AMENDED IN ASSEMBLY MARCH 10, 2025

AMENDED IN ASSEMBLY FEBRUARY 25, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

# ASSEMBLY BILL No. 487

**Introduced by Committee on Insurance**

February 10, 2025

An act to amend Sections 1670, 1729.2, 1800, 1871.7, 10123.13, ~~10123.1991,~~ 10270.2, 10295.11, and 12800 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 487, as amended, Committee on Insurance. Insurance.

(1) Existing law establishes the powers and duties of the Department of Insurance and the Insurance Commissioner. Existing law requires an application for specified licenses, including a production agency license, to be automatically denied without prejudice to the filing of a new application for the license, except in specified circumstances, if the applicant does not fully qualify for and receives the license on a permanent basis or is denied the issuance of the license, as specified.

This bill would additionally include applications for bail, insurance adjuster, or public insurance adjuster licenses.

(2) Existing law requires an insurance licensee or applicant for a license to notify the commissioner when any of their background information changes after the application has been submitted or the license has been issued. For this purpose, existing law defines "background information" to include an administrative action regarding a professional or occupational license, among other things.

This bill would expand the definition for "background information" to also include an administrative action regarding conduct or activity for which a professional or occupational license was required, but not possessed, and an administrative or civil action filed by, or on behalf of, a government or regulatory agency alleging any unlawful conduct, activity, or omission.

(3) Existing law permits blanket insurance to be issued to a college, school, or other institution of learning, or a sports team, camp, sponsor, or proprietor of a sports team, providing benefits to students, teachers, or employees, or sports team participants, campers, employees, officials, supervisors, or persons responsible for their support, for death or dismemberment resulting from accident, or for hospital, medical, surgical, or nursing expenses resulting from accident or sickness, as specified. Existing law defines "blanket insurance" for purposes of these provisions.

This bill would expand the groups for which blanket insurance may be issued to include coverage of volunteers for the entities described above.

(4) Existing law prohibits knowingly employing runners, cappers, steerers, or other persons to procure clients or patients to perform or obtain services or benefits under workers' compensation coverage or a contract of insurance or that will be the basis for a claim against an insured individual or their insurer. Existing law authorizes a district attorney, the Insurance Commissioner, or an interested person to bring a civil action for a violation of that provision. Existing law requires the district attorney or commissioner, for actions brought by an interested person, to either proceed with the action, in which case the action would be conducted by the district attorney or commissioner or to notify the court that it declines to take over the action, in which case the person bringing the action has the right to conduct the action. Existing law prohibits a court from having jurisdiction over an action under these provisions based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing in a legislative or administrative report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

This bill would instead prohibit a court from having jurisdiction, unless the action is brought by the district attorney or commissioner, the district attorney or commissioner proceeds with an action brought

by an interested person, or the person bringing the action is an original source of the information.

(5) This bill would make additional technical changes to eliminate outdated references and correct other errors.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 1670 of the Insurance Code is amended to read:

1670. If an applicant for any license under this chapter, Chapter 7 (commencing with Section 1800) of this part, or Chapter 1 (commencing with Section 14000) or Chapter 2 (commencing with Section 15000) of Division 5, within one year from the date of the receipt by the commissioner of the application, whether or not the filing is complete, or within one year from the date of the issuance to the applicant of a certificate of convenience, if any, whichever is the later date, neither fully qualifies for and receives that license on a permanent basis, nor is denied its issue, the application is automatically denied without prejudice to the filing of a new application for the license unless in a proceeding under a statement of issues the commissioner for good cause determines the denial should be set aside or stayed.

SEC. 2. Section 1729.2 of the Insurance Code is amended to read:

1729.2. (a) An applicant or licensee shall notify the commissioner when any of the background information set forth in this section changes after the application has been submitted or the license has been issued. If the licensee is listed as an endorsee on any business entity license, the licensee shall also provide this notice to any officer, director, or partner listed on that business entity license.

(b) A business entity licensee, upon learning of a change in background information pertaining to any unlicensed person listed on its business entity license or application therefor, shall notify the commissioner of that change. The changes subject to this requirement include changes pertaining to any unlicensed officer, director, partner, member, or controlling person, or any other

natural person named under the business entity license or in an application therefor.

(c) The following definitions apply for the purposes of this section:

(1) "License" includes all types of licenses issued by the commissioner pursuant to Chapter 5 (commencing with Section 1621), Chapter 5A (commencing with Section 1759), Chapter 6 (commencing with Section 1760), Chapter 6.5 (commencing with Section 1781.1), Chapter 7 (commencing with Section 1800), and Chapter 8 (commencing with Section 1831) of Part 2 of Division 1, Chapter 1 (commencing with Section 10110) of Part 2 of Division 2, Chapter 4 (commencing with Section 12280) of Part 5 of Division 2, Article 8 (commencing with Section 12418) of Chapter 1 of Part 6 of Division 2, and Chapter 1 (commencing with Section 14000) and Chapter 2 (commencing with Section 15000) of Division 5.

(2) "Background information" means any of the following: a misdemeanor or felony conviction; a filing of felony criminal charges in state or federal court; an administrative action regarding a professional or occupational license or regarding conduct or activity for which a professional or occupational license was required but not possessed; an administrative or civil action filed by, or on behalf of, a government or regulatory agency alleging any unlawful conduct, activity, or omission; any licensee's discharge or attempt to discharge, in a personal or organizational bankruptcy proceeding, an obligation regarding any insurance premiums or fiduciary funds owed to any person, including a premium finance company, or managing general agent; and any admission, or judicial finding or determination, of fraud, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty.

(3) "Applicant" and "licensee" include individual and organization applicants and licensees, and officers, directors, partners, members, and controlling persons (as defined in subdivision (b) of Section 1668.5) of an organization.

(d) Notification to the commissioner shall be in writing and shall be sent within 30 days of the date the applicant or licensee learns of the change in background information.

(e) The commissioner may adopt regulations necessary or desirable to implement this section.

SEC. 3. Section 1800 of the Insurance Code is amended to read:

1800. (a) An insurer shall not execute an undertaking of bail except by and through a person holding a bail license issued as provided in this chapter. A person shall not in this state solicit or negotiate in respect to execution or delivery of an undertaking of bail or bail bond by an insurer, or execute or deliver such an undertaking of bail or bail bond unless licensed as provided in this chapter, but if so licensed, such person may so solicit, negotiate, and effect such undertakings or bail bonds without holding or being named in any license specified in Chapter 5 of this part.

(b) (1) A person shall not perform in this state the activities of a bail fugitive recovery agent, as defined in paragraph (4) of subdivision (a) of Section 1299.01 of the Penal Code, or solicit or negotiate to perform the activities of a bail fugitive recovery agent, as defined in paragraph 4 of subdivision (a) of Section 1299.01 of the Penal Code, unless licensed pursuant to this chapter.

(2) Any person, persons, or entity, including licensed bail agents and surety insurers, that hire, contract, solicit, or appoint another person or persons to act as a bail fugitive recovery agent shall ensure that the hired person or persons are duly licensed by the department as a bail fugitive recovery agent under paragraph (4) of subdivision (a) of Section 1801.

(c) For purposes of this section, "solicit" shall include any written or printed presentation or advertising made by mail or other publication, or any oral presentation or advertising by means of telephone, radio, or television which implies that an individual is licensed under this chapter, and any activity in arranging for bail which results in remuneration to the individual conducting that activity.

SEC. 4. Section 1871.7 of the Insurance Code is amended to read:

1871.7. (a) It is unlawful to knowingly employ runners, cappers, steerers, or other persons to procure clients or patients to perform or obtain services or benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code or to procure clients or patients to perform or obtain services or benefits under a contract of insurance or that will be the basis for a claim against an insured individual or their insurer.

(b) Every person who violates any provision of this section or Section 549, 550, or 551 of the Penal Code shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000), plus an assessment of not more than three times the amount of each claim for compensation, as defined in Section 3207 of the Labor Code or pursuant to a contract of insurance. The court shall have the power to grant other equitable relief, including temporary injunctive relief, as is necessary to prevent the transfer, concealment, or dissipation of illegal proceeds, or to protect the public. The penalty prescribed in this paragraph shall be assessed for each fraudulent claim presented to an insurance company by a defendant and not for each violation.

(c) The penalties set forth in subdivision (b) are intended to be remedial rather than punitive, and shall not preclude, nor be precluded by, a criminal prosecution for the same conduct. If the court finds, after considering the goals of disgorging unlawful profit, restitution, compensating the state for the costs of investigation and prosecution, and alleviating the social costs of increased insurance rates due to fraud, that such a penalty would be punitive and would preclude, or be precluded by, a criminal prosecution, the court shall reduce that penalty appropriately.

(d) The district attorney or commissioner may bring a civil action under this section. Before the commissioner may bring that action, the commissioner shall be required to present the evidence obtained to the appropriate local district attorney for possible criminal or civil filing. If the district attorney elects not to pursue the matter, then the commissioner may proceed with the action.

(e) (1) Any interested persons, including an insurer, may bring a civil action for a violation of this section for the person and for the State of California. The action shall be brought in the name of the state. The action may be dismissed only if the court and the district attorney or the commissioner, whichever is participating, give written consent to the dismissal.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the district attorney and commissioner. The complaint shall be filed in camera, shall remain under seal for at least 60 days from the date of service on the district attorney

and commissioner, and shall not be served on the defendant until the court so orders. The local district attorney or commissioner may elect to intervene and proceed with the action within 60 days after the district attorney or commissioner receives both the complaint and the material evidence and information. If more than one governmental entity elects to intervene, the district attorney shall have precedence.

(3) The district attorney or commissioner may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). The motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the district attorney or commissioner shall either:

(A) Proceed with the action, in which case the action shall be conducted by the district attorney or commissioner.

(B) Notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person or governmental agency brings an action under this section, no person other than the district attorney or commissioner may intervene or bring a related action based on the facts underlying the pending action unless that action is authorized by another statute or common law.

(f) (1) If the district attorney or commissioner proceeds with the action, the district attorney or commissioner shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. That person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2) (A) The district attorney or commissioner may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the district attorney or commissioner of the filing of the motion, and the court has provided the person with an opportunity for a hearing on the motion.

(B) The district attorney or commissioner may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, the hearing may be held in camera.

(C) Upon a showing by the district attorney or commissioner that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the district attorney's or commissioner's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, including, but not limited to, the following:

(i) Limiting the number of witnesses the person may call.

(ii) Limiting the length of the testimony of those witnesses.

(iii) Limiting the person's cross-examination of witnesses.

(iv) Otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the district attorney or commissioner elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the district attorney or commissioner so requests, the district attorney or commissioner shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts, at the district attorney's or commissioner's expense. When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the district attorney or commissioner to intervene at a later date upon a showing of good cause.

(4) If at any time both a civil action for penalties and equitable relief pursuant to this section and a criminal action are pending against a defendant for substantially the same conduct, whether brought by the government or a private party, the civil action shall be stayed until the criminal action has been concluded at the trial

court level. The stay shall not preclude the court from granting or enforcing temporary equitable relief during the pendency of the actions. Whether or not the district attorney or commissioner proceeds with the action, upon a showing by the district attorney or commissioner that certain actions of discovery by the person initiating the action would interfere with a law enforcement or governmental agency investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay discovery for a period of not more than 180 days. A hearing on a request for the stay shall be conducted in camera. The court may extend the 180-day period upon a further showing in camera that the agency has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subdivision (e), the district attorney or commissioner may elect to pursue its claim through any alternate remedy available to the district attorney or commissioner.

(g) (1) (A) (i) If the district attorney proceeds with an action brought by a person under subdivision (e), that person shall, subject to subparagraph (B), receive at least 30 percent but not more than 40 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action.

(ii) If the commissioner has brought an action or has proceeded with an action brought by another person under this section on or after January 1, 2006, the commissioner shall be entitled to attorney's fees and costs in addition to any judgment, regardless of the date that judgment is entered. The court shall determine and award the commissioner the amount of reasonable attorney's fees, including, but not limited to, reasonable fees for time expended by attorneys employed by the department and for costs incurred. Any attorney's fees or costs awarded to the commissioner and collected shall be deposited in the Insurance Fund. In cases in which the commissioner has intervened, the commissioner and the person bringing the claim may stipulate to an allocation. The court may allocate the funds pursuant to the stipulation if, after the court's ruling on objection by the district attorney, if any, the court finds it is in the interests of justice to follow the stipulation.

(iii) If the commissioner has proceeded with an action, if there is no stipulation regarding allocation, and if a judgment has been obtained or a settlement has been reached with the defendants, the court shall determine the allocation, upon motion of the commissioner or the person bringing the action, according to the following priority:

(I) The person bringing the action, regardless of whether that person paid money to the defendants as part of the acts alleged in the complaint, shall first receive the amount the court determines is reasonable for attorney's fees, costs, and expenses that the court determines to have been necessarily incurred.

(II) The commissioner shall receive the amount the court determines for reasonable attorney's fees and costs.

(III) If the person bringing the suit has paid moneys to the defendants as part of the acts alleged in the complaint, that person shall receive the amount paid to the defendants.

(IV) At least 30 percent, but not more than 40 percent, of the remaining assets or moneys, shall be allocated to the person bringing the action, depending upon the extent to which the person substantially contributed to the prosecution of the action.

(iv) Those portions of a judgment or settlement not distributed pursuant to this subdivision shall be paid to the General Fund of the state and, upon appropriation by the Legislature, shall be apportioned between the Department of Justice and the Department of Insurance for enhanced fraud investigation and prevention efforts.

(B) Where the action is one that the court finds to be based primarily on disclosures of specific information, other than information provided by the person bringing the action, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative or administrative report, hearing, audit, or investigation, or from the news media, the court may award those sums that it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation.

(C) Any payment to a person under subparagraph (A) or under subparagraph (B) shall be made from the proceeds. The person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney's

fees and costs. All of those expenses, fees, and costs shall be awarded against the defendant.

(2) (A) If the district attorney or commissioner does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages. Except as provided in subparagraph (B), the amount shall not be less than 40 percent and not more than 50 percent of the proceeds of the action or settlement and shall be paid out of the proceeds. That person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney's fees and costs. All of those attorney's fees and costs shall be imposed against the defendant. The parties shall serve the commissioner and the local district attorney with complete copies of any and all settlement agreements, and terms and conditions, for actions brought under this article at least 10 days prior to filing any motion for allocation with the court under this paragraph. The court may allocate the funds pursuant to the settlement agreement if, after the court's ruling on objection by the commissioner or the local district attorney, if any, the court finds it is in the interests of justice to follow the settlement agreement.

(B) If the person bringing the action, as a result of a violation of this section has paid money to the defendant or to an attorney acting on behalf of the defendant in the underlying claim, then the person shall be entitled to up to double the amount paid to the defendant or the attorney if that amount is greater than 50 percent of the proceeds. That person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney's fees and costs. All of those expenses, fees, and costs shall be awarded against the defendant.

(3) If a local district attorney has proceeded with an action under this section, one-half of the penalties not awarded to a private party, as well as any costs awarded shall go to the treasurer of the appropriate county. Those funds shall be used to investigate and prosecute fraud, augmenting existing budgets rather than replacing them. All remaining funds shall go to the state and be deposited in the General Fund and, when appropriated by the Legislature, shall be apportioned between the Department of Justice and the Department of Insurance for enhanced fraud investigation and prevention efforts.

(4) Whether or not the district attorney or commissioner proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of this section, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. The dismissal shall not prejudice the right of the district attorney or commissioner to continue the action on behalf of the state.

(5) If the district attorney or commissioner does not proceed with the action, and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorney's fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(h) (1) In no event may a person bring an action under subdivision (e) that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the Attorney General, district attorney, or commissioner is already a party.

(2) (A) A court shall not have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing in a legislative or administrative report, hearing, audit, or investigation, or from the news media, unless the action is brought by the district attorney or commissioner, the district attorney or commissioner proceeds with an action brought by a person under subdivision (e), or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the district attorney or commissioner before filing an action under this section that is based on the information.

(i) Except as provided in subdivision (j), the district attorney or commissioner is not liable for expenses that a person incurs in bringing an action under this section.

(j) In civil actions brought under this section in which the commissioner or a district attorney is a party, the court shall retain discretion to impose sanctions otherwise allowed by law, including

the ability to order a party to pay expenses as provided in Sections 128.5 and 1028.5 of the Code of Civil Procedure.

(k) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by their employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in, an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole. That relief shall include reinstatement with the same seniority status the employee would have had but for the discrimination, two times the amount of backpay, interest on the backpay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees. An employee may bring an action in the appropriate superior court for the relief provided in this subdivision. The remedies under this section are in addition to any other remedies provided by existing law.

(*l*) (1) An action pursuant to this section may not be filed more than three years after the discovery of the facts constituting the grounds for commencing the action.

(2) Notwithstanding paragraph (1) no action may be filed pursuant to this section more than eight years after the commission of the act constituting a violation of this section or a violation of Section 549, 550, or 551 of the Penal Code.

SEC. 5. Section 10123.13 of the Insurance Code, as amended by Section 6 of Chapter 763 of the Statutes of 2024, is amended to read:

10123.13. (a) Every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer, unless the claim or portion thereof is contested or denied by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The

notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, internet website address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working

days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

(e) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 6. Section 10123.13 of the Insurance Code, as added by Section 7 of Chapter 763 of the Statutes of 2024, is amended to read:

10123.13. (a) Every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse a complete claim or portion thereof, whether in state or out of state, for those expenses as soon as practicable, but no later than 30 calendar days after receipt of the claim by the insurer, unless the insurer is contesting or denying the claim or a portion thereof, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 calendar days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, internet website address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain

a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 calendar days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period. An insurer shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. An insurer failing to comply with this requirement shall pay the claimant a fee of the greater of an additional fifteen dollars ($15) or 10 percent of the accrued interest.

(c) (1) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. An insurer may not contest a complete claim that is consistent with an approved prior authorization request if the prior authorization approval has been provided in the appropriate field on the claim.

(2) If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 calendar days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

(e) (1) The department may issue guidance and regulations relating to this section. The guidance and regulations shall not be subject to the rulemaking provisions of the Administrative

Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2027.

(2) After January 1, 2028, the department may issue regulations relating to this section subject to the rulemaking provisions of the Administrative Procedure Act ((Chapter 3.5 commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2030.

(f) This section shall become operative on January 1, 2026.

~~SEC. 7. Section 10123.1991 of the Insurance Code is amended to read:~~

~~10123.1991. (a) (1) A health insurer shall provide to insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age.~~

~~(2) "Behavioral health and wellness screening" means a screening, test, or assessment to identify indicators or symptoms of behavioral health issues in an individual, including, but not limited to, depression or anxiety.~~

~~(b) The notice shall provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety.~~

~~(c) A health insurer shall provide notice pursuant to this section annually.~~

~~(d) This section does not apply to Medi-Cal managed care that contracts with the State Department of Health Care Services entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.~~

~~SEC. 8.~~

*SEC. 7.* Section 10270.2 of the Insurance Code is amended to read:

10270.2. (a) Blanket insurance is that form of insurance providing coverage for specified circumstances and insuring by description all or nearly all persons within a class of persons defined in a policy issued to a master policyholder, and not by specifically naming the persons covered, by certificate or otherwise, although a statement of the coverage provided may be given, or required by the policy to be given, to eligible persons. The

permitted types of blanket insurance are those where the blanket policy is issued to any of the following:

(1) A volunteer or governmental fire department, emergency medical services company, or similar volunteer or governmental organization providing benefits to members or participants only in the event of accident incurred while performing actions incident to an activity or operation sponsored or supervised by the department, company, or organization.

(2) A college, school, or other institution of learning, a school district or districts or school jurisdictional unit, or to the head, principal, or governing board of an educational unit who or which shall be deemed the policyholder; providing benefits to students without necessarily any restriction as to activity, time, or place, or to teachers, employees, or volunteers, while performing actions incident to special duties, such as at camps, at summer playgrounds, or during tours or excursions; and providing benefits to students, teachers, employees, or volunteers, and spouses and dependents of students, teachers, and employees, for death or dismemberment resulting from accident, or for hospital, medical, surgical, drug, or nursing expenses resulting from accident or sickness.

(3) A sports team, camp, sponsor, or proprietor thereof, who shall be deemed the policyholder, providing benefits to sports team participants, campers, employees, officials, supervisors, volunteers, or persons responsible for their support, for death or dismemberment resulting from accident, or for hospital, medical, surgical, or nursing expenses resulting from accident, to those participants, campers, employees, officials, supervisors, volunteers, or persons responsible for their support, or arising out of sickness of those participants, campers, employees, officials, supervisors, volunteers, or persons responsible for their support, provided the accident or the first manifestation of sickness occurs while those participants, campers, employees, officials, supervisors, volunteers, or persons responsible for their support are in or on the buildings or premises of the sports team or camp, being transported between their homes and the sports team or camp, or while at any other place as an incident to sports team- or camp-sponsored activities or while being transported to, from, or between those places.

(4) (A) A newspaper, farm paper, magazine, or other periodical publication, which shall be deemed the policyholder, providing benefits for independent contractors, such as carriers, newsboys,

dealers, distributors, wholesalers, or others engaged in the sale, distribution, collecting for, or other activities pertaining to the marketing and delivery of the publication, including attendance at a coaching school or participation as a member of a trip organized, supervised, and sponsored as a reward for meritorious service, on account of loss resulting from accident or sickness, the benefit to be payable to the independent contractors or to their parents, guardians, or other persons responsible for their support.

(B) When the premium for the insurance is paid by the person insured, the person may, upon request, obtain from the insurer in certificate form a copy of the policy.

(5) Any religious, charitable, recreational, educational, athletic, civic organization, or branch thereof, which shall be deemed the policyholder, providing benefits to any group of members, employees, or participants for death or dismemberment or for hospital, medical, surgical, or nursing expenses resulting from accident incurred incident to specific hazards pertaining to any activity or activities or operations sponsored or supervised by, or on the premises of, the policyholder.

(6) An employer, a majority of the employees in this state of an employer, or both, upon application, to pay the benefits afforded by a voluntary plan of unemployment compensation disability insurance. Notwithstanding the provisions of Section 10113, the policy may incorporate by reference any of the appropriate provisions of Part 2 (commencing with Section 2601) of Division 1 of the Unemployment Insurance Code and the authorized regulations of the Director of Employment Development.

(7) An employer, who shall be deemed the policyholder, providing benefits to any group of workers, dependents, or guests, limited by reference to specified hazards incident to activities or operations of the policyholder, for death or dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident. When the premium for the insurance is paid by the person insured, the person may, upon request, obtain from the insurer in certificate form a copy of the policy.

(8) Any common carrier or any operator, owner, or lessor of a means of transportation, who shall be deemed the policyholder, providing benefits to any group of persons who may become lessees or passengers, limited by reference to their travel status on that common carrier or that means of transportation, for death or

dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident. When the premium for the insurance is paid by the person insured, the person may, upon request, obtain from the insurer in certificate form a copy of the policy.

(9) An entertainment production company, who shall be deemed the policyholder, providing benefits to any group of participants, volunteers, audience members, contestants, or workers for death or dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident while engaged in any activity or operation of the policyholder. When the premium for the insurance is paid by the person insured, the person may, upon request, obtain from the insurer in certificate form a copy of the policy.

(b) A "blanket policy" is any disability policy of the nature herein described sold to any of the entities described in paragraphs (1) to (9), inclusive, of subdivision (a) that provides coverage for any group of persons within permitted categories defined in the policy. Policies referred to in paragraph (6) of subdivision (a) shall comply with the provisions of this section specifically referring thereto. Policies referred to in paragraphs (1) to (5), inclusive, or (7) to (9), inclusive, of subdivision (a) may provide that the cost of the insurance coverage shall be borne by either the policyholder, or the individuals insured or their parents or guardians, payable through the policyholder. In the absence of a policy provision excluding coverage for otherwise covered individuals who have not individually enrolled with the policyholder and undertaken to pay all or a specified portion of the premium allocable to the individual, the policy shall provide the described insurance for all who fall within the categories of covered individuals defined in the policy. The policy may, but is not required to, contain provisions requiring a minimum number of participating persons or a minimum percentage of participation before the policy is effective. In the absence of such a provision, coverage shall not be denied any individual otherwise eligible on those grounds.

(c) A policy described in paragraphs (1) to (5), inclusive, or (7) to (9), inclusive, of subdivision (a) shall not be issued until approved as to substance and form by the commissioner. The commissioner may, after notice and hearing, promulgate reasonable rules and regulations relating to the substance, form, and issuance

of the policies that are necessary or desirable to preserve, insofar as applicable, standards of substance, form, and issuance comparable to the standards prescribed by this chapter that are applicable to other types of disability policies, and to further the purposes for which the policies are issued.

(d) A policy described in paragraph (6) of subdivision (a) shall not be issued until approved as to form by the commissioner. The commissioner may, after notice and hearing, promulgate reasonable rules and regulations relating to the form and issuance of the policies that do not affect the substance of the coverage, and that are necessary or desirable to preserve, insofar as applicable, standards of form and issuance comparable to the standards prescribed by this chapter that are applicable to other types of disability policies, and to further the purposes for which the policies are issued. Notwithstanding the provisions of Section 10113, the policy may incorporate by reference any of the appropriate provisions of Part 2 (commencing with Section 2601) of Division 1 of the Unemployment Insurance Code and the authorized regulations of the Director of Employment Development.

(e) A policy described in this section shall not constitute workers' compensation insurance, as defined in Section 109. A policy described in paragraphs (3), (5), (7), (8), or (9) of subdivision (a) shall not be marketed or sold as a substitute for health insurance coverage compliant with the requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(f) (1) An insurer that intends to issue a policy of blanket insurance authorized by the amendments to this section pursuant to the act adding this subdivision, or authorized pursuant to Section 10270.2.5, using a policy form previously approved by the commissioner, where the only new language in the policy is the specification of the policyholder, covered persons, or the hazards or activities insured, shall file that new language with the commissioner prior to issuance of the policy. Submissions of documents containing variable text or blanks shall include complete lists of the variable wording or accurate descriptions of the material to be inserted in lieu of the variable wording or in the blanks of these documents.

(2) A policy using the new language shall not be issued until either 30 days expires without notice from the commissioner after the new language is filed, or the commissioner gives their written approval prior to that time. If the commissioner at any time notifies the insurer, in writing and specifying the reasons for their opinion, that the filed new language does not comply with the requirements of law, the insurer shall not issue any policy containing that language.

(3) This subdivision shall not be construed to provide separate authority for the commissioner to reopen review of previously approved policy forms.

~~SEC. 9.~~

*SEC. 8.* Section 10295.11 of the Insurance Code is amended to read:

10295.11. (a) An accelerated death benefit shall not be advertised or marketed as long-term care insurance, nursing home insurance, or home care insurance. Any advertisement, description, comparison, marketing material, or illustration shall state in bold type:

"This is a life insurance benefit that also gives you the option to accelerate some or all of the death benefit in the event that you meet the criteria for a qualifying event described in the policy. This policy or certificate does not provide long-term care insurance subject to California long-term care insurance law. This policy or certificate is not a California Partnership for Long-Term Care program policy. This policy or certificate is not a Medicare supplement (policy or certificate)."

An insurer shall also include in any advertisement or marketing materials for these insurance policies all of the following:

(1) A statement that the policy or certificate pays proceeds that are or are not intended to receive favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C. Sec. 101(g)).

(2) A description of the accelerated death benefits provided by the policy, including a description of the acceleration of the death benefit to pay an unrestricted cash benefit when the insured has become chronically ill or otherwise eligible for benefits from a qualified event.

(3) A comparison between the benefits provided by life insurance policies, riders, or endorsements that contain accelerated

death benefits and the benefits provided by long-term care insurance.

(b) Advertising for term life insurance policies or certificates that contain an accelerated death benefit to be attached to an existing term life policy shall include a prominent statement that the accelerated death benefit will terminate with the policy.

(c) On or after January 1, 2014, every insurer offering accelerated death benefits shall file with the commissioner copies of all advertising for accelerated death benefits that the insurer proposes to disseminate in the state prior to use of that material. The commissioner shall have the authority to disapprove any advertising that does not meet the requirements of this code. If the commissioner disapproves the advertising, the insurer shall not use and shall stop using the disapproved advertising. Nothing in this subdivision shall be construed as requiring prior approval of advertising prior to dissemination in this state.

~~SEC. 10.~~

*SEC. 9.* Section 12800 of the Insurance Code is amended to read:

12800. The following definitions apply for purposes of this part:

(a) "Motor vehicle" means a self-propelled device operated solely or primarily upon land and may include both self-propelled motor homes or recreational vehicles, non-self-propelled camping and recreational trailers, off-road vehicles, and trailers designed to transport off-road vehicles. However, "motor vehicle" shall not include a self-propelled vehicle, or a component part of such a vehicle, that has any of the following characteristics:

(1) Has a gross vehicle weight rating of 30,000 pounds or more, and is not a recreational vehicle as defined by Section 18010 of the Health and Safety Code.

(2) Is designed to transport more than 15 passengers, including the driver.

(3) Is used in the transportation of materials considered hazardous pursuant to the Hazardous Materials Transportation Act (49 U.S.C. Sec. 5101 et seq.), as amended.

(b) "Watercraft" means a vessel, as defined in Section 21 of the Harbors and Navigation Code, and may include any non-self-propelled trailer used to transport such watercraft upon land.

(c) (1) "Vehicle service contract" means a contract or agreement for a separately stated consideration and for a specific duration to repair, replace, or maintain a motor vehicle or watercraft, or to indemnify for the repair, replacement, or maintenance of a motor vehicle or watercraft, necessitated by an operational or structural failure due to a defect in materials or workmanship, or due to normal wear and tear.

(2) (A) A vehicle service contract may also provide for the incidental payment of indemnity under limited circumstances only in the form of the following additional benefits: coverage for towing, substitute transportation, emergency road service, rental car reimbursement, reimbursement of deductible amounts under a manufacturer's warranty, and reimbursement for travel, lodging, or meals.

(B) A provider seeking to offer a vehicle service contract, including any of the benefits described in subparagraph (A), shall, when filing a specimen of the contract in accordance with subdivision (a) of Section 12820, certify that the indemnity benefits provided are incidental. For purposes of subparagraph (A) and this certification, indemnity benefits are incidental if the cost to provide them based on historical data, or projected data if historical data is unavailable or insufficient, is substantially less than the cost of providing all the benefits described in paragraphs (1), (3), (4), and (5). The commissioner may request the historical or projected data at any time.

(3) "Vehicle service contract" also includes an agreement of a term of at least one year, for separately stated consideration, that promises routine maintenance.

(4) Notwithstanding Section 116, and paragraphs (1) and (2) of this subdivision, a vehicle service contract also includes one or more of the following:

(A) An agreement that promises the repair or replacement of a tire or wheel necessitated by wear and tear, defect, or damage caused by a road hazard. However, an agreement that promises the repair or replacement of a tire necessitated by wear and tear, defect, or damage caused by a road hazard, in which the obligor is the tire manufacturer, is exempt from the requirements of this part. A warranty provided by a tire or wheel distributor or retailer is exempt from the requirements of this part as long as the warranty

covers only defects in the material or workmanship of the tire or wheel.

(B) An agreement that promises the repair or replacement of glass on a vehicle necessitated by wear and tear, defect, or damage caused by a road hazard. However, a warranty provided by a vehicle glass or glass sealant manufacturer is exempt from the requirements of this part. A warranty provided by a vehicle glass distributor or retailer is exempt from the requirements of this part as long as the warranty covers only defects in the material or workmanship of the vehicle glass.

(C) An agreement that promises the removal of a dent, ding, or crease without affecting the existing paint finish using paintless dent repair techniques, and which expressly excludes the replacement of vehicle body panels, sanding, bonding, or painting.

(D) An agreement that promises the replacement of a motor vehicle key or key fob in the event that the key or key fob becomes inoperable or is lost or stolen.

(5) "Vehicle service contract" also includes an agreement covering any of a vehicle's mechanical components, provided with or without separate consideration, that promises to repair, replace, or maintain a motor vehicle or watercraft, or to indemnify for the repair, replacement, or maintenance of a motor vehicle or watercraft, conditioned upon the use of a specific brand or brands of lubricant, treatment, fluid, or additive.

(d) "Service contract administrator" or "administrator" means any person, other than an obligor, who performs or arranges, directly or indirectly, any of the following activities:

(1) Providing sellers with service contract forms.

(2) Participating in the adjustment of claims arising from service contracts.

(3) Coordinating the performance or arrangement of any of the benefits permissible under subdivision (c).

(4) Collecting, maintaining, or disbursing of moneys to compensate any person for claims, repairs, or refunds pursuant to a vehicle service contract.

(e) "Purchaser" means any person who purchases a vehicle service contract from a seller.

(f) "Seller" means either of the following:

(1) With respect to motor vehicles, a dealer or lessor-retailer licensed in one of those capacities by the Department of Motor

Vehicles and who sells vehicle service contracts incidental to their business of selling or leasing motor vehicles.

(2) With respect to watercraft, a person who sells vehicle service contracts incidental to that person's business of selling or leasing watercraft vehicles.

(g) "Obligor" means the entity legally obligated under the terms of a service contract.

(h) "Road hazard" means a hazard that is encountered while driving a motor vehicle and that may include, but is not limited to, potholes, rocks, debris, metal parts, glass, plastic, curbs, or composite scraps.

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