

AMENDED IN SENATE MAY 1, 1997  
AMENDED IN SENATE APRIL 3, 1997

**SENATE BILL**

**No. 1063**

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**Introduced by Senator Peace**

February 27, 1997

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~~An act to amend Section 1879.2 of the Insurance Code, and~~  
*An act to amend Sections 4062.9, 4065, and 4600.5 of, to add*  
~~Sections 4600.6 and 5102.5 to, and 4600.5, and 5401.7 of, to add~~  
*Section 4600.6 to, and to repeal Part 3.2 (commencing with*  
~~Section 5150) of Division 4 of, the Labor Code, relating to~~  
*workers' compensation.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1063, as amended, Peace. Workers' compensation.

~~(1) Existing law requires any insurer that prints, reproduces, or furnishes a form to any person upon which that person gives notice to the insurer of a claim under any contract of insurance or makes a claim against the insurer for any loss, damage, liability, or other covered event shall cause to be printed or displayed, in comparative prominence compared to other contents, a statement to the effect that any person who knowingly presents false or fraudulent claims for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.~~

~~This bill would exempt from the above requirement any form giving notice or information concerning a claim for workers' compensation benefits, as specified.~~

~~(2) Existing law provides that in cases where an additional comprehensive medical evaluation is obtained for purposes of determining the extent of an employee's permanent disability, the findings of the treating physician are presumed to be correct. Existing law further provides that this presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of impairment, but that this presumption shall not apply where both parties select qualified medical examiners.~~

This bill would also exclude application of the presumption where both parties reach agreement on a physician to prepare the comprehensive medical evaluation.

~~(3) Existing law provides that in cases where either the employer or the employee have obtained evaluations of the employee's permanent impairment and limitations from a qualified medical evaluator and either party contests the comprehensive medical evaluation of the other party, the workers' compensation judge or the Workers' Compensation Appeals Board shall be limited to choosing between either party's proposed permanent disability rating. Existing law further provides that, depending on the appeals board's choice of permanent disability rating, an employee's permanent disability benefit award shall either be decreased or increased by the cost of the employer's or employee's comprehensive medical-legal evaluation.~~

~~This bill would provide, in addition, that in cases where either the employer or the employee have obtained evaluations of medical issues from a qualified medical evaluator in accordance with a specified provision, and where a medical evaluation addresses permanent impairment and limitations, and either party contests the formal medical evaluation of the other party, the workers' compensation judge or the appeals board shall be limited to choosing between either party's proposed permanent disability rating. The bill would also provide that, depending on the appeals board's choice of permanent disability rating, an employee's permanent disability benefit award shall either be decreased or increased by the cost of the employer's or employee's formal evaluation.~~



~~(4) Existing law provides that at the time of making its award, or at any time thereafter, the appeals board may commute the compensation payable under the workers' compensation provisions to a lump sum and order it to be paid forthwith or at some future time if certain conditions appear. Existing law also provides that the appeals board may order the lump sum paid directly to the injured employee or his or her dependents, or deposited with any savings bank or trust company authorized to transact business in this state, which agrees to accept the lump sum as a deposit bearing interest, or with the State Compensation Insurance Fund, to be held in trust for the injured employee, or in the event of his or her death, for his or her dependents.~~

~~This bill would authorize a savings bank or trust company to delay payment of a lump sum cash benefit payment for up to 48 hours for the purpose of verifying the validity of the claim, and would require a savings bank or trust company that delays payment to pay interest on the benefit amount.~~

~~(5)~~

~~(2) Existing law provides that medical services for workers' compensation may be provided by various organizations, including a workers' compensation health care provider organization, and provides for the authorization and regulation of those organizations by the Commissioner of Corporations.~~

~~This bill would repeal the provisions providing for workers' compensation health care provider organizations authorized by the Commissioner of Corporations, and would instead provide for the authorization of workers' compensation health care organizations by the Administrative Director of the Division of Workers' Compensation.~~

~~The bill would make related changes.~~

~~(3) Existing law requires a workers' compensation claim form to contain certain information including a statement that it is a felony to make or cause the making of any false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments.~~

~~This bill would permit, but not require, the statements required to be printed or displayed by an insurer relating to~~



false or fraudulent claims under a contract of insurance to appear on the workers' compensation claim form.

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

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

1 SECTION 1. Section 1879.2 of the Insurance Code is  
2 amended to read:

3 1879.2. (a) Any insurer that prints, reproduces, or  
4 furnishes a form to any person upon which that person  
5 gives notice to the insurer of a claim under any contract  
6 of insurance or makes a claim against the insurer for any  
7 loss, damage, liability, or other covered event shall cause  
8 to be printed or displayed, in comparative prominence  
9 compared to other contents, the following statement:  
10 "Any person who knowingly presents a false or fraudulent  
11 claim for the payment of a loss is guilty of a crime and may  
12 be subject to fines and confinement in state prison." The  
13 statement shall be preceded by the words: "For your  
14 protection California law requires the following to appear  
15 on this form" or other explanatory words of similar  
16 meaning.

17 (b) Any insurer that has produced or caused to be  
18 printed forms containing the statement required by  
19 subdivision (a), as originally added by Chapter 1008 of the  
20 Statutes of 1994, may continue to use those forms until  
21 December 31, 1996. This subdivision is intended to  
22 prevent any unnecessary waste of resources that might  
23 result from insurers' efforts to comply with conflicting  
24 provisions of law.

25 (c) This section shall not apply to any form giving  
26 notice or information concerning a claim for workers'  
27 compensation benefits pursuant to Section 5401.7 of the  
28 Labor Code.

29 SEC. 2.

30 SECTION 1. Section 4062.9 of the Labor Code is  
31 amended to read:

32 4062.9. In cases where an additional comprehensive  
33 medical evaluation is obtained under Section 4061 or



1 4062, the findings of the treating physician are presumed  
2 to be correct. This presumption is rebuttable and may be  
3 controverted by a preponderance of medical opinion  
4 indicating a different level of impairment. However, this  
5 presumption shall not apply where both parties select  
6 qualified medical examiners or where both parties reach  
7 agreement on a physician to prepare the comprehensive  
8 medical evaluation.

9 ~~SEC. 3. Section 4065 of the Labor Code is amended to~~  
10 ~~read:~~

11 ~~4065. (a) In cases where either the employer or the~~  
12 ~~employee have obtained evaluations of the employee's~~  
13 ~~permanent impairment and limitations from a qualified~~  
14 ~~medical evaluator under Section 4061 and either party~~  
15 ~~contests the comprehensive medical evaluation of the~~  
16 ~~other party, the workers' compensation judge or the~~  
17 ~~appeals board shall be limited to choosing between either~~  
18 ~~party's proposed permanent disability rating.~~

19 ~~(b) In cases where either the employer or the~~  
20 ~~employee have obtained evaluations of medical issues~~  
21 ~~from a qualified medical evaluator under Section 4062,~~  
22 ~~and where a medical evaluation addresses permanent~~  
23 ~~impairment and limitations, and either party contests the~~  
24 ~~formal medical evaluation of the other party, the workers'~~  
25 ~~compensation judge or the appeals board shall be limited~~  
26 ~~to choosing between either party's proposed permanent~~  
27 ~~disability rating.~~

28 ~~(c) The employee's permanent disability benefit~~  
29 ~~awarded under paragraph (a) or (b) shall be adjusted~~  
30 ~~based on the disability rating selected by the appeals~~  
31 ~~board. If the appeals board chooses the permanent~~  
32 ~~disability rating recommended by the employer, then the~~  
33 ~~employee's permanent disability benefit award shall be~~  
34 ~~reduced by the cost of the employee's comprehensive~~  
35 ~~medical-legal evaluation or formal medical evaluation. If~~  
36 ~~the judge chooses the permanent disability rating~~  
37 ~~recommended by the employee, the permanent~~  
38 ~~disability benefit award shall be increased by the cost of~~  
39 ~~the employer's comprehensive medical-legal evaluation~~  
40 ~~or formal medical evaluation.~~



1 ~~SEC. 4.~~

2 SEC. 2. Section 4600.5 of the Labor Code is amended  
3 to read:

4 4600.5. (a) Any health care service plan licensed  
5 pursuant to the Knox-Keene Health Care Service Plan  
6 Act, a disability insurer licensed by the Department of  
7 Insurance, or any entity, including, but not limited to,  
8 workers' compensation insurers and third-party  
9 administrators authorized by the administrative director  
10 under subdivision (e), may make written application to  
11 the administrative director to become certified as a  
12 health care organization to provide health care to injured  
13 employees for injuries and diseases compensable under  
14 this article.

15 (b) Each application for certification shall be  
16 accompanied by a reasonable fee prescribed by the  
17 administrative director. A certificate is valid for the  
18 period that the director may prescribe unless sooner  
19 revoked or suspended.

20 (c) If the health care organization is a health care  
21 service plan licensed pursuant to the Knox-Keene Health  
22 Care Service Plan Act, the administrative director shall  
23 certify the plan to provide health care pursuant to Section  
24 4600.3 if the director finds that the plan is in good standing  
25 with the Department of Corporations and meets the  
26 following additional requirements:

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

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

34 (3) Proposes a timely and accurate method to meet  
35 the requirements set forth by the administrative director  
36 for all carriers of workers' compensation coverage to  
37 report necessary information regarding medical and  
38 health care service cost and utilization, rates of return to  
39 work, average time in medical treatment, and other  
40 measures as determined by the administrative director to



1 enable the director to determine the effectiveness of the  
2 plan.

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

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

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

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

25 (d) If the health care organization is a disability  
26 insurer licensed by the Department of Insurance, and is  
27 in compliance with subdivision (d) of Sections 10133 and  
28 10133.5 of the Insurance Code, the administrative  
29 director shall certify the organization to provide health  
30 care pursuant to Section 4600.3 if the director finds that  
31 the plan is in good standing with the Department of  
32 Insurance and meets the following additional  
33 requirements:

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

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



1 (3) Proposes a timely and accurate method to meet  
2 the requirements set forth by the administrative director  
3 for all carriers of workers' compensation coverage to  
4 report necessary information regarding medical and  
5 health care service cost and utilization, rates of return to  
6 work, average time in medical treatment, and other  
7 measures as determined by the administrative director to  
8 enable the director to determine the effectiveness of the  
9 plan.

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

19 Disclosure of peer review proceedings and records to  
20 the administrative director shall not alter the status of the  
21 proceedings or records as privileged and confidential  
22 communications pursuant to subdivision (d) of Section  
23 10133 of the Insurance Code.

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

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

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

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



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

6 (3) Proposes a timely and accurate method to meet  
7 the requirements set forth by the administrative director  
8 for all carriers of workers' compensation coverage to  
9 report necessary information regarding medical and  
10 health care service cost and utilization, rates of return to  
11 work, average time in medical treatment, and other  
12 measures as determined by the administrative director to  
13 enable the director to determine the effectiveness of the  
14 plan.

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

24 Disclosure of peer review proceedings and records to  
25 the administrative director shall not alter the status of the  
26 proceedings or records as privileged and confidential  
27 communications pursuant to subdivision (d) of Section  
28 10133 of the Insurance Code.

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

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

36 (7) Complies with the following requirements:

37 (A) An organization certified by the administrative  
38 director under this subdivision may not provide or  
39 undertake to arrange for the provision of health care to  
40 employees, or to pay for or to reimburse any part of the



1 cost of that health care in return for a prepaid or periodic  
2 charge paid by or on behalf of those employees.

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

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

12 (f) (1) A workers' compensation health care provider  
13 organization authorized by the Department of  
14 Corporations on December 31, 1997, shall be eligible for  
15 certification as a health care organization under  
16 subdivision (e).

17 (2) An entity that had, on December 31, 1997,  
18 submitted an application with the Commissioner of  
19 Corporations under Part 3.2 (commencing with Section  
20 5150) shall be considered an applicant for certification  
21 under subdivision (e) and shall be entitled to priority in  
22 consideration of its application. The Commissioner of  
23 Corporations shall provide complete files for all pending  
24 applications to the administrative director on or before  
25 January 31, 1998.

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

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

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

38 (j) In consultation with interested parties, including  
39 the Department of Corporations and the Department of



1 Insurance, the administrative director shall adopt rules  
2 necessary to carry out this section.

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

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

9 (2) A health care service plan licensed by the  
10 Department of Corporations, a workers' compensation  
11 health care provider organization authorized by the  
12 Department of Corporations, or a carrier licensed by the  
13 Department of Insurance is not in good standing with its  
14 licensing agency.

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

17 (l) (1) When an injured employee requests  
18 chiropractic treatment for work-related injuries, the  
19 health care organization shall provide the injured worker  
20 with access to the services of a chiropractor pursuant to  
21 guidelines for chiropractic care established by paragraph  
22 (2). Within five working days of the employee's request  
23 to see a chiropractor, the health care organization and  
24 any person or entity who directs the kind or manner of  
25 health care services for the plan shall refer an injured  
26 employee to an affiliated chiropractor for work-related  
27 injuries that are within the guidelines for chiropractic  
28 care established by paragraph (2). Chiropractic care  
29 rendered in accordance with guidelines for chiropractic  
30 care established pursuant to paragraph (2) shall be  
31 provided by duly licensed chiropractors affiliated with  
32 the plan.

33 (2) The health care organization shall establish  
34 guidelines for chiropractic care in consultation with  
35 affiliated chiropractors who are participants in the health  
36 care organization's utilization review process for  
37 chiropractic care, which may include qualified medical  
38 evaluators knowledgeable in the treatment of  
39 chiropractic conditions. The guidelines for chiropractic  
40 care shall, at a minimum, explicitly require the referral of



1 any injured employee who so requests to an affiliated  
2 chiropractor for the evaluation or treatment, or both of  
3 neuromusculoskeletal conditions.

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

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

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

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

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

35 ~~SEC. 5.~~

36 *SEC. 3.* Section 4600.6 is added to the Labor Code, to  
37 read:

38 4600.6. Any workers' compensation insurer,  
39 third-party administrator, or other entity seeking  
40 certification as a health care organization under



1 subdivision (e) of Section 4600.5 shall be subject to the  
2 following rules and procedures:

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

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

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

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

27 (4) A copy of any contract made, or to be made,  
28 between the applicant and any provider of health care,  
29 or persons listed in paragraph (3), or any other person or  
30 organization agreeing to perform an administrative  
31 function or service for the plan. The administrative  
32 director by rule may identify contracts excluded from this  
33 requirement and make provision for the submission of  
34 form contracts. The payment rendered or to be rendered  
35 to the provider of health care services shall be deemed  
36 confidential information that shall not be divulged by the  
37 administrative director, except that the payment may be  
38 disclosed and become a public record in any legislative,  
39 administrative, or judicial proceeding or inquiry. The  
40 organization shall also submit the name and address of



1 each provider employed by, or contracting with, the  
2 organization, together with his or her license number.

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

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

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

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

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

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

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



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

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

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

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

16 (16) Evidence of fidelity bonds that the administrative  
17 director may prescribe by regulation.

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

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

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

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



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

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

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

25 (d) (1) An organization may not publish or distribute,  
26 or allow to be published or distributed on its behalf, any  
27 advertisement unless (A) a true copy thereof has first  
28 been filed with the administrative director, at least 30  
29 days prior to any such use, or any shorter period as the  
30 administrative director by rule or order may allow, and  
31 (B) the administrative director by notice has not found  
32 the advertisement, wholly or in part, to be untrue,  
33 misleading, deceptive, or otherwise not in compliance  
34 with this part or the rules thereunder, and specified the  
35 deficiencies, within the 30 days or any shorter time as the  
36 administrative director by rule or order may allow.

37 (2) If the administrative director finds that any  
38 advertisement of an organization has materially failed to  
39 comply with this part or the rules thereunder, the  
40 administrative director may, by order, require the



1 organization to publish in the same or similar medium, an  
2 approved correction or retraction of any untrue,  
3 misleading, or deceptive statement contained in the  
4 advertising.

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

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

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

36 (3) In addition to the other disclosures required by this  
37 section, every organization and any agent or employee of  
38 the organization shall, when representing an  
39 organization for examination or sale to any individual  
40 purchaser or the representative of a group consisting of



1 25 or fewer individuals, disclose in writing the ratio of  
2 premium cost to health care paid for contracts with  
3 individuals and with groups of the same or similar size for  
4 the organization's preceding fiscal year. An organization  
5 may report that information by geographic area,  
6 provided the organization identifies the geographic area  
7 and reports information applicable to that geographic  
8 area.

9 (4) Where the administrative director finds it  
10 necessary in the interest of full and fair disclosure, all  
11 advertising and other consumer information  
12 disseminated by an organization for the purpose of  
13 influencing persons to become members of an  
14 organization shall contain any supplemental disclosure  
15 information that the administrative director may require.

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

23 (g) (1) An organization may not refuse to enter into  
24 any contract or may not cancel or decline to renew or  
25 reinstate any contract because of the race, color, national  
26 origin, ancestry, religion, sex, marital status, sexual  
27 orientation, or age of any contracting party, prospective  
28 contracting party, or person reasonably expected to  
29 benefit from that contract as an employee or otherwise.

30 (2) The terms of any contract shall not be modified,  
31 and the benefits or coverage of any contract shall not be  
32 subject to any limitations, exceptions, exclusions,  
33 reductions, copayments, coinsurance, deductibles,  
34 reservations, or premium, price, or charge differentials,  
35 or other modifications because of the race, color, national  
36 origin, ancestry, religion, sex, marital status, sexual  
37 orientation, or age of any contracting party, potential  
38 contracting party, or person reasonably expected to  
39 benefit from that contract as an employee or otherwise;  
40 except that premium, price, or charge differentials



1 because of the sex or age of any individual when based on  
2 objective, valid, and up-to-date statistical and actuarial  
3 data are not prohibited. Nothing in this section shall be  
4 construed to permit an organization to charge different  
5 rates to individual employees within the same group  
6 solely on the basis of the employee's sex.

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

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

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

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

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



1 (i) Each organization shall meet the following  
2 requirements:

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

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

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

18 (4) The organization shall furnish services in a manner  
19 providing continuity of care and ready referral of patients  
20 to other providers at ~~such times~~ *any time* as may be  
21 appropriate *and* consistent with good professional  
22 practice.

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

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

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

37 (8) All contracts with employers, insurers of  
38 employers, and self-insured employers and all contracts  
39 with providers, and other persons furnishing services,  
40 equipment, or facilities to or in connection with the



1 workers' compensation health care organization, shall be  
2 fair, reasonable, and consistent with the objectives of this  
3 part.

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

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

17 (2) Every organization shall inform employees upon  
18 enrollment and annually thereafter of the procedures for  
19 processing and resolving grievances. The information  
20 shall include the location and telephone number where  
21 grievances may be submitted.

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

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

30 (k) Every organization shall establish procedures in  
31 accordance with regulations of the administrative  
32 director for continuously reviewing the quality of care,  
33 performance of medical personnel, utilization of services  
34 and facilities, and costs. Notwithstanding any other  
35 provision of law, there shall be no monetary liability on  
36 the part of, and no cause of action for damages shall arise  
37 against, any person who participates in quality of care or  
38 utilization reviews by peer review committees that are  
39 composed chiefly of physicians, as defined by Section  
40 3209.3, for any act performed during the reviews if the



1 person acts without malice, has made a reasonable effort  
2 to obtain the facts of the matter, and believes that the  
3 action taken is warranted by the facts, and neither the  
4 proceedings nor the records of the reviews shall be  
5 subject to discovery, nor shall any person in attendance  
6 at the reviews be required to testify as to what transpired  
7 thereat. Disclosure of the proceedings or records to the  
8 governing body of an organization or to any person or  
9 entity designated by the organization to review activities  
10 of the committees shall not alter the status of the records  
11 or of the proceedings as privileged communications.

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

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

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



1 immunity from monetary liability and actions for civil  
2 damages as persons who participate in organization or  
3 provider peer review committees pursuant to subdivision  
4 (i).

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

8 (1) Adequate provision for continuity of care.

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

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

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

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

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

39 (4) Nothing in this section shall be construed to  
40 require the medical survey team to review peer review



1 proceedings and records conducted and compiled under  
2 this section or *in* medical records. However, the  
3 administrative director shall be authorized to require  
4 onsite review of these peer review proceedings and  
5 records or medical records where necessary to determine  
6 that quality health care is being delivered to employees.  
7 Where medical record review is authorized, the survey  
8 team shall ensure that the confidentiality of the  
9 physician-patient relationship is safeguarded in  
10 accordance with existing law and neither the survey team  
11 nor the administrative director or the administrative  
12 director's staff may be compelled to disclose this  
13 information except in accordance with the  
14 physician-patient relationship. The administrative  
15 director shall ensure that the confidentiality of the peer  
16 review proceedings and records is maintained. The  
17 disclosure of the peer review proceedings and records to  
18 the administrative director or the medical survey team  
19 shall not alter the status of the proceedings or records as  
20 privileged and confidential communications.

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

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

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

34 (8) Reports of all surveys, deficiencies, and correction  
35 plans shall be open to public inspection, except that no  
36 surveys, deficiencies or correction plans shall be made  
37 public unless the organization has had an opportunity to  
38 review the survey and file a statement of response within  
39 30 days, to be attached to the report. Deficiencies shall not



1 be made public if they are corrected within 30 days of the  
2 date that the organization was notified.

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

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

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

29 (2) The expense of conducting any additional or  
30 nonroutine examinations pursuant to this section, and the  
31 expense of conducting any additional or nonroutine  
32 medical surveys pursuant to subdivision (o) shall be  
33 charged against the organization being examined or  
34 surveyed. The amount shall include the actual salaries or  
35 compensation paid to the persons making the  
36 examination or survey, the expenses incurred in the  
37 course thereof, and overhead costs in connection  
38 therewith as fixed by the administrative director. In  
39 determining the cost of examinations or surveys, the  
40 administrative director may use the estimated average



1 hourly cost for all persons performing examinations or  
2 surveys of workers' compensation health care  
3 organizations for the fiscal year. The amount charged  
4 shall be remitted by the organization to the  
5 administrative director.

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

11 ~~SEC. 6. Section 5102.5 is added to the Labor Code, to~~  
12 ~~read:~~

13 ~~5102.5. (a) A savings bank or trust company may~~  
14 ~~delay payment of a lump sum cash benefit payment for~~  
15 ~~up to 48 hours for the purpose of verifying the validity of~~  
16 ~~the claim. A savings bank or trust company that delays~~  
17 ~~payment shall pay interest on the benefit amount.~~

18 ~~(b) Notwithstanding subdivision (a), lump sum~~  
19 ~~benefit payments made by check shall be made on~~  
20 ~~demand.~~

21 ~~SEC. 7.~~

22 ~~SEC. 4. Part 3.2 (commencing with Section 5150) of~~  
23 ~~Division 4 of the Labor Code is repealed.~~

24 ~~SEC. 8.~~

25 ~~SEC. 5. Section 5401.7 of the Labor Code is amended~~  
26 ~~to read:~~

27 ~~5401.7. The claim form shall contain, prominently~~  
28 ~~stated, the following statement:~~

29 ~~“Any person who makes or causes to be made any~~  
30 ~~knowingly false or fraudulent material statement or~~  
31 ~~material representation for the purpose of obtaining or~~  
32 ~~denying workers' compensation benefits or payments is~~  
33 ~~guilty of a felony.”~~

34 ~~*The statements required to be printed or displayed*~~  
35 ~~*pursuant to Sections 1871.2 and 1879.2 of the Insurance*~~  
36 ~~*Code may, but are not required to, appear on the claim*~~  
37 ~~*form.*~~

38 ~~SEC. 6. The Administrative Director of the Division~~  
39 ~~of Workers' Compensation is authorized to adopt for~~  
40 ~~purposes of provisions added by this act appropriate~~



1 regulations adopted by the Commissioner of  
2 Corporations under the Workers' Compensation Health  
3 Care Provider Organization Act of 1993 by filing those  
4 regulations with the Office of Administrative Law which,  
5 upon receipt, shall immediately approve the regulations  
6 and file them with the Secretary of State, at which time  
7 they shall become immediately effective.

O

