SB-1255 Insurance. (2019-2020)

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Senate Bill No. 1255

CHAPTER 184

An act to amend Sections 32, 769.56, 1104.9, 1592, 1622, 1626, 1637, 1639, 1668, 1668.5, 1669, 1675, 1676, 1677, 1682, 1707.7, 1738.5, 1749, 1749.3, 1749.31, 1749.32, 1749.33, 1749.4, 1750, 1754, 1758.1, 1758.3, 1758.8, 1758.81, 1758.82, 1758.83, 1758.84, 1758.85, 1758.86, 1758.87, 1758.88, 1758.89, 10181.45, 10234.75, 10235.45, 10271, 10291.5, 12921.2, and 13550 of, to amend the heading of Article 16.6 (commencing with Section 1758.8) of Chapter 5 of Part 2 of Division 1 of, to add Section 799.11 to, and to repeal and add Article 6.9 (commencing with Section 799) of Chapter 1 of Part 2 of Division 1 of, the Insurance Code, relating to insurance.

[Approved by Governor September 26, 2020. Filed with Secretary of State September 26, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1255, Committee on Insurance. Insurance.

Existing law provides for the powers and duties of the Department of Insurance and the Insurance Commissioner. Existing law authorizes the commissioner to deny an application for a production agency license, or revoke an existing license, if the applicant or licenseholder has engaged in specified activities. Existing law requires a hearing to suspend or revoke a license, registration, or certificate of authority that involves allegations of misconduct perpetrated against a person age 65 or over to be held within 90 days after the department's receipt of the notice of defense, unless a continuance is granted. Existing law requires the department to maintain certain records in its office in the City and County of San Francisco.

This bill would make technical, nonsubstantive changes to those provisions and would require a proceeding as described above to be upon the request of the department. The bill would authorize that hearing to be set on the earliest available date if the Office of Administrative Hearings cannot accommodate the hearing within 90 days after the department's receipt of the notice of defense. The bill would require the department to maintain certain records in its office in the San Francisco Bay area.

Existing law authorizes a life licensee to act on behalf of a life insurer or a disability insurer to transact life insurance and accident and health insurance, as specified. Existing law authorizes a life licensee to act as a life agent and specifies that these licenses are either "life-only" or "accident and health" licenses.

This bill would instead refer to those licenses as "life" and "accident and health or sickness" licenses and would make conforming changes.

Existing law prohibits the commissioner from approving a disability insurance policy, contract, or supplemental contract for insurance or delivery in this state if it meets certain criteria.

This bill would clarify that the commissioner cannot approve a disability insurance policy, contract, or supplemental contract for issuance or delivery in this state if it meets certain criteria.

Existing law prohibits a life insurance policy issued on or after January 1, 2021, that contains long-term care benefits and permits policy loans or cash withdrawals from prohibiting or limiting a loan or withdrawal while the insured receives payment of long-term care benefits, but authorizes future access to policy loans to be limited to the remaining cash value of the policy.

This bill would additionally authorize future access to cash withdrawals to be limited to the remaining cash value of the policy.

Existing law authorizes a life or disability income insurer to decline a life or disability income insurance application or enrollment request on the basis of positive test results from certain tests that detect antibodies to the human immunodeficiency virus (HIV) performed by or at the direction of the insurer.

This bill, on and after January 1, 2023, would instead prohibit an insurer from declining an application or enrollment request for coverage under a policy or certificate for life insurance or disability income insurance based solely on the results of a positive HIV test, regardless of when or at whose direction the test was performed. However, the bill would not prevent or restrict an insurer from refusing to insure an applicant that is HIV positive, limiting the amount, extent, or kind of coverage for an applicant that is HIV positive, or charging a different rate to an applicant that is HIV positive, if the refusal, limitation, or charge is based on sound actuarial principles and actual or reasonably anticipated experience.

Existing law imposes a civil penalty on a person who negligently or willfully discloses results of an HIV antibody test to a 3rd party, except pursuant to written authorization or informed consent, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply. Under existing law, the penalty for a negligent violation of those provisions is a civil penalty in an amount not to exceed $1,000 plus court costs, and the penalty for a willful violation of those provisions is a civil penalty in an amount not less than $1,000 and not more than $5,000 plus court costs. If the negligent or willful disclosure results in economic, bodily, or psychological harm to the subject of the test, existing law makes the person guilty of a misdemeanor punishable by imprisonment in a county jail for a period not to exceed one year, by a fine not to exceed $10,000, or by both that fine and imprisonment. Existing law defines “HIV antibody test” for these purposes to mean an ELISA test or a Western Blot Assay, or both.

On and after January 1, 2023, this bill would eliminate the references to an HIV antibody test for purposes of those civil and criminal penalty provisions and instead would impose penalties for the negligent, willful, or malicious disclosure of results of an HIV test. The bill would increase the civil penalty for a negligent violation of those provisions to an amount not to exceed $2,500 plus court costs and would increase the civil penalty for a willful violation of those provisions to an amount not less than $5,000 and not more than $10,000 plus court costs. The bill would impose the same civil penalty for a malicious violation of those provisions as is provided for the willful violation. The bill would also increase the amount of the fine that may be imposed for a misdemeanor violation of those provisions to an amount not to exceed $25,000. By changing the definition of a crime, the bill would impose a state-mandated local program.

Existing law provides for the licensing of rental car agents and prohibits a rental car company from offering or selling insurance unless it is licensed as an insurance agent or broker, as described, or has been issued a license by the commissioner to act as a rental car agent, as specified.

This bill would revise the name of that license and the holder of that license to instead refer to a car rental agent license and a car rental agent. The bill would make conforming changes.

Existing law requires a health insurer to file with the department, for large group health insurance policies, the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. Existing law also requires a health insurer that is subject to that requirement to disclose specified aggregate rate information for the large group market submitted pursuant to that requirement. Existing law requires the department to conduct an annual public meeting regarding large group rates in order to permit a public discussion of the reasons for the changes in the rates.

This bill would instead require the department to conduct that public meeting in every even-numbered year.

Existing law enacts provisions, only until January 1, 2023, creating the Long Term Care Insurance Task Force in the Department of Insurance to examine the components necessary to design and implement a statewide long-term care insurance program. Existing law requires the task force to submit a report containing recommended options for establishing a statewide long-term care insurance program to the commissioner, the Governor, and the Legislature on or before July 1, 2021. Existing law also requires the department to produce an actuarial report of the recommendations no later than July 1, 2022.

This bill would extend those deadlines to January 1, 2023, and January 1, 2024, respectively. The bill would repeal these provisions on July 1, 2024.

Existing law requires an insurer to cooperate with the Department of Child Support Services and to identify and report a claimant to that department if a claim seeks an economic benefit for an obligor who owes past-due child support. Existing law defines an economic benefit under a life insurance policy, disability income insurance policy, or annuity to mean a payment totaling at least

$1,000 in which an individual is paid as the payee or copayee for, among other, specified payments, a loan against the cash value or surrender value of an insurance policy or annuity, including loans for premium payments.

This bill would revise that definition by excluding loans for premium payments.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 32 of the Insurance Code is amended to read:

32. (a) A life and accident and health or sickness licensee is a person authorized to act as a life agent on behalf of a life insurer or a disability insurer to transact any of the following:

(1) Life insurance.

(2) Accident and health or sickness insurance.

(3) Life and accident and health or sickness insurance.

(b) Licenses to act as a life agent under this chapter shall be of the types as set forth in Section 1626.

(c) A life agent may be authorized to transact 24-hour care coverage, as defined in Section 1749.02, pursuant to the requirements of subdivision (d) of Section 1749 or subdivision (b) of Section 1749.33.

SEC. 2. Section 769.56 of the Insurance Code is amended to read:

769.56. (a) A material change made by a health insurer, as defined in subdivision (b) of Section 106, to the terms and conditions of a contract between the health insurer and a life and accident and health or sickness agent shall not become effective until the health insurer has delivered to the life and accident and health or sickness agent, at least 45 days prior to the effective date of the change, written or electronic notice indicating the change or changes to the contract. For purposes of this section, a “material change” is a change made to a provision of the contract affecting any of the following:

(1) Commissions, bonuses, and incentives paid to the life and accident and health or sickness agent.

(2) Right of survivorship.

(3) Indemnification of the life and accident and health or sickness agent by the health insurer.

(4) Errors and omissions coverage requirements for the life and accident and health or sickness agent.

(b) Subdivision (a) shall not apply under either of the following circumstances:

(1) The change to the contract is mutually agreed upon by the health insurer and the life and accident and health or sickness agent.

(2) The change to the contract is required by state or federal law.

SEC. 3. Article 6.9 (commencing with Section 799) is added to Chapter 1 of Part 2 of Division 1 of the Insurance Code, to read:

Article 6.9. The Equal Insurance HIV Act

799. (a) The Legislature finds and declares all of the following:

(1) Article 6.9 (commencing with Section 799) of Chapter 1 of Part 2 of Division 1 of the Insurance Code was originally enacted in 1988 and was last amended in 1997. These laws require an update to reflect advancements in testing and medical treatments for individuals living with the human immunodeficiency virus (HIV).

(2) When the HIV/AIDS epidemic began in the United States, HIV was considered a life-threatening condition because relatively little was known at the time about HIV detection, transmission, or treatment. Today, however, just as with other chronic health conditions, HIV can be effectively managed.

(3) According to data collected by the Antiretroviral Therapy Cohort Collaboration from 1996 to 2013, inclusive, modern antiretroviral therapy (ART) is more sophisticated than original treatments, causes fewer adverse effects, and results in a life expectancy similar to people not living with HIV.

(4) The National Institutes of Health notes that ART can suppress an individual's viral load to a point where HIV is undetectable in the blood, and the chance of HIV developing into AIDS is reduced.

(5) Research shows that in recent years, people living with HIV who are receiving treatment have a life expectancy of approximately 70 to 78 years or more, depending on other determinants of health and how early treatment was commenced, compared to a life expectancy of 39 years in 1996. The risk of death due to AIDS-related causes has declined dramatically.

(6) It is now possible for HIV-positive individuals to have an average life expectancy. They should have the same opportunities as other individuals with chronic medical conditions to purchase life insurance and disability income insurance.

(b) It is, therefore, the intent of the Legislature to ensure the equitable health and well-being of all people living in California.

(c) The purposes of this article are to do all of the following:

(1) Establish standards that prevent life or disability income insurers from making or permitting unfair distinctions between individuals of the same class in underwriting life insurance or disability income insurance for individuals living with HIV.

(2) Require the maintenance of strict confidentiality for personal information obtained through testing.

(3) Require informed consent before a life or disability income insurer tests for HIV.

799.01. As used in this article, the following terms have the following meanings:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "Certificate" means a certificate of group life insurance or a certificate of group disability income insurance delivered in this state, regardless of the situs of the group master policy. A certificate of life insurance benefits or disability income insurance benefits issued or delivered in this state by a fraternal benefit society is a "policy" as defined in subdivision (h).

(c) "Disability income insurance" means insurance against loss of occupational earning capacity arising from injury, sickness, or disablement.

(d) "HIV" or "human immunodeficiency virus" means the etiologic virus of AIDS.

(e) "HIV test" means any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV.

(f) "Life or disability income insurer" means an insurer licensed to transact life insurance or disability insurance in this state that is transacting life insurance or disability income insurance in this state, or a fraternal benefit society licensed in this state that is transacting life insurance or disability income insurance in this state.

(g) "Life insurance" means the class of coverage described in Section 101, but, as used in this article, excludes annuities.

(h) "Policy" means an individual life insurance policy or individual disability income insurance policy issued or delivered in this state, or a certificate of life insurance benefits or disability income insurance benefits issued or delivered in this state by a fraternal benefit society.

799.02. (a) A life or disability income insurer shall not decline an application or enrollment request for coverage under a policy or certificate for life insurance or disability income insurance based solely on the results of a positive HIV test, regardless of when or at whose direction the test was performed.

(b) Notwithstanding any other law, this article does not prevent or otherwise restrict a life or disability income insurer from refusing to insure an applicant that is HIV positive, limiting the amount, extent, or kind of coverage for an applicant that is HIV positive, or charging a different rate to an applicant that is HIV positive, if the refusal, limitation, or charge is based on sound actuarial principles and actual or reasonably anticipated experience.

(c) Transferring an applicant from a simplified, expedited, accelerated, or algorithmic underwriting process to a traditional medical underwriting process, based solely on the results of a positive HIV test, does not constitute a denial of the application or a violation of this section.

(d) This section applies to a policy, certificate, application, or enrollment request that meets both of the following requirements:

(1) It is issued, delivered, or received on or after January 1, 2023.

(2) In order to be effective, its issuance, delivery, or granting is contingent upon medical review for other diseases or medical conditions.

799.03. (a) A life or disability income insurer shall not require a test for HIV or for the presence of antibodies to HIV for the purpose of determining insurability other than in accordance with the informed consent, counseling, and privacy protection provisions of this article and Article 6.6 (commencing with Section 791). Notwithstanding any other law, this constitutes the exclusive requirements for counseling, informed consent, and privacy protection for that testing.

(b) A life or disability income insurer that asks an applicant to undergo an HIV test shall obtain the applicant's written informed consent for the test. Written informed consent shall include a description of the test to be performed, including its purpose, potential uses, and limitations, the meaning of its results, procedures for notifying the applicant of the results, and the right to confidential treatment of the results. Before the applicant signs the consent, the insurer shall provide the applicant with both of the following, on paper or electronically, whichever the applicant chooses, but not by telephone:

(1) Material describing HIV, its causes and symptoms, the manner in which it is spread, the test or tests used to detect HIV or the HIV antibody, and what a person can do whose test results are positive or negative.

(2) A list of counseling resources available, where the applicant can obtain assistance in understanding the meaning of the test and its results. The list shall be provided from publicly available information or internet websites, and shall include resources available from the State Department of Public Health and the federal Centers for Disease Control and Prevention.

(c) The life or disability income insurer that asks an applicant to undergo an HIV test shall notify an applicant of a positive test result by notifying the applicant's designated physician. If the applicant tested has not given written consent authorizing a physician to receive the test results, the applicant shall be urged, at the time the applicant is informed of the positive test results, to contact a private physician, the county department of health, the State Department of Public Health, local medical societies, or alternative test sites for appropriate counseling.

799.04. A life or disability income insurer shall not require an applicant to undergo an HIV test unless the cost of the test is borne by the insurer.

799.05. A life or disability income insurer shall not consider the marital status, actual or perceived sexual orientation, gender, gender identity, gender expression, race, color, religion, national origin, ancestry, living arrangements, beneficiary designation, or ZIP Codes or other territorial classification within this state, or any combination thereof, of an applicant for life insurance or disability income insurance in determining whether to require an HIV test of that applicant.

799.06. All underwriting activities undertaken by life or disability income insurers pursuant to this article shall be subject to all applicable provisions of Article 6.6 (commencing with Section 791). An application or enrollment request for life insurance or disability income insurance shall not contain a question pertaining to prior HIV tests unless the question is limited in scope to prior testing for the purpose of obtaining insurance.

799.07. If an applicant has had a positive HIV test, a life or disability income insurer shall not report a code to an insurance support organization as defined in Section 791.02 or another insurer unless a nonspecific test result code is used that does not indicate that the individual was subject to an HIV test.

799.08. A policy or certificate shall not limit benefits otherwise payable if loss is caused or contributed to by HIV or AIDS unless the life or disability income insurer could have declined the application or enrollment request of the insured as provided in Section 799.02.

799.09. A life or disability income insurer shall not require an applicant to take an HIV test if the results of the test would be used exclusively or nonexclusively for the purpose of determining eligibility for hospital, medical, or surgical insurance coverage or eligibility for coverage under a nonprofit hospital service plan or health care service plan.

799.10. (a) This section applies to the disclosure of the results of HIV tests requested by a life or disability income insurer pursuant to this article and, notwithstanding Section 120980 of the Health and Safety Code, Section 120980 of the Health and Safety Code does not apply to the disclosure of the results of HIV tests conducted pursuant to this article.

(b) A person who negligently discloses results of an HIV test to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Section 1603.1, 1603.3, or 121022 of the Health and Safety Code, or in any other

law that expressly provides an exemption to this section, shall be assessed a civil penalty in an amount not to exceed two thousand five hundred dollars ($2,500) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) A person who willfully or maliciously discloses the results of an HIV test to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Section 1603.1, 1603.3, or 121022 of the Health and Safety Code, or in any other law that expressly provides an exemption to this section, shall be assessed a civil penalty in an amount not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) A person who willfully, maliciously, or negligently discloses the results of an HIV test to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in this article or in Section 1603.1, 1603.3, or 121022 of the Health and Safety Code, or in any other law that expressly provides an exemption to this section, that results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor punishable by imprisonment in a county jail for a period not to exceed one year, or by a fine not to exceed twenty-five thousand dollars ($25,000), or by both that fine and imprisonment.

(e) A person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or psychological harm that is a proximate cause of the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) “Written authorization,” as used in this section, applies only to the disclosure of test results by a person responsible for the care and treatment of the person subject to the test. Written authorization is required for each separate disclosure of the test results, and shall include to whom the disclosure would be made.

799.11. This article shall become operative on January 1, 2023.

SEC. 4. Section 799.11 is added to the Insurance Code, to read:

799.11. This article shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 5. Section 1104.9 of the Insurance Code is amended to read:

1104.9. (a) (1) As used in this section, “qualified custodian” means: (A) commercial banks (as defined in Section 105 of the Financial Code), savings and loan associations (as defined in Section 5102 of the Financial Code), and trust companies (other than trust departments of title insurance companies), or any entity approved by the commissioner as a qualified custodian; (B) that is either (i) domiciled and has a principal place of business in this state or (ii) a national banking association with a trust office located in this state; and (C) that either has a net worth of at least one hundred million dollars ($100,000,000) or is able to demonstrate to the satisfaction of the commissioner that it is financially secure. The commissioner may consider, among other factors, evidence of the following in order to determine whether a custodian is financially secure for the purpose of this subdivision: (i) its obligations under an agreement approved by the commissioner pursuant to subdivision (c) are guaranteed by its parent holding company, (ii) its parent holding company has a net worth of at least one hundred million dollars ($100,000,000), or (iii) it is a member of a holding company system with a net worth of at least one hundred million dollars ($100,000,000).

(2) (A) As used in this section, “qualified depository” means an entity that is located in this state or a reciprocal state and is (i) a depository that provides for the long-term immobilization of securities or a clearing corporation that is also a depository, and that in either case has been approved by or registered with the United States Securities and Exchange Commission, (ii) a Federal Reserve bank, or (iii) an entity approved by the commissioner as a qualified depository.

(B) A “qualified depository” may also include an entity that is located outside the United States, if it is a securities depository and clearing agency, incorporated or organized under the laws of a country other than the United States, (i) that operates a transnational system for securities or equivalent book entries (specifically Euroclear and Cedel, or successors to all or substantially all of their operations), or (ii) that operates a central system for securities or equivalent book entries, but solely for securities issued by, or by entities within, the country in which the securities depository and clearing agency is incorporated or organized. The depository shall meet all qualifying requirements imposed by this section upon Euroclear or Cedel.

(3) As used in this section, “qualified subcustodian” means an entity located in this state or a reciprocal state (A) that holds securities of the domestic insurer, and maintains an account through which the securities are held, in this state or a reciprocal state and (B) that has shareholder equity of at least one hundred million dollars ($100,000,000) or is able to demonstrate to the satisfaction of the commissioner that it is financially secure. The qualified subcustodian shall be: (A) a commercial bank, a

savings and loan association, or a trust company (other than trust departments of title insurance companies); (B) a subsidiary of a qualified custodian; or (C) any entity approved by the commissioner as a qualified subcustodian. The commissioner may consider, among other factors, evidence of the following in order to determine whether a subcustodian is financially secure for the purpose of this subdivision: (i) its obligations are guaranteed by its parent company, (ii) its parent holding company has shareholder equity of at least one hundred million dollars ($100,000,000), or (iii) it is a member of a holding company system with shareholder equity of at least one hundred million dollars ($100,000,000). A “qualified subcustodian” may also include an entity that is located outside the United States that is used by the domestic insurer for the purpose of obtaining access to a qualified depository located outside the United States. The qualified foreign subcustodian shall be a banking institution or trust company, incorporated or organized under the laws of a country other than the United States, that is regulated by that country’s government or an agency thereof, and that has shareholders’ equity in excess of two hundred million dollars ($200,000,000), whether in United States dollars or the equivalent of United States dollars, as of the close of its most recently completed fiscal year; or a majority-owned direct or indirect subsidiary of a qualified United States bank or bank holding company, if the subsidiary is incorporated or organized under the laws of a country other than the United States and has shareholders’ equity in excess of one hundred million dollars ($100,000,000), whether in United States dollars or the equivalent of United States dollars, as of the close of its most recently completed fiscal year; or is able to demonstrate to the satisfaction of the commissioner that it is financially secure. The commissioner may consider, among other factors, evidence of the following in order to determine whether a qualified foreign subcustodian is financially secure for purposes of this subdivision: (i) its obligations are guaranteed by its parent company, (ii) its parent holding company has shareholder equity of at least two hundred million dollars ($200,000,000), or (iii) it is a member of a holding company system with shareholder equity of at least two hundred million dollars ($200,000,000).

(4) As used in this section, “subsidiary” means: (A) an entity all of whose voting securities (other than director qualifying shares, if any) are owned, directly or indirectly, by a qualified custodian; or (B) any affiliated entity approved by the commissioner as a subsidiary of a qualified custodian. For the purpose of this section, an affiliated entity means an entity that (A) controls or is controlled, either directly or indirectly or through one or more intermediaries, by a qualified custodian or (B) is under the common control, directly or indirectly, as or with a qualified custodian.

(5) As used in this section, “entity approved by the commissioner as a qualified custodian,” “entity approved by the commissioner as a qualified depository,” “entity approved by the commissioner as a qualified subcustodian,” and “entity approved by the commissioner as a subsidiary of a qualified custodian” mean those entities that meet the conditions or standards established by the commissioner. The commissioner shall charge and collect in advance a one-time fee of two thousand two hundred forty-one dollars ($2,241) to review an application for approval of any entity pursuant to this section.

(6) As used in this section, “reciprocal state” has the same meaning as in subdivision (f) of Section 1064.1.

(7) As used in this section, “moneys” means cash held incidental to securities transactions occurring in the ordinary course of business with respect to securities held pursuant to the custodial agreements under this section.

(8) (A) Except as provided in subparagraph (B), as used in this section, “insurer,” “domestic insurer,” and “domestic admitted insurer” mean any insurer, other than a domestic life insurer that is incorporated or that has its principal place of business in this state. Except as provided in subparagraph (B), no portion of this section applies to domestic life insurers nor shall this section affect the interpretation of any other portion of this code with respect to domestic life insurers nor is it intended to create a precedent for the application of its provisions to those insurers. However, the exclusion of domestic life insurers from this section shall not be construed to diminish the commissioner’s existing authority over those insurers under any other provision of this code.

(B) Domestic life insurers that are wholly owned by any insurer other than a domestic life insurer or are part of an insurance holding company system whose other insurer affiliates are not domestic life insurers may elect to be subject to this section by affirmatively stating that election in the statement otherwise required to be filed by that system pursuant to Section 1215.4.

(b) Notwithstanding Section 1104.1, a domestic admitted insurer may maintain its securities and moneys in a reciprocal state, subject to the requirements of this section, through a custodian account located in California in or with a qualified custodian, and that qualified custodian may maintain those securities or moneys in a qualified depository or qualified subcustodian, either or both of which may be located in a reciprocal state. In addition, a domestic insurer that has foreign investments or any other investments that require delivery outside of the United States upon sale or maturity that qualify under Section 1240, 1241, or 10506, or any other provision of this code, may maintain those securities or moneys in or with a qualified depository located in a jurisdiction outside the United States. However, the aggregate amount of general account investments so deposited shall not exceed the lesser of 5 percent of the total admitted assets of the insurer or 25 percent of the excess of admitted assets over the sum of paid-up capital, liabilities, and surplus required by Section 700.02. However, unless exempted by the commissioner, not more than 50 percent of that amount of assets that an insurer is authorized to invest pursuant to Section 1241 or 1241.1 may be

maintained in any single country in a qualified depository as defined in clause (ii) of paragraph (2) of subdivision (a) and as to life companies not more than 12.5 percent of that amount of assets that an insurer is authorized to invest pursuant to Section 1241 or 1241.1 may be maintained in any single country in a qualified depository as defined in clause (ii) of paragraph (2) of subdivision (a). The percentage or dollar value of admitted assets and paid-up capital and liabilities shall be determined by the insurer's last preceding annual statement of conditions and affairs made as of the preceding December 31 that has been filed with the commissioner pursuant to law. A broker or agent, as defined in the Federal Securities Exchange Act of 1934 (15 U.S.C. Sec. 78c et seq.), may not serve as a qualified custodian, qualified subcustodian, or qualified depository under this section. However, no otherwise qualified custodian or subcustodian shall be disqualified on account of its activities as a broker or dealer, as so defined, when the activities are incidental to its custodial or other business.

(c) Securities shall not be deposited in or with a qualified custodian, qualified depository, or qualified subcustodian except as authorized by an agreement between the insurer and the qualified custodian, if the agreement is satisfactory to and has been approved by the commissioner. The agreement shall require that the securities be held by the qualified custodian for the benefit of the insurer and that the books and records of the qualified custodian shall so designate. The agreement shall further require that beneficial title to the securities remain in the insurer and shall require that the qualified subcustodian and qualified depository be the agents of the qualified custodian. The agreement shall also specifically require that the qualified custodian shall exercise the standard of care of a professional custodian engaged in the banking or trust company industry and having professional expertise in financial and securities processing transactions and custody would observe in these affairs. This section does not affect the burden of proof under applicable law with respect to the assertion of liability in any claim, action, or dispute alleging any breach of, or failure to observe, that standard of care.

(d) An agreement between the qualified custodian and the insurer shall not be approved by the commissioner unless the qualified custodian agrees therein to comply with this section. Except when the agreement is submitted in conjunction with an application for an original certificate of authority or variable life and variable annuity qualification, a fee of seven hundred forty-eight dollars ($748) shall be paid to the commissioner at the time of filing the agreement for approval. However, a fee shall not be required if the form of the agreement has been previously submitted for approval and approved by the commissioner as certified by the insurer and qualified custodian submitting the agreement to the commissioner. The agreement shall be deemed approved unless, within 60 days after receipt by the commissioner of that agreement and any required filing fee, the commissioner has disapproved the agreement in writing citing specific reasons for disapproval.

(e) Notwithstanding the maintenance of securities with an out-of-state qualified depository or qualified subcustodian pursuant to agreement, if the commissioner has reasonable cause to believe that the domestic insurer (1) is conducting its business and affairs in a manner as to threaten to render it insolvent, or (2) is in a hazardous condition or is conducting its business and affairs in a manner that is hazardous to its policyholders, creditors, or the public, or (3) has committed or is committing or has engaged or is engaging in any act that would constitute grounds for rendering it subject to conservation or liquidation proceedings, or if the commissioner determines that irreparable loss and injury to the property and business of the domestic insurer has occurred or may occur unless the commissioner acts immediately, then the commissioner may, without hearing, order the insurer and the qualified custodian promptly to effect the transfer of the securities back to a qualified custodian, qualified subcustodian, or qualified depository located in this state from any qualified depository or qualified subcustodian located outside of this state (the transfer order). Upon receipt of the transfer order, the qualified custodian shall promptly effect the return of the securities. Notwithstanding the pendency of any hearing or action provided for in subdivision (f), the transfer order shall be complied with by those persons subject to that order. Any challenge to the validity of the transfer order shall be made in accordance with subdivision (f). It is the responsibility of both the insurer and the qualified custodian to oversee that compliance with the transfer order is completed as expeditiously as possible. Upon receipt of a transfer order, there shall be no trading of the securities without specific instructions from the commissioner until the securities are received in this state, except to the extent trading transactions are in process on the day the transfer order is received by the insurer and the failure to complete the trade may result in loss to the insurer's account. Issuance of a transfer order does not affect the qualified custodian's liabilities with regard to the securities that are the subject of the order.

(f) At the same time the transfer order is served, the commissioner shall issue and also serve upon the insurer a notice of hearing to be held at a time and place fixed therein which shall not be less than 20 nor more than 45 days after the service thereof. Upon request of the insurer and agreement of the department, the hearing may be held within a shorter time but in no event less than 10 days after the service of the notice of hearing. The transfer order and notice of hearing may be served by certified mail, express mail, messenger, telegram, or any other means calculated to give prompt actual notice to (1) the California office of the insurer designated in the agreement, its home office as shown on its most recently filed annual or quarterly statement, or its California agent for service of process; and (2) the California office of the qualified custodian designated in the agreement. If, as a result of the hearing, any of the statements as to conduct, conditions, or grounds for the transfer order are found to be true, or if other conditions or grounds are discovered or become known at the hearing and are found to be true, the commissioner shall affirm the transfer order and may make additional order or orders, pertaining to the transfer order, as may be reasonably necessary.

The insurer subject to the transfer order is entitled to judicial review in the state of the commissioner's order issued as a result of the hearing.

Alternatively, at any time prior to the commencement of the hearing on the transfer order, the insurer may waive the hearing and have judicial review in this state of the transfer order by petition for writ of mandate and declaratory relief without first exhausting administrative remedies or procedures. In that event the insurer is not entitled to any extraordinary remedies prior to trial.

No person other than the insurer has standing at the hearing by the commissioner or for any judicial review of the transfer order.

SEC. 6. Section 1592 of the Insurance Code is amended to read:

1592. The statement required by Section 1591 shall be verified in the manner prescribed in Sections 903 and 903.5 and the certificate of each trustee in the United States holding trusteed assets of the alien insurer shall be filed, showing the description and amount of the trusteed assets and the purpose for which they are held. The statement shall be filed in quadruplicate by the alien insurer with the office of the department in Los Angeles. Upon receipt of the four copies, the commissioner shall ensure that one copy is maintained at the department's office in Los Angeles, one copy at the department's office in the San Francisco Bay area, and one copy at the department's office in Sacramento.

The commissioner may at other times require an admitted alien insurer to file similar statements, showing the information specified in Section 1591 with respect to another date prescribed by the commissioner.

SEC. 7. Section 1622 of the Insurance Code is amended to read:

1622. (a) A life and accident and health or sickness licensee is a person authorized to act on behalf of a life insurer or a disability insurer to transact any of the following:

(1) Life insurance.

(2) Accident and health insurance.

(3) Life and accident and health or sickness insurance.

(b) Licenses to act as a life and accident and health or sickness agent under this chapter shall be of the types set forth in Section 1626.

SEC. 8. Section 1626 of the Insurance Code is amended to read:

1626. (a) A life and accident and health or sickness licensee is a person authorized to act as a life and accident and health or sickness agent. Licenses to act as a life and accident and health or sickness agent under this chapter shall be of the following types:

(1) Life, which license shall entitle the licensee to transact insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income.

(2) Accident and health or sickness, which license shall entitle the licensee to transact insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income.

(b) An accident and health or sickness agent licensee also is authorized to transact 24-hour care coverage, as defined in Section 1749.02, pursuant to subdivision (d) of Section 1749 or subdivision (d) of Section 1749.33.

SEC. 9. Section 1637 of the Insurance Code is amended to read:

1637. An organization may hold any license or licenses necessary to act in the following capacities under this chapter and no others:

(a) A license to act as a life agent.

(b) A license to act as an accident and health or sickness agent.

(c) A license to act as a property broker-agent.

(d) A license to act as a casualty broker-agent.

(e) A license to act as a cargo shipper's agent.

(f) A license to act as a personal lines licensee.

(g) A license to act as a credit insurance agent.

(h) A license to act as a car rental agent.

(i) A nonresident license to act as a limited lines licensee pursuant to subdivision (i) of Section 1639.

(j) A license to act as a self-service storage agent.

(k) A license to act as a limited lines automobile insurance agent.

SEC. 10. Section 1639 of the Insurance Code is amended to read:

1639. The following types of licenses under this chapter may be issued to nonresidents:

(a) A property broker-agent or a casualty broker-agent if the nonresident is duly licensed to transact those lines of insurance described in Section 1625, under the laws of the state, territory of the United States, or province of Canada where the resident license is maintained.

(b) A personal lines broker-agent if the nonresident is duly licensed to transact those lines of insurance described in Section 1625.5, under the laws of the state, territory of the United States, or province of Canada where the resident license is maintained.

(c) A life agent or an accident and health or sickness agent if the nonresident possesses a resident license in another state, territory of the United States, or province of Canada to transact life insurance or disability insurance.

(d) A nonresident may be granted authority to transact variable life and variable annuity contracts if the person has been granted that authority by the state where the resident license is maintained. To qualify for this authority, the nonresident is required to also be licensed as a life agent in the state where the resident license is maintained.

(e) A surplus line broker and a special lines surplus broker if the nonresident holds that type of license in the state or territory of the United States where the resident license is maintained.

(f) A credit insurance agent if the nonresident holds that type of license in the state, territory of the United States, or province of Canada where the resident license is maintained.

(g) A car rental agent if the nonresident holds that type of license in the state, territory of the United States, or province of Canada where the resident license is maintained.

(h) A cargo shipper's agent if the nonresident holds that type of license in the state, territory of the United States, or province of Canada where the resident license is maintained.

(i) A limited lines license if the nonresident holds that type of license in the state, territory of the United States, or province of Canada where the resident license is maintained. As used in this section, "limited lines license" means any authority granted by the resident state that restricts the authority of the license to less than the total authority granted by any of the types of licenses identified in this section.

(j) A self-service storage agent if the nonresident holds that type of license in the state, territory of the United States, or province of Canada where the resident license is maintained.

SEC. 11. Section 1668 of the Insurance Code is amended to read:

1668. The commissioner may deny an application for a license issued pursuant to this chapter if any of the following are true:

(a) The applicant is not properly qualified to perform the duties of a person holding the license for which the applicant applied.

(b) The granting of the license will be against public interest.

(c) The applicant does not intend actively and in good faith to carry on as a business with the general public the transactions that would be permitted by the issuance of the license for which the applicant applied.

(d) The applicant is not of good business reputation.

(e) The applicant is lacking in integrity.

(f) The applicant has been refused a professional, occupational, or vocational license or had a professional, occupational, or vocational license suspended or revoked by a licensing authority for reasons that should preclude the granting of the license for

which the applicant applied.

(g) The applicant seeks the license for the purpose of avoiding or preventing the operation or enforcement of the insurance laws of this state.

(h) The applicant has knowingly or willfully made a misstatement in an application to the commissioner for a license, or in a document filed in support of that application, or has made a false statement in testimony given under oath before the commissioner or another person acting in the commissioner's stead.

(i) The applicant has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner.

(j) The applicant has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with the applicant to the danger of loss.

(k) The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract.

(l) The applicant has failed to perform a duty expressly enjoined upon them by this code or has committed an act expressly forbidden by this code.

(m) The applicant has been convicted of any of the following:

(1) A felony.

(2) A misdemeanor specified by this code or other laws regulating insurance.

(3) A public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in acceptance, custody, or payment of money or property.

(n) The applicant has aided or abetted a person in an act or omission that would constitute grounds for the suspension, revocation, or refusal of a license or certificate issued under this code to the person aided or abetted.

(o) The applicant has permitted a person in the applicant's employ to violate this code.

(p) The applicant has violated a law relating to conduct of business that could lawfully be done only under authority conferred by that license.

(q) The applicant has submitted to the commissioner a false or fraudulent certificate pursuant to subdivision (d) of Section 1749.5.

A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

SEC. 12. Section 1668.5 of the Insurance Code is amended to read:

1668.5. (a) The commissioner may deny an application for a license issued pursuant to this chapter, and may suspend or revoke the permanent license of an organization licensed pursuant to this chapter as authorized by Section 1738, if the applicant or holder of the permanent license is an organization and a controlling person of the organization is any of the following:

(1) The controlling person has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner.

(2) The controlling person has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with the controlling person to the danger of loss.

(3) The controlling person has knowingly misrepresented the terms or effect of an insurance policy or contract.

(4) The controlling person has failed to perform a duty expressly enjoined upon them by a provision of this code or has committed an act expressly forbidden by a provision of this code.

(5) The controlling person has been convicted of any of the following:

(A) A felony.

(B) A misdemeanor specified by this code or other laws regulating insurance.

(C) A public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in acceptance, custody, or payment of money or property.

A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(6) The controlling person has aided or abetted a person in an act or omission that would constitute grounds for the suspension, revocation, or refusal of a license or certificate issued under this code to the person aided or abetted.

(7) The controlling person has permitted a person in the controlling person's employ to violate this code.

(8) The controlling person has violated a law relating to conduct of business that could lawfully be done only under authority conferred by a license under this chapter.

(b) As used in this section, "controlling person" means a person who possesses, directly or indirectly, the power to direct or cause the direction of the management and policies of the organization, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, including, but not limited to, power that is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, more than 10 percent of the voting securities of the organization. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may, after furnishing all persons in interest notice and opportunity to be heard, determine that control exists in fact, notwithstanding the absence of a presumption to that effect.

SEC. 13. Section 1669 of the Insurance Code is amended to read:

1669. The commissioner may, without hearing, deny an application if the applicant has done one or more of the following:

(a) (1) Been convicted of a felony.

(2) Been convicted of a misdemeanor specified by this code or by other laws regulating insurance.

(3) A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of this subdivision.

(b) Had a previous application for a professional, occupational, or vocational license denied for cause by a licensing authority, within five years of the date of the filing of the application to be acted upon, on grounds that should preclude the granting of a license by the commissioner under this chapter.

(c) Had a previously issued professional, occupational, or vocational license suspended or revoked for cause by a licensing authority, within five years of the date of the filing of the application to be acted upon, on grounds that should preclude the granting of a license by the commissioner under this chapter.

If the commissioner issues an order based on a plea that does not at any time result in a judgment of conviction, the commissioner shall vacate the order upon petition by the applicant.

SEC. 14. Section 1675 of the Insurance Code is amended to read:

1675. The following applicants who have theretofore been licensed under this code are exempt from the requirements of this article:

(a) An applicant for a license to act as a property broker-agent or a casualty broker-agent who has been licensed as a property broker-agent, casualty broker-agent, or surplus line broker during any part of the license year in which the application is filed or the immediately preceding license year.

(b) An applicant for a license to act as a life agent who has been licensed as a life agent during any part of the license year in which the application is filed or the immediately preceding license year.

(c) An applicant for a license to act as an accident and health or sickness agent who has been licensed as an accident and health or sickness agent during any part of the license year in which the application is filed or the immediately preceding license year.

(d) An applicant for a license to act as a travel insurance agent.

(e) An applicant specifically exempted from the particular qualifying examination requirement by other provisions of this code.

(f) (1) A nonresident licensee who applies for a property broker-agent, casualty broker-agent, personal lines broker-agent, or life agent resident license in this state, and who is currently licensed for the same lines of authority in the state of the current resident license, shall not be required to complete an examination. The application shall be received within 90 days of the cancellation of the applicant's resident license and the producer database records, maintained by the National Association of Insurance Commissioners, shall indicate that the producer is licensed in good standing for the line of authority requested.

(2) Upon issuance of the California resident license, the examination waiver also applies to adding additional lines of authority to the California resident license provided that the individual was previously licensed in good standing for the requested additional lines of authority, and the application is received within 12 months of the cancellation of the applicant's previous resident license in another state.

SEC. 15. Section 1676 of the Insurance Code is amended to read:

1676. (a) Except as set forth in Sections 1675 and 1679, the commissioner shall not issue a permanent license pursuant to this chapter to an applicant therefor unless the applicant has within the 12-month period next preceding the date of issue of the license taken and passed the qualifying examination for that license. This section shall not apply to a person licensed as a property broker-agent or as a casualty broker-agent who applies for a license as a personal lines broker-agent.

(b) An application for both the life and accident and health or sickness license types shall meet the requirement in subdivision (a) by passing one examination covering subjects pertaining to both license types. These applicants shall pay the fee for a life agent, as specified in paragraph (4) of subdivision (a) of Section 1751.

(c) An applicant for a life license pursuant to Section 1626 or a life license limited to the payment of funeral and burial expenses who is limited by the terms of a written agreement with an insurer that has filed on that life agent's behalf a notice of appointment with the commissioner to transact only specific life insurance policies or annuities having an initial face amount of twenty thousand dollars ($20,000) or less that are designated by the purchaser for the payment of funeral and burial expenses, shall not be required to take the full life agent examination to obtain a license. The applicant shall be required to take an examination developed to test their knowledge of topics relevant to the type of policies that they are restricted to sell.

SEC. 16. Section 1677 of the Insurance Code, as amended by Section 2 of Chapter 560 of the Statutes of 2016, is amended to read:

1677. (a) Each qualifying examination for a license pursuant to this chapter shall be in writing and shall be of sufficient scope to satisfy the commissioner that the applicant has sufficient knowledge of, and is reasonably familiar with, the insurance laws of this state and with the provisions, terms, and conditions of the insurance that may be transacted pursuant to the license sought, and that the applicant has a general and fair understanding of the obligations and duties of the holder of that license.

(b) On and after January 1, 2018, the examination for a license as a life agent and accident and health or sickness agent shall be provided in English and Spanish.

(c) The commissioner shall evaluate the qualifying examination taken in Spanish and submit a report of the results to the Legislature no later than March 1, 2023. The report shall be submitted in compliance with Section 9795 of the Government Code and shall include, but not be limited to, all of the following:

(1) The number of people taking the examination.

(2) The pass rate, including a comparison between the comparable licensing examination taken in English.

(3) The number of licenseholders that sat for the examination provided in Spanish and passed the examination that remain licensed.

(4) The number of consumer complaints received and enforcement actions taken with regard to the licenseholders who passed the examination in Spanish.

(d) This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2024, deletes or extends that date.

SEC. 17. Section 1682 of the Insurance Code is amended to read:

1682. (a) (1) A person shall not be admitted to more than 10 license qualification examinations of the same type in any 12-month period.

(2) If a person is admitted to 10 license qualification examinations of the same type in any 12-month period, that person shall not be admitted to another examination of that type until a 12-month period has passed since that 10th examination.

(3) For purposes of this subdivision, the 12-month period ends at the end of the day immediately preceding the one-year anniversary date of the examination administration in question.

(b) For purposes of subdivision (a), the covered types of license qualification examinations are as follows:

(1) The accident and health or sickness agent type examinations, which include both of the following:

(A) The accident and health or sickness agent examination.

(B) The life and accident and health or sickness agent combination examination.

(2) The bail agent examination.

(3) The casualty broker-agent type examinations, which include all of the following:

(A) The casualty broker-agent examination.

(B) The commercial insurance examination.

(C) The property and casualty broker-agent combination examination.

(4) The commercial insurance type examinations, which include all of the following:

(A) The commercial insurance examination.

(B) The casualty broker-agent examination.

(C) The property and casualty broker-agent combination examination.

(D) The property broker-agent examination.

(5) The insurance adjuster examination.

(6) The life and disability analyst examination.

(7) The life limited to the payment of funeral and burial expense type examinations, which include all of the following:

(A) The life limited to the payment of funeral and burial expense examination.

(B) The life and accident and health or sickness agent combination examination.

(C) The life agent examination.

(8) The life and accident and health or sickness agent combination type examinations, which include all of the following:

(A) The life and accident and health or sickness agent combination examination.

(B) The accident and health or sickness agent examination.

(C) The life limited to the payment of funeral and burial expense examination.

(D) The life agent examination.

(9) The life agent type examinations, which include all of the following:

(A) The life agent examination.

(B) The life and accident and health or sickness agent combination examination.

(C) The life limited to the payment of funeral and burial expense examination.

(10) The limited lines automobile type examinations, which include all of the following:

(A) The limited lines automobile examination.

(B) The personal lines broker-agent examination.

(C) The property and casualty broker-agent combination examination.

(D) The property broker-agent examination.

(11) The personal lines broker-agent type examinations, which include all of the following:

(A) The personal lines broker-agent examination.

(B) The limited lines automobile examination.

(C) The property and casualty broker-agent combination examination.

(D) The property broker-agent examination.

(12) The property broker-agent type examinations, which include all of the following:

(A) The property broker-agent examination.

(B) The commercial insurance examination.

(C) The limited lines automobile examination.

(D) The personal lines broker-agent examination.

(E) The property and casualty broker-agent combination examination.

(13) The property and casualty broker-agent combination type examinations, which include all of the following:

(A) The property and casualty broker-agent combination examination.

(B) The casualty broker-agent examination.

(C) The commercial insurance examination.

(D) The limited lines automobile examination.

(E) The personal lines broker-agent examination.

(F) The property broker-agent examination.

(14) The public insurance adjuster examination.

(c) Notwithstanding subdivision (a), a person who has passed any of the following license qualification examinations shall not be admitted to a subsequent administration of that examination, unless that person is required by the commissioner or applicable law to retake the examination.

(1) The accident and health or sickness agent examination.

(2) The bail agent examination.

(3) The casualty broker-agent examination.

(4) The commercial insurance examination.

(5) The insurance adjuster examination.

(6) The life and disability analyst examination.

(7) The life limited to the payment of funeral and burial expense examination.

(8) The life and accident and health or sickness agent combination examination.

(9) The life agent examination.

(10) The limited lines automobile examination.

(11) The personal lines broker-agent examination.

(12) The property broker-agent examination.

(13) The property and casualty broker-agent combination examination.

(14) The public insurance adjuster examination.

(d) Except as provided in this article, there is not a limitation on the frequency with which a person may take license qualification examinations.

SEC. 18. Section 1707.7 of the Insurance Code is amended to read:

1707.7. As part of the report required under Section 12922, the commissioner shall provide the following information for the previous calendar year ending December 31 for five years after the operative date of this section:

(a) The total number of applications filed for a property and casualty broker-agent license, a property broker-agent license, a casualty broker-agent license, a personal lines broker-agent license, a limited lines auto-only agent license, a life agent license, and an accident and health or sickness agent license.

(b) The total number of licensees issued a property and casualty license, a property broker-agent license, a casualty broker-agent license, a personal lines license, a limited lines automobile license, a life license, and an accident and health or sickness license.

(c) The total number of licensees with both a life agent license and an accident and health or sickness agent license.

(d) The total justified complaints against the licensees enumerated in subdivision (b) annually for five years.

(e) At the end of five years following the issuance of auto-only agent, life agent, and accident and health or sickness agent licenses, a cumulative summary of the data required by this section compared to the licenses issued for property and casualty broker-agent, property broker-agent, casualty broker-agent, personal lines broker-agent, and life agent for the year immediately preceding the creation of this section.

SEC. 19. Section 1738.5 of the Insurance Code is amended to read:

1738.5. Upon the request of the department, a proceeding held pursuant to Section 1668, 1668.5, 1738, 1739, or 12921.8 that involves allegations of misconduct perpetrated against a person age 65 or over shall be held within 90 days after receipt by the department of the notice of defense, unless a continuance of the hearing is granted by the department or the administrative law judge. If the Office of Administrative Hearings cannot accommodate a hearing within 90 days, the hearing shall be set on the earliest available date and the delay shall not prejudice either party. When the matter has been set for hearing, only the administrative law judge may grant a continuance of the hearing. The administrative law judge may, but need not, grant a continuance of the hearing, only upon finding the existence of one or more of the following:

(a) The death or incapacitating illness of a party, a representative or attorney of a party, a witness to an essential fact, or of the parent, child, or member of the household of any of these persons, when it is not feasible to substitute another representative, attorney, or witness because of the proximity of the hearing date.

(b) Lack of notice of hearing as provided in Section 11509 of the Government Code.

(c) A material change in the status of the case where a change in the parties or pleadings requires postponement, or an executed settlement or stipulated findings of fact obviate the need for hearing. A partial amendment of the pleadings shall not be good cause for continuance to the extent that the unamended portion of the pleadings is ready to be heard.

(d) A stipulation for continuance signed by all parties, or their authorized representatives, that is communicated with the request for continuance to the administrative law judge no later than 25 business days before the hearing.

(e) The substitution of the representative or attorney of a party upon showing that the substitution is required.

(f) The unavailability of a party, representative, or attorney of a party, or witness to an essential fact, due to a conflicting and required appearance in a judicial matter if, when the hearing date was set, the person did not know and could neither anticipate nor at any time avoid the conflict, and the conflict, with the request for continuance, is immediately communicated to the administrative law judge.

(g) The unavailability of a party, a representative or attorney of a party, or a material witness due to an unavoidable emergency.

(h) Failure by a party to comply with a timely discovery request if the continuance request is made by the party who requested the discovery.

SEC. 20. Section 1749 of the Insurance Code is amended to read:

1749. The department shall require all new applicants for license as a property broker-agent, casualty broker-agent, limited lines automobile insurance agent, personal lines broker-agent, life agent, or accident and health or sickness agent to meet prelicensing education standards as follows:

(a) Require a minimum of 20 hours of prelicensing study as a prerequisite to qualification for a property broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(b) Require a minimum of 20 hours of prelicensing study as a prerequisite to qualification for a casualty broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(c) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a personal lines broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(d) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a life agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(e) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a limited lines automobile insurance agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements under this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(f) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for an accident and health or sickness insurance agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements under this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department. This curriculum shall also include instruction in workers' compensation and general principles of employers' liability.

(g) In addition to the 20 hours of prelicensing education required to qualify for a license as a property broker-agent, casualty broker-agent, personal lines broker-agent, a life agent, or an accident and health or sickness agent, or the 20 hours of prelicensing education required to qualify for a license as a limited lines automobile insurance agent, the department shall require 12 hours of study on ethics and this code. Where an applicant seeks a license for more than one of the following license types: a property broker-agent license, a casualty broker-agent license, a personal lines broker-agent license, a life license, or an accident and health or sickness license, the applicant shall only be required to complete one 12-hour course on ethics and this code. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval.

(h) An applicant for a life agent license, an accident and health or sickness license, a personal lines broker-agent license, or a limited lines automobile insurance agent license, who is currently licensed as a nonresident in this state shall be required to complete only the course of study on ethics and this code, as required by this section. Additionally, any applicant for that license holding one or more of the designations specified in subdivisions (a) to (p), inclusive, of Section 1749.4 shall be exempted from any requirement for courses in general insurance that would otherwise be a condition of issuance of the license.

(i) An applicant for a property broker-agent or casualty broker-agent license who is currently licensed as a nonresident in this state shall be required to complete only the course of study on ethics and this code, as required by subdivision (g). Additionally, any applicant for a license holding one or more of the designations specified in subdivisions (a) to (p), inclusive, of Section 1749.4, shall be exempted from any requirement for courses in general insurance that would otherwise be a condition of issuance of a license.

(j) An applicant for a property broker-agent or casualty broker-agent license or both who is licensed as a personal lines agent shall complete a minimum of 20 hours of prelicensing study as a prerequisite for each of these licenses. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. The applicant shall not be required to repeat any prelicensing requirements completed as a prerequisite to being licensed as a personal lines agent.

(k) Review and approval of prelicensing courses not conducted in a classroom, as referenced in subdivisions (a) to (j), inclusive, shall include an evaluation of the safeguards in place to ensure that the student completing the course is the person enrolled in the course, methods used to monitor the student's attendance are adequate, methods for the student to interact with the entity providing the training exist, and methods used to record the times spent completing the course are adequate.

(l) Prelicensing certificates of completion expire three years from the completion date of the course, whether or not a license is issued.

SEC. 21. Section 1749.3 of the Insurance Code is amended to read:

1749.3. An individual licensed as a life agent or an accident and health or sickness agent and also licensed as a property or casualty broker-agent, or an individual only licensed as a property or casualty broker-agent, shall complete those courses, programs of instruction, or seminars approved by the commissioner for the type of license held. Completion of specified product training required in subdivision (d) of Section 1749.33, subdivision (b) of Section 1749.8, and paragraph (4) of subdivision (a) of Section 10234.93 may result in the completion of more than the minimum of required continuing education hours. The minimum number of hours required is as follows:

(a) A licensee, as specified in this section, shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(b) An individual licensed as a property broker-agent or casualty broker-agent and as a life agent or an accident and health or sickness agent shall satisfy the requirements of this section by demonstrating completion of the courses, programs of instruction, or seminars approved by the commissioner for any of the license types listed in this section.

(c) A licensee is not required to comply with the requirements of this article if the licensee submits proof satisfactory to the commissioner that the licensee has been a licensee in good standing for 30 continuous years in this state and is 70 years of age or older. This exemption does not apply to those individuals licensed for the first time on or after January 1, 2010.

SEC. 22. Section 1749.31 of the Insurance Code is amended to read:

1749.31. (a) An individual licensed as a personal lines broker-agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The personal lines broker-agent shall complete 24 hours, of which three hours shall be in ethics, during each two-year license term as defined in subdivision (d) of Section 1625.5.

(b) An individual licensed as a personal lines broker-agent and as a life agent or accident and health or sickness agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 23. Section 1749.32 of the Insurance Code is amended to read:

1749.32. (a) An individual licensed as a limited lines automobile insurance agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The minimum number of hours required is 20 hours, of which three hours shall be in ethics, per license term prior to the renewal of the license.

(b) An individual licensed as a limited automobile insurance agent and as a life agent or accident and health or sickness agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 24. Section 1749.33 of the Insurance Code is amended to read:

1749.33. (a) A life agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(b) An accident and health or sickness agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(c) An agent licensed as both a life agent and as an accident and health or sickness agent shall satisfactorily complete a total of 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. These hours of instruction may be completed at any time prior to renewal of the license.

(d) Any accident and health or sickness agent who wishes to sell 24-hour care coverage, as defined in Section 1749.02, shall complete a course, program of instruction, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability, which shall be completed by examination approved by the commissioner as part of the continuing education course, program of instruction, or seminar prior to selling this coverage. The required number of instruction hours shall be equal to but no greater than that required by the curriculum board for the prelicensing requirements of a property broker-agent or a casualty broker-agent on these subjects. For resident licensees, this requirement shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section. This section does not authorize an accident and health or sickness agent to satisfy the obligations set forth in this section by other than a proctored examination administered or approved by the department.

SEC. 25. Section 1749.4 of the Insurance Code is amended to read:

1749.4. The courses or programs of instruction successfully completed that shall be deemed to meet the standards for continuing educational requirements, and the number of classroom hours for which they are equivalent, are as follows:

(a) Any part of the Life Underwriter Training Council Fellow (LUTCF) program totaling 30 hours for the life license and the accident and health or sickness license.

(b) Any part of the Chartered Life Underwriter (CLU) curriculum totaling 30 hours for the life license and the accident and health or sickness license.

(c) Any part of the Accredited Advisor in Insurance (AAI) program totaling 25 hours for the property broker-agent license or the casualty broker-agent license.

(d) Any part of the Chartered Property Casualty Underwriter (CPCU) program totaling 30 hours for the property broker-agent license or the casualty broker-agent license.

(e) Any part of the Certified Insurance Counselor (CIC) program totaling 25 hours for the life or accident and health or sickness agent license and the property broker-agent license or the casualty broker-agent license.

(f) Any part of the Certified Employee Benefit Specialists (CEBS) program totaling 25 hours for the life license and the accident and health or sickness license.

(g) Any part of the Chartered Financial Consultant (ChFC) program totaling 30 hours for the life license.

(h) Any part of the Certified Financial Planner (CFP) program totaling 30 hours for the life license.

(i) Any part of the Fellow, Life Management Institute (FLMI) program totaling 30 hours for the life license and the accident and health or sickness license.

(j) Any part of the Health Insurance Associate (HIA) program totaling 25 hours for the accident and health or sickness license.

(k) Any part of the Registered Employee Benefits Consultant (REBC) program totaling 30 hours for the accident and health or sickness license.

(l) Any part of the Registered Health Underwriter (RHU) program totaling 30 hours for the accident and health or sickness license.

(m) Any part of the Associate in Risk Management (ARM) program totaling 30 hours for the property broker-agent license or the casualty broker-agent license.

(n) An insurance-related course approved by the curriculum board and the commissioner taught by an accredited college or university per credit hour granted totaling 15 hours.

(o) A course or program of instruction or seminar developed or sponsored by an authorized insurer, recognized agents' association, or insurance trade association, or any independent program of instruction shall, if approved by the curriculum board and the commissioner, qualify for the equivalency of the number of classroom hours assigned thereto by the curriculum board and the commissioner.

(p) A correspondence course approved by the curriculum board and the commissioner shall qualify for the equivalency of the number of classroom hours assigned thereto by the commissioner.

SEC. 26. Section 1750 of the Insurance Code is amended to read:

1750. The commissioner shall require, in advance, as a fee for filing application for the hereinafter designated licenses, renewals thereof, or changes in outstanding licenses, an amount calculated as set forth herein. The fee is determined by multiplying the number of license years in the period of the license applied for or the remaining period of an existing license counting any initial fractional license year of that period as one year for that purpose, as follows:

(a) Casualty broker-agent, eighty-five dollars ($85).

(b) Property broker-agent, eighty-five dollars ($85).

(c) Property and casualty broker-agent, when applied for on a single application, eighty-five dollars ($85).

(d) Personal lines broker-agent, resident, eighty-five dollars ($85).

(e) Life agent, resident, eighty-five dollars ($85).

(f) Life agent, nonresident, eighty-five dollars ($85).

(g) Surplus line broker who is an individual transacting only on behalf of a surplus line broker organization, two hundred fifty dollars ($250).

(h) Surplus line broker not described in subdivision (g), five hundred dollars ($500).

(i) Variable life and variable annuity authority, nonresident, when not also applying for a nonresident life agent license, eighty-five dollars ($85).

SEC. 27. Section 1754 of the Insurance Code is amended to read:

1754. Transaction of travel insurance under the license of an organization holding a limited lines travel insurance agent license shall be subject to the following conditions:

(a) A limited lines travel insurance agent may authorize a travel retailer to transact travel insurance on behalf of and under its authority under the following conditions:

(1) The limited lines travel insurance agent is clearly identified on marketing materials and fulfillment packages distributed by the travel retailers to customers. The marketing materials and fulfillment packages shall include the agent's name, business address, email address, telephone number, license number, and the availability of the department's toll-free consumer hotline.

(2) The limited lines travel insurance agent, at the time of licensure and thereafter, maintains a register noting each travel retailer that transacts travel insurance on the licensee's behalf. The register shall be maintained and updated annually by the licensee in a form prescribed by, or format acceptable to, the commissioner and shall include the name and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, and the travel retailer's federal employer identification number (FEIN). The licensee shall also certify that the registered travel retailer complies with Section 1033 of Title 18 of the United States Code. The licensee shall submit the register for review and inspection upon request by the department.

(3) The limited lines travel insurance agent has designated one of its employees to be responsible for its compliance with the insurance laws, rules, and regulations of the state. The limited lines travel insurance agent and its designated responsible employees shall hold property, casualty, life, and accident and health or sickness agent licenses, to the extent required by this chapter, based upon the types of insurance transacted by the licensee.

(4) The employee designated by the limited lines travel insurance agent, pursuant to paragraph (3), and any of the organization's partners, members, controlling persons, officers, directors, and managers comply with the background check requirements as required by the commissioner.

(5) The limited lines travel insurance agent has paid all applicable licensing fees required under California law.

(6) The limited lines travel insurance agent uses all reasonable means at its disposal to ensure compliance by the travel retailer and the travel retailer's employees with their obligations under this article. This includes requiring each employee of the travel retailer whose duties include transacting travel insurance to receive training. The training shall be provided whenever there is a material change that requires a modification to the training materials, but in no event less frequently than every three years. Training materials used by or on behalf of the limited lines travel insurance agent to train the employees of a travel retailer shall be submitted to the department at the time the travel insurance agent applies for a license under this article, and whenever modified thereafter. The training materials, at a minimum, should contain instruction on the types of insurance offered, ethical sales practices, and disclosures to prospective insurance customers. Any changes to previously submitted training materials shall be submitted to the department with the changes highlighted 30 days prior to their use by the limited lines travel insurance agent. Training materials and changes to those materials submitted to the department pursuant to this subdivision shall be deemed approved for use by the limited lines travel insurance agent unless it is notified by the department to the contrary. Failure by a limited lines travel insurance agent to submit training materials or changes for departmental review or use of unapproved or disapproved training materials shall constitute grounds for denial of an application for a license, nonrenewal of a license, or suspension of a license, or other action as deemed appropriate by the commissioner.

(7) The limited lines travel insurance agent or the travel retailer provides disclosure to the consumer, in either the marketing materials or fulfillment packages, that is substantively similar to the following:

This plan provides insurance coverage that only applies during the covered trip. You may have coverage from other sources that provides you with similar benefits but may be subject to different restrictions depending upon your other coverages. You may wish to compare the terms of this policy with your existing life, health, home, and automobile insurance policies. If you have any questions about your current coverage, call your insurer or insurance agent or broker.

(8) The limited lines travel insurance agent or the travel retailer makes all of the following disclosures to the prospective insured, which shall be acknowledged in writing by the purchaser or displayed by clear and conspicuous signs that are posted at every location where contracts are executed, including, but not limited to, the counter where the purchaser signs the service agreement, or provided in writing to the purchaser:

(A) That purchasing travel insurance is not required in order to purchase any other product or service offered by the travel retailer.

(B) If not individually licensed, that the travel retailer's employee is not qualified or authorized to:

(i) Answer technical questions about the benefits, exclusions, and conditions of any of the insurance offered by the travel retailer.

(ii) Evaluate the adequacy of the prospective insured's existing insurance coverage.

(b) A travel retailer that meets the requirements set forth in this section and whose activities are limited to offering and selling travel insurance on behalf of a licensed limited lines travel insurance agent is authorized to receive compensation.

(c) (1) If the commissioner determines that a travel retailer, or a travel retailer's employee, has violated any provision of this article or any other provision of this code, the commissioner may:

(A) Direct the limited lines travel insurance agent to implement a corrective action plan with the travel retailer.

(B) Direct the limited lines travel insurance agent to revoke the authorization of the travel retailer to transact travel insurance on its behalf and under its license and to remove the travel retailer's name from its register.

(2) If the commissioner determines that a travel retailer, or a travel retailer's employee, has violated any provision in this article or any other provision of this code, the commissioner, after notice and hearing, may:

(A) Suspend or revoke the license of the limited lines travel insurance agent as authorized under this code.

(B) Impose a monetary fine on the limited lines travel insurance agent.

(3) A limited lines travel insurance agent who aids and abets a travel retailer in the transaction of travel insurance, as defined in this code, or aids and abets a travel retailer in any activity concerning travel insurance after being directed to revoke the travel retailer's authorization, in addition to any other action authorized under this code, shall be subject to a monetary penalty pursuant to paragraph (3) of subdivision (a) of Section 12921.8.

(d) The conduct of employees of the travel retailer who have been designated to transact travel insurance on behalf of the licensed limited lines travel insurance agent shall be deemed the conduct of the licensed limited lines travel insurance agent for purposes of this article.

SEC. 28. Section 1758.1 of the Insurance Code is amended to read:

1758.1. (a) For the purpose of making provision for the issuance of policies or contracts authorized by Article 5 (commencing with Section 10506) of Chapter 5 of Part 2 of Division 2, the commissioner may grant authority to transact variable life and variable annuity to a person or a natural person named on a license of an organization licensed as a life agent that is appointed by an admitted insurer that is required to register itself or to register a separate account or fund with the United States Securities and Exchange Commission under the Federal Investment Company Act of 1940, or to register its variable policies or contracts with the Securities and Exchange Commission under the Federal Securities Act of 1933, and has complied with that requirement. The commissioner may grant variable life and variable annuity authority to a person who is not a resident of California and is not a licensed life agent in California provided that the person is licensed for both life and variable annuity authority in the resident state.

(b) A person shall not act as an agent of the insurer in the transaction of the policies or contracts unless the person holds a valid authority under this article.

SEC. 29. Section 1758.3 of the Insurance Code is amended to read:

1758.3. The commissioner shall not grant authority to transact variable life and variable annuity unless the life agent or applicant furnishes proof that the person is registered to sell securities in California in accordance with the rules of the United States Securities and Exchange Commission or the Financial Industry Regulatory Authority. Any authority granted to a life agent to transact variable life and variable annuity shall immediately terminate upon the life agent no longer being registered to sell securities in accordance with the rules of the United States Securities and Exchange Commission or the Financial Industry Regulatory Authority.

SEC. 30. The heading of Article 16.6 (commencing with Section 1758.8) of Chapter 5 of Part 2 of Division 1 of the Insurance Code is amended to read:

Article 16.6. Car Rental Agents

SEC. 31. Section 1758.8 of the Insurance Code is amended to read:

1758.8. (a) A rental car company shall not offer or sell insurance unless it is licensed as an insurance agent or broker pursuant to Article 3 (commencing with Section 1631) or has complied with the requirements of this article and has been issued a license by the commissioner as provided in this article.

(b) The commissioner may issue to a rental car company, or to a franchisee of a rental car company, that has complied with the requirements of this article, a license that authorizes the rental car company or the franchisee of a rental car company to act as a car rental agent to offer or sell those types of insurance specified in Section 1758.85, in connection with and incidental to rental agreements, on behalf of any insurer authorized to write those types of insurance in this state.

SEC. 32. Section 1758.81 of the Insurance Code is amended to read:

1758.81. (a) An applicant for a car rental agent license under this article shall file the following documents with the commissioner:

(1) A written application for licensure, signed by the applicant or an officer of the applicant, in the form prescribed by the commissioner.

(2) A certificate by the insurer that is to be named in the car rental agent license, stating that the insurer has satisfied itself that the named applicant is trustworthy and competent to act as its insurance agent limited to this purpose and that the insurer will appoint the applicant to act as its agent to transact the kind or kinds of insurance that are permitted by this article, if the car rental agent license applied for is issued by the commissioner. The certification shall be subscribed by an officer or managing agent of the insurer on a form prescribed by the commissioner.

(3) An application fee, and, each license period thereafter, a renewal fee, of four hundred sixty-three dollars ($463).

(4) Not less than 60 days before a permanent license will expire, the commissioner may use an electronic delivery method, including email or other similar electronic method of delivery, to deliver, or may mail, to the latest email or mailing address appearing on the licensee's records, an application to the licensee to renew the license for the appropriate succeeding license period. It is the licensee's responsibility to renew whether or not a renewal application is received. The commissioner may accept a late renewal without a penalty, provided the licensee's failure to comply is due to clerical error or inadvertence on the part of the department.

(A) The application for renewal of a license shall be filed on or before the expiration date.

(B) The application for renewal of an expired license may be filed after the expiration date and until that same month and day of the next succeeding year. A licensee who files the renewal application after the license has expired shall be charged, in addition to the renewal fee, a penalty of 50 percent of the renewal fee.

(b) Notwithstanding any other law to the contrary, Sections 1667, 1668, 1668.5, 1669, 1670, 1720, 1738, and 1739 apply to any application for or issuance of a license pursuant to this article.

(c) Costs associated with any enforcement action or investigation shall be paid for by the person or organization licensed pursuant to this article.

SEC. 33. Section 1758.82 of the Insurance Code is amended to read:

1758.82. (a) An employee of a rental car company or franchisee of a rental car company that has been issued a car rental agent license pursuant to this article may be an endorsee authorized to offer insurance products under the authority of the car rental agent license if all of the following conditions have been met:

(1) The employee is 18 years of age or older.

(2) The rental car company, at the time it submits its car rental agent license application pursuant to Section 1758.81, also establishes a list of the names of all endorsees to its car rental agent license. The list shall be maintained by the rental car company in a form prescribed by the commissioner and updated annually. The list shall be retained by the rental car company for three years and made available to the commissioner for review and inspection.

(3) The rental car company submits to the commissioner with its initial car rental agent license application and annually thereafter a certification, subscribed by an officer of the company on a form prescribed by the commissioner, stating all of the following:

(A) The number of endorsees offering insurance products under the authority of the car rental agent license for the applicable period.

(B) A statement that no person other than an endorsee sells or offers insurance on its behalf.

(C) That all endorsees have completed training as required by this article.

(b) Each rental car company licensed pursuant to this article shall provide for the training of its endorsees prior to allowing its endorsees to offer or sell insurance products. The training shall meet the following minimum standards:

(1) Each car rental endorsee shall receive instruction about the types of insurance specified in Section 1758.85 that are offered for sale to prospective renters.

(2) Each car rental endorsee shall receive training about ethical sales practices.

(3) Each car rental endorsee shall receive training about the disclosures to be given to prospective renters pursuant to subdivision (c) of Section 1758.86.

(c) Training materials used by or on behalf of the rental car company to train its endorsees shall be submitted to the department at the time the rental car company applies for a license under this article, and whenever modified thereafter. Any changes to previously submitted training materials shall be submitted to the department with the changes highlighted 30 days prior to their use by the licensee. Training materials and changes to those materials submitted to the department pursuant to this subdivision shall be deemed approved for use by the company unless it is notified by the department to the contrary. Failure by a rental car company to submit training materials or changes for departmental review or use of unapproved or disapproved training materials shall constitute grounds for denial of an application for a license, nonrenewal of a license, or suspension of a license, as appropriate.

(d) The rental car company shall periodically retrain its endorsees on the subject matter described in subdivision (b), as prescribed by the commissioner.

SEC. 34. Section 1758.83 of the Insurance Code is amended to read:

1758.83. (a) The manager at each location of a rental car company or a franchisee of a rental car company licensed pursuant to this article, or the direct supervisor of the company's endorsees at each location or region shall be an endorsee and shall be responsible for the supervision of each additional endorsee at that location or region. Each licensee shall identify the endorsee who is the manager or supervisor at each location for the purposes of this article.

(b) An endorsee may act on behalf and under the supervision of the car rental agent in matters relating to transacting insurance under that agent's license. The conduct of an endorsee of a car rental agent acting within the scope of employment or agency shall be deemed the conduct of the car rental agent for purposes of this article.

SEC. 35. Section 1758.84 of the Insurance Code is amended to read:

1758.84. (a) If a licensee or endorsee violates any provision of this article or any other provision of this code, the commissioner may do any of the following:

(1) After notice and hearing, suspend or revoke the license of the car rental agent.

(2) After notice and hearing impose fines on the car rental agent for its conduct or that of its endorsees.

(3) After notice and hearing, impose other penalties, that the commissioner deems necessary and convenient to carry out the purpose of this code, including suspending the privilege of transacting insurance at specific rental locations where violations have occurred, and suspending or revoking the endorsement of individual endorsees or manager endorsees.

(b) If any person sells insurance in connection with, or incidental to, rental car agreements or claims to be or holds an organization out as a car rental agent without obtaining the license required by this article, or as being an endorsee when that person is not an endorsee, or as being licensed pursuant to Chapter 5 (commencing with Section 1631) without obtaining that license, the commissioner may issue a cease and desist order pursuant to Section 12921.8.

(c) Notwithstanding any other provision of law to the contrary, the provisions of Section 1748.5 are applicable to both the car rental agent and any endorsee to the license of the car rental agent.

SEC. 36. Section 1758.85 of the Insurance Code is amended to read:

1758.85. A rental car company or franchisee licensed under this article may act as a car rental agent for an authorized insurer only in connection with the rental of vehicles and only with respect to the following kinds of insurance:

(a) Personal accident insurance for renters and other rental vehicle occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental vehicle during the rental period.

(b) Liability insurance, which may include uninsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides coverage to the renters and to other authorized drivers of a rental vehicle and is nonduplicative of any standard liability coverage or self-insurance limits provided by the rental company in its rental agreement, for liability arising from the negligent operation of the rental vehicle during the rental period.

(c) Personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental vehicle during the rental period.

(d) Roadside assistance insurance.

(e) Emergency sickness insurance.

SEC. 37. Section 1758.86 of the Insurance Code is amended to read:

1758.86. A car rental agent shall not sell insurance pursuant to this article unless all of the following conditions are satisfied:

(a) The rental period of the rental agreement does not exceed 30 consecutive days, except for any renewals or extension of the original rental period.

(b) The car rental agent provides brochures or other written materials to the prospective renter that do all of the following:

(1) Summarize the material terms and conditions of coverage offered to renters, including the identity of the insurer.

(2) Describe the process for filing a claim, including a toll-free telephone number to report a claim.

(3) Disclose any additional information on the price, benefits, exclusions, conditions, or other limitations of those policies that the commissioner may by rule prescribe.

(4) Provide the licensee's name, address, telephone number, and license number, as well as the availability of the department's toll-free consumer hotline.

(c) The car rental agent or its endorsee makes all of the following disclosures to the renter, which shall be acknowledged in writing by the renter, or displayed by clear and conspicuous signs that are posted at every location where rental agreements are executed, such as the counter where the renter signs the rental agreement:

(1) That the purchase by the renter of the kinds of insurance prescribed in this article is not required in order to rent a vehicle.

(2) That the insurance policies offered by the car rental agent may provide a duplication of coverage already provided by a renter's personal automobile insurance policy or by another source of coverage.

(3) That the endorsee on the car rental agent's license is not qualified or authorized to evaluate the adequacy of the purchaser's existing insurance coverages.

(d) Evidence of coverage is stated on the face of the rental agreement or evidence of coverages provided to every renter who elects to purchase that coverage is indicated to the renter.

(e) The insurance is provided under an individual policy issued to the purchaser, or under a group, or master policy issued to an organization licensed as a car rental agent by an insurer authorized to transact the applicable kinds or types of insurance in this state.

SEC. 38. Section 1758.87 of the Insurance Code is amended to read:

1758.87. A car rental agent shall not do any of the following:

(a) Offer to sell insurance except in conjunction with, and incidental to, authorized rental agreements.

(b) Advertise, represent, or otherwise portray itself or its employees or endorsees as licensed insurers, life agents, property broker-agents, or casualty broker-agents.

(c) Pay an endorsee any compensation, fee, or commission dependent on the placement of insurance under the agent's license. Nothing in this code shall prohibit the payment of a "performance-related incentive." For the purposes of this subdivision, a

“performance-related incentive” is not a commission as otherwise defined. A “performance-related incentive” is money or other tangible or intangible items of value paid or given to any endorsee of the licensee which is not based solely on the offering or selling of the insurance products listed in Section 1758.85.

SEC. 39. Section 1758.88 of the Insurance Code is amended to read:

1758.88. Any insurer that provides insurance to be sold by a rental car company or franchisee of a rental car company under this article shall file a copy of any individual policy issued to a purchaser, or any policy or certificate issued under a group or master policy to an organization licensed as a car rental agent, with the commissioner, who shall make that policy available to the public.

SEC. 40. Section 1758.89 of the Insurance Code is amended to read:

1758.89. As used in this article, the following definitions have the following meanings:

(a) (1) “License period” means all of that two-year period beginning as described in subparagraph (A) or (B) of paragraph (2), as applicable, and ending the second succeeding year on the last calendar day of the month in which the initial license was issued.

(2) A license period shall be determined for each person as follows:

(A) Upon initial licensing, the license period starts on the date the license is issued.

(B) Subsequently, the license period starts the first day of the month following the month in which the initial license was issued.

(3) A license is required to be renewed on or before the expiration date of the license period.

(b) “Rental vehicle” or “vehicle” means a motor vehicle operated by a driver who is not required to possess a commercial driver’s license to operate the motor vehicle and the motor vehicle is either of the following:

(1) A private passenger motor vehicle, including a passenger van, minivan, or sports utility vehicle.

(2) A cargo vehicle, including a cargo van, pickup truck, or truck with a gross vehicle weight of less than 26,000 pounds.

(c) “Renter” means any person who obtains the use of a vehicle from a rental car company under the terms of a rental agreement.

(d) “Rental car company” means any person in the business of renting vehicles to the public.

(e) “Rental agreement” means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental car company.

(f) “Car rental agent” means a person or organization licensed pursuant to this article to offer insurance in connection with and incidental to rental car agreements on behalf of an insurer authorized to write those types of insurance in this state.

(g) “Endorsee” means an unlicensed employee of a car rental agent who meets the requirements of this article.

SEC. 41. Section 10181.45 of the Insurance Code is amended to read:

10181.45. (a) For large group health insurance policies, a health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer’s large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct a public meeting in every even-numbered year regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of insureds.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Insureds' share of premiums.

(H) Insureds' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345 of the Health and Safety Code, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The insurer's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual policy trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(C) A comparison of the aggregate per insured per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in insured cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in insured cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of insureds.

(E) Any changes in insured benefits over the prior year, including a description of benefits added or eliminated as well as any aggregate changes as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts made since the insurer's prior year's information pursuant to this section for the same category of health insurer. To the extent possible, the insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health insurer.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health insurer spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The insurer shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The insurer shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The insurer shall also include the name or names of the pharmacy benefit manager, or managers if the insurer uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 10181.7.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 42. Section 10234.75 of the Insurance Code is amended to read:

10234.75. (a) The Long Term Care Insurance Task Force is hereby created in the Department of Insurance. Under the leadership of the commissioner, the task force shall examine the components necessary to design and implement a statewide long-term care insurance program.

(b) The task force shall consist of the following 15 voting members:

(1) The commissioner, or the commissioner's designee, who shall serve as the chair of the task force.

(2) The Director of Health Care Services, or the director's designee.

(3) The Director of the Department of Aging, or the director's designee.

(4) Four persons appointed by the Governor, as follows:

(A) A certified actuary with expertise in long-term care insurance.

(B) A nongovernment health policy expert.

(C) A representative of a long-term care provider association.

(D) A representative of a senior or consumer organization.

(5) One person, appointed by the Speaker of the Assembly, from an employee representative organization that represents long-term care workers.

(6) One person, appointed by the Senate Committee on Rules, from the long-term care insurance industry.

(7) Six persons appointed by the commissioner, as follows:

(A) A representative of residential care facilities for the elderly.

(B) A representative of adult day services providers.

(C) A representative of hospice and palliative care providers.

(D) A representative of long-term care health professionals.

(E) A representative of independent providers of in-home personal care services.

(F) A representative of family caregivers.

(c) A task force member shall not receive a per diem or other similar compensation for serving as a member of the task force.

(d) The Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code) applies to meetings of the task force.

(e) The task force shall do all of the following:

(1) Explore how a statewide long-term care insurance program could be designed and implemented to expand the options for people who are interested in insuring themselves against the risk of costs associated with functional or cognitive disability, and require long-term care, services, and supports.

(2) Explore options for the design of the program, including eligibility, enrollment, benefits, financing, administration, and interaction with the Medi-Cal program and other publicly funded resources. In exploring these options, the task force shall consider all of the following:

(A) Whether and how a long-term care insurance program could be included as a benefit in the state disability insurance program structure, possibly through a nominal increase in the payroll tax, and whether the program could be structured in the same manner as Paid Family Leave benefits.

(B) Allowing for enrollment in the program of working adults who would make voluntary premium contributions either directly or through payroll deductions through their employer.

(C) To the extent feasible, requiring a mandatory enrollment with a voluntary opt-out option.

(D) Giving working adults the opportunity to plan for future long-term care needs by providing a basic insurance benefit to those who meet work requirements and have developed functional or equivalent cognitive limitations.

(E) Helping individuals with functional or cognitive limitations remain in their communities by purchasing nonmedical services and supports, including home health care and adult daycare.

(F) Helping offset the costs incurred by adults with chronic and disabling conditions. The program need not be designed to cover the entire cost associated with an individual’s long-term care needs.

(3) Evaluate how benefits under the program would be coordinated with existing private health care coverage benefits.

(4) Evaluate the demands on the long-term care workforce as the need for long-term care in California grows, and how the long-term care workforce can be prepared to meet those demands.

(5) Consider the establishment of a joint public and private system to make long-term care accessible to as many individuals within California as possible.

(6) Make recommendations related to key regulatory provisions necessary for the public to access existing long-term care insurance programs and participate in future long-term care insurance programs, whether those programs are recommended by the task force or otherwise.

(f) The department shall operate within its existing budgetary resources for purposes of implementing this section. A governmental agency that participates in the task force shall operate within its existing budgetary resources for purposes of that participation.

(g) The task force shall recommend options for establishing a statewide long-term care insurance program and comment on the respective degrees of feasibility of those options in a report submitted to the commissioner, the Governor, and the Legislature on or before January 1, 2023. The report submitted to the Legislature shall be submitted in accordance with Section 9795 of the Government Code.

(h) To ensure an adequate benefit within a solvent program, the department shall, no later than January 1, 2024, produce an actuarial report of the recommendations made by the task force pursuant to subdivision (g). The report shall be shared with and approved by the members of the task force. If approved the report shall be submitted to the Legislature in accordance with Section 9795 of the Government Code.

(i) The commissioner may seek private funds for purposes of implementing this section.

(j) This section shall remain in effect only until July 1, 2024, and as of that date is repealed.

SEC. 43. Section 10235.45 of the Insurance Code is amended to read:

10235.45. (a) If a life insurance policy issued on or after January 1, 2021, contains long-term care benefits and permits policy loans or cash withdrawals, then access to those loans or withdrawals shall not be prohibited or limited due to the payment of long-term care benefits, except as provided in paragraphs (1) and (2).

(1) Payment of an accelerated death benefit for long-term care shall result in no more than a pro rata reduction in the cash value of the life insurance policy. A reduction in cash value shall be proportionally equal to the percentage of death benefits accelerated to produce the accelerated death benefit payment. Future access to policy loans and cash withdrawals may be limited to the remaining cash value.

(2) Notwithstanding paragraph (1), payment of an accelerated death benefit for long-term care may be considered a lien against the death benefit of the life insurance policy, and access to the cash value of the life insurance policy may be restricted to the excess of the cash value over the sum of outstanding policy loans and the lien. Future access to policy loans and cash withdrawals may also be limited to the excess of the cash value over the sum of outstanding policy loans and the lien.

(b) If payment of an accelerated death benefit for long-term care results in a pro rata reduction in the cash value of the life insurance policy, the payment may be applied toward repayment of a pro rata portion of outstanding policy loans. The amount of the loan repayment shall be proportionally equal to the percentage of death benefits accelerated to produce the accelerated death benefit payment.

(c) At least 30 days before the first payment of an accelerated death benefit for long-term care, the insurer shall send the policyholder or certificate holder a statement that includes all of the following:

(1) The scheduled payment date and an option to cancel the payment before the payment date. The policyholder or certificate holder may cancel the payment by contacting the insurer at the insurer’s address or telephone number at any time before the payment date.

(2) An explanation of changes to the policy that would occur as a result of the payment, including, but not limited to, a prohibition or limitation of access to loans or cash withdrawals.

(3) A numerical demonstration of the effect of the payment on the remaining death benefit, cash value or accumulation amount, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, and premium payments or cost of insurance charges.

(4) A notice stating: “WARNING: Payment of an accelerated death benefit for long-term care will reduce and may potentially eliminate your death benefit. Receipt of an accelerated death benefit for long-term care may be taxable and may also adversely affect your eligibility for Medicaid or other government entitlements. Please consult a financial advisor.”

(d) The statement required by subdivision (c) is required only once per policy, or once per policyholder if a policy has multiple policyholders, and does not need to be provided for later accelerated death benefit claims by the same policyholder.

(e) No later than 30 days after every payment of an accelerated death benefit for long-term care, the insurer shall provide the policyholder or certificate holder with a report that includes all of the following:

(1) The accelerated death benefits paid out during the prior month.

(2) An explanation of changes to the remaining death benefit, cash value or accumulation account, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, and premium payments or cost of insurance charges.

(3) The amount of the remaining benefits that can be accelerated.

(f) If a policyholder or certificate holder initiates a request to take a loan or withdrawal from the cash value of a life insurance policy that accelerates benefits for long-term care, the insurer shall provide the policyholder or certificate holder with the information described in paragraphs (1) to (7), inclusive, of this subdivision. The request shall be deemed incomplete, and the insurer shall not approve the loan or withdrawal, until the information has been provided and the policyholder or certificate holder submits a response that finalizes the request for the loan or withdrawal. The insurer shall send the policyholder or certificate holder a dated statement that includes all of the following:

(1) An explanation of changes to the policy that would occur as a result of the loan or withdrawal.

(2) A numerical demonstration of the effect of the payment on the remaining death benefit, cash value or accumulation amount, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, premium payments or cost of insurance charges, and daily, monthly, or lifetime long-term care benefits.

(3) If a policyholder or certificate holder is initiating a request for a loan, a notice stating: “WARNING: Loans may reduce and potentially eliminate your death benefit and your long-term care benefits. Receipt of a loan may adversely affect your eligibility for Medicaid or other government entitlements, and loan proceeds may be taxable at your death if the loan is not repaid. Please consult a financial advisor.”

(4) If a policyholder or certificate holder is initiating a request for a withdrawal, a notice stating: “WARNING: Cash withdrawals may reduce and potentially eliminate your death benefit and your long-term care benefits. Receipt of a cash withdrawal may be taxable and may also adversely affect your eligibility for Medicaid or other government benefits or entitlements. Please consult a financial advisor.”

(5) A description of circumstances in which a loan or withdrawal may result in or contribute to the lapse of the policy.

(6) If applicable, a hypothetical demonstration of how loan repayment may be deducted from a future payment of an accelerated death benefit for long-term care.

(7) If applicable, a notice explaining the rate at which the loan will accrue interest and stating the projected outstanding loan amount after five years, assuming that the interest rate does not change, no loan repayments are made, and no additional loans are taken.

(g) The statements and notices required by this section shall be in at least 12-point type.

SEC. 44. Section 10271 of the Insurance Code is amended to read:

10271. (a) Except as set forth in this section, this chapter does not apply to, or in any way affect, provisions in life insurance, endowment, or annuity contracts, or contracts supplemental thereto, that provide additional benefits in case of death or dismemberment or loss of sight by accident, or that operate to safeguard those contracts against lapse, as described in subdivision (a) of Section 10271.1, or give a special surrender benefit, as defined in subdivision (b) of Section 10271.1, or an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295), in the event that the owner, insured, or annuitant, as applicable, meets the benefit triggers specified in the life insurance or annuity contract or supplemental contract.

(b) For the purposes of this section, the term “supplemental benefit” means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a).

(c) A supplemental benefit described in subdivision (a) shall contain all of the following provisions. However, an insurer, at its option, may substitute for one or more of the provisions a corresponding provision of different wording approved by the commissioner that is not less favorable in any respect to the owner, insured, or annuitant, as applicable. The required provisions shall be preceded individually by the appropriate caption, or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A life insurance policy or annuity contract that contains a supplemental benefit shall provide that the contract, supplemental contract, and papers attached thereto by the insurer, including the application if attached, constitute the entire insurance or annuity contract and shall also provide that an agent does not have the authority to change the contract or to waive its provisions. This provision shall be preceded individually by a caption stating “ENTIRE CONTRACT; CHANGES:” or other appropriate caption as the commissioner may approve.

(2) The supplemental benefit shall provide that reinstatement of the supplemental benefit shall be on the same or more favorable terms as reinstatement of the underlying life insurance policy or annuity contract. Following reinstatement, the insured and insurer shall have the same rights under reinstatement as they had under the supplemental benefit immediately before the due date of the defaulted premium, subject to the provisions endorsed in the rider or endorsement or attached to the rider or endorsement in connection with the reinstatement. This reinstatement provision shall be preceded individually by a caption stating “REINSTATEMENT:” or other appropriate caption as the commissioner may approve.

(3) A supplemental benefit subject to underwriting shall include an incontestability statement that provides that the insurer shall not contest the supplemental benefit after it has been in force during the lifetime of the insured for two years from its date of issue, and that the supplemental benefit may only be contested based on a statement made in the application for the supplemental benefit, if the statement is attached to the contract and if the statement was material to the risk accepted or the hazard assumed by the insurer. This provision shall be preceded individually by a caption stating “INCONTESTABILITY:” or other appropriate caption as the commissioner may approve.

(4) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide either that the insurer may accept written notice of claim at any time or that the insurer may require that written notice of claim be submitted by a due date that is no less than 20 days after an occurrence covered by the supplemental benefit, or commencement of a loss covered by the supplemental benefit, or as soon after the due date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary, as applicable, to the insurer at the insurer’s address or telephone number, or to an authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating “NOTICE OF CLAIM:” or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide either that the insured may give notice of claim at any time or that the insured shall give notice of claim by a due date that is at least 20 days after the insured receives documentation that establishes the occurrence of a qualifying event, or as soon after the due date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary, as applicable, to the insurer at the insurer’s address or telephone number, or to an authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating “NOTICE OF CLAIM:” or other appropriate caption as the commissioner may approve.

(5) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant those forms as are usually furnished by it for filing a proof of occurrence or a proof of loss. If the forms are not furnished within 15 days after giving notice, the claimant shall be deemed to have complied with the requirements of the supplemental benefit as to proof of occurrence or proof of loss upon submitting, within the time fixed by the supplemental benefit for filing proof of occurrence or proof of loss, written proof covering the character and the extent of the occurrence or loss. This provision shall be preceded individually by a caption stating “CLAIM FORMS:” or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant any forms required for filing proof of loss. If the forms are not furnished within 15 days after notice of claim is given to the insurer, the claimant shall be deemed to have provided proof of loss upon sending, within the time fixed by the supplemental benefit for filing proof of loss, documentation that establishes the occurrence of a qualifying event. This provision shall be preceded individually by a caption stating “CLAIM FORMS:” or other appropriate caption as the commissioner may approve.

(6) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide that the insurer may require, in the case of a claim for which the supplemental benefit provides a periodic payment contingent upon continuing occurrence or loss, that the insured provide written proof of occurrence or proof of loss no less than 90 days after the termination of the period for which the insurer is liable, and, in the case of claim for any other occurrence or loss, that the insured provide written proof of occurrence or proof of loss within 90 days after the date of the occurrence or loss. Failure to furnish proof within the time required shall not invalidate or reduce the claim if it was not reasonably possible to give proof within the time, provided proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall be preceded individually by a caption stating “PROOF OF LOSS:” or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide that the insured shall send completed claim forms and documentation that establishes the occurrence of a qualifying event within 90 days of receiving that documentation. Failure to send proof within the time required shall not invalidate or reduce the claim as long as proof is sent as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall

be preceded individually by a caption stating “PROOF OF LOSS:” or other appropriate caption as the commissioner may approve.

(7) The supplemental benefit shall provide that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as the insurer may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law. This provision shall be preceded individually by a caption stating “PHYSICAL EXAMINATIONS:” or other appropriate caption as the commissioner may approve.

(d) The commissioner shall not approve a contract or supplemental contract for issuance or delivery in this state if the commissioner finds that the contract or supplemental contract does any of the following:

(1) Contains a provision, label, description of its contents, title, heading, backing, or other indication of its provisions that is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the supplemental benefit is offered, delivered, or issued.

(2) Constitutes fraud, unfair trade practices, or insurance economically unsound to the owner, insured, or annuitant, as applicable.

(3) Contains actuarial information that is materially incomplete, incorrect, or inadequate.

(e) A supplemental benefit described in subdivision (a) shall not contain a title, description, or any other indication that would describe or imply that the supplemental benefit provides long-term care coverage.

(f) Commencing two years from the date of the issuance of the supplemental benefit, no claim for loss incurred or disability, as defined by the supplemental benefit, may be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed before the effective date on the coverage of the supplemental benefit.

(g) With regard to supplemental benefits set forth in subdivision (a), the supplemental benefit shall specify any applicable exclusions, which shall be limited to the following:

(1) Condition or loss caused or substantially contributed to by any attempt at suicide or intentionally self-inflicted injury, while sane or insane.

(2) Condition or loss caused or substantially contributed to by war or an act of war, as defined in the exclusion provisions of the contract.

(3) Condition or loss caused or substantially contributed to by active participation in a riot, insurrection, or terrorist activity.

(4) Condition or loss caused or substantially contributed to by committing or attempting to commit a felony.

(5) Condition or loss caused or substantially contributed to by voluntary intake of either:

(A) A drug, unless prescribed or administered by a physician and taken in accordance with the physician’s instructions.

(B) Poison, gas, or fumes, unless they are the direct result of an occupational accident.

(6) Condition or loss in consequence of the insured being intoxicated, as defined by the jurisdiction where the condition or loss occurred.

(7) Condition or loss caused or substantially contributed to by engaging in an illegal occupation.

(8) Condition or loss caused or substantially contributed to by engaging in aviation, other than as a fare-paying passenger.

(h) If the commissioner notifies the insurer, in writing, that the filed form or actuarial information does not comply with the law and specifies the reasons for the commissioner’s opinion, it is unlawful for an insurer to issue a policy in that form.

SEC. 45. Section 10291.5 of the Insurance Code is amended to read:

10291.5. (a) The purpose of this section is to achieve both of the following:

(1) Prevent, in respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Assure that the language of all insurance policies can be readily understood and interpreted.

(b) The commissioner shall not approve a disability policy for issuance or delivery in this state in any of the following circumstances:

(1) If the commissioner finds that it contains a provision, or has a label, description of its contents, title, heading, backing, or other indication of its provisions that is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(2) If it contains a provision for payment at a rate, or in an amount (other than the product of rate times the periods for which payments are promised) for loss caused by particular event or events (as distinguished from character of physical injury or illness of the insured) more than triple the lowest rate, or amount, promised in the policy for the same loss caused by another event or events (loss caused by sickness, loss caused by accident, and different degrees of disability each being considered, for the purpose of this paragraph, a different loss); or if it contains a provision for payment for a confining loss of time at a rate more than six times the least rate payable for a partial loss of time or more than twice the least rate payable for a nonconfining total loss of time; or if it contains a provision for payment for any nonconfining total loss of time at a rate more than three times the least rate payable for any partial loss of time.

(3) If it contains a provision for payment for disability caused by particular event or events (as distinguished from character of physical injury or illness of the insured) payable for a term more than twice the least term of payment provided by the policy for the same degree of disability caused by another event or events; or if it contains a benefit for total nonconfining disability payable for lifetime or for more than 12 months and a benefit for partial disability, unless the benefit for partial disability is payable for at least three months; or if it contains a benefit for total confining disability payable for lifetime or for more than 12 months, unless it also contains benefit for total nonconfining disability caused by the same event or events payable for at least three months, and, if it also contains a benefit for partial disability, unless the benefit for partial disability is payable for at least three months. This paragraph shall apply separately to accident benefits and to sickness benefits.

(4) If it contains a provision or provisions that would have the effect, upon termination of the policy, of reducing or ending the liability as the insurer would have, but for the termination, for loss of time resulting from accident occurring while the policy is in force or for loss of time commencing while the policy is in force and resulting from sickness contracted while the policy is in force or for other losses resulting from accident occurring or sickness contracted while the policy is in force, and also contains provision or provisions reserving to the insurer the right to cancel or refuse to renew the policy, unless it also contains other provision or provisions the effect of which is that termination of the policy as the result of the exercise by the insurer of that right shall not reduce or end the liability in respect to the hereinafter specified losses as the insurer would have had under the policy, including its other limitations, conditions, reductions, and restrictions, had the policy not been terminated.

The specified losses referred to in the preceding paragraph are:

(i) Loss of time that begins while the policy is in force and results from sickness contracted while the policy is in force.

(ii) Loss of time that begins within 20 days following and results from accident occurring while the policy is in force.

(iii) Losses that result from accident occurring or sickness contracted while the policy is in force and arise out of the care or treatment of illness or injury and which occur within 90 days from the termination of the policy or during a period of continuous compensable loss or losses which period commences before the end of those 90 days.

(iv) Losses other than those specified in clause (i), (ii), or (iii) that result from accident occurring or sickness contracted while the policy is in force and which losses occur within 90 days following the accident or the contraction of the sickness.

(5) If a caption, label, title, or description of contents the policy states, implies, or infers without reasonable qualification that it provides loss of time indemnity for lifetime, or for a period of more than two years, if the loss of time indemnity is made payable only when house confined or only under special contingencies not applicable to other total loss of time indemnity.

(6) If it contains a benefit for total confining disability payable only upon condition that the confinement be of an abnormally restricted nature unless the caption of the part containing that benefit is accurately descriptive of the nature of the confinement required and unless, if the policy has a description of contents, label, or title, at least one of them contain reference to the nature of the confinement required.

(7) (A) If, irrespective of the premium charged therefor, a benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured.

(B) In determining whether benefits are of real economic value to the insured, the commissioner shall not differentiate between insureds of the same or similar economic or occupational classes and shall give due consideration to all of the following:

(i) The right of insurers to exercise sound underwriting judgment in the selection and amounts of risks.

(ii) Amount of benefit, length of time of benefit, nature or extent of benefit, or any combination of those factors.

(iii) The relative value in purchasing power of the benefit or benefits.

(iv) Differences in insurance issued on an industrial or other special basis.

(C) To be of real economic value, it shall not be necessary that any benefit or benefits cover the full amount of a loss which might be suffered by reason of the occurrence of a hazard or event insured against.

(8) If it substitutes a specified indemnity upon the occurrence of accidental death for a benefit of the policy, other than a specified indemnity for dismemberment, that would accrue before that death or if it contains a provision that has the effect, other than at the election of the insured exercisable within not less than 20 days in the case of benefits specifically limited to the loss by removal of one or more fingers or one or more toes or within not less than 90 days in all other cases, of doing any of the following:

(A) Of substituting, upon the occurrence of the loss of both hands, both feet, one hand and one foot, the sight of both eyes or the sight of one eye and the loss of one hand or one foot, some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than the total of the benefit or benefits for which that specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of that dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(B) Of substituting, upon the occurrence of any other dismemberment some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than one-fourth of the total of the benefit or benefits for which the specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of the dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(C) Of substituting a specified indemnity upon the occurrence of a dismemberment for a benefit of the policy which would accrue before the time of dismemberment.

As used in this section, loss of a hand shall be severance at or above the wrist joint, loss of a foot shall be severance at or above the ankle joint, loss of an eye shall be the irrecoverable loss of the entire sight thereof, loss of a finger shall mean at least one entire phalanx thereof and loss of a toe the entire toe.

(9) If it contains a provision, other than as provided in Section 10369.3, reducing an original benefit more than 50 percent on account of age of the insured.

(10) If the insuring clause or clauses contain no reference to the exceptions, limitations, and reductions (if any) or no specific reference to, or brief statement of, each abnormally restrictive exception, limitation, or reduction.

(11) If it contains benefit or benefits for loss or losses from specified diseases only unless:

(A) All of the diseases so specified in each provision granting the benefits fall within some general classification based upon the following:

(i) The part or system of the human body principally subject to all those diseases.

(ii) The similarity in nature or cause of those diseases.

(iii) In case of diseases of an unusually serious nature and protracted course of treatment, the common characteristics of all those diseases with respect to severity of affliction and cost of treatment.

(B) The policy is entitled and each provision granting the benefits is separately captioned in clearly understandable words so as to accurately describe the classification of diseases covered and expressly point out, when that is the case, that not all diseases of the classification are covered.

(12) If it does not contain provision for a grace period of at least the number of days specified below for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force provided, that the grace period to be included in the policy shall be not less than seven days for policies providing for weekly payment of premium, not less than 10 days for policies providing for monthly payment of premium and not less than 31 days for all other policies.

(13) If it fails to conform with a law of this state.

(c) The commissioner shall not approve a disability policy covering hospital, medical, or surgical expenses unless the commissioner finds that the application conforms to both of the following requirements:

(1) All applications for disability insurance covering hospital, medical, or surgical expenses, except that which is guaranteed issue, which include questions relating to medical conditions, shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions designed to ascertain the health condition or history of the applicant shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that states:

“California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.”

(d) This section does not authorize the commissioner to establish or require a single or standard application form for application questions.

(e) The commissioner may, from time to time as conditions warrant, after notice and hearing, promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient, to establish, in advance of the submission of policies, the standard or standards conforming to subdivision (b), by which the commissioner shall disapprove or withdraw approval of a disability policy.

(1) In promulgating a rule or regulation the commissioner shall give consideration to the criteria established in this section and to the desirability of approving for use in policies in this state uniform provisions, nationwide or otherwise, and is hereby granted the authority to consult with insurance authorities of any other state and their representatives individually or by way of convention or committee, to seek agreement upon those provisions.

(2) A rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) (1) The commissioner may withdraw approval of filing of any policy or other document or matter required to be approved by the commissioner, or filed with the commissioner, by this chapter when the commissioner would be authorized to disapprove or refuse filing of the same if originally submitted at the time of the action of withdrawal.

(2) A withdrawal pursuant to paragraph (1) shall be in writing and shall specify reasons. An insurer adversely affected by a withdrawal may, within a period of 30 days following mailing or delivery of the writing containing the withdrawal, by written request secure a hearing to determine whether the withdrawal should be annulled, modified, or confirmed. Unless, at any time, it is mutually agreed to the contrary, a hearing shall be granted and commenced within 30 days following filing of the request and shall proceed with reasonable dispatch to determination. Unless the commissioner in writing in the withdrawal, or subsequent thereto, grants an extension, a withdrawal shall, in the absence of a hearing request, be effective, prospectively and not retroactively, on the 91st day following the mailing or delivery of the withdrawal, and, if request for the hearing is filed, on the 91st day following mailing or delivery of written notice of the commissioner’s determination.

(g) A proceeding under this section is not subject to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) (1) Except as provided in subdivision (k), an action taken by the commissioner under this section is subject to review by the courts of this state and proceedings on review shall be in accordance with the Code of Civil Procedure.

(2) Notwithstanding any other law, a petition for review may be filed at any time before the effective date of the action taken by the commissioner. No action of the commissioner shall become effective before the expiration of 20 days after written notice and a copy thereof are mailed or delivered to the person adversely affected, and an action so submitted for review shall not become effective for a further period of 15 days after the filing of the petition in court. The court may stay the effectiveness thereof for a longer period.

(i) This section shall be liberally construed to effectuate the purpose and intentions of this section, but shall not be construed to grant the commissioner power to fix or regulate rates for disability insurance or prescribe a standard form of disability policy, except that the commissioner shall prescribe a standard supplementary disclosure form for presentation with all disability insurance policies, pursuant to Section 10603.

(j) This section shall be effective on and after July 1, 1950, as to all policies thereafter submitted and on and after January 1, 1951, the commissioner may withdraw approval pursuant to subdivision (d) of a policy thereafter issued or delivered in this state irrespective of when its form may have been submitted or approved, and before those dates the law in effect on January 1, 1949, shall apply to those policies.

(k) A policy issued by an insurer to an insured on a form approved by the commissioner before July 1, 1950, and in accordance with the conditions, if any, contained in the approval, at a time when that approval is outstanding shall, as between the insurer

and the insured, or a person claiming under the policy, be conclusively presumed to comply with, and conform to, this section.

SEC. 46. Section 12921.2 of the Insurance Code is amended to read:

12921.2. All public records of the department and the commissioner subject to disclosure under Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code shall be available for inspection and copying pursuant to those provisions at the offices of the department in the San Francisco Bay area, in the City of Los Angeles, and in the City of Sacramento. Adequate copy facilities for this purpose shall be made available. Notwithstanding any other law, a person requesting copies of these records shall receive the copies from employees of the department and the fee charged for the copies shall not exceed the actual cost of producing the copies. Notwithstanding Section 6256 of the Government Code, a public record submitted to the department as computer data on an electronic medium shall, in addition to other formats, be made available to the public pursuant to this section through an electronic medium.

SEC. 47. Section 13550 of the Insurance Code is amended to read:

13550. (a) An insurer shall cooperate with the Department of Child Support Services to identify claimants who are also obligors who owe past-due child support and report those claimants to the Department of Child Support Services.

(b) An insurer shall identify and report a claimant to the Department of Child Support Services if the claim seeks an economic benefit for an obligor who owes past-due child support.

(1) An “economic benefit” under a life insurance policy, disability income insurance policy, or annuity means a payment totaling at least one thousand dollars ($1,000) in which an individual is paid as the payee or copayee for any of the following:

(A) A claim by a beneficiary under a life insurance policy.

(B) A payment of the cash surrender value of a life insurance policy or annuity.

(C) A payment to an annuitant.

(D) A payment from a disability income insurance policy.

(E) A loan against the cash value or surrender value of an insurance policy or annuity, excluding loans for premium payments.

(2) An “economic benefit” under a property and casualty insurance policy means a payment totaling at least one thousand dollars ($1,000) under a liability insurance policy or underinsured motorist policy issued by an insurance company authorized to do business in this state. An “economic benefit” under a property and casualty insurance policy does not include payments to replace or repair lost or damaged property.

(c) Notwithstanding subdivision (b), and except as provided in subdivision (h), a claimant with any of following economic benefits shall not be reported:

(1) Payments resulting from an accelerated death benefit.

(2) A claim for benefits assigned to be paid to a health care provider or facility for actual medical expenses owed by the insured that are not otherwise paid or reimbursed, or a payment made after the claimant provides proof of the amount actually paid by the claimant to a health care provider if the amount is at least as much as the insurance payment, but not any amounts billed but not paid.

(3) A claim for benefits to be paid under a limited benefit insurance policy that provides one of the following:

(A) Coverage for one or more specified diseases or illnesses.

(B) Dental or vision benefits.

(C) Hospital indemnity or other fixed indemnity coverage.

(D) Accident only coverage.

(4) A claim for benefits that are the result of a state of emergency, as defined in Section 8558 of the Government Code.

(5) A claim for benefits under a workers’ compensation policy, except as provided in Section 17510 of the Family Code and Section 138.5 of the Labor Code.

(d) An insurer in California subject to the requirements of this article shall identify and report a claimant to the Department of Child Support Services if either of the following apply:

(1) A payment is made to the owner of a life policy or annuity that was issued to the owner while residing or located in California.

(2) A beneficiary making a claim resides or is located in California.

(e) Withholding from a qualifying disability insurance payment made to an obligor who owes past-due child support shall be limited to 50 percent of the claim for benefits.

(f) (1) If an insurer identifies a claimant as an obligor who owes past-due child support and reports the claimant to the Department of Child Support Services, the Department of Child Support Services shall provide the insurer with either of the following to secure the payment of the amount of past-due child support:

(A) A notice of child support lien.

(B) An income-withholding order.

(2) Upon receiving notice from the Department of Child Support Services that a reported insurance claim is payable to an obligor with a child support delinquency, an insurer shall comply with the requirements of the notice.

(3) Notwithstanding paragraph (2), this section does not require an insurer to comply with a notice from the Department of Child Support Services on a reported insurance claim payable to an obligor with a child support delinquency if the notice is received after the insurer has paid the claim.

(g) For the purposes of this section, “insurer” includes a fraternal benefit society.

(h) This section does not prohibit an insurer from cooperating voluntarily with the Department of Child Support Services to identify claimants who are also obligors who owe past-due child support and report those claimants to the Department of Child Support Services.

SEC. 48. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.