Assembly Bill No. 3012

CHAPTER 258

An act to amend Sections 678, 1063.1, 1063.5, 1063.14, 2051.5, 2060, 10095, and 10103.7 of the Insurance Code, relating to insurance.

[Approved by Governor September 29, 2020. Filed with Secretary of State September 29, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

AB 3012, Wood. Residential property insurance.

Existing law generally regulates classes of insurance, including fire and property insurance. Existing law requires a residential property insurer to allow an insured that has suffered a loss relating to a declared state of emergency to combine the policy limits for primary dwelling and other structures, and to use the combined amount to rebuild or replace the dwelling, as specified. Existing law requires a policy to provide coverage for additional living expenses for a period of no less than 24 months from the inception of the loss, for a loss relating to a state of emergency. Existing law prohibits, in the event of a total loss of the insured structure, a policy from limiting or denying payment of the building code upgrade cost or the replacement cost on the basis that the insured has decided to rebuild at a new location or to purchase an already built home at a new location.

For a total loss of a furnished residence related to a declared state of emergency, this bill would require an insurer to provide a payment for contents of no less than 30% of the policy limit, as specified, without requiring an itemized claim. For a covered loss relating to a state of emergency, on and after July 1, 2021, the bill would prohibit a policy that provides coverage for additional living expenses from limiting the policyholder's right to recovery if the insured home is rendered uninhabitable by a covered peril, but would authorize an insurer to provide a reasonable alternative remedy that addresses the property condition that precludes reasonable habitation of the insured premises. On and after July 1, 2021, the bill would require additional living expense coverage to be provided for at least 2 weeks, with additional 2-week extensions, in the event of a state of emergency and an order of civil authority restricting access to the home, as specified. The bill would require the measure of damages available to a policyholder to use to rebuild or replace the insured home at another location to be the amount that would have been recoverable had the insured dwelling been rebuilt at its original location, without deduction for the value of land at the new location.

Existing law requires the Insurance Commissioner to establish the California Home Insurance Finder on the Department of Insurance internet website to connect homeowners in need of insurance assistance to an

insurance agent or broker for residential property insurance. Under existing law, the California FAIR Plan Association, a joint reinsurance association in which all insurers licensed to write basic property insurance participate, administers a program for the equitable apportionment of basic property insurance for persons who are unable to obtain that coverage through normal channels. Existing law requires an insurance agent or broker to assist a person to obtain property insurance coverage by one of several specified methods.

This bill would require a notice of nonrenewal for a residential property insurance policy expiring on or after July 1, 2021, to be accompanied by a specified statement that includes an explanation of how the California Home Insurance Finder can help a person find a homeowners' insurance policy and information about FAIR Plan policies. The bill would require the California FAIR Plan Association, on or before July 1, 2021, to develop and implement a clearinghouse program to help reduce the number of existing FAIR Plan policies and provide the opportunity for admitted insurers to offer homeowners' insurance policies to FAIR Plan policyholders. The bill would require an insurer that participates in the clearinghouse program to sign an agreement that sets forth the terms and conditions for the insurer to offer homeowners insurance through the policy's listed agent or broker of record.

Existing law creates the California Insurance Guarantee Association (CIGA) and requires all insurers admitted to transact specified insurance lines in this state to become members. Under existing law, CIGA pays and discharges covered claims, which are the obligations of an insolvent insurer that meet specified requirements, including, for a policy of workers' compensation insurance, that the obligation is to provide workers' compensation benefits under California's workers' compensation law. Under existing law, an obligation to a state or to the federal government is not a covered claim. Existing law requires CIGA to collect premium payments from its member insurers sufficient to discharge its obligations. Existing law requires CIGA to adopt a plan of operation that requires a member insurer to recoup the premium charge paid by the member insurer through a surcharge on premiums charged for insurance policies. Existing law requires CIGA to reimburse member insurers who report surcharge collections that are less than what they paid in the preceding year's premium charge.

This bill would expand covered claims under CIGA to include benefits under the workers' compensation law of any state if the injured worker is a California resident and not otherwise entitled to coverage from another organization similar to CIGA, obligations for medical services provided by a medical facility owned in whole or in part by a state or federal agency, and claims arising under a policy that has been statutorily allocated to or assumed by a company that is later placed in liquidation if the claim would have been a covered claim if the original company had been placed in liquidation. The bill would require each member insurer to file a report to CIGA within 90 days after filing an annual statement indicating the amount

of premiums not subject to CIGA's premium charge and the amount of special excess workers' compensation premiums for the preceding calendar year. The bill would authorize an insurer to amend its reports indicating the amount of surcharges collected for the prior 5 years if it discovers there was an error in the original reports.

This bill would incorporate additional changes to Section 678 of the Insurance Code proposed by AB 2756 to be operative only if this bill and AB 2756 are enacted and this bill is enacted last.

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

SECTION 1. Section 678 of the Insurance Code is amended to read:

678. (a) At least 45 days before policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(1) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating each of the following:

(A) Any reduction of limits or elimination of coverage.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the renewal offer.

(2) A notice of nonrenewal of the policy. That notice shall contain all of the following:

(A) The reason or reasons for the nonrenewal.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the notice of nonrenewal.

(C) Until July 1, 2020, a brief statement indicating that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

(D) On or after July 1, 2020, a statement that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the department's internet website, www.insurance.ca.gov, the department's telephone number, (800) 927-HELP (4357), and the mailing address of the department's Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013.

(b) If an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be

provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Notwithstanding subdivisions (a) and (b), with respect to a notice of nonrenewal for a policy that expires on or after July 1, 2020, the following timelines apply:

(1) At least 75 days before the policy expiration, the insurer shall deliver the notice of nonrenewal to the named insured or mail the notice of nonrenewal to the named insured at the address shown in the policy. The notice shall include the information contained in paragraph (2) of subdivision (a).

(2) If an insurer fails to give the named insured a notice of nonrenewal at least 75 days before the policy expiration, as required by paragraph (1), the existing policy, with no change in its terms and conditions, shall remain in effect for 75 days from the date that the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the notice of nonrenewal.

(d) A policy written for a term of less than one year shall be considered as if written for a term of one year. A policy written for a term longer than one year, or a policy with no fixed expiration date, shall be considered as if written for successive policy periods or terms of one year.

(e) A notice of nonrenewal for a residential property insurance policy expiring on or after July 1, 2021, shall be accompanied by the following notice:

The California Department of Insurance has developed the California Home Insurance Finder, an online tool that can assist you in obtaining insurance for your home. The Finder contains names, addresses, phone numbers, and internet website links of licensed insurance agents, brokers, and insurance companies that may be able to sell insurance to you. The Finder is organized by ZIP Code and the languages in which the agent, broker, or insurance company sells insurance.

The California FAIR Plan (FAIR Plan) provides basic property insurance as the “insurer of last resort” if you cannot find insurance coverage for your property in the normal (voluntary) insurance market. The FAIR Plan provides basic property insurance coverage for residential structures, as well as personal property coverage for residential and business occupancies. However, FAIR Plan policies may not cover liability, theft, or water damage, among other things. There are also optional coverages available for both residential properties. Applications can be made directly with the FAIR Plan (cfpnet.com), although the FAIR Plan strongly encourages use of a licensed agent or broker for assistance in preparing and obtaining a quote. There is no additional cost for using an agent or broker for purchasing a FAIR Plan policy.

California law requires an agent or broker to assist a person seeking a FAIR Plan policy by (1) submitting a coverage application to the FAIR Plan on behalf of the consumer, (2) providing the consumer the FAIR Plan’s

website address and toll-free telephone number, or (3) obtaining a policy for the consumer through an admitted or nonadmitted insurer.

To supplement a FAIR Plan policy, a Difference in Conditions (DIC) policy should be considered. A DIC policy is sold by some private insurers, and provides coverage for things not covered by the basic property insurance policy provided by the FAIR Plan. A consumer who wants broader coverage than that provided by the FAIR Plan policy should contact an agent, broker, or insurance company that offers a DIC policy to obtain this additional coverage. The Department of Insurance maintains a list of insurance companies that sell DIC policies on its internet website (insurance.ca.gov). Additional assistance may be obtained by contacting an agent or broker listed with the department's online agent locator.

(f) An insurer may use a notice substantially similar to the notice set forth in subdivision (e) to the extent that the notice provides additional or more detailed information.

(g) This section applies only to policies of insurance specified in Section 675.

SEC. 1.5. Section 678 of the Insurance Code is amended to read:

678. (a) At least 45 days before the policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(1) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating each of the following:

(A) Any reduction of limits or elimination of coverage. That reduction of limits or elimination of coverage shall identify the specific limits being reduced or coverage being eliminated by the offer of renewal. The elimination of coverage for the previously covered peril of fire shall be subject to subdivision (b) of Section 10103.6.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the renewal offer.

(2) A notice of nonrenewal of the policy. That notice shall contain all of the following:

(A) The specific reason or reasons for the nonrenewal.

(B) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the notice of nonrenewal.

(C) Until July 1, 2020, a brief statement indicating that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

(D) On or after July 1, 2020, a statement that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement

shall include the department's internet website, www.insurance.ca.gov, the department's telephone number, (800) 927-HELP (4357), and the mailing address of the department's Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013.

(b) If an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Notwithstanding subdivisions (a) and (b), with respect to a notice of nonrenewal for a policy that expires on or after July 1, 2020, the following timelines apply:

(1) At least 75 days before the policy expiration, the insurer shall deliver the notice of nonrenewal to the named insured or mail the notice of nonrenewal to the named insured at the address shown in the policy. The notice shall include the information contained in paragraph (2) of subdivision (a).

(2) If an insurer fails to give the named insured a notice of nonrenewal at least 75 days before the policy expiration, as required by paragraph (1), the existing policy, with no change in its terms and conditions, shall remain in effect for 75 days from the date that the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the notice of nonrenewal.

(d) A policy written for a term of less than one year shall be considered as if written for a term of one year. A policy written for a term longer than one year, or a policy with no fixed expiration date, shall be considered as if written for successive policy periods or terms of one year.

(e) A notice of nonrenewal for a residential property insurance policy expiring on or after July 1, 2021, shall be accompanied by the following notice:

The California Department of Insurance has developed the California Home Insurance Finder, an online tool that can assist you in obtaining insurance for your home. The Finder contains names, addresses, phone numbers, and internet website links of licensed insurance agents, brokers, and insurance companies that may be able to sell insurance to you. The Finder is organized by ZIP Code and the languages in which the agent, broker, or insurance company sells insurance.

The California FAIR Plan (FAIR Plan) provides basic property insurance as the "insurer of last resort" if you cannot find insurance coverage for your property in the normal (voluntary) insurance market. The FAIR Plan provides basic property insurance coverage for residential structures, as well as personal property coverage for residential and business occupancies. However, FAIR Plan policies may not cover liability, theft, or water damage, among other things. There are also optional coverages available for both

residential properties. Applications can be made directly with the FAIR Plan (cfpnet.com), although the FAIR Plan strongly encourages use of a licensed agent or broker for assistance in preparing and obtaining a quote. There is no additional cost for using an agent or broker for purchasing a FAIR Plan policy.

California law requires an agent or broker to assist a person seeking a FAIR Plan policy by (1) submitting a coverage application to the FAIR Plan on behalf of the consumer, (2) providing the consumer the FAIR Plan's website address and toll-free telephone number, or (3) obtaining a policy for the consumer through an admitted or nonadmitted insurer.

To supplement a FAIR Plan policy, a Difference in Conditions (DIC) policy should be considered. A DIC policy is sold by some private insurers, and provides coverage for things not covered by the basic property insurance policy provided by the FAIR Plan. A consumer who wants broader coverage than that provided by the FAIR Plan policy should contact an agent, broker, or insurance company that offers a DIC policy to obtain this additional coverage. The Department of Insurance maintains a list of insurance companies that sell DIC policies on its internet website (insurance.ca.gov). Additional assistance may be obtained by contacting an agent or broker listed with the department's online agent locator.

(f) An insurer may use a notice substantially similar to the notice set forth in subdivision (e) to the extent that the notice provides additional or more detailed information.

(g) This section applies only to policies of insurance specified in Section 675.

SEC. 2. Section 1063.1 of the Insurance Code is amended to read:

1063.1. As used in this article:

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

(b) "Insolvent insurer" means an insurer that was a member insurer of the association, consistent with paragraph (11) of subdivision (c), either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, or, in the case of the State Compensation Insurance Fund, if a finding of insolvency is made by a duly enacted legislative measure.

(c) (1) "Covered claims" means the obligations of an insolvent insurer, including the obligation for unearned premiums, that satisfy all of the following requirements:

(A) Imposed by law and within the coverage of an insurance policy of the insolvent insurer.

(B) Which were unpaid by the insolvent insurer.

(C) Which are presented as a claim to the liquidator in the state of domicile of the insolvent insurer or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings.

(D) Which were incurred before the date coverage under the policy terminated and before, on, or within 30 days after the date the liquidator was appointed.

(E) For which the assets of the insolvent insurer are insufficient to discharge in full.

(F) In the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state or under the workers' compensation law of any state if the injured worker is a resident of this state and not otherwise entitled to coverage from an organization similar to the association in any other state.

(G) In the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

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

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

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

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

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

(D) Credit insurance.

(E) Title insurance.

(F) Ocean marine insurance or ocean marine coverage under an insurance policy, including claims arising from the following: the Jones Act (46 U.S.C. Secs. 30104 and 30105), the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sec. 901 et seq.), or any other similar federal statutory enactment, or an endorsement or policy affording protection and indemnity coverage.

(G) A claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers' compensation policy issued pursuant to subdivision (c) of Section

3702.8 of the Labor Code that covers all or any part of workers' compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.

(4) "Covered claims" does not include an obligation of the insolvent insurer arising out of a reinsurance contract, an obligation incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured, canceled at the insured's request, or canceled by the liquidator, or an obligation to a state or to the federal government. If the individual has a covered claim that includes medical services provided by a medical facility owned in whole or in part by a state or federal agency, the association may pay that claim directly to the facility, as long as the services provided otherwise qualify as a covered claim and the claim is owned by the medical facility asserting the claim.

(5) (A) "Covered claims" does not include an obligation to insurers, insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

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

(6) "Covered claims," except in cases involving a claim for workers' compensation benefits or for unearned premiums, does not include a claim in an amount of one hundred dollars ($100) or less or the portion of a claim that is in excess of the applicable limits provided in the insurance policy issued by the insolvent insurer.

(7) (A) "Covered claims" does not include that portion of a claim, other than a claim for workers' compensation benefits, that is in excess of five hundred thousand dollars ($500,000).

(B) For purposes of subparagraph (A), with respect to a policy of residential property insurance, each claim for a loss under a different coverage category shall be considered a separate covered claim.

(C) Notwithstanding subparagraph (A), a claim for damage to, or loss of, a dwelling structure under a policy of residential property insurance shall not exceed one million dollars ($1,000,000) or the amount recoverable under the policy, whichever is less.

(8) "Covered claims" does not include an amount awarded as punitive or exemplary damages, or an amount awarded by the Workers' Compensation Appeals Board pursuant to Section 5814 or 5814.5 of the Labor Code because payment of compensation was unreasonably delayed or refused by the insolvent insurer.

(9) "Covered claims" does not include either of the following:

(A) A claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured.

(B) A claim by a person other than the original claimant under the insurance policy in the claimant's own name, the claimant's assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into before insolvency, or the claimant's executor, administrator, guardian, or other personal representative or trustee in bankruptcy, and does not include a claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

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

(11) "Covered claims" does not include an obligation of the insolvent insurer arising from a policy or contract of insurance issued or renewed before the insolvent insurer's admission to transact insurance in the State of California.

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

(13) "Covered claims" shall also include an obligation arising under an insurance policy written to indemnify a permissibly self-insured employer pursuant to subdivision (b) or (c) of Section 3700 of the Labor Code for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention. However, for purposes of this article, those claims shall not be considered workers' compensation claims and therefore are subject to the per-claim limit in paragraph (7), and any payments and expenses related thereto shall be allocated to category (c) for claims other than workers' compensation, homeowners', and automobile, as provided in Section 1063.5.

These provisions shall apply to obligations arising under a policy as described herein issued to a permissibly self-insured employer or group of self-insured employers pursuant to Section 3700 of the Labor Code and notwithstanding any other provision of this code, those obligations shall be governed by this provision in the event that the Self-Insurers' Security Fund is ordered to assume the liabilities of a permissibly self-insured employer or group of self-insured employers pursuant to Section 3701.5 of the Labor Code. This paragraph applies only to insurance policies written to indemnify a permissibly self-insured employer or group of self-insured employers under subdivision (b) or (c) of Section 3700 of the Labor Code, for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention, and this paragraph does not apply to special excess workers' compensation insurance policies unless issued pursuant to authority granted in subdivision (c) of Section 3702.8 of the Labor Code, and as provided for in subparagraph (G) of paragraph (3). In addition, this paragraph does not apply to a claims servicing agreement or insurance policy providing

retroactive insurance of a known loss or losses as are excluded in subparagraph (G) of paragraph (3).

A permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall, to the extent required by the Labor Code, be responsible for paying, adjusting, and defending each claim arising under policies of insurance covered under this section, unless the benefits paid on a claim exceed the specific or aggregate retention, in which case:

(A) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy requires the insurer to defend and adjust the claim, the association shall be solely responsible for adjusting and defending the claim, and shall make all payments due under the claim, subject to the limitations and exclusions of this article with regard to covered claims. As to each claim subject to this paragraph, notwithstanding any other provisions of this code or the Labor Code, and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(B) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy does not require the insurer to defend and adjust the claim, the permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall not have any further payment obligations with respect to the claim, but shall continue defending and adjusting the claim, and shall have the right, but not the obligation, in a proceeding to assert all applicable statutory limitations and exclusions as contained in this article with regard to the covered claim. CIGA shall have the right, but not the obligation, to intervene in a proceeding in which the self-insured employer, group of self-insured employers, or the Self-Insurers' Security Fund is defending a claim and shall be permitted to raise the appropriate statutory limitations and exclusions as contained in this article with respect to covered claims. Regardless of whether the self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, asserts the applicable statutory limitations and exclusions, or whether CIGA intervenes in a proceeding, CIGA shall be solely responsible for paying all benefits due on the claim, subject to the exclusions and limitations of this article with respect to covered claims. As to each claim subject to this paragraph, notwithstanding any other provision of this code or the Labor Code and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund, shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(C) In the event that the benefits paid on the covered claim exceed the per-claim limit in paragraph (7), the responsibility for paying, adjusting, and defending the claim shall be returned to the permissibly self-insured employer or group of employers, or the Self-Insurers' Security Fund.

These provisions shall apply to all pending and future insolvencies. For purposes of this paragraph, a pending insolvency is one involving a company that is currently receiving benefits from the guarantee association.

(14) Notwithstanding any other provision in this section or Section 1063, if an insurance policy has been allocated to or assumed by a company that did not issue the policy pursuant to a state statute that provides for the division of an insurance company or the statutory assumption of designated policies by a new company, that statute provides a novation has been deemed to have occurred with respect to those policies, and that company is placed in liquidation, then to the extent a claim arising under that allocated or transferred policy would have been a covered claim had the original company been placed in liquidation before the statutory allocation or assumption, any claim arising under that same policy shall be a covered claim regardless of whether the company that allocated or assumed the policy was or was not a member at the time the policy was issued or when the insured event occurred.

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

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

(f) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing that control does not in fact exist.

(g) "Claimant" means an insured making a first party claim or a person instituting a liability claim. However, no person who is an affiliate of the insolvent insurer may be a claimant.

(h) "Net direct written premiums" means the amount of direct written premiums in the annual financial statement on file with the commissioner, adjusted for any premiums written for any lines of insurance or types of coverages not covered by this article, plus premiums written in this state for coverage under a special excess workers' compensation policy.

(i) "Ocean marine insurance" includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, that are usually insured against by traditional marine insurance such as hull and machinery, marine builders' risks, and marine protection and indemnity. Those perils and risks insured against include,

without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of a vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person.

(j) "Unearned premium" means that portion of a premium as calculated by the liquidator that had not been earned because of the cancellation of the insolvent insurer's policy and is that premium remaining for the unexpired term of the insolvent insurer's policy. "Unearned premium" does not include an amount sought as return of a premium under a policy providing retroactive insurance of a known loss or return of a premium under a retrospectively rated policy or a policy subject to a contingent surcharge or a policy in which the final determination of the premium cost is computed after expiration of the policy and is calculated on the basis of actual loss experienced during the policy period.

SEC. 3. Section 1063.5 of the Insurance Code is amended to read:

1063.5. (a) (1) To the extent necessary to secure funds for the association for payment of the administrative expenses of the association, covered claims of insolvent insurers, and for payment of reasonable costs of adjusting the claims, the association shall collect premium payments from its member insurers sufficient to discharge its obligations.

(2) The association shall allocate its claim payments and costs, incurred or estimated to be incurred, to one or more of the following categories:

(A) Workers' compensation claims.

(B) Homeowners' claims and automobile claims, including all of the following:

(i) Automobile material damage.

(ii) Automobile liability (both personal injury and death and property damage).

(iii) Medical payments.

(iv) Uninsured motorist claims.

(C) Claims other than workers' compensation, homeowners', and automobile, as defined above.

(3) Separate premium payments shall be required for each category.

(4) The premium payments for each category shall be used to pay the claims and costs allocated to that category.

(b) (1) The rate of premium charged shall be a uniform percentage of net direct written premium in the preceding calendar year applicable to that category.

(2) The rate of premium charges to each member insurer in the appropriate categories shall be based on the net direct written premium of each member insurer as shown in the latest year's annual financial statement on file with the commissioner.

(3) In cases of a dispute as to the amount of the net direct written premium between the association and one of its member insurers, the written decision of the commissioner shall be final.

(c) Within 90 days after the filing of an annual statement, each member insurer shall file a report to the association indicating the amount of premiums not subject to the association's premium charge and the amount of special excess workers' compensation premiums for the preceding calendar year. The report is not required in any year in which a premium charge is not made by the association.

(d) In charging premiums to member insurers, the association shall adjust, if necessary, the net direct written premiums shown on a member insurer's annual statement by excluding any premiums written for any lines of insurance or types of coverage not covered by this article under paragraph (3) of subdivision (c) of Section 1063.1.

(e) (1) The premium charged to any member insurer for any of the three categories or a category established by the association shall not be more than 2 percent of the net direct written premium unless there are bonds outstanding that were issued pursuant to Article 14.25 (commencing with Section 1063.50) or Article 14.26 (commencing with Section 1063.70).

(2) If bonds issued pursuant to either article are outstanding, the premium charged to a member insurer for the category for which the bond proceeds are being used to pay claims and expenses shall not be more than 1 percent of the net direct written premium for that category.

(f) (1) The association may exempt or defer, in whole or in part, the premium charge of any member insurer, if the premium charge would cause the member insurer's financial statement to reflect an amount of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders by the company whose premium charge was deferred.

(2) Deferred premium charges shall be paid when the payment will not reduce capital or surplus below required minimums.

(g) After all covered claims of insolvent insurers and expenses of administration have been paid, any unused premiums and any reimbursements or claims dividends from liquidators remaining in any category shall be retained by the association and applied to reduce future premium charges in the appropriate category.

(h) The commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer that fails to pay a premium when due and after demand has been made.

(i) Interest at a rate equal to the current federal reserve discount rate plus 2 ½ percent per annum shall be added to the premium of any member insurer that fails to submit the premium requested by the association within 30 days after the mailing request. However, in no event shall the interest rate exceed the legal maximum.

(j) This section shall apply only to premium charges paid on or after January 1, 2017.

SEC. 4. Section 1063.14 of the Insurance Code is amended to read:

1063.14. (a) (1) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain provisions whereby each member insurer is required to recoup, in the year following the premium charge, a sum calculated to recoup the premium charge paid by the member insurer under this article by way of a surcharge on premiums charged for insurance policies to which this article applies.

(2) Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

(b) (1) The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The association shall determine the rate of the surcharge and the collection period for each category, and these shall be mandatory for all member insurers of the association who write business in those categories.

(2) Each member insurer shall file a report in accordance with the provisions of the plan of operation indicating the amount of surcharges it has collected.

(A) Member insurers who collect surcharges in excess of premium charges paid in the preceding year pursuant to Section 1063.5 shall remit the excess to the association as an additional premium within 30 days after the association has determined the amount of the excess recoupment and given notice to the member insurer of that amount. The excess shall be applied to reduce future premium charges in the appropriate category.

(B) Member insurers who report surcharge collections that are less than what they paid in the preceding year's premium charge shall receive reimbursement from the association for the shortfall in surcharge collection.

(C) Member insurers may amend their reports indicating the amount of surcharges collected for the prior five years if they discover there was an error in the original reports filed with the association.

(c) The plan of operation may permit a member insurer to omit collection of the surcharge from any of its insureds only if the expense of collecting the surcharge would exceed the amount of the surcharge, provided, however, that a member insurer is not entitled to reimbursement from the association pursuant to subparagraph (B) of paragraph (2) of subdivision (b) of any amount omitted from collection pursuant to this subdivision.

(d) This section applies only to premium charges paid on or after January 1, 2017.

SEC. 5. Section 2051.5 of the Insurance Code is amended to read:

2051.5. (a) (1) Under an open policy that requires payment of the replacement cost for a loss, the measure of indemnity is the amount that it would cost the insured to repair, rebuild, or replace the thing lost or injured, without a deduction for physical depreciation, or the policy limit, whichever is less.

(2) If the policy requires the insured to repair, rebuild, or replace the damaged property in order to collect the full replacement cost, the insurer shall pay the actual cash value of the damaged property, as defined in Section 2051, until the damaged property is repaired, rebuilt, or replaced. Once the

property is repaired, rebuilt, or replaced, the insurer shall pay the difference between the actual cash value payment made and the full replacement cost reasonably paid to replace the damaged property, up to the limits stated in the policy.

(b) (1) (A) A time limit of less than 12 months from the date that the first payment toward the actual cash value is made shall not be placed upon an insured in order to collect the full replacement cost of the loss, subject to the policy limit.

(B) In the event of a loss relating to a "state of emergency," as defined in Section 8558 of the Government Code, a time limit of less than 36 months from the date that the first payment toward the actual cash value is made shall not be placed upon the insured in order to collect the full replacement cost of the loss, subject to the policy limit.

(C) This section does not prohibit an insurer from allowing the insured additional time to collect the full replacement cost.

(2) An insurer shall provide to a policyholder one or more additional extensions of six months for good cause pursuant to subparagraph (A) or (B) of paragraph (1) if the insured, acting in good faith and with reasonable diligence, encounters a delay or delays in approval for, or reconstruction of, the home or residence that are beyond the control of the insured. Circumstances beyond the control of the insured include, but are not limited to, unavoidable construction permit delays, the lack of necessary construction materials, or the unavailability of contractors to perform the necessary work.

(c) (1) In the event of a total loss of the insured structure, a policy issued or delivered in this state shall not contain a provision that limits or denies, on the basis that the insured has decided to rebuild at a new location or to purchase an already built home at a new location, payment of the building code upgrade cost or the replacement cost, including any extended replacement cost coverage, to the extent those costs are otherwise covered by the terms of the policy or any policy endorsement. However, the measure of indemnity shall not exceed the replacement cost, including the building code upgrade cost and any extended replacement cost coverage, if applicable, to repair, rebuild, or replace the insured structure at its original location.

(2) Notwithstanding any other law, for a residential property insurance policy, the measure of damages available to a policyholder to use to rebuild or replace the insured home at another location shall be the amount that would have been recoverable had the insured dwelling been rebuilt at its original location, and a deduction for the value of land at the new location shall not be permitted from that measure of damages. However, the measure of indemnity shall not exceed the cost, including the building code upgrade cost and any extended replacement cost coverage, if applicable, to rebuild the insured structure at its original location.

(d) This section does not prohibit an insurer from restricting payment in cases of suspected fraud.

(e) (1) On and after July 1, 2005, and only until July 1, 2019, all policy forms used by an insurer shall be in compliance with this section, except for the changes made to this section by the act that added paragraph (2).

(2) On and after July 1, 2019, all policy forms issued or renewed by an insurer shall comply with this section in its entirety, including the changes made to this section by the act that added this paragraph.

SEC. 6. Section 2060 of the Insurance Code is amended to read:

2060. (a) In the event of a loss under a homeowners' insurance policy for which the insured has made a claim for additional living expenses, the insurer shall provide the insured with a list of items that the insurer believes may be covered under the policy as additional living expenses. The list may include a statement that the list is not intended to include all items covered under the policy, but only those that are commonly claimed, if this is the case. If the department develops a list for use by insurers, the insurer may use that list.

(b) (1) In the event of a covered loss relating to a state of emergency, as defined in Section 8558 of the Government Code, coverage for additional living expenses shall be for a period of no less than 24 months from the inception of the loss, but shall be subject to other policy provisions. An insurer shall grant an extension of up to 12 additional months, for a total of 36 months, if an insured acting in good faith and with reasonable diligence encounters a delay or delays in the reconstruction process that are the result of circumstances beyond the control of the insured. Circumstances beyond the control of the insured include, but are not limited to, unavoidable construction permit delays, lack of necessary construction materials, and lack of available contractors to perform the necessary work. Additional extensions of six months shall be provided to policyholders for good cause.

(2) A policy that provides coverage for additional living expenses subject to this subdivision shall not limit the policyholder's right to recovery if the insured home is rendered uninhabitable by a covered peril. However, an insurer may, in lieu of making living expense payments required by this subdivision, provide a reasonable alternative remedy that addresses the property condition that precludes reasonable habitation of the insured premises. The additional living expense coverage subject to this section does not include a utility public safety power shut off event, which is the deenergization of a portion of the electrical distribution or transmission system to reduce the risk of wildfire ignition.

(c) For a loss that is otherwise not subject to subdivision (b) or (c), in the event of a state of emergency, as defined in Section 8558 of the Government Code, that is accompanied by an order of civil authority restricting access to the home, related to a covered peril, additional living expense coverage shall be provided for at least two weeks. Additional extensions of two weeks shall be provided to a policyholder for good cause, but shall be subject to other policy provisions.

(d) The amendments made by the act that added this subdivision shall be operative on July 1, 2021.

SEC. 7. Section 10095 of the Insurance Code is amended to read:

10095. (a) Within 30 days following the effective date of this chapter, the association shall submit to the commissioner, for the commissioner's review, a proposed plan of operation, consistent with this chapter, creating

an association consisting of all insurers licensed to write and engaged in writing in this state, on a direct basis, basic property insurance or any component of basic property insurance in homeowners or other dwelling multiperil policies. An insurer described in this subdivision shall be a member of the association and shall remain a member as a condition of its authority to transact those kinds of insurance in this state.

(b) The proposed plan shall authorize the association to assume and cede reinsurance on risks written by insurers in conformity with the program.

(c) Under the plan, an insurer shall participate in the writings, expenses, and profits and losses of the association in the proportion that its premiums written during the second preceding calendar year bear to the aggregate premiums written by all insurers in the program, excluding that portion of the premiums written attributable to the operation of the association. Premiums written on a policy of basic residential earthquake insurance issued by the California Earthquake Authority pursuant to Section 10089.6 shall be attributed to the insurer that writes the underlying policy of residential property insurance.

(d) The plan shall provide for administration by a governing committee under rules to be adopted by the governing committee with the approval of the commissioner. Voting on administrative questions of the association and facility shall be weighted in accordance with each insurer's premiums written during the second preceding calendar year as disclosed in the reports filed by the insurer with the commissioner.

(e) The plan shall provide for a plan to encourage persons to secure basic property insurance through normal channels from an admitted insurer or a licensed surplus line broker by informing those persons what steps they must take in order to secure the insurance through normal channels.

(f) The plan shall be subject to the approval of the commissioner and shall go into effect upon the tentative approval of the commissioner. The commissioner may, at any time, withdraw tentative approval or the commissioner may, at any time after giving final approval, revoke that approval if the commissioner feels it is necessary to carry out the purposes of the chapter. The withdrawal or revocation of that approval shall not affect the validity of any policies executed before the date of the withdrawal. If the commissioner disapproves or withdraws or revokes their approval to all or any part of the plan of operation, the association shall, within 30 days, submit for review an appropriately revised plan or part of a revised plan, and, if the association fails to do so, or if the revised plan is unacceptable, the commissioner shall promulgate a plan of operation or part of a plan as the commissioner may deem necessary to carry out this chapter.

(g) The association may, on its own initiative or at the request of the commissioner, amend the plan of operation, subject to approval by the commissioner, who shall have supervision of the inspection bureau, the facility, and the association. The commissioner, or any person designated by the commissioner, shall have the power of visitation of and examination into the operation and free access to all the books, records, files, papers, and documents that relate to operation of the facility and association, and

may summon, qualify, and examine as witnesses all persons having knowledge of those operations, including officers, agents, or employees thereof.

(h) An insurer member of the plan shall provide to an applicant who is denied coverage, or a policyholder whose policy is canceled or not renewed, the internet website address and statewide toll-free telephone number for the plan established pursuant to Section 10095.5 for the purpose of obtaining information and assistance in obtaining basic property insurance.

(i) To reduce the association's concentration and number of policies, and to encourage maximum use of the normal insurance market consistent with subdivision (c) of Section 10090, the association shall develop and implement a clearinghouse program on or before July 1, 2021, to help reduce the number of existing FAIR Plan policies and provide the opportunity for admitted insurers to offer homeowners' insurance policies to FAIR Plan policyholders. An insurer that participates in the clearinghouse program shall sign an agreement with the association that sets forth the terms and conditions for the insurer to offer homeowners insurance through the policy's listed agent or broker of record, if any. The clearinghouse program may include a provision to include nonadmitted insurers if admitted insurers have the first option.

SEC. 8. Section 10103.7 of the Insurance Code is amended to read:

10103.7. (a) In the event of a covered loss relating to a state of emergency, as defined in Section 8558 of the Government Code, an insured under a residential property insurance policy shall be permitted to combine payments for claims for losses up to the policy limits for the primary dwelling and other structures, for any of the covered expenses reasonably necessary to rebuild or replace the damaged or destroyed dwelling, if the policy limits for coverage to rebuild or replace the primary dwelling are insufficient. Any claims payments for losses pursuant to this subdivision for which replacement cost coverage is applicable shall be for the full replacement value of the loss without requiring actual replacement of the other structures or contents. Claims payments for other structures in excess of the amount applied towards the necessary cost to rebuild or replace the damaged or destroyed dwelling shall be paid according to the terms of the policy.

(b) (1) In the event of a covered total loss of a primary dwelling under a residential property insurance policy resulting from a state of emergency, as defined in Section 8558 of the Government Code, if the residence was furnished at the time of the loss, the insurer shall offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim.

(2) After receiving the payment described in paragraph (1), the insured may recover additional amounts up to the policy limit for contents coverage by filing a claim pursuant to the terms of the policy for the loss of contents that exceeds the value of the payment provided pursuant to paragraph (1).

(3) When an insured files a claim relating to a state of emergency, as defined in Section 8558 of the Government Code, the insurer shall notify the insured of the option to receive payment for loss of contents pursuant to paragraph (1) and of the insured's option to subsequently file a full itemized claim pursuant to paragraph (2).

(4) This subdivision does not affect payment under the policy for scheduled personal property.

(5) This section does not prohibit an insurer from restricting payment in cases of suspected fraud.

SEC. 9. Section 1.5 of this bill incorporates amendments to Section 678 of the Insurance Code proposed by both this bill and Assembly Bill 2756. That section shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2021, (2) each bill amends Section 678 of the Insurance Code, and (3) this bill is enacted after Assembly Bill 2756, in which case Section 1 of this bill shall not become operative.

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