

Assembly Bill No. 486

Passed the Assembly August 31, 2002

Chief Clerk of the Assembly

Passed the Senate August 31, 2002

Secretary of the Senate

This bill was received by the Governor this _____ day of
_____, 2002, at _____ o'clock __M.

Private Secretary of the Governor

Second enrollment



CHAPTER _____

An act to amend Sections 78, 123.5, 123.6, 3201.5, 3501, 3742, 4453, 4600.5, 4614, 4702, and 5502 of, and to add Sections 3201.7, 3701.8, 5307.21, and 6354.7 to, the Labor Code, and to amend Section 86 of Chapter 6 of the Statutes of 2002, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 486, Calderon. Workers' compensation: administration and benefits.

(1) Existing law provides that the Commission on Health and Safety and Workers' Compensation in the Department of Industrial Relations is to be funded by appropriations from the Workplace Health and Safety Revolving Fund, into which certain civil and administrative penalties are deposited. Existing law requires the commission to review and approve applications from employers and employee organizations, or both, for grants to assist in establishing effective occupational injury and illness prevention programs.

This bill would instead provide for the deposit of these penalties in the Workers' Compensation Administration Revolving Fund. This bill would authorize the department to expend these funds upon approval by the commission, and upon appropriation from the fund by the Legislature, to fund the grants and other activities and expenses of the commission.

(2) Existing law provides for the Department of Industrial Relations to be divided into at least 6 divisions, including the Division of Workers' Compensation, which is under the direction of an administrative director. Existing law provides that the administrative director has various powers and duties with respect to the Workers' Compensation Appeals Board and workers' compensation administrative law judges who hear appeals of workers' compensation claims.

This bill would add various provisions, including certain qualifications and ethics requirements for workers' compensation administrative law judges and other provisions relating to the operation of the workers' compensation courts.



This bill would also require the administrative director, in consultation with the court administrator and the Commission on Judicial Performance, to adopt regulations to enforce the applicable ethics requirements for workers' compensation administrative law judges, and would authorize the court administrator to enforce these regulations.

(3) Existing law authorizes collective bargaining agreements between a private employer or groups of employers engaged in certain activities and a recognized or certified exclusive bargaining representative that establishes a dispute resolution process for workers' compensation instead of the hearing before the Workers' Compensation Appeals Board and its workers' compensation administrative law judges, or that provides for specified other alternative workers' compensation programs.

This bill would enact similar provisions with respect to employers in the aerospace and timber industries, as specified. By requiring certain information in connection with these provisions to be submitted by an employer under penalty of perjury, this bill would expand the definition of the crime of perjury, thereby imposing a state-mandated local program.

(4) Existing law makes certain conclusive presumptions regarding a child's or spouse's dependency on a deceased employee for support as it pertains to workers' compensation benefits.

This bill would require a finding by a trier of fact, as specified, as to the physical or mental incapacitation to earn by a dependent child of any age.

(5) Existing law requires every employer, except as specified, to secure the payment of compensation by either being insured against liability to pay compensation, or by securing from the Director of Industrial Relations a certificate of consent to self-insure.

Existing law establishes the Self-Insurers' Security Fund, governed by a 7-member board of trustees and administered by the Director of Industrial Relations, to provide for the continuation of workers' compensation benefits delayed as a result of the failure of a private, self-insured employer to meet its compensation obligations when the employer's security deposit is either inadequate or not immediately accessible for the payment of benefits.



Existing law requires every private, self-insuring employer to secure incurred liabilities for the payment of workers' compensation by making a deposit based on estimated future liability for compensation.

This bill would authorize the director to provide by regulation for an alternative security system, as an alternative to that required by existing law, that would require private, self-insured employers to collectively secure all, or a portion of, their aggregate liabilities through the Self-Insurers' Security Fund.

(6) Existing law requires the Self-Insurers' Security Fund to establish bylaws in order to carry out the purposes and responsibilities of the fund.

This bill would require that those bylaws include any obligations imposed on the director by the above provisions relating to the alternative security system whereby all private, self-insureds, collectively, would be required to secure all, or a portion of, their aggregate liabilities through the Self-Insurers' Security Fund. The bill would also authorize the director to impose specified financial obligations on fund members to satisfy the security requirements set by the director with respect to participation in the fund.

(7) Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of temporary disability, permanent total disability, permanent partial disability, and in case of death.

This bill would provide for increased temporary disability and permanent partial disability and death benefits for injuries or deaths occurring on or after January 1, 2003, with additional increases in benefits phased in over several years.

(8) Existing law establishes certification requirements for specified health care organizations that provide health care services for injured employees.

This bill would revise these certification requirements.

(9) Existing law provides for the payment of death benefits to the dependents of an injured employee who has died. Existing law establishes varying amounts of death benefits, in the case of dependents who are totally or partially dependent, or both, based on the date of the injury and on the number of dependent children.

This bill would increase the amount of those death benefits for injuries occurring on or after January 1, 2006.



(10) Existing law requires injured employees to be provided with medical services, including surgical treatment.

The bill would provide that the administrative director has the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract.

(11) Existing law establishes various procedures for workers' compensation claims proceedings, and gives exclusive jurisdiction to the Workers' Compensation Appeals Board regarding those claims. Existing law establishes procedures for the filing of pleadings, and for setting the times for hearings.

This bill would make changes to that procedure and would require a court administrator, rather than the Workers' Compensation Appeals Board, to establish various forms and to perform various administrative functions relating to these proceedings. This bill would also require the court administrator to establish a priority conferences calendar in specified cases, and require that the conferences shall be conducted by a workers' compensation administrative law judge, as prescribed. This bill would provide that if the dispute cannot be resolved at the conference, the case would be set for trial, as specified.

(12) Existing law requires workers' compensation insurers to maintain or provide occupational safety and health loss control consultation services certified by the Director of Industrial Relations.

The bill would require the Commission on Health and Safety and Workers' Compensation to establish and maintain a worker and occupational safety and health training and education program and an insurance loss control services coordinator position, to be funded from the Workers' Occupational Safety and Health Education Fund that would be created by the bill. The bill would require the director to levy and collect fees from workers' compensation insurers for purposes of the program, with the fees to be deposited in the Workers' Occupational Safety and Health Education Fund. Moneys in the fund would be available for expenditure for the above purposes upon appropriation by the Legislature.

(13) This bill would make related and technical changes.

(14) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by



the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 78 of the Labor Code is amended to read:

78. (a) The commission shall review and approve applications from employers and employee organizations, as well as applications submitted jointly by an employer organization and an employee organization, for grants to assist in establishing effective occupational injury and illness prevention programs. The commission shall establish policies for the evaluation of these applications and shall give priority to applications proposing to target high-risk industries and occupations, including those with high injury or illness rates, and those in which employees are exposed to one or more hazardous substances or conditions or where there is a demonstrated need for research to determine effective strategies for the prevention of occupational illnesses or injuries.

(b) Civil and administrative penalties assessed and collected pursuant to Sections 129.5 and 4628 shall be deposited in the Workers' Compensation Administration Revolving Fund. Moneys in the fund, when appropriated by the Legislature to fund the grants under subdivision (a) and other activities and expenses of the commission set forth in this code, shall be expended by the department, upon approval by the commission.

SEC. 2. Section 123.5 of the Labor Code is amended to read:

123.5. (a) Workers' compensation administrative law judges employed by the administrative director and supervised by the court administrator pursuant to this chapter shall be taken from an eligible list of attorneys licensed to practice law in this state, who have the qualifications prescribed by the State Personnel Board. In establishing eligible lists for this purpose, state civil service examinations shall be conducted in accordance with the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code). Every workers'



compensation judge shall maintain membership in the State Bar of California during his or her tenure.

A workers' compensation administrative law judge may not receive his or her salary as a workers' compensation administrative law judge while any cause before the workers' compensation administrative law judge remains pending and undetermined for 90 days after it has been submitted for decision.

(b) All workers' compensation administrative law judges appointed on or after January 1, 2003, shall be attorneys licensed to practice law in California for five or more years prior to their appointment and shall have experience in workers' compensation law.

SEC. 3. Section 123.6 of the Labor Code, as amended by Chapter 6 of the Statutes of 2002, is amended to read:

123.6. (a) All workers' compensation administrative law judges employed by the administrative director and supervised by the court administrator shall subscribe to the Code of Judicial Ethics adopted by the Supreme Court pursuant to subdivision (m) of Section 18 of Article VI of the California Constitution for the conduct of judges and shall not otherwise, directly or indirectly, engage in conduct contrary to that code or to the commentary to the Code of Judicial Ethics made by the California Judges Association.

In consultation with both the court administrator and the Commission on Judicial Performance, the administrative director shall adopt regulations to enforce this section. Existing regulations shall remain in effect until new regulations based on the recommendations of the court administrator and the Commission on Judicial Performance have become effective. To the extent possible, the rules shall be consistent with the procedures established by the Commission on Judicial Performance for regulating the activities of state judges, and, to the extent possible, with the gift, honoraria, and travel restrictions on legislators contained in the Political Reform Act of 1974 (Title 9 (commencing with Section 81000) of the Government Code). The court administrator shall have the authority to enforce the rules adopted by the administrative director.

(b) Honoraria or travel allowed by the court administrator, and not otherwise prohibited by this section in connection with any public or private conference, convention, meeting, social event, or



like gathering, the cost of which is significantly paid for by attorneys who practice before the board, may not be accepted unless the court administrator has provided prior approval in writing to the workers' compensation administrative law judge allowing him or her to accept those payments.

SEC. 4. Section 3201.5 of the Labor Code is amended to read:

3201.5. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, and construction inspection and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the



exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

(5) A light-duty, modified job or return-to-work program.

(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.

(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars (\$250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars (\$250,000) in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of two million dollars (\$2,000,000) or more.

(3) Employers or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(4) Employers covered by an owner or general contractor provided wrap-up insurance policy applicable to a single construction site that develops workers' compensation insurance premiums of two million dollars (\$2,000,000) or more with respect to those employees covered by that wrap-up insurance policy.



(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.

(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.5 of the Insurance Code.

(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a) of Section 3201.5.

(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.

(4) The name, address, and telephone number of the contact person of the employer.

(5) Any other information that the administrative director deems necessary to further the purposes of this section.

(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.



(h) Commencing July 1, 1995, and annually thereafter, the Division of Workers' Compensation shall report to the Director of the Department of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.

(i) By June 30, 1996, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

- (1) Person hours and payroll covered by agreements filed.
- (2) The number of claims filed.
- (3) The average cost per claim shall be reported by cost components whenever practicable.
- (4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeal.
- (5) The number of contested claims resolved prior to arbitration.
- (6) The projected incurred costs and actual costs of claims.
- (7) Safety history.
- (8) The number of workers participating in vocational rehabilitation.
- (9) The number of workers participating in light-duty programs.

The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.

(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.

SEC. 5. Section 3201.7 is added to the Labor Code, to read:



3201.7. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in the aerospace or timber industries and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filled by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeal pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

(5) A light-duty, modified job or return-to-work program.

(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.



(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages of the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars (\$250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars (\$250,000), in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, which develops or projects annual workers' compensation insurance premiums of two million dollars (\$2,000,000) or more.

(3) Employer or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(4) In the aerospace and timber industry, this section shall apply only to an affiliate of a national or international labor organization that has one or more affiliate local unions that negotiated an agreement or agreements pursuant to Section 3201.5 prior to January 1, 2003.

(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.



(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.5 of the Insurance Code.

(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a).

(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.

(4) The name, address, and telephone number of the contact person of the employer.

(5) Upon its original application, a plan agreed to between an employer and any affected union prior to the commencement of collective bargaining, that establishes a framework for the implementation of the system to be developed pursuant to paragraph (1) of subdivision (a).

(6) Any other information that the administrative director deems necessary to further the purposes of this section.

(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(h) Commencing July 1, 2004, and annually thereafter, the Division of Workers' Compensation shall report to the Director of



Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.

(i) By June 30, 2004, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

- (1) Person hours and payroll covered by agreements filed.
- (2) The number of claims filed.
- (3) The average cost per claim shall be reported by cost components whenever practicable.
- (4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeals.
- (5) The number of contested claims resolved prior to arbitration.
- (6) The projected incurred costs and actual costs of claims.
- (7) Safety history.
- (8) The number of workers participating in vocational rehabilitation.
- (9) The number of workers participating in light-duty programs.
- (10) Overall worker satisfaction.

The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.

(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis, the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.

SEC. 6. Section 3501 of the Labor Code is amended to read:

3501. (a) A child under the age of 18 years, or a child of any age found by any trier of fact, whether contractual, administrative,



regulatory, or judicial, to be physically or mentally incapacitated from earning, shall be conclusively presumed to be wholly dependent for support upon a deceased employee-parent with whom that child is living at the time of injury resulting in death of the parent or for whose maintenance the parent was legally liable at the time of injury resulting in death of the parent, there being no surviving totally dependent parent.

(b) A spouse to whom a deceased employee is married at the time of death shall be conclusively presumed to be wholly dependent for support upon the deceased employee if the surviving spouse earned thirty thousand dollars (\$30,000) or less in the twelve months immediately preceding the death.

SEC. 7. Section 3701.8 is added to the Labor Code, to read:

3701.8. (a) As an alternative to each private self-insuring employer securing its own incurred liabilities as provided in Section 3701, the director may provide by regulation for an alternative security system whereby all private self-insureds designated for full participation by the director shall collectively secure their aggregate incurred liabilities through the Self-Insurers' Security Fund. The regulations shall provide for the director to set a total security requirement for these participating self-insured employers based on a review of their annual reports and any other self-insurer information as may be specified by the director. The Self-Insurers' Security Fund shall propose to the director a combination of cash and securities, surety bonds, irrevocable letters of credit, insurance, or other financial instruments or guarantees satisfactory to the director sufficient to meet the security requirement set by the director. Upon approval by the director and posting by the Self-Insurers' Security Fund on or before the date set by the director, that combination shall be the composite deposit. The noncash elements of the composite deposit may be one-year or multiple-year instruments. If the Self-Insurers' Security Fund fails to post the required composite deposit by the date set by the director, then within 30 days after that date, each private self-insuring employer shall secure its incurred liabilities in the manner required by Section 3701. Self-insured employers not designated for full participation by the director shall meet all requirements as may be set by the director pursuant to subdivision (g).



(b) In order to provide for the composite deposit approved by the director, the Self-Insurers' Security Fund shall assess, in a manner approved by the director, each fully participating private self-insuring employer a deposit assessment payable within 30 days of assessment. The amount of the deposit assessment charged each fully participating self-insured employer shall be set by the Self-Insurers' Security Fund, based on its reasonable consideration of all the following factors:

(1) The total amount needed to provide the composite deposit.

(2) The self-insuring employer's paid or incurred liabilities as reflected in its annual report.

(3) The financial strength and creditworthiness of the self-insured.

(4) Any other reasonable factors as may be authorized by regulation.

(5) In order to make a composite deposit proposal to the director and set the deposit assessment to be charged each fully participating self-insured, the Self-Insurers' Security Fund shall have access to the annual reports and other information submitted by all self-insuring employers to the director, under terms and conditions as may be set by the director, to preserve the confidentiality of the self-insured's financial information.

(c) Upon payment of the deposit assessment and except as provided herein, the self-insuring employer loses all right, title, and interest in the deposit assessment. To the extent that in any one year the deposit assessment paid by self-insurers is not exhausted in the purchase of securities, surety bonds, irrevocable letters of credit, insurance, or other financial instruments to post with the director as part of the composite deposit, the surplus shall remain posted with the director, and the principal and interest earned on that surplus shall remain as part of the composite deposit in subsequent years. In the event that in any one year the Self-Insurers' Security Fund fails to post the required composite deposit by the date set the by the director, and the director requires each private self-insuring employer to secure its incurred liabilities in the manner required by Section 3701, then any deposit assessment paid in that year shall be refunded to the self-insuring employer that paid the deposit assessment.

(d) If any private self-insuring employer objects to the calculation, posting, or any other aspect of its deposit assessment,



upon payment of the assessment in the time provided, the employer shall have the right to appeal the assessment to the director, who shall have exclusive jurisdiction over this dispute. If any private self-insuring employer fails to pay the deposit assessment in the time provided, the director shall order the self-insuring employer to pay a penalty of not less than 10 percent of its deposit assessment, and to post a separate security deposit in the manner provided by Section 3701. The penalty shall be added to the composite deposit held by the director. The director may also revoke the certificate of consent to self-insure of any self-insuring employer who fails to pay the deposit assessment in the time provided.

(e) Upon the posting by the Self-Insurers' Security Fund of the composite deposit with the director, the deposit shall be held until the director determines that a private self-insured employer has failed to pay workers' compensation as required by this division, and the director orders the Self-Insurers' Security Fund to commence payment. Upon ordering the Self-Insurers' Security Fund to commence payment, the director shall make available to the fund that portion of the composite deposit necessary to pay the workers' compensation benefits of the defaulting self-insuring employer. In the event additional funds are needed in subsequent years to pay the workers' compensation benefits of any self-insuring employer who defaulted in earlier years, the director shall make available to the Self-Insurers' Security Fund any portions of the composite deposit as may be needed to pay those benefits. In making the deposit available to the Self-Insurers' Security Fund, the director shall also allow any amounts as may be reasonably necessary to pay for the administrative and other activities of the fund.

(f) The cash portion of the composite deposit shall be segregated from all other funds held by the director, and shall be invested by the director for the sole benefit of the Self-Insurers' Security Fund and the injured workers of private self-insured employers, and may not be used for any other purpose by the state. Alternatively, the director, in his discretion, may allow the Self-Insurers' Security Fund to hold, invest, and draw upon the cash portion of the composite deposit as prescribed by regulation.

(g) Notwithstanding any other provision of this section, the director shall, by regulation, set minimum credit, financial, or



other conditions that a private self-insured must meet in order to be a fully participating self-insurer in the alternative security system. In the event any private self-insuring employer is unable to meet the conditions set by the director, or upon application of the Self-Insurers' Security Fund to exclude an employer for credit or financial reasons, the director shall exclude the self-insuring employer from full participation in the alternative security system. In the event a self-insuring employer is excluded from full participation, the nonfully participating private self-insuring employer shall post a separate security deposit in the manner provided by Section 3701 and pay a deposit assessment set by the director. Alternatively, the director may order that the nonfully participating private self-insuring employer post a separate security deposit to secure a portion of its incurred liabilities and pay a deposit assessment set by the director.

(h) An employer who self-insures through group self-insurance and an employer whose certificate to self-insure has been revoked may fully participate in the alternative security system if both the director and the Self-Insurers' Security Fund approve the participation of the self-insurer. If not approved for full participation, or if an employer is issued a certificate to self-insure after the composite deposit is posted, the employer shall satisfy the requirements of subdivision (g) for nonfully participating private self-insurers.

(i) At all times, a self-insured employer shall have secured its incurred workers' compensation liabilities either in the manner required by Section 3701 or through the alternative security system, and there shall not be any lapse in the security.

SEC. 8. Section 3742 of the Labor Code is amended to read:

3742. (a) The Self-Insurers' Security Fund shall be established as a Nonprofit Mutual Benefit Corporation pursuant to Part 3 (commencing with Section 7110) of Division 2 of Title 1 of the Corporations Code and this article. If any provision of the Nonprofit Mutual Benefit Corporation Law conflicts with any provision of this article, the provisions of this article shall apply. Each private self-insurer shall participate as a member in the fund as a condition of maintaining its certificate of consent to self-insure.

(b) The fund shall be governed by a seven member board of trustees. The director shall hold ex officio status, with full powers



equal to those of a trustee, except that the director shall not have a vote. The director, or a delegate authorized in writing to act as the director's representative on the board of trustees, shall carry out exclusively the responsibilities set forth in Division 1 (commencing with Section 50) through Division 4 (commencing with Section 3200) and shall not have the obligations of a trustee under the Nonprofit Mutual Benefit Corporation Law. The fund shall adopt bylaws to segregate the director from all matters that may involve fund litigation against the department or fund participation in legal proceedings before the director. Although not voting, the director or a delegate authorized in writing to represent the director, shall be counted toward a quorum of trustees. The remaining six trustees shall be representatives of private self-insurers. The self-insurer trustees shall be elected by the members of the fund, each member having one vote. Three of the trustees initially elected by the members shall serve two-year terms, and three shall serve four-year terms. Thereafter, trustees shall be elected to four-year terms, and shall serve until their successors are elected and assume office pursuant to the bylaws of the fund.

(c) The fund shall establish bylaws as are necessary to effectuate the purposes of this article and to carry out the responsibilities of the fund, including, but not limited to, any obligations imposed by the director pursuant to Section 3701.8. The fund may carry out its responsibilities directly or by contract, and may purchase services and insurance and borrow funds as it deems necessary for the protection of the members and their employees. The fund may receive confidential information concerning the financial condition of self-insured employers whose liabilities to pay compensation may devolve upon it and shall adopt bylaws to prevent dissemination of that information.

(d) The director may also require fund members to subscribe to financial instruments or guarantees to be posted with the director in order to satisfy the security requirements set by the director pursuant to Section 3701.8.

SEC. 9. Section 4453 of the Labor Code is amended to read:

4453. (a) In computing average annual earnings for the purposes of temporary disability indemnity and permanent total disability indemnity only, the average weekly earnings shall be taken at:



(1) Not less than one hundred twenty-six dollars (\$126) nor more than two hundred ninety-four dollars (\$294), for injuries occurring on or after January 1, 1983.

(2) Not less than one hundred sixty-eight dollars (\$168) nor more than three hundred thirty-six dollars (\$336), for injuries occurring on or after January 1, 1984.

(3) Not less than one hundred sixty-eight dollars (\$168) for permanent total disability, and, for temporary disability, not less than the lesser of one hundred sixty-eight dollars (\$168) or 1.5 times the employee's average weekly earnings from all employers, but in no event less than one hundred forty-seven dollars (\$147), nor more than three hundred ninety-nine dollars (\$399), for injuries occurring on or after January 1, 1990.

(4) Not less than one hundred sixty-eight dollars (\$168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars (\$189) or 1.5 times the employee's average weekly earnings from all employers, nor more than five hundred four dollars (\$504), for injuries occurring on or after January 1, 1991.

(5) Not less than one hundred sixty-eight dollars (\$168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars (\$189) or 1.5 times the employee's average weekly earnings from all employers, nor more than six hundred nine dollars (\$609), for injuries occurring on or after July 1, 1994.

(6) Not less than one hundred sixty-eight dollars (\$168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars (\$189) or 1.5 times the employee's average weekly earnings from all employers, nor more than six hundred seventy-two dollars (\$672), for injuries occurring on or after July 1, 1995.

(7) Not less than one hundred sixty-eight dollars (\$168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars (\$189) or 1.5 times the employee's average weekly earnings from all employers, nor more than seven hundred thirty-five dollars (\$735), for injuries occurring on or after July 1, 1996.

(8) Not less than one hundred eighty-nine dollars (\$189), nor more than nine hundred three dollars (\$903), for injuries occurring on or after January 1, 2003.



(9) Not less than one hundred eighty-nine dollars (\$189), nor more than one thousand ninety-two dollars (\$1,092), for injuries occurring on or after January 1, 2004.

(10) Not less than one hundred eighty-nine dollars (\$189), nor more than one thousand two hundred sixty dollars (\$1,260), for injuries occurring on or after January 1, 2005. For injuries occurring on or after January 1, 2006, average weekly earnings shall be taken at not less than one hundred eighty-nine dollars (\$189), nor more than one thousand two hundred sixty dollars (\$1,260) or 1.5 times the state average weekly wage, whichever is greater. Commencing on January 1, 2007, and each January 1 thereafter, the limits specified in this paragraph shall be increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year. For purposes of this paragraph, “state average weekly wage” means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred.

(b) In computing average annual earnings for purposes of permanent partial disability indemnity, except as provided in Section 4659, the average weekly earnings shall be taken at:

(1) Not less than seventy-five dollars (\$75), nor more than one hundred ninety-five dollars (\$195), for injuries occurring on or after January 1, 1983.

(2) Not less than one hundred five dollars (\$105), nor more than two hundred ten dollars (\$210), for injuries occurring on or after January 1, 1984.

(3) When the final adjusted permanent disability rating of the injured employee is 15 percent or greater, but not more than 24.75 percent: (A) not less than one hundred five dollars (\$105), nor more than two hundred twenty-two dollars (\$222), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars (\$105), nor more than two hundred thirty-one dollars (\$231), for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars (\$105), nor more than two hundred forty dollars (\$240), for injuries occurring on or after July 1, 1996.

(4) When the final adjusted permanent disability rating of the injured employee is 25 percent or greater, not less than one



hundred five dollars (\$105), nor more than two hundred twenty-two dollars (\$222), for injuries occurring on or after January 1, 1991.

(5) When the final adjusted permanent disability rating of the injured employee is 25 percent or greater but not more than 69.75 percent: (A) not less than one hundred five dollars (\$105), nor more than two hundred thirty-seven dollars (\$237), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars (\$105), nor more than two hundred forty-six dollars (\$246), for injuries occurring on or after July 1, 1995; and (C) not less than one hundred five dollars (\$105), nor more than two hundred fifty-five dollars (\$255), for injuries occurring on or after July 1, 1996.

(6) When the final adjusted permanent disability rating of the injured employee is less than 70 percent: (A) not less than one hundred fifty dollars (\$150), nor more than two hundred seventy-seven dollars and fifty cents (\$277.50), for injuries occurring on or after January 1, 2003; (B) not less than one hundred fifty-seven dollars and fifty cents (\$157.50), nor more than three hundred dollars (\$300), for injuries occurring on or after January 1, 2004; (C) not less than one hundred fifty-seven dollars and fifty cents (\$157.50), nor more than three hundred thirty dollars (\$330), for injuries occurring on or after January 1, 2005; and (D) not less than one hundred ninety-five dollars (\$195), nor more than three hundred forty-five dollars (\$345), for injuries occurring on or after January 1, 2006.

(7) When the final adjusted permanent disability rating of the injured employee is 70 percent or greater, but less than 100 percent: (A) not less than one hundred five dollars (\$105), nor more than two hundred fifty-two dollars (\$252), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars (\$105), nor more than two hundred ninety-seven dollars (\$297), for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars (\$105), nor more than three hundred forty-five dollars (\$345), for injuries occurring on or after July 1, 1996; (D) not less than one hundred fifty dollars (\$150), nor more than three hundred forty-five dollars (\$345), for injuries occurring on or after January 1, 2003; (E) not less than one hundred fifty-seven dollars and fifty cents (\$157.50), nor more than three hundred seventy-five dollars (\$375), for injuries



occurring on or after January 1, 2004; (F) not less than one hundred fifty-seven dollars and fifty cents (\$157.50), nor more than four hundred five dollars (\$405), for injuries occurring on or after January 1, 2005; and (G) not less than one hundred ninety-five dollars (\$195), nor more than four hundred five dollars (\$405), for injuries occurring on or after January 1, 2006.

(c) Between the limits specified in subdivisions (a) and (b), the average weekly earnings, except as provided in Sections 4456 to 4459, shall be arrived at as follows:

(1) Where the employment is for 30 or more hours a week and for five or more working days a week, the average weekly earnings shall be the number of working days a week times the daily earnings at the time of the injury.

(2) Where the employee is working for two or more employers at or about the time of the injury, the average weekly earnings shall be taken as the aggregate of these earnings from all employments computed in terms of one week; but the earnings from employments other than the employment in which the injury occurred shall not be taken at a higher rate than the hourly rate paid at the time of the injury.

(3) If the earnings are at an irregular rate, such as piecework, or on a commission basis, or are specified to be by week, month, or other period, then the average weekly earnings mentioned in subdivision (a) shall be taken as the actual weekly earnings averaged for this period of time, not exceeding one year, as may conveniently be taken to determine an average weekly rate of pay.

(4) Where the employment is for less than 30 hours per week, or where for any reason the foregoing methods of arriving at the average weekly earnings cannot reasonably and fairly be applied, the average weekly earnings shall be taken at 100 percent of the sum which reasonably represents the average weekly earning capacity of the injured employee at the time of his or her injury, due consideration being given to his or her actual earnings from all sources and employments.

(d) Every computation made pursuant to this section beginning January 1, 1990, shall be made only with reference to temporary disability or the permanent disability resulting from an original injury sustained after January 1, 1990. However, all rights existing under this section on January 1, 1990, shall be continued in force. Except as provided in Section 4661.5, disability indemnity



benefits shall be calculated according to the limits in this section in effect on the date of injury and shall remain in effect for the duration of any disability resulting from the injury.

SEC. 10. Section 4600.5 of the Labor Code is amended to read:

4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article.

(b) Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application. A certificate is valid for the period that the director may prescribe unless sooner revoked or suspended.

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, and has provided the Managed Care Unit of the Division of Workers' Compensation with the necessary documentation to comply with this subdivision, that organization shall be deemed to be a health care organization able to provide health care pursuant to Section 4600.3, without further application duplicating the documentation already filed with the Department of Managed Health Care. These plans shall be required to remain in good standing with the Department of Managed Health Care, and shall meet the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and



utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Managed Health Care in compliance with the Knox-Keene Health Care Service Plan Act, relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees in compliance with the requirements of this code.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 1370 and 1370.1 of the Health and Safety Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Insurance and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary



information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Insurance in compliance with the Insurance Code relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of Section 4600.6, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that it meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary



information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records relating to provider accessibility, peer review, utilization review, quality assurance, advertising, disclosure, medical and financial audits, and grievance systems, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(7) Complies with the following requirements:

(A) An organization certified by the administrative director under this subdivision may not provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost of that health care in return for a prepaid or periodic charge paid by or on behalf of those employees.

(B) Every organization certified under this subdivision shall operate on a fee-for-service basis. As used in this section, fee for service refers to the situation where the amount of reimbursement paid by the employer to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.

(C) An organization certified under this subdivision is prohibited from assuming risk.

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on



December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

(2) An entity that had, on December 31, 1997, submitted an application with the Commissioner of Corporations under Part 3.2 (commencing with Section 5150) shall be considered an applicant for certification under subdivision (e) and shall be entitled to priority in consideration of its application. The Commissioner of Corporations shall provide complete files for all pending applications to the administrative director on or before January 31, 1998.

(g) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(h) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a per-enrollee-periodic-charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(i) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(j) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(k) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Health Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(l) (1) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization



shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a chiropractor, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated chiropractor for work-related injuries that are within the guidelines for chiropractic care established by paragraph (2). Chiropractic care rendered in accordance with guidelines for chiropractic care established pursuant to paragraph (2) shall be provided by duly licensed chiropractors affiliated with the plan.

(2) The health care organization shall establish guidelines for chiropractic care in consultation with affiliated chiropractors who are participants in the health care organization's utilization review process for chiropractic care, which may include qualified medical evaluators knowledgeable in the treatment of chiropractic conditions. The guidelines for chiropractic care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated chiropractor for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of chiropractic care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for chiropractic care in accordance with the health care organization's guidelines for chiropractic care established by paragraph (2).

Chiropractic utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for chiropractic care. Chiropractors affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of chiropractic care for work-related injuries, the review shall include review by a chiropractor affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to chiropractic care, including the location and telephone number where grievances may be submitted.



(5) All guidelines for chiropractic care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

(m) Individually identifiable medical information on patients submitted to the division shall not be subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(n) (1) When an injured employee requests acupuncture treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist pursuant to guidelines for acupuncture care established by paragraph (2). Within five working days of the employee's request to see an acupuncturist, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated acupuncturist for work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.

(2) The health care organization shall establish guidelines for acupuncture care in consultation with affiliated acupuncturists who are participants in the health care organization's utilization review process for acupuncture care, which may include qualified medical evaluators. The guidelines for acupuncture care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated acupuncturist for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of acupuncture care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for acupuncture care in accordance with the health care organization's guidelines for acupuncture care established by paragraph (2).

Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall have access to the health care organization's provider



appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to acupuncture care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for acupuncture care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

SEC. 11. Section 4614 of the Labor Code is amended to read:

4614. (a) (1) Notwithstanding Section 5307.1, where the employee's individual or organizational provider of health care services rendered under this division and paid on a fee-for-service basis is also the provider of health care services under contract with the employee's health benefit program, and the service or treatment provided is included within the range of benefits of the employee's health benefit program, and paid on a fee-for-service basis, the amount of payment for services provided under this division, for a work-related occurrence or illness, shall be no more than the amount that would have been paid for the same services under the health benefit plan, for a non-work-related occurrence or illness.

(2) A health care service plan that arranges for health care services to be rendered to an employee under this division under a contract, and which is also the employee's organizational provider for nonoccupational injuries and illnesses, with the exception of a nonprofit health care service plan that exclusively contracts with a medical group to provide or arrange for medical services to its enrollees in a designated geographic area, shall be paid by the employer for services rendered under this division only on a capitated basis.

(b) (1) Where the employee's individual or organizational provider of health care services rendered under this division who is not providing services under a contract is not the provider of health care services under contract with the employee's health benefit program or where the services rendered under this division are not within the benefits provided under the employer-sponsored health benefit program, the provider shall receive payment that is



no more than the average of the payment that would have been paid by five of the largest preferred provider organizations by geographic region. Physicians, as defined in Section 3209.3, shall be reimbursed at the same averaged rates, regardless of licensure, for the delivery of services under the same procedure code. This subdivision shall not apply to a health care service plan that provides its services on a capitated basis.

(2) The administrative director shall identify the regions and the five largest carriers in each region. The carriers shall provide the necessary information to the administrative director in the form and manner requested by the administrative director. The administrative director shall make this information available to the affected providers on an annual basis.

(c) Nothing in this section shall prohibit an individual or organizational health care provider from being paid fees different from those set forth in the official medical fee schedule by an employer, insurance carrier, third-party administrator on behalf of employers, or preferred provider organization representing an employer or insurance carrier provided that the administrative director has determined that the alternative negotiated rates between the organizational or individual provider and a payer, a third-party administrator on behalf of employers, or a preferred provider organization will produce greater savings in the aggregate than if each item on billings were to be charged at the scheduled rate.

(d) For the purposes of this section, “organizational provider” means an entity that arranges for health care services to be rendered directly by individual caregivers. An organizational provider may be a health care service plan, disability insurer, health care organization, preferred provider organization, or workers’ compensation insurer arranging for care through a managed care network or on a fee-for-service basis. An individual provider is either an individual or institution that provides care directly to the injured worker.

SEC. 12. Section 4702 of the Labor Code, as amended by Chapter 6 of the Statutes of 2002, is amended to read:

4702. (a) Except as otherwise provided in this section and Sections 4553, 4554, 4557, and 4558, the death benefit in cases of total dependency shall be as follows:



(1) In the case of two total dependents and regardless of the number of partial dependents, for injuries occurring before January 1, 1991, ninety-five thousand dollars (\$95,000), for injuries occurring on or after January 1, 1991, one hundred fifteen thousand dollars (\$115,000), for injuries occurring on or after July 1, 1994, one hundred thirty-five thousand dollars (\$135,000), for injuries occurring on or after July 1, 1996, one hundred forty-five thousand dollars (\$145,000), and for injuries occurring on or after January 1, 2006, two hundred ninety thousand dollars (\$290,000).

(2) In the case of one total dependent and one or more partial dependents, for injuries occurring before January 1, 1991, seventy thousand dollars (\$70,000), for injuries occurring on or after January 1, 1991, ninety-five thousand dollars (\$95,000), for injuries occurring on or after July 1, 1994, one hundred fifteen thousand dollars (\$115,000), for injuries occurring on or after July 1, 1996, one hundred twenty-five thousand dollars (\$125,000), and for injuries occurring on or after January 1, 2006, two hundred fifty thousand dollars (\$250,000), plus four times the amount annually devoted to the support of the partial dependents, but not more than the following: for injuries occurring before January 1, 1991, a total of ninety-five thousand dollars (\$95,000), for injuries occurring on or after January 1, 1991, one hundred fifteen thousand dollars (\$115,000), for injuries occurring on or after July 1, 1994, one hundred twenty-five thousand dollars (\$125,000), for injuries occurring on or after July 1, 1996, one hundred forty-five thousand dollars (\$145,000), and for injuries occurring on or after January 1, 2006, two hundred ninety thousand dollars (\$290,000).

(3) In the case of one total dependent and no partial dependents, for injuries occurring before January 1, 1991, seventy thousand dollars (\$70,000), for injuries occurring on or after January 1, 1991, ninety-five thousand dollars (\$95,000), for injuries occurring on or after July 1, 1994, one hundred fifteen thousand dollars (\$115,000), for injuries occurring on or after July 1, 1996, one hundred twenty-five thousand dollars (\$125,000), and for injuries occurring on or after January 1, 2006, two hundred fifty thousand dollars (\$250,000).

(4) (A) In the case of no total dependents and one or more partial dependents, for injuries occurring before January 1, 1991, four times the amount annually devoted to the support of the partial dependents, but not more than seventy thousand dollars (\$70,000),



for injuries occurring on or after January 1, 1991, a total of ninety-five thousand dollars (\$95,000), for injuries occurring on or after July 1, 1994, one hundred fifteen thousand dollars (\$115,000), and for injuries occurring on or after July 1, 1996, but before January 1, 2006, one hundred twenty-five thousand dollars (\$125,000).

(B) In the case of no total dependents and one or more partial dependents, eight times the amount annually devoted to the support of the partial dependents, for injuries occurring on or after January 1, 2006, but not more than two hundred fifty thousand dollars (\$250,000).

(5) In the case of three or more total dependents and regardless of the number of partial dependents, one hundred fifty thousand dollars (\$150,000), for injuries occurring on or after July 1, 1994, one hundred sixty thousand dollars (\$160,000), for injuries occurring on or after July 1, 1996, and three hundred twenty thousand dollars (\$320,000), for injuries occurring on or after January 1, 2006.

(6) For injuries occurring on or after January 1, 2004, in the case of no total dependents and no partial dependents, two hundred fifty thousand dollars (\$250,000) to the estate of the deceased employee.

(b) The death benefit in all cases shall be paid in installments in the same manner and amounts as temporary total disability indemnity would have to be made to the employee, unless the appeals board otherwise orders. However, no payment shall be made at a weekly rate of less than two hundred twenty-four dollars (\$224).

(c) Disability indemnity shall not be deducted from the death benefit and shall be paid in addition to the death benefit when the injury resulting in death occurs after September 30, 1949.

(d) All rights under this section existing prior to January 1, 1990, shall be continued in force.

SEC. 13. Section 5307.21 is added to the Labor Code, to read:

5307.21. (a) The administrative director shall have the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract, provided that the schedule meets all of the following requirements:

(1) The schedule shall include all facility charges for outpatient surgeries performed in any facility authorized by law to perform



the surgeries. The schedule may not include the fee of any physician and surgeon providing services in connection with the surgery.

(2) The schedule shall promote payment predictability, minimize administrative costs, and ensure access to outpatient surgery services by injured workers.

(3) The schedule shall be sufficient to cover the costs of each surgical procedure, as well as access to quality care.

(4) The schedule shall include specific provisions for review and revision of related fees no less frequently than biennially.

(5) The schedule shall be adopted after public hearings pursuant to Section 5307.3 and shall be included within the official medical fee schedule.

(b) The process used by the administrative director to develop an outpatient surgery fee schedule shall contain the following elements:

(1) A formal analysis of one year of published data collected pursuant to Section 128737 of the Health and Safety Code, with the assistance of an independent consultant with demonstrated expertise in outpatient surgery service.

(2) Any published data collected from providers of outpatient surgery services.

(3) Payment data including, but not limited to, type of payer and amount charged.

(4) Cost data including, but not limited to, actual expenses for labor, supplies, equipment, implants, anesthesia, overhead, and administration.

(5) Outcome data including, but not limited to, expected level of rehabilitation, expected coverage timeframe, and incidence of infection.

(6) Access data including, but not limited to, date of injury, date of surgery recommendation, and date of procedure.

(7) Other data that is mutually agreed to by the Office of Statewide Health Planning and Development and the administrative director. The administrative director shall consult with the Office of Statewide Health Planning and Development to ensure that the data collected is comprehensive and relevant to the development of a fee schedule.

(c) The outpatient surgery facility fee schedule shall reflect input from workers' compensation insurance carriers, businesses,



organized labor, providers of outpatient surgical services, and patients receiving outpatient surgical services.

(d) At least 90 days prior to commencing the public hearings related to an outpatient surgery fee schedule as prescribed by Section 5307.3, the administrative director shall provide the Assembly Committee on Insurance and the Senate Committee on Labor and Industrial Relations a comprehensive report on the data analysis required by this section and the administrative director's recommendations for an outpatient surgery fee schedule.

SEC. 14. Section 5502 of the Labor Code is amended to read:

5502. (a) Except as provided in subdivisions (b) and (d), the hearing shall be held not less than 10 days, and not more than 60 days, after the date a declaration of readiness to proceed, on a form prescribed by the court administrator, is filed. If a claim form has been filed for an injury occurring on or after January 1, 1990, and before January 1, 1994, an application for adjudication shall accompany the declaration of readiness to proceed.

(b) The court administrator shall establish a priority calendar for issues requiring an expedited hearing and decision. A hearing shall be held and a determination as to the rights of the parties shall be made and filed within 30 days after the declaration of readiness to proceed is filed if the issues in dispute are any of the following:

(1) The employee's entitlement to medical treatment pursuant to Section 4600.

(2) The employee's entitlement to, or the amount of, temporary disability indemnity payments.

(3) The employee's entitlement to vocational rehabilitation services, or the termination of an employer's liability to provide these services to an employee.

(4) The employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(5) Any other issues requiring an expedited hearing and determination as prescribed in rules and regulations of the administrative director.

(c) The court administrator shall establish a priority conference calendar for cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment. The conference shall be conducted by a workers' compensation



administrative law judge within 30 days after the declaration of readiness to proceed. If the dispute cannot be resolved at the conference, a trial shall be set as expeditiously as possible, unless good cause is shown why discovery is not complete, in which case status conferences shall be held at regular intervals. The case shall be set for trial when discovery is complete, or when the workers' compensation administrative law judge determines that the parties have had sufficient time in which to complete reasonable discovery. A determination as to the rights of the parties shall be made and filed within 30 days after the trial.

(d) The court administrator shall report quarterly to the Governor and to the Legislature concerning the frequency and types of issues which are not heard and decided within the period prescribed in this section and the reasons therefor.

(e) (1) In all cases, a mandatory settlement conference shall be conducted not less than 10 days, and not more than 30 days, after the filing of a declaration of readiness to proceed. If the dispute is not resolved, the regular hearing shall be held within 75 days after the declaration of readiness to proceed is filed.

(2) The settlement conference shall be conducted by a workers' compensation administrative law judge or by a referee who is eligible to be a workers' compensation administrative law judge or eligible to be an arbitrator under Section 5270.5. At the mandatory settlement conference, the referee or workers' compensation administrative law judge shall have the authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial. The appeals board shall adopt any regulations needed to implement this subdivision. The presiding workers' compensation administrative law judge shall supervise settlement conference referees in the performance of their judicial functions under this subdivision.

(3) If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the



evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.

(f) In cases involving the Director of the Department of Industrial Relations in his or her capacity as administrator of the Uninsured Employers Fund, this section shall not apply unless proof of service, as specified in paragraph (1) of subdivision (d) of Section 3716 has been filed with the appeals board and provided to the Director of Industrial Relations, valid jurisdiction has been established over the employer, and the fund has been joined.

(g) Except as provided in subdivision (a) and in Section 4065, the provisions of this section shall apply irrespective of the date of injury.

SEC. 15. Section 6354.7 is added to the Labor Code, to read:

6354.7. (a) The Workers' Occupational Safety and Health Education Fund is hereby created as a special account in the State Treasury. Proceeds of the fund may be expended, upon appropriation by the Legislature, by the Commission on Health and Safety and Workers' Compensation for the purpose of establishing and maintaining a worker occupational safety and health training and education program and an insurance loss control services coordinator. The director shall levy and collect fees to fund these purposes from insurers subject to Section 6354.5. However, the fee assessed against any insurer shall not exceed the greater of one hundred dollars (\$100) or 0.0286 percent of paid workers' compensation indemnity amounts for claims as reported for the previous calendar year to the designated rating organization for the analysis required under subdivisions (b) and (c) of Section 11759.1 of the Insurance Code. All fees shall be deposited in the fund.

(b) The commission shall establish and maintain a worker safety and health training and education program. The purpose of the worker occupational safety and health training and education program shall be to promote awareness of the need for prevention education programs, to develop and provide injury and illness prevention education programs for employees and their representatives, and to deliver those awareness and training programs through a network of providers throughout the state. The commission may conduct the program directly or by means of contracts or interagency agreements.



(c) The commission shall establish an employer and worker advisory board for the program. The advisory board shall guide the development of curricula, teaching methods, and specific course material about occupational safety and health, and shall assist in providing links to the target audience and broadening the partnerships with worker-based organizations, labor studies programs, and others that are able to reach the target audience.

(d) The program shall include the development and provision of a needed core curriculum addressing competencies for effective participation in workplace injury and illness prevention programs and on joint labor-management health and safety committees. The core curriculum shall include an overview of the requirements related to injury and illness prevention programs and hazard communication.

(e) The program shall include the development and provision of additional training programs for any or all of the following categories:

- (1) Industries on the high hazard list.
- (2) Hazards that result in significant worker injuries, illnesses, or compensation costs.
- (3) Industries or trades in which workers are experiencing numerous or significant injuries or illnesses.
- (4) Occupational groups with special needs, such as those who do not speak English as their first language, workers with limited literacy, young workers, and other traditionally underserved industries or groups of workers. Priority shall be given to training workers who are able to train other workers and workers who have significant health and safety responsibilities, such as those workers serving on a health and safety committee or serving as designated safety representatives.

(f) The program shall operate one or more libraries and distribution systems of occupational safety and health training material, which shall include, but not be limited to, all material developed by the program pursuant to this section.

(g) The advisory board shall annually prepare a written report evaluating the use and impact of programs developed.

(h) The payment of administrative costs incurred by the commission in conducting the program shall be made from the Workers' Occupational Safety and Health Education Fund.



SEC. 16. Section 86 of Chapter 6 of the Statutes of 2002 is amended to read:

Sec. 86. It is the intent of the Legislature that all reimbursement expended by the Administrative Director of the Division of Workers' Compensation for the administration of the workers' compensation Return-to-Work Program established in Section 139.48 of the Labor Code shall be funded from the funds collected in the annual premium tax, collected under Section 12201 of the Revenue and Taxation Code, which is directly attributable to the compensation benefit rates and amounts set forth in Chapter 6 of the Statutes of 2002.

SEC. 17. It is the intent of the Legislature that annual appropriations to the Division of Workers' Compensation be sufficient to enable the division to hire necessary staff and to obtain adequate resources and technology to carry out and complete each of its mandates under Divisions 1 (commencing with Section 50), 4 (commencing with Section 3200), and 4.5 (commencing with Section 6100) of the Labor Code in a timely manner and in a manner consistent with the directives set forth in Section 4 of Article XIV of the California Constitution.

SEC. 18. Sections 3, 12, and 16 of this act shall be effective only if Chapter 6 of the Statutes of 2002 becomes operative.

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.



Approved _____, 2002

Governor

