

**COMPILATION OF  
CHANGES IN THE  
WORKERS' COMPENSATION LAWS**

**EFFECTIVE AS OF  
JANUARY 1, 1998**

**Compiled by  
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**§1872.8 ANNUAL FEES; DISTRIBUTION OF PROCEEDS; DUTIES OF BUREAU**

(a) Each insurer doing business in this state shall pay an annual fee to be determined by the commissioner, but not to exceed one dollar (\$1) annually for each vehicle insured under an insurance policy it issues in this state, in order to fund increased investigation and prosecution of fraudulent automobile insurance claims and economic automobile theft. Thirty-four percent of those funds received from ninety-five cents (\$0.95) of the assessment fee per insured vehicle shall be distributed to the Bureau of Fraudulent Claims for enhanced investigative efforts, 15 percent of that ninety-five cents (\$0.95) shall be deposited in the Motor Vehicle Account for appropriation to the Department of the California Highway Patrol for enhanced prevention and investigative efforts to deter economic automobile theft, and 51 percent of the funds shall be distributed to district attorneys for purposes of investigation and prosecution of automobile insurance fraud cases, including fraud involving economic automobile theft.

(b) The commissioner shall award funds to district attorneys according to population. The commissioner may alter this distribution formula as necessary to achieve the most effective distribution of funds. Each local district attorney desiring a portion of those funds shall submit to the commissioner an application detailing ~~their~~ **the** proposed use of any moneys which ~~that~~ **that** may be provided. The application shall include a detailed accounting of assessment funds received and expended in prior years, including at a minimum (1) the amount of funds received and expended; (2) the uses to which those funds were put, including payment of salaries and expenses, purchase of equipment and supplies, and other expenditures by type; (3) results achieved as a consequence of expenditures made, including the number of investigations, arrests, complaints filed, convictions, and the amounts originally claimed in cases prosecuted compared to payments actually made in those cases; and (4) other relevant information as the commissioner may reasonably require. Any district attorney who fails to submit an application within 90 days of the commissioner's deadline for applications shall be subject to loss of distribution of the money. The commissioner may consider recommendations and advice of the bureau and the Commissioner of the California Highway Patrol in allocating moneys to local district attorneys. Any district attorney that receives funds shall submit an annual report to the commissioner, which may be made public, as to the success of the program ~~that they have~~ administered. The report shall provide information and statistics on the number of active investigations, arrests, indictments, and convictions. Both the application for moneys and the distribution of moneys shall be public documents. Information submitted to the commissioner pursuant to this section concerning ~~active cases~~ **criminal investigations, whether active or inactive**, shall be confidential.

(c) The remaining five cents (\$.05) shall be spent pursuant to Article 6 (commencing with Section 1876) of this chapter.

(d) Except for funds to be deposited in the Motor Vehicle Account for allocation to the California Highway Patrol for purposes of the

Motor Vehicle Prevention Act, (Chapter 5 (commencing with Section 10900) of Division 4 of the Vehicle Code), the funds received under this section shall be deposited in the Insurance Fund and be expended and distributed when appropriated by the Legislature.

(e) In the course of its investigations, the Bureau of Fraudulent Claims shall aggressively pursue all reported incidents of probable fraud and, in addition, shall forward to the appropriate disciplinary body the names of any individuals licensed under the Business and Professions Code who are suspected of actively engaging in fraudulent activity along with all relevant supporting evidence.

(f) As used in this section "economic automobile theft" means automobile theft perpetrated for financial gain, including, but not limited to, the following:

(1) Theft of a motor vehicle for financial gain.

(2) Reporting that a motor vehicle has been stolen for the purpose of filing a false insurance claim.

(3) Engaging in any act prohibited by Chapter 3.5 (commencing with Section 10801) of Division 4 of the Vehicle Code.

(4) Switching of vehicle identification numbers to obtain title to a stolen motor vehicle.

(Amended by Stats. 1997, C.364 (A.B. 349). Effective January 1, 1998.)

**§1872.83 INVESTIGATION OF FRAUDULENT CLAIMS; FRAUD ASSESSMENT COMMISSION; ASSESSMENT AND FINE COLLECTION AND DEPOSIT; DISPOSITION OF FUNDS; REGULATIONS; REPORTS; FUNDS**

(a) The commissioner shall ensure that the Bureau of Fraudulent Claims aggressively pursues all reported incidents of probable workers' compensation fraud, as defined in Sections 11760 and 11880, in subdivision (a) of Section 1871.4, and in Section 549 of the Penal Code, and forwards to the appropriate disciplinary body the names, along with all supporting evidence, of any individuals licensed under the Business and Professions Code who are suspected of actively engaging in fraudulent activity. The Bureau of Fraudulent Claims shall forward to the Insurance Commissioner or the Director of Industrial Relations, as appropriate, the name, along with all supporting evidence, of any insurer, as defined in subdivision (c) of Section 1877.1, suspected of actively engaging in the fraudulent denial of claims.

(b) To fund increased investigation and prosecution of workers' compensation fraud, there shall be an annual assessment as follows:

(1) The aggregate amount of the assessment shall be determined by the Fraud Assessment Commission, which is hereby established. The commission shall be composed of five members consisting of two representatives of self-insured employers, one representative of insured employers, one representative of workers' compensation insurers, and the President of the State Compensation Insurance Fund, or his or her designee.

The Governor shall appoint members representing self-insured employers, insured employers, and insurers. The term of office of members of the commission shall be four years, and a member shall hold office until the appointment of a successor. However, the initial terms of three of the members appointed by the Governor shall expire, respectively, on December 31, 1992, December 31, 1993, and December 31, 1994. The President of the State Compensation Insurance Fund shall be an ex officio, voting member of the commission. Members of the commission shall receive one hundred dollars (\$100) for each day of actual attendance at commission meetings and other official commission business, and shall also receive their actual and necessary traveling expenses incurred in the performance of commission duties. Payment of per diem and travel expenses shall be made from the Workers' Compensation Fraud Account in the Insurance Fund, established in paragraph (4), upon appropriation by the Legislature.

(2) In determining the aggregate amount of the assessment, the Fraud Assessment Commission shall consider the advice and recommendations of the Bureau of Fraudulent Claims and the commissioner.

(3) The aggregate amount of the assessment shall be collected by the Director of Industrial Relations pursuant to Section 62.6 of the Labor Code. The Fraud Assessment Commission shall annually advise the Director of Industrial Relations, not later than March 15, of the aggregate amount to be assessed for the next fiscal year.

(4) The amount collected, together with the fines collected for violations of the unlawful acts specified in Sections 1871.4, 11760, and 11880, and Section 549 of the Penal Code, shall be deposited in the Workers' Compensation Fraud Account in the Insurance Fund, which is hereby created, and may be used, upon appropriation by the Legislature, only for enhanced workers' compensation fraud investigation and prosecution as provided in this section.

(c) For each fiscal year, the total amount of revenues derived from the assessment pursuant to subdivision (b) shall, together with amounts collected pursuant to fines imposed for unlawful acts described in Sections 1871.4, 11760, and 11880, and Section 549 of the Penal Code, not be less than three million dollars (\$3,000,000). Any funds appropriated by the Legislature pursuant to subdivision (b) that are not expended in the fiscal year for which they have been appropriated, and that have not been allocated under subdivision (f), shall be applied to satisfy for the immediately following fiscal year the minimum total amount required by this subdivision. In no case may that money be transferred to the General Fund.

(d) After incidental expenses, 50 at least 40 percent of the funds to be used for the purposes of this section shall be provided to the Bureau of Fraudulent Claims of the Department of Insurance for enhanced investigative efforts and 50 at least 40 percent of the funds shall be distributed to district attorneys, pursuant to a determination by the commissioner with the advice and consent of the bureau and the Fraud Assessment Commission, as to the most effective distribution of moneys for purposes of the investigation and prosecution of workers' compensation insurance fraud cases. Each district attorney seeking a portion of the funds shall submit to the commissioner an application setting forth in detail the proposed use of any funds provided. A district attorney receiving funds pursuant to this subdivision shall submit an annual report to the commissioner with respect to the success of his or her efforts. Upon receipt, the commissioner shall provide copies to the bureau and the Fraud Assessment Commission of any application, annual report, or other documents with respect to the allocation of money pursuant to this subdivision. ~~These documents shall be public records.~~ **Both the application for moneys and the distribution of moneys shall be public documents. Information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.**

(e) If a district attorney is determined by the commissioner to be unable or unwilling to investigate and prosecute workers' compensation fraud claims, the commissioner shall discontinue distribution of funds allocated for that county and may redistribute those funds according to this subdivision.

(1) The commissioner shall promptly determine whether any other county could assert jurisdiction to prosecute the fraud claims that would have been brought in the nonparticipating county, and if so, the commissioner may award funds to conduct the prosecutions redirected pursuant to this subdivision. These funds may be in addition to any other fraud prosecution funds otherwise awarded under this section. Any district attorney receiving funds pursuant to this subdivision shall first agree that the funds shall be used solely for investigating and prosecuting those cases of workers' compensation fraud redirected pursuant to this subdivision and submit an annual report to the commissioner with respect to the success of the district attorney's efforts. The commissioner shall keep the Fraud Assessment Commission fully informed of all reallocations of funds under this paragraph.

(2) If the commissioner determines that no district attorney is willing or able to investigate and prosecute the workers' compensation fraud claims arising in the nonparticipating county, the commissioner, with the advice and consent of the Fraud Assessment Commission, may award to the Attorney General some or all of the funds previously awarded to the nonparticipating county. Before the commissioner may award any funds, the Attorney General shall submit to the commissioner an application setting forth in detail his or her proposed use of any funds provided and agreeing that any funds awarded shall be used solely for investigating and prosecuting those cases of workers' compensation fraud redirected pursuant to this

subdivision. The Attorney General shall submit an annual report to the commissioner with respect to the success of the fraud prosecution efforts of his or her office.

(3) Neither the Attorney General nor any district attorney shall be required to relinquish control of any investigation or prosecution undertaken pursuant to this subdivision unless the commissioner determines that satisfactory progress is no longer being made on the case or the case has been abandoned.

(4) No county that has become a nonparticipating county due to the inability or unwillingness of its district attorney to investigate and prosecute workers' compensation fraud shall become eligible to receive funding under this section until it has submitted a new application that meets the requirements of subdivision (d) and the applicable regulations.

(f) If in any fiscal year the Bureau of Fraudulent Claims does not use all of the funds made available to it under subdivision (d), any remaining funds may be distributed to district attorneys pursuant to a determination by the commissioner in accordance with the same procedures set forth in subdivision (d).

(g) The commissioner shall adopt rules and regulations to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Included in the rules and regulations shall be the criteria for redistributing funds to district attorneys and the Attorney General. The adoption of the rules and regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare.

(h) The department shall report on an annual basis to the Legislature and the Fraud Assessment Commission on the activities of the Bureau of Fraudulent Claims and local district attorneys supported by the funds provided by this section.

The annual report shall include, but is not limited to, all of the following information for the department and each district attorney's office:

- (1) All allocations, distributions, and expenditures of funds.
- (2) The number of search warrants issued.
- (3) The number of arrests, and prosecutions, and the aggregate number of parties involved in each.
- (4) The number of convictions, and names of all convicted fraud perpetrators.
- (5) The estimated value of all assets frozen, penalties assessed, and restitutions made for each conviction.

(6) Any additional items necessary to fully inform the Fraud Assessment Commission and the Legislature of the fraud-fighting efforts financed through this section.

(i) In order to meet the requirements of subdivision (g), the department shall submit a biannual information request to those district attorneys who have applied for and received funding through the annual assessment process under this section.

(j) Assessments levied or collected to fight workers' compensation fraud and insurance fraud are not taxes. Those funds are entrusted to the state to fight fraud by funding state and local investigation and prosecution efforts. Accordingly, any funds resulting from assessments, fees, penalties, fines, restitution, or recovery of costs of investigation and prosecution deposited in the Insurance Fund shall not be deemed "unexpended" funds for any purpose and, if remaining in that account at the end of any fiscal year, shall be applied as provided in subdivision (f) and to offset or augment subsequent years' program funding.

(Amended by Stats. 1997, C. 99 (A.B. 1004) and C. 364 (A.B. 349) Effective January 1, 1998.)

**§11735 FILING OF RATES, RATING PLANS, AND SUPPLEMENTARY RATE INFORMATION; REPORT AND RECORD OF LOSSES**

(a) Every insurer shall file with the commissioner all rates, rating plans, and supplementary rate information which ~~which~~ **that** are to be used in this state. The rates and supplementary information shall be filed not later than 30 days prior to the effective date. If the commissioner finds, after a hearing, that an insurer's rates require closer supervision because of the insurer's financial condition, as determined pursuant to Section 11733, the insurer shall file with the commissioner at least 30 days before the effective date, all of those rates and the supplementary rate information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

(b) Rates filed pursuant to this section shall be filed in the form and manner prescribed by the commissioner. All rates, supplementary information and any supporting information for rates filed under this article shall, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge.

(c) Upon the written application of the insurer and insured, stating its reasons therefor, filed with the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

(d) Notwithstanding Section 679.70, no rating organization may issue nor may any insurer use any classification system or rate, as applied or used, that violates Section 679.71 or 679.72 or that violates the Unruh Civil Rights Act.

(e) Notwithstanding Sections 11657 to 11660, inclusive, a rating plan or supplementary rate information filed with the commissioner for purposes of offering deductibles to policyholders for all or part of benefits payable under the policy shall be deemed complete if the filing contains the following:

(1) A copy of the deductible endorsement that is to be attached to the policy to effectuate deductible coverage.

(2) Endorsement language that protects the rights of injured workers and ensures that benefits are paid by the insurer without regard to any deductible. The endorsement shall specify that the nonpayment of deductible amounts by the policyholder shall not relieve the insurer from payment of compensation for injuries sustained by the employee during the period of time the endorsed policy was in effect. The endorsement shall provide that deductible policies for workers' compensation insurance coverage shall not be terminated retroactively for nonpayment of deductible amounts.

(3) The endorsement shall provide that notwithstanding the deductible, the insurer shall pay all the obligations of the employer for workers' compensation benefits for injuries occurring during the policy period. Payment by the insurer of any amounts within the deductible shall be treated as an advancement of funds by the insurer to the employer and shall create a legal obligation for reimbursements, and may be secured by appropriate security.

(4) The endorsement shall specify whether loss adjustment expenses are to be treated as advancements within the deductible to be reimbursed by the employer.

(5) An explanation of premium reductions reflecting the type and level of the deductible will be clearly set forth for the policyholder.

(6) The filing shall provide that premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount, and the premium reductions reflect the type and level of deductible consistent with accepted actuarial standards.

(7) The filing shall provide that nonpayment of deductible amounts by the insured employer to its insurer, or failure to comply with any security-related terms of the policy, shall be treated under the policy in the same manner as payment or nonpayment of premium pursuant to paragraph (1) of subdivision (b) of Section 676.8.

(f) The insurer shall report and record losses subject to the deductible as losses for purposes of ratemaking and application of the an experience rating plan on the same bases as losses under policies providing first dollar coverage.

(Amended by Stats. 1997, C. 748 (S.B. 1217). Effective January 1, 1998.)

**§11736 EXPERIENCE RATING PLAN; CONTENTS**

The An experience rating plan shall contain reasonable eligibility standards, provide adequate incentives for loss prevention, and shall provide for sufficient premium differentials so as to encourage safety.

(Amended by Stats. 1997, C. 748 (S.B. 1217). Effective January 1, 1998.)

**§11737 DISAPPROVAL OF RATES BY COMMISSIONER; HEARINGS; PERSONS AGGRIEVED BY APPLICATION OF FILINGS; HEARINGS UPON WRITTEN REQUEST; APPEAL TO COMMISSIONER; ORDER FOR DISCONTINUANCE; INTERIM RATES**

(a) The commissioner may disapprove a rate if the insurer fails to comply with the filing requirements under Section 11735.

(b) If the commissioner believes that rates may violate any of the requirements of this article, he or she shall call a hearing prior to any disapproval. The commissioner shall disapprove a rate if he or she finds that the rate would, if continued in use, tend to impair or threaten the solvency of an insurer or tend to create a monopoly in the market pursuant to Section 11732.

(c) Every insurer or rating organization shall provide within this state reasonable means whereby any person aggrieved by the application of its filings may be heard on written request to review the manner in which the rating system has been applied in connection with the insurance afforded or offered. If the insurer or rating organization fails to grant or reject the request within 30 days, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the insurer or rating organization on the request may, within 30 days after written notice of the action, appeal to the commissioner who, after a hearing held upon within 60 days from the date on which the party requests the appeal, or longer upon agreement of the parties and not less than 10 days' written notice to the appellant and to the insurer or rating organization, may affirm, modify, or reverse such that action. If the commissioner has information on the subject from which the appeal is taken and believes that a reasonable basis for the appeal does not exist or that the appeal is not made in good faith, the commissioner may deny the appeal without a hearing. The denial shall be in writing and shall set for the basis for the denial and shall be served on all parties.

(d) If the commissioner disapproves a rate, the commissioner shall issue an order specifying in what respects it fails to meet the requirements of this article and stating when within a reasonable period thereafter such that rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within 30 days after the close of the hearing or

within such reasonable time extension as the commissioner may fix. The order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on that date.

(e) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request of the insurer specify interim rates for the insurer that are adequate to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him or her. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds of less than ten dollars (\$10) per policyholder shall not be required.

(Amended by Stats. 1997, C. 517 (A.B. 877) Effective January 1, 1998)

**§11751.8 CORRECTIONS OR REVISIONS OF LOSSES; REPORT TO RATING ORGANIZATION**

An insurer shall report to its rating organization as corrections or revisions of losses, pursuant to the unit statistical plan and uniform experience rating plan approved by the commissioner, if any of the following is applicable:

(a) A loss record detail was incorrectly reported through mistake other than error of judgment.

(b) One or more claims are declared noncompensable. A claim is declared noncompensable if any of the following applies:

(1) There is an official ruling specifically holding that a claimant is not entitled to benefits under the workers' compensation laws of the state, even though the claimant may have been awarded reimbursement for expenses incurred by the claimant in presenting the case.

(2) No claim was filed during the period of limitation provided by the workers' compensation laws for the filing of the claim, and the carrier, therefore, closes the claim.

(3) Where the carrier contends, prior to the valuation date, that a claimant is not entitled to benefits under the workers' compensation laws and the claim is officially closed because of the claimant's failure to prosecute the claim.

(c) The carrier has recovered in an action against a third party.

(d) A death claim has been compromised over the sole issue of the applicability of the workers' compensation laws of the state.

(e) The exposure has been reassigned to another classification through the revision of an audit, in which case the insurer shall file with the revision of exposure a revision of losses that will reassign all claims to the appropriate classification.

(f) A clerical error in either the classification assignment or the type of injury assignment of a given claim, or a group of claims, has been discovered by the insurer.

(g) A clerical error in either the classification assignment or the type of injury assignment of a given claim has been discovered by the rating organization. The insurer shall, when notified by the rating organization, file a revision of losses or make satisfactory explanation.

(h) A correction is made in a classification assignment of a given claim, or a group of claims, as a result of the organization test audit of an insured for which the experience has been submitted.

(i) The claim has been determined to be a joint coverage claim in accordance with the unit statistical plan approved by the commissioner.

~~(j) The claim has closed for 60 percent or less of its highest reported incurred value.~~

(Amended by Stats. 1997, C. 748 (S.B. 1217). Effective January 1, 1998.)

**§11751.9 REVISION OF EXPERIENCE RATINGS**

Whenever a claim or claims used in an experience rating are closed and reported pursuant to the unit statistical plan approved by the commissioner and are valued, in the aggregate, at an amount that is less than 60 percent of the highest reported aggregate value of all of these claims, then the experience rating shall be revised pursuant to the uniform experience rating plan approved by the commissioner based on the most current reported values for all claims used in the experience rating.

(Added by Stats. 1997, C. 748 (S.B. 1217). Effective January 1, 1998.)

**§11753.1 REQUESTS FOR CONSIDERATION OF ORGANIZATION'S DECISION OR ACTION; APPEALS TO COMMISSIONER; NOTIFICATIONS OF EMPLOYER CLASSIFICATION ASSIGNMENT CHANGES**

(a) Any person aggrieved by any decision, action, or omission to act of a rating organization may request that the rating organization reconsider the decision, action, or omission. If the request for reconsideration is rejected or is not acted upon within 30 days by the rating organization, the person requesting

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reconsideration may, within a reasonable time, appeal from the decision, action, or omission of the rating organization. The appeal shall be made to the commissioner by filing a written complaint and request for a hearing specifying the grounds relied upon. If the commissioner has information on the subject appealed from and believes that probable cause for the appeal does not exist or that the appeal is not made in good faith, the commissioner may deny the appeal without a hearing. The commissioner shall otherwise hold a hearing to consider and determine the matter presented by the appeal.

(b) Any insurer adopting a change in the classification assignment of an employer that results in an increased premium shall notify the employer in writing, or where the insurance was transacted through an insurance agent or broker, the insurer shall notify the agent or broker who shall notify the employer in writing of the change and the reasons for the change. Any employer receiving this notice shall have the right to request reconsideration and appeal the reclassification pursuant to this section. The notice required by this section shall inform the employer of his or her rights pursuant to this section. No notification shall be required when the change is a result of a regulation adopted by the Department of Insurance or other action by or under the authority of the commissioner.

An insurer shall provide written notification of the revised classification assignment to an employer within 30 days after adoption.

**(c) On or before January 1, 1999, the commissioner shall adopt regulations to implement the appeals processes set forth in this section and subdivision (c) of Section 11737 and consolidate these processes into the appropriate section of the administrative regulations governing the powers and duties of the commissioner.**

(Amended by Stats. 1997, C. 517 (A.B. 877) Effective January 1, 1998)

**§138.6 Development of Workers' Compensation Information System.**

(a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a **cost-efficient** workers' compensation information system, ~~to do the following:~~ **which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.**

(b) The information system shall do the following:

~~(a)~~(1) Assist the department to manage the workers' compensation system in an effective and efficient manner.

~~(b)~~(2) Facilitate the evaluation of the efficiency and effectiveness of the benefit delivery system.

~~(c)~~(3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.

~~(d)~~(4) Provide statistical data for research into specific aspects of the workers' compensation program.

~~(c)~~ It is the intent of the Legislature that the information system **The data collected electronically shall** be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. The director shall issue a report on the development of the system, and recommendations for any necessary legislative action, no later than July 1, 1995, and shall, upon request, make the report available to the Governor, the Legislature, and the public.

(Amended by Stats. 1997, C. 641 (S.B. 450). Effective January 1, 1998.)

**§138.7. Workers' Compensation Confidential Information;  
Precluded Access and Exceptions**

**(a) Except as expressly permitted in subdivision (b), a person or public or private entity not a party to a claim for workers' compensation benefits may not obtain individually identifiable information obtained or maintained by the division on that claim. For purposes of this section, "individually identifiable information" means any data concerning an injury or claim that is linked to a uniquely identifiable employee, employer, claims administrator, or any other person or entity.**

**(b) (1) The administrative director, or a statistical agent designated by the administrative director, may use individually identifiable information for purposes of creating and maintaining the workers' compensation information system as specified in Section 138.6.**

(2) The State Department of Health Services may use individually identifiable information for purposes of establishing and maintaining a program on occupational health and occupational disease prevention as specified in Section 105175 of the Health and Safety Code.

(3) Individually identifiable information may be used by the Division of Workers' Compensation, the Division of Occupational Safety and Health, and the Division of Labor Statistics and Research as necessary to carry out their duties. The administrative director shall adopt regulations governing the access to the information described in this subdivision by these divisions. Any regulations adopted pursuant to this subdivision shall set forth the specific uses for which this information may be obtained.

(4) The administrative director shall adopt regulations allowing reasonable access to individually identifiable information by other persons or public or private entities for the purpose of bona fide statistical research. This research shall not divulge individually identifiable information concerning a particular employee, employer, claims administrator, or any other person or entity. The regulations adopted pursuant to this paragraph shall include provisions guaranteeing the confidentiality of individually identifiable information.

(5) This section shall not operate to exempt from disclosure any information that is considered to be a public record pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) contained in an individual's file once an application for adjudication has been filed pursuant to Section 5501.5 of the Labor Code.

(c) Except as provided in subdivision (b), individually identifiable information obtained by the division is privileged and is not subject to subpoena in a civil proceeding unless, after reasonable notice to the division and a hearing, a court determines that the public interest and the intent of this section will not be jeopardized by disclosure of the information. This section shall not operate to restrict access to information by any law enforcement agency or district attorney's office or to limit admissibility of that information in a criminal proceeding.

(d) It shall be unlawful for any person who has received individually identifiable information from the division pursuant to this section to provide that information to any person who is not entitled to it under this section.

(Added by Stats. 1997, C. 674 (S.B. 1141). Effective January 1, 1998.)

**§139.5 Vocational Rehabilitation Unit - Created, Duties, Salaries  
Disability Indemnity Payments, Maintenance Allowance**

(a) The administrative director shall establish a vocational rehabilitation unit, which shall include appropriate professional staff, and which shall have the following duties:

(1) To foster, review, and approve vocational rehabilitation plans developed by a qualified rehabilitation representative of the employer, insurer, state agency, or employee. Plans agreed to by the employer and employee do not require approval by the vocational rehabilitation unit unless the employee is unrepresented.

(2) To develop rules and regulations, to be promulgated by the administrative director, providing for a procedure in which an employee may waive the services of a qualified rehabilitation representative where the employee has been enrolled and made substantial progress toward completion of a degree or certificate from a community college, California State University, or the University of California and desires a plan to complete the degree or certificate. These rules and regulations shall provide that this any such waiver as well as any plan developed without the assistance of a qualified rehabilitation representative must be approved by the rehabilitation unit.

(3) To develop rules and regulations, to be promulgated by the administrative director, which would expedite and facilitate the identification, notification and referral of industrially injured employees to vocational rehabilitation services.

(4) To coordinate and enforce the implementation of vocational rehabilitation plans.

(5) To develop a fee schedule, to be promulgated by the administrative director, governing reasonable fees for vocational rehabilitation services provided on and after January 1, 1991. The initial fee schedule promulgated under this paragraph shall be designed to reduce the cost of vocational rehabilitation services by 10 percent from the level of fees paid during 1989. On or before July 1, 1994, the administrative director shall establish the maximum aggregate permissible fees that may be charged for counseling. Those fees shall not exceed four thousand five hundred dollars (\$4,500) and shall be included within the sixteen thousand dollar (\$16,000) cap. The fee schedule shall permit up to (A) three thousand dollars (\$3,000) for vocational evaluation, evaluation of vocational feasibility, initial interview, vocational testing, counseling and research for plan development, and preparation of the Division of Workers' Compensation Form 102, and (b) three thousand five hundred dollars (\$3,500) for plan monitoring, job seeking skills, and job placement research and counseling. However, in no event shall the aggregate of (A) and (B) exceed four thousand five hundred dollars (\$4,500). ~~establish maximum aggregate permissible fees for evaluation, plan development, and job placement services.~~

(6) To develop standards, to be promulgated by the administrative director, for governing the timeliness and the quality of vocational rehabilitation services.

(b) The salaries of the personnel of the vocational rehabilitation unit shall be fixed by the Department of Personnel Administration.

(c) When an employee is determined to be medically eligible and chooses to participate in a vocational rehabilitation program, he or she shall continue to receive temporary disability indemnity payments only until his or her medical condition becomes permanent and stationary and, thereafter, may receive a maintenance allowance. Rehabilitation maintenance allowance payments shall begin after the employee's medical condition becomes permanent and stationary, upon a request for vocational rehabilitation services. Thereafter, the maintenance allowance shall be paid for a period not to exceed 52

weeks in the aggregate, except where the overall cap on vocational rehabilitation services can be exceeded under this section or Section 4642 or subdivision (d) or (e) of Section 4644.

The employee also shall receive additional living expenses necessitated by the vocational rehabilitation services, together with all reasonable and necessary vocational training, at the expense of the employer, but in no event shall the expenses, counseling fees, training, maintenance allowance, and costs associated with, or arising out of, vocational rehabilitation services incurred after the employee's request for vocational rehabilitation services, except temporary disability payments, exceed sixteen thousand dollars (\$16,000). The administrative director shall adopt regulations to ensure that the continued receipt of vocational rehabilitation maintenance allowance benefits is dependent upon the injured worker's regular and consistent attendance at, and participation in, his or her vocational rehabilitation program.

(d) The amount of the maintenance allowance due under subdivision (c) shall be two-thirds of the employee's average weekly earnings at the date of injury payable as follows:

(1) The amount the employee would have received as continuing temporary disability indemnity, but not more than two hundred forty-six dollars (\$246) a week for injuries occurring on or after January 1, 1990.

(2) At the employee's option, an additional amount from permanent disability indemnity due or payable, sufficient to provide the employee with a maintenance allowance equal to two-thirds of the employee's average weekly earnings at the date of injury subject to the limits specified in subdivision (a) of Section 4453 and the requirements of Section 4661.5. In no event shall temporary disability indemnity and maintenance allowance be payable concurrently.

If the employer disputes the treating physician's determination of medical eligibility, the employee shall continue to receive that portion of the maintenance allowance payable under paragraph (1) pending final determination of the dispute. If the employee disputes the treating physician's determination of medical eligibility and prevails, the employee shall be entitled to that portion of the maintenance allowance payable under paragraph (1) retroactive to the date of the employee's request for vocational rehabilitation services. These payments shall not be counted against the maximum expenditures for vocational rehabilitation services provided by this section.

(e) No provision of this section nor of any rule, regulation, or vocational rehabilitation plan developed or promulgated under this section nor any benefit provided pursuant to this section shall apply to an injured employee whose injury occurred prior to January 1, 1975. Nothing in this section shall affect any plan, benefit, or program authorized by this section as added by Chapter 1513 of the Statutes of 1965 or as amended by Chapter 83 of the Statutes of 1972.

(f) The time within which an employee may request vocational rehabilitation services is set forth in Sections 5405.5, 5410, and 5803.

(g) An offer of a job within state service to a state employee in State Bargaining Unit 1, 4, 15, 18, or 20 at the same or similar salary and the same or similar geographic location is a prima facie offer of vocational rehabilitation under this statute.

(h) It shall be unlawful for a qualified rehabilitation representative or rehabilitation counselor to refer any employee to any work evaluation facility or to any education or training program if the qualified rehabilitation representative or rehabilitation counselor, or a spouse, employer, coemployee, or any party with whom he or she has entered into contract, express or implied, has any proprietary interest in or contractual relationship with the work evaluation facility or education or training program. It shall also be unlawful for any insurer to refer any injured worker to any rehabilitation provider or facility if the insurer has a proprietary interest in the rehabilitation provider or facility or for any insurer to charge against any claim for the expenses of employees of the insurer to provide vocational rehabilitation services unless those expenses are disclosed to the insured and agreed to in advance.

(i) Any charges by an insurer for the activities of an employee who supervises outside vocational rehabilitation services shall not exceed the vocational rehabilitation fee schedule, and shall not be counted against the overall cap for vocational rehabilitation or the limit on counselor's fees provided for in this section. These charges shall be attributed as expenses by the insurer and not losses for purposes of insurance rating pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Division 2 of the Insurance Code.

(j) Any costs of an employer of supervising vocational rehabilitation services shall not be counted against the overall cap for vocational rehabilitation or the limit on counselor's fees provided for in this section.

(Amended by Stats. 1997, C. 256 (A.B. 237) Effective January 1, 1998.)

### **§3209.3 Physician, Psychologist - Defined**

(a) "Physician" includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(b) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting, or has met the standards of the National Register of the Health Service Providers in Psychology.

(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under Section 2708 of the Unemployment Insurance Code.

~~(f) The administrative director shall evaluate the participation of acupuncturists in the medical treatment of workers' compensation cases and shall report his or her findings to the Legislature on or before December 31, 1995.~~

~~(g) This section shall remain in effect until January 1, 1999, and as of that date is repealed.~~

(Amended by Stats. 1997, C. 98 (S.B. 212), Effective January 1, 1998.)

**§3209.3 Physician, Psychologist - Defined**

~~(a) "Physician" includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.~~

~~(b) "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting, or has met the standards of the National Register of the Health Service Providers in Psychology.—~~

~~(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.~~

~~(d) This section shall be operative on January 1, 1999.~~

(Repealed by Stats. 1997, C. 98 (S.B. 212), Effective January 1, 1998.)

**§3209.9 Acupuncturists - Misrepresentation by**

The inclusion of acupuncturists in Section 3209.3 does not imply any right or entitle any acupuncturist to represent, advertise, or hold himself or herself out as a physician or surgeon holding an M.D. or D.O. degree .

(Added by Stats. 1997, C. 98 (S.B. 212), Effective January 1, 1998.)

**§4600.5. Application for Certification as Health Care Organization; Charges for services; Revocation of Certification; Chiropractic care.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) ~~If the health care organization is a workers' compensation health care provider organization authorized by the Department of Corporations,~~ **insurer, third-party administrator, or any other entity that the administrative director determines to meet the requirements of Section 4600.6, the administrative director** shall certify the plan organization to provide health care pursuant to Section 4600.3 if the director finds that ~~the plan is in good standing with the Department of Corporations, and it meets the following additional requirements:~~

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

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

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

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Corporations in compliance with Section 54 and Part 3.2 (commencing with Section 5150) relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, **advertising, disclosure, medical and financial audits, and grievance systems,** upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

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

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

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

(7) Complies with the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(k)~~(l)(1) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a

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

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

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

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

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

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

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

(Amended by Stats. 1997, C. 346 (S.B.1063). Effective January 1, 1998.)

§4600.6 Application for Health Care Organization Certification by  
Workers' Compensation Insurer, Third-Party Administrator,  
or Other Entity

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 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.

(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 race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age 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.

(1) 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

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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.

(Added by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

#### **§4644 - Termination of Employer's Liability for Services**

(a) The liability of the employer for vocational rehabilitation services shall terminate when any of the following events occur:

(1) An employee who has received notice of potential eligibility to participate in a rehabilitation plan under Section 4637 declines vocational rehabilitation services in the form and manner prescribed by the administrative director.

(2) A qualified injured worker completes a vocational rehabilitation plan except as otherwise provided in subdivisions (c) and (d).

(3) The qualified injured worker unreasonably failed to complete a vocational rehabilitation plan.

(4) An employee has not requested vocational rehabilitation services within 90 days of the notification that the employee is medically eligible for vocational rehabilitation services. The liability of the employer for vocational rehabilitation services shall not terminate under this paragraph unless the employer, not earlier than 45 days nor later than 70 days after the employee's receipt of the notice required by Section 4637, reminds the employee of his or her right to vocational rehabilitation services or until the 21st day after the employee receives the reminder notification. The reminder notification shall be in writing, in the form and manner prescribed by the administrative director, and shall be served by certified mail. The provisions of this paragraph shall not apply if the employee shows he or she was unable to comprehend the consequences of failing to timely request vocational rehabilitation services, or that, because of conditions beyond the control of the employee, the employee was unable to exercise his or her right to accept or decline vocational rehabilitation services.

(5) The employer offers, and the employee accepts or rejects, in the form and manner prescribed by the administrative director, modified work lasting at least 12 months, provided that an employer who offers modified work that is available for the 12-month period required by this paragraph meets the requirements of this paragraph even if the employee voluntarily quits prior to the end of that 12-month period.

(6) The employer offers and the employee accepts or rejects, in the form and manner prescribed by the administrative director, alternative work meeting all of the following conditions:

(A) The employee has the ability to perform the essential functions of the job provided.

(B) The job provided is in a regular position lasting at least 12 months. An employer who offers alternative work that is available for the 12-month period required by this paragraph meets the requirements of this paragraph even if the employee voluntarily quits prior to the end of the 12-month period.

(C) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(D) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

(7) The employer offers, and the employee accepts, in the form and manner prescribed by the administrative director, work not meeting

the conditions of paragraph (5) or (6) provided that the work lasts at least 12 months. The employee shall be required to reject the offer, in the form and manner prescribed by the administrative director, in order for the employee to be eligible for vocational rehabilitation services. An employer who offers work that is available for the 12-month period meets the requirements of this paragraph, even if the employee voluntarily quits prior to the end of that 12-month period.

(b) Nothing in this article shall preclude the deferral or interruption of vocational rehabilitation services upon agreement of the employee and employer or, if no agreement can be reached, upon a good cause determination by the administrative director.

(c)(1) Except as provided in this section, vocational rehabilitation plans prepared pursuant to Section 4638 shall be limited to one plan per injured worker. The plans shall be completed within an 18-month period after approval of the plan, and. The plan shall not include a period of job placement exceeding 60 days, unless the plan is exclusively utilizing transferable skills and experience for direct placement activities. In these cases, the period of job placement may be up to 90 days.

(2) The employee shall be entitled to one additional vocational rehabilitation plan only if the original plan is determined to be inappropriate due to one of the following:

(1)(A) The employee's disability has deteriorated to the point where the worker is unable to meet the physical demands of the first plan.

(2)(B) The first plan is disrupted due to circumstances beyond the control of the employee.

(3)(C) Failure by the employer to provide timely service required by this article and the vocational rehabilitation plan when the plan has not been completed.

The cost of the original and the additional plan plus all other vocational rehabilitation costs shall not exceed the overall cap and the counselor fee cap established in subdivision (c) of Section 139.5.

(d) Notwithstanding subdivision (c), an employee may apply to the rehabilitation unit for approval of a second vocational rehabilitation plan which exceeds the overall cap provided for in subdivision (c) of Section 139.5 if all of the following conditions are met:

(1) The employee has a permanent disability rating of 25 percent or greater. In reaching this determination, the rehabilitation unit shall consider any treating physicians' reports.

(2) The first plan cannot be completed due to circumstances beyond the control of the employee. Those circumstances include the deterioration of the employee's disability to the point where the worker cannot meet the requirements of the first plan.

(3) The rehabilitation unit finds that a second plan is necessary to provide the employee the opportunity for suitable gainful employment. Approval for circumstances other than a change in the employee's disability must be based on objective and verifiable facts pursuant to rules promulgated by the administrative director.

However, in no case shall the cost solely attributable to the second plan exceed the overall cap and the counseling fee cap contained in subdivision (c) of Section 139.5.

(e) Notwithstanding subdivision (c), an employee may receive a second vocational rehabilitation plan that exceeds the overall cap provided for in subdivision (c) of Section 139.5 if the rehabilitation unit finds that the employee cannot complete the plan because the school or other training facility has closed or the worker has a sudden and unexpected change in disability that renders the plan inappropriate or other similar circumstances.

(f) Notwithstanding paragraph (2) of subdivision (a), if a qualified injured worker returns to modified or alternative work with the same employer or to work with a different employer as a result of direct job placement assistance and that employment terminates, other than for cause, within 12 months of the date the employee was employed at the modified or alternative work, and if that work is unavailable in the labor market, the employer shall be liable, subject to Section 4642, for additional vocational rehabilitation services, provided that the employer's liability for vocational rehabilitation services shall terminate if the employee voluntarily quits prior to the end of that 12-month period. To qualify for additional vocational rehabilitation services, the employee shall demonstrate an inability to compete for suitable gainful employment with his or her existing skills.

(g) An employer shall not be liable to provide vocational rehabilitation services at a location outside the state, unless upon agreement of the employer and the employee, or a determination by the Division of Workers' Compensation that those services are more cost-effective than similar services provided in the state.

(Amended by Stats. 1997, C. 256 (A.B. 237) Effective January 1, 1998.)

**~~§5150. Title of Part~~**

~~— This part shall be known and may be cited as the Workers' Compensation Health Care Provider Organization Act of 1993.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

**~~§5151. Enforcement of part; references~~**

~~— Responsibility for the administration and enforcement of this part is vested in the Commissioner of Corporations. All references to commissioner in this part shall be references to the Commissioner of Corporations and all references to department shall be references to the Department of Corporations.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

**~~§5152. Legislative Intent~~**

~~— It is the intent of the Legislature that workers' compensation health care provider organizations be subject only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.~~

~~— This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the above-described groups, any person who is lawfully qualified to~~

~~perform the services to be performed by the members of the group, where the ground for exclusion is failure to possess the same license or certification as is possessed by the members of the group.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

**~~§5153. Comissioner to consult with director to ensure consistency in adopted regulations relating to workers' compensation health care~~**

~~— The commissioner shall consult with the Director of the Department of Industrial Relations prior to the adoption of regulations applicable to workers' compensation health care provider organizations subject to this part for the purpose of ensuring, to the extent practical, that there is consistency of regulations adopted by the director and the Commissioner of Corporations.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

**~~§5154. Burden of providing exemption or exception~~**

~~— In any proceeding under this part, the burden of providing an exemption or an exception from a definition is upon the person claiming it.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5155. Commissioner's authority to adopt, amend, and rescind rules and orders, to honor requests, and to adopt emergency rules~~**

~~— (a) The commissioner may from time to time adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this part, including rules governing applications and reports, and defining any terms, whether or not used in this part, insofar as the definitions are not inconsistent with the provisions of this part. For the purpose of rules and forms, the commissioner may classify persons and matters within the commissioner's jurisdiction, and may prescribe different requirements for different classes. The commissioner may waive any requirement of any rule or form in situations where in the commissioner's discretion such requirement is not necessary in the public interest or for the protection of the public, persons, or organizations subject to this part.~~

~~— (b) The commissioner may honor requests from interested parties for interpretive opinions.~~

~~— (c) No provision of this part imposing any liability applied to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the commissioner, or any such opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be amended or rescinded or be determined by judicial or other authority to be invalid for any reason.~~

~~— (d) Notwithstanding the provisions of the Administrative Procedure Act, the Legislature has determined that an emergency exists, and that to promote the public interest, the commissioner is authorized to adopt emergency regulations. After the public comment period required by the Administrative Procedure Act, the Office of Administrative Law shall, immediately upon receiving the regulations adopted by the commissioner, file the regulations with the Secretary of State for immediate effectiveness.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5156. Definitions~~**

~~— As used in this part:~~

~~— (a) "Advertisement" means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of health care contracts.~~

~~— (b) "Authorize" means, and "authorized" refers to, an authorization as a workers' compensation health care provider organization pursuant to Section 5163. "Authorize" shall have no legal meaning outside of health care for occupational injuries or illnesses.~~

~~— (c) "Commissioner" means the Commissioner of Corporations.~~

~~— (d) "Disclosure form" means any certificate, agreement, contract, brochure, or other materials issued or otherwise disseminated to an employee and employer setting forth the workers' compensation health care, and terms of that care, as required to be provided by Sections 4600.3 and 4600.5 to which the employee is entitled.~~

~~— (e) "Employee" means an individual who has elected to receive workers' compensation health care from an authorized workers' compensation health care provider organization.~~

~~— (f) "Workers' compensation health care provider organization" or "organization" means a person organized to provide, either directly or indirectly, workers' compensation health care.~~

~~— (g) "Provider" means any professional person or other person licensed by the state to deliver or furnish workers' compensation health care.~~

~~— (h) "Person" means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.~~

~~— (i) "Service area" means a geographical area designated by the organization within which the organization shall provide workers' compensation health care.~~

~~— (j) "Solicitation" means any presentation or advertising conducted by, or on behalf of, an organization, where information regarding the organization, or workers' compensation health care offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the organization.~~

~~— (k) "Solicitor" means any person who engages in the acts defined in subdivision (j).~~

~~— (l) "Solicitor firm" means any person, other than an organization, who through one or more solicitors, engages in the acts defined in subdivision (k).~~

~~— (m) "Workers' compensation health care" or "health care" means those services, treatment, and care for work-related injuries required by this code.~~

~~— (n) All references in this part to financial statements, assets, liabilities, and other accounting items mean such financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters that they purport to present, subject to any specific requirement imposed by this part or by the commissioner.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

## ~~CHAPTER 2 — ADMINISTRATION~~

### ~~§5157. — Powers of commissioner~~

~~— The commissioner shall administer and enforce this part.~~

~~— The commissioner shall have the following powers:~~

~~— (a) Recommend and propose the enactment of any legislation necessary to protect and promote the interests of the public, subscribers, enrollees, and providers of workers' compensation health care in workers' compensation health care provider organizations in the State of California.~~

~~— (b) Provide information to federal and state legislative committees and executive agencies concerning organizations.~~

~~— (c) Assist, advise, and cooperate with federal, state, and local agencies and officials to protect and promote the interests of organizations, employees, and the public.~~

~~— (d) Study, investigate, research, and analyze matters affecting the interests of organizations, employees, and the public.~~

~~— (e) Hold public hearings, subpoena witnesses, take testimony, compel the production of books, papers, documents, and other evidence, and call upon other state agencies for information to implement the purposes of and to enforce this part.~~

~~— (f) Conduct audits and examinations of the books and records of organizations and other persons subject to this part, and may prescribe by rule or order the following:~~

~~— (1) The form and contents of financial statements required under this part.~~

~~— (2) The circumstances under which consolidated statements shall be filed.~~

~~— (3) The circumstances under which financial statements shall be audited by independent certified public accountants or public accountants.~~

~~— (g) Conduct necessary onsite medical surveys of the health care delivery system of each organization.~~

~~— (h) Propose, develop, conduct, and assist in educational programs for organizations, employees, and the public.~~

~~— (i) Promote and establish standards of ethical conduct for the administration of organizations and undertake activities to encourage responsibility in the promotion and sale of workers' compensation health care provider organization contracts and the enrollment of employees in the organizations.~~

~~— (j) Advise the Governor on all matters affecting the interests of organizations, employees, and the public.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

### **CHAPTER 3 - AUTHORIZATION**

#### **~~§5158. Workers' compensation health care provider organization must have authorization and certification; exceptions~~**

~~— It is unlawful for any person, other than a provider as defined by subdivision (g) of Section 5156 providing workers' compensation health care pursuant to a contract with an authorized and certified workers' compensation health care provider organization, but only when that provider renders health care pursuant to that contract, to engage in business as a workers' compensation health care provider organization in this state or to receive compensation or other consideration in connection with a workers' compensation health care provider organization from or on behalf of persons in this state unless such person has first secured from the commissioner and Administrative Director of the Department of Industrial Relations an authorization and certification, respectively, then in effect, as a workers' compensation health care provider organization to provide health care for work-related injuries under Sections 4600.3 and 4600.5, unless such person is (a) exempted by the provisions of subdivision (c) and (d) of Section 4600.5, or a provider, as defined by subdivision (h) of Section 1345 of the Health and Safety Code, providing health care services pursuant to a contract with a licensed health care service plan exempt under subdivision (c) of Section 4600.5, but only when that provider renders services pursuant to that contract; or a person providing health care services pursuant to a contract with an admitted disability insurer exempt under subdivision (d) of Section 4600.5, but only when that person renders services pursuant to that contract; or (b) engaging in any activities permitted by Section 4600 or exempted by a rule adopted thereunder.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

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**~~§5159. — Application for authorization requirements~~**

~~— Each application for authorization as an organization under this part shall be verified by an authorized representative of the applicant, and shall be in a form prescribed by the department. — Such application shall be accompanied by the fee prescribed by~~

~~subdivision (a) of Section 5166 and shall set forth or be accompanied by each and all of the following:~~

~~— (a) 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.~~

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

~~— (c) 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.~~

~~— (d) A copy of any contract made, or to be made, between the applicant and any provider of health care, or persons listed in subdivision (c), or any other person or organization agreeing to perform an administrative function or service for the plan. — The commissioner by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered to or to be rendered to such provider of health care services shall be deemed confidential information that shall not be divulged by the commissioner, except that such 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.~~

~~— (e) 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 of the Department of Industrial Relations under Sections 4600.3 and 4600.5.~~

~~—(f) A copy of the disclosure forms or materials which are to be issued to employees.~~

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

~~—(h) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, 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 such requirements as may be established by regulation of the commissioner.~~

~~—(i) 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.~~

~~—(j) A power of attorney duly executed by any applicant, not domiciled in this state, appointing the commissioner the true and lawful attorney in fact of such applicant in this state for the purposes of service of all lawful process in any legal action or proceeding against the organization on a cause of action arising in this state.~~

~~—(k) 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 commissioner.~~

~~—(l) A description of organization grievance procedures to be utilized as required by this part, and a copy of the form specified by subdivision (c) of Section 5178.~~

~~—(m) 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.~~

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

~~—(o) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the commissioner.~~

~~—(p) 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.~~

~~—(g) Such other information as the commissioner may reasonably require.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5160. — Additional requirement for application; authorization for disclosure of financial records~~

~~—In addition to the requirements of Section 5159 and upon request of the commissioner, each application shall be accompanied by authorization for disclosure to the commissioner of financial records of each organization authorized under this part pursuant to Section 7473 of the Government Code. For the purpose of this part, the authorization for disclosure shall also include the financial records of any association, partnership, or corporation controlling, controlled by, or otherwise affiliated with an organization.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5161. — Amendment to application; notice; fee~~

~~—(a) An authorized organization shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the commissioner may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the organization shall necessitate the filing, within a 30-day period, of an authorization for disclosure to the commissioner of financial records of the person pursuant to Section 7473 of the Government Code.~~

~~—(b) Prior to any material modification of its contracts or operations, an organization shall give notice thereof to the commissioner, who shall, within 20 business days or such additional time as the organization may specify, by order approve, disapprove, suspend, or postpone the effectiveness of any such change, subject to Section 5164.~~

~~—(c) An organization shall, within five days, give written notice to the commissioner in the form as by rule may be prescribed, of any change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the organization and of any management company of the organization, and of any parent company of the organization or management company. The commissioner may by rule define the positions, duties, and relationships which are referred to in this subdivision.~~

~~—(d) The fee for filing a notice of major modification pursuant to subdivision (b) shall be the actual cost to the commissioner of~~

processing the notice, including overhead, but shall not exceed seven hundred fifty dollars (\$750).

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**§5162. — ~~Entering new or modified contracts; restrictions~~**

— (a) ~~Except as provided in subdivision (b), no organization shall enter into any new or modified contract or publish or distribute, or allow to be published or distributed on its behalf, any disclosure form, unless (1) a true copy thereof has first been filed with the commissioner, at least 30 days prior to any such use, or any shorter period as the commissioner by rule or order may allow, and (2) the commissioner by notice has not found the contract, disclosure form, or evidence of coverage 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 at least 30 days or any shorter time as the commissioner by rule or order may allow.~~

— (b) ~~Except as provided in subdivision (c), an authorized organization which has been continuously authorized under this part for the preceding 18 months and which has had group contracts in effect at all times during that period may enter a new or modified contract or may publish or distribute, or allow to be published or distributed on its behalf, any disclosure form without having filed the same for the commissioner's prior approval, if the contracts and the materials comply with each of the following conditions:~~

— (1) ~~The contract, disclosure form, or any material provision thereof, has not been previously disapproved by the commissioner by written notice to the organization and the organization reasonably believes that the contract and disclosure form do not violate any requirements of this part or the rules thereunder.~~

— (2) ~~The organization files the contract and any related disclosure form with the commissioner not later than 10 business days after entering the contract, or within any additional period as the commissioner by rule or order may provide.~~

— (c) ~~The commissioner by order may require an organization which has entered any contract or published or distributed, or allowed to be published or distributed on its behalf, any disclosure form in violation of this part or the rules thereunder to comply with subdivision (a) prior to entering contracts and prior to publishing or distributing, or allowing to be published or distributed on its behalf, related disclosure forms. An order issued pursuant to this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the contracts or disclosure forms submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this part and the rules thereunder.~~

~~—(d) An authorized organization or other person regulated under this part may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the commissioner.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5163. — Acceptance or denial of application for authorization**~~

~~—(a) The commissioner shall issue an authorization to any person filing an application pursuant to this chapter, if the commissioner, upon due consideration of the application and of the information obtained in any investigation, including, if necessary, an onsite inspection, determines that the applicant has satisfied the provisions of this part and that, in the judgment of the commissioner, a disciplinary action pursuant to Section 5191 would not be warranted against such applicant. Otherwise, the commissioner shall deny the application.~~

~~—(b) Prior to the operative date of this part, an applicant may file an application for authorization on the first five business days of the fourth month prior to the operative date. The commissioner shall provide a written comment letter to the applicant within the 60-day period from the date of the filing of an application.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5164. — Notification of denial; right to a hearing**~~

~~—Upon denial of application for authorization, or the issuance of an order pursuant to Section 5161 disapproving, suspending, or postponing a material modification, the commissioner shall notify the applicant in writing, stating the reason for the denial and that the applicant has the right to a hearing if the applicant makes written request within 30 days after the date of mailing of the notice of denial. Service of the notice required by this subdivision may be made by certified mail addressed to the applicant at the latest address filed by the applicant in writing with the department.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5165. — Authorization in effect until revoked or suspended**~~

~~—Every organization's authorization issued under this part shall remain in effect until revoked or suspended by the commissioner.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5166. Reimbursement of application processing cost to  
 commissioner; obligation to pay share of administrative  
 expense; additional and special assessments~~

~~(a) Each organization applying for licensure under this part shall reimburse the commissioner for the actual cost of processing the application, including overhead, up to an amount not to exceed twelve thousand five hundred dollars (\$12,500). The cost shall be billed not more frequently than monthly and shall be remitted by the applicant to the commissioner within 30 days of the date of billing. The commissioner shall not issue a license to any applicant prior to receiving payment in full for all amounts charged pursuant to this subdivision.~~

~~(b) In addition to other fees and reimbursements required to be paid under this part, each organization authorized under this part shall pay to the commissioner an amount as estimated by the commissioner for the ensuing fiscal year, as a reimbursement of its share of all costs and expenses, including routine financial examinations, medical surveys, and overhead, reasonably incurred in the administration of this part and not otherwise recovered by the commissioner under this part or from the State Corporations Fund. The amount may be paid in two equal installments. The first installment shall be paid on or before July 1 of each year, and the second installment shall be paid on or before December 15 of each year.~~

~~(c) The amount paid by each organization shall be an amount calculated by multiplying a number which equals the ratio of the gross revenues of the organization attributable to the provisions of workers' compensation health care as of the preceding March 31 to the total gross revenues attributable to the provision of workers' compensation health care of all of those organizations for the same period multiplied by the total assessment for the ensuing year. An additional assessment shall be imposed during the first four years to pay back the initial loan to the Department of Corporations for implementation of this act. The assessment shall be fixed by the commissioner by notice to all organizations authorized under this part on or before May 15 of each year.~~

~~In determining the amount assessed, the commissioner shall consider all appropriations from the State Corporations Fund for the support of this part and all reimbursements provided for in this part.~~

~~(d) In no case shall the reimbursement, payment, or other fee authorized by this section exceed the cost, including overhead, reasonably incurred in the administration of this part.~~

~~(e) During the first 12 months after the operative date of this part, the commissioner may levy a special assessment at the end of the first six months from the operative date to cover unanticipated costs of administration of this part, over and above the initial~~

~~appropriation from the General Fund as provided for in this chapter. The assessment shall be calculated pursuant to subdivision (c) and shall be paid by the organization within 30 days of notice of the assessment. Funds deposited in the State Corporations Fund from this special assessment shall be immediately appropriated from that fund to the commissioner for the support of this part.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5167. — Assessment and adjustment of charges if previous year's assessments exceed or fall short of amount necessary to meet expenses~~

~~—Notwithstanding subdivision (c) of Section 4876, if the commissioner determines that the charges and assessments set forth in this part for any year are in excess of the amount necessary, or are insufficient, to meet the expenses of administration of this part, for that year, the assessments and charges for the following year shall be adjusted on a pro rata basis in accordance with the percentage of the excess or insufficiency as related to the actual charges and assessments for the year for which the excess or insufficiency occurred, in order to recover the actual costs of administration.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**CHAPTER 4 — SOLICITORS**

~~§5168. — Solicitors to meet standards set by commissioner~~

~~(a) The commissioner may require that solicitors and solicitor firms, and principal persons engaged in the supervision of solicitation for organizations of solicitor firms, meet such reasonable and appropriate standards with respect to training, experience, and other qualifications as the commissioner finds necessary and appropriate in the public interest or for the protection of organizations and employees. For such purposes, the commissioner may do the following:~~

- ~~— (1) Appropriately classify such persons and individuals.~~
- ~~— (2) Specify that all or any portion of such standards shall be applicable to any such class.~~
- ~~— (3) Require individuals in any such class to pass examinations prescribed in accordance with such rules.~~

~~(b) The commissioner may prescribe by rule reasonable fees and charges to defray the costs of carrying out this section, including, but not limited to, fees for any examination administered by the commissioner or under his or her direction.~~

~~—(c) The commissioner may consult with the Director of the Department of Industrial Relations and the Industrial Medical Council in promulgating advertising requirements in order to minimize duplicative requirements under Sections 139.4, 139.43, and 139.45.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5169. Untrue, misleading, or deceptive printed solicitations and verbal statements prohibited~~

~~—(a) No organization, solicitor, solicitor firm, or representative shall use or permit the use of any advertising or solicitation which is untrue or misleading, or any form of disclosure that is deceptive. For purposes of this chapter:~~

~~—(1) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is or may be significant to an employer or employee, or potential employer or employee.~~

~~—(2) 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 such item of information is communicated, such 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.~~

~~—(3) 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 which the disclosure form does not provide or which the organization issuing such disclosure form does not regularly make available to employees.~~

~~—(b) No organization, solicitor, or representative shall use or permit the use of any verbal statement which 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 subdivision (a).~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5170. Misrepresentation of commissioner approval is unlawful~~

~~—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 commissioner.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5171. Requirements for distributing advertisement; failure to comply~~

~~(a) Except as provided in subdivision (b), no organization shall publish or distribute, or allow to be published or distributed on its behalf, any advertisement not subject to Section 5162 unless (1) a true copy thereof has first been filed with the commissioner, at least 30 days prior to any such use, or any shorter period as the commissioner by rule or order may allow, and (2) the commissioner 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 commissioner by rule or order may allow.~~

~~(b) Except as provided in subdivision (c), an authorized organization which has been continuously authorized under this part for the preceding 18 months may publish or distribute or allow to be published or distributed on its behalf an advertisement not subject to Section 5162 without having filed the same for the commissioner's prior approval, if the organization and the material comply with each of the following conditions:~~

~~(1) The advertisement or a material provision thereof has not been previously disapproved by the commissioner by written notice to the organization and the organization reasonably believes that the advertisement does not violate any requirement of this part or the rules thereunder.~~

~~(2) The organization files a true copy of each new or materially revised advertisement, used by it or by any person acting on behalf of the organization, with the commissioner not later than 10 business days after publication or distribution of the advertisement or within such additional period as the commissioner may allow by rule or order.~~

~~(c) If the commissioner finds that any advertisement of an organization has materially failed to comply with this part or the rules thereunder, the commissioner 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, and may prohibit the organization from publishing or distributing, or allowing to be published or distributed on its behalf, the advertisement or any new materially revised advertisement without first having filed a copy thereof with the commissioner, 30 days prior to the publication or distribution thereof, or any shorter period specified in the order. An order issued under this subdivision shall be effective for 12~~

~~months from its issuance, and may be renewed by order if the advertisements submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this part and the rules thereunder.~~

~~—(d) An authorized organization or other person regulated under this part may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the commissioner.~~

~~—(e) The commissioner 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 subdivisions (a) and (b).~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5172. — "Presenting for examination or sale"; "disclosure form"~~

~~—As used in Sections 5173 and 5174:~~

~~—(a) "Presenting for examination or sale" means either (1) publication and dissemination of any brochure, mailer, advertisement, or form which constitutes a presentation of the provisions of a contract and which provides an organization enrollment or application form, or (2) consultations or discussions between prospective organization members or their contract agents and solicitors or representatives of an organization, when such consultations or discussions include presentation of formal, organized information about the organization which is intended to influence or inform the prospective employer, such as brochures, summaries, charts, slides, or other modes of information.~~

~~—(b) "Disclosure form" means the disclosure form, material, or information required pursuant to Section 5173.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5173. — Disclosure requirements~~

~~—(a) The commissioner shall require the use by each organization of disclosure forms or materials containing such information regarding the health care and terms of the workers' compensation health care contract as the commissioner 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 commissioner 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 Director of the Department of Industrial Relations 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 such additional information as may be required by the commissioner, in connection with the organization or contract.~~

~~—(b) 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 commissioner pursuant to this section for each contract so examined or sold.~~

~~—(c) 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 costs 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.~~

**~~§5174. Supplemental disclosure information required~~**

~~—Where the commissioner 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 such supplemental disclosure information as the commissioner may require.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5175. Discrimination prohibited~~**

~~—(a) No organization shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract 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.~~

~~—(b) 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 race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age 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.~~

~~—(c) 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.~~

~~—(d) This section shall not be construed to limit the authority of the commissioner to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

#### ~~§5176. — Restrictions on business names~~

~~—(a) No organization may 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 such organization controls or is controlled by an entity licensed as a health care service plan or insurer pursuant to the provisions of the Health and Safety Code or the Insurance Code and the organization employs a name related to that of such controlled or controlling entity.~~

~~—(b) Section 2415 of the Business and Professions Code, pertaining to fictitious names, shall not apply to organizations.~~

~~—(c) No organization or solicitor firm may 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 such affiliation or endorsement exists.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

### ~~CHAPTER 5 — STANDARDS~~

#### ~~§5177. — Organization requirements —~~

~~—Each organization shall meet the following requirements:~~

~~—(a) 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.~~

~~—(b) 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.~~

~~—(c) 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.~~

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

~~—(e) 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.~~

~~—(f) 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.~~

~~—(g) 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.~~

~~—(h) 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 provider organization, shall be fair, reasonable, and consistent with the objectives of this part.~~

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

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5178. Establishment of grievance system for employees~~

~~—(a) Every organization shall establish and maintain a grievance system approved by the commissioner under which employees may submit their grievances to the organization. Each system shall~~

~~provide reasonable procedures in accordance with regulations adopted by the commissioner which shall ensure adequate consideration of employee grievances and rectification when appropriate.~~

~~—(b) Every organization shall inform employees upon enrollment and annually thereafter of such procedures for processing and resolving grievances. Such information shall include the location and telephone number where grievances may be submitted.~~

~~—(c) Every organization shall provide forms for complaints to be given to employees who wish to register written complaints. The forms used by organizations authorized pursuant to Section 5163 shall be approved by the commissioner in advance as to format.~~

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

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5179. — Regulations for reviewing quality care; discovery~~**

~~—Every organization shall establish procedures in accordance with department regulations 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 which 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 shall 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 commissioner in conducting surveys pursuant to Section 5186.~~

~~—This section shall not be construed to confer immunity from liability on any workers' compensation health care provider 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.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~**§5180. — Use of subcommittees not prohibited**~~

~~— Nothing in this chapter shall be construed to prevent an organization from utilizing subcommittees to participate in peer review activities, nor to prevent a plan from delegating the responsibilities required by Section 5179 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 Section 5179.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~**CHAPTER 6 — REGULATION**~~

~~**§5181. — Requirements of organization**~~

~~— (a) Every organization shall have and shall demonstrate to the commissioner that it has all of the following:~~

- ~~— (1) A fiscally sound operation.~~
- ~~— (2) Adequate provision for continuity of care.~~
- ~~— (3) A procedure for prompt payment and denial of provider claims.~~

~~— (b) In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the following:~~

- ~~— (1) The financial soundness of the organization's arrangements for health care and the schedule of rates and charges used by the organization.~~
- ~~— (2) The adequacy of working capital.~~
- ~~— (3) Agreements with providers for the provision of health care.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~**§5182. — Organization must act in accordance with rules and regulations**~~

~~— (a) No organization shall conduct any activity regulated by~~

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~~this part in contravention of such rules and regulations as the commissioner may prescribe as necessary or appropriate in the public interest or for the protection of organizations and employees to provide safeguards with respect to the requirements of the preceding section.~~

~~—(b) Each solicitor and solicitor firm shall handle funds received for the account of workers' compensation health care provider organizations, subscribers, or groups in accordance with such rules as the commissioner may adopt pursuant to this subdivision.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5183. Health care to be based on "fee-for-service" basis; organization may not assume risk**~~

~~—(a) No organization shall provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost for such health care in return for a prepaid or periodic charge paid by or on behalf of such employees.~~

~~—(b) Every organization shall operate on a "fee-for-service" basis.~~

~~—As used in this part, "fee-for-service" refers to the situation where the amount of reimbursement paid by the employee to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.~~

~~—(c) An authorized organization is prohibited from assuming risk.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5184. Excessive amount of aggregate payments may not be used for administrative costs**~~

~~—No organization shall expend for administrative costs in any fiscal year an excessive amount of the aggregate payments received by the organization for providing health care to employees. The term "administrative costs," as used herein, includes costs incurred in connection with the solicitation of subscribers or enrollees for the organization.~~

~~—This section shall not preclude an organization from expending additional sums of money for administrative costs provided such money is not derived from revenue obtained from subscribers or enrollees of the organization.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5185. — Contracts to be in writing~~

~~— Every contract between an organization and an employer or insurer of an employer, and every contract between an organization and a provider of health care, shall be in writing.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5186. — Onsite medical survey~~

~~— (a) The commissioner 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.~~

~~— (b) The survey shall be conducted by a panel of qualified health professionals experienced in evaluating the delivery of workers' compensation health care. The commissioner 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 such health care.~~

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

~~— (d) Nothing in this section shall be construed to require the medical survey team to review peer review proceedings and records conducted and compiled under Section 5179 or medical records. However, the commissioner 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 commissioner or the commissioner's staff may be compelled to disclose such information except in accordance with the physician-patient relationship. The commissioner 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 commissioner or the medical survey team shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to Sections 5179 and 5180.~~

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

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

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

~~(h) 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 or response within 30 days, to be attached to the report. Deficiencies shall not be made public if they are corrected within 30 days of the date that the organization was notified.~~

~~— (i) Nothing in this section shall be construed as affecting the commissioner's authority pursuant to Chapter 7 (commencing with Section 5191) or Chapter 8 (commencing with Section 5195).~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5187. Books and records to be open to inspection and located in state**~~

~~— (a) 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 commissioner.~~

~~— (b) To the extent feasible, all such records, books, and papers described in subdivision (a) shall be located in this state. In examining such records outside this state, the commissioner shall consider the cost to the organization, consistent with the effectiveness of the commissioner's examination, and may upon reasonable notice require that such 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 such records, books, and papers, or a specified portion thereof, be furnished to the commissioner.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5188. Examination of fiscal and administrative affairs~~**

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

~~—(b) 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 Section 5186 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 commissioner. In determining the cost of examinations or surveys, the commissioner may use the estimated average hourly cost for all persons performing examinations or surveys of workers' compensation health care provider organizations for the fiscal year. The amount charged shall be remitted by the organization to the commissioner. If recovery of these costs cannot be made from the organization, these costs may be added to, but subject to the limitation of, the assessment provided for in subdivision (b) of Section 5166.~~

~~—(c) 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. Deficiencies shall not be made public if they are corrected within 30 days of the date that the organization was notified of the deficiency.~~

~~—(d) Upon receipt of the written request of the Director of the Department of Industrial Relations, the commissioner may, consistent with Section 6254.5 of the Government Code, permit the Department of Industrial Relations to review the organization's examination report.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5189. Reports and financial statements to be submitted to commissioner~~**

~~—(a) Within 90 days after receipt of a request from the commissioner, an organization or other person subject to this part shall submit to the commissioner an audit report containing audited financial statements covering the 12 calendar months next preceding the month of receipt of the request, or such other period as the commissioner may require.~~

~~—(b) An organization whose authorization has been surrendered or revoked shall submit to the commissioner on or before 105 days after the effective date of such surrender or revocation, a closing audit~~

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~~report containing audited financial statements as of such effective date for the 12 months ending with such effective date, or for such other period as the commissioner may specify. Such report shall include other relevant information as specified by rule of the commissioner.~~

~~— (c) Each organization shall submit financial statements prepared as of the close of its fiscal year within 120 days after the close of such fiscal year. The financial statements referred to in this subdivision and in subdivisions (a) and (b) shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. The audits shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the commissioner. However, 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 or independent public accountant, and the audit shall be conducted in accordance with governmental auditing standards.~~

~~— (d) An organization, solicitor, or solicitor firm shall make such special reports to the commissioner as the commissioner may from time to time require.~~

~~— (e) For good cause and upon written request, the commissioner may extend the time for compliance with subdivisions (a), (b), and (h).~~

~~— (f) An organization, solicitor, or solicitor firm shall, when requested by the commissioner, for good cause, submit its unaudited financial statement, prepared in accordance with generally accepted accounting principles and consisting of at least a balance sheet and statement of income, as of the date and for the period specified by the commissioner. The commissioner may require the submission of such reports on a monthly or other periodic basis.~~

~~— (g) If the report, certificate, or opinion of the independent accountant referred to in subdivision (c) is in any way qualified, the commissioner may require the organization to take such action as the commissioner deems appropriate to permit an independent accountant to remove such qualification from the report, certificate, or opinion.~~

~~— (h) The commissioner may reject any financial statement, report, certificate, or opinion filed pursuant to this section by notifying the organization, solicitor, or solicitor firm required to make such filing of its rejection and the cause thereof. Within 30 days after the receipt of such notice, such person shall correct such deficiency, and the failure so to do shall be deemed a violation of this part. The commissioner shall retain a copy of all filings so rejected.~~

~~— (i) The commissioner may make rules and regulations specifying the form and content of the reports and financial statements referred to in this section, and may require that such reports and financial~~

~~statements be verified by the organization or other person subject to this part in such manner as the commissioner may prescribe.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~§5190. — Maintenance of current books of account, etc.; reports of surcharge and copayment moneys~~

~~— Each organization, solicitor, and solicitor firm shall keep~~

~~and maintain current such books of account and other records as the commissioner may by rule require for the purposes of this part. Every organization shall require all providers who contract with the organization to report to the organization in writing all surcharge and copayment moneys paid by employees directly to such providers, unless the commissioner expressly approves otherwise.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

**CHAPTER 7 — DISCIPLINE**

~~§5191 — Acts constituting grounds for disciplinary action on authorized organization; penalties~~

~~— (a) The commissioner may suspend or revoke any authorization issued under this part to an organization or assess civil penalties if the commissioner determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.~~

~~— (b) The following acts or omissions constitute grounds for disciplinary action by the commissioner:~~

~~— (1) The organization is operating at variance with the basic organizational documents as filed pursuant to Section 5159 or 5161 or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the contract as contained in its application for authorization and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the commissioner.~~

~~— (2) The organization has issued, or permits others to use, a disclosure form or uses a schedule of charges for health care which do not comply with those published in the latest disclosure form found unobjectionable by the commissioner.~~

~~— (3) The organization does not provide health care to its employees as set forth in the disclosure form.~~

~~— (4) The organization is no longer able to meet the standards set forth in Chapter 5 (commencing with Section 5177).~~

~~— (5) The continued operation of the organization will constitute a substantial risk to employees.~~

~~— (6) The organization has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this part or any rule or regulation adopted by the commissioner pursuant to this part.~~

~~— (7) The organization has engaged in any conduct which constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.~~

~~— (8) The organization has permitted, or aided or abetted, any violation by an employee or contractor who is a holder of any certificate, license, permit, registration, or exemption issued pursuant to the Business and Professions Code, the Health and Safety Code, or this code which would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.~~

~~— (9) The organization has aided or abetted or permitted the commission of any illegal act.~~

~~— (10) The engagement of a person as an officer, director, employee, associate, or provider of the organization contrary to the provisions of an order issued by the commissioner pursuant to subdivision (c) or pursuant to subdivision (d) of Section 5193.~~

~~— (11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the commissioner pursuant to Section 5193.~~

~~— (12) The organization, its management company, or any other affiliate of the organization, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the organization, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this part. The commissioner may revoke or deny an authorization hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.~~

~~— (c) The commissioner may prohibit any person from serving as an officer, director, employee, associate, or provider of any organization or solicitor firm, or of any management company of any organization, or as a solicitor, if (1) the prohibition is in the public interest and the person has committed or caused, participated in, or had knowledge of a violation of this part by an organization, management company, or solicitor firm, or (2) the person was an officer, director, employee, associate, or provider of an organization or of a management company or solicitor firm of any organization whose license has been suspended or revoked pursuant to~~

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~~this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked. A proceeding for the issuance of an order under this subdivision may be included with a proceeding against an organization under this section or may constitute a separate proceeding, subject in either case to appropriate notice and opportunity for hearing to the person affected in accordance with subdivision (a) of Section 5207.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5192. Violation of part; penalties~~**

~~—(a) Any person who violates any provision of this part, or who violates any rule or order adopted or issued pursuant to this part, shall be liable for a civil penalty not to exceed two thousand five hundred dollars (\$2,500) for each violation, which shall be assessed and recovered in a civil action brought in the name of the people of the State of California by the commissioner in any court of competent jurisdiction.~~

~~—(b) As applied to the civil penalties for acts in violation of this part, the remedies provided by this section and by other sections of this part are not exclusive, and may be sought and employed in any combination to enforce this part.~~

~~—(c) No action shall be maintained to enforce any liability created under subdivision (a), unless brought before the expiration of four years after the act or transaction constituting the violation.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5193. Acts constituting grounds for disciplinary action on solicitor; penalties~~**

~~—(a) The commissioner may, after appropriate notice and opportunity for hearing, by order censure a person acting as a solicitor or solicitor firm, or suspend for a period not exceeding 24 months or bar a person from operating as a solicitor or solicitor firm, or assess civil penalties against a person acting as a solicitor or solicitor firm if the commissioner determines that such person has committed any of the acts or omissions constituting grounds for disciplinary action.~~

~~—(b) The following acts or omissions constitute grounds for disciplinary action by the commissioner:~~

~~—(1) The continued operation of the solicitor or solicitor firm in a manner which may constitute a substantial risk to an organization or employees.~~

~~—(2) The solicitor or solicitor firm has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted~~

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~~in or abetted a violation or conspiracy to violate any provision of this part or any rule or regulation adopted by the commissioner pursuant to the part.~~

~~—(3) The solicitor or solicitor firm has engaged in any conduct which constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.~~

~~—(4) The engagement of a person as an officer, director, employee, or associate of the solicitor firm contrary to the provisions of an order issued by the commissioner pursuant to subdivision (d) of this section or subdivision (c) of Section 5191.~~

~~—(5) The solicitor or solicitor firm, or its management company, or any other affiliate of the solicitor firm, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in such solicitor firm, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with the provisions of this part. The commissioner may issue an order hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.~~

~~—(c) The commissioner shall notify organizations of any order issued pursuant to subdivision (a) which suspends or bars a person from engaging in operations as a solicitor or solicitor firm. It shall be unlawful for any organization, after receipt of notice of such an order, to receive any new subscribers or enrollees through such a person or to otherwise utilize any solicitation services of such person in violation thereof.~~

~~—(d) The commissioner may prohibit any person from serving as an officer, director, employee, or associate of any organization or solicitor firm, or as a solicitor, if such person was an officer, director, employee, or associate of a solicitor firm which has been the subject of an order of suspension or bar from engaging in operations as a solicitor firm pursuant to this section and such person had knowledge of, or participated in, any of the prohibited acts for which such order was issued. A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a solicitor firm under this section or may constitute a separate proceeding, subject in either case to appropriate notice and opportunity for hearing to the person affected in accordance with the provisions of subdivision (a) of Section 5207.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5194. — Petition to reinstate license, for reduction of penalty, and for restoration; fee~~

~~—(a) A person whose authorization has been revoked, or suspended for more than one year, may petition the commissioner to~~

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~~reinstate the license as provided by Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this part, or any offense which would constitute grounds for discipline, or denial of licensure under this part, including any period of probation or parole.~~

~~— (b) A person who is barred, or suspended for more than one year, from acting as a solicitor or solicitor firm pursuant to Section 5193, or who is subject to an order, pursuant to subdivision (c) of Section 5191 or subdivision (d) of Section 5193, which by its terms is effective for more than one year, may petition the commissioner to reduce by order such penalty in a manner generally consistent with the provisions of Section 11522 of the Government Code. No petition may be considered if the petitioner is under criminal sentence for a violation of this part, or any offense which would constitute grounds for discipline under this part, including any period of probation or parole.~~

~~— (c) The petition for restoration shall be in the form prescribed by the commissioner and the commissioner may condition the granting of such petition upon such additional information and undertakings as the commissioner may require in order to determine whether such person, if restored, would engage in business in full compliance with the objectives and provisions of this part and the rules and regulations adopted by the commissioner pursuant to this part.~~

~~— (d) The fee for the filing of a petition for restoration pursuant to this section is two hundred fifty dollars (\$250). In addition, the commissioner may condition the granting of such a petition to an organization upon payment of the assessment due and unpaid pursuant to subdivision (b) of Section 5166 as of the 15th day of December occurring within the preceding 12 calendar months and, if the organization's suspension or revocation was in effect for more than 12 months, upon the filing of a new organization application and the payment of the fee prescribed by subdivision (a) of Section 5166.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

## **CHAPTER 8 -- CRIMES**

### **§5195. — Violation of part; penalty**

~~— Any person who willfully violates any provision of this part or of any rule or order thereunder shall upon conviction be fined not more than ten thousand dollars (\$10,000) or imprisoned in the state prison, or in a county jail for not more than one year, or be punished by both such fine and imprisonment, but no person may be imprisoned for the violation of any rule or order if it is proven that such person had no knowledge of the rule or order.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5196. Order to cease and desist; request for hearing will stay order~~**

~~—(a) The commissioner may issue an order directing an organization, solicitor firm, or any representative thereof, or a solicitor to cease and desist from engaging in any act or practice in violation of the provisions of this part.~~

~~—If that person fails to file a written request for a hearing within one year from the date of service of the order, the order shall be deemed a final order of the commissioner and shall not be~~

~~subject to review by any court or agency, notwithstanding subdivision (b) of Section 5207.~~

~~—(b) If a timely request for a hearing is made by an authorized organization, the request shall automatically stay the effect of the order only to the extent that the order requires the cessation of operation of the organization or prohibits acceptance of new members by the organization or both. However, no automatic stay shall be issued if any examination or inspection of the organization performed by the commissioner discloses, or reports or documents submitted to the commissioner by the organization on their face show, that the organization is in violation of any fiscal requirement of this part or in violation of any requirement of Section 5189 or 5190. In the event of an automatic stay, only that portion of the order requiring cessation of operation or prohibiting contracting shall be stayed and all other portions of the order shall remain effective. If a hearing is held, and a finding is made that the health or safety of the employees and potential employees to be provided health care by the organization might be adversely affected by its continued operation, the stay shall be terminated. Such a finding shall be made, if at all, not later than 30 days after the date of the hearing.~~

~~—(c) If a timely request for a hearing is made by an unauthorized organization the commissioner may stay the effect of the order to the extent that the order requires the cessation of operation of the organization or prohibits acceptance of new members by the organization, for such period and subject to such conditions as the commissioner may require, upon a determination by the commissioner that the action would be in the public interest.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**~~§5197. Proceeding to obtain injunctive or other equitable relief for violation of part~~**

~~—(a) In the case of any violation of the provisions of this part, the commissioner may institute a proceeding, or the commissioner may request the Attorney General to institute a proceeding, to obtain injunctive or other equitable relief, including the appointment of a receiver or conservator for the defendant or the defendant's assets, in the superior court in and for the county~~

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~~in which the violation occurs, or in which the principal place of business of the organization is located. The proceeding under this section shall conform with the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure, except that the commissioner shall not be required to allege facts necessary to show lack of adequate remedy at law, or to show irreparable loss or damage.~~

~~— (b) Upon a proper showing, the court shall grant the relief provided by law and requested by the commissioner.~~

~~— (c) A receiver or conservator appointed by the superior court pursuant to this section may, with the approval of the court, exercise all of the powers of the officers and directors of the organization, including the filing of a petition for bankruptcy. No action at law or in equity may be maintained by any party against the commissioner, or a receiver or conservator, by reason of their exercising the powers of the officers and directors of an organization pursuant to the order of, or with the approval of, the superior court.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5198. — Upon filing application showing grounds for disciplinary action, commissioner shall be given vested title to organization's assets and shall take possession of organization's records; refusal to deliver records or assets is misdemeanor; penalty**~~

~~— (a) The superior court of the county in which is located the principal office of the organization in this state shall, upon the filing by the commissioner of a verified application showing any of the conditions enumerated in Section 5191 to exist, issue its order vesting title to all of the assets of the organization, wheresoever situated, in the commissioner or the commissioner's successor in office, in his or her official capacity as such, and direct the commissioner to take possession of all of its books, records, property, real and personal, and assets, and to conduct, as conservator, the business or portion of the business of the person to the commissioner as may seem appropriate, and enjoining the person and its officers, directors, agents, servants, and employees from the transaction of its business or disposition of its property until the further order of the court.~~

~~— (b) Whenever it appears to the commissioner that irreparable loss and injury to the property and business of the organization has occurred or may occur unless the commissioner acts immediately, the commissioner, without notice and before applying to the court for any order, shall take possession of the property, business, books, records, and accounts of such organization, and of the offices and premises occupied by it for the transaction of its business, and retain possession subject to the order of the court. Any person having possession of and refusing to deliver any of the books, records, or assets of an organization against whom a seizure order~~

~~has been issued by the commissioner, shall be guilty of a misdemeanor and punishable by fine not exceeding one thousand dollars (\$1,000) or imprisonment not exceeding one year, or both such fine and imprisonment.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5199. — Civil penalties for engaging in business as workers' compensation health care provider without proper authorization**~~

~~—(a) A person who violates Section 5158, or any person who directly or indirectly participates in the direction of the management or policies of the person in violation of Section 5158, including, but not limited to, any officer, director, partner, or other person occupying a principal management or supervisory position, shall be liable for civil penalties as follows:~~

~~—(1) A sum not exceeding two thousand five hundred dollars (\$2,500), and~~

~~—(2) A sum not exceeding five hundred dollars (\$500) for each employee under a contract that was entered into or renewed while such person was in violation of Section 5158.~~

~~—(b) The civil penalty may be assessed and recovered only in a civil action. The cause of action may be brought in the name of the people of the State of California by the Attorney General or the commissioner, as determined by the commissioner.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5200. — Remedies available to commissioner not exclusive**~~

~~—The civil, criminal, and administrative remedies available to the commissioner pursuant to this chapter are not exclusive, and may be sought and employed in a combination deemed advisable by the commissioner to enforce the provisions of this part.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~**§5201. — Complaint for involuntary dissolution**~~

~~—Notwithstanding any other provision of law, the commissioner may file a verified complaint for involuntary dissolution of an organization on any one or more of the grounds specified in subdivision (b) of Section 5191. The complaint shall be filed in the superior court of the county where the principal executive office of the organization is located or, if the principal executive office of the organization is not located in this state, or the organization has no such office, the County of Sacramento.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

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~~§5202. — Priority of expenses and claims in involuntary dissolution~~

~~—Notwithstanding any other provision of law, in any involuntary dissolution of an organization as provided for in Section 5201, or other insolvency proceeding involving an organization, the following expenses and claims have priority in the following order:~~

~~—(a) First, administrative expenses allowed by the superior court and any fees and charges assessed against the estate of the dissolved organization in conjunction with the dissolution of the estate.~~

~~—(b) Second, taxes due the State of California.~~

~~—(c) Third, claims having preference by the laws of the United States and by the laws of this state.~~

~~—(d) Fourth, claims of organization contract holders for reimbursement for health care rendered by providers to employees.~~

~~—(e) Fifth, any and all claims, including all officers' and directors' claims for indemnity, arising against the estate of the dissolved organization.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5203. — Guidelines for involuntary dissolution; Corporations Code Chapters 15 and 18~~

~~—Except as provided for in Sections 5201 and 5202, the involuntary dissolution of an organization shall be in accordance with either:~~

~~—(1) Chapter 18 (commencing with Section 1800) of Division 1 of Title 1 of the Corporations Code if the organization is incorporated under the General Corporation Law.~~

~~—(2) Chapter 15 (commencing with Section 8510) of Part 3 of Division 2 of Title 1 of the Corporations Code if the organization is incorporated under the Nonprofit Corporation Law.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~CHAPTER 8.5 - SERVICE OF PROCESS~~

~~§5204. — Commissioner may receive lawful process in noncriminal action for person for whom personal jurisdiction cannot be obtained; how service may be made; effective upon notice being sent~~

~~—When any person, including any nonresident of this state, engages in conduct prohibited or made actionable by this chapter of any rule, regulation, or order adopted hereunder, whether or not the person has filed a power of attorney under subdivision (j) of Section~~

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~~5159, and personal jurisdiction equivalent over the person cannot otherwise be obtained in this state, that conduct shall be considered equivalent to the appointment of the commissioner or the commissioner's successor in office to be the attorney in fact to receive any lawful process in any noncriminal suit, action, or proceeding instituted by him or her, with the same force and validity as if personally served. Service may be made by leaving a copy of the process in the office of the commissioner, but it is not effective unless the plaintiff or petitioner, who may be the commissioner in a suit, action, or proceeding instituted by him or her, forthwith sends notice of the service and a copy of the process by registered or certified mail to the defendant or respondent at his or her last known address or takes other steps which are reasonably calculated to give actual notice, and in a court action, an affidavit of compliance with this section is filed in the case on or before the return day of the process, if any, or within such further time as the court allows. In the case of administrative orders issued by the commissioner, the affidavit of compliance need not be filed with the administrative tribunal unless the respondent requests a hearing.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

#### ~~CHAPTER 9 - MISCELLANEOUS~~

##### ~~§5205. Requirements for advertising cost of subscription and services rendered~~

~~—Notwithstanding Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code, any organization may, except as limited by this subdivision, solicit or advertise with regard to the cost of subscription or enrollment, facilities and services rendered, provided, however, Article 5 (commencing with Section 600) of Chapter 1 of Division 2 of the Business and Professions Code remains in effect. Any price advertisement shall be exact, without the use of such phrases as "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to health care, or costs for the health care, and that uses words of comparison must be based on verifiable data substantiating the comparison. Any organization so advertising shall be prepared to provide information sufficient to establish the accuracy of the comparison. Price advertising shall not be fraudulent, deceitful, or misleading, nor contain any offers of discounts, premiums, gifts, or bait of similar nature. In connection with price advertising, the price for health care shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.~~

~~—Nothing in this part shall be construed to repeal, abolish, or diminish the effect of Section 129450 of the Health and Safety Code.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~§5206. — Submission of untrue fact and omission of fact in application to commissioner unlawful~~

~~—It is unlawful for any person willfully to make any untrue statement of material fact in any application, notice, amendment, report, or other submission filed with the commissioner under this part or regulations adopted thereunder, or willfully to omit to state in any application, notice, or report any material fact which is required to be stated therein.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~§5207. — Hearings to be held in accordance with APA; commissioner's acts subject to judicial review~~

~~—(a) Whenever reference is made in this part to a hearing before or by the commissioner, the hearing shall be held in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and the commissioner shall have all of the powers granted under that act.~~

~~—(b) Every final order, decision, license, or other official act of the commissioner under this part is subject to judicial review in accordance with the law.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~§5208. — Commisisoner and department employees may receive care from organization subject to this part~~

~~—Neither the commissioner nor any employee of the Department of Corporations shall be precluded from choosing to receive care from an organization which is subject to the provisions of this part, subject to such rules as may be adopted hereunder or pursuant to other proper authority.~~

~~(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)~~

~~§5209. — Effectiveness of surrender of organization's authorization; basis for commissioner's revocation or suspension of authorization~~

~~—(a) Surrender of an organization's authorization becomes effective 30 days after receipt of an application to surrender the authorization or within a shorter period of time as the commissioner may determine, unless a revocation or suspension proceeding is pending when the application is filed or a proceeding to revoke or suspend or to impose conditions upon the surrender is instituted within 30 days after the application is filed. If such a proceeding is pending or instituted, surrender becomes effective at the time and upon the conditions as the commissioner by order determines.~~

~~—(b) If the commissioner finds that any organization is no longer in existence, or has ceased to do business or has failed to initiate business activity as a licensee within six months after authorization, or cannot be located after reasonable search, the commissioner may by order summarily revoke such authorization.~~

~~—(c) The commissioner may summarily suspend or revoke the authorization of an organization upon (1) failure to pay any fee required by this part within 15 days after notice by the commissioner that such fee is due and unpaid, or (2) failure to file any amendment or report required under this part within 15 days after notice by the commissioner that the report is due.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

~~§5210. — Operative date of part; contingency~~

~~—This part shall become operative August 1, 1994. However, this part shall not be implemented unless the Legislature appropriates money to the Department of Corporations for costs related to the department's initial duties in authorizing workers' compensation health care provider organizations.~~

(Repealed by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)

**§5401.7. Statement must accompany claim form.**

The claim form shall contain, prominently stated, the following statement:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

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

(Amended by Stats. 1997, C. 346 (S.B. 1063). Effective January 1, 1998.)