"SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2025-2026 Regular Session

SB 1244 (Allen)
Version: March 25, 2026
Hearing Date: April 21, 2026
Fiscal: Yes
Urgency: No
AM

SUBJECT

Public Agency Benefits Intermediary Compensation Disclosure Act

DIGEST

This bill establishes disclosure requirements for brokers, agents, consultants, advisors, and other service providers that provide brokerage services or consulting services to California public agencies in connection with health care employee benefits, regardless of whether the covered service provider is domiciled, headquartered, or maintains a principal place of business within or outside of this state

EXECUTIVE SUMMARY

Brokers and agents can help employers, including public entities, navigate the process of purchasing heath care plans and other benefits for their employees. Generally, these brokers are paid for their services by the industry. There is currently little to no transparency into what compensation brokers receive when working with public entities as there are no disclosure requirements under existing law. Existing federal law places disclosure requirements on broker compensation for private health plans, but governmental entities are exempted from the federal law. This bills seeks to address this issue by establishing disclosure requirements for agents, brokers, and other service providers that provide brokerage services or consulting services to California public agencies in connection with health care employee benefits. The purpose of the bill is to ensure that public agencies receive transparent disclosure of compensation and potential conflicts of interest on a reasonable timeframe to inform procurement and renewal decisions regarding health care benefits and benefits-related services. This bill requires similar disclosures as under federal law; however, it is broader than federal law as it requires more stringent disclosures and applies to more service providers. The bill is author sponsored and supported by various labor organizations and Health Access California. The bill is opposed by the California Agents and Health Insurance Professionals.

PROPOSED CHANGES TO THE LAW

Existing federal law:

1) Requires, under the Employee Retirement Security Act of 1974 (ERISA), certain retirement and health plans to provide participants with certain information. ERISA generally does not cover plans maintained by governmental entities. (29 U.S.C. § 1001 et seq.)

2) Requires, under the Consolidated Appropriations Act of 2021 (CAA), comprehensive broker, agent, and consultant compensation disclosure for ERISA-covered group health plans. (§ 202, Pub. L. No 116-260 (Dec. 27, 2020).)

Existing state law:

1) Requires a health care service plan or a health insurer to annually disclose to the governing board of a public agency that is the subscriber of a group contract or the policyholder of a group health insurance policy specified information, including, but not limited to, any fees or commissions paid to any agent, broker, or other individual related to the public agency's group contract or policy. (Health & Saf. Code § 1367.08; Ins. Code § 10604.5.)

This bill:

1) Requires a covered service provider to disclose to the responsible public agency official, and to the governing body of the public agency or the clerk or other designee identified by the governing body, in writing, specified information before the covered service provider enters into, extends, renews, or materially amends a contract or arrangement for brokerage services or consulting services with the public agency or covered plan.
    a) The disclosure must include sufficient detail to permit the responsible public agency official and the governing body to understand the nature and potential magnitude of compensation and to identify potential conflicts of interest.
    b) The disclosure must be signed by an authorized representative of the covered service provider and shall include a certification that the disclosure is true, correct, and complete to the best of the signer's knowledge and that the covered service provider will comply with the update and true-up requirements under the bill.
    c) The disclosures are required for a prospective contract or arrangement, the covered service provider shall provide the required disclosure with the first written communication to the responsible public agency representative or governing board that contains a formal offer, proposal, or solicitation to provide brokerage, agent, advisory, or consulting services, and must be

updated before execution if there is any material change to the expected compensation.

d) The disclosures are required for an extension, renewal, or material amendment of an existing contract or arrangement, the covered service provider is required to provide the disclosure not later than 60 days before the effective date of the extension, renewal, or material amendment.
e) If the covered service provider delivers ongoing services, the covered service provider shall give an updated disclosure annually, not later than 60 days before the renewal date of each covered health care benefits arrangement for which the covered service provider provides brokerage services or consulting services.
f) For any compensation disclosed as an estimate, the covered service provider must provide an annual true-up that includes revised disclosure not later than 90 days after the end of the contract year or plan year, as applicable. For purposes of this requirement, the "contract year" or "plan year" means the 12-month period used for coverage under the covered health care benefits arrangement, or, if that period is not specified, the 12-month period following the effective date or renewal date of the contract.
g) A covered service provider that discovers an error or omission in a disclosure must provide corrected information as soon as practicable, but not later than 30 days after the date the covered service provider knows of the error or omission.

2) Requires the disclosure in 1) to include the following information listed below.
   a) A description of the brokerage services or consulting services to be provided.
   b) If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the public agency or covered plan as a fiduciary under applicable law. This does not create or expand fiduciary status under state law.
   c) A description of all direct compensation, either in the aggregate or by service, that the covered service provider, an affiliate, a subcontractor, or a related party reasonably expects to receive in connection with the services.
   d) A description of all indirect compensation that the covered service provider, an affiliate, a subcontractor, or a related party reasonably expects to receive in connection with the services, including all of the following:
      i. a description of the arrangement pursuant to which the indirect compensation is paid;
      ii. identification of the services for which the indirect compensation will be received, if applicable;
      iii. Identification of the payer of the indirect compensation;
      iv. Indirect compensation includes compensation from a carrier, vendor, or third party based on a structure of incentives not solely related to the public agency's contract or policy, including book-of-business

incentives, volume bonuses, retention bonuses, and other market-derived income; and

v. disclosure that identifies categories, types, or sources of compensation without providing corresponding amounts, good-faith estimates, or formulas for calculating amounts for each identified category, type, or source does not satisfy the requirements of this article. General descriptions of compensation arrangements that may exist or that the covered service provider may from time to time receive are insufficient. The disclosure shall state if the covered service provider reasonably expects to receive the compensation in connection with the specific public agency or covered plan during the applicable contract period.

e) A description of any compensation that will be paid among the covered service provider, an affiliate, subcontractor, or related party in connection with the services described in paragraph (1) if the compensation is set on a transaction basis, such as commissions, finder's fees, placement fees, or other similar incentive compensation based on business placed or retained, including identification of the services for which the compensation will be paid and identification of the payers and recipients of that compensation.

f) A description of any compensation that the covered service provider, an affiliate, related party, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon termination.

g) A description of the manner in which the compensation described in this section will be received.

h) A description of noncash compensation, including the nature of the noncash compensation and a reasonable good faith estimate of fair market value.

i) Identification of an ownership interest, equity stake, or other financial interest, including a pending or proposed interest under negotiation or under consideration, that the covered service provider or any related party holds in a carrier, vendor, or other entity that is a party to, or is recommended in connection with, a covered health care benefits arrangement.

j) If any compensation cannot reasonably be expressed as a monetary amount at the time of disclosure, a reasonable and good faith estimate and an explanation of the methodology and assumptions used to prepare the estimate, including any reasonable allocation methodology for compensation that is pooled across multiple clients.

k) For all compensation disclosed pursuant to (c), (d), (e), and (h), a breakdown showing all of the following separately:

i. compensation to the individual broker, agent, consultant, or advisor;

ii. compensation to the firm or company by which the individual is employed or contracted; and

iii. compensation to an affiliate, subcontractor, or related party, regardless of whether the compensation is paid directly or routed through a third party or other entity.

l) For covered service providers that recommend, place, or service benefits arrangements for retirees, including Medicare supplement plans, Medicare Advantage plans, retiree health exchanges, or other retiree coverage, a separate statement disclosing all of the following:
   i. all compensation related to retiree benefits arrangements, broken out separately from compensation related to active employee arrangements;
   ii. whether compensation for retiree-related services is considered by the covered service provider in determining or offsetting fees for active employee services; and
   iii. any arrangement pursuant to which retiree-related compensation subsidizes, offsets, or is otherwise connected to the pricing of services for active employee benefits.

m) Identification of a material business relationship between the covered service provider, or any related party, and a carrier, vendor, or other entity that is a party to, or is recommended in connection with, a covered health care benefits arrangement. A business relationship is "material" if the covered service provider or related party received or expects to receive compensation exceeding $10,000 in the aggregate from the carrier or vendor during the 12 months preceding the disclosure or the 12 months following the disclosure.

3) Requires a covered service provider to disclose compensation and material financial interests related to a covered health care benefits arrangement that the covered service provider recommends, places, renews, services, or materially influences for a public agency or covered plan, including compensation paid by carriers, vendors, third-party administrators, pharmacy benefit managers, enrollment firms, joint powers authorities, captives, and other sources, whether or not the compensation is solely attributable to the public agency's specific contract or policy.
   a) This includes compensation received for recommending, facilitating, or influencing a public agency's decision to join, remain with, or purchase coverage through a joint powers authority, regardless of whether the compensation is paid by the joint powers authority, a vendor contracting with the joint powers authority, or any other source.

4) Requires disclosure under 1) and 3) if a covered service provider reasonably expects it would receive, during the term of the contract or arrangement, $1,000 or more in compensation, direct or indirect, including compensation received by a related party. Noncash compensation must be included in this calculation and must be disclosed if it exceeds $250 in the aggregate during the term of the contract or arrangement, or if a reasonable person would consider it material.

   a) A description of compensation or cost may be expressed as a monetary amount, formula, percentage, or a per capita charge for each participant, beneficiary, enrollee, or insured.
   b) If the compensation or cost cannot reasonably be expressed in those terms, it may be described by any other reasonable method.
   c) The description may include a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost, if the covered service provider explains the methodology and assumptions used to prepare the estimate.
   d) The description must contain sufficient information to permit the public agency to understand the nature and potential magnitude of the compensation or cost and identify potential conflicts of interest.

5) Requires a covered service provider that provides brokerage services, consulting services, or administrative services to a joint powers authority (JPA) to do all of the following:
   a) provide the disclosures described above to the responsible official of the joint powers authority and governing body; and
   b) make the disclosures available, either directly or through the joint powers authority, to the governing body or responsible official of each public agency that participates in the pooled arrangement, upon request and at least annually.

6) Authorizes a JPA that receives disclosures under this bill to do both of the following:
   a) maintain the disclosures and make them available to its member public agencies upon request; and
   b) include in its annual reporting to member agencies a summary of compensation disclosed by covered service providers or provide a copy of the full disclosure.

7) Requires a covered service provider that recommends, facilitates, or materially influences a public agency's decision to join, remain with, or purchase coverage through a joint powers authority to disclose to that public agency all compensation received or reasonably expected to be received, directly or indirectly, in connection with that recommendation, including all of the following:
   a) referral fees, finder's fees, or placement fees paid by the pooling arrangement or an entity affiliated with the pooling arrangement;
   b) commissions, overrides, or other compensation paid by a carrier, vendor, or third party contracting with or through the pooling arrangement;
   c) administrative fees, marketing allowances, or other payments received for maintaining or increasing membership in the pooling arrangement; and
   d) an ownership interest, board position, governance role, or profit-sharing arrangement the covered service provider or a related party holds with respect to the pooling arrangement.

8) Prohibits a covered service provider from doing any of the following:
    a) requesting, accepting, or receiving direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or covered plan unless the compensation is disclosed;
    b) structuring, routing, recharacterizing, allocating, or otherwise arranging compensation, including through an affiliate, subcontractor, or other related party, for the purpose of evading the disclosure requirements;
    c) relabeling, renaming, or recharacterizing compensation as fees, consulting payments, administrative charges, service fees, or any other designation for the purpose of circumventing the disclosure requirements; and
    d) avoiding disclosure obligations by entering into a separate consulting agreement or advisory agreement for substantially similar services that would otherwise require disclosure.

9) Requires a covered service provider to retain records sufficient to support the required disclosures for not less than three years following the later of the following:
    a) the date the disclosure is provided; or
    b) the termination of the contract or arrangement. Upon request by the Attorney General, a county counsel, a city attorney, or an authorized local prosecutor, a covered service provider is to make these records available for inspection.

10) Provides that these provisions apply to contracts or arrangements entered into, extended, or renewed on or after January 1, 2028.
    a) Public agencies and covered service providers are encouraged to voluntarily comply with this article before January 1, 2028.

COMMENTS

1. Stated need for the bill

The author writes:

> Healthcare premiums have more than tripled over the past 20 years. Public agencies have been grappling with these rising prices that are, in some cases, compounded by compensation paid to insurance intermediaries who advise employers on health care options to select for their employees' benefits package. Private employers receive compensation disclosures from these intermediaries, which can help guide decisions on which benefits to select and which intermediaries to contact with. Public agencies, however, currently receive no such transparency, and thus have to make large financial decisions with less information available to them.
>
> SB 1244 will close this gap in the law and help public agencies make more fiscally sound decisions when selecting employee benefits options by requiring insurance

intermediaries to proactively disclose the compensation they earn for advising these agencies to select certain health care options.

2. This bill requires disclosures for brokers, agents, consultants, advisors, and other service providers that provide brokerage services or consulting services to California public agencies in connection with health care employee benefits

Public agencies, including school districts, cities, counties, community colleges, and special districts, spend billions annually on employee health benefits. Just like private employers, public agencies often rely on brokers and consultants to recommend insurance carriers, negotiate rates, and select vendors for benefits. These brokers generally receive compensation directly from the carriers. The fact that they are being compensated is usually disclosed; however, the exact amount of compensation is not. The author of the bill provided the Committee with an example of a brokerage services contract from EPIC Insurance Brokers & Consultants that states:

> […] EPIC is compensated in a variety of ways for the services it provides to its clients, and a particular placement may involve one or a combination of such arrangements. Primarily, EPIC is compensated through commission payments that are based on (and a part of) the premium charged and collected by Insurers for each insurance policy secured for EPIC's clients. In some cases, EPIC may receive specific fees from clients in lieu of or in addition to such commissions for the placement of coverage and/or for other services or projects. […]

This bill is intended to ensure that public agencies receive transparent disclosure of compensation and potential conflicts of interest on a reasonable timeframe to inform procurement and renewal decisions regarding health care benefits and benefits-related services. In order to effectuate this policy, the bill places disclosure requirements on a covered service provider related to monetary compensation over $1,000 and any non-monetary compensation over $250 for covered health care benefits arrangements. A "covered service provider" means a broker, agent, consultant, or advisor that enters into a contract or arrangement with a covered plan or public agency and reasonably expects, knew, or should have known it would receive, compensation, direct or indirect, to be received in connection with providing brokerage services or consulting services. A "covered health care benefit" arrangement includes numerous types of services ranging from medical, dental, and vision coverage to pharmacy benefit managers, employee assistance programs, and other service providers.

The disclosure requirements apply to any extension, renewal, or material amendment of an existing contract or arrangement, and is to be provided no later than 60 days before the effective date of the extension, renewal, or material amendment. If the covered service provider provides ongoing services, the covered service provider is required to provide an updated disclosure annually, and an annual true-up that includes revised disclosure for any compensation previously disclosed as an estimate.

Other disclosure requirements under the bill include the following listed below:

- Identification of a material business relationship between the covered service provider, or any related party, and a carrier, vendor, or other entity that is a party to, or is recommended in connection with, a covered health care benefits arrangement. A business relationship is considered "material" if the covered service provider or related party received or expects to receive compensation exceeding $10,000 in the aggregate from the carrier or vendor during the 12 months preceding the disclosure or the 12 months following the disclosure.
- Separate information regarding retiree coverage, including for Medicare supplement plans, Medicare Advantage plans, retiree health exchanges, or other retiree coverage.
- Identification of an ownership interest, equity stake, or other financial interest, including a pending or proposed interest under negotiation or under consideration, that the covered service provider or any related party holds in a carrier, vendor, or other entity that is a party to, or is recommended in connection with, a covered health care benefits arrangement.
- A description of the brokerage services or consulting services to be provided.
- If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the public agency or covered plan as a fiduciary under applicable law.

Under the bill, a covered service provider would be prohibited from doing any of the following listed below.

- Request, accept, or receive direct or indirect compensation in connection with brokerage services or consulting services provided to a public agency or covered plan unless the compensation is disclosed as required under the bill.
- Structure, route, recharacterize, allocate, or otherwise arrange compensation, including through an affiliate, subcontractor, or other related party, for the purpose of evading the disclosure requirements of the bill.
- Relabel, rename, or recharacterize compensation as fees, consulting payments, administrative charges, service fees, or any other designation for the purpose of circumventing the disclosure requirements of the bill. The substance and economic reality of compensation arrangements governs their treatment under this article, regardless of the terminology used by the parties.
- Avoid disclosure obligations under this bill by entering into a separate consulting agreement or advisory agreement for substantially similar services that would otherwise require disclosure.

The bill provides that its provisions apply to a JPA and that the following information must also be disclosed if a covered service provider is providing services to a JPA:

- referral fees, finder's fees, or placement fees paid by the pooling arrangement or an entity affiliated with the pooling arrangement;
- commissions, overrides, or other compensation paid by a carrier, vendor, or third party contracting with or through the pooling arrangement;
- administrative fees, marketing allowances, or other payments received for maintaining or increasing membership in the pooling arrangement; and
- an ownership interest, board position, governance role, or profit-sharing arrangement the covered service provider or a related party holds with respect to the pooling arrangement.

A covered service provider would be required to retain records sufficient to support the disclosures required by the bill for not less than three years following the later of the following: (1) the date the disclosure is provided; or (2) the termination of the contract or arrangement. Upon request by the Attorney General, a county counsel, a city attorney, or an authorized local prosecutor, a covered service provider is to make the records available for inspection. The bill's provisions would apply to contracts or arrangements entered into, extended, or renewed on or after January 1, 2028; however, the bill encourages public agencies and covered service providers to voluntarily comply with this article before January 1, 2028.

3. Stakeholder statements

SEIU California, a supporter of the bill, writes in support stating:

> […] Public entities spend billions of dollars annually on employee health benefits. They rely on insurance brokers, agents, and consultants to recommend insurance carriers, negotiate rates, and select vendors. However, these intermediaries often receive compensation from insurers and third parties that public agencies never see. It is common for the service contracts between public agencies and intermediaries to contain a general disclosure that they may receive either direct or indirect compensation that may be based on the premium charged by the insurer with little to no other details. These hidden compensation arrangements can create misaligned incentives, steering public agencies toward more expensive vendors because the compensation for the insurance broker is greater if that option is chosen. These costs are ultimately borne by taxpayers and employees.
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> Commissions can be as high as 50 percent of the premium for some supplemental products, which are built into the premiums that the employers and employees pay. Base commissions can be between three to six percent of the total premium for an entire health insurance plan and bonuses could be as high as $150,000 for a single employer group. In addition, they are often treated to trips and other experiences, such as going to the Super Bowl or a luxury resort. Insurance plan costs have tripled in the last 20 years, which makes added opaque forms of compensation a serious issue compounding the affordability problems for public agencies.[…]

The California Agents and Health Insurance Professionals (CAHIP) writes in opposition unless amended. They raise several concerns with bill, including that it goes beyond requirements required at the federal level, applies to a broader category of providers and services than at the federal level, places burdensome requirements that could be operationally difficult to comply with, and may discourage agents and brokers from working with public agencies. CAHIP states they welcome an opportunity to work with the author to address their concerns and writes:

> […] In its current form, SB 1244 risks creating a system in which compliance is impractical, liability is misaligned, and administrative burdens may discourage qualified agents and brokers from serving public agencies. This would not be because agents are uninterested in providing transparency, but because there is no effective way of delivering the transparency that this bill requires – which simply means that agents would be putting themselves in legal jeopardy for participating in the marketplace for governmental plans. This could ultimately limit competition, reduce choice, and negatively impact the public entities the bill seeks to protect.[…]

The California Association of Joint Powers Authority writes that it would support the bill if amended to extend the requirements of the bill to public joint labor-management trusts (JLMTs) arguing these entities function in a manner substantially similar to JPAs. They write:

> […] many public entities including school districts, cities, and counties use the joint powers authority mechanism to effectively self-fund their healthcare in a non-profit, public entity risk pool. Public joint labor-management trusts are also commonly used to provide and administer health and welfare benefits for public employees and retirees. […]
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> This creates a risk of inconsistent regulatory treatment across entities performing equivalent functions and may result in uneven transparency requirements depending solely on the governance structure of the public benefit arrangement.

SUPPORT

California Federation of Labor Unions
California Federation of Teachers
California School Boards Association
California School Employees Association
California Teachers Association
Health Access California
Orange County Employees Association
SEIU California
SMART-Transportation Division

OPPOSITION

California Agents and Health Insurance Professionals

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation: AB 2589 (Solorio, Ch. 331, Stats. 2008) required a health care service plan or a health insurer to annually disclose to the governing board of a public agency that is the subscriber of a group contract or the policyholder of a group health insurance policy specified information, including, but not limited to, any fees or commissions paid to any agent, broker, or other individual related to the public agency's group contract or policy.

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