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INSURANCE CODE - INS

DIVISION 1. GENERAL RULES GOVERNING INSURANCE [100 - 1879.8] (Division 1 enacted by Stats. 1935, Ch. 145.)

PART 2. THE BUSINESS OF INSURANCE [680 - 1879.8] (Part 2 enacted by Stats. 1935, Ch. 145.)

CHAPTER 12. The Insurance Frauds Prevention Act [1871 - 1879.8] (Chapter 12 added by Stats. 1989, Ch. 1119, Sec. 3.)

ARTICLE 2. Bureau of Fraudulent Claims [1872 - 1872.96] (Article 2 added by Stats. 1989, Ch. 1119, Sec. 3.)

1872. There is created within the department the Fraud Division to enforce the provisions of Sections 549, and 550 of the Penal Code, and to administer the provisions of Article 3 (commencing with Section 1873).

(Amended by Stats. 2005, Ch. 717, Sec. 1. Effective January 1, 2006.)

1872.2. For purposes of this article, "insurer" means any person who undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event, including reciprocals and interinsurance exchanges.

(Added by Stats. 1989, Ch. 1119, Sec. 3.)

1872.3. (a) If, by its own inquiries or as a result of complaints, the Fraud Division has reason to believe that a person has engaged in, or is engaging in, an act or practice that violates Section 1871.4 of this code, or Section 549 or 550 of the Penal Code, the commissioner in his or her discretion may do either or both of the following:

(1) Make those public or private investigations within or outside of this state that he or she deems necessary to determine whether any person has violated or is about to violate any provision of Section 1871.4 of this code, or Section 549 or 550 of the Penal Code, or to aid in the enforcement of this chapter.

(2) Publish information concerning any violation of this chapter or Section 550 of the Penal Code.

(b) For purposes of any investigation under this section, the commissioner or any officer designated by the commissioner may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner deems relevant or material to the inquiry, as provided by Section 12924.

(c) If any matter that the commissioner seeks to obtain by request is located outside the state, the person so requested may make it available to the commissioner or his or her representative to be examined at the place where it is located. The commissioner may designate representatives, including officials of the state in which the matter is located, to inspect the matter on his or her behalf, and he or she may respond to similar requests from officials of other states.

(d) Except as provided in subdivision (e), the department's papers, documents, reports, or evidence relative to the subject of an investigation under this section shall not be subject to public inspection for so long a period as the commissioner deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to serve the public interest. Furthermore, those papers, documents, reports, or evidence shall not be subject to subpoena or subpoena duces tecum until opened for public inspection by the commissioner, unless the commissioner otherwise consents or, after notice to the commissioner and a hearing, the superior court determines that the public interest and any ongoing investigation by the commissioner would not be unnecessarily jeopardized by compliance with the subpoena duces tecum.

(e) The Fraud Division shall furnish all papers, documents, reports, complaints, or other facts or evidence to any police, sheriff, or other law enforcement agency, when so requested, and shall assist and cooperate with those law enforcement agencies.

(Amended by Stats. 2005, Ch. 717, Sec. 3. Effective January 1, 2006.)

1872.4. (a) Any company licensed to write insurance in this state that has determined, after the completion of the insurer's special investigative unit investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring shall, within 60 days after that determination by the insurer, send to the Fraud Division, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances regarding the alleged insurance fraud and person or entity that may have committed or is committing insurance fraud, as specified in Section 2698.38 of Title 10 of the California Code of Regulations. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, claims, application, or other insurance transaction, the commissioner shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, the commissioner shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This section shall not require an insurer to submit to the Fraud Division the information specified in subdivision (a) in either of the following instances:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but further investigation revealed that it was not fraudulent.

(2) The insurer and the claimant have reached agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe that claim to be fraudulent.

(c) Nothing contained in this article shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Fraud Division, when so requested, and shall otherwise assist and cooperate with the division.

(e) If an insurer, at the time the insurer, pursuant to subdivision (a) forwards to the Fraud Division information on a claim that appears to be fraudulent, has no evidence to believe the insured on that claim is involved with the fraud or the fraudulent collision, the insurer shall take all necessary steps to assure that no surcharge is added to the insured's premium because of the claim.

(Amended by Stats. 2022, Ch. 424, Sec. 21. (SB 1242) Effective January 1, 2023.)

1872.41. (a) An agent or broker who, before placing an insurance application with an insurer, reasonably suspects or knows that a fraudulent application is being made shall, within 60 days after the determination by the agent or broker that the application appears to be fraudulent, submit to the Fraud Division, using the electronic form within Fraud Division's Consumer Fraud Reporting Portal, the information requested by the form and any additional information relative to the factual circumstances of the application and the alleged material misrepresentations contained in the application. All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form shall be completed accurately, to the best of the agent or broker's ability. An agent or broker shall not submit a fraud referral anonymously. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations.

(b) An agent or broker who, after an insurance application has been placed with an insurer, reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the insurer's special investigative unit. An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the insurer's special investigative unit upon request, and shall otherwise assist and cooperate with the insurer's special investigative unit.

(c) An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the department upon request, and shall otherwise assist and cooperate with the department.

(d) (1) For purposes of this section, an "agent or broker" is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5, 1625.55, 1626, or 1758.1 and is not the employee of an insurer.

(2) An agent or broker is not considered a "contracted entity" or "integral antifraud personnel" pursuant to Section 2698.30 of Title 10 of the California Code of Regulations.

(Amended by Stats. 2023, Ch. 204, Sec. 12. (AB 1140) Effective January 1, 2024.)

1872.45. A district attorney who files a criminal complaint pursuant to Section 549 or 550 of the Penal Code shall promptly do all of the following:

(a) Notify each insurer affected by the acts that are the subject of the criminal complaint of the existence of the complaint and the names of all persons insured by the insurer who are the victims.

(b) Notwithstanding any other provision of law, when an insurer receives notification pursuant to subdivision (a), and the insurer has increased the premiums of a person who is a victim because of a claim that is the subject of the criminal complaint, the insurer shall promptly rebate to that person the increased premiums that were charged to and paid by that person.

(c) Notify the Department of Motor Vehicles of the criminal complaint and the names of all persons who are the victims.

(d) Notify all the persons who are the victims in simple understandable language that a criminal complaint has been filed and that subdivision (b) of Section 1806 of the Vehicle Code requires the Department of Motor Vehicles not to record the accident on the record of the victim.

(Added by Stats. 1999, Ch. 885, Sec. 4. Effective January 1, 2000.)

1872.5. No insurer, or the employees or agents of any insurer, shall be subject to civil liability for libel, slander, or any other relevant tort cause of action by virtue of providing any of the following without malice:

(a) Any information or reports relating to suspected fraudulent insurance transaction furnished to law enforcement officials, or licensing officials governed by the Business and Professions Code.

(b) Any reports or information relating to suspected fraudulent insurance transaction furnished to other persons subject to this chapter.

(c) Any information or reports required by this article or required by the commissioner under the authority granted in this chapter.

(Added by Stats. 1989, Ch. 1119, Sec. 3.)

1872.51. (a) An agent or broker who furnishes written or oral information pursuant to Section 1872.41, or an authorized governmental agency, or its employees, that furnishes or receives written or oral information pursuant to Section 1872.41 or assists in an investigation of a suspected insurance fraud violation conducted by an authorized governmental agency, shall not be subject to any civil liability in a cause or action if the insurer, authorized agent, agent or broker, or authorized governmental agency acted in good faith, without malice, and reasonably believes that the action taken was warranted by the then-known facts, obtained by reasonable efforts.

(b) This chapter does not abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on its behalf, agent or broker, licensed rating organization, or any authorized governmental agency or its employees.

(Added by Stats. 2022, Ch. 424, Sec. 23. (SB 1242) Effective January 1, 2023.)

1872.6. Nothing contained in this article shall:

(a) Preempt the authority of other law enforcement or licensing agencies to investigate and prosecute suspected violations of law.

(b) Prevent or prohibit a person from voluntarily disclosing any information concerning violations of this chapter to any law enforcement or licensing agency governed by the Business and Professions Code.

(c) Limit any of the powers granted to the department or the commissioner to investigate possible violations of the chapter and take appropriate action against wrongdoers.

(Added by Stats. 1989, Ch. 1119, Sec. 3.)

1872.8. (a) An insurer doing business in this state shall pay an annual special purpose assessment to be determined by the commissioner, but not to exceed one dollar (\$1) annually, for each vehicle insured under an insurance policy it issues in this state, in order to fund increased investigation and prosecution of fraudulent automobile insurance claims and economic automobile theft. Thirty-four percent of those funds received from ninety-five cents (\$0.95) of the special purpose assessment per insured vehicle shall be distributed to the Fraud Division for enhanced investigative efforts, 15 percent of that ninety-five cents (\$0.95) shall be deposited in the Motor Vehicle Account for appropriation to the Department of the California Highway Patrol for enhanced prevention and investigative efforts to deter economic automobile theft, and 51 percent of that ninety-five cents (\$0.95) shall be distributed to district attorneys for purposes of investigation and prosecution of automobile insurance fraud cases, including fraud involving economic automobile theft.

(b) (1) The commissioner shall award funds to district attorneys according to population. The commissioner may alter this distribution formula as necessary to achieve the most effective distribution of funds. A local district attorney desiring a portion of those funds shall submit to the commissioner an application detailing the proposed use of any moneys that may be provided. The application shall include a detailed accounting of assessment funds received and expended in prior years, including, at a minimum, all of the following:

(A) The amount of funds received and expended.

(B) The uses to which those funds were put, including payment of salaries and expenses, purchase of equipment and supplies, and other expenditures by type.

(C) The results achieved as a consequence of expenditures made, including the number of investigations, arrests, complaints filed, convictions, and the amounts originally claimed in cases prosecuted compared to payments actually made in those cases.

(D) Other relevant information as the commissioner may reasonably require.

A district attorney who fails to submit an application by the deadline set by the commissioner shall be subject to loss of distribution of the moneys. The commissioner may consider recommendations and advice of the Fraud Division and the Commissioner of the California Highway Patrol in allocating moneys to local district attorneys. A district attorney that receives funds shall submit an annual report to the commissioner, which may be made public, as to the success of the program administered. The report shall provide information and statistics on the number of active investigations, arrests, indictments, and convictions. Both the application for moneys and the distribution of moneys shall be public documents. The commissioner shall conduct a fiscal audit of the programs administered under this subdivision at least once every three years. The costs of a fiscal audit shall be shared equally between the department and the district attorney. Information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential. If the commissioner determines that a district attorney is unable or unwilling to investigate and prosecute automobile insurance fraud claims as provided by this subdivision or Section 1874.8, the commissioner may discontinue the distribution of funds allocated for that county and may redistribute those funds to other eligible district attorneys.

(2) The Department of the California Highway Patrol shall submit to the commissioner, for informational purposes only, a report detailing the department's proposed use of funds under this section and an annual report in the same format as required of district attorneys under paragraph (1).

(c) The remaining five cents (\$0.05) shall be spent for enhanced automobile insurance fraud investigation by the Fraud Division.

(d) Except for funds to be deposited in the Motor Vehicle Account for allocation to the Department of the California Highway Patrol for purposes of the Motor Vehicle Theft Prevention Act (Chapter 5 (commencing with Section 10900) of Division 4 of the Vehicle Code), the funds received under this section shall be deposited in the Insurance Fund and be expended and distributed when appropriated by the Legislature.

(e) In the course of its investigations, the Fraud Division shall pursue aggressively all reported incidents of probable fraud and, in addition, shall forward to the appropriate disciplinary body the names of individuals licensed under the Business and Professions Code who are suspected of actively engaging in fraudulent activity along with all relevant supporting evidence.

(f) As used in this section, "economic automobile theft" means automobile theft perpetrated for financial gain, including, but not limited to, the following:

(1) Theft of a motor vehicle for financial gain.

(2) Reporting that a motor vehicle has been stolen for the purpose of filing a false insurance claim.

(3) Engaging in any act prohibited by Chapter 3.5 (commencing with Section 10801) of Division 4 of the Vehicle Code.

(4) Switching of vehicle identification numbers to obtain title to a stolen motor vehicle.

(Amended by Stats. 2008, Ch. 179, Sec. 170. Effective January 1, 2009.)

1872.81. In addition to the special purpose assessment imposed pursuant to Section 1872.8, effective July 1, 2014, an insurer doing business in this state shall, until January 1, 2016, pay to the commissioner an annual special purpose assessment of twenty-six cents (\$0.26), and thereafter pay to the commissioner an annual special purpose assessment in an amount not to exceed twenty-six cents (\$0.26), as determined by the commissioner, for each vehicle insured under an insurance policy it issues in this state, for expenditure, upon appropriation by the Legislature, as follows:

(a) Two-thirds of the special purpose assessment shall be used for the purpose of funding the consumer service functions of the department that are related to regulating automobile insurers, including those functions performed by the rating and underwriting service bureau, the claims service bureau, the investigations bureau, or any successor bureaus of the department that may assume the consumer service functions of these bureaus, and legal services in support of these bureaus.

(b) One-third of the special purpose assessment shall be used for the purpose of improving consumer functions identified in subdivision (a) of the department that are related to regulating automobile insurers, including, for improving the ability of the department to respond to consumer complaints and information requests through the department's toll-free telephone number, and for improving the ability of the department to offer information about automobile insurance rates to the public.

(c) Upon appropriation by the Legislature, the department may use up to five cents (\$0.05) of the special purpose assessment revenues collected pursuant to this section to notify insurers and other members of the public about the existence of any low-cost automobile insurance program established pursuant to Section 11629.7 or other statutes that establish a program of the type identified in Section 11629.7. In requesting an appropriation for this purpose under its proposed plan developed pursuant to Section 11629.85, the department shall explain, with as much specificity as is reasonably possible, the objectives for the use of the funds and the quantitative criteria by which the Legislature may evaluate the effectiveness of the department's use of the funds.

(d) The commissioner shall include, in the annual report submitted pursuant to Section 12922, all of the following information:

- (1) The number of opened consumer complaints related to automobile insurance.
- (2) The number of opened investigations related to automobile insurance.
- (3) The number of investigations related to automobile insurance referred to prosecuting agencies.
- (4) The number of administrative or regulatory cases related to automobile insurance referred to the department's legal division.
- (5) The number of administrative or regulatory enforcement actions taken in cases related to automobile insurance.
- (6) Total aggregate annual assessment revenue and expenditures pursuant to the assessment.

(Amended by Stats. 2014, Ch. 407, Sec. 1. (AB 1395) Effective January 1, 2015.)

1872.83. (a) The commissioner shall ensure that the Fraud Division aggressively pursues all reported incidents of probable workers' compensation fraud, as defined in Sections 11760 and 11880, and in subdivision (a) of Section 1871.4, and in Section 549 of the Penal Code, and forwards to the appropriate disciplinary body the names, along with all supporting evidence, of any individuals licensed under the Business and Professions Code who are suspected of actively engaging in fraudulent activity. The Fraud Division shall forward to the Insurance Commissioner or the Director of Industrial Relations, as appropriate, the name, along with all supporting evidence, of any insurer, as defined in subdivision (c) of Section 1877.1, suspected of actively engaging in the fraudulent denial of claims.

(b) To fund increased investigation and prosecution of workers' compensation fraud, and of willful failure to secure payment of workers' compensation, in violation of Section 3700.5 of the Labor Code, there shall be an annual assessment as follows:

- (1) The aggregate amount of the assessment shall be determined by the Fraud Assessment Commission, which is hereby established. The commission shall be composed of seven members consisting of two representatives of organized labor, two representatives of self-insured employers, one representative of insured employers, one representative of workers' compensation insurers, and the President of the State Compensation Insurance Fund, or their designee.

The Governor shall appoint members representing organized labor, self-insured employers, insured employers, and insurers. The term of office of members of the commission shall be four years, and a member shall hold office until the appointment of a successor. The President of the State Compensation Insurance Fund shall be an ex officio, voting member of the commission. Members of the commission shall receive one hundred dollars (\$100) for each day of actual attendance at commission meetings and other official commission business, and shall also receive their actual and necessary traveling expenses incurred in the performance of commission duties. Payment of per diem and travel expenses shall be made from the Workers' Compensation Fraud Account in the Insurance Fund, established in paragraph (4), upon appropriation by the Legislature.

- (2) In determining the aggregate amount of the assessment, the Fraud Assessment Commission shall consider the advice and recommendations of the Fraud Division and the commissioner.

- (3) The aggregate amount of the assessment shall be collected by the Director of Industrial Relations pursuant to Section 62.5 of the Labor Code. The Fraud Assessment Commission shall annually advise the Director of Industrial Relations, not later than March 15, of the aggregate amount to be assessed for the next fiscal year.

- (4) The amount collected, together with the fines collected for violations of the unlawful acts specified in Sections 1871.4, 11760, and 11880, Section 3700.5 of the Labor Code, and Section 549 of the Penal Code, shall be deposited in the Workers' Compensation Fraud Account in the Insurance Fund, which is hereby created, and may be used, upon appropriation by the Legislature, only for enhanced investigation and prosecution of workers' compensation fraud and of willful failure to secure payment of workers' compensation as provided in this section.

(c) For each fiscal year, the total amount of revenues derived from the assessment pursuant to subdivision (b) shall, together with amounts collected pursuant to fines imposed for unlawful acts described in Sections 1871.4, 11760, and 11880, Section 3700.5 of the Labor Code, and Section 549 of the Penal Code, not be less than three million dollars (\$3,000,000). Any funds appropriated by the Legislature pursuant to subdivision (b) that are not expended in the fiscal year for which they have been appropriated, and that have not been allocated under subdivision (f), may be applied to satisfy for the immediately following fiscal year the minimum total

amount required by this subdivision or, subject to appropriation by the Legislature, may be used to augment funding in the immediately following fiscal year. The money shall not be transferred to the General Fund.

(d) After incidental expenses, at least 40 percent of the funds to be used for the purposes of this section shall be provided to the Fraud Division of the Department of Insurance for enhanced investigative efforts, and at least 40 percent of the funds shall be distributed to district attorneys, pursuant to a determination by the commissioner with the advice and consent of the division and the Fraud Assessment Commission, as to the most effective distribution of moneys for purposes of the investigation and prosecution of workers' compensation fraud cases and cases relating to the willful failure to secure the payment of workers' compensation. Each district attorney seeking a portion of the funds shall submit to the commissioner an application setting forth in detail the proposed use of any funds provided. A district attorney receiving funds pursuant to this subdivision shall submit an annual report to the commissioner with respect to the success of their efforts. Upon receipt, the commissioner shall provide copies to the Fraud Division and the Fraud Assessment Commission of any application, annual report, or other documents with respect to the allocation of money pursuant to this subdivision. Both the application for moneys and the distribution of moneys shall be public documents. Information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.

(e) If a district attorney is determined by the commissioner to be unable or unwilling to investigate and prosecute workers' compensation fraud claims or claims relating to the willful failure to secure the payment of workers' compensation, the commissioner shall discontinue distribution of funds allocated for that county and may redistribute those funds according to this subdivision.

(1) The commissioner shall promptly determine whether any other county could assert jurisdiction to prosecute the fraud claims or claims relating to the willful failure to secure the payment of workers' compensation that would have been brought in the nonparticipating county, and, if so, the commissioner may award funds to conduct the prosecutions redirected pursuant to this subdivision. These funds may be in addition to any other fraud prosecution funds or claims relating to the willful failure to secure the payment of workers' compensation prosecution otherwise awarded under this section. Any district attorney receiving funds pursuant to this subdivision shall first agree that the funds shall be used solely for investigating and prosecuting those cases of workers' compensation fraud or claims relating to the willful failure to secure the payment of workers' compensation that are redirected pursuant to this subdivision and submit an annual report to the commissioner with respect to the success of the district attorney's efforts. The commissioner shall keep the Fraud Assessment Commission fully informed of all reallocations of funds under this paragraph.

(2) If the commissioner determines that no district attorney is willing or able to investigate and prosecute the workers' compensation fraud claims or claims relating to the willful failure to secure the payment of workers' compensation arising in the nonparticipating county, the commissioner, with the advice and consent of the Fraud Assessment Commission, may award to the Attorney General some or all of the funds previously awarded to the nonparticipating county. Before the commissioner may award any funds, the Attorney General shall submit to the commissioner an application setting forth in detail their proposed use of any funds provided and agreeing that any funds awarded shall be used solely for investigating and prosecuting those cases of workers' compensation fraud or claims relating to the willful failure to secure the payment of workers' compensation that are redirected pursuant to this subdivision. The Attorney General shall submit an annual report to the commissioner with respect to the success of the fraud prosecution efforts of their office.

(3) Neither the Attorney General nor any district attorney shall be required to relinquish control of any investigation or prosecution undertaken pursuant to this subdivision unless the commissioner determines that satisfactory progress is no longer being made on the case or the case has been abandoned.

(4) A county that has become a nonparticipating county due to the inability or unwillingness of its district attorney to investigate and prosecute workers' compensation fraud or the willful failure to secure the payment of workers' compensation shall not become eligible to receive funding under this section until it has submitted a new application that meets the requirements of subdivision (d) and the applicable regulations.

(f) If in any fiscal year the Fraud Division does not use all of the funds made available to it under subdivision (d), any remaining funds may be distributed to district attorneys pursuant to a determination by the commissioner in accordance with the same procedures set forth in subdivision (d).

(g) The commissioner shall adopt rules and regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Included in the rules and regulations shall be the criteria for redistributing funds to district attorneys and the Attorney General. The adoption of the rules and regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare.

(h) The department shall report to the Governor, the Legislature, to the committees of the Senate and Assembly having jurisdiction over insurance, and the Fraud Assessment Commission on the activities of the Fraud Division and district attorneys supported by the funds provided by this section in the annual report submitted pursuant to Section 12922.

The annual report shall include, but is not limited to, all of the following information for the department and each district attorney's office:

- (1) All allocations, distributions, and expenditures of funds.
- (2) The number of search warrants issued.
- (3) The number of arrests and prosecutions, and the aggregate number of parties involved in each.
- (4) The number of convictions and the names of all convicted fraud perpetrators.
- (5) The estimated value of all assets frozen, penalties assessed, and restitutions made for each conviction.
- (6) Any additional items necessary to fully inform the Fraud Assessment Commission and the Legislature of the fraud-fighting efforts financed through this section.

(i) In order to meet the requirements of subdivision (g), the department shall submit a biannual information request to those district attorneys who have applied for and received funding through the annual assessment process under this section.

(j) Assessments levied or collected to fight workers' compensation fraud and insurance fraud are not taxes. Those funds are entrusted to the state to fight fraud and the willful failure to secure the payment of workers' compensation by funding state and local investigation and prosecution efforts. Accordingly, any funds resulting from assessments, fees, penalties, fines, restitution, or recovery of costs of investigation and prosecution deposited in the Insurance Fund shall not be deemed "unexpended" funds for any purpose and, if remaining in that account at the end of any fiscal year, shall be applied as provided in subdivision (f) and to offset or augment subsequent years' program funding.

(Amended by Stats. 2025, Ch. 23, Sec. 3. (SB 129) Effective June 30, 2025.)

1872.84. The commissioner shall ensure that the Fraud Division forwards to the appropriate disciplinary body, in addition to the names and supporting evidence of individuals described in subdivision (a) of Section 1872.83, the names, along with all supporting evidence, of any individuals licensed under the Chiropractic Initiative Act who are suspected of actively engaging in fraudulent activity.

(Added by Stats. 2005, Ch. 415, Sec. 2. Effective January 1, 2006.)

1872.85. (a) Every admitted disability insurer or other entity liable for any loss due to health insurance fraud doing business in this state shall pay an annual special purpose assessment to be determined by the commissioner, but not to exceed twenty cents (\$0.20) annually for each person in this state covered under an individual or group insurance policy regardless of the situs of the contract or master group policyholder, and regardless of whether the insured has been issued an individual certificate of coverage, and including blanket insurance as defined in Section 10270.2, in order to fund increased investigation and prosecution of fraudulent disability insurance claims. The data supporting the special purpose assessment shall not be required to be submitted more often than once each calendar year, except that responses to questions from the commissioner and clarifying information regarding the data shall not be considered as additional submissions of data. For group and blanket insurance contracts, insurers may rely on information requested from and provided by the group policyholder after a reasonable effort to obtain timely and accurate information. After incidental expenses, 30 percent of those funds received from the assessment per insured shall be distributed to the Fraud Division of the Department of Insurance for enhanced investigative efforts, and 70 percent of the funds shall be distributed to local district attorneys, pursuant to subdivisions (b) and (c), for investigation and prosecution of disability insurance fraud cases. The funds received pursuant to this section shall be deposited into the Disability Insurance Fraud Account, which is hereby created in the Insurance Fund, and shall be expended and distributed, when appropriated by the Legislature, only for enhanced investigation and prosecution of disability insurance fraud.

In the course of its investigation, the Fraud Division shall aggressively pursue all reported incidents of probable fraud and, in addition, shall forward to the appropriate disciplinary body the names of any individuals licensed under the Business and Professions Code who are convicted of engaging in fraudulent activity along with all relevant supporting evidence.

(b) The commissioner shall distribute funds pursuant to subdivision (a) to district attorneys who are able to show a likely positive outcome that will enhance the prosecution of disability insurance fraud in their jurisdiction based on specific criteria promulgated by the commissioner. A district attorney desiring funds pursuant to subdivision (a) shall submit to the commissioner an application that includes, but is not limited to, all of the following:

- (1) The proposed use of the moneys and the anticipated outcome.
- (2) A list of all prior cases or projects in the district attorney's jurisdiction that have been funded under the provisions of this section, and a copy of the final accounting for each case or project. If a case or project is ongoing, the most recent accounting shall be provided.

(3) A detailed budget for the moneys, including salaries and general expenses, that specifically identifies the purchase or rental cost of equipment or supplies.

(c) (1) A district attorney who receives moneys pursuant to this section shall submit a final detailed accounting at the conclusion of each case or project funded. For a case or project that continues for longer than six months, an interim accounting shall be submitted every six months, or as otherwise directed by the commissioner.

(2) A district attorney who receives moneys pursuant to this section shall submit a final report to the commissioner, which may be made public, as to the success of each case or project funded by this section. The report shall provide information and statistics on the number of active investigations, arrests, indictments, and convictions associated with a case or project. The applications for moneys, the distribution of moneys, and the annual report required by Section 1872.9 shall be public documents.

(3) Notwithstanding any other provision of this section, information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.

(4) The commissioner may conduct a fiscal audit of the programs administered under this subdivision. The fiscal audit shall be conducted by an internal audit unit of the department. The cost of fiscal audits shall be paid from the Disability Insurance Fraud Account, upon appropriation by the Legislature.

(5) If the commissioner determines that a district attorney is unable or unwilling to investigate or prosecute a relevant disability insurance fraud case, the commissioner may discontinue distribution of moneys allocated for that matter pursuant to this section, and may redistribute moneys to other eligible district attorneys.

(d) Activities of the Fraud Division with regard to investigating and prosecuting fraudulent disability insurance claims pursuant to this section shall be included in the report required by Section 1872.9.

(e) This section shall not apply to policies issued by a reciprocal or interinsurance exchange, as defined by Sections 1303 and 1350, or coverage provided by or through a motor club, as defined by Section 12142, affiliated with a reciprocal or interinsurance exchange, if the annual premium charged for the coverage or the annual cost to the insurer for providing that coverage does not exceed one dollar (\$1) per insured.

(f) The commissioner shall adopt regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(Amended by Stats. 2014, Ch. 251, Sec. 1. (SB 1142) Effective January 1, 2015.)

1872.86. (a) An insurer doing business in this state shall pay an annual special purpose assessment to be determined by the commissioner, not to exceed five thousand one hundred dollars (\$5,100), to be used exclusively for the support of the Fraud Division. All moneys received by the commissioner from insurers pursuant to this section shall be transmitted to the Treasurer to be deposited in the State Treasury to the credit of the Insurance Fund.

(b) The Fraud Division shall report annually, on the department's Internet Web site, all of the following information:

(1) The number of suspected fraudulent claim referrals made to the Fraud Division pursuant to Section 1872.4, by line of insurance.

(2) The number of investigations opened by the Fraud Division, by line of insurance, at the local, state, and federal levels.

(3) The number of investigations referred by the Fraud Division for criminal prosecution, by line of insurance, at the local, state, and federal levels.

(4) The number of insurer fraud cases investigated by the department's Enforcement Branch.

(5) The number of criminal complaints filed by prosecutors at the local, state, and federal levels.

(6) The number of convictions at the local, state, and federal levels.

(7) The total amount of court-ordered restitution, and the amount collected by the courts for the victims.

(8) The number of training presentations focusing on the current schemes and trends, investigative tools and techniques, and proper reporting requirements needed to increase the quality of suspected fraudulent referrals by insurance industry special investigation units.

(9) The number of vacant peace officer positions, including information on the number and rate of vacancies for which an employment commitment has been made and on the number and rate of vacancies required to meet budgeted salary savings requirements.

(Amended by Stats. 2008, Ch. 179, Sec. 172. Effective January 1, 2009.)

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

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

(Amended by Stats. 2013, Ch. 321, Sec. 22. (AB 1391) Effective January 1, 2014.)

1872.9. The Fraud Division shall annually compile and report, as a part of the commissioner's annual report as required by Section 12922, the following information:

(a) The number of cases reported to the division pursuant to this chapter.

(b) The number of cases rejected for which an investigation was not initiated by the division due to insufficient evidence to proceed and the number of cases rejected for which an investigation was not initiated by the division due to any other reason.

(c) The number of cases that were prosecuted in cooperation with licensing agencies governed by the Business and Professions Code.

(d) The number and kind of cases prosecuted as a result of moneys received under Section 1872.7.

(e) An estimate of the economic value of insurance fraud by type of insurance fraud.

(f) Recommendations on ways insurance fraud may be reduced.

(g) A summary of the division's activities with respect to pursuing a reduction of fraud with all of the following:

(1) Insurance companies.

(2) The Department of Motor Vehicles.

(3) The Department of the California Highway Patrol.

(4) Licensing agencies governed by the Business and Professions Code.

(5) The Department of Insurance.

(6) Local and state law enforcement agencies.

(7) Employers, as defined in Section 3300 of the Labor Code, who are self-insured for workers' compensation and doing business in the state.

(h) Basic claims information including trends of payments by type of claim and other claim information that is generally provided in a closed claim study.

(i) A summary of the division's activities with respect to the reduction, pursuant to Section 1871.4, of fraudulent denials and payments of compensation.

(j) The number and types of cases investigated and prosecuted with funds specified in Section 1872.83.

(Amended by Stats. 2005, Ch. 717, Sec. 10. Effective January 1, 2006.)

1872.95. (a) Within existing resources, the Medical Board of California, the Board of Chiropractic Examiners, and the State Bar shall each designate employees to investigate and report on possible fraudulent activities relating to workers' compensation, motor vehicle insurance, or disability insurance by licensees of the board or the bar. Those employees shall actively cooperate with the Fraud Division in the investigation of those activities.

(b) The Medical Board of California and the Board of Chiropractic Examiners shall each report annually, on or before March 1, to the committees of the Senate and Assembly having jurisdiction over insurance on their activities established pursuant to subdivision (a) for the previous year. The State Bar shall include this report in its Annual Discipline Report on or before April 30. That report shall specify, at a minimum, the number of cases investigated, the number of cases forwarded to the Fraud Division or other law

enforcement agencies, the outcome of all cases listed in the report, and any other relevant information concerning those cases or general activities conducted under subdivision (a) for the previous year. The report shall include information regarding activities conducted in connection with cases of suspected automobile insurance fraud.

(Amended by Stats. 2018, Ch. 659, Sec. 149. (AB 3249) Effective January 1, 2019.)

1872.96. The commissioner shall prepare an annual report, which shall be a public record, with respect to the receipts, expenditures, and activities of the Fraud Division for the year just ended. The report shall be submitted to the Governor and to the Legislature, no later than January 31 of the following year. This report shall not contain any individually identifiable information.

(Amended by Stats. 2005, Ch. 717, Sec. 12. Effective January 1, 2006.)