AB-1140 Insurance. (2023-2024)

Date Published: 09/22/2023 09:00 PM

Assembly Bill No. 1140

CHAPTER 204

An act to amend Sections 922.425, 927, 927.1, 927.2, 927.3, 927.4, 1280.7, 1652, 1678, 1821, 1872.41, 1877.3, 10113.2, 11622, 12830, and 12921.8 of, and to add Section 805 to, the Insurance Code, to amend Section 1236 of the Unemployment Insurance Code, to amend Sections 16056, 16451, and 16500 of the Vehicle Code, and to amend Section 22005.1 of the Welfare and Institutions Code, relating to insurance.

[Approved by Governor September 22, 2023. Filed with Secretary of State September 22, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1140, Committee on Insurance. Insurance.

(1) Existing law requires an owner or operator of a motor vehicle, or an owner of a vehicle used to transport passengers for hire not regulated by the Public Utilities Commission, to maintain liability insurance coverage for the named insured and any other person using the vehicle with permission in the amount of $15,000 for the bodily injury or death of any one person, $30,000 for the bodily injury or death of all persons, and $5,000 for damage to the property of others resulting from any one accident.

Commencing on January 1, 2025, existing law would increase those minimum coverage amounts to $30,000 for the bodily injury or death of any one person, $60,000 for the bodily injury or death of all persons, and $15,000 for damage to the property of others resulting from any one accident, and would again increase those amounts, as specified, on January 1, 2035.

This bill would limit application of the above-described increases for minimum liability insurance coverage to those policies and bonds that are issued or renewed on or after January 1, 2025, and on or after January 1, 2035, as applicable.

(2) Existing law creates the Department of Insurance, headed by the Insurance Commissioner, and generally regulates the business of insurance in the state. Existing law requires, biennially on July 1 of each even-numbered year after July 1, 2020, each admitted insurer with California premiums written of $75,000,000 or more to report to the commissioner on its minority, lesbian, gay, bisexual, and transgender (LGBT), veteran, and disabled veteran-owned business procurement efforts and its governing board and board diversity efforts during the previous 2 years. Existing law requires the commissioner to establish and appoint an Insurance Diversity Task Force with at least 13, but not more than 15, members, including 2 members who are representatives of a minority business enterprise and a member who is a representative of an LGBT business enterprise.

This bill would include persons with disabilities, as defined, as part of each admitted insurer’s procurement and diversity efforts that it reports to the commissioner biennially. The bill would require a member of the Insurance Diversity Task Force to be a member who is a representative of a persons with disabilities business enterprise, as defined.

(3) Existing law prescribes the commissioner’s powers and duties, including various duties to regulate the business of insurance in this state and to enforce the execution of those laws. Existing law provides for the issuance of various licenses under the jurisdiction of the commissioner.

Existing law requires specified businesses and corporations to file certain business-related information with the Secretary of State and to pay specified filing fees. Existing law authorizes the Secretary of State to suspend the powers, rights, and privileges of a corporation if the corporation fails to perform specified acts.

This bill would make inactive the license of a licensee that is suspended by the Secretary of State. The bill would prohibit the licensee from conducting any activity for which a license issued by the commissioner is required until the licensee is no longer suspended by the Secretary of State.

(4) Existing law requires the commissioner to submit to the Department of Justice fingerprint images and related information as specified by statute for specified applicants applying for a license, including a surplus line broker and a car rental agent. Existing law also requires the commissioner to give monthly qualifying examinations in each of the cities in which the commissioner has an office.

This bill would require the commissioner to submit fingerprint images and related information for applicants applying for a license as a self-service storage agent, a variable life and variable annuity agent, and a vehicle service contract provider. The bill would, instead, require the commissioner to administer qualifying license examinations at test centers designated by the commissioner and online, as specified.

(5) Existing law generally regulates the business of insurance in the state, including the conduct of insurance licensees. Existing law requires a specified licensee to include their license number in a type size, as specified, on business cards, written price quotations, and print advertisements and in an email that involves an activity for which a license is required. Existing law makes a person in violation of these provisions subject to a fine levied by the commissioner, as specified.

This bill would make those provisions applicable to bail licensees.

(6) Existing law authorizes the commissioner, after a hearing, to revoke the license, or issue an order suspending the license for a period, as specified, of a person to transact life settlements business if the commissioner concludes that it is contrary to the interests of the public for the licensee to continue.

This bill would authorize the commissioner, without a hearing, to suspend or revoke the license of a broker of life settlement contracts if the broker has been convicted of a felony, a specified misdemeanor, or had a previously issued professional, occupational, or vocational license suspended or revoked for cause within the preceding 5 years on grounds that would preclude the granting of a license by the commissioner.

(7) Existing law authorizes interindemnity, reciprocal, or interinsurance contracts to be entered into by physicians and surgeons, with respect to certain types of claims, including, but not limited to, bodily injury or property damage arising out of the conduct and of the operations of the member's professional practice occurring on the member's premises, in addition to medical malpractice claims. Existing law requires each participating member to enter into and receive an executed copy of a trust agreement that governs the collection and disposition of all funds of the interindemnity arrangement. Existing law requires the members to receive specified notifications and ballots by first-class mail.

This bill would allow the members to be also notified by electronic transmission as well as allow for electronic ballots.

(8) Existing law requires that prior to incurring an obligation under a vehicle service contract, an obligor file with the Insurance Commissioner, and receive the commissioner's approval to use, a copy of an insurance policy covering 100% of the obligor's vehicle service contract obligations. In lieu of complying with this provision, existing law allows the obligor or its parent company to establish to the commissioner's satisfaction that it possesses a net worth of $100,000,000. Existing law authorizes an obligor to have on file with the commissioner only one active policy from one insurer at any time.

This bill would, instead, require the obligor to have on file only one active policy from one insurer at any time. The bill would specify that the obligor, unless exempted, is required to comply with either provision, but not both.

(9) Existing law authorizes the commissioner to impose a monetary penalty on a person, or an individual who aids or abets the person, who has acted in a capacity for which a license, registration, or certificate of authority from the commissioner was required but not possessed. Existing law prohibits the commissioner from imposing this monetary penalty on the person or individual who has held a specified license or registration within the prior 5 years, including as an insurance agent, broker, or solicitor, surplus line broker, a bail licensee, or life and disability insurance analyst.

This bill would delete this prohibition, thereby authorizing the commissioner to assess a monetary penalty against these licensees.

(10) Existing law authorizes the Director of Employment Development to approve a settlement of a civil employment tax matter in dispute involving a reduction of tax in settlement of $7,500 or less, and imposes specified procedures for settlements, including approval by the Attorney General, the administrative law judge, or the California Unemployment Insurance Appeals Board under

certain conditions. For a settlement of any civil employment tax matter dispute involving a reduction of tax or penalties in settlement, existing law authorizes the director, and the administrative law judge or the appeals board, to approve settlements not exceeding $5,000 without prior submission to the Attorney General. Existing law authorizes the director to recommend to the appeals board a settlement of a civil employment tax matter dispute involving a reduction in tax exceeding $7,500, and requires the recommended proposed settlement to be submitted to the Attorney General, as specified.

This bill would increase the dollar limits of those settlements to $11,500 for purposes of the above-described provisions, thereby authorizing the director to approve settlements that are $11,500 or less with or without approval from the Attorney General, and, beginning on January 1, 2025, would require the Employment Development Department to compute annual adjustments of that $11,500 limitation by using a detailed calculation that considers the California Consumer Price Index.

(11) Existing law requires an insurer to file financial statements with the commissioner. For purposes of those financial statements, existing law authorizes a domestic insurer to take a credit for reinsurance when the reinsurance is ceded to an assuming insurer if specified requirements are met, including assurances from the assuming insurer that, among other assurances, the assuming insurer is not presently participating in any solvent scheme of arrangement, as defined, which involves ceding insurers in this state, and shall agree to provide security in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer if the assuming insurer enters into a solvent scheme of arrangement.

This bill would specify that the assuming insurer shall provide its security consistent with the terms of the scheme.

(12) Existing law establishes a Fraud Division within the Department of Insurance to investigate fraudulent claims. Existing law requires an insurer or licensed rating organization to notify the local district attorney's office and the Fraud Division of the Department of Insurance when the insurer or licensed rating organization knows or reasonably believes it knows the identity of a person or entity that committed a fraudulent act relating to a workers' compensation insurance claim or policy or reasonably believes that the fraudulent act was not reported to an authorized governmental agency.

This bill would delete the notification requirement for when the insurer or licensed rating organization reasonably believes the fraudulent act was not reported to an authorized governmental agency. The bill would also make a technical change to correct an erroneous reference in a related provision.

(13) Existing law creates the California Automobile Assigned Risk Plan to provide automobile insurance to those persons who would not otherwise be able to procure it, and requires the plan to issue policies affording coverage, with exceptions, in the amount of $15,000 for bodily injury to, or death of, each person as a result of any one accident and, subject to that limit as to one person, the amount of $30,000 for bodily injury to, or death of, all persons as a result of any one accident, and the amount of $5,000 for damage to property of others as a result of any one accident.

This bill would require a plan, for a policy or bond issued or renewed on or after January 1, 2025, to issue policies affording coverages, with exceptions, in the amount of $30,000 for bodily injury to, or death of, each person as a result of any one accident and, subject to that limit as to one person, the amount of $60,000 for bodily injury to, or death of, all persons as a result of any one accident, and the amount of $15,000 for damage to property of others as a result of any one accident. The bill would also require a plan, for a policy or bond issued or renewed on or after January 1, 2035, to issue policies affording coverages, with exceptions, in the amount of $50,000 for bodily injury to, or death of, each person as a result of any one accident and, subject to that limit as to one person, the amount of $100,000 for bodily injury to, or death of, all persons as a result of any one accident, and the amount of $25,000 for damage to property of others as a result of any one accident.

(14) Existing law establishes the California Partnership for Long-Term Care Program, administered by the State Department of Health Care Services, to link private long-term care insurance policies and health care service plan contracts that cover long-term care with the In-Home Supportive Services Program and the Medi-Cal program. Existing law requires a long-term care insurance policy or a health care service plan contract to contain certain provisions certified by the department, including protection against loss of benefits due to inflation. Existing law requires an insurer, if a premium increases, to offer the policyholder or certificate holder options to reduce coverage and lower the premium that would maintain partnership certification. Existing law requires a premium increase notification to include specified options, including additional options to reduce the daily benefit.

This bill would prohibit a premium rate schedule increase from exceeding a cumulative total of 40% over any 3-year period, and would require the amount of the increase to be spread equally over each of the 3 years. The bill would also require an insurer to send a premium increase notification each of the 3 years. The bill would require a premium increase notification to include these specified options, including additional options to reduce the daily benefit, if the Department of Insurance approves a premium rate schedule increase on or after January 1, 2023.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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

SECTION 1. Section 805 is added to the Insurance Code, to read:

805. The license of any licensee that is suspended by the Secretary of State shall become inactive. The inactive licensee shall not conduct any activity for which a license, issued by the commissioner, is required until the licensee is no longer suspended by the Secretary of State.

SEC. 2. Section 922.425 of the Insurance Code is amended to read:

922.425. (a) Credit shall be allowed a domestic insurer when the reinsurance is ceded to an assuming insurer that meets all of the following requirements:

(1) The assuming insurer has its head office or is domiciled in, as applicable, and is licensed to transact reinsurance in, a reciprocal jurisdiction. A "reciprocal jurisdiction" is a jurisdiction, as designated by the commissioner pursuant to subdivision (b), that meets one of the following criteria:

(A) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this section, a "covered agreement" is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act (Sections 313 and 314 of Title 31 of the United States Code), that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into a reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(B) A United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program.

(C) A qualified jurisdiction, as determined by the commissioner pursuant to subdivision (g) of Section 922.41, that is not otherwise described in subparagraph (A) or (B) and that the commissioner determines meets all of the following additional requirements, consistent with the terms and conditions of in-force covered agreements:

(i) Provides that an insurer that has its head office or is domiciled in a qualified jurisdiction shall receive credit for reinsurance ceded to a United States-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in that qualified jurisdiction.

(ii) Does not require a United States-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with a ceding insurer subject to regulation by the non-United States jurisdiction or as a condition to allow the ceding insurer to recognize credit for that reinsurance.

(iii) Recognizes the United States' regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in the qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the National Association of Insurance Commissioners (NAIC) shall be subject only to worldwide prudential insurance group supervision, including worldwide group governance, solvency and capital, and reporting, as applicable, by the commissioner or the commissioner of the domiciliary state and shall not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction.

(iv) Provides written confirmation by a competent regulatory authority in the qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the commissioner in accordance with a memorandum of understanding or similar document between the commissioner and the qualified jurisdiction, including the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

(2) The assuming insurer has and maintains, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in paragraph (7) according to the methodology of its domiciliary jurisdiction, in either of the following amounts:

(A) No less than two hundred fifty million dollars ($250,000,000).

(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters it must have and maintain, both of the following on an ongoing basis:

(i) Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least two hundred fifty million dollars ($250,000,000), calculated according to the methodology applicable in its domiciliary jurisdiction.

(ii) A central fund containing a balance of the equivalent of at least two hundred fifty million dollars ($250,000,000).

(3) The assuming insurer has and maintains, on an ongoing basis, a minimum solvency or capital ratio, as applicable, as follows:

(A) If the assuming insurer has its head office or is domiciled in a reciprocal jurisdiction as defined in subparagraph (A) of paragraph (1), the ratio specified in the applicable covered agreement.

(B) If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subparagraph (B) of paragraph (1), a risk-based capital (RBC) ratio of 300 percent of the authorized control level, calculated in accordance with the formula developed by the NAIC.

(C) If the assuming insurer is domiciled in a reciprocal jurisdiction as defined in subparagraph (C) of paragraph (1), after consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC Committee Process, the solvency or capital ratio that the commissioner determines to be an effective measure of solvency.

(D) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(4) The assuming insurer agrees to and provides adequate assurance to the commissioner, in the form of a properly executed Form RJ-1, as published on the department's internet website, of its agreement to all of the following:

(A) The assuming insurer shall provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in paragraph (2) or (3) or if any regulatory action is taken against it for serious noncompliance with applicable law.

(B) The assuming insurer shall consent, in writing, to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. This subparagraph does not limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent those agreements are unenforceable under applicable insolvency or delinquency laws.

(C) The assuming insurer shall consent, in writing, to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained.

(D) Each reinsurance agreement shall include a provision requiring the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate.

(E) The assuming insurer shall confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers, and shall agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to 100 percent of the assuming insurer's liabilities to the ceding insurer, consistent with the terms of the scheme, if the assuming insurer enters into such a solvent scheme of arrangement. Security shall be in a form consistent with the provisions of paragraph (1) of subdivision (i) of Section 922.41 and Section 922.5 and as specified by regulation. For purposes of this section, "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and that may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

(F) The assuming insurer shall agree, in writing, to meet the applicable information filing requirements as set forth in paragraph (5).

(5) The assuming insurer or its legal successor shall provide, if requested by the commissioner, on behalf of itself and any legal predecessors, the following documentation to the commissioner:

(A) For the two years preceding entry into the reinsurance agreement, and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report.

(B) For the two years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor.

(C) Before entry into the reinsurance agreement, and not more than semiannually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States.

(D) Before entry into the reinsurance agreement, and not more than semiannually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in paragraph (6).

(6) The assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if one of the following criteria is met:

(A) More than 15 percent of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the commissioner.

(B) More than 15 percent of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of 90 days or more that are not in dispute and that exceed one hundred thousand dollars ($100,000) for each ceding insurer, or as otherwise specified in a covered agreement.

(C) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more, exceeds fifty million dollars ($50,000,000), or as otherwise specified in a covered agreement.

(7) The assuming insurer's supervisory authority shall confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in paragraphs (2) and (3).

(8) This subdivision does not preclude an assuming insurer from providing the commissioner with information on a voluntary basis.

(b) The commissioner shall timely create and publish a list of reciprocal jurisdictions.

(1) A list of reciprocal jurisdictions is published through the NAIC Committee Process. The commissioner's list shall include any reciprocal jurisdiction as defined under subparagraphs (A) and (B) of paragraph (1) of subdivision (a), and shall consider any other reciprocal jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions as provided by applicable law or regulation, or in accordance with criteria published through the NAIC Committee Process.

(2) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a reciprocal jurisdiction, as provided by applicable law, a process set forth in regulations issued by the commissioner, or in accordance with criteria published through the NAIC Committee Process, except that the commissioner shall not remove from the list a reciprocal jurisdiction as defined under subparagraphs (A) and (B) of paragraph (1) of subdivision (a). Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant Section 922.4, 922.41, or 922.5.

(c) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section. The commissioner may add an assuming insurer to the list if a NAIC accredited jurisdiction has added the assuming insurer to a list of assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under paragraph (4) of subdivision (a) and complies with any additional requirements that the commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

(1) If a NAIC accredited jurisdiction has determined that the conditions set forth in subdivision (a) have been met, the commissioner has the discretion to defer to that jurisdiction's determination, and add an assuming insurer to the list of assuming insurers to which cessions shall be granted credit. The commissioner may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of subdivision (a).

(2) When requesting that the commissioner defer to another NAIC accredited jurisdiction's determination, an assuming insurer shall submit a properly executed Form RJ-1, as published on the department's internet website, and additional information as the commissioner may require. Upon receiving the request, the commissioner shall notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

(d) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition.

(1) While an assuming insurer's eligibility is suspended, a reinsurance agreement issued, amended, or renewed after the effective date of the suspension shall not qualify for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Section 922.5.

(2) If an assuming insurer's eligibility is revoked, credit for reinsurance shall not be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Section 922.5.

(e) Before denying statement credit, imposing a requirement to post security with respect to subdivision (d), or adopting a similar requirement that will have substantially the same regulatory impact as security, the commissioner shall do all of the following:

(1) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in subdivision (a).

(2) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect, and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection.

(3) After the expiration of 90 days or less, as set forth in paragraph (2), if the commissioner determines that no or insufficient action was taken by the assuming insurer, the commissioner may impose any of the requirements of this subdivision.

(4) Provide a written explanation to the assuming insurer of any of the requirements set out in this subdivision.

(f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(g) This section does not limit or alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by Sections 922.1 to 922.9, inclusive, or other applicable law or regulation.

(h) Credit may be taken under this section only for reinsurance agreements entered into, amended, or renewed on or after January 1, 2021, and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements pursuant to subdivision (a) and the effective date of the new reinsurance agreement, amendment, or renewal.

(1) This subdivision does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this section, as long as the reinsurance qualifies for credit under Sections 922.1 to 922.9, inclusive.

(2) This section does not authorize an assuming insurer to withdraw or reduce the security provided under a reinsurance agreement, except as permitted by the terms of the agreement.

(3) This section does not limit or alter the capacity of parties to a reinsurance agreement to renegotiate the agreement.

SEC. 3. Section 927 of the Insurance Code is amended to read:

927. The Legislature finds and declares all of the following:

(a) It is in the state's interest to encourage competitive business opportunities for all of its people. Insurers are uniquely positioned to build relationships within the communities they serve through the development, inclusion, and utilization of certified minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business enterprises whenever possible.

(b) It is in the state's interest to encourage corporate leadership opportunities for all of its people. Insurers are uniquely positioned to build relationships within the communities they serve through the development of a corporate board that represents the diversity of the state.

(c) According to the California Insurance Diversity Survey, in 2021, among at least 1,600 board seats reported by 386 insurance companies, nearly 64 percent of those seats were occupied by Caucasians, and 62 percent of board members identified as men. Meanwhile, less than 1 percent of board members publicly identified as LGBT, 4.1 percent publicly identified as veterans, and less than 1 percent publicly identified as disabled veterans. Moreover, diverse board members from historically underrepresented communities continue to remain disproportionately low. Blacks and African Americans, Asians-Pacific Islanders, Hispanics-Latinos, and Native Americans comprised only 7.8 percent, 4.4 percent, 3.4 percent, and 0 percent, of board seats, respectively.

(d) An analysis by KPMG of 2020 proxy statement data from Equilar, Inc. revealed that nearly 23 percent of the directors serving on the boards of publicly held insurance companies in the Russell 3000 Index are women. At more than 35 percent of insurance companies, women comprise less than 10 percent of the board.

(e) By requiring each major insurer to report to the Insurance Commissioner, explaining the insurer's supplier diversity statement, expressing its goals regarding certified minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business enterprises, and detailing the insurer's efforts and goals regarding board diversity, and by having the commissioner place that information on the department's internet website, will help facilitate these relationships.

SEC. 4. Section 927.1 of the Insurance Code is amended to read:

927.1. For the purposes of this article, the following definitions apply:

(a) "Control" means to exercise the power to make policy decisions.

(b) "Disabled veteran business enterprise" has the same meaning as defined in subparagraph (A) of paragraph (7) of subdivision (b) of Section 999 of the Military and Veterans Code, or any successor provision. Disabled veteran business enterprise certification eligibility requirements shall be consistent with those imposed by the Department of General Services, and this section applies only to those disabled veteran business enterprises certified by the Department of General Services.

(c) "LGBT business enterprise" means a business enterprise that is 51 percent owned, managed, operated, and controlled by one or more lesbian, gay, bisexual, or transgender (LGBT) individuals, has been legally formed in the United States, and exercises independence from any non-LGBT business enterprise.

(d) "Minority business enterprise" means a business enterprise, physically located in the United States or its trust territories, that is at least 51 percent owned by a minority group or groups, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more minority groups, and whose management and daily business operations are controlled by one or more of those individuals. "Minority" includes African Americans, Hispanic Americans, Native Americans, and Asian Pacific Americans.

(e) "Operate" means to be actively involved in the day-to-day management of the enterprise and not to be merely officers or directors.

(f) "Person with disabilities" means a person who identifies as having any of the following:

(1) A physical or mental impairment that substantially limits one or more major life activities as defined by subdivision (2) of Section 12102 of Title 42 of the United States Code, also known as the federal Americans with Disabilities Act of 1990.

(2) A record of such an impairment.

(3) Being regarded as having such an impairment as described under subdivision (3) of Section 12102 of the federal Americans with Disabilities Act of 1990.

(g) (1) "Persons with disabilities business enterprise" or "Disability-owned business enterprise" or "Disabled-owned business enterprise" means a business enterprise physically located in the United States or its trust territories, that is at least 51 percent owned by a person or persons with a disability or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by one or more persons with a disability, and whose management and daily business operations are controlled by one or more of those individuals.

(2) "Disabled" means an individual who self-identifies as having a disability, as defined in Section 12102 of the federal Americans with Disabilities Act of 1990.

(h) "Women business enterprise" means a business enterprise physically located in the United States or its trust territories, that is at least 51 percent owned by a woman or women, or, in the case of any publicly owned business at least 51 percent of the stock of which is owned by one or more women, and whose management and daily business operations are controlled by one or more of those individuals.

(i) “Veteran business enterprise” means a business enterprise physically located in the United States or its trust territories that is at least 51 percent owned by one or more veteran groups or, in the case of a publicly owned business, at least 51 percent of the stock of which is owned by one or more veteran groups, and whose management and daily business operations are controlled by one or more of those individuals.

SEC. 5. Section 927.2 of the Insurance Code is amended to read:

927.2. (a) (1) Commencing July 1, 2020, and biennially on July 1 of each even-numbered year thereafter, each admitted insurer, with California premiums written of seventy-five million dollars ($75,000,000) or more, shall report to the commissioner on its minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business procurement efforts during the previous two years.

(2) The insurer shall provide all of the following:

(A) The insurer’s supplier diversity policy statement.

(B) The insurer’s outreach and communications to minority, women, LGBT, persons with disabilities, veteran, and disabled veteran business enterprises, including:

(i) How the insurer encourages and seeks out minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business enterprises to become potential suppliers.

(ii) How the insurer encourages its employees involved in procurement to seek out minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business enterprises to become potential suppliers.

(iii) How the insurer conducts outreach and communication to minority, women, LGBT, persons with disabilities, veteran, and disabled veteran business enterprises.

(iv) How the insurer supports organizations that promote or certify minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business enterprises.

(v) Information regarding appropriate contacts at the insurer for interested business enterprises.

(C) Information about which procurements are made from minority, women, LGBT, persons with disabilities, and veteran business enterprises with a headquarters’ address in California, and from disabled veteran business enterprises, as defined in subdivision (b) of Section 927.1, with each category aggregated separately, to the extent that information is readily accessible. An insurer may also include other relevant information.

(D) Information about which procurements are made from minority, women, LGBT, persons with disabilities, veteran, and disabled veteran business enterprises with at least a majority of the enterprise’s workforce in California, with each category aggregated separately, to the extent that information is readily accessible. An insurer may also include other relevant information.

(E) Information related to total procurement contract dollars awarded, to the extent that information is readily accessible. An insurer may also include other relevant information.

(3) An insurer that does not enter into contracts to procure goods or services in California satisfies the requirements of paragraph (2) by filing a statement with the commissioner attesting that it does not enter into procurement contracts in California.

(b) This section does not require quotas, set-asides, or preferences in an admitted insurer’s procurement of goods or services, and this section does not apply to insurer producer or licensee contracts. Admitted insurers retain the authority to use business judgment to select the supplier for a particular contract.

(c) This section does not preclude an admitted insurer that is a member of an insurance holding company system, as defined in Article 4.7 (commencing with Section 1215) of Chapter 2, from complying with paragraphs (1) and (2) of subdivision (a) through a single filing on behalf of the entire group of affiliated companies.

(d) Failure to report the information required by subdivision (a), by the reporting deadline, shall subject the admitted insurer to a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000), or if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000). An insurer may request, and the commissioner may grant, a 30-day extension to report the information if needed due to unintended or unforeseen delays. If the insurer has failed to report the information within 30 days of a written notice by the commissioner that the insurer has failed to report the information, the commissioner may find that the failure to report the information was willful and increase the civil penalty to an amount not to exceed ten thousand dollars ($10,000). The penalty imposed by this section shall be enforced by the commissioner and is

appealable by means of any remedy provided by Section 12940, or by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. This subdivision is the sole means for enforcement of this section.

(e) By November 1 of the reporting year, the commissioner shall establish and maintain a link on the department's internet website that provides public access to the contents of each admitted insurer's reported information on minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned business procurement efforts. The commissioner shall include a statement on the department's internet website that the information on minority, women, LGBT, persons with disabilities, veteran, and disabled veteran-owned businesses posted pursuant to this subdivision is provided for informational purposes only.

SEC. 6. Section 927.3 of the Insurance Code is amended to read:

927.3. (a) (1) Commencing July 1, 2020, and biennially on July 1 of each even-numbered year thereafter, each admitted insurer with California premiums written of seventy-five million dollars ($75,000,000) or more, shall report to the commissioner on its governing board and board diversity efforts during the previous two years.

(2) The insurer shall provide all of the following information:

(A) The demographic makeup of the insurer's governing board.

(B) The insurer's goals regarding board diversity, including outreach and communication strategies to diversify its board.

(C) A board diversity policy statement or a measurable goal or goals to include at least one diverse board member on the insurer's board of directors. For purposes of this subparagraph:

(i) A "board diversity policy statement" is any language that refers to an insurer's corporate governance policy or guidelines, with the goal of increasing diversity on the insurer's board of directors. Board diversity language as part of an insurer's corporate governance policy describes how the board considers gender, ethnicity, race, age, geographic location, sexual orientation, skills, disability, and experience when identifying director candidates and throughout the nomination process.

(ii) A "diverse board member" means an individual who self-identifies as a woman, nonbinary, Black, African American, Hispanic, Latino-Latina, Asian, Pacific Islander, Native American, Native Hawaiian, Alaskan Native, person with disabilities, veteran or disabled veteran, lesbian, gay, bisexual, transgender, or queer.

(b) (1) An insurer shall provide each board member with an opportunity to participate in a survey for the purpose of collecting and reporting the information described in subparagraph (A) of paragraph (2) of subdivision (a).

(2) The insurer shall distribute a written disclosure to each board member prior to, or concurrently with, the survey. The disclosure shall notify the board member that the board member's decision to disclose their demographic information is voluntary, that no adverse action may be taken against the board member or the insurer if the board member declines to participate in the survey, and that the aggregate data collected for each demographic category will be reported.

(3) The survey shall be completed using a standardized form to be specified by the commissioner.

(4) Neither an insurer nor the department shall in any way encourage, incentivize, or attempt to influence the decision of a board member to participate in the survey.

(5) An insurer required to conduct the survey shall do both of the following:

(A) Collect survey response data from board members in a manner that maintains the anonymity of the responding board member and the confidentiality of the data reported.

(B) Transmit the survey response data to the department in a manner that does not associate the survey response data with an individual board member.

(c) This section does not require quotas, set-asides, or preferences in regard to an admitted insurer's governing board.

(d) This section does not preclude an admitted insurer that is a member of an insurance holding company system, as defined in Article 4.7 (commencing with Section 1215) of Chapter 2, from complying with subdivisions (a) and (b) through a single filing by the insurance holding company on behalf of an entire group of affiliated companies that identifies the aggregated survey results for each affiliated insurer.

(e) By November 1 of the reporting year, the commissioner shall establish and maintain a link on the department's internet website that provides public access to the information submitted pursuant to this section. The commissioner shall publish the information submitted pursuant to this section in the aggregate, and shall not identify an individual respondent or insurer. The

commissioner shall include a statement on the department's internet website that the information posted pursuant to this subdivision is provided for informational purposes only.

(f) The data collected pursuant to this section is confidential and shall not be released by the department or an insurer under any circumstances, except as provided in this section.

SEC. 7. Section 927.4 of the Insurance Code is amended to read:

927.4. (a) The commissioner shall establish and appoint an Insurance Diversity Task Force.

(b) The task force shall be comprised of at least 13, but not more than 15, members as follows:

(1) The commissioner or the commissioner's designee.

(2) Two members who are representatives in the insurance industry, one of whom shall, at the time of appointment, serve as a practitioner in the field of supplier diversity, and one of whom shall, at the time of appointment, have expertise in governing board diversity.

(3) Two members who are representatives of a minority business enterprise.

(4) Two members who are representatives of a women business enterprise.

(5) A member who is a representative of a disabled veteran business enterprise or a veteran business enterprise.

(6) A member who is a representative of an LGBT business enterprise.

(7) A member who is representative of a persons with disabilities business enterprise.

(8) Two members with expertise in the field of supplier diversity.

(9) Two members with expertise in the field of governing board diversity.

(c) The term of each member shall be for two years. Staggered terms shall be established by drawing lots at the first meeting of the task force so that a simple majority of the members shall initially serve a two-year term, and the remainder shall initially serve a one-year term.

(d) The task force shall have all of the following duties:

(1) To advise and provide recommendations to the department on the best methods to increase procurement with diverse suppliers and to increase diversity on governing boards within the insurance industry.

(2) To meet quarterly, or as deemed necessary by the commissioner, or the commissioner's designee.

(3) Assist the department in promoting and providing outreach to insurance companies that are actively engaged in supplier and governing board diversity issues.

(e) The members of the task force shall not receive compensation from the state for their services under this section but may be reimbursed for their actual and necessary expenses incurred in connection with attending a task force meeting.

(f) The department shall review and revise, if necessary, the department's conflicts of interest regulations to ensure that each task force member is required to disclose conflicts of interest to the public.

SEC. 8. Section 1280.7 of the Insurance Code is amended to read:

1280.7. (a) This chapter and the other provisions of this code, except as set forth in this paragraph, shall not apply to or affect unincorporated interindemnity or reciprocal or interinsurance contracts between members of a cooperative corporation, organized and operating under Part 2 (commencing with Section 12200) of Division 3 of Title 1 of the Corporations Code, whose members consist solely of physicians and surgeons licensed in California, which contracts indemnify solely in respect to medical malpractice claims against those members, and which do not collect in advance of loss any moneys other than contributions by each member to a collective reserve trust fund or for necessary expenses of administration. However, interindemnity, reciprocal, or interinsurance contracts with respect to the following types of claims, in addition to medical malpractice claims, may be entered into in conjunction with contracts with respect to medical malpractice claims if the reserve trust fund is at least twenty million dollars ($20,000,000):

(1) Bodily injury or property damage arising out of the conduct and of the operations of the member's professional practice occurring on the member's premises.

(2) Officers', directors', and administrators' liability, to the extent that the member's professional practice is operated as a professional corporation or group.

(3) Nonowned automobile coverage.

The provisions of Chapter 3 (commencing with Section 330) of Part 1 of Division 1 shall apply to unincorporated interindemnity or reciprocal or interinsurance contracts. Those unincorporated interindemnity or reciprocal or interinsurance contracts shall comply with all of the following requirements:

(b) Each participating member shall enter into and, concurrently therewith, receive an executed copy of a trust agreement, which shall govern the collection and disposition of all funds of the interindemnity arrangement.

The trust agreement shall, at a minimum, contain provision for all the following matters:

(1) An initial trust corpus of not less than ten million dollars ($10,000,000), which corpus shall be a trust fund to secure enforcement of the interindemnity arrangement. The average contribution to the initial trust corpus shall be not less than twenty thousand dollars ($20,000) per member participating in the interindemnity arrangement. The average contribution to the trust fund shall continue at all times to be not less than twenty thousand dollars ($20,000) per participating member unless the interindemnity arrangement is qualified to admit members under the terms of subdivision (k). No such interindemnity arrangement shall become operative until the requisite minimum reserve trust fund has been established by contributions from not fewer than 500 participating members.

(2) The reserve trust fund created by the trust agreement shall be administered by a board of trustees of three or more members, all of whom shall be physicians and surgeons licensed in California, participating members in the interindemnity arrangement, and elected biennially or more frequently by at least a majority of all members participating in the interindemnity arrangement.

(3) The members of the board of trustees are fiduciaries and the board shall be the custodian of all funds of the interindemnity arrangement, and all those funds shall be deposited in the bank or banks and savings and loan associations in California as the board may designate. Each account shall require two or more signatories for withdrawal of funds in excess of ten thousand dollars ($10,000). The authorized signatories shall be appointed by the board and, as to any withdrawal in excess of one hundred thousand dollars ($100,000), at least one of the two or more authorized signatories shall be a physician and surgeon licensed in California and a participating member in the interindemnity arrangement. Each signatory on those accounts shall maintain, at all times while empowered to draw on those funds, for the benefit of the interindemnity arrangement, a bond against loss suffered through embezzlement, mysterious disappearance, holdup or burglary, or other loss issued by a bonding company licensed to do business in California in a penal sum of not less than one hundred thousand dollars ($100,000).

(4) All funds held in trust that are in excess of current financial needs shall be invested and reinvested from time to time, under the direction of the board of trustees, in eligible securities, as defined in Section 16430 of the Government Code, in portfolios of eligible securities, in exchange traded financial futures contracts or exchange traded options contracts to hedge investment in those eligible securities, or in certificates of deposits or time deposits issued by banks and savings and loan associations in California duly insured by instrumentalities of the United States government.

Pursuant to the authority contained in Section 1 of Article XV of the California Constitution, the restrictions upon rates of interest contained in Section 1 of Article XV of the California Constitution shall not apply to any obligations of, loans made by, or forbearances of, any trust established by a cooperative corporation providing indemnity pursuant to this section.

(5) The income earned on the corpus of the trust fund shall be the source for the payment of the claims, costs, judgments, settlements, and costs of administration contemplated by the interindemnity arrangement, and to the extent the income is insufficient for those purposes, the board of trustees shall have the power and authority to assess participating members for all amounts necessary to meet the obligations of the interindemnity arrangement in accordance with the terms thereof. If necessary in the best interests of the interindemnity arrangement, the board of trustees may make assessments to increase the corpus of the trust fund in accordance with the terms of the interindemnity arrangement. Any assessment levied against a member shall be the personal obligation of the member. Any person who obtains a final judgment of recovery for medical malpractice or other liability authorized by this section against a member of the interindemnity arrangement shall have, in addition to any other remedy, the right to assert directly all rights to indemnification that the judgment debtor has under the interindemnity arrangement. The final judgment shall be a lien on the reserve trust fund to secure payment of the judgment, limited to the extent of the judgment debtor's rights to indemnification.

Any change in the assessment agreement between the interindemnity arrangement and its membership shall be submitted to the entire membership for ratification. If the ratification process is to be performed by ballot, a ballot shall be sent to each member by first-class mail, postage prepaid, or by electronic transmission. Within 45 days after the posted date on the ballot, each member who decides to vote on the assessment change shall return their mail or electronic ballot to the interindemnity arrangement for

the tallying of the ballots. An affirmative vote of 75 percent of those voting shall be required to effectuate any change in the assessment agreement.

If a change in the assessment agreement is to be submitted to members at a properly called meeting, the membership shall be notified of the meeting and the proposed assessment change by first-class mail, postage prepaid, or by electronic transmission at least 45 days prior to the meeting. Seventy-five percent of those present in person or by proxy at the meeting shall be required to effectuate any change in the assessment agreement.

(6) Each participating member shall be covered by the interindemnity arrangement for not less than one million dollars ($1,000,000) for each occurrence of professional negligence or other liability authorized by this section, with the terms and conditions of the coverage to be specified in the trust agreement, except that the interindemnity arrangement may provide participating members with an aggregate limit for all payments on behalf of the member and may provide participating members with less than one million dollars ($1,000,000) of coverage for each occurrence of professional negligence or other liability authorized by this section if the interindemnity arrangement obtains for the benefit of the members reinsurance of excess limits coverage in an amount that when added to the coverage provided by the interindemnity arrangement would equal not less than one million dollars ($1,000,000) for each occurrence of professional negligence or other liability authorized by this section.

Any change in the coverage provided by the trust agreement between the interindemnity arrangement and its membership shall be submitted to the entire membership for ratification. If the ratification process is to be performed by ballot, a ballot shall be sent to each member by first-class mail, postage prepaid, or by electronic transmission. Within 45 days after the posted date on the ballot, each member who decides to vote on the coverage change shall return their mail or electronic ballot to the interindemnity arrangement for the tallying of the ballot. An affirmative vote of 75 percent of those voting shall be required to effectuate any change in the coverage provided by the trust agreement, except that at least 50 percent of the entire membership must agree to any change.

If any change is to be submitted to members at a properly called meeting, the membership shall be notified of the meeting and the proposed coverage change by first-class mail, postage prepaid, or by electronic transmission at least 45 days prior to the meeting. An affirmative vote of 75 percent of the membership present at the meeting, in person or by proxy, shall be required to effectuate any change, except that at least 50 percent of the entire membership must agree to any change.

(7) Withdrawal of all, or any portion of, the corpus of the reserve trust fund shall be upon the written authorization signed by at least two-thirds of the members of the board of trustees.

(8) The board of trustees shall cause both of the following to be furnished to each member participating in the interindemnity arrangement by first-class mail, postage prepaid, or by electronic transmission, and to be filed with the Commissioner of Financial Protection and Innovation:

(A) Within 90 days after the end of each fiscal year, a statement of the assets and liabilities of the interindemnity arrangement as of the end of that year, a statement of the revenue and expenditures of the interindemnity arrangement, and a statement of the changes in corpus of the reserve trust for that year, in each case accompanied by a certificate signed by a firm of independent certified public accountants selected by the board of trustees indicating that the firm has conducted an audit of those statements in accordance with generally accepted auditing standards and indicating the results of the audit.

(B) Within 45 days after the end of each of the first three quarterly periods of each fiscal year, a statement of the assets and liabilities of the interindemnity arrangement as of the end of the quarterly period, a statement of the revenue and expenditures of the interindemnity arrangement, and a statement of the changes in corpus of the reserve trust for the period, in each case accompanied by a certificate signed by a majority of the members of the board of trustees to the effect that the statements were prepared from the official books and records of the interindemnity arrangement.

(C) In addition to the statements required to be filed pursuant to this paragraph, the board of trustees shall annually file with the Commissioner of Financial Protection and Innovation an authorization for disclosure to the commissioner of all financial records pertaining to the interindemnity arrangement. For the purpose of this subparagraph, the authorization for disclosure shall also include the financial records of any association, partnership, or corporation that has management or control of the funds or the operation of the interindemnity arrangement.

(9) The trust agreement shall also provide for all the following:

(A) In the event a participating member who is in full compliance with the trust agreement, including the payment of all outstanding dues and assessments, dies, the initial contribution made by the decedent shall be returned to the member’s estate or designated beneficiary; the indemnity coverage shall continue for the benefit of the decedent’s estate in respect of occurrences during the time the decedent was a participating member; and neither the person receiving the repayment of

the initial contribution nor the decedent's estate shall be responsible for any assessments levied following the death of the member.

(B) A participating member who is then in full compliance with the trust agreement and who has reached the age of 65 years and who has retired completely from the practice of medicine may elect to retire from the interindemnity arrangement, in which case the member shall not be responsible for assessments levied following the date notice of retirement is given to the trust. Following that retirement, the indemnity coverage shall continue for the benefit of the member in respect of occurrences prior to the time the member retired from the interindemnity arrangement. That retired member's initial contribution shall be repaid 10 years from the date the notice of retirement is received by the trust, or an earlier date as specified in the trust agreement. The board of trustees may reduce the age for retirement to not less than 55 years subject to all other requirements in this paragraph and any additional requirements deemed necessary by the board.

(C) During any period in which a participating member, who is then in full compliance with the trust agreement, has, in the judgment of the board of trustees, become unable to perform any and every duty of their regular professional occupation, the participating member may request disability status in accordance with the terms of the interindemnity arrangement. During any period of disability status, the member shall not be responsible for assessments levied during the period and, if so provided in the interindemnity arrangement, all indemnity coverage, both as to defense and payment of claims, shall terminate as to occurrences arising out of the actions of the participating member during the period of disability status.

(D) In the event a participating member fails to pay any assessment when due, the board of trustees may terminate that person's membership status if the failure to pay is not cured within 30 days from the date the assessment was due. Upon that termination the former participating member shall not be entitled to the return of all or any part of their initial contribution, and the indemnity coverage shall thereupon terminate as to all claims then pending against that person and in respect to all occurrences prior to the date of that termination of membership. However, in the event the interindemnity arrangement is then providing legal defense services to that person, the interindemnity arrangement shall continue to provide those services for a period of 10 days following that termination.

(E) In the event a participating member fails to comply with any provision of the trust agreement (other than a failure to pay assessments when due), the board of trustees may terminate that person's membership status if the failure to comply is not cured within 60 days from the date the person is notified of the failure, provided that before that membership status may be terminated the person shall be given the right to call for a hearing before the board of trustees (to be held before the expiration of the 60-day period), at which hearing the person shall be given the opportunity to demonstrate to the board of trustees that no failure to comply has occurred or, if it has occurred, that it has been cured. Upon that termination, the former participating member shall not be entitled to the return of all or any part of their initial contribution, and the indemnity coverage shall thereupon terminate as to all claims then pending against the person and in respect to all occurrences prior to the date of the termination of membership. However, in the event the interindemnity arrangement is then providing legal defense services to that person, the interindemnity arrangement shall continue to provide those services for a period of 10 days following the termination.

(F) A participating member who is then in full compliance with the trust agreement may elect voluntarily to terminate their membership in the interindemnity arrangement. Upon that voluntary termination, that person may further elect to cease being responsible for future assessments, or to continue to pay those assessments until the time as the person's initial contribution is repaid. In the event the person elects to cease being responsible for future assessments, the indemnity coverage shall thereupon terminate and the person shall either be responsible for their own exposure for acts committed while a participating member in the interindemnity arrangement, or they may request the interindemnity arrangement to purchase or provide, at the cost of the person, coverage for that exposure. The initial contribution of the person shall be repaid on the 10th anniversary of the date the contribution was made. In the event the person elects to continue to be responsible for assessments, the indemnity coverage shall continue in respect of occurrences prior to the date of the voluntary termination, and the initial contribution of the person shall be repaid at the time as the board of trustees is satisfied that (i) there are no claims pending against the person in respect of occurrences during the time the person was a participating member, and (ii) the statute of limitations has run on all claims that might be asserted against that person in respect of occurrences during that time. In no event shall that repayment be made earlier than the 10th anniversary of the date the contribution was made.

Any person whose membership in an interindemnity arrangement is involuntarily terminated for failure to pay assessments or who voluntarily terminates that membership and elects to be responsible for their own exposure for acts committed while a participating member, shall not be eligible to become a member of any other interindemnity arrangement for a period of five years after the termination unless, on the effective date of the act which amended this section during the 1985–86 Regular Session, the person had on file with the Department of Financial Protection and Innovation a copy of a subscription agreement signifying the person's agreement to transfer membership or had paid a minimum of ten thousand dollars ($10,000) to another interindemnity arrangement that was granted a permit to organize prior to January 1, 1985.

(G) The board of trustees shall have the right to terminate the membership of a participating member if the board of trustees determines that the termination is in the best interests of the interindemnity arrangement even though that person has complied with all of the provisions of the trust agreement. A termination may be effected only if at least two-thirds of the members of the board of trustees indicate in writing their decision to terminate. If the board of trustees proposes to terminate a member, the member shall have the right to call a special meeting of all participating members in accordance with the rules established by the board of trustees for the purpose of voting on whether or not the member shall be terminated. The member shall not be terminated if at least two-thirds of the participating members present, in person or by proxy, indicate that the member should not be terminated. In the event a member is terminated, the person shall elect either: (i) to request the return of their initial contribution, in which case the contribution shall be repaid and the indemnity coverage shall thereupon terminate as to all claims then pending against the person and in respect to all occurrences prior to the date of the termination of membership. However, in the event the interindemnity arrangement is then providing legal defense services to the person, the interindemnity arrangement shall continue to provide those services for a period of 30 days to enable the person to assume their own defense; or (ii) to release all rights to the return of the initial contribution, in which case the indemnity coverage shall continue for the benefit of the member in respect of occurrences during the time the person was a participating member and the person shall have no responsibility for assessments levied following that termination. The interindemnity arrangement may provide that if a member is terminated and fails to make the election set forth herein within 45 days of the date of notification of termination of membership, the participating member shall be deemed to have elected to release all rights to a return of their initial contribution, in which case indemnity coverage shall apply for the benefit of the member with respect to occurrences occurring prior to the termination.

(10) Each member participating in the interindemnity arrangement shall have the right of access to, and the inspection of, the books and records of the interindemnity arrangement, which rights shall be similar to the corporate shareholders pursuant to Section 3003 of the Corporations Code, or, commencing January 1, 1977, Sections 1600 to 1605, inclusive, of the Corporations Code.

(11) There shall be a meeting of all members participating in the interindemnity arrangement, at least annually, after not less than 10 days' written notice has been given, at a location reasonably convenient to the participating members and on a date that is within a reasonable period of time following the distribution of the annual financial statements.

(12) Notwithstanding Sections 12453 and 12703 of the Corporations Code, on any matter to be voted upon by the membership at either a regular or special meeting, a member shall have the right to vote in person or by written proxy filed with the corporate secretary prior to the meeting. No proxy shall be made irrevocable, nor be valid beyond the earliest of the following dates:

(A) The date of expiration set forth in the proxy.

(B) The date of termination of membership.

(C) Eleven months from the date of execution of the proxy.

(D) Such time as may be specified in the bylaws, not to exceed 11 months.

(13) The interindemnity arrangement, and the reserve trust fund incident thereto, shall be subject to termination at any time by the vote or written consent of not less than three-fourths of the participating members.

(c) The board of trustees shall cause to be recorded with the office of the county recorder of the county of the principal place of business of the interindemnity arrangement within 90 days following the end of each fiscal year, a written statement, executed by a majority of the board of trustees under penalty of perjury, reciting that each member participating in the interindemnity arrangement was mailed a copy of the annual financial statement and quarterly audit certificates by first-class mail, postage prepaid, required pursuant to paragraph (8) of subdivision (a).

(d) Each person solicited to become a participating member in an interindemnity arrangement shall receive in writing, at least 48 hours prior to the execution by the prospective participating member of the trust agreement, and at least 48 hours prior to the payment by the prospective participating member of any consideration in connection with the interindemnity arrangement, the following information:

(1) A copy of the articles of incorporation and bylaws of the cooperative corporation and a copy of the form of trust agreement to be executed by the prospective participating member.

(2) A disclosure statement regarding the interindemnity arrangement. The disclosure statement shall contain on the first or cover page a legend in boldface type reading substantially as follows:

“THE INTERINDEMNITY ARRANGEMENT CONTEMPLATED HEREIN PROVIDES THAT PARTICIPATING MEMBERS HAVE UNLIMITED PERSONAL LIABILITY FOR ASSESSMENTS THAT MAY BE LEVIED TO PAY FOR THE PROFESSIONAL NEGLIGENCE OR OTHER LIABILITY AUTHORIZED BY THIS SECTION. NO ASSURANCES CAN BE GIVEN REGARDING THE AMOUNT OR FREQUENCY OF ASSESSMENTS WHICH MAY BE LEVIED, OR THAT ALL PARTICIPATING MEMBERS WILL MAKE TIMELY PAYMENT OF THEIR ASSESSMENTS TO COVER THE PROFESSIONAL NEGLIGENCE OR OTHER LIABILITY AUTHORIZED BY THIS SECTION.”

(3) The disclosure statement shall further contain all of the following information:

(A) The amount, nature, and terms and conditions of the professional negligence or other liability relating to a member’s professional practice coverage available under the interindemnity arrangement.

(B) The amount of the initial contribution required of each participating member and a statement of the minimum number of members and aggregate contributions required for the interindemnity arrangement to commence.

(C) The names, addresses, and professional experience of each member of the board of trustees.

(D) The requirements for admission as a participating member.

(E) A statement of the services to be provided under the interindemnity arrangement to each participating member.

(F) A statement regarding the obligation of each member to pay assessments and the consequences for failure to do so.

(G) A statement of the rights and obligations of a participating member in the event the member dies, retires, becomes disabled, or terminates participation for any reason, or the interindemnity arrangement terminates for any reason.

(H) A statement regarding the services to be provided, indicating whether these services will be delegated to others pursuant to a contractual arrangement. For those services delegated to others pursuant to a contractual arrangement, a statement fully disclosing and itemizing all consideration received directly or indirectly under the arrangement, and indicating what the consideration is for, and how, when, and to whom the consideration will be paid.

(I) A statement of the voting rights of the members and the circumstances under which participation of a member may be terminated and under which the interindemnity arrangement may be terminated.

(J) If any statement of estimated or projected financial information for the interindemnity arrangement is used, a statement of the estimation or projection and a summary of the data and assumptions upon which it is based.

(4) A list with the names and addresses of current participating members of the interindemnity arrangement.

(e) No officer, director, trustee, employee, or member of the interindemnity arrangement or the cooperative corporation shall receive, or be entitled to receive, any payment, bonus, salary, income, compensation, or other benefit whatsoever, either from the reserve trust fund or the income therefrom or from any other funds of the interindemnity arrangement or the members thereof based on the number of participating members, or the amount of the reserve trust fund or other funds of the interindemnity arrangement.

(f) A peer review committee or committees shall be established by the trust agreement to review the qualifications of any physician and surgeon to participate or continue to participate in the interindemnity arrangement, and to review the quality of medical services rendered by any participating member, as well as the validity of medical malpractice claims made against participating members. Any physician and surgeon, prior to becoming a participating member of the interindemnity arrangement, shall be reviewed and approved by a majority of the members of the peer review committee. No peer review committee, or any of its members, shall be liable for any action taken by the committee in reviewing the qualifications of a physician and surgeon to participate or continue to participate, or the quality of medical services rendered, or the validity of a medical malpractice claim, unless it is alleged and proved that the action was taken with actual malice.

(g) The following are hereby defined as unfair methods of competition and deceptive acts or practices with respect to cooperative corporations or interindemnity arrangements provided for in this section:

(1) Making any false or misleading statement as to, or issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any interindemnity arrangement or the benefits or advantages promised thereby, or making any misleading representation or any misrepresentation as to the financial condition of the interindemnity arrangement, or making any misrepresentation to any participating member for the purpose of inducing or tending to induce the member to lapse, forfeit, or surrender their rights to indemnification under the interindemnity arrangement. It shall be a false or misleading statement to state or represent that a cooperative corporation or interindemnity arrangement is or constitutes “insurance” or an “insurance company” or an “insurance policy.”

(2) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation, or statement with respect to those cooperative corporations or interindemnity arrangements, or with respect to any person in the conduct of those cooperative corporations or interindemnity arrangements, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading. It shall be a false or misleading statement to state or represent that a cooperative corporation or interindemnity arrangement is or constitutes “insurance” or an “insurance company” or an “insurance policy.”

(3) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in an unreasonable restraint of, or monopoly in, those cooperative corporations or interindemnity arrangements.

(4) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, or delivered to any person, or placed before the public any false statement of financial condition of a cooperative corporation or interindemnity arrangement with intent to deceive.

(5) Making any false entry in any book, report, or statement of a cooperative corporation or interindemnity arrangement with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom a cooperative corporation or interindemnity arrangement is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to a cooperative corporation or interindemnity arrangement in any book, report, or statement of a cooperative corporation or interindemnity arrangement.

(6) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, whether directly or by implication, any statement that a cooperative corporation or interindemnity arrangement is a member of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This paragraph shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or of the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063) of Chapter 1.

(7) Knowingly committing or performing with a frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(A) Misrepresenting to claimants pertinent facts or provisions relating to any coverage at issue.

(B) Failing to acknowledge and act promptly upon communications with respect to claims arising under those interindemnity arrangements.

(C) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under those interindemnity arrangements.

(D) Failing to affirm or deny coverage of claims within a reasonable time after proof of claim requirements have been completed and submitted by the participating member.

(E) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(F) Compelling participating members to institute litigation to recover amounts due under an interindemnity arrangement by offering substantially less than the amounts ultimately recovered in actions brought by those participating members when those participating members have made claims under those interindemnity arrangements for amounts reasonably similar to the amounts ultimately recovered.

(G) Attempting to settle a claim by a participating member for less than the amount to which a reasonable person would have believed they were entitled by reference to written or printed advertising material accompanying or made part of an application for membership in an interindemnity arrangement.

(H) Attempting to settle claims on the basis of an interindemnity arrangement that was altered without notice to the participating member.

(I) Failing, after payment of a claim, to inform participating members, upon request by them, of the coverage under which payment has been made.

(J) Making known to claimants a practice of the cooperative corporation or interindemnity arrangement of appealing from arbitration awards in favor of claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(K) Delaying the investigation or payment of claims by requiring a claimant, or their physician, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(L) Failing to settle claims promptly, where liability has become apparent, under one portion of an interindemnity arrangement in order to influence settlements under other portions of the interindemnity arrangement.

(M) Failing to provide promptly a reasonable explanation of the basis relied on in the interindemnity arrangement, in relation to the facts of applicable law, for the denial of a claim or for the offer of a compromise settlement.

(N) Directly advising a claimant not to obtain the services of an attorney.

(O) Misleading a claimant as to the applicable statute of limitations.

(h) Notwithstanding any contrary provisions of Part 2 (commencing with Section 12200) of Division 3 of Title 1 of the Corporations Code, it shall not be necessary to hold a meeting of members of the cooperative corporation for the purpose of electing directors if the bylaws provide the election may be held by first-class mail balloting or balloting by electronic transmission. First-class mail balloting or balloting by electronic transmission may also be used in conjunction with a meeting at which directors are to be elected and all mail and electronic ballots shall count toward establishing a quorum for the meeting for the limited purpose of the issues set forth in the mail and electronic ballot. Directors shall be elected as follows:

(1) The candidates receiving the highest number of votes, up to the number of directors to be elected, by a specified date at least 45 days but not later than 60 days after the ballots are first mailed, postage prepaid, to the members (or the date of a meeting of members held in conjunction therewith) shall be elected.

(2) In the event that no candidate receives a majority of the votes cast for a vacant office, a runoff election shall be held between the two candidates receiving the highest number of votes cast. The runoff election shall be held at least 45 days but not more than 60 days after the ballots for the election are mailed, postage prepaid. In the event that there is more than one office for which no candidate receives a majority of the votes cast, the candidates for the runoff shall be twice the number of vacant offices, and shall be those persons who received the highest number of votes therefor.

A record of the mail and electronic ballots shall be kept on file for a period of three months after all vacant board positions have been filled, and shall be subject to inspection at any reasonable time by any members of the cooperative corporation.

(i) No officer, director, trustee, or member of the interindemnity arrangement or the cooperative corporation, or any entity in which that person has a material financial interest, shall enter into or renew any transaction or contract with the trust unless the material facts as to the transaction or contract and as to the interest of the person are fully disclosed to the participating members, and the transaction or contract is approved by an affirmative vote of at least 75 percent of the membership present at a meeting, in person or by proxy. If any transaction or contract is to be submitted to members at a properly called meeting, the membership shall be notified of the meeting and of the transaction or contract by first-class mail, postage prepaid, or by electronic transmission at least 45 days prior to the meeting.

(j) Services provided to the trust pursuant to a delegated contractual arrangement shall be embodied in a written contract. Each written contract shall provide for reasonable consideration to the parties. In addition, each written contract shall be disclosed annually to participating members in a disclosure report containing the information described in subparagraph (H) of paragraph (3) of subdivision (d). The disclosure report shall be sent to participating members by first-class mail, postage prepaid, or by electronic transmission, and shall be sent separately from any statements, records, or other documents. The disclosure requirements of this subdivision shall apply to all existing and future written contracts.

(k) Upon request of the Commissioner of Financial Protection and Innovation, an interindemnity arrangement shall immediately forward to the commissioner a current list of participating members, including the names, addresses, and telephone numbers of those members.

(l) Notwithstanding any provision to the contrary, whenever the membership of a cooperative organization, organized pursuant to Part 2 (commencing with Section 12200) of Division 3 of Title 1 of the Corporations Code and consisting solely of physicians and surgeons licensed in this state amounts to 2,000 or more members and the trust fund is at least forty million dollars ($40,000,000), which is available to the public for malpractice claims or other claims authorized by this section, the cooperative is authorized to admit members without a contribution to that trust fund if assessments are charged to each of those members

within the first 50 months in an amount equal to the amount of the contribution to the reserve fund that would otherwise be required.

SEC. 9. Section 1652 of the Insurance Code is amended to read:

1652. (a) The commissioner shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice pursuant to subdivision (u) of Section 11105 of the Penal Code, and the Department of Justice shall provide to the commissioner a state or federal response pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code, for all applicants of each of the following:

(1) A property licensee or a casualty licensee, as defined in Section 1625.

(2) A personal lines licensee, as defined in Sections 1625.5.

(3) A limited lines automobile insurance agent, as defined in Section 1625.55.

(4) A life and accident and health or sickness licensee, as defined in Section 1626.

(5) A life licensee limited to the payment of funeral and burial expenses, as defined in Section 1676.

(6) A special lines' surplus line broker, as defined in Section 1760.5.

(7) A surplus line broker, as defined in Section 47.

(8) A cargo owner's or shipper's agent, as defined in Section 1757.1.

(9) A portable electronics agent license, as defined in Section 1758.69.

(10) A car rental agent, as defined in Section 1758.89.

(11) A credit insurance agent license, as defined in Section 1758.992.

(12) An administrator, as defined in Section 1759.

(13) A reinsurance intermediary-broker, as defined in Section 1781.2.

(14) A bail agent license, as defined in Section 1802.

(15) A bail permittee license, as defined in Section 1802.5.

(16) A bail solicitor license, as defined in Section 1803.

(17) A bail fugitive recovery agent license, as defined in Section 1802.3.

(18) A life and disability analyst, as defined in Section 32.5.

(19) A stock agent who sells securities, as defined in Section 825.

(20) An insurance adjuster, as defined in Section 14021.

(21) A crop insurance adjuster as defined in Section 14085.

(22) A public insurance adjuster, as defined in Section 15007.

(23) A part-time fraternal licensee, as described in Sections 11102 and 11103.

(24) A life settlement broker, as defined in Section 10113.1.

(25) A motor club agent, as defined in Section 12143.

(26) A title marketing representative, as defined in Section 12418.

(27) A self-service storage agent, as defined in Section 1758.791.

(28) A variable life and variable annuity agent, as defined in Section 1758.1.

(29) A vehicle service contract provider, as defined in Section 12800.

(b) A license shall be applied for, and renewed by the filing with the commissioner of a written application therefor. The application shall be on a form prescribed by the commissioner, which form shall prescribe the disclosure of information that will aid the

commissioner in determining whether the prerequisites for the license sought have been met. The applicant shall declare, under penalty of perjury, that the contents of the application are true and correct.

(c) The forms prescribed by the commissioner other than for renewal applications may require authenticated fingerprints of any of the following:

(1) Individual applicants.

(2) Specified partners or officers of organization applicants.

(3) The individuals who are to transact insurance for an organization applicant.

(d) The forms may require the fingerprints to be affixed to the application or to an attachment to be affixed to the application. The commissioner, in the commissioner's discretion, may require the fingerprints on applications for any, some, or all of the licenses issued pursuant to this chapter or Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), or Chapter 8 (commencing with Section 1831), provided that as to any one such type of license the requirement is applied without discrimination to all applicants within specified classifications. The classifications may be made upon any or all of the following bases:

(1) Length of continuous residence in this state.

(2) Whether or not previously or currently licensed by the commissioner.

(3) Whether or not currently licensed by specified regulatory agencies of the State of California which require fingerprints on applications for licenses and routinely process the fingerprints for positive identification.

(4) Other reasonable criteria.

(e) The commissioner may decline to act on an incomplete or defective application until an amended application which completes the prescribed form is filed with the commissioner.

SEC. 10. Section 1678 of the Insurance Code is amended to read:

1678. The commissioner shall administer qualifying license examinations under this chapter at test centers designated by the commissioner and through online proctored license examinations. The commissioner may give the examinations at more frequent intervals or in other places throughout the state.

SEC. 11. Section 1821 of the Insurance Code is amended to read:

1821. (a) A license shall not be refused by the commissioner without proceedings in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, being initiated within 60 days from the date of filing the completed application.

(b) Sections 1724.5, 1733, 1734, 1735 and Articles 6 (commencing with Section 1666) and 13 (commencing with Section 1737) of Chapter 5 apply to persons licensed under this chapter, and "insurance agent" or "licensee", as used in those provisions, include persons licensed under this chapter.

(c) Subdivisions (a), (c), (e), (f), (g), and (h) of Section 1725.5 apply to persons licensed under this chapter, and "person" or "licensee," as used in those provisions, include persons licensed under this chapter.

SEC. 12. Section 1872.41 of the Insurance Code is amended to read:

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

(b) An agent or broker who, after an insurance application has been placed with an insurer, reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the insurer's special investigative unit. An agent or broker shall

furnish all papers, documents, reports, or other facts or evidence to the insurer's special investigative unit upon request, and shall otherwise assist and cooperate with the insurer's special investigative unit.

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

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

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

SEC. 13. Section 1877.3 of the Insurance Code is amended to read:

1877.3. (a) Upon written request to an insurer or a licensed rating organization by an authorized governmental agency, an insurer, an agent authorized by that insurer, or a licensed rating organization to act on behalf of the insurer, shall release to the requesting authorized governmental agency any or all relevant information deemed important to the authorized governmental agency that the insurer or licensed rating organization may possess relating to any specific workers' compensation insurance fraud investigation.

(b) (1) When an insurer or licensed rating organization knows or reasonably believes it knows the identity of a person or entity whom it has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or a workers' compensation insurance policy, including any policy application, or has knowledge of such a fraudulent act, then, for the purpose of notification and investigation, the insurer, or agent authorized by an insurer to act on its behalf, or licensed rating organization shall notify the local district attorney's office and the Fraud Division of the Department of Insurance, and may notify any other authorized governmental agency of that suspected fraud and provide any additional information in accordance with subdivision (a). The insurer or licensed rating organization shall state in its notice the basis of the suspected fraud.

(2) Insurers shall use a form prescribed by the department for the purposes of reporting suspected fraudulent workers' compensation acts pursuant to this subdivision.

(3) This section does not abrogate or impair the rights or powers created under subdivision (a).

(c) The authorized governmental agency provided with information pursuant to subdivision (a), (b), or (e) shall, upon request, unless it would violate federal law or otherwise compromise an investigation, release or provide that information in a confidential manner to any other authorized governmental agency for purposes of investigation, prosecution, or prevention of insurance fraud or workers' compensation fraud.

(d) An insurer or licensed rating organization providing information to an authorized governmental agency pursuant to this section shall provide the information within a reasonable time, but not exceeding 60 days from the day on which the duty arose.

(e) Upon written request by an authorized governmental agency, as specified in subdivision (o) of Section 1095 of the Unemployment Insurance Code, the Employment Development Department shall release to the requesting agency any or all relevant information that the Employment Development Department may possess relating to any specific workers' compensation insurance fraud investigation. If an authorized governmental agency seeks to disclose this information to any other governmental agency that is not authorized to receive that information pursuant to subdivision (o) of Section 1095 of the Unemployment Insurance Code or subdivision (c) of Section 603.9 of Title 20 of the Code of Federal Regulations, that agency shall submit a request to the Employment Development Department for approval prior to disclosure. Relevant information may include, but is not limited to, all of the following:

(1) Copies of unemployment and disability insurance application and claim forms and copies of any supporting medical records, documentation, and records pertaining thereto.

(2) Copies of returns filed by an employer pursuant to Section 1088 of the Unemployment Insurance Code and copies of supporting documentation.

(3) Copies of benefit payment checks issued to claimants.

(4) Copies of any documentation that specifically identifies the claimant by social security number, residence address, or telephone number.

SEC. 14. Section 10113.2 of the Insurance Code is amended to read:

10113.2. (a) This section applies to any person entering into, brokering, or soliciting life settlements pursuant to this section and Sections 10113.1 and 10113.3.

(b) (1) Except as provided in subparagraph (B) or (D), a person may not enter into, broker, or solicit life settlements pursuant to Section 10113.1 unless that person has been licensed by the commissioner under this section. The person shall file an application for a license in the form prescribed by the commissioner, and the application shall be accompanied by a fee of one hundred seventy-one dollars ($171). The annual license renewal fee shall be one hundred seventy-one dollars ($171). The applicant shall provide any information the commissioner may require. The commissioner may issue a license, or deny the application if, in the commissioner's discretion, it is determined that it is contrary to the interests of the public to issue a license to the applicant. The reasons for a denial shall be set forth in writing.

(A) An individual acting as a broker under this section shall complete at least 15 hours of continuing education related to life settlements and life settlement transactions, as required and approved by the commissioner, prior to operating as a broker. This requirement shall not apply to a life insurance producer who qualifies under subparagraph (D).

(B) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner, and whose compensation is not paid directly or indirectly by the provider or purchaser, may negotiate a life settlement contract on behalf of the owner without having to obtain a license as a broker.

(C) A person licensed to act as a viatical settlement broker or provider as of December 31, 2009, shall be deemed qualified for licensure as a life settlement broker or provider, and shall be subject to all the provisions of this article as if the person were originally licensed as a life settlement broker or provider.

(D) (i) A life insurance producer who has been duly licensed as a life agent for at least one year or as a licensed nonresident producer in this state for one year shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a broker.

(ii) Not later than 10 days from the first day of operating as a broker, the life insurance producer shall notify the commissioner that the life insurance producer is acting as a broker, on a form prescribed by the commissioner, and shall pay a fee of eighty-five dollars ($85).

(iii) The fee shall be paid by the life insurance producer for each license term the producer intends to operate as a broker. The fee shall be calculated pursuant to Section 1750. The notification to the commissioner shall include an acknowledgment by the life insurance producer that the life insurance producer will operate as a broker in accordance with this act.

(iv) The insurer that issued the policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a broker or provider arising out of, or in connection with, the life settlement transaction, unless the insurer receives compensation for the replacement of the life settlement contract for the provider or broker.

(E) The commissioner shall review the examination for the licensing of life insurance agents and may recommend any changes to the examination to the department's curriculum committee in order to carry out the purposes of this section and Sections 10113.1 and 10113.3.

(2) Except as provided in subparagraphs (A) and (B), whenever it appears to the commissioner that it is contrary to the interests of the public for a person licensed pursuant to this section to continue to transact life settlements business, the commissioner or their designee shall issue a notice to the licensee stating the reasons therefor. If, after a hearing, the commissioner concludes that it is contrary to the interests of the public for the licensee to continue to transact life settlements business, the commissioner may revoke the person's license, or issue an order suspending the license for a period as determined by the commissioner. Any hearing conducted pursuant to this paragraph shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearing may be conducted by administrative law judges chosen pursuant to Section 11502 or appointed by the commissioner, and the commissioner shall have the powers granted therein.

(A) The commissioner may, without hearing, suspend or revoke the license of a broker, as defined in subdivision (b) of Section 10113.1, if the broker has done one or more of the following:

(i) Been convicted of a felony.

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

(iii) Had a previously issued professional, occupational, or vocational license suspended or revoked for cause by a licensing authority within the preceding five years of the commissioner's action on grounds that would preclude the

granting of a license by the commissioner under this section.

(B) A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of subparagraph (A). 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 broker.

(3) Each licensee shall owe and pay in advance to the commissioner an annual renewal fee in an amount to be determined by the commissioner pursuant to paragraph (1) of subdivision (b). This fee shall be for each license year, as defined by Section 1629.

(4) Any licensee that intends to discontinue transacting life settlements in this state shall so notify the commissioner, and shall surrender its license.

(c) A life settlements licensee shall file with the department a copy of all life settlement forms used in this state. A licensee may not use any life settlement form in this state unless it has been provided in advance to the commissioner. The commissioner may disapprove a life settlement form if, in the commissioner's discretion, the form, or provisions contained therein, are contrary to the interests of the public, or otherwise misleading or unfair to the consumer. In the case of disapproval, the licensee may, within 15 days of notice of the disapproval, request a hearing before the commissioner or the commissioner's designee, and the hearing shall be held within 30 days of the request.

(d) Life settlements licensees shall be required to provide any applicant for a life settlement contract, at the time of application for the life settlement contract, all of the following disclosures in writing and signed by the owner, in at least 12-point type:

(1) That there are possible alternatives to life settlements, including, but not limited to, accelerated benefits options that may be offered by the life insurer.

(2) The fact that some or all of the proceeds of a life settlement may be taxable and that assistance should be sought from a professional tax adviser.

(3) Consequences for interruption of public assistance as provided by information provided by the State Department of Health Care Services and the State Department of Social Services under Section 11022 of the Welfare and Institutions Code.

(4) That the proceeds from a life settlement could be subject to the claims of creditors.

(5) That entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited by the owner and that assistance should be sought from a professional financial adviser.

(6) That a change in ownership of the settled policy could limit the insured's ability to purchase insurance in the future on the insured's life because there is a limit to how much coverage insurers will issue on one life.

(7) That the owner has a right to rescind a life settlement contract within 30 days of the date it is executed by all parties and the owner has received all required disclosures, or 15 days from receipt by the owner of the proceeds of the settlement, whichever is sooner. Rescission, if exercised by the owner, is effective only if both notice of rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(8) That proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or the interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

(9) The date by which the funds will be available to the owner and the transmitter of the funds.

(10) The disclosure document shall include the following language:

"All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(11) That the insured may be contacted by either the provider or the broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

(12) Any affiliations or contractual relations between the provider and the broker, and the affiliation, if any, between the provider and the issuer of the policy to be settled.

(13) That a broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

(14) The name, business address, and telephone number of the broker.

(e) Prior to the execution of the life settlement contract by all parties, the life settlement provider entering into a life settlement contract with the owner shall provide, in a document signed by the owner, the gross purchase price the life settlement provider is paying for the policy, the amount of the purchase price to be paid to the owner, the amount of the purchase price to be paid to the owner's life settlement broker, and the name, business address, and telephone number of the life settlement broker. For purposes of this section, "gross purchase price" means the total amount or value paid by the provider for the purchase of one or more life insurance policies, including commissions and fees.

(f) The broker shall provide the owner and the insured with at least all of the following disclosures in writing prior to the signing of the life settlement contract by all parties. The disclosures shall be clearly displayed in the life settlement contract or in a separate document signed by the owner:

(1) The name, business address, and telephone number of the broker.

(2) A full, complete, and accurate description of all of the offers, counteroffers, acceptances, and rejections relating to the proposed life settlement contract.

(3) A disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contract.

(4) All estimates of the life expectancy of the insured that are obtained by the licensee in connection with the life settlement, unless that disclosure would violate any California or federal privacy laws.

(5) The commissioner may consider any failure to provide the disclosures or rights described in this section as a basis for suspending or revoking a broker's or provider's license pursuant to paragraph (2) of subdivision (b).

(g) All medical information solicited or obtained by any person soliciting or entering into a life settlement is subject to Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1, concerning confidentiality of medical information.

(h) Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance producer, information bureau, rating agency, or company, or any other person with actual knowledge of an insured's identity, shall not disclose the identity of an insured or information that there is a reasonable basis to believe that could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure is one of the following:

(1) It is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure.

(2) It is necessary to effectuate the sale of life settlement contracts, or interests therein, as investments, provided the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure.

(3) It is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or any other provision of law.

(4) It is a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall be required to comply with the confidentiality requirements of Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1.

(5) It is necessary to allow the provider or broker or their authorized representatives to make contacts for the purpose of determining health status. For the purposes of this section, the term "authorized representative" shall not include any person who has or may have any financial interest in the settlement contract other than a provider, licensed broker; further, a provider or broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this act.

(6) It is required to purchase stop loss coverage.

(i) In addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(1) If the premium finance loan provides funds that can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application may be rejected as a prohibited practice under this act.

(2) If the financing does not violate paragraph (1), the existence of premium financing may not be the sole criterion employed by an insurer in a decision whether to reject an application for life insurance. The insurance carrier may make disclosures to the applicant, either on the application or an amendment to the application to be completed no later than the delivery of the policy, including, but not limited to, the following:

“If you have entered into a loan arrangement where the policy is used as collateral, and the policy changes ownership at some point in the future in satisfaction of the loan, the following may be true:

(A) A change of ownership could lead to a stranger owning an interest in the insured’s life.

(B) A change of ownership could in the future limit your ability to purchase insurance on the insured’s life because there is a limit to how much coverage insurers will issue on a life.

(C) You should consult a professional adviser since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan.”

(3) In addition to the disclosures in paragraph (2), the insurance carrier may require the following certifications from the applicant or the insured:

“(A) I have not entered into any agreement or arrangement under which I have agreed to make a future sale of this life insurance policy.

(B) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy.

(C) The borrower has an insurable interest in the insured.”

(j) Life insurers shall provide individual life insurance policyholders with a statement informing them that if they are considering making changes in the status of their policy, they should consult with a licensed insurance or financial adviser. The statement may accompany or be included in notices or mailings otherwise provided to the policyholders.

(k) The commissioner may, whenever the commissioner deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The commissioner shall have the authority to order any licensee or applicant to produce any records, books, files, or other information as is reasonably necessary to ascertain whether or not the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(l) The commissioner may investigate the conduct of any licensee, its officers, employees, agents, or any other person involved in the business of the licensee, or any applicant for a license, whenever the commissioner has reason to believe that the licensee or applicant for a license may have acted, or may be acting, in violation of the law, or otherwise contrary to the interests of the public. The commissioner may initiate an investigation on the commissioner’s own initiative, or upon a complaint filed by any other person.

(m) The commissioner may issue orders to licensees whenever the commissioner determines that it is reasonably necessary to ensure or obtain compliance with this section, or Section 10113.3. This authority includes, but is not limited to, orders directing a licensee to cease and desist in any practice that is in violation of this section, or Section 10113.3, or otherwise contrary to the interests of the public. Any licensee to which an order pursuant to this subdivision is issued may, within 15 days of receipt of that order, request a hearing at which the licensee may challenge the order.

(n) The commissioner may, after notice and a hearing at which it is determined that a licensee has violated this section or Section 10113.3 or any order issued pursuant to this section, order the licensee to pay a monetary penalty of up to ten thousand dollars ($10,000), which may be recovered in a civil action. Any hearing conducted pursuant to this subdivision shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearing may be conducted by administrative law judges chosen pursuant to Section 11502 or appointed by the commissioner, and the commissioner shall have the powers granted therein.

(o) Each licensed provider shall file with the commissioner on or before March 1 of each year an annual statement in the form prescribed by the commissioner. The information that the commissioner may require in the annual statement shall include, but not be limited to, the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the brokers that have settled those policies, and that information shall be received in confidence within the meaning of Section 7929.000 of the Government Code and exempt from disclosure pursuant to the Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). The annual statement shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

(p) A person who is not a resident of California may not receive or maintain a license unless a written designation of an agent for service of process is filed and maintained with the commissioner. The provisions of Article 3 (commencing with Section 1600) of Chapter 4 of Part 2 of Division 1 shall apply to life settlements licensees as if they were foreign insurers, their license a certificate of authority, and the life settlements a policy, and the commissioner may modify the agreement set forth in Section 1604 accordingly.

(q) A person licensed pursuant to this section shall not engage in any false or misleading advertising, solicitation, or practice. In no case shall a broker or provider, directly or indirectly, market, advertise, solicit, or otherwise promote the purchase of a new policy for the sole purpose of or with a primary emphasis on settling the policy or use the words “free,” “no cost,” or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy. The provisions of Article 6 (commencing with Section 780) and Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 shall apply to life settlements licensees as if they were insurers, their license a certificate of authority or producer’s license, and the life settlements a policy, and the commissioner shall liberally construe these provisions so as to protect the interests of the public.

(r) Any person who enters into a life settlement with a life settlements licensee shall have the absolute right to rescind the settlement within 30 days of the date it is executed by all parties and the owner has received all required disclosures, or 15 days from receipt by the owner of the proceeds of the settlement, whichever is sooner, and any waiver or settlement language contrary to this subdivision shall be void. Rescission, if exercised by the owner, is effective only if both notice of rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner’s estate of all proceeds and any premiums, loans, and loan interest to the provider.

(s) Records of all consummated transactions and life settlement contracts shall be maintained by the provider for three years after the death of the insured and shall be available to the commissioner for inspection during reasonable business hours.

(t) A violation of this section is a misdemeanor.

SEC. 15. Section 11622 of the Insurance Code is amended to read:

11622. (a) A plan shall require the issuance of a policy affording coverage in the amount of fifteen thousand dollars ($15,000) for bodily injury to, or death of, each person as a result of any one accident and, subject to that limit as to one person, the amount of thirty thousand dollars ($30,000) for bodily injury to, or death of, all persons as a result of any one accident, and the amount of five thousand dollars ($5,000) for damage to property of others as a result of any one accident, or in those minimum amounts as are necessary to provide exemption from the security requirements of Section 16021 of the Vehicle Code or for which proof of ability to respond in damages or adequate protection against liability is otherwise required by law, but shall not require the issuance of a policy affording coverage in excess of those amounts.

(b) For a policy or bond issued or renewed on or after January 1, 2025, a plan shall require the issuance of a policy affording coverage in the amount of thirty thousand dollars ($30,000) for bodily injury to, or death of, each person as a result of any one accident and, subject to that limit as to one person, the amount of sixty thousand dollars ($60,000) for bodily injury to, or death of, all persons as a result of any one accident, and the amount of fifteen thousand dollars ($15,000) for damage to property of others as a result of any one accident, or in those minimum amounts as are necessary to provide exemption from the security requirements of Section 16021 of the Vehicle Code or for which proof of ability to respond in damages or adequate protection against liability is otherwise required by law, but shall not require the issuance of a policy affording coverage in excess of those amounts.

(c) For a policy or bond issued or renewed on or after January 1, 2035, a plan shall require the issuance of a policy affording coverage in the amount of fifty thousand dollars ($50,000) for bodily injury to, or death of, each person as a result of any one accident and, subject to that limit as to one person, the amount of one hundred thousand dollars ($100,000) for bodily injury to, or death of, all persons as a result of any one accident, and the amount of twenty-five thousand dollars ($25,000) for damage to property of others as a result of any one accident, or in those minimum amounts as are necessary to provide exemption from the security requirements of Section 16021 of the Vehicle Code or for which proof of ability to respond in damages or adequate protection against liability is otherwise required by law, but shall not require the issuance of a policy affording coverage in excess of those amounts.

SEC. 16. Section 12830 of the Insurance Code is amended to read:

12830. (a) Prior to incurring an obligation under a vehicle service contract, an obligor shall file with the commissioner, to the attention of the legal division, and receive the commissioner's approval to use, a copy of an insurance policy covering 100 percent of the obligor's vehicle service contract obligations. The policy must be issued by an insurer admitted in this state and authorized by the commissioner to issue that insurance in this state. The policy may also be issued by a risk retention group, as that term is defined in 15 U.S.C. Sec. 3901(a)(4), as long as that risk retention group is in full compliance with the federal Liability Risk Retention Act of 1986 (15 U.S.C. Sec. 3901 and following), is in good standing in its domiciliary jurisdiction, and has registered with the commissioner pursuant to Chapter 1.5 (commencing with Section 125) of Part 1 of Division 1. The insurance required by this subdivision shall be subject to the following:

(1) The insurer or risk retention group shall, at the time the policy is filed with the commissioner, and continuously thereafter, be rated "B++" or better by A. M. Best Company, Inc., maintain surplus as to policyholders and paid-in capital of at least fifteen million dollars ($15,000,000), and annually file audited financial statements with the commissioner.

(2) The commissioner may authorize an insurer or risk retention group that has surplus as to policyholders and paid-in capital of less than fifteen million dollars ($15,000,000) but at least equal to ten million dollars ($10,000,000) to issue the insurance required by this paragraph if the insurer or risk retention group demonstrates to the satisfaction of the commissioner that the company maintains a ratio of direct written premiums, wherever written, to surplus as to policyholders and paid-in capital of not more than 3 to 1.

(3) An obligor required to maintain insurance pursuant to this paragraph who is an affiliate of a distributor of new motor vehicles licensed as such in any state prior to January 1, 2003, and continuously thereafter, is exempt from the requirement that its insurer or risk retention group satisfy the rating, surplus, and paid-in capital requirements of paragraph (1). This exemption shall apply only if the distributor sold or distributed at least 25,000 new motor vehicles to licensed dealers in the preceding five years. For the purpose of this paragraph, "affiliate" has the meaning set forth in subdivision (a) of Section 1215.

(b) An insurance policy filed with the commissioner pursuant to subdivision (a) shall state the name of the obligor. The policy shall provide that all purchasers of vehicle service contracts shall be entitled to satisfaction by the insurer of any and all obligations arising under vehicle service contracts of the named obligor, upon the existence of all of the following conditions and no others:

(1) The service contract obligor refuses or fails to satisfy an obligation arising under the vehicle service contract within 60 days of the date the purchaser submits proof of loss to the obligor.

(2) The purchaser provides written notice to the insurer that the obligor has failed to comply with an obligation under the vehicle service contract.

(3) The purchaser possesses a vehicle service contract sold after the inception and prior to any cancellation of the insurance policy required by subdivision (a), and the vehicle service contract recites the name of the obligor that is insured by the policy as the obligor of the service contract.

(c) An insurer's liability under a policy filed pursuant to subdivision (a) shall not be negated by any failure of the seller, an administrator, the obligor, or agents of any of these persons, to report the issuance of a vehicle service contract or to remit moneys to another person pursuant to a contractual agreement. The policy must state that the insurer is deemed to have received the premium for the policy upon payment by the purchaser for a vehicle service contract insured by that policy.

(d) In lieu of complying with Section 12836, an obligor shall have on file with the commissioner only one active policy from one insurer at any time. Unless exempt under paragraph (1) of subdivision (a) of Section 12805, an obligor shall comply with either this section or Section 12836, but not both.

(e) No policy cancellation by an insurer shall be valid unless a notice of the intent to cancel the policy was filed with the commissioner 30 days prior to the effective date of the cancellation, or 10 days prior in the event that the cancellation is due to fraud, material misrepresentation, or defalcation by the obligor or its administrator, if any.

SEC. 17. Section 12921.8 of the Insurance Code is amended to read:

12921.8. (a) The commissioner may do the following:

(1) Issue a cease and desist order to a person who has acted in a capacity for which a license, registration, or certificate of authority from the commissioner was required but not possessed.

(2) Issue a cease and desist order to a person who has aided or abetted a person described in paragraph (1).

(3) Impose a monetary penalty, pursuant to an order to show cause, on a person described in paragraph (1) or (2). The monetary penalty shall be the greater of the following:

(A) Five times the amount of money received by the person for acting in the capacity for which the license, registration, or certificate of authority was required but not possessed.

(B) Five thousand dollars ($5,000) for each day the person acted in the capacity for which the license, registration, or certificate of authority was required but not possessed. In the absence of contrary evidence, it shall be presumed that a person continuously acted in a capacity for which a license, registration, or certificate of authority was required on each day from the date of the earliest such act until the date those acts were discontinued, as proven by the person at a hearing.

(b) A person to whom a cease and desist order or order to show cause has been issued, may, within seven days after service of the order, if a hearing has not already been scheduled by the commissioner, request a hearing by filing a request for the hearing with the commissioner. The hearing shall be conducted in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the commissioner shall have all the powers granted therein.

(c) A person who has a hearing pursuant to subdivision (b) shall be entitled to have the proceedings and the order of the commissioner reviewed by means of any remedy provided by the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 18. Section 1236 of the Unemployment Insurance Code is amended to read:

1236. Any civil employment tax matter dispute arising under Article 8 (commencing with Section 1126), Article 9 (commencing with Section 1176), or Article 11 (commencing with Section 1221), may be settled under the following conditions:

(a) (1) The director may approve a settlement of a civil employment tax matter in dispute involving a reduction of tax or penalties, or both, that does not exceed the amount specified in subparagraph (A) of paragraph (3). However, once an appeal of an employment tax matter dispute has been filed with the appeals board, the appeal has been assigned to an administrative law judge, and a notice of hearing has been issued, approval of the settlement by the assigned administrative law judge shall be obtained. If the decision of the administrative law judge has been appealed, approval of the appeals board shall be obtained. A proposed settlement shall be grounds for continuance of the scheduled hearing until the Attorney General has completed a review of the proposed settlement. “Civil employment tax matters in dispute” means those matters that are the subject of protests, appeals, or refund claims.

(2) Except as provided by subparagraph (A) of paragraph (3), each proposed settlement shall be submitted to the Attorney General. Within 30 days of receiving that proposed settlement, the Attorney General shall review the recommendation and advise, in writing, of their conclusions as to whether the recommendation is reasonable from an overall perspective. If the Attorney General determines that the settlement is reasonable from an overall perspective, the director, and the administrative law judge or the appeals board, as applicable, may then determine if a settlement will be approved.

(3) (A) A settlement of any civil employment tax matter dispute involving a reduction of tax or penalties, or both, in settlement, the total of which reduction of tax or penalties, or both, in settlement does not exceed eleven thousand five hundred dollars ($11,500), may be approved by the director, and the administrative law judge or the appeals board, as applicable, without prior submission to the Attorney General.

(B) On January 1 of each calendar year beginning on January 1, 2025, the Employment Development Department shall increase the amount specified in subparagraph (A). That adjustment shall be made as follows:

(i) The Department of Industrial Relations shall transmit annually to the Employment Development Department the percentage change in the California Consumer Price Index, as modified for rental equivalent home ownership for all

items, from June of the prior calendar year to June of the current calendar year, no later than August 1 of the current calendar year.

(ii) The Employment Development Department shall then:

(I) Compute the percentage change in the California Consumer Price Index from the later of June 2024 or June of the calendar year prior to the last increase in the amount specified in this subparagraph.

(II) Compute the inflation adjustment factor by adding 100 percent to the percentage change so computed, and converting the resulting percentage to the decimal equivalent.

(III) Multiply the amount specified in subparagraph (A) for the immediately preceding calendar year, as adjusted under this subparagraph, by the inflation adjustment factor determined in subclause (II), and round off the resulting product to the nearest one hundred dollars ($100).

(b) The director may recommend to the appeals board a settlement of a civil employment tax matter dispute involving a reduction in tax or penalties, or both, exceeding the amount specified in subparagraph (A) of paragraph (3) of subdivision (a) and arising under Article 8 (commencing with Section 1126), Article 9 (commencing with Section 1176), or Article 11 (commencing with Section 1221). Each proposed settlement shall be submitted to the Attorney General in the same manner as described in subdivision (a).

(c) Whenever a reduction of tax or penalties or total tax and penalties in excess of five hundred dollars ($500) is approved pursuant to this section, there shall be placed on file in the office of the director a public record with respect to that settlement. The public record shall include, but need not be limited to, all of the following information:

(1) The name or names of the taxpayers who are parties to the settlement.

(2) The total amount involved.

(3) The amount payable or refundable pursuant to the settlement.

(4) A summary of the reasons why the settlement is in the best interests of the state.

(5) The Attorney General’s conclusion as to whether the recommendation of settlement was reasonable from an overall perspective.

The public record shall not include any information that relates to any trade secret, patent, process, style of work, apparatus, business secret, or organizational structure that, if disclosed, would adversely affect the taxpayer or the national defense.

(d) All settlements entered into pursuant to this section shall be final and nonappealable, except upon a showing of fraud or misrepresentation with respect to a material fact.

(e) Any proceedings undertaken by the appeals board relating to a settlement as described in this section shall be conducted in a closed session or sessions. Except as provided in subdivision (c), any settlement entered into pursuant to this section shall constitute confidential tax information.

(f) Any settlement of a civil employment tax matter arising out of a disagreement between the department and the employing unit on the status of a worker as an employee or an independent contractor may also include an agreement on the prospective classification of that worker and any worker similarly situated for employment tax purposes, except as provided in subdivision (g).

(g) If a settlement includes a commitment on the prospective status of workers or reporting responsibilities of the employer, then the following shall apply:

(1) The settlement shall not operate to deprive workers of their eligibility for unemployment, workers’ compensation, or disability insurance benefits.

(2) The commitment concerning the status of workers or reporting responsibilities of the employer will terminate if there is a change in material facts, a change in an applicable statute, or a ruling by the appeals board on the workers or employer subject to the settlement that is contrary to the commitment.

(h) For purposes of this section, settlement is defined as a compromise on the amount of the tax liability, consistent with the reasonable evaluation of the costs and risks associated with litigation of these matters.

(i) The amendments to this section made in the 1997 portion of the 1997–98 Regular Session shall become operative January 1, 1998.

SEC. 19. Section 16056 of the Vehicle Code, as added by Section 3 of Chapter 717 of the Statutes of 2022, is amended to read:

16056. (a) A policy or bond shall not be effective under Section 16054 unless issued by an insurance company or surety company admitted to do business in this state by the Insurance Commissioner, except as provided in subdivision (b), and unless the policy or bond is subject to either of the following:

(1) If the accident has resulted in bodily injury or death, to a limit, exclusive of interest and costs, of not less than fifteen thousand dollars ($15,000) because of bodily injury to or death of one person in any one accident and, subject to that limit for one person, to a limit of not less than thirty thousand dollars ($30,000) because of bodily injury to or death of two or more persons in any one accident, and, if the accident has resulted in injury to, or destruction of property, to a limit of not less than five thousand dollars ($5,000) because of injury to or destruction of property of others in any one accident.

(2) Notwithstanding paragraph (1), for any policy or bond issued or renewed on or after January 1, 2025, if the accident has resulted in bodily injury or death, to a limit, exclusive of interest and costs, of not less than thirty thousand dollars ($30,000) because of bodily injury to or death of one person in any one accident and, subject to that limit for one person, to a limit of not less than sixty thousand dollars ($60,000) because of bodily injury to or death of two or more persons in any one accident, and, if the accident has resulted in injury to, or destruction of property, to a limit of not less than fifteen thousand dollars ($15,000) because of injury to or destruction of property of others in any one accident.

(b) A policy or bond shall not be effective under Section 16054 with respect to any vehicle that was not registered in this state or was a vehicle that was registered elsewhere than in this state at the effective date of the policy or bond or the most recent renewal thereof, unless the insurance company or surety company issuing the policy or bond is admitted to do business in this state, or if the company is not admitted to do business in this state, unless it executes a power of attorney authorizing the department to accept service on its behalf of notice or process in any action upon the policy or bond arising out of an accident mentioned in subdivision (a).

(c) Any nonresident driver whose driving privilege has been suspended or revoked based upon an action that requires proof of financial responsibility may, in lieu of providing a certificate of insurance from a company admitted to do business in California, provide a written certificate of proof of financial responsibility that is satisfactory to the department, covers the operation of a vehicle in this state, meets the liability requirements of this section, and is from a company that is admitted to do business in that person's state of residence.

(d) For a policy or bond issued or renewed on or after January 1, 2035, the minimum liability coverage shall be increased by twenty thousand dollars ($20,000) for bodily injury or death for one person, by forty thousand dollars ($40,000) for bodily injury or death for all persons, and by ten thousand dollars ($10,000) for property damage.

(e) This section shall become operative on January 1, 2025.

SEC. 20. Section 16451 of the Vehicle Code, as added by Section 9 of Chapter 717 of the Statutes of 2022, is amended to read:

16451. (a) (1) An owner's policy of motor vehicle liability insurance shall insure the named insured and any other person using any motor vehicle registered to the named insured with the express or implied permission of the named insured against loss from the liability imposed by law for damages arising out of ownership, maintenance, or use of the motor vehicle within the continental limits of the United States to the extent and aggregate amount, exclusive of interest and costs, with respect to each motor vehicle, of fifteen thousand dollars ($15,000) for bodily injury to or death of each person as a result of any one accident, and, subject to the limit as to one person, the amount of thirty thousand dollars ($30,000) for bodily injury to or death of all persons as a result of any one accident and the amount of five thousand dollars ($5,000) for damage to property of others as a result of any one accident.

(2) Notwithstanding paragraph (1), an owner's policy of motor vehicle liability insurance issued or renewed on or after January 1, 2025, shall insure the named insured and any other person using any motor vehicle registered to the named insured with the express or implied permission of the named insured, against loss from the liability imposed by law for damages arising out of ownership, maintenance, or use of the motor vehicle within the continental limits of the United States to the extent and aggregate amount, exclusive of interest and costs, with respect to each motor vehicle, of thirty thousand dollars ($30,000) for bodily injury to or death of each person as a result of any one accident, and, subject to the limit as to one person, the amount of sixty thousand dollars ($60,000) for bodily injury to or death of all persons as a result of any one accident and the amount of fifteen thousand dollars ($15,000) for damage to property of others as a result of any one accident.

(b) For an owner's policy of motor vehicle liability insurance issued or renewed on or after January 1, 2035, the minimum liability coverage shall be increased by twenty thousand dollars ($20,000) for bodily injury or death for one person, by forty thousand dollars ($40,000) for bodily injury or death for all persons, and by ten thousand dollars ($10,000) for property damage.

(c) This section shall become operative on January 1, 2025.

SEC. 21. Section 16500 of the Vehicle Code, as added by Section 11 of Chapter 717 of the Statutes of 2022, is amended to read:

16500. (a) (1) Every owner of a vehicle used in the transportation of passengers for hire, including taxicabs, when the operation of the vehicle is not subject to regulation by the Public Utilities Commission, shall maintain, whenever the owner may be engaged in conducting those operations, either of the following:

(A) Proof of financial responsibility resulting from the ownership or operation of the vehicle and arising by reason of personal injury to, or death of, any one person, of at least fifteen thousand dollars ($15,000), and, subject to the limit of fifteen thousand dollars ($15,000) for each person injured or killed, of at least thirty thousand dollars ($30,000) for the injury to, or the death of, two or more persons in any one accident, and for damages to property of at least five thousand dollars ($5,000) resulting from any one accident.

(B) (i) Notwithstanding subparagraph (A), proof of financial responsibility resulting from the ownership or operation of the vehicle and arising by reason of personal injury to, or death of, any one person, of at least thirty thousand dollars ($30,000), and, subject to the limit of thirty thousand dollars ($30,000) for each person injured or killed, of at least sixty thousand dollars ($60,000) for the injury to, or the death of, two or more persons in any one accident, and for damages to property of at least fifteen thousand dollars ($15,000) resulting from any one accident.

(ii) The proof of financial responsibility limits required by clause (i) shall apply to a motor vehicle liability policy, described in subparagraph (A) of paragraph (2), or bond, described in subparagraph (B) of paragraph (2), issued or renewed on or after January 1, 2025.

(2) Proof of financial responsibility may be maintained by any of the following:

(A) Being insured under a motor vehicle liability policy against that liability.

(B) Obtaining a bond of the same kind, and containing the same provisions, as those bonds specified in Section 16434.

(C) By depositing with the department seventy-five thousand dollars ($75,000), which shall be deposited in a special deposit account with the Controller for the purpose of this section.

(D) Qualifying as a self-insurer under Section 16053.

(b) The department shall return the deposit to the person entitled thereto when the person is no longer required to maintain proof of financial responsibility as required by this section or upon the person's death.

(c) On January 1, 2035, each of the following shall occur:

(1) The minimum liability coverage shall be increased by twenty thousand dollars ($20,000) for bodily injury or death for one person, by forty thousand dollars ($40,000) for bodily injury or death for all persons, and by ten thousand dollars ($10,000) for property damage.

(2) The minimum liability coverage required by paragraph (1) shall apply to a motor vehicle liability policy, described in subparagraph (A) of paragraph (2) of subdivision (a), or bond, described in subparagraph (B) of paragraph (2) of subdivision (a), issued or renewed on or after January 1, 2035.

(3) The deposit requirement in subparagraph (C) of paragraph (2) of subdivision (a) shall be increased by fifty thousand dollars ($50,000).

(d) This section shall become operative on January 1, 2025.

SEC. 22. Section 22005.1 of the Welfare and Institutions Code is amended to read:

22005.1. (a) The State Department of Health Care Services shall only certify a long-term care insurance policy that substantially meets the requirements of Chapter 2.6 (commencing with Section 10231) of Part 2 of Division 2 of the Insurance Code, except the requirements of Sections 10232.1, 10232.2, 10232.8, 10232.9, and 10232.92 of the Insurance Code, and that provides all of the items specified in subdivision (b). The State Department of Health Care Services shall only certify a health care service plan contract that has been approved by the Department of Managed Health Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code as providing substantially equivalent coverage to that required by Chapter 2.6 (commencing with Section 10231) of Part 2 of Division 2 of the Insurance Code, and that provides all of the items specified in subdivision (b). Policies issued by organizations subject to the Insurance Code and regulated by the Department of Insurance shall also be approved by the Department of Insurance.

(b) Only policies and contracts that provide all of the following items shall be certified by the department:

(1) Individual assessment and case management by a coordinating entity designated and approved by the department.

(2) Levels and durations of benefits that meet minimum standards set by the department pursuant to Section 22009.

(3) Protection against loss of benefits due to inflation. An applicant shall be offered, at the time of purchase, the following options:

(A) One option that provides, at a minimum, protection against inflation that automatically increases benefit levels by 5 percent each year over the previous year, up to an age specified by the program.

(B) At least one lower-cost option that provides protection against inflation that automatically increases benefit levels by, at a minimum, either 3 percent each year over the previous year or a fixed amount each year equal to 5 percent of the original benefit levels.

(4) A periodic record issued to the insured including an explanation of insurance payments or benefits paid that count toward Medi-Cal asset protection under this division.

(5) Compliance with any other requirements imposed by regulations adopted by the State Department of Health Care Services or the State Department of Social Services and consistent with the purposes of this division.

(c) (1) The State Department of Health Care Services may also certify a new policy or certificate, or maintain certification of a previously issued policy or certificate when the policyholder or certificate holder elects to reduce benefit levels, with a per diem benefit of at least one hundred dollars ($100) per day for a nursing facility, residential care facility, and home care and community-based services, if the policy or certificate provides a lifetime maximum benefit of not less than seventy-three thousand dollars ($73,000). A policy or certificate certified pursuant to this subdivision shall provide protection against inflation that automatically increases benefit levels by, at a minimum, either 3 percent each year over the previous year or a fixed amount each year equal to 5 percent of the original benefit levels, or, for a policyholder or certificate holder who elects to reduce benefit levels and is 70 years of age or older, 1 percent each year over the previous year.

(2) An insurer may offer a policy or certificate with the benefits described in paragraph (1) only if the insurer also offers the applicant policy benefits that provide at least a lifetime maximum benefit that, at the time of purchase, is equivalent in dollars to at least 365 times 70 percent of the average daily private pay rate for a nursing facility and a nursing facility per diem benefit of no less than 70 percent of the average daily private pay rate for a nursing facility.

(3) Except for the lifetime maximum benefit, per diem benefit, and inflation protection levels permitted by paragraphs (1) and (2), policies and certificates authorized by this subdivision shall comply with the standards described in paragraph (2) of subdivision (b).

(d) A premium rate schedule increase shall not exceed a cumulative total of 40 percent over any three-year period, and the amount of the increase shall be spread equally over each of the three years. The insurer shall send a premium increase notification each of the three years and include options, if available to the policyholder, to reduce coverage and lower the premium that would maintain partnership certification. If the Department of Insurance approves a premium rate schedule increase on or after January 1, 2023, the premium increase notification shall include the options described in paragraphs (1) to (7), inclusive, as applicable, and disclose that the policyholder or certificate holder may have additional options to lower the premium, including additional options to increase the elimination period or to reduce the daily benefit, benefit duration, and protection against inflation. Paragraphs (1) to (6), inclusive, do not require an insurer to create new benefit levels or amend its approved rate schedule. Each of the options set forth in paragraphs (1) to (7), inclusive, shall maintain partnership certification as long as the policy or certificate maintains at least the minimum benefit levels permitted by paragraph (1) of subdivision (c). Notwithstanding subdivision (b), a policy or certificate shall also maintain partnership certification if the policy or certificate is converted to a nonforfeiture benefit or a contingent benefit upon lapse. Even if a policyholder or certificate holder is not subject to a premium increase, the election of one of the available options set forth in paragraphs (1) to (7), inclusive, shall not result in a loss of partnership certification as long as the policy or certificate maintains at least the minimum benefit levels permitted by paragraph (1) of subdivision (c).

(1) Reduce the daily benefit by 50 percent, rounded up or down to the closest daily benefit level on the insurer’s approved rate schedule.

(2) Reduce the daily benefit by 25 percent, rounded up or down to the closest daily benefit level on the insurer’s approved rate schedule.

(3) Reduce the benefit duration to the lowest duration on the insurer’s approved rate schedule, but not below 12 months.

(4) Reduce the benefit duration to the next highest duration on the insurer's approved rate schedule, relative to the current duration, but not below 12 months.

(5) Increase the elimination period to 90 days for a policy or certificate with an elimination period of less than 90 days, if the insurer's approved rate schedule includes a 90-day elimination period.

(6) Convert a policy or certificate to a minimum coverage policy or certificate as described in paragraph (1) of subdivision (c), if the insurer offers such a policy for sale in California.

(7) Reduce the protection against inflation to a lower-cost option that automatically increases benefit levels by either 3 percent each year over the previous year or a fixed amount each year equal to 5 percent of the original benefit levels. If the policyholder or certificate holder is 70 years of age or older and experiences a 50-percent or greater increase in premium over the life of the policy or certificate, the insurer shall also offer protection against inflation that automatically increases benefit levels by 1 percent each year over the previous year. An offer made pursuant to this paragraph to reduce protection against inflation shall allow a policyholder or certificate holder, regardless of the issue date, issue age, or present age, to retain the accrued daily, weekly, monthly, and lifetime benefit amounts in effect at the time of the reduction.