Assembly Bill No. 2654

CHAPTER 682

An act to amend Sections 50260 and 54701.12 of the Government Code, to amend Sections 679.71, 679.72, 699.5, 10141, 11628, and 12095 of the Insurance Code, to amend Section 4600.6 of the Labor Code, and to amend Sections 103 and 14200.1 of the Welfare and Institutions Code, relating to discrimination.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2654, Laird. Discrimination.

(1) Existing law provides that the purpose of certain provisions regarding human relations is to promote the establishment in counties and cities and counties throughout the state of commissions designed to foster peaceful relations in the interest of preserving the public peace among citizens of different races, religions, and national origins.

This bill would provide that the purpose of those provisions is to promote the establishment of commissions designed to foster peaceful relations in the interest of preserving the public peace among residents. This bill would add ethnic group identification, age, sex, sexual orientation, color, and disability to the characteristics described above.

(2) Existing law allows local agencies to construct or cause to be constructed rental housing for employees. Existing law requires a local agency to require that contractors and subcontractors engaged in construction financed under these provisions provide equal opportunity for employment, without discrimination as to race, sex, marital status, color, religion, national origin, or ancestry, and requires that all contracts and subcontracts for construction financed under this chapter be let without discrimination as to race, sex, marital status, color, religion, national origin, or ancestry.

This bill would, instead, require a local agency to require that the above contractors and subcontractors provide equal opportunity for employment, without discrimination as to marital status, race, national origin, age, sex, sexual orientation, color, medical condition, religious creed, ancestry, mental disability, or physical disability. By increasing duties of local agencies, this bill would impose a state-mandated local program.

(3) Existing law prohibits certain property insurers from taking specified actions regarding the issuance or cancellation of insurance under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every marital status, sex, race, color, religion, national origin, or ancestry, and prohibits sex, race, color, religion,

national origin, or ancestry from constituting a condition or risk for which a higher rate, premium, or charge may be required of the insured.

This bill would add medical condition, disability, and sexual orientation, as defined, to the characteristics prohibited for use as described above.

(4) Existing law prohibits an application for certain property insurance, or an insurance investigation report furnished by an insurer to its agents or employees for use in determining the insurability of the applicant, from carrying or requiring any identification of the applicant's race, color, religion, national origin, or ancestry.

This bill would, in addition, prohibit an application described above from carrying or requiring any identification of the applicant's medical condition, disability, marital status, or sexual orientation, as defined.

(5) Existing law provides that the ownership or financial control of any domestic, foreign, or alien insurer, by any state of the United States or by a foreign government, shall not restrict the Insurance Commissioner from issuing, renewing, or continuing in effect the license of that insurer to transact insurance, unless the commissioner makes any of specified determinations, including that the insurer is subject to governmental practices that discriminate on the basis of race, color, creed, or national origin.

This bill would delete creed from the above list of characteristics relating to governmental discrimination that the Insurance Commissioner may consider, and would add sex, ancestry, religion, disability, medical condition, marital status, and sexual orientation, as defined, to that list.

(6) Existing law prohibits certain insurers licensed to issue and issuing motor vehicle liability policies, as defined, from taking certain actions regarding the issuance or cancellation of that insurance under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every race, language, color, religion, national origin, ancestry, or the same geographic area, and prohibits race, language, color, religion, national origin, ancestry, or location within a geographic area from constituting a condition or risk for which a higher rate, premium, or charge may be required of the insured.

This bill would, instead, prohibit the above insurers from taking those actions under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every language, sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, sexual orientation, or the same geographic area, and would prohibit language, sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, sexual orientation, or location within a geographic area from constituting a condition or risk for which a higher rate, premium, or charge may be required of the insured.

(7) Existing law prohibits certain surety insurers from failing or refusing to take specified actions regarding performance bonds under conditions less favorable to the obligor than in other comparable cases, except for reasons applicable alike to persons of every race, color, gender, religion, national origin, ancestry, or geographical area, and prohibits race, color, gender,

religion, national origin, ancestry, or location within a county, of itself, from constituting a condition or risk for which a greater rate, premium, charge, guaranty, or collateral may be required of the applicant.

This bill would, instead, prohibit those surety insurers from failing or refusing to take the actions described above under conditions less favorable to the obligor than in other comparable cases, except for reasons applicable alike to persons of every sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, sexual orientation, or geographical area, and would prohibit any of those characteristics, of itself, from constituting a condition or risk for which a greater rate, premium, charge, guaranty, or collateral may be required of the applicant.

(8) Existing law prohibits any workers' compensation insurer, 3rd-party administrator, or other entity seeking certification as a health care organization from taking specified actions regarding contracts because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise.

This bill would add disability and medical condition to those characteristics.

(9) Existing law provides for the appointment of persons by a juvenile court as court-appointed special advocates. Existing law provides that an adult otherwise qualified to act as a court-appointed special advocate shall not be discriminated against based upon sex, socioeconomic, religious, racial, ethnic, or age factors.

This bill would provide, instead, that an adult otherwise qualified to act as a court-appointed special advocate shall not be discriminated against based upon race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, disability, marital status, or socioeconomic factors.

(10) Existing law provides that the purpose of certain provisions of law relating to prepaid health plans is to afford persons eligible to receive certain government-supported medical benefits the opportunity to enroll as regular subscribers in prepaid health plans, without reference to the race, sex, age, religion, creed, color, national origin, or ancestry of any eligible person.

This bill would provide, instead, that the purpose of those provisions is to afford persons eligible to receive certain government-supported medical benefits the opportunity to enroll as regular subscribers in prepaid health plans, without reference to race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, marital status, or disability.

(11) 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

SECTION 1. Section 50260 of the Government Code is amended to read:

50260. The purpose of this article is to promote the establishment in counties and cities and counties throughout the state of commissions designed to foster peaceful relations in the interest of preserving the public peace among residents of different races, religions, national origins, and the other characteristics listed or defined in Section 11135.

SEC. 2. Section 54701.12 of the Government Code is amended to read:

54701.12. A local agency shall require that contractors and subcontractors engaged in construction financed under this chapter shall provide equal opportunity for employment, without discrimination as to any characteristic listed or defined in Section 12926 or 12926.1. All contracts and subcontracts for construction financed under this chapter shall be let without discrimination as to any of those characteristics.

SEC. 3. Section 679.71 of the Insurance Code is amended to read:

679.71. No admitted insurer that is licensed to issue any policy of insurance covered by this chapter shall fail or refuse to accept an application for, or to issue a policy to an applicant for, that insurance (unless the insurance is to be issued to the applicant by another insurer under the same management and control), or cancel that insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code; nor shall any of those characteristics, of itself, constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance.

SEC. 4. Section 679.72 of the Insurance Code is amended to read:

679.72. No application for insurance specified in this chapter or insurance investigation report furnished by an insurer to its agents or employees for use in determining the insurability of an applicant shall carry any identification, or any requirement therefor, of any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code with respect to the applicant.

SEC. 5. Section 699.5 of the Insurance Code is amended to read:

699.5. (a) The ownership or financial control, in part, direct or indirect, of any domestic, foreign, or alien insurer, by any state of the United States or by a foreign government or by any political subdivision of either, or by an agency of any other state, government, or subdivision thereof, shall not, provided the insurer complies with all other requirements for issuance, renewal, or continuation of a license, restrict the commissioner from issuing, renewing, or continuing in effect the license of that insurer to transact in this state the kinds of insurance business for which that insurer is otherwise qualified under the provisions of this chapter and under its charter, unless the commissioner finds that any of the following is true:

(1) The insurer is subject to any form of subsidy that would enable it to compete unfairly with domestic insurers.

(2) The insurer is subject to governmental practices that discriminate on the basis of any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code.

(3) The ownership or financial control will create the presence of any sovereign immunity in the insurer.

(4) Appropriate measures and controls do not exist to avoid security problems resulting from an insurer's access to confidential information and data of its insured.

(5) The ownership or financial control results in substantial or undue influence being asserted over the insurer.

(b) The failure by any applicant for a license to submit the information requested by the commissioner for the purposes of determining whether to make a finding pursuant to subdivision (a) shall be sufficient to deny the application.

(c) Nothing in the amendments to this section enacted during the 1994 portion of the 1993–94 Regular Session of the Legislature shall be interpreted to authorize the issuance of a license to an insurer wholly owned by any governmental entity described in subdivision (a).

SEC. 6. Section 10141 of the Insurance Code is amended to read:

10141. No application for insurance or insurance investigation report furnished by such an insurer to its agents or employees for use in determining the insurability of the applicant shall carry any identification, or any requirement therefor, of the applicant's race, color, religion, ancestry, national origin, or sexual orientation.

SEC. 7. Section 11628 of the Insurance Code is amended to read:

11628. (a) (1) No admitted insurer that is licensed to issue and issuing motor vehicle liability policies, as defined in Section 16450 of the Vehicle Code, shall fail or refuse to accept an application for that insurance, to issue that insurance to an applicant therefor, or issue or cancel that insurance under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, including, but not limited to, language, or persons of the same geographic area; nor shall any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, including, but not limited to, language, or location within a geographic area, of itself, constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for that insurance.

(2) As used in this section "geographic area" means a portion of this state of not less than 20 square miles defined by description in the rating manual of an insurer or in the rating manual of a rating bureau of which the insurer is a member or subscriber. In order that geographic areas used for rating purposes may reflect homogeneity of loss experience, a record of loss experience for the geographic area shall include the breakdown of actual loss experience statistics by ZIP Code area (as designated by the United States Postal Service) within each geographic area for family owned private passenger motor vehicles and lightweight commercial motor vehicles, under

1½-ton load capacity, used for local service or retail delivery, normally within a 50-mile radius of garaging, and that are not part of a fleet of five or more motor vehicles under one ownership. A record of loss experience for the geographic area, including that statistical data by ZIP Code area, shall be submitted annually to the commissioner for examination by each insurer licensed to issue and issuing motor vehicle liability policies, motor vehicle physical damage policies, or both. Loss experience shall include separate loss data for each type of coverage, including liability or physical damage coverage, underwritten. That report shall include the insurer's statewide loss ratio, loss adjustment expense ratio, expense ratio, and combined ratio on its assigned-risk business. An insurer may satisfy its obligation to report statistical data under this subdivision by providing its loss experience data and statewide expense ratio and combined ratio on its assigned-risk business to a rating or advisory organization for submission to the commissioner. This data shall be made available to the public by the commissioner annually after examination. However, the data shall be released in aggregate form by ZIP Code in order that no individual insurer's loss experience for any specific geographic area be revealed. Differentiation in rates between geographical areas shall not constitute unfair discrimination.

(3) All information reported to the department pursuant to this subdivision shall be confidential.

(4) As used in this section:

(A) "Language" means the inability to speak, read, write, or comprehend the English language.

(B) "Dependents" shall include, but not be limited to, issue regardless of generation.

(C) "Spouse" shall be determined without regard to current marital status.

(b) The commissioner may require insurers with combined ratios on statewide assigned-risk business that are 10 percent above the mean combined ratio for all plan participants to also report the following:

(1) The reason for the excessive ratio.

(2) A plan for reducing the ratio, and when the reduction can be expected to occur. The commissioner may require insurers subject to this subdivision to provide periodic reports on the progress in reducing the combined ratio.

(c) (1) No admitted insurer, licensed to issue and issuing motor vehicle liability insurance policies as defined in Section 16450 of the Vehicle Code, shall fail or refuse to accept an application for that insurance, refuse to issue that insurance to an applicant therefor, or cancel that insurance solely for the reason that the applicant for that insurance or any insured is employed in a specific occupation, or is on active duty service in the Armed Forces of the United States.

(2) Nothing in this section shall prohibit an insurer from doing any of the following:

(A) Considering the occupation of the applicant or insured as a condition or risk for which a higher rate or discounted rate may be required or offered for coverage in the course and scope of his or her occupation.

(B) Charging a deviated rate to any classification of risks involving a specific occupation, or grouping thereof, if the rate meets the requirements of Chapter 9 (commencing with Section 1850) of Part 2 of Division 1 and is based upon actuarial data which demonstrates a significant actual historical differential between past losses or expenses attributable to the specific occupation, or grouping thereof, and the past losses or expenses attributable to other classification of risks. For purposes of compiling that actuarial data for a specific occupation or grouping thereof, a person shall be deemed employed in the occupation in which that data is compiled if any of the following is true:

(i) The majority of his or her employment during the previous year was in the occupation.

(ii) The majority of his or her aggregate earnings for the immediate preceding three-year period were derived from the occupation.

(iii) The person is a member in good standing of a union that is an authorized collective bargaining agent for persons engaged in the occupation.

(3) Nothing in this section shall be construed to include in the definition of "occupation" any status or activity that does not result in remuneration for work done or services performed, or self-employment in a business operated out of an applicant's or insured's place of residence or persons engaged in the renting, leasing, selling, repossessing, rebuilding, wrecking, or salvaging of motor vehicles.

(d) Nothing in this section shall limit or restrict the ability of an insurer to refuse to accept an application for or refuse to issue or cancel insurance for the reason that it is a commercial vehicle or based upon the consideration of a vehicle's size, weight, design, or intended use.

(e) It is the intent of the Legislature that actuarial data by occupation may be examined for credibility by the commissioner on the same basis as any other automobile insurance data which he or she is empowered to examine.

(f) (1) Except as provided in Article 4 (commencing with Section 11620), nothing in this section or in Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1 or in any other provision of this code, shall prohibit an insurer from limiting the issuance or renewal of insurance, as defined in subdivision (a) of Section 660, to persons who engage in, or have formerly engaged in, governmental or military service or segments of categories thereof, and their spouses, dependents, direct descendants, and former dependents or spouses.

(2) The term "military service" includes, but is not limited to, officers, warrant officers, and enlisted persons, officer and warrant officer candidates, cadets or midshipmen at a service academy, cadets or midshipmen in advance Reserve Officer Training Corps programs or on Reserve Officer Training Corps program scholarships, National Guard officer candidates, students in government-sponsored precommissioning programs, and foreign military officers while on temporary duty in the United States.

(g) Any person subject to regulation by the commissioner pursuant to this code who fails to comply with a data call required by the department

pursuant to subdivision (a) shall be liable to the state for a civil penalty in an amount not exceeding five thousand dollars ($5,000) for each 30-day period that the person is not in compliance, unless the failure to comply is willful, in which case the civil penalty shall be in an amount not to exceed ten thousand dollars ($10,000) for each 30-day period that the person is not in compliance, but not to exceed an aggregate amount of one hundred thousand dollars ($100,000). The commissioner shall collect the amount so payable and may bring an action in the name of the people of the State of California to enforce collection. These penalties shall be in addition to other penalties provided by law.

(h) This section shall be known and may be cited as the "Rosenthal Auto Insurance Nondiscrimination Law."

SEC. 8. Section 12095 of the Insurance Code is amended to read:

12095. No insurer admitted in this state to issue surety insurance shall fail or refuse to accept an application for a contractor's license or performance bond, or to issue such a bond to an applicant therefor, or refuse or cancel such a bond, under conditions less favorable to the obligor than in other comparable cases, except for reasons applicable alike to persons of every characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, or persons of every geographical area; nor shall any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, or location within a county, of itself, constitute a condition or risk for which a greater rate, premium, charge, guaranty, or collateral may be required of the applicant for such a bond.

SEC. 9. Section 4600.6 of the Labor Code is amended to read:

4600.6. Any workers' compensation insurer, third-party administrator, or other entity seeking certification as a health care organization under subdivision (e) of Section 4600.5 shall be subject to the following rules and procedures:

(a) Each application for authorization as an organization under subdivision (e) of Section 4600.5 shall be verified by an authorized representative of the applicant and shall be in a form prescribed by the administrative director. The application shall be accompanied by the prescribed fee and shall set forth or be accompanied by each and all of the following:

(1) The basic organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

(2) A copy of the bylaws, rules, and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include, among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, each shareholder with over 5 percent interest in the case of a corporation, and all partners or members in the case of a partnership or association, and each person who has loaned funds to the applicant for the operation of its business.

(4) A copy of any contract made, or to be made, between the applicant and any provider of health care, or persons listed in paragraph (3), or any other person or organization agreeing to perform an administrative function or service for the plan. The administrative director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to the provider of health care services shall be deemed confidential information that shall not be divulged by the administrative director, except that the payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The organization shall also submit the name and address of each provider employed by, or contracting with, the organization, together with his or her license number.

(5) A statement describing the organization, its method of providing for health services, and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the organization, including the number of full-time and part-time physicians under Section 3209.3, the numbers and types of licensed or state-certified health care support staff, the number of hospital beds contracted for, and the arrangements and the methods by which health care will be provided, as defined by the administrative director under Sections 4600.3 and 4600.5.

(6) A copy of the disclosure forms or materials that are to be issued to employees.

(7) A copy of the form of the contract that is to be issued to any employer, insurer of an employer, or a group of self-insured employers.

(8) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, the financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the financial statement complies with any requirements that may be established by regulation of the administrative director.

(9) A description of the proposed method of marketing the organization and a copy of any contract made with any person to solicit on behalf of the organization or a copy of the form of agreement used and a list of the contracting parties.

(10) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the organization and the location of any other organization facilities where required by the administrative director.

(11) A description of organization grievance procedures to be utilized as required by this part, and a copy of the form specified by paragraph (3) of subdivision (j).

(12) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this part.

(13) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of workers' compensation health care.

(14) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the administrative director.

(15) Evidence of adequate workers' compensation coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of an organization against the organization.

(16) Evidence of fidelity bonds in such amount as the administrative director prescribes by regulation.

(17) Other information that the administrative director may reasonably require.

(b) (1) An organization, solicitor, solicitor firm, or representative may not use or permit the use of any advertising or solicitation that is untrue or misleading, or any form of disclosure that is deceptive. For purposes of this chapter:

(A) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect that is or may be significant to an employer or employee, or potential employer or employee.

(B) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an employer or employee, or potential employer or employee.

(C) A disclosure form shall be deemed to be deceptive if the disclosure form taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of workers' compensation health care, and the disclosure form therefor, to expect benefits, service charges, or other advantages that the disclosure form does not provide or that the organization issuing that disclosure form does not regularly make available to employees.

(2) An organization, solicitor, or representative may not use or permit the use of any verbal statement that is untrue, misleading, or deceptive or make any representations about health care offered by the organization or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in paragraph (1).

(c) It is unlawful for any person, including an organization, subject to this part, to represent or imply in any manner that the person or organization has been sponsored, recommended, or approved, or that the person's or organization's abilities or qualifications have in any respect been passed upon, by the administrative director.

(d) (1) An organization may not publish or distribute, or allow to be published or distributed on its behalf, any advertisement unless (A) a true copy thereof has first been filed with the administrative director, at least 30 days prior to any such use, or any shorter period as the administrative director by rule or order may allow, and (B) the administrative director by notice has not found the advertisement, wholly or in part, to be untrue, misleading,

deceptive, or otherwise not in compliance with this part or the rules thereunder, and specified the deficiencies, within the 30 days or any shorter time as the administrative director by rule or order may allow.

(2) If the administrative director finds that any advertisement of an organization has materially failed to comply with this part or the rules thereunder, the administrative director may, by order, require the organization to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising.

(3) The administrative director by rule or order may classify organizations and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivision (a).

(e) (1) The administrative director shall require the use by each organization of disclosure forms or materials containing any information regarding the health care and terms of the workers' compensation health care contract that the administrative director may require, so as to afford the public, employers, and employees with a full and fair disclosure of the provisions of the contract in readily understood language and in a clearly organized manner. The administrative director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between contracts of the same or other types of organizations. The disclosure form shall describe the health care that is required by the administrative director under Sections 4600.3 and 4600.5, and shall provide that all information be in concise and specific terms, relative to the contract, together with any additional information as may be required by the administrative director, in connection with the organization or contract.

(2) All organizations, solicitors, and representatives of a workers' compensation health care provider organization shall, when presenting any contract for examination or sale to a prospective employee, provide the employee with a properly completed disclosure form, as prescribed by the administrative director pursuant to this section for each contract so examined or sold.

(3) In addition to the other disclosures required by this section, every organization and any agent or employee of the organization shall, when representing an organization for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium cost to health care paid for contracts with individuals and with groups of the same or similar size for the organization's preceding fiscal year. An organization may report that information by geographic area, provided the organization identifies the geographic area and reports information applicable to that geographic area.

(4) Where the administrative director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by an organization for the purpose of influencing persons to

become members of an organization shall contain any supplemental disclosure information that the administrative director may require.

(f) When the administrative director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by an organization for the purpose of influencing persons to become members of an organization shall contain any supplemental disclosure information that the administrative director may require.

(g) (1) An organization may not refuse to enter into any contract, or may not cancel or decline to renew or reinstate any contract, because of the age or any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise.

(2) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the age or any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as an employee or otherwise; except that premium, price, or charge differentials because of the sex or age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. Nothing in this section shall be construed to permit an organization to charge different rates to individual employees within the same group solely on the basis of the employee's sex.

(3) It shall be deemed a violation of subdivision (a) for any organization to utilize marital status, living arrangements, occupation, gender, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting organizations from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(4) This section shall not be construed to limit the authority of the administrative director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(h) (1) An organization may not use in its name any of the words "insurance," "casualty," "health care service plan," "health plan," "surety," "mutual," or any other words descriptive of the health plan, insurance, casualty, or surety business or use any name similar to the name or description of any health care service plan, insurance, or surety corporation doing business in this state unless that organization controls or is controlled by an entity licensed as a health care service plan or insurer pursuant to the Health and Safety Code or the Insurance Code and the organization employs a name related to that of the controlled or controlling entity.

(2) Section 2415 of the Business and Professions Code, pertaining to fictitious names, does not apply to organizations certified under this section.

(3) An organization or solicitor firm may not adopt a name style that is deceptive, or one that could cause the public to believe the organization is affiliated with or recommended by any governmental or private entity unless this affiliation or endorsement exists.

(i) Each organization shall meet the following requirements:

(1) All facilities located in this state, including, but not limited to, clinics, hospitals, and skilled nursing facilities, to be utilized by the organization shall be licensed by the State Department of Health Services, if that licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(2) All personnel employed by or under contract to the organization shall be licensed or certified by their respective board or agency, where that licensure or certification is required by law.

(3) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for that equipment shall be licensed or certified as required by law.

(4) The organization shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at any time as may be appropriate and consistent with good professional practice.

(5) All health care shall be readily available at reasonable times to all employees. To the extent feasible, the organization shall make all health care readily accessible to all employees.

(6) The organization shall employ and utilize allied health manpower for the furnishing of health care to the extent permitted by law and consistent with good health care practice.

(7) The organization shall have the organizational and administrative capacity to provide services to employees. The organization shall be able to demonstrate to the department that health care decisions are rendered by qualified providers, unhindered by fiscal and administrative management.

(8) All contracts with employers, insurers of employers, and self-insured employers and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the workers' compensation health care organization, shall be fair, reasonable, and consistent with the objectives of this part.

(9) Each organization shall provide to employees all workers' compensation health care required by this code. The administrative director shall not determine the scope of workers' compensation health care to be offered by an organization.

(j) (1) Every organization shall establish and maintain a grievance system approved by the administrative director under which employees may submit their grievances to the organization. Each system shall provide reasonable procedures in accordance with regulations adopted by the administrative director that shall ensure adequate consideration of employee grievances and rectification when appropriate.

(2) Every organization shall inform employees upon enrollment and annually thereafter of the procedures for processing and resolving grievances.

The information shall include the location and telephone number where grievances may be submitted.

(3) Every organization shall provide forms for complaints to be given to employees who wish to register written complaints. The forms used by organizations shall be approved by the administrative director in advance as to format.

(4) The organization shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.

(k) Every organization shall establish procedures in accordance with regulations of the administrative director for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in quality of care or utilization reviews by peer review committees that are composed chiefly of physicians, as defined by Section 3209.3, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of an organization or to any person or entity designated by the organization to review activities of the committees shall not alter the status of the records or of the proceedings as privileged communications.

The above prohibition relating to discovery or testimony does not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the administrative director in conducting surveys pursuant to subdivision (o).

This section shall not be construed to confer immunity from liability on any workers' compensation health care organization. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against an organization, the cause of action shall exist notwithstanding the provisions of this section.

(*l*) Nothing in this chapter shall be construed to prevent an organization from utilizing subcommittees to participate in peer review activities, nor to prevent an organization from delegating the responsibilities required by subdivision (i) as it determines to be appropriate, to subcommittees including subcommittees composed of a majority of nonphysician health care providers licensed pursuant to the Business and Professions Code, as long as the organization controls the scope of authority delegated and may revoke all or part of this authority at any time. Persons who participate in the subcommittees shall be entitled to the same immunity from monetary liability

and actions for civil damages as persons who participate in organization or provider peer review committees pursuant to subdivision (i).

(m) Every organization shall have and shall demonstrate to the administrative director that it has all of the following:

(1) Adequate provision for continuity of care.

(2) A procedure for prompt payment and denial of provider claims.

(n) Every contract between an organization and an employer or insurer of an employer, and every contract between any organization and a provider of health care, shall be in writing.

(o) (1) The administrative director shall conduct periodically an onsite medical survey of the health care delivery system of each organization. The survey shall include a review of the procedures for obtaining health care, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the organization in providing health care and meeting the health needs of employees.

(2) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of workers' compensation health care. The administrative director shall be authorized to contract with professional organizations or outside personnel to conduct medical surveys. These organizations or personnel shall have demonstrated the ability to objectively evaluate the delivery of this health care.

(3) Surveys performed pursuant to this section shall be conducted as often as deemed necessary by the administrative director to assure the protection of employees, but not less frequently than once every three years. Nothing in this section shall be construed to require the survey team to visit each clinic, hospital, office, or facility of the organization.

(4) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under this section or in medical records. However, the administrative director shall be authorized to require onsite review of these peer review proceedings and records or medical records where necessary to determine that quality health care is being delivered to employees. Where medical record review is authorized, the survey team shall ensure that the confidentiality of the physician-patient relationship is safeguarded in accordance with existing law and neither the survey team nor the administrative director or the administrative director's staff may be compelled to disclose this information except in accordance with the physician-patient relationship. The administrative director shall ensure that the confidentiality of the peer review proceedings and records is maintained. The disclosure of the peer review proceedings and records to the administrative director or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications.

(5) The procedures and standards utilized by the survey team shall be made available to the organizations prior to the conducting of medical surveys.

(6) During the survey, the members of the survey team shall offer such advice and assistance to the organization as deemed appropriate.

(7) The administrative director shall notify the organization of deficiencies found by the survey team. The administrative director shall give the organization a reasonable time to correct the deficiencies, and failure on the part of the organization to comply to the administrative director's satisfaction shall constitute cause for disciplinary action against the organization.

(8) Reports of all surveys, deficiencies, and correction plans shall be open to public inspection, except that no surveys, deficiencies or correction plans shall be made public unless the organization has had an opportunity to review the survey and file a statement of response within 30 days, to be attached to the report.

(p) (1) All records, books, and papers of an organization, management company, solicitor, solicitor firm, and any provider or subcontractor providing medical or other services to an organization, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the administrative director.

(2) To the extent feasible, all the records, books, and papers described in paragraph (1) shall be located in this state. In examining those records outside this state, the administrative director shall consider the cost to the organization, consistent with the effectiveness of the administrative director's examination, and may upon reasonable notice require that these records, books, and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of these records, books, and papers, or a specified portion thereof, be furnished to the administrative director.

(q) (1) The administrative director shall conduct an examination of the administrative affairs of any organization, and each person with whom the organization has made arrangements for administrative, or management services, as often as deemed necessary to protect the interest of employees, but not less frequently than once every five years.

(2) The expense of conducting any additional or nonroutine examinations pursuant to this section, and the expense of conducting any additional or nonroutine medical surveys pursuant to subdivision (o) shall be charged against the organization being examined or surveyed. The amount shall include the actual salaries or compensation paid to the persons making the examination or survey, the expenses incurred in the course thereof, and overhead costs in connection therewith as fixed by the administrative director. In determining the cost of examinations or surveys, the administrative director may use the estimated average hourly cost for all persons performing examinations or surveys of workers' compensation health care organizations for the fiscal year. The amount charged shall be remitted by the organization to the administrative director.

(3) Reports of all examinations shall be open to public inspection, except that no examination shall be made public, unless the organization has had an opportunity to review the examination report and file a statement or response within 30 days, to be attached to the report.

SEC. 10. Section 103 of the Welfare and Institutions Code is amended to read:

103. (a) Persons acting as a CASA shall be individuals who have demonstrated an interest in children and their welfare. Each CASA shall participate in a training course conducted under the rules and regulations adopted by the Judicial Council and in ongoing training and supervision throughout his or her involvement in the program. Each CASA shall be evaluated before and after initial training to determine his or her fitness for these responsibilities. Ongoing training shall be provided at least monthly.

(b) Each CASA shall commit a minimum of one year of service to a child until a permanent placement is achieved for the child or until relieved by the court, whichever is first. At the end of each year of service, the CASA, with the approval of the court, may recommit for an additional year.

(c) A CASA shall have no associations that create a conflict of interest with his or her duties as a CASA.

(d) An adult otherwise qualified to act as a CASA shall not be discriminated against based upon marital status, socioeconomic factors, or because of any characteristic listed or defined in Section 11135 of the Government Code.

(e) Each CASA is an officer of the court, with the relevant rights and responsibilities that pertain to that role and shall act consistently with the local rules of court pertaining to CASAs.

(f) Each CASA shall be sworn in by a superior court judge or commissioner before beginning his or her duties.

(g) A judge may appoint a CASA when, in the opinion of the judge, a child requires services which can be provided by the CASA, consistent with the local rules of court.

(h) To accomplish the appointment of a CASA, the judge making the appointment shall sign an order, which may grant the CASA the authority to review specific relevant documents and interview parties involved in the case, as well as other persons having significant information relating to the child, to the same extent as any other officer of the court appointed to investigate proceedings on behalf of the court.

SEC. 11. Section 14200.1 of the Welfare and Institutions Code is amended to read:

14200.1. The purpose of this chapter is to afford persons eligible to receive benefits under Chapter 7 (commencing with Section 14000) of this part the opportunity to enroll as regular subscribers in prepaid health plans, without reference to marital status or any characteristic listed or defined in Section 11135 of the Government Code.

SEC. 12. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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