statement that the broker made a diligent effort to place the coverage with an admitted insurer and the results of these efforts.[9] Chapter 1205 further provides that a surplus line broker must file with the Insurance Commissioner, within sixty days of placing insurance with a nonadmitted insurer, a written report regarding the insurance which includes: (1) the name and address of the insured; (2) a description of the risk; (3) the amount of the premium; (4) a copy of the declaration page of the policy or a copy of the surplus broker's certificate or binder evidencing the placement

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v. Koram Ins. Ctr., Inc., 1 Cal. App. 4th 1437, 1447, 2 Cal. Rptr. 2d 683, 689 (1991) (holding that a broker's failure to obtain insurance from an admitted insurer or from a nonadmitted insurer without using a surplus line broker may constitute actionable negligence), *review denied,* 1992 Cal. LEXIS 1521. *But see* CAL. INS. CODE § 1760.5 (West Supp. 1992) (creating exceptions to the rule that persons may not purchase insurance from a nonadmitted insurer unless through a surplus line broker). *See generally* SAMUEL H. WEESE, SURPLUS LINE INSURANCE, THE MISUNDERSTOOD MARKET (1985) (discussing surplus line insurance).

6. 1937 Cal. Stat. ch. 729, sec. 4, at 2034 (amending CAL. INS. CODE § 1763).

7. CAL. INS. CODE § 1763(a) (amended by Chapter 1205); *cf.* FLA. STAT. ANN. § 626.915 (West Supp. 1992); ILL. ANN. STAT. ch. 73, para. 1057 (Smith-Hurd Supp. 1992); TEX. REV. CIV. STAT. ANN. art. 1.14-2 (West Supp. 1992) (promulgating surplus line requirements for insurance that cannot be procured through admitted insurers).

8. CAL. INS. CODE § 1763(a) (amended by Chapter 1205); *see id.* § 1763(b) (amended by Chapter 1205) (providing that prima facia evidence of a diligent search will exist if the form required by subsection (a) establishes either that three admitted insurers who write the particular risk declined to do so, or that fewer than three admitted insurers actually write the risk); *see also id.* § 1763(c) (amended by Chapter 1205) (providing that the placement of insurance with a nonadmitted insurer at a lower rate than the lowest obtainable rate of an admitted insurer is a conclusive presumption of a violation of the act, unless a statement of such is filed with the Commissioner, at the time the insurance attaches).

9. *Id.* § 1763(a) (amended by Chapter 1205).

of insurance; and (5) any other pertinent information that the Commissioner may reasonably require.[10]

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Insurance; unemployment compensation

Unemployment Insurance Code §§ 1269, 1270, 1274.10, 15079 (amended).
SB 2004 (Russell); 1992 STAT. Ch. 577

Existing law provides that unemployed individuals[1] who participate in qualified job training programs[2] that last longer than the normal duration[3] of unemployment compensation benefits[4] may, while in training, receive benefits for an extended period of time.[5] Under prior law, participants in retraining programs authorized by the

10. *Id.*

1. CAL. UNEMP. INS. CODE § 1279.5(a) (West Supp. 1992) (defining unemployed individual).

2. *See id.* § 1269(a)-(d) (amended by Chapter 577) (enumerating the qualified training programs); *see also* 29 U.S.C. § 1517 (1988) (outlining the requirements of a qualified training program under the Federal Job Training Partnership Act [JTPA]); *infra* note 6 (discussing the Federal Job Training Partnership Act); *cf.* 18 U.S.C. § 665 (1988) (creating criminal liability for any person connected with an agency receiving financial assistance under JTPA, who knowingly embezzles or steals money or assets which are the subject of a financial assistance agreement). The theft of funds received under JTPA, may also be the basis of criminal liability under state theft statutes. Perdue v. State, 249 S.E.2d 657, 661 (Ga. 1978).

3. *See* CAL. UNEMP. INS. CODE § 1281(b) (West Supp. 1992) (providing for the maximum amount of annual benefits as the lower of either 26 times the applicant's weekly benefits amount or one half the total wages paid to the individual during his or her base period). Other states offer extended benefits if the recipient is involved in training programs. *See, e.g.*, ILL. ANN. STAT. ch. 48, para. 420(c)(5) (Smith-Hurd Supp. 1992); FLA. STAT. ANN. § 443.091(2) (West Supp. 1992).

4. *See* CAL. UNEMP. INS. CODE § 140 (West 1986) (defining unemployment compensation benefits). *See generally* California Dept. of Human Resources Dev. v. Java, 402 U.S. 121, 125 (1971) (explaining the California unemployment compensation system).

5. CAL. UNEMP. INS. CODE § 1271(a) (West Supp. 1992); *see* 39 Cal. Op. Att'y Gen. 205, 206-07 (1962) (describing the California retraining benefits system, and holding that an unemployed individual is eligible for retraining benefits if they enroll in retraining relating to their current skills or obtain entirely new skills depending on the job opportunities that exist).

Federal Job Training Partnership Act (JTPA)[6] were eligible for extended training benefits only if their programs were performance based.[7] Chapter 577 broadens the scope of participants potentially eligible to receive extended benefits by eliminating the requirement that training must be performance based.[8] Chapter 577 further expands the extended benefits program by including participants of the Greater Avenue of Independence (GAIN) program.[9]

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6. CAL. UNEMP. INS. CODE § 1269 (amended by Chapter 577); *see* Job Training Partnership Act, Pub. L. No. 97-300, 96 Stat. 1322; 29 U.S.C. §§ 1500-1781 (1988 & Supp. 1990); 20 C.F.R. §§ 626.1-638 (1991) (promulgating JTPA). *See generally* Royal S. Dellinger, *Implementing the Job Training Partnership Act*, 35 LAB. L.J. 195 (1984) (describing the creation, implementation, and policy considerations of the JTPA); Robert F. Cook & Wayne M. Turnage, *The New Federal-State Program to Train Dislocated Workers*, 108 MONTHLY LAB. REV. 32 (1985) (outlining Title III of the JTPA, which is generally concerned with the training of workers who have lost their jobs because of plant closures and massive layoffs caused by world competition and technical changes).

7. 1987 Cal. Stat. ch. 956, sec. 2, at 3232 (amending CAL. UNEMP. INS. CODE § 1269); *see* 1984 Cal. Stat. ch. 1211, sec. 8, at 4156 (renumbering and amending CAL. UNEMP. INS. CODE § 1274.4) (defining performance based); *see also* 20 C.F.R. § 629.38(e)(2)(i) (1991) (defining performance based for purposes of JTPA).

8. CAL. UNEMP. INS. CODE § 1269(b) (amended by Chapter 577). Under prior law, participants enrolled in job training authorized by the JTPA, other than Title III, could only receive benefits if the training was performance based. 1987 Cal. Stat. ch. 957, sec. 2, at 3232 (amending CAL. UNEMP. INS. CODE § 1269). Chapter 577 also extends retraining benefits to individuals who have lost employment due to foreign competition as set forth in petitions certified under the Federal Trade Act of 1974 (19 U.S.C. §§ 2101-2300). CAL. UNEMP. INS. CODE § 1269(b) (amended by Chapter 577). Prior law allowed extended retraining benefits to such individuals only if they satisfied other enumerated criteria. 1987 Cal. Stat. ch. 957, sec. 2, at 3232 (amending CAL. UNEMP. INS. CODE § 1269).

9. CAL. UNEMP. INS. CODE § 1269(c) (amended by Chapter 577); *see* CAL. WELF. & INST. CODE §§ 11320-11336 (West 1991 & Supp. 1992) (codifying the Greater Avenue of Independence Act of 1985). Chapter 577 further amends existing law by changing the January 1, 1993, sunset date on retraining benefits provisions to January 1, 1997. CAL. UNEMP. INS. CODE § 1274.10 (amended by Chapter 577).