2012

2011-2012 Legislative Summary

Assembly Committee on Insurance

California State Legislature

Assembly Committee on Insurance

2011-2012 LEGISLATIVE SUMMARY

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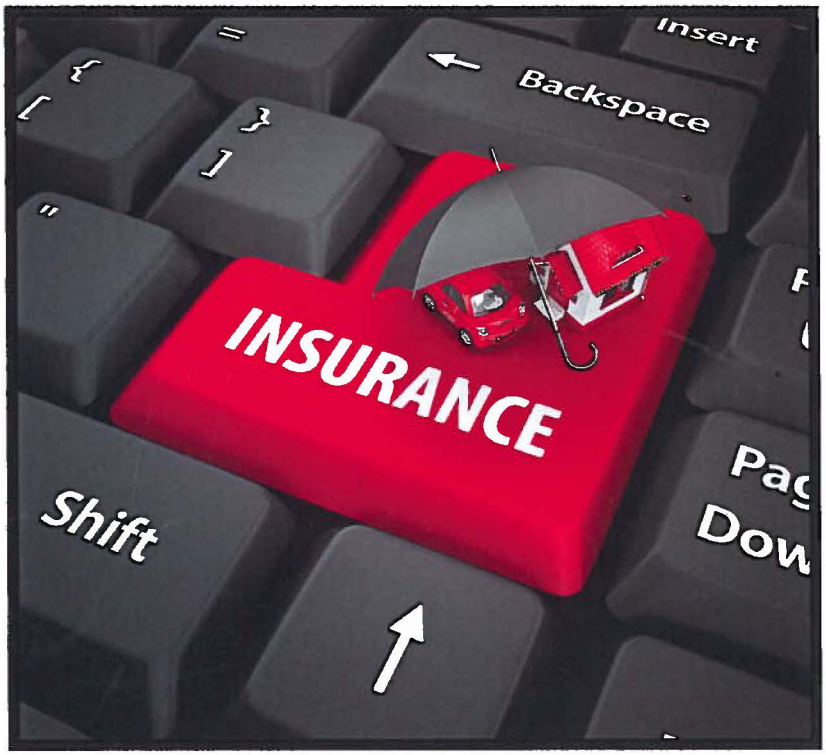

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Assembly
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ASSEMBLY COMMITTEE ON INSURANCE

October 23, 2012

To Assembly Members and All Interested Parties:

The following is a summary of all the bills that were referred to the Assembly Insurance Committee in 2011-2012. The bills are organized in numerical order and their status noted as of the publication date of this legislative summary.

The summary of each bill is not intended to be a definitive or comprehensive statement of the provisions of the bill. For more detailed information about any bill, please go to the Assembly's web page at www.assembly.ca.gov and click on "Legislation."

In addition to regular bill hearings, the Committee held the following subject matter & oversight hearings:

- Unemployment Insurance trust fund solvency
- Joint hearing with the Senate Labor and Industrial Relations Committee on workers' compensation reform.
- Informational hearing on Senate Bill 863 (DeLeon) which enacts a comprehensive reform of the workers' compensation system.
- Joint hearing with the Senate Insurance Committee regarding Proposition 33, a ballot measure regarding automobile insurance rating factors.

For additional information regarding this summary or other activities of the committee, please contact the committee staff at (916) 319-2086.

Respectfully,

Henry T. Perea, Chair

Curt Hagman, Vice Chair

TABLE OF CONTENTS

AB 53 (Solorio) Insurance: procurement contracts: minority, woman, and disabled veteran business enterprises 1

AB 55 (Gatto) Unemployment compensation: employer: motion picture industry..... 1

AB 125 (Committee on Insurance) Insurance guaranteed asset protection 1

AB 211 (Cedillo) Workers' compensation: permanent disability benefits 1

AB 226 (Solorio) Unemployment insurance: reporting requirements: status of funds 1

AB 228 (Fuentes) State Compensation Insurance Fund: out of state risks..... 2

AB 274 (Garrick) Unemployment insurance benefits: claims: right to respond 2

AB 315 (Solorio) Workers' compensation: notices 2

AB 335 (Solorio) Workers' compensation: notices 2

AB 375 (Skinner) Workers' compensation: hospital employees: presumption..... 2

AB 378 (Solorio) Workers' compensation: pharmacy products 3

AB 480 (Solorio) Insurance: solid waste facilities 3

AB 500 (Solorio) (Solorio) – Unemployment Insurance Code: penalties 3

AB 584 (Fong) Workers' compensation: utilization review 3

AB 585 (Fong) Workers' compensation: cancer presumption 4

AB 624 (John A. Perez) California Organized Investment Network..... 4

AB 689 (Blumenfield) Insurance: annuity transactions: suitability..... 4

AB 690 (Solorio) Portable electronics insurance 4

AB 705 (Blumenfield) Insurance: risk retention..... 4

AB 736 (Charles Calderon) Insurance: license: fraud prevention 4

AB 793 (Eng) Insurance producers: reverse mortgage..... 4

AB 804 (Yamada) Unemployment compensation: disability benefits: paid family leave 5

AB 947 (Solorio) Workers' compensation: temporary disability payments. 5

AB 974 (Portantino) Workers' compensation: insurance: rates 5

AB 999 (Yamada) Long-term care insurance 5

AB 1004 (Hagman) Insurance: Conservation and Liquidation Office: receivership..... 5

AB 1024 (Hueso) Insurance: low-cost automobile insurance: sales 6

AB 1063 (Bradford) Automobile insurance: underinsured motorist coverage 6

AB 1098 (Hagman) Insurance: unlawful practices 6

AB 1106 (Achadjian) Occupational safety and health: local public entities: penalty moneys: grans..... 6

AB 1129 (Portantino) Employment Information: student loan guaranty agencies..... 6

AB 1145 (Cedillo) Workers' compensation: permanent disability benefits 6

AB 1155 (Alejo) Workers' compensation 7

AB 1168 (Pan) Workers' compensation: vocational expert fee schedule 8

AB 1263 (Williams) State Compensation Insurance Fund: directors and officers: postemployment 8

AB 1363 (Alejo) Workers' compensation insurance: ratings organizations: Statistical agent 8

AB 1416 (Committee on Insurance) Insurance omnibus 8

AB 1425 (Committee on Insurance) Insurance..... 8

AB 1426 (Solorio) Workers' compensation: court administrator..... 8

AB 1427 (Solorio) Workers' compensation insurance: fraud 8

AB 1454 (Solorio) Workers' compensation: audiologists 9

AB 1551 (Torres) Insurance: public safety employees: accidents 9

AB 1603 (Feuer) Mortgages and deeds of trust: mortgage services: force-placed insurance 9

AB 1687 (Fong) Workers' compensation 9

AB 1708 (Gatto) Vehicles: electronic verification of financial responsibility and insurance 10

AB 1734 (Hagman) Insurance: Conservation and Liquidation Office 10

AB 1747 (Feuer) Life insurance: nonpayment premium lapse: notice 10

AB 1794 (Williams) Unemployment insurance: use of employer reports: reporting and payroll: enforcement 10

AB 1845 (Solorio) Unemployment compensation benefits: overpayment assessments: termination: income tax withholding 10

AB 1949 (Cedillo) Public employees: annuities and mutual fund custodial accounts..... 11

AB 2069 (Solorio) Workers' compensation: peace officer benefits 11

AB 2072 (Eng) Workers' compensation: acupuncturists 11

AB 2084 (Solorio) Blanket insurance..... 11

AB 2138 (Blumenfield) Health insurance fraud: annual fee 11

AB 2160 (Blumenfield) Insurance: Iranian investments 11

AB 2219 (Knight) Contractors' workers' compensation insurance coverage 11

AB 2244 (Conway) Workers' compensation: supplemental job displacement benefits..... 12

AB 2264 (Knight) Insurance fraud: release of information: other unlawful activity 12

AB 2298 (Solorio) Insurance: public safety employees: accidents 12

AB 2301 (Committee on Insurance) California Insurance Guarantee Association: definitions 12

AB 2302 (Committee on Insurance) Workers' compensation: studies..... 12

AB 2303 (Committee on Insurance) Insurance omnibus 12

AB 2310 (Morrell) Unemployment insurance benefits: governmental pension

and retirement payments. 13

AB 2354 (Solorio) Travel insurance 13

AB 2373 (Norby) Independent contractors: definition 13

AB 2451 (John A. Perez) Workers' compensation: firefighters 13

AB 2589 (Bradford) Automobile insurance: underinsured motorist coverage: survey ...14

AB 2627 (Allen) Benefits payment: director deposit 14

AB 2659 (Blumenfield) Shared Work Program 14

SENATE BILLS

SB 127 (Emmerson) Official medical fee schedule: physician services 15

SB 131 (Gaines) Insurance: surplus line brokers: statement of business transacted..... 15

SB 220 (Price) Life insurance: group policies 15

SB 457 (Calderon) Workers' compensation: liens 15

SB 596 (Price) Insurance: disclosures 16

SB 599 (Kehoe) Life insurance: retained-asset account 16

SB 615 (Calderon) Multiple employer welfare arrangements: benefits 16

SB 621 (Calderon) Insurance: life: disability discretionary clauses 16

SB 684 (Corbett) Worker's compensation insurance: dispute resolution: arbitration clauses: 16

SB 691 (Lieu) Unemployment insurance: use of information 17

SB 711 (Rubio) Insurance: guarantee association 17

SB 712 (Committee on Insurance) Insurance 17

SB 713 (Calderon) Insurance: proceeds: disclosure 17

SB 715 (Calderon) Annuity transactions 17

SB 777 (Lieu) Workers' compensation insurance: coverage program 18

SB 826 (Leno) Workers' compensation: data reporting requirement: administrative penalties..... 18

SB 863 (De Leon) Workers' compensation 18

SB 923 (De Leon) Workers' compensation: official medical fee schedule: physician services 18

SB 959 (Lieu) Workers' compensation: provider reimbursement: implantable medical devices, hardware and instrumentation 18

SB 1105 (Lieu) Workers' compensation: liens 18

SB 1164 (Emmerson) Insurance 19

SB 1170 (Leno) Senior insurance 19

SB 1177 (Leno) Restitution for crime victims 19

SB 1184 (Corbett) Senior insurance: veterans benefits 19

SB 1212 (Calderon) Insurance: electronic transmission 19

SB 1216 (Lowenthal) Reinsurance: professional reinsurers 19

SB 1291 (Evans) Unemployment benefits: training: teacher credentialing..... 19

SB 1448 (Calderon) Insurance 19

SB 1449 (Calderon) Life insurance and annuities 20

SB 1450 (Calderon) Mortgage guaranty insurance 20

SB 1451 (Calderon) Insurance 20

SB 1513 (Negrete McLeod) State Compensation Insurance Fund: investments 20

2011-2012 Oversight Hearings

Appendix 1 – March 2, 2011 – Unemployment Insurance Fund Solvency Crisis

Appendix 2 – March 28, 2012 – Joint Hearing Assembly Insurance Committee and Senate Labor and Industrial Relations Committee on workers' compensation Reform and the impacts of SB 899 on Permanent Disability Benefits.

Appendix 3 – August 28, 2012 – Joint Hearing Assembly Insurance Committee and Senate Labor and Industrial Relations Committee on workers' compensation reform

Appendix 4 - September 25, 2012 – Joint Hearing with Assembly Insurance Committee and Senate Insurance regarding Proposition 33, a ballot measure regarding automobile insurance rating factor.

ASSEMBLY INSURANCE COMMITTEE
2011-2012
LEGISLATIVE SUMMARY

Assembly Bills

AB 53 (Solorio) – Insurance: procurement contracts: minority, women, and disabled veteran business enterprises.
Requires major insurers with written premiums equal to or in excess of $100,000,000 to submit a report to the Insurance Commissioner, by July 1, 2013, on its minority, women, and disabled veteran-owned business procurement efforts.
Status: Chapter 414, Statues of 2012.

AB 55 (Gatto) – Unemployment compensation: employer: motion picture industry.
Repeals the January 1, 2012, sunset date that allows a motion picture payroll services company to serve as the employer of motion picture production workers for purposes of payroll tax reporting and employee benefits pursuant to the unemployment insurance and state disability insurance programs.
Status: Chapter 160, Statues of 2011.

AB 125 (Committee on Insurance) – Insurance guaranteed asset protection.
Clarifies that a deductible required by an automobile insurance policy may be covered by guaranteed automobile protection insurance and related contracts.
Status: Chapter 24, Statutes of 2011.

AB 211 (Cedillo) – Workers' compensation: permanent disability benefits.
Would have provided, for injuries that cause permanent partial disability and occur on or after January 1, 2012, a supplemental job displacement benefit in the form of a voucher for up to $6,000 to cover various reeducation and skill enhancement expenses which would expire two years after the date the voucher is furnished to the employee or five years after the date of injury.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "This bill represents an effort to improve benefits for workers by providing vouchers for those who need additional training in order to return to employment after permanently disabling injuries. I am, however, reluctant to enact piecemeal changes to the Workers' Compensation system in the absence of more comprehensive reform that addresses both the cost and benefits under the system."

AB 226 (Solorio) – Unemployment insurance: reporting requirements: status of funds.
Would have required the Employment Development Department, whenever the Unemployment Fund indicated a negative balance, to include in its status report the estimated impact on employers from changes in federal tax credits and the estimated amount the state is expected to pay in interest charges on any outstanding loan to the federal government.
Status: Ordered to Senate Inactive File.

AB 228 (Fuentes) – State Compensation Insurance Fund: out of state risks.
Confers limited authority to the State Compensation Insurance Fund (SCIF) to provide specified California employers workers' compensation coverage for their non-California employees as an accommodation alongside their California-based employees, provided that there is a contractual arrangement between SCIF and a qualified admitted insurer in the other state.
Status: Chapter 670, Statutes of 2011.

AB 274 (Garrick) – Unemployment insurance benefits: claims: right to respond.
Would have required that employers be notified of the circumstances that establish "good cause" under which an employer may get an extension of time from the director (from the current 10 day period) to submit information to the Employment Development Department regarding a claim for unemployment insurance benefits.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "This bill is unnecessary. It directs employers to a technical guide used by the Employment Development Department (EDD) to adjudicate Unemployment Insurance eligibility.
>
> Use of this guide, however, may cause confusion rather than assist employers in understanding what qualifies as "good cause" for responding late to an Unemployment Insurance claim notification. Information about what constitutes good cause is already stated on the existing form sent to employers when a claim is filed."

AB 315 (Solorio) – Surplus line brokers.
Conforms California law governing surplus line insurance to mandatory changes included in the federal Nonadmitted and Reinsurance Reform Act provisions of last year's Dodd-Frank Wall Street Reform and Consumer Protection Act.
Status: Chapter 83, Statutes of 2011.

AB 335 (Solorio) – Workers' compensation: notices.
Requires the Administrative Director of the Division of Workers' Compensation, in consultation with the Commission on Health and Safety and Workers' Compensation, to prescribe reasonable rules and regulations for serving certain notices on an employee. Further requires the administrative director, in consultation with the commission, to develop and make available plain language descriptions of the workers' compensation claims process. Further requires each notice to be written in plain language and to reference the informational material to enable employees to understand the context of the notices.
Status: Chapter 544, Statutes of 2011.

AB 375 (Skinner) – Workers' compensation: hospital employees: presumption.
Would have provided, with respect to hospital employees who provide direct patient care in an acute care hospital, that the term "injury" include a blood borne infectious disease or

methicillin-resistant Staphylococcus aureus that develops or manifests itself during the period of the person's employment with the hospital.
Status: Failed passage on the Senate Floor.

AB 378 (Solorio) – Workers' compensation: pharmacy products.
Regulates the dispensing of compounded medications and other pharmacy goods in the workers' compensation system.
Status: Chapter 545, Statutes of 2011.

AB 480 (Solorio) – Insurance: solid waste facilities.
Requires the Department of Resources, Recycling, and Recovery to accept the use of a captive insurer for up to 50% of the financial assurance required of an operator of a solid waste landfill.
Status: Chapter 713, Statutes of 2012.

AB 500 (Solorio) – Unemployment Insurance Code: penalties.
Would have allowed for the forfeiture of Unemployment Insurance compensation benefits if the recipient was convicted of certain offenses in a court of competent jurisdiction of this state, any other state, or the federal government. Would have deleted the requirement that the Employment Development Department provide 10 days notice before filing criminal charges for making false statements related to Unemployment Insurance compensation claims. Would have made numerous changes to the penalties for violations of the Unemployment Insurance Code.
Status: Died pursuant to Art. IV, Sec. 10(c) of the Constitution.

AB 584 (Fong) – Workers' compensation: utilization review.
Would have required physicians who are authorized to conduct utilization reviews to be licensed in the state.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "This bill would require that the physician conducting utilization review of requests for medical treatment in Workers Compensation claims be licensed in California.
>
> This requirement of using only California-licensed physicians to conduct utilization review in Workers Compensation cases would be an abrupt change and inconsistent with the manner in which utilization review is conducted by health care service plans under the Knox-Keene Act and by those regulated by the California Department of Insurance.
>
> I am not convinced that establishing a separate standard for Workers Compensation utilization review makes sense."

AB 585 (Fong) – Workers' compensation: cancer presumption.
Extends the disputable presumption of cancer as an occupational injury to active firefighting members of a fire department that serves a National Aeronautics and Space Administration installation and who adhere to specified training standards.
Status: Chapter 550, Statues of 2011.

AB 624 (John A. Perez) – California Organized Investment Network.
Extends the Community Development Financial Institution investments tax credit until January 1, 2017. Authorizes the Insurance Commissioner to establish a California Organized Investment Network Advisory Board until January 1, 2015.
Status: Chapter 436, Statutes of 2011.

AB 689 (Blumenfield) – Insurance: annuity transactions: suitability.
Requires insurance producers and insurers selling annuities to have reasonable grounds to believe their recommendations are suitable for consumers, and adoption of a regulatory process to enforce this requirement.
Status: Chapter 295, Statues of 2011.

AB 690 (Solorio) – Portable electronics insurance.
Revises and recasts the laws governing the sale of insurance in connection with portable electronic devices, their accessories, and associated services.
Status: Chapter 165, Statues of 2011.

AB 705 (Blumenfield) – Insurance: relating to insurance.
Would have prohibited domestic insurers from acquiring foreign investments from or located in foreign jurisdictions designated as state sponsors of terrorism by the United States Secretary of State.
Status: Died pursuant to Art. IV, Sec. 10(c) of the Constitution.

AB 736 (Charles Calderon) – Insurance: licenses: fraud prevention.
Would have authorized a person licensed to transact accident and health insurance to be an agent, a broker, or both.
Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 793 (Eng) – Insurance producers: reverse mortgages.
Prohibits an insurance broker or agent from participating in, being associated with, or employing any party that participates in, or is associated with, the origination of a reverse mortgage if the broker or agent has a direct financial incentive to issue the reverse mortgage. Also prohibits, with exceptions, individuals transacting insurance from receiving compensation, commission, or direct incentive for providing reverse mortgage borrowers with a noncasualty insurance product that is connected to or a result of the reverse mortgage.
Status: Chapter 223, Statues of 2011.

AB 804 (Yamada) – Unemployment compensation: disability benefits: paid family leave.
Would have extended eligibility for the state's family leave act temporary disability insurance benefits to grandparents, grandchildren, siblings or parents-in-law.
Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 947 (Solorio) – Workers' compensation: temporary disability payments.
Would have authorized up to 240 weeks of temporary disability benefits for workers who, on the advice of a workers' compensation system physician, 1) delayed surgery while less expensive or invasive treatment was tried 2) would have used up to 104 weeks of temporary disability benefits during that time, and 3) required surgery and post-surgery recovery period exhausted any remaining weeks of temporary disability benefits.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "This bill would extend the requirement to pay workers' compensation temporary disability payments for up to 240 weeks in cases where surgery or recovery from surgery occurs after the current 104 week temporary disability limit.
>
> It is vital that injured workers receive adequate compensation to provide for their needs when they are unable to work due to work related injuries. Workers' compensation reforms, however, need to be addressed on a broad and balanced scale -- ensuring workers receive adequate and timely benefits and treatment, while also ensuring that the costs of the system are sustainable."

AB 974 (Portantino) – Workers' compensation: insurance: rates.
Would have provided that workers' compensation insurance rates may not include a price differential for policies sold through brokers as opposed to direct sale by the insurer.
Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 999 (Yamada) – Long-term care insurance.
Revises long-term care insurance oversight to enhance consumer information and revise rate calculation requirements.
Status: Chapter 627, Statutes of 2012.

AB 1004 (Hagman) – Insurance: Conservation and Liquidation Office: receivership.
Would have required the Conservation and Liquidation Office of the Department of Insurance to report and publish specified claims on a quarterly basis through a public filing with the court in which an insurer's liquidation proceeding is pending. Would have required the CLO to provide specified notice to claimants whose claims have been allowed. Would have required the receiver, the Insurance Commissioner, or the CLO, as applicable, upon receipt of notice that an allowed claim has been assigned to another party, to process that claim within 21 days.

Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 1024 (Hueso) – Insurance: low-cost automobile insurance: sales.
Authorizes insurance agents and brokers to sell low-cost auto insurance through an Internet website, and requires the California Automobile Assigned Risk Plan to create a website for referring consumers to certified agents or brokers for the purchase of low-cost automobile insurance. Requires the Department of Motor Vehicles to update the insert regarding the low-cost automobile insurance program that is included in registration renewals to reflect the online program established by this bill.
Status: Chapter 401, Statutes of 2011.

AB 1063 (Bradford) – Automobile insurance: underinsured motorist coverage.
Would have expanded the scope of underinsured motorist coverage by repealing certain statutory limitations on the scope of coverage.
Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 1098 (Hagman) – Insurance: unlawful practices.
Would have required that requests be made in writing when the Department of Insurance requests that an auto body repair shop was denied participation in the insurer's direct repair program.
Status: The bill was subsequently changed to be a non-insurance bill.

AB 1106 (Achadjian) – Occupational safety and health: local public entities: penalty moneys: grants.
Would have allowed any county, city, special district, public authority, public agency, or joint powers authority to apply for a refund of civil penalties assessed for violations of occupational safety and health laws if the conditions that violated the laws have been corrected.
Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 1129 (Portantino) – Employment information: student loan guaranty agencies.
Would have allowed the Director of the Employment Development Department to share information with a designated student loan guaranty agency with an operating agreement with the California Student Aid Commission.
Status: Held in Assembly Judiciary Committee.

AB 1145 (Cedillo) – Workers' compensation: permanent disability benefits.
Would have provided, for injuries that cause permanent partial disability and occur on or after January 1, 2013, for a supplemental job displacement benefit in the form of a voucher for up to $6,000 to cover various reeducation and skill enhancement expenses which would expire two years after the date the voucher is furnished to the employee or five years after the date of injury, whichever is later.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

"I commend the author for his hard work on this measure to more effectively re-train injured workers and improve return to work rates. I note that the provisions in this measure are included in the recently enacted comprehensive workers' compensation reform legislation - - making a second measure unnecessary at this time.

These reforms - backed by both Democrats and Republicans - reduce costs to businesses and protect workers. Further, they will help to avert an imminent crisis of skyrocketing rates that would have hurt both injured workers and businesses."

AB 1155 (Alejo) -- Workers' compensation.
Would have stated the intent of the Legislature to prohibit the use of risk factors and specified characteristics to deny an injured worker his/her rightful benefit when disabled in the workplace. Would have specified that the approximate percentage of a permanent disability of an injured employee caused by other factors not directly arising out of the industrial injury of the employee shall not include consideration of race, religious creed, color, national origin, age, gender, marital status, sex, sexual orientation, or genetic characteristics, in the determination of worker's compensation benefit.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

"This bill would state that workers' compensation injury determinations shall not include consideration of race, religious creed, color, national origin, age, gender, marital status, sex, sexual orientation, or genetic characteristics.

The courts already recognize that apportioning a disability award to any of these classifications is antithetical to our states' non-discrimination policies. The courts also recognize that apportioning to an actual non-industrial condition that contributes to causing a disability is permissible and required by the principle that apportionment is based on causation.

This bill would not change existing law as interpreted by the courts to date. This bill would, however, generate new litigation over questions of whether it is intended to change existing interpretations. At best, that additional litigation would add to employers' costs for workers' compensation. At worst, this bill could disturb the appropriate interpretation of existing law that is already taking shape in the courts."

AB 1168 (Pan) – Workers' compensation: vocational expert fee schedule.
Requires the Administrative Director of the Division of Workers' Compensation to adopt a fee schedule for services and testimony by vocational experts in the workers' compensation system.
Status: Chapter 555, Statutes of 2011.

AB 1263 (Williams) – State Compensation Insurance Fund: directors and officers: postemployment.
Extends current post-employment lobbying restrictions for State Compensation Insurance Fund Board Members and exempt employees from one year to two years and requires board approval of consulting contracts with former board members or exempt employees.
Status: Chapter 53, Statutes 2011.

AB 1363 (Alejo) – Workers' compensation insurance: rating organizations: statistical agent.
Would have required the Workers' Compensation Insurance Rating Bureau to comply with the open meetings and public records laws that govern public entities in California.
Status: Died pursuant to Art. IV, Sec. 10 (c) of the Constitution.

AB 1416 (Committee on Insurance) – Insurance omnibus.
A Department of Insurance Code Maintenance bill, which updates terminology to make the code consistent, delete erroneous cross-references, and perform other non-controversial code clean-up.
Status: Chapter 411, Statutes of 2011.

AB 1425 (Committee on Insurance) – Insurance.
Standardizes the adoption of future regulations implementing California's life settlement law under standard, rather than emergency, Administrative Procedures Act procedures, repeals an obsolete reporting requirement by the Insurance Commissioner regarding credit insurance agents, and repeals the requirement to adopt emergency regulations in connection with implementing the low-cost automobile insurance program.
Status: Chapter 414, Statutes of 2011.

AB 1426 (Solorio) – Workers' compensation: court administrator.
Eliminates the position of court administrator in the workers' compensation system and distributes the duties to the Workers' Compensation Appeals Board and the Administrative Director of the Division of Workers' Compensation.
Status: Chapter 559, Statutes 2011.

AB 1427 (Solorio) – Worker's compensation insurance: fraud.
Would have repealed an obsolete requirement of the Bureau of State Audits to submit a report on workers' compensation, and replaces a rarely used word in the Insurance Code with a commonly used word.
Status: The bill was subsequently changed to a non-insurance bill.

AB 1454 (Solorio) – Workers' compensation: audiologists.
Would have included doctors of audiology who meet specified requirements among those medical professionals who may be appointed by the Administrative Director of the Division of Workers' Compensation as a qualified medical evaluator.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "I commend the author for his leadership role in reforming California's Workers' Compensation system.
>
> These reforms - backed by both Democrats and Republicans - reduce costs to businesses and protect workers. Further, they will help to avert an imminent crisis of skyrocketing rates that would have hurt both injured workers and businesses."

AB 1551 (Torres) – Insurance: public safety employees: accidents.
Would have provided an exemption from the duty to report automobile accidents to a private insurer if the accident occurs while a public safety officer is driving his or her personal vehicle at the request or direction of the employer, in the course of the officer's duties, and would shift liability for damages and injuries arising from those accidents to the employers.
Status: The bill was subsequently changed to a non-insurance bill. The contents of AB 1551 as passed by the committee were amended into AB 2298.

AB 1603 (Feuer) – Mortgages and deeds of trust: mortgage servicers: force-placed insurance.
Would have regulated the practice of force-placing replacement homeowner's insurance by mortgage servicers.
Status: Ordered to inactive.

AB 1687 (Fong) – Workers' compensation.
Would have required notice to an employee of the options available to object to a decision made pursuant to a workers' compensation utilization review process that would modify, delay, or deny medical treatment. Would have authorized an award of attorney's fees to an injured employee who successfully challenges an employer's workers' compensation utilization review determination.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "The recently enacted landmark comprehensive workers' compensation reform legislation makes this measure unnecessary.
>
> These reforms - backed by both Democrats and Republicans - reduce costs to businesses and protect workers. Further, they will help to avert an

imminent crisis of skyrocketing rates that would have hurt both injured workers and businesses."

AB 1708 (Gatto) – Vehicles: electronic verification of financial responsibility and insurance.
Clarifies existing law to allow motorists to present proof of insurance electronically to law enforcement agents upon request. Authorizes auto insurance companies to provide, upon request of a policyholder, an electronic version of the proof of insurance card required by law.
Status: Chapter 236, Statutes of 2012.

AB 1734 (Hagman) – Insurance: Conservation and Liquidation Office.
Would have required the Conservation and Liquidation Office (CLO) at the Department of Insurance to publish data identifying the businesses with claims against insurers being liquidated by the CLO.
Status: Held in the Assembly Judiciary Committee.

AB 1747 (Feuer) – Life insurance: nonpayment premium lapse: notice.
Establishes a statutory minimum 60-day grace period for nonpayment of premium on life insurance policies. Requires that life insurers permit policy owners to designate at least one other person to receive notice of a missed payment and prohibits termination of an individual life insurance policy until that notice has been mailed 30 days prior to the effective date of termination for nonpayment of premium.
Status: Chapter 315, Statutes 2012.

AB 1794 (Williams) – Unemployment insurance: use of employer reports: reporting and payroll: enforcement.
Authorizes the Employment Development Department to provide specific new employee information to the Joint Enforcement Strike Force on the Underground Economy, the Contractors State License Board, and the State Compensation Insurance Fund; permits those agencies to share the new hire information for the purposes of auditing, investigating, and prosecuting violations of tax and cash-pay reporting laws; extends the sunset date, to January 1, 2019, of the expanded contractor payroll audit provision; and directs that the specified requirements under the memorandum of understanding regarding the administration and enforcement of the reporting and payroll duties relating to contractors are to be executed on or before July 1, 2013.
Status: Chapter 811, Statutes of 2012.

AB 1845 (Solorio) – Unemployment compensation benefits: overpayment assessments: termination: income tax withholding.
Conforms the state's unemployment insurance program administered by the Employment Development Department to changes in federal law.
Status: Chapter 783, Statutes of 2012.

AB 1949 (Cedillo) – Public employees: annuities and mutual fund custodial accounts.
Would have permitted a school district to restrict the investment products offered in its "403(b)" plan based on a competitive review process.
Status: Held in the Assembly Insurance Committee.

AB 2069 (Solorio) – Workers' compensation: peace officer benefits.
Allows the children and spouses of a Sheriff's Special Officer of the County of Orange the right to receive educational scholarships and health benefits should he/she die or be totally disabled in the line of duty.
Status: Chapter 819, Statutes of 2012

AB 2072 (Eng) – Workers' compensation: acupuncturists.
Would have required the Commission on Health and Safety and Workers' Compensation to report to the Legislature by December 31, 2013, on whether acupuncturists, whether or not they have obtained qualified medical evaluator status, possess the knowledge, skills and abilities to conduct disability evaluations in the workers' compensation system.
Status: Held in the Assembly Appropriations Committee.

AB 2084 (Solorio) – Blanket insurance.
Expands the classes of policy holders to whom blanket insurance that may be offered by California admitted insurers.
Status: Chapter 321, Statutes of 2012.

AB 2138 (Blumenfield) – Health insurance fraud: annual fee.
Grants the Insurance Commissioner the authority to raise the special purpose assessment that funds investigations and prosecution of fraudulent disability insurance claims up to 20 cents annually per insured.
Status: Chapter 444, Statutes of 2012.

AB 2160 (Blumenfield) – Insurance: Iranian investments.
Deems an investment by a domestic insurer in specified companies as a nonadmitted asset for the purposes of meeting the insurer's capital requirements. The targeted investment activities involve companies included on the list of companies prepared by the Department of General Services (DGS) pursuant to the Iran Contracting Act of 2010.
Status: Chapter 479, Statutes of 2012.

AB 2219 (Knight) – Contractors' workers' compensation insurance coverage.
Deletes the sunset date, thereby extending indefinitely the existing law requiring roofing contractors who hold a C-39 classification to maintain workers' compensation insurance, whether or not they have employees, and makes additional changes to law regarding C-39 contractors.
Status: Chapter 389, Statutes of 2012.

AB 2244 (Conway) – Workers' compensation: supplemental job displacement benefits.
Would have amended existing workers' compensation laws to require employers to compensate their employees for injuries sustained during the course of employment. Would have provided that if an injury caused permanent disability and the injured employee did not return to work for the employer within 60 days of the termination of temporary disability, the injured employee would have been eligible for supplemental job displacement benefits in the form of a nontransferable voucher for education-related retraining or skill enhancement.
Status: Read first time. Never referred to committee.

AB 2264 (Knight) – Insurance fraud: release of information: other unlawful activity.
Would have provided civil immunity for private insurance fraud investigators when they report unlawful activity not related to insurance fraud in the course of an investigation.
Status: Held in the Assembly Insurance Committee.

AB 2298 (Solorio) - Insurance: public safety employees: accidents.
Prohibits an insurer from increasing auto insurance premiums for a peace officer, member of the California Highway Patrol or firefighter if that individual was involved in an accident while operating his/her private motor vehicle while in the performance of his/her duty, and provides that the employer will assume all liability that results from such an accident.
Status: Chapter 823, Statutes of 2012.

AB 2301 (Committee on Insurance) – California Insurance Guarantee Association: definitions.
Conforms California statutes governing insolvent insurers to existing practices in cases involving multi-state insurer insolvencies.
Status: Chapter 57, Statutes of 2012.

AB 2302 (Committee on Insurance) – Workers' compensation: studies.
Would have repealed obsolete statutory requirements regarding studies on the workers' compensation system.
Status: Ordered to inactive.

AB 2303 (Committee on Insurance) – Insurance omnibus.
Annual Assembly Insurance Committee omnibus bill which conforms state law to federal insurance law, makes technical changes to the state Insurance Code, and makes changes to various insurance licensing laws.
Status: Chapter 786, Statutes of 2012.

AB 2310 (Morrell) – Unemployment insurance benefits: governmental pension and retirement payments.
Would have required Unemployment Insurance Compensation Insurance benefits to be reduced if the claimant receives a government pension.
Status: Held in the Assembly Insurance Committee.

AB 2354 (Solorio) – Travel insurance.
Updates the definition of travel insurance and shifts the licensing and regulatory compliance responsibilities from travel retailers to limited lines travel insurance agents.
Status: Chapter 257, Statues of 2012.

AB 2373 (Norby) – Independent contractor: definition.
Would have amended the definition of "independent contractor" to state that whether a person is an independent contractor is determined by considering various factors. Would have amended various other statutory codes to incorporate this definition of independent contractor.
Status: Held in the Assembly Labor and Employee Committee

AB 2451 (John A. Perez) – Workers' compensation: firefighters.
Would have provided that certain proceedings related to the collection of death benefits of firefighters and peace officers may be commenced within, but no later than, 480 weeks from the date of injury, and in no event more than one year after the date of death.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "California faces fiscal challenges unparalleled since the Great Depression. While much progress has been made to reduce our structural deficit, balance our budget, reform workers' compensation and rein in spiraling pension costs - - much work remains.
>
> This measure seeks to redress a problem whose scope is not fully knowable. Proponents cite the case of the firefighter who dies a lingering and painful death from cancer and note that if that death occurs even one day past an arbitrary statute of limitation - originally established in 1913 - the surviving dependent family members are denied substantial death benefits.
>
> Meanwhile opponents decry any expansion of this nearly 100 year old limitation as wildly fiscally imprudent, opening the doors to fiscal ruin and damnation of our efforts to restore fiscal sanity to our state.
>
> What is needed is rational, thoughtful consideration of balancing the serious fiscal constraints faced at all levels of government against our shared priority to adequately and fairly compensate the families of those public safety heroes who succumb to work-related injuries and disease.
>
> Unfortunately, little more than anecdotal evidence is available to base such deliberations upon. If deaths due to cancer for firefighters and peace officers approximate, let alone exceed, those of the general population, we can surmise the potential impact of doubling the statute of limitations. It

could increase costs to the state by tens of millions of dollars and at the local level by hundreds of millions. Alternatively, there is little credible evidence that the circumstance this measure intends to address occurs other than rarely, yet tragically. In the later circumstance the costs would be modest and reasonable.

I understand that the National Institute for Occupational Safety and Health is in the midst of one of the largest studies of firefighters and risks of death from cancer and other job related disease ever conducted. It is my sincere hope that this study, as well as data collected through our comprehensive reform of the workers' compensation system, will provide a basis to make a more informed policy and research based decision on this question in the future.

In the interim, I cannot expose state and local governments to the serious fiscal risks enactment of this measure may entail. I reserve the option to revisit this question upon the availability of more thorough research and study of this matter and direct my Department of Industrial Relations to take all steps necessary to ensure that the State collects, maintains and studies the relevant data and third party research upon which to make informed policy decisions on this matter in the future."

AB 2589 (Bradford) – Automobile insurance: underinsured motorist coverage: survey.
Would have required the California Research Bureau to conduct a survey relating to underinsured motorist insurance coverage and report its findings to the Legislature
Status: Held in the Senate Rules Committee.

AB 2627 (Allen) – Benefits payment: direct deposit.
Would have authorized the Employment Development Department (EDD) to administer the state unemployment insurance and the disability compensation programs and to distribute those benefits by direct deposit not linked to an EDD issued debit card.
Status: Held in Assembly Insurance Committee.

AB 2659 (Blumenfield) - Shared Work Program.
Would have required the Employment Development Department to implement an outreach plan for the shared work program.
d re-referred out of the Assembly Insurance Committee.

SENATE BILLS

SB 127 (Emmerson) -- Official medical fee schedule: physician services.
Would have required the Administrative Director of the Division of Workers' Compensation to annually adopt the Current Procedural Terminology codes, descriptors, and modifiers published by the American Medical Association.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "This bill would require the Administrative Director of the Division of Workers' Compensation, in order to keep the Official Medical Fee Schedule for physician services appropriately updated, to annually adopt the Current Procedural Terminology codes, descriptors, and modifiers published by the American Medical Association.
>
> Updating these codes without updating other components of the fee schedule, such as the relative values and conversion factors, would produce neither a more efficient nor accurate physician fee schedule. The bill is a piecemeal approach which would lead to additional costs and increased disputes. It also would detract from updating the fee schedule in its entirety which the Division of Workers' Compensation is currently doing."

SB 131 (Gaines) – Insurance: surplus line brokers: statement of business transacted.
Clarifies the allocation of Department of Insurance reporting requirements under the surplus lines law when multiple brokers are involved in a single surplus lines transaction by permitting delegation of the responsibility by mutual agreement among the brokers as a recognized option.
Status: Chapter 302, Statutes of 2011.

SB 220 (Price) – Life insurance: group policies.
Authorizes dependent children to be eligible for coverage under group life insurance policies up to age 26.
Status: Chapter 126, Statutes of 2011.

SB 457 (Calderon) – Workers' compensation: liens.
Requires the Workers' Compensation Appeals Board to determine, on the basis of liens filed, reimbursement for benefits paid or services provided by a self-insured employee welfare benefit plan, notwithstanding the Official Medical Fee Schedule, when an award is made for reimbursement for self-procured medical costs for the effects of an injury or illness arising out of and in the course of employment. This bill states that its provisions do not modify in any way the rights of any health care provider to file and prosecute a lien.
Status: Chapter 564, Statutes of 2011.

SB 596 (Price) – Insurance: disclosures.
Consolidates the notice of the California Earthquake Authority coverage with the notice of available discounts for earthquake coverage into a single mailing, and revises the contents of the insurance claim related written notice.
Status: Chapter 240, Statutes of 2011.

SB 599 (Kehoe) – Life insurance: retained-asset account.
Requires that all life insurance benefits be paid in the form of a lump-sum payment to the beneficiary or by another settlement option that is clearly described in the claim form. If the beneficiary does not choose one of the available settlement options, a retained-asset account would be authorized to be the default option only if the claim form provides a prominent disclosure, as prescribed, that in the absence of a choice by the beneficiary, payment of policy benefits would be made through establishment of a retained-asset account on the beneficiary's behalf. Any life insurance benefits settlement an insurer offers or recommends, other than for a lump-sum payment, would be required to conform to specified conditions. Authorizes the Insurance Commissioner to adopt regulations specifying reasonable requirements for the form of agreements entered into and written disclosures provided by these provisions.
Status: Chapter 423, Statutes of 2011.

SB 615 (Calderon) – Multiple employer welfare arrangements: benefits.
Prohibits multiple employer welfare arrangements from offering, marketing, representing, or selling any product, contract, or discount arrangement as a minimum essential coverage or as compliant with Essential Health Benefits as defined by the federal Patient Protection and Affordable Care Act, unless it meets the applicable requirements.
Status: Chapter 266, Statutes of 2012.

SB 621 (Calderon) – Insurance: life: disability discretionary clauses.
Invalidates any provision in a life insurance or disability insurance policy that provides discretionary authority to the insurer to determine eligibility for benefits or coverage.
Status: Chapter 425, Statutes of 2011.

SB 684 (Corbett) – Workers' compensation insurance: dispute resolution: arbitration clauses.
Requires an insurer that intends to use a dispute resolution or arbitration agreement to resolve disputes arising in California out of a workers' compensation insurance policy or endorsement issued to a California employer, to disclose to the employer, contemporaneously with any written quote that offers to provide insurance coverage, that choice of law and choice of venue or forum may be a jurisdiction other than California and that these terms are negotiable between the insurer and the employer. Requires that the employer sign the disclosure, as evidence of receipt, when the employer accepts the offer of coverage. Also authorizes the dispute resolution or arbitration agreement to be negotiated before any dispute arises. These provisions will apply to workers' compensation policies issued or renewed on or after July 1, 2012.
Status: Chapter 566, Statutes of 2011.

SB 691 (Lieu) – Unemployment insurance: use of information.
Permits information sharing between the Employment Development Department (EDD) and the Contractors' State License Board to assist with its workers' compensation fraud investigations. Requires the Director of EDD to provide the Agricultural Labor Relations Board with information in EDD's possession including employee, wage, and employer information for use in the investigation or enforcement of the Agricultural Labor Relations Act.
Status: Chapter 832, Statutes of 2012.

SB 711 (Rubio) – Insurance: guarantee associations.
Would have extended the time for bonds to be issued on behalf of the California Insurance Guarantee Association to pay claims of insolvent workers compensation insurers, and codified an insurance law regarding the California Life and Health Insurance Guarantee Association.
Status: The bill was subsequently changed to a non-insurance bill.

SB 712 (Committee on Insurance) – Insurance.
Requires every admitted property and casualty insurer to annually submit a Statement of Actuarial Opinion with supporting documents and an Actuarial Opinion Summary, and exempts from public disclosure, required under the California Public Records Act, all actuarial reports, work papers, or opinion summaries submitted in support of the Statement of Actuarial Opinion, and such records would not be subject to subpoena or discovery, or be admissible in evidence in any private party civil action. Extends, from January 1, 2013 to January 1, 2023, the time for bonds to be issued on behalf of the California Insurance Guarantee Association to pay the claims of insolvent workers' compensation insurers.
Status: Chapter 426, Statutes of 2011.

SB 713 (Calderon) – Insurance: proceeds: disclosure.
Establishes the Life Insurance Proceeds Disclosure Act of 2011, which requires life insurers to provide disclosures regarding death settlement payment options, including retained asset accounts, to policyholders and beneficiaries, as specified. Requires the insurer to provide to the beneficiary a supplemental contract disclosing the rights of the beneficiary and obligations of the insurer.
Status: Chapter 130, Statutes of 2011.

SB 715 (Calderon) – Annuity transactions.
Would have required adoption of more stringent procedures to assess suitability of proposed annuity sales for customers, including requiring insurers to establish a system to supervise the suitability of annuity sale recommendations. Would have established mandatory standards, procedures and processes, for insurers and producers, for assessing suitability and monitoring annuity sales recommendations made to consumers so that the insurance needs and financial objectives of consumers at the time of the transaction are appropriately addressed.
Status: Vetoed by the Governor.

GOVERNOR'S VETO MESSAGE:

> "I have just signed AB 689, a bill virtually identical to the one before me. Another won't be needed.
>
> I am returning Senate Bill 715 without my signature."

SB 777 (Lieu) – Workers' compensation insurance: coverage program.
Would have required that the final determination of the reasonableness of a request to share information in order to investigate possible workers' compensation insurance fraud be decided by the Director of the Department of Industrial Relations and the agency or organization in possession of the information.
Status: Ordered to inactive.

SB 826 (Leno) – Workers' compensation: data reporting requirement: administrative penalties.
Requires the Administrative Director (AD) of the Division of Workers' Compensation to assess an administrative penalty against a claims administrator for a violation of data reporting requirements. Requires the AD to promulgate a schedule of penalties providing for an assessment of no more than $5,000 against a claims administrator in any single year, calculated by violation type and excluding threshold rates of violations. Requires the AD to publish an annual report disclosing the compliance rates of claims administrators and would authorize the AD to publish the identity of claims administrators for this purpose.
Status: Chapter 568, Statutes of 2011.

SB 863 (De Leon) – Workers' compensation.
Enacts major comprehensive reforms to the workers' compensation system.
Status: Chapter 363, Statutes of 2012.

SB 923 (De Leon) – Workers' compensation: official medical fee schedule: physician services.
Would have required the Administrative Director of the Division of Workers' Compensation to adopt a resource-based relative value scale for physician services.
Status: The bill was subsequently changed to a non-insurance bill.

SB 959 (Lieu) – Workers' compensation: provider reimbursement: implantable medical devices, hardware, and instrumentation.
Repeals the additional, separate reimbursement in excess of the Official Medical Fee Schedule, for implantable medical devices, hardware, and instrumentation for spinal surgeries, also known as "spinal pass-through."
Status: Ordered to inactive.

SB 1105 (Lieu) – Workers' compensation: liens.
Requires the Workers' Compensation Appeals Board to allow a lien for loss-of-time benefits paid by a self-insured employee welfare benefit plan.
Status: Chapter 712, Statutes of 2012.

SB 1164 (Emmerson) – Insurance.
Extends the sunset date, from January 1, 2013 to January 1, 2016, of a limited immunity for professional liability insurers that issue non-renewal notice statements to healthcare provider policyholders that specify the reason for the nonrenewal.
Status: Chapter 131, Statutes of 2012.

SB 1170 (Leno) – Senior insurance.
Expands consumer protections governing the sale of insurance to seniors, and adds specific protections for senior veterans.
Status: Chapter 653, Statutes of 2012.

SB 1177 (Leno) – Restitution for crime victims.
Provides that, in cases where an employer is convicted of a crime against an employee, a payment to the employee or the employee's dependent that is made by the employer's workers' compensation insurance carrier shall not be used to offset the amount of a court's restitution order unless the court finds substantial evidence that all premiums for that insurance coverage have been paid in full accordance with the law.
Status: Chapter 868, Statutes of 2012.

SB 1184 (Corbett) – Senior insurance: veterans benefits.
Prohibits an insurance agent from providing assistance to a senior in obtaining veterans benefits through government programs, unless the agent maintains procedural safeguards designed to ensure that the agent or broker transacting insurance has no direct financial incentive to refer the policyholder or purchaser to any government benefits program.
Status: Chapter 222, Statutes of 2012.

SB 1212 (Calderon) – Insurance: electronic transmission.
Would have authorized insurers, if certain conditions, including voluntary policyholder opt-in, are met, to electronically provide offers of coverage or renewal of certain motor vehicle and property-casualty policies.
Status: Held in the Assembly Judiciary Committee.

SB 1216 (Lowenthal) – Reinsurance: professional reinsurers.
Conforms California law to the National Association of Insurance Commissioners' Credit for Reinsurance Model Law.
Status: Chapter 277, Statutes of 2012.

SB 1291 (Evans) – Unemployment benefits: training: teacher credentialing.
Permits teachers participating in credential preparation programs in math, science, and special education to automatically qualify for the California Training Benefits Program.
Status: Chapter 278, Statutes of 2012.

SB 1448 (Calderon) – Insurance.
Conforms California law to the recently revised Insurance Holding Company System Regulatory Act drafted by National Association of Insurance Commissioners.

Status: Chapter 282, Statutes of 2012.

SB 1449 (Calderon) – Life insurance and annuities.
Permits life insurance policies to include premium and surrender charge waivers triggered by specified medical conditions, disability, and unemployment.
Status: Chapter 567, Statutes of 2012.

SB 1450 (Calderon) – Mortgage guaranty insurance.
Eliminates, as of January 1, 2008, requirements that limit the percentage of coverage a mortgage guaranty insurer may provide for the class of insurance that insures against financial loss by reason of nonpayment of principal, interest, and other sums under any evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a first lien or charge on a residential building or a condominium unit or buildings designed for occupancy by not more than four families.
Status: Chapter 105, Statutes of 2012.

SB 1451 (Calderon) – Insurance.
Explicitly exempts policy loans from existing law that prohibits a fraternal benefit society's officers, directors, agents, employees from loaning, borrowing, or making arrangements for the loan of funds of the society. In addition, this bill allows a society to lend funds to an agent for the specific purpose of starting a business that sells the society's insurance products.
Status: Held in the Assembly Insurance Committee.

SB 1513 (Negrete McLeod) – State Compensation Insurance Fund: investments.
Expands, until January 1, 2025, the investment options available to the State Compensation Insurance Fund (SCIF) to include preferred and common equity and additional fix asset investments, and allows SCIF to participate in the Federal Home Loan Bank of San Francisco.
Status: Chapter 839, Statutes of 2012.

APPENDIX 1

Assembly Insurance Committee Hearing on:
Unemployment Insurance Fund Solvency Crisis

March 2, 2011 at 9:00 am
State Capitol, Room 437

Introduction

California's unemployment insurance (UI) system provides partial wage replacement on a weekly basis to workers who lose their job through no fault of their own. Unemployment insurance benefits are financed through employer taxes, which are held in a UI Trust Fund.

Over the past two years, a substantial increase in pay-outs has been made by the UI Fund for several reasons, including the ongoing downturn it the national economy which has led to a higher number of UI claims (and which was resulted in a negative UI fund balance in other states such as Texas, New York, Minnesota, Missouri, Illinois and North Carolina), incr3eased claim duration, an unanticipated number of unemployed high-swage earners, and an increase in benefit levels through 2005.

As a result of this increase in pay-outs, the UI Fund is expected to go bankrupt in early 2004. Consequently, for the first time, California will seek federal assistance in the form of a loan so as to be able to continue providing benefits to unemployed workers. A federal loan, however, will provide only a short-term fix. To effectively deal with the diminishing solvency and ultimate insolvency of the UI Fund, it is important to also consider other measures. Labor organizations generally support raising the taxable wage base and shifting the UI financing structure from "pay-as-you-go" to "counter-cyclical" (described below). Employer groups, on the other hand, advocate freezing the UI benefit increases, modifying the eligibility requirements to receive UI benefits, and enacting additional measures to prevent UI fraud.

Background

The Federal Social Security Act of 1935 established the UI system. The primary objective of the UI is to provide temporary financial assistance to eligible workers who become unemployed through no fault of their own. UI benefits paid to unemployed workers serve as partial wage replacement and, by adding to consumer purchasing power during recessions, they help to prevent an even further worsening of economic condonitions.

Under the Social Security Act of 1935, UI was created as a unique federal-state program. Each state creates its own laws regarding UI benefits and administers its own UI system by paying benefits and collecting tax contributions from employers. In California, the Employment Development Department (EDD) is responsible for administering the state's UI system. The federal government's role with respect to UI is approved state UI systems (this is done by the U.S. Department of Labor).

California's UI System

A. Financing of UI System

A state can finance its UI system by using either the counter-cyclical (also known as forward funding) approach or by using the pay-as-you-go approach. Under counter-cyclical funding, during periods of economic growth, the employers pay into the UI fund at levels that build trust fund reserves large enough to support the UI system through future recessions (i.e., employers pay more during economic good time and less in economic bad times). Counter-cyclical funding is based on the notion of creating a rainy day reserve to ensure that the UI Fund remains solvent during an economic slowdown.

Under the pay-as-you-go mode, employers pay UI taxes that sufficient to cover UI benefits payments but are not sufficient to build a rest fund reserve. Consequently, pay-as-you-go financing contemplates that employers must increase their contributions

during periods of recession, even though this is when the increase would be economically burdensome.

Prior to the 1980's most states' UI systems were financed using the counter-cyclical approach. Since then, however, many states have adopted the pay-as-you-go approach. California shifted to pay-as-you-go financing in 1983.

In 2003, pursuant to *AB 444 (committee on Budget), Chapter 1022, Statues of 2002,* EDD convened in a workgroup to review and revise California's UI tax structure. This is the first time in 20 years that the UI tax structure has been reviewed. According to EDD, during the past twenty years, the taxable wage ceiling has remained at the first $7,000 of an employee's wages. Meanwhile, the average weekly wage has doubled. Consequently, a higher percentage of unemployed workers qualify for the higher benefit, while the contribution rate employers pay into the UI Fund has remained constant and unchanged.

The EDD workgroup, which is comprised of representative from labor, business, the public sector, and academia, is expected to provide a recommendation to the Legislature and the Governor by the end of 2003.

B. Tax Provisions

1. Federal Tax

The Federal Unemployment Tax Act (FUTA) imposes a federal tax on employers at a rate of 6.2% on ages up to $7,000 a year paid to a worker. FUTA, however, provides a tax credit of up to 5.4% to employers who timely pay state taxes under a federally-approved state UI program. Thus, in states where the UI program complies with federal guidelines, such as California's, employers pay a federal tax of 0.8%, or a maximum of

$56 per worker, per year. The taxes levied under FUTA generally pay for federal and state administration costs for the UI program.

2. State Tax

UI benefits are financed through employer taxes. In California, in addition to the federal tax, employers pay taxes on a up to $7,000 in wages paid to each worker per year, which is the minimum wage base required under federal law. The majority of states have higher taxable wage bases than California's $7,000 wage base. The states with the highest taxable wage bases are Hawaii ($29,300), Washington ($28,500), Idaho ($27,600), and Oregon ($25,000).

California has seen basic employer contributions-rate schedules (AA – F, and a F+ schedule) with tax rates ranging from a low of 0.1% to a high of 5.4%. The tax schedule for a calendar year is determined by the ratio of the UI Fund balance on September 30, of the prior calendar year to total coverage paid for the priori completed fiscal year. As the balance decrease, employer tax contributions increase (this is how pay-as-you-go financing works).

In 2003, employers were on the "D" contribution rate schedule. Under the "D" schedule, the ratio of the UI Fund to total covered paid ranges from 1.2% to more than 1.0%, and the actual tax rate paid by employers is anywhere from 0.9% to 5.4% on the taxable wage base of $7,000. According to EDD, employers tax contributions for 2003 are forecasted at $3.01 billion, a 16.2% increase from $2.59 billion 2002.

In 2004 and 2005, due to the UI Fund's extremely low balance, employers will be on the "F" contribution rate schedule plus a 15% surcharge. Under this particular schedule, the ratio of the Fund to total covered wages paid is below 0.6%, and the tax rate paid by employers ranges from 1.5% to 6.2. EDD expects employer tax contributions to be $4.96 billion in 2004 and $5.10 billion in 2005.

Within each contribution-rate schedule, an experience rating system is used in which employer tax rates vary, depending on the amount of UI benefits paid to former employees. In other words, an employer may receive a lower tax rate when fewer claims are made by former employees or, conversely, an employer maybe assigned a higher tax rate when a greater number of claims are filed by former employees. Experience rating promotes workforce stability by encouraging employers to minimize employee turnover, manage UI claims, and reduce their tax liability.

However, California's experience rating system caps an employer's tax rate at 5.4%, despite the fact that certain employers' former employees may be receiving UI benefits in numbers much higher than other employer's former employees.

Newly-covered employers pay a "new employer tax rate" of 3.4% until they meet the requirements for experiencing rating.

C. Eligibility

In order to receive UI benefits, an individual must meet specific eligibility requirements. These requirements include being totally or particularly unemployed, being unemployed through no fault of his or her own, being physically able to work, being available for work, and actively looking for work.

In addition, an individual must have received enough wages during the 12-month "base period' to establish a claim. This requirement is based on the assumption that low earnings during the base period reflect a short or temporary attachment to the labor force, The base period is broken up into 4 quarters of three mots each, with the quarter in the which the highest wages were received determining the weekly benefits amount.

D. Benefits

As mentioned above, the amount of UI benefits for which an individual is eligible is based on the individual's' earnings in the base period. To qualify for benefits, an

individual must have either (1) earned at least $1,300 in the highest quarter of the base period, or (2) earned at least $900 in the highest quarter and earned total base period earnings of at least 1.25 times the high quarter earnings.

The maximum amount of a regular UI claim is either 26 times the individual's weekly UI benefit amount or one-half of the individual's base period wages, whichever is less.

In 2001, *SB 40 (Alarcon), Chapter 409, Statutes of 2001*, was signed into law. SB 40 enacted the first increase in UI benefits in California since 1989. The weekly UI benefit increases will be phased in annual starting in 2002 and ending in 2005. Specifically, for new claims filed with a beginning date of January 6, 2002, or after, the maximum weekly benefit amounts will increase from $230 to $330. For new claims filed with a beginning date of January 5, 2003, or after, the maximum weekly benefit amounts will increase from $330 to $370. For new claims filed with a beginning date of January 4, 2004, or after, the maximum weekly benefit amounts will increase from $370 to $410. For new claims filed with a beginning date of January 3, 2005, or after, the maximum weekly benefit amounts will increase from $410 to $450.

As of October 2003, EDD reported that there were 480,969 people receiving regular UI benefits during the October 2003 survey week. This compares with 488,123 in September 2003 and 471,881 in October of last year. At the same time, the new claims for UI were 68,326 in October 2003, compared with 48,935 in September 2003 and 60,803 in October of last year.

E. UI Disbursements and Fund Balance

According to the UI Fund Forecast developed by EDD in November 2003, disbursements are 2003 are expected to be $6.5 billion, up 6.9% from the 2002 level of $6.08 billion. In 2004, disbursements are forecasted to be $6.82 billion, and then decrease to $6.49 billion in 2005. EDD states that the projected increase in

disbursements for 2003 is due to a combination of a projected increase in the number of unemployed individuals and the UI weekly benefit increase.

According to the UI Fund Forecast developed by EDD in November 2003, EDD projects that the UI Fund will have a balance of $0.47 billion at the end of 2003. It is further projected that het UI Fund will have a $1.15 billion deficit at the end of 2004, and will increase to a $2.31 billion deficit at the end of 2005. EDD expects the UI Fund to reach insolvency in January 2004.

As noted above, in December 2003, California will join other states, including New York, Texas, Minnesota, Missouri, Illinois, and North California in applying for a federal loan. California will request up to $1.3 billion to ensure monies are available to pay UI benefits to unemployed workers. Interest will be charged on the loan if the loan is not paid back before September 30, 2004. Federal law also provides that when a state has an outstanding loan balance on January 1 for two consecutive years or the FUTA tax credit available to employers will be reduced until the loan is repaid.

Conclusion

Given the impending insolvency of the UI Fund, it is critical that the Legislature take necessary and immediate action to address this issue. In exploring the various options for restoring the solvency of the UI Fund, the challenge will be to strike the appropriate balance between ensuring that the primary purpose of the UI system, helping unemployed workers partially replace their loss of income, is not diminished and alleviating the increased tax burden employers face during an economic downtown.

APPENDIX 2

Injured Workers Since S.B. 899 (Statutes of 2004): A Discussion on the Impacts of S.B. 899 on Permanent Disability Benefits

Background Information for the Joint Hearing of the Senate Committee on Labor and Industrial Relations and Assembly Committee on Insurance

March 28, 2012 at 9:30 A.M.
State Capitol, Rm. 2040

Introduction

In April 2004, the Legislature and the Governor approved SB 899 (Poochigian), a comprehensive reform of the workers' compensation system. In 2003, AB 227 (Vargas) and SB 228 (Alarcon) were enacted to make substantial changes in the laws governing workers compensation medical benefits. In the years that followed this 2-year intensive focus on workers' compensation reform, it became clear that there were several unintended consequences. The Schwarzenegger administration, however, largely blocked further legislative reforms to address these concerns. With the election of Governor Brown, the possibility of workers' compensation reform is present and demands further exploration.

This March 28, 2012, hearing of the Senate Labor and Industrial Relations and Assembly Insurance Committees will look at impacts of SB 899 (Poochigian) of 2004 on Permanent Disability (PD) benefits for injured workers.

Workers' Compensation Basics

The two primary benefits for injured workers are medical care and indemnity payments. Indemnity payments include compensation for temporary disability (TD) and permanent disability (PD). TD is a wage replacement benefit. Workers unable to return to work within three days are entitled to temporary disability benefits to partially replace wages lost as a result of the injury. The benefits are generally designed to replace two-thirds of the lost wages, up to a statutory maximum cap. Since 2007, the TD minimum and maximum limits have been indexed every year to the percent increase in the State Average Weekly Wage (SAWW). Currently, the minimum TD award in California is $151.57 per week and the maximum award is $1010.50 per week.

PD is a benefit designed to compensate the injured worker for the permanent bodily impairment caused by the injury as well as the loss of future earning capacity that results from the injury. The details of the PD system will be discussed more fully below.

Permanent Disability (PD) Benefits

One of the most significant changes to the system enacted by SB 899 was in the PD system. There were two major changes to the PD system in SB 899. First, the old PD system was criticized as being overly subjective. Similar injuries would receive widely divergent ratings by different raters; many injuries that did not have "objective medical findings" were nonetheless

frequently rated as having compensable permanent disabilities.[1] The response was to adopt the *American Medical Association Guides to the Evaluation of Permanent Impairment* (AMA Guides). These guidelines are designed to enable the physicians who make disability reports to objectively measure the degree of impairment that various injuries cause for the injured worker. The AMA Guides recognize only objective medically identifiable injuries and impairments.

The second major change to the PD system involves one of the standards used to convert an "impairment rating" into a permanent disability rating (which then is translated into the degree of monetary compensation paid to the injured worker.) Under the old PD system, state law required an attempt to measure the extent to which the injury impeded the ability of the inured worker to compete in the labor market. Thus, just as with the impairment measurements, this standard generated a high level of subjectivity, and different results for many similar injuries. Again, an attempt was made in SB 899 to inject a more objective approach. In this case, the "compete in the labor market" standard was replaced with a standard intended to measure the extent to which the injured worker's future earning capacity was adversely affected. Specifically, Labor Code Section 4660 provides, in pertinent part, "employee diminished future earning capacity shall be a numeric formula based on empirical data and findings that aggregate the average percentage of long-term loss of income resulting from each type of injury for similarly situated employees."[2]

The manner in which the Administrative Director of the Division of Workers' Compensation (DWC) implemented this new diminished future earning capacity (FEC) factor, and the way this FEC multiplier is built into the formula that produces disability ratings, has generated substantial controversy.

By 2005, it became apparent that, since the implementation of the new Permanent Disability Rating Schedule (PDRS), ratings were coming out much lower than under the old system. Some results were expected. For example, certain injuries that received low to moderate ratings under the old system, but for which there were no "objective medical findings" to support the impairment, received a rating of no PD under the new rules. These so-called "zeros" were expected. However, many injured workers who have significant, objectively verifiable injuries saw their PD ratings come out much lower than under the old system – often 40-50% lower.

While the shift to the new system using the AMA Guides involved a degree of uncertainty, it is fair to say that few predicted a ratings reduction of the magnitude that early indications suggested, in particular for the types of injuries involved. But there is a problem with reliance on early indications, especially in workers' compensation, because it takes several years to generate statistically valid historical date to provide a precise picture of the effects of the

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[1] Despite relatively low PD benefits compared to many other states, California's system awarded some degree of PD benefits to far more injured workers than any other state. Aggregate PD costs were therefore much higher in California than in other states. One of the challenges in the various reforms over the past few years has been to figure out how to improve compensation for the more seriously, objectively injured workers without increasing costs unnecessarily.

[2] There were several goals in the move toward "objective" standards. Many argued that these standards would be the most scientifically accurate results. But just as important, the problem with the subjective standards used in the old system is that results varied so widely that parties on both sides of a case would see the results, and be aware of other similar cases that were much more favorable to their position. Thus, far more cases were being litigated than necessary simply because no one had a firm belief that the ratings were sound and unchangeable.

changes. Nonetheless, legislators and others expressed concerns, and asked the Commission on Health and Safety and Workers' Compensation (CHSWC) to evaluate the impacts of the reforms on PD ratings.

Based on the CHSWC analysis (but not its recommendations), and the analysis of others, the 2006 Legislature passed SB 815 (Perata), which would have increased PD benefits. The bill was vetoed by Governor Schwarzenegger. The Senate Committee on Labor and Industrial Relations held an informational hearing in 2010, inquiring as to why the Division of Workers' Compensation had failed to update the Permanent Disability Schedule as required. The Administrative Director of the Division at that time, Carrie Nevans, pointed to economic stressors and workers' compensation insurance market instability as to why the Division had neglected to act.

In 2010, the Senate Committee on Labor and Industrial Relations held an informational hearing, inquiring as to why the Division of Workers' Compensation had failed to update the Permanent Disability Schedule as required by statute. The then-Administrative Director of the Division, Carrie Nevans, pointed to economic stressors and workers' compensation insurance market instability to explain why the Division had refused to act.

More recent research, which will be presented to the Committee by two highly respected researchers from U.C. Berkeley and the California Workers' Compensation Institute, respectively, shows that the earlier reports of 40-50% reductions have continued. That is, of the injured workers still receiving PD benefits under the new rules, there has been a substantial reduction of benefits, in addition to the intended savings from the system reforms adopted by SB 899.

This hearing seeks to review where the workers' compensation system is nearly 8 years after the passage of SB 899 and how that system is serving permanently injured workers. Specifically, we are seeking guidance from the Insurance Commissioner and the Administration on what their priorities are in revising the Permanent Disability system through workers' compensation fraud investigations, stabilizing the workers' compensation insurance market, and both statutory and regulatory reforms that will lessen the cuts to Permanent Disability awards due to SB 899.

This hearing will also be an opportunity for the different stakeholders in the workers' compensation system to provide input on what their impression is of the workers' compensation system since SB 899 and what reforms they would like to see. Specifically, we will hear from employer and injured worker representatives, as well as medical providers. Finally, we will have a public comment period where members of the public will be offered the opportunity to make a brief comment to the committee.

APPENDIX 3

(Without Reference to File)

SENATE THIRD READING
SB 863 (De León)
As Amended August 30, 2012
Majority vote

SENATE VOTE: Vote not relevant

INSURANCE 10-0

Ayes: Perea, Hagman, Bradford, Carter, Feuer, Beth Gaines, Miller, Mitchell, Olsen, Skinner

SUMMARY: Enacts major reforms to the workers' compensation system. Specifically, this bill:

1) Eliminates one of the two pathways for chiropractors to qualify as Qualified Medical Evaluators (QME).

2) Limits the number of office locations that a QME may file with the Division of Workers' Compensation (DWC) to 10.

3) Reduces the scope of evaluations that QMEs perform by establishing an Independent Medical Review (IMR) system, patterned after the existing IMR process implemented by the Department of Managed Health Care (DMHC) for resolving health insurance disputes, to resolve medical treatment issues.

4) Establishes a hierarchy of standards that are to be applied by IMR, with the Medical Treatment Utilization Schedule adopted by the Administrative Director (AD) as the highest source for evaluating the appropriateness of medical treatment, followed by the same ranked standards that apply to HMOs under the Knox-Keene Act.

5) Eliminates the Workers' Compensation Appeals Board's (WCAB) authority to adjudicate medical treatment disputes that are directed to the IMR process.

6) Permits the employee to provide new information to the IMR not reviewed by utilization review (UR), provided the employee gives this additional information to the employer to allow the employer an opportunity to reconsider based on this information.

7) Allows the employee to appeal a UR decision by requesting an IMR either immediately after the UR decision or after getting a second utilization review with addition information.

8) Makes the results of the IMR process binding on all parties, absent clear and convincing evidence of fraud or conflict of interest, that the AD acted in excess of his or her authority, that the decision was the result of bias relating to protected classes, or that the decision was the result of a plainly erroneous express or implied finding of fact that is a matter of ordinary

knowledge and not a matter that is subject to expert opinion.

9) Prohibits the WCAB or a court to make a determination on a medical matter in the event of a reversal of an IMR decision, and instead requires that the matter be returned to IMR, for additional appropriate proceedings.

10) Establishes penalties in the event an employer fails to notify an injured worker of his or her right to IMR, or fails to implement a decision by IMR favorable to the injured worker.

11) Provides that a reversal of a UR decision by IMR is not necessarily an unreasonable delay in providing treatment within the meaning of the provisions that penalize an insurer or employer for unreasonably denied treatment.

12) Adopts findings and declarations of legislative intent with respect to the IMR process and its value to injured workers and to the workers' compensation system.

13) Establishes an Independent Bill Review (IBR) process to take medical billing disagreements out of the jurisdiction of the WCAB adjudication system under rules similar to the IMR process.

14) Adopts a severability clause for the IMR provisions.

15) Provides for the AD of the DWC to contract with qualified organizations to implement the IMR and IBR functions, subject to detailed conflict of interest rules and substantive responsibilities, as specified.

16) Co1 tains findings relating to the need to contract for IMR and IBR services.

17) Allows an employee who has health insurance from any source to pre-designate his or her own physician as the primary treating physician in the event of a subsequent workplace injury.

18) Repeals several outdated annual reporting requirements.

19) Prohibits Professional Employer Organizations (PEOs) and temporary staffing agencies from becoming self-insured for workers' compensation purposes, and requires any of these entities that are currently self-insured to become insured by January 1, 2015.

20) Requires public agencies that are self-insured to submit specified data to the Department of Industrial Relations (DIR) for purposes of policy analysis, and directs the Commission on Health and Safety and Workers' Compensation (CHSWC) to conduct a study of public sector self-insured programs.

21) Provides that the costs incurred by DIR in administering the public sector workers' compensation program are to be paid from the Workers' Compensation Administration Revolving Fund (user funding as opposed to General Fund).

22) Repeals the requirement that a second opinion be obtained in cases of spinal surgery, and instead would resolve questions of appropriateness of spinal surgery in the IMR process.

23) Streamlines the Agreed Medical Evaluator (AME) and QME process to eliminate unnecessary delays and friction in the system.

24) Provides that a report by a physician procured independently by an injured worker cannot be the sole basis of an award for compensation, but that a QME or authorized treating physician, when the QME or authorized treating physician is preparing a report, shall address any such report and indicate whether he or she agrees with the findings or conclusions of the independently procured physician, and there reasons therefore.

25) Establishes a prohibition for any interested party in the workers' compensation system to have a financial interest in another entity to which it is referring a party for services, or for which it is paying or receiving compensation, if the employer is paying the charges; provided that financial interests in affiliated entities in claims handling are subject to mandatory disclosure rather than this prohibition.

26) Increases aggregate Permanent Disability (PD) benefits by approximately $740 million per year, phased in over a two-year period, and adjusts the formula for calculating the benefit amount so that compensation amounts more accurately reflect loss of future earnings, and to ensure that no class of injured workers receive a lower award than under the present system.

27) Eliminates sleep disorder and sexual dysfunction "add-ons" to primary injuries that do not include these injuries when calculating the level of PD, but require all appropriate medical treatment for these injuries.

28) Eliminates the diminished future earnings capacity from the determination of permanent disability, and limits the definition of permanent disability to include only a consideration of how age and occupation affects the overall classification of employment of the injured worker, rather than the individual injured worker's ability to compete in the open labor market or reduction of future earnings.

29) Limits psychological add-ons when calculating a PD rating to cases involving catastrophic injury or that involved a violent workplace incident.

30) Provides that all permanent disability awards are increased by a multiplier of 1.4.

31) Establishes a return to work program administered by the Director of the DIR, funded with $120 million annually from the workers' compensation revolving fund, for the purpose of making supplemental payments to workers whose PD benefits are disproportionately low in comparison to their earnings loss.

32) Requires the Director to adopt regulations to establish eligibility for these payments, based on studies conducted by the Director in consultation with the Commission on Health and Safety and Workers' Compensation (CHSWC).

33) Provides that in enacting the bill adding these changes to the PD system, it is not the intent of the Legislature to overrule the holding in *Milpitas Unified School District v. Workers' Comp.*

Appeals Bd. (Guzman), which established that the presumption that an American Medical Association (AMA) Guides rating is correct is rebuttable by evidence presented by the injured worker.

34) Clarifies that an insurer or employer can pay for physical medicine treatments in excess of the 24-visit cap without that payment constituting a blanket waiver of the cap.

35) Provides that a chiropractor who has reached the 24-visit cap cannot serve as the injured worker's primary treating physician.

36) Eliminates the requirement that a Medical Provider Network (MPN) have non-occupational medicine specialists constitute at least 25% of the physicians in the network.

37) Requires an MPN to obtain a written acknowledgement from a physician that the physician agrees to be in the MPN.

38) Requires all MPNs to have a "medical access assistant" staff person or persons, who need not be employees, but who must be located within the United States, to aid injured workers in obtaining appointments or referrals within the MPN.

39) Allows the AD to generically approve an MPN, as opposed to requiring a separate approval for each employer.

40) Provides that the approval of an MPN by the AD is conclusive in a matter before the WCAB that the MPN is valid, subject to proof that there was a specific failure as to a specific injured worker.

41) Requires periodic administrative audits of MPNs by the AD.

42) Authorizes discretionary administrative audits of MPNs by the AD.

43) Limits the reasons that can be used to avoid obtaining treatment within an MPN, and establishes an expedited process to resolve any disputes about whether the injured worker is required to be treated within the MPN.

44) Requires a physician who knows or should know that the patient is suffering from an occupational injury to notify the employer within five days that the injured worker is being treated outside the MPN, and prohibits payment by an employer or insurer for any treatment provided to the injured worker when the notice requirements have not been complied with.

45) Provides that where interpreter services are needed, the injured worker shall make a request to the employer or insurer, and the employer or insurer shall pay for the interpreter services.

46) Requires that interpreters be certified, and authorizes the AD to establish, operate or contract for an interpreter certification program.

47) Prohibits an interpreter certification entity from having a financial interest in training or employing interpreters.

48) Modifies the Supplemental Job Displacement Benefit (SJDB) rules to:

a) Change the point in time the benefit is triggered;

b) Prohibit "cashing out" the retraining voucher in settlements;

c) Establish which schools are qualified to be paid by the retraining voucher;

d) Limit the time period during which the voucher is valid to 2 years; and,

e) Specify that an injury that occurs during retraining does not constitute a compensable injury.

49) Prohibits the filing of a lien against an award for matters that are subject to IMR and IBR dispute resolution.

50) Establishes a $150 filing fee in order to file a lien, recoverable if the lien claimant prevails.

51) Establishes a $100 activation fee for legacy liens (unless the lien was previously subject to a since-sunsetted $100 filing fee), recoverable if the lien claimant prevails.

52) Adopts firm time limits within which liens must be filed.

53) Adopts a fee schedule for ambulatory surgery centers (ASCs).

54) Requires the DIR to study the feasibility of establishing a facility fee for services performed in ASCs.

55) Requires the AD to adopt a medical fee schedule methodology based on Medicare's resource based relative value system (RBRVS) system, with specified modifications for California's workers' compensation system, including geographic adjustments.

56) Clarifies the rules that govern the fee schedule applicable to vocational expert compensation, and provides that written testimony, in lieu of live testimony, is proper.

57) Provides that if the Medi-Cal fee schedule for prescription medications is reduced in order to meet specified Medi-Cal budget needs, that reduction shall not be included in the workers' compensation official medical fee schedule, which is otherwise linked to the Medi-Cal schedule.

58) Prohibits payment for home care services where the services were already being provided prior to injury (i.e., no pay for cooking for the injured worker if a spouse was already doing that function prior to injury); authorizes the AD to adopt a home care services utilization and fee schedule, and limits the re-opening of old cases where home care services are alleged to have been provided but were not authorized or ordered by a physician before the services were rendered.

59) Authorizes the AD to adopt a fee schedule for copying services, and establishes substantive rules to govern these services.

60) Eliminates the "double-payment" pass-through for implantable surgical hardware, subject to the AD adopting a regulation to allow an additional reimbursement where the basic hospital fee schedule does not adequately cover the cost of the hardware.

61) Contains language to prevent chaptering problems with SB 1105 (Lieu).

EXISTING LAW:

1) Provides, based on the state constitution, that the Legislature has plenary authority to establish a system of providing workers' compensation benefits to workers who suffer injuries that arise out of or in the course of employment.

2) Grants the Legislature broad discretion is establishing the means by which disputes in the workers' compensation system may be resolved.

3) Includes both medical services and indemnification payments for permanently disabled workers among the various benefits that are available to injured employees.

4) Provides for "employer control" of medical treatment if the employer establishes an MPN that meets detailed criteria, including a requirement that 25% of the doctors in the MPN are not occupational medicine specialists.

5) Provides that an employer is entitled to require an injured employee to be treated for a workplace injury within its MPN, provided that the MPN is approved by the AD, and various notice requirements have been met.

6) Allows, via case law, injured employees to be treated outside the MPN due to minor failures in pre-employment notice requirements, workplace notice posting requirements, as well as substantive deficiencies in the MPN.

7) Allows an entity that arranges for networks of medical providers to require a physician to participate in a workers' compensation network as a condition of participation in other networks arranged by that entity.

8) Limits the right to predesignate a person's own physician as the primary treating physician in the event of a workplace injury to employee's who have employer provided health insurance.

9) Provides that most services provided to parties in the workers' compensation system are subject to a fee schedule, but does not have a formal fee schedule for interpreter, copying, transportation or ambulatory surgery center services.

10) Provides that disputes about medical treatment are resolved based on pre-litigation utilization review by employers, expert medical opinion obtained through the QME/AME process, and litigation before a workers' compensation judge.

11) Requires billing disputes (that is, conflicts over whether billing codes were properly complied with, fee schedules properly applied, and related matters that do not involve a challenge to the actual services provided) be resolved by a workers' compensation judge in connection with the case-in-chief, often causing delays in settling cases, and creating a huge backlog of low-priority workload for workers' compensation judges.

12) Allows a report from a self-procured physician to be admitted into evidence on any disputed issue, even if the employee has improperly declined to seek treatment within the MPN.

13) Establishes selected, but not comprehensive, financial conflict of interest rules for participants in the workers' compensation system.

14) Allows basic PD ratings to be increased due to individualized evidence that the injured worker has suffered "compensable consequences" of the primary injury due to sleep and sexual disorders that flow from the primary injury.

15) Allows an injured worker to present evidence to rebut a PD rating derived from the basic PD rating formula, and to present evidence of a diminished future earning capacity.

16) Establishes a Supplemental Job Displacement Benefit, but contains functional impediments in most cases that prevent delivery of these benefits in a manner helpful to an injured worker who needs retraining.

17) Contains a soft statute of limitation on the filing of liens for disputed medical or other services, and requires that liens be adjudicated by workers' compensation judges.

18) Requires the AD to adopt and periodically update an Official Medical Fee Schedule, but does not mandate or prohibit that this schedule be based on medicare's RBRVS system.

19) Provides that medications provided to injured workers shall be paid for at the rate determined by the MediCal fee schedule.

20) Allows generally for home care services to be paid for where an injured worker needs these services as a result of the injury, but does not provide any specific rules governing the scope of or payment for these services.

FISCAL EFFECT: Unknown

COMMENTS:

Purpose. This bill reflects a negotiated compromise between employers and employees to adopt a substantial increase in permanent disability benefits ($740 million), to ameliorate unexpected reductions that flowed from the 2004 reforms, balanced by substantial changes in the benefit delivery system to eliminate waste, inefficiency, and other loopholes that result in unnecessary employer costs that go to recipients other than injured workers.

Workers' Compensation – the Great Compromise. Fundamentally, workers' compensation is an agreement between employers and employees to each give up a right in exchange for the stability and certainty of the workers' compensation system. Employees give up the right to sue in tort for

injuries, and employers give up the right to contest fault. Employees give up the right to tort damages in favor of more limited, but more certain and more easily obtained benefits. Employers agree to pay benefits in all cases where the injury is work related. The hallmark of this arrangement is that relatively certain defined benefits are to be delivered to injured workers on a no fault basis in a relatively timely manner.

In this system, the relevant parties to the agreement are employees and employers. Every other stakeholder – providers of medical services and products, lawyers, insurers, and various providers of a range of related services – are service providers contributing goods and services necessary to carry out the agreement between employees and employers. However, they are not direct parties to the agreement.

Over the years, the principles of relatively certain defined benefits and relatively timely delivery have been seriously eroded. Inconsistency in parties' ability to ascertain exactly what benefits an injured worker is entitled to have forced the system to develop a complex, cumbersome, and slow litigation-based dispute resolution system. At a fundamental level, the proposal contained in this bill is an effort by the direct parties to the workers' compensation agreement (employees and employers) to return to the principles of relatively certain defined benefits, and relatively timely delivery of those benefits.

The 2004 Reforms. In 2004, with recently-elected Governor Schwarzenegger poised to file signatures to place a workers' compensation reform initiative on the ballot, the Legislature passed and the Governor signed SB 899 (Poochigian), Chapter 34, Statutes of 2004 – in lieu of the initiative. These reforms enacted a broad range of changes to the workers' compensation system, but two issue areas are of primary importance to the reform proposal contained in this bill.

First, SB 899 (Poochigian) substantially changed the permanent disability rating system. Employers and insurers had long complained that the rating system was far too subjective, which resulted in widely varying results for similar cases. The result of this variation was a tremendous amount of litigation because both sides could see the potential of changing the result in a great number of cases. SB 899 adopted several changes to the law designed to resolve this problem. The bill required objective medical findings, the use of the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition (AMA Guides), and use of a numerical formula to address the impact on the injured worker's future earning capacity (FEC). These changes were intended to reduce litigation and increase consistency of results. They were also intended to eliminate some cases altogether – so-called "zeroes" who under the old system obtained a rating based on subjective but not medically verifiable pain. Under the new rules, this class of injured worker receives a "zero" percent PD rating.

These reforms did not have as much impact on litigation as predicted, largely due to a clearly unexpected result – PD awards for injured workers who still obtained a rating fell by approximately 50% or more on average. This result was largely due to the way the Schwarzenegger Administration's regulations implemented SB 899. The call for reform had never included an argument that widespread benefit reductions be included. As these reductions became evident, lawyers sought aggressive means to develop ways to increase the low ratings, and they succeeded in certain respects, discussed in more detail below. Contemporaneously, political pressure began to build for a PD benefit increase, which is a key component of this bill.

Second, SB 899 authorized the establishment of medical provider networks (MPNs) that, if properly established by the employer and approved by the AD, were intended to grant "employer control" over medical treatment. Prior to SB 899, the injured worker had the choice of treating physician starting 30 days after the injury. This right was criticized because of employer concerns that injured workers were being directed to physicians who were not using evidence-based treatments, and instead were engaging in treatment patterns designed to increase the legal case for higher disability ratings. The MPN was intended to provide quality evidence-based treatment for injured workers but with a network of physicians developed by the employer, which would presumably decline to contract with outlier physicians.

Two primary problems have developed with MPNs. Injured workers have far too frequently found it difficult or impossible to find physicians on the MPN list to treat them. A related problem is that because of these difficulties, many injured workers are being directed to the same outside physicians that employers sought to avoid by creation of the MPNs. In addition, physicians have complained that they are leveraged to be in networks they do not want to be in, and get listed in networks that they had no notice of. A major part of the reforms proposed by this bill involve strengthening the rules to ensure that the MPNs are sound, and strengthening the rules requiring treatment of injured workers by MPN physicians.

MPN Reforms. One of the primary concerns expressed by employers is that the expected control of medical care and delivery of evidence-based medicine to injured workers through MPNs authorized by SB 899 has not materialized. Employers point out that the workers' compensation courts have allowed a range of erosions to what was expected after SB 899 was enacted. Specifically, they point to cases where employees, after being in treatment within an MPN, simply go to outside physicians, expect those physicians to be paid by the employer, and justify this through technical notice errors that have nothing to do with the delivery of health care services. In response, this bill requires out-of-network physicians treating an injured worker to notify the employer within five days, establishes an expedited hearing process to determine if treatment outside the MPN is legitimate, and prohibits payment to physicians violating these rules. The bill is designed to eliminate existing practices whereby weeks or months of out of network treatment is being provided, often without any notice to the employer, and liens are being filed in staggering number (see below) by providers seeking payment for treatments that were not pre-authorized.

In addition, the bill tightens regulatory oversight to ensure that MPNs are viable entities, and provides rights to physicians who may not want to be included in the MPN, including a repeal of the rule at least 25% of each MPN's providers must be non-occupational medicine specialists. The concern has been that these are the providers least likely to be willing to take workers' compensation cases, and account for a high percentage of providers on the lists given to injured workers who will not schedule appointments.

These reforms are designed to improve the quality of the MPNs, and in that regard improve the quality of evidence-based medicine as the basis of treating injured workers, and based on these improvements, enhance the ability of employers to provide treatment for injured workers within the MPN.

The bill expressly eliminates some of the reasons that attorneys for injured workers have used to justify getting treated outside of MPNs. For example, the law requires a pre-employment notice to an employee that the employer uses an MPN, and there are requirements for on-site posting of

MPN notices in workplaces. Deficiencies in meeting these requirements have been used to get out of MPNs, even by injured workers who, at the time of injury received all necessary information about accessing the MPN, and who in fact had been treated by MPN providers for some time. The bill eliminates these technical violations as a basis to obtain treatment outside of the MPN, establishes a presumption that an approved MPN is valid, but continues to allow an injured worker to prove that the MPN is failing to make appropriate treatment available, thereby justifying outside treatment.

The bill also addresses one of the incentives to seek treatment outside of an MPN. Case law at the WCAB level had held that a medical report obtained outside an MPN that should have been used for treating the worker was inadmissible in WCAB proceedings. The Court of Appeal revered this rule in the *Valdez* case. Employers have argued that allowing this sort of evidentiary use would incentivize wrongful efforts to seek treatment outside of the MPN. The bill stops short of overruling the Court of Appeal, but adds two rules: first, the bill provides that a report from an outside physician shall not be the sole basis of an award of compensation, and second, a QME or treating physician shall consider the outside report in any report they make, and indicate agreement of disagreement, and the reasons therefore.

Independent Medical Review. This bill proposes to change the way medical disputes are resolved. Currently, when there is a disagreement about medical treatment issues, each side attempts to obtain medical opinions favorable to its position, and then counsel for each side tries to convince a workers' compensation judge based on this evidence what the proper treatment is. This system of "dueling doctors" with lawyers/judges making medical decisions has resulted in an extremely slow, inefficient process that many argue does not provide quality results. Long delays in obtaining treatment result in poorer outcomes, reduced return to work potential, and excessive costs in the system, none of which are good for injured workers. This bill would instead adopt an independent medical review system patterned after the long-standing and widely applauded IMR process used to resolve medical disputes in the health insurance system. Thus, a conflict-free medical expert would be evaluating medical issues and making sound medical decisions, based on a hierarchy of evidence-based medicine standards drawn from the health insurance IMR process, with workers' compensation-specific modifications. The bill contains findings that this system would result in faster and better medical dispute resolution than existing law.

The IMR system is designed to ensure that medical expertise is used to resolve medical disagreements. Thus, the decision from the IMR is final and binding on the parties. Nonetheless, in the exercise of the Legislature's plenary authority to establish a workers' compensation system that includes a review of decisions, there is a process to appeal the IMR result, but this review process does not allow the second-guessing of medical expertise. Rather, the appeal is limited to circumstances where there was fraud, conflict of interest, discrimination based on protected classes, or clear mistakes of facts that do not involve medical expertise.

According to the California Applicants' Attorneys Association (CAAA) the IMR process prohibits WCAB or judicial review of medical necessity for treatment of work injuries, and is in direct conflict with the California Supreme Court's Determination in *State Compensation Insurance Fund v. Workers' Compensation Appeals Board (Sandhagen)*, which provided that an injured worker was entitled to an expeditious, complete and final judicial review of all treatment disputes. It should be noted that *Sandhagen* was not decided in the context of an IMR process,

and may not be on point with respect to reviewing an IMR decision.

PD Reforms. PD reforms are probably the most controversial element of the proposal. Despite increasing annual PD payments to injured workers by an estimated $740 million (after a two-year phase-in), some have objected to the way that this increase is structured, as well as changes in how approximately $1 billion in existing PD expenditures are redirected. There are numerous ways that a PD system can be structured. At one end of the spectrum, there can be relatively broad guidelines, and every injured worker could be entitled to prove to the workers' compensation courts his or her individual circumstances. This approach, of course, would have little predictability, and would have tremendous frictional costs and delays in delivering benefits. At the other end of the spectrum, there can be a total formulaic approach where there is no opportunity to bring in individualized proof. Employers have argued that the current system operates too close to the former, and this bill moves in the direction of the latter, while retaining key rights for limited individual proof of unique circumstances. Employees have agreed to these changes in exchange for increased benefits for all classes of employee, and increased certainty and speed in the delivery of the benefits.

The bill specifically limits some of the "add-ons" that can be established by individualized proof – sleep disorders, sex disorders, and to a limited extent, psychological disorders – because these add-ons have greatly expanded in recent years, largely as a result of the inappropriately low PD ratings that followed from the 2004 reforms. Since benefit levels are being substantially increased by the bill, many believe that these add-ons, which generate substantial litigation expense, are no longer needed.

Not everyone agrees with this conclusion. For example, the CAAA argues that the bill alters the existing statutory description of permanent disability and may undermine or reverse fifty years of California Supreme Court case law allowing injured workers to recover compensation for their lost ability to earn a living, citing the Court of Appeal decision in *Ogilvie v. Workers' Compensation Appeals Board* and the 2007 Supreme Court Decision in *Brodie v Workers' Compensation Appeals Board.*

Return to Work Program. The bill establishes a new return to work program within the DIR designed to direct additional benefits, without excess frictional costs, to those injured workers whose PD ratings are disproportionately low in comparison to their earnings loss. This approach was adopted in lieu of the "bump up" provisions that were in prior versions of the bill.

Lien Reforms. The current lien system in workers' compensation is out of control. There is no effective statute of limitations, because case law has developed tolling rules that result in most billing matters remaining alive indefinitely. In addition, the method of resolution requires formal litigation in an already overcrowded workers' compensation court system. There are presently hundreds of thousands of backlogged liens, possibly in excess of a million, and many of these are related to long-since closed cases.

One of the concerns most often expressed by employers is that liens get filed by providers for months of treatment when the employer had no idea that there was any treatment being provided. The bill seeks to avoid these situations by mandatory notice by providers to the employer, an expedited hearing process to determine if the provider has a right to be treating the injured worker, and a prohibition against paying bills submitted in violation of these rules.

But lien abuse is not limited to treatment the employer has no notice of. For example, it has become common for third parties to purchase old receivables from providers, who often billed at (higher) usual and customary rates but were properly paid according to established fee schedules. These third parties then file liens in an effort to leverage settlements. Another example of lien abuse involves a provider filing a lien for excessive amounts after being paid, again with the hope of obtaining a settlement. Nuisance-value settlements are rampant because the workers' compensation courts simply don't have time for these minor matters when crucial right to benefits issues are the priority cases. To address this growing volume of problem liens, the bill proposes to re-enact a lien filing fee, so that potential filers of frivolous liens have a disincentive to file. This approach worked well in the past before it sunset (due to the DWC's inability to track the fees – a problem DWC says no longer exists.) The lien filing fee is refundable if the lien-claimant prevails. In addition, for liens that are pending, and were filed after the prior filing fee sunset, the bill provides for the payment of an activation fee. Again, the purpose is to provide a disincentive to file frivolous liens.

Not surprisingly, there has been concern expressed that filing fees are a burden on providers who may have legitimate billing disputes with the employer or insurer. Therefore, in order to further eliminate a major portion of the unnecessary volume of liens, the bill would create an "independent bill review" process where expert bill reviewers would make determinations in cases where it is merely a billing, and not a substantive treatment, dispute. This IBR process would relieve substantial congestion in the workers' compensation courts, provide much faster dispute resolution, and result in better decisions by billing experts as opposed to judges, who have no special training in the arcane world of billing codes and procedures.

RBRVS. Medicare uses a resource based relative value system (RBRVS) as the foundation for calculating payment for physician services. Most states use RBRVS in their workers' compensation system. In California, this issue has been debated for years, and subject to substantial consideration and hearings by the DWC. However, it has not been adopted. Last year, the Assembly Insurance Committee passed SB 923 (De León), which would have required the DWC to adopt RBRVS, but the bill was not taken up on the Assembly Floor.

RBRVS is not without controversy within the medical community, even as it is a well-understood system that is virtually self-updating as medicare regularly updates it. Specifically, it is argued by specialists that the RBRVS rules favor primary care physicians over specialists, and would result in unfair reimbursement cuts to specialists. On the other hand, primary care physicians argue that some specialties receive reimbursement at over 300% of the Medicare rate by California's workers' compensation system. It should be noted that this bill does not provide the "revenue neutrality" provision that rendered SB 923 controversial.

Other Fee Schedules. Market pricing does not work well in workers' compensation, since the people who receive services (injured workers) are not the payors. There is not market pressure for the injured worker to say "no" to over-priced services. As a result of this dynamic, most services that employers are mandated to pay for in workers' compensation are subject to a fee schedule, and in many cases, to utilization schedules as well (as over-utilization has the same inflationary impact as over-pricing). However, not all services have been subjected to fee schedules, and some services are covered by fee schedules that allow for overly generous payments according to research data reported by CHSWC. As a result, the bill proposes establishing or updating utilization and/or fee schedules for the following services: ambulatory surgery center facility fees, interpreter services, vocational experts, home care services, and

copying services.

With respect to home care services, the bill seeks to adopt a fee schedule, identify appropriate utilization, require a physician to order the services, and cut off a practice of re-opening old cases where there had never been a physician order for home care, and pursuing a lien on behalf of a family member who cared for the injured worker. Since attorneys pursuing these claims are not representing the injured worker, the usual attorneys fee rules for workers' compensation cases do not apply. There have been reports of 50% contingency fees on claims of months of 24/7 home care services, where there had never been any notice that the services were needed or ordered by a physician.

SJDB. Return to work after an injury is crucial to an injured worker's long term financial and emotional health. California, unfortunately does a poor job of returning its injured workers to work. In 2004, SB 899 adopted a supplemental job displacement benefit designed to provide retraining services for injured workers who could not return to their existing job. However, this program has never worked well because the trigger for the benefit occurs far too late for the benefit to work well. This bill attempts to reform the SJDB to make its promise of retraining viable.

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APPENDIX 4

JOINT OVERSIGHT HEARING

Senate Committee on Insurance &
Assembly Committee on Insurance

September 25, 2012

Background Paper on Proposition 33 – Automobile Insurance Rating Factors

INTRODUCTION

Proposition 33 has been qualified to appear on the November, 2012, Statewide Ballot as a proposed initiative statute. Proposition 33 allows auto insurance companies to base their premiums, in part, on a driver's history of insurance coverage.

OFFICIAL BALLOT TITLE AND SUMMARY OF PROPOSITION 33[1]

AUTO INSURANCE COMPANIES. PRICES BASED ON DRIVER'S HISTORY OF INSURANCE COVERAGE. INITIATIVE STATUTE.

- Changes current law to allow insurance companies to set prices based on whether the driver previously carried auto insurance with any company.
- Allows insurance companies to give proportional discounts to drivers with some history of prior insurance coverage.
- Will allow insurance companies to increase cost of insurance to drivers who have not maintained continuous coverage.
- Treats drivers with lapse as continuously covered if lapse is due to military service or loss of employment, or if lapse is less than 90 days.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact:

- Probably no significant fiscal effect on state insurance premium tax revenues.

BACKGROUND

Proposition 103 of 1988

In 1988, California voters approved Proposition 103 following a decade of steadily increasing costs for auto insurance in California. Proposition 103 was the only one of four insurance reform initiatives to pass. In a November 18, 1988 editorial commenting on the passage of Proposition 103 ten days earlier, the New York Times noted that for Californians, "the typical auto insurance premium" had doubled since 1982.[2]

This doubling of the cost for auto insurance during the decade of the 1980's did not operate in a vacuum. By 1988, California's level of uninsured drivers was very high, estimated variously as either 28.4% (California DMV) or 25.6% (California DOI).[3]

In this historical context, Proposition 103 was qualified and placed on the November 1988 statewide General Election ballot with a stated goal of improving the affordability of auto insurance. It included various Findings and Declarations, among them a statement that "Enormous increases in the cost of insurance have made it both unaffordable and unavailable to millions of Californians."

Proposition 103 imposed new rules for how auto insurance rates were to be calculated as well as a system of prior approval of rates, to be administered by an elected Insurance Commissioner. As to rate-setting, Proposition 103 provides that automobile insurance rates are to be determined *"by application of the following factors in decreasing order of importance:*

(1) The insured's driving safety record.
(2) The number of miles he or she drives annually.
(3) The number of years of driving experience the insured has had.
(4) *Those other factors that the commissioner may adopt by regulation and that have a substantial relationship to the risk of loss.*

Pursuant to this 4th statutory category, the Insurance Commissioner has adopted regulations that include 16 optional rating factors that insurers may lawfully use when setting auto insurance rates and premiums. Among these optional factors is "persistency."

The regulations provide that, at policy renewal, a persistency discount can be applied by an insurer for the current named insured if *"the individual is currently insured by that company or an affiliate*". The regulations prohibit giving a persistency discount for a policy, at any time, if it is based in whole or in part on auto insurance coverage provided by a non-affiliated insurer.

The prohibition in the Insurance Commissioner's "optional rating factors" regulation against an insurance company offering a persistency-type discount to a new customer based on being insured by an unaffiliated insurance company is due to an express prohibition in Proposition 103. Specifically, Proposition 103 provides that *"The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability."*[4]

Even before enactment of Proposition 103, the issue of surcharges on drivers who lacked prior insurance was controversial. In 1985 the Department of Insurance issued Bulletin No. 85-11 specifically addressing the practice of insurers surcharging, or even refusing to cover drivers who were not currently insured.[5] The Bulletin provided, in part:

> "The intent of this bulletin is to inform recipients that [surcharging drivers who have not previously carried insurance] could result in a charge of unfair discrimination. It has been the position of this Department that lack of evidence of prior insurance in itself is not a proper rating standard. There are many reasons why an applicant may not have had prior insurance, many of which have no bearing on the applicant's future loss potential."

In the context of November 1988, when Proposition 103 was passed, with insurance rates soaring and an estimated 1 of every 4 drivers uninsured, this rule can be understood as an attempt to help persons who were then uninsured, for whatever reason, to be able to get auto insurance coverage at the best rate possible, subject to the new mandatory and optional rating factors, without being penalized by their prior lack of insurance.

Proposition 103 also includes a provision that it's new rules governing the business of insurance in California *"shall not be amended by the Legislature except to further its own purposes by means of a statute passed by a 2/3rds roll call vote or by a statute approved by the electorate."*[6]

Related Legislation – SB 689 of 2002 and SB 841 of 2003

In 2002, the Legislature passed SB 689 (Perata), which contained substantially the same proposal as Proposition 33. However, the Governor vetoed the bill, asking the Insurance Commissioner to prepare a report evaluating driver discounts that are consistent with the will of the electorate in passing Proposition 103.[7] The ensuing report by the Insurance Commissioner indicated that SB 689 conflicted with the provision of Proposition 103 that bars consideration of prior insured status. It further noted that, while the overall impact across all drivers is neutral, it would cause an increase in premiums for some drivers. (This principle is discussed in more detail, below.)

In 2003, the Legislature passed SB 841 (Perata), which contained substantially the same provisions as SB 689. This time, the Governor signed the bill. The courts, however, subsequently ruled that the bill failed to satisfy the "further its own purposes" requirement for Legislative amendments to Proposition 103.

In June 2010, a very similar initiative (Proposition 17) was voted down (48% Yes, 52).

To fully understand the controversy it is unfortunately necessary to delve into some of the details of automobile insurance rating. The Department of Insurance has explained it this way:

> "California automobile rating is unique in many ways. However, the nature of applying discounts and surcharges is not unique and reflects a basic principle of insurance ratemaking. This basic principle is "zero-sum" in the following sense: Every automobile insurer must have an approved "rate plan" that establishes its average premium. Within that rate plan, every "discount" requires a corresponding "surcharge" so that every factor will balance evenly over an insurer's book of business."

The Department's explanation continues:

> "That is, if an insurer offers a continuous coverage discount for some drivers it will result in a surcharge for other drivers."

Essentially, the "rate" is the average premium, and the price that any particular person pays is determined by what the Department refers to as the "class plan" – the matrix of discounts and surcharges that take into account all of the 19 considerations, or rating

factors, that are used to determine what a driver will be billed for his or her auto insurance.

It is impossible to predict the specific impact on a specific customer of a specific insurance company until that company submits its proposed rating plan and supporting data to the Department of Insurance. If an insurer were to propose an overall rate reduction, coupled with adoption of the Proposition 33 continuous coverage discount, it is theoretically possible that customers who did, and those who did not, have prior insurance could experience a lower premium than under that insurer's previous rating structure. Similarly, if an insurer were to propose an overall rate increase, coupled with adoption of the Proposition 33 continuous coverage discount, it is theoretically possible that customers who did, and those who did not, have prior insurance could experience a higher premium than under that insurer's previous rating structure. What is clear, however, is that the customer without prior insurance will pay relatively more if a Proposition 33 continuous coverage discount is included as part of the insurer's rate application.

The primary policy question posed by Proposition 33 is whether the potential benefits from increased competition for current customers of other insurers is outweighed by the burdens placed on certain other drivers, and the impact on the public generally should the initiative lead to an increase in uninsured drivers.

DESCRIPTION OF PROPOSITION 33[8]

According to the Legislative Analyst, "This measure amends Proposition 103 to allow an insurance company to offer a "continuous coverage" discount on automobile insurance policies to insurance consumers if they have continuously followed the mandatory insurance law. Under this measure, continuous coverage means uninterrupted automobile insurance coverage. Consumers with a lapse in coverage would still be eligible for this discount, however, if the lapse was:

- Not more than 90 days in the past five years for any reason.
- For no more than 18 months in the last five years due to loss of employment resulting from layoff or furlough.
- Due to active military service.

Also, children residing with a parent could qualify for the discount based on their parent's eligibility.

If an insurance company chose to provide such a discount, it would be provided on a proportional basis. The discount would be based on the number of years in the immediate previous five years (rounded to a whole number) that the customer was insured. For example, if a customer was able to demonstrate that he or she had coverage for three of the five previous years, the customer would receive 60 percent of the total continuous coverage discount."

ARGUMENTS PRO AND CON

According to the proponents:[9]

"CALIFORNIA CONSUMERS DESERVE A REWARD FOR FOLLOWING THE LAW AND PURCHASING CAR INSURANCE. PROPOSITION 33 LETS YOU SHOP YOUR DISCOUNT FOR A BETTER DEAL.

California law requires all drivers to buy automobile insurance. Approximately 85% of California drivers follow the law and buy insurance. If you follow the law and maintain continuous automobile insurance coverage, you are currently eligible for a discount, but only if you stay with the same insurance company.

Current law punishes you for seeking better insurance or trying to get a better deal by taking away your discount for being continuously insured.

Proposition 33 corrects this problem and offers this discount to consumers who maintain automobile insurance with any company. Proposition 33 allows you to shop for a better insurance deal.

Leaders from both parties, Democrats and Republicans, the Veterans of Foreign Wars (VFW), the American GI Forum of California, firefighters, small business owners, individual consumers, and Chambers of Commerce join in their support of Proposition 33. VOTE YES ON PROPOSITION 33. It rewards those who follow the law.

The reward you get for being responsible and following the law is yours to keep under Proposition 33, even if you exercise your right to move to a different insurance company. That is why some insurance companies like Proposition 33 and others don't. It creates competition. Your neighborhood insurance agents support Proposition 33 because it will force insurance companies to compete for your business.

We encourage you to read Proposition 33. It is simple. It makes sense.

VOTE YES ON PROPOSITION 33 because you should get the discount that you have earned, regardless of which insurance company you pick.

Proposition 33 also encourages those who don't have insurance to obtain it, because Proposition 33 makes it easier to earn the continuous coverage discount. You get a share of the discount for every full year you are insured. The longer you are insured, the greater the discount. This encourages uninsured drivers to become insured and make our roads safer.

Proposition 33 provides other protections as well:

If you are active military, Proposition 33 says you will not lose the discount. That's why our military families, led by the American GI Forum and Veterans of Foreign Wars, say Yes on Proposition 33.

If you are laid off or furloughed, Proposition 33 allows you to keep your status as a continuously covered driver for up to 18 months.

Under Proposition 33, driving age children get the discount whether they are living with their parents or are away at school.

Proposition 33 allows you to miss payments for 90 days for any reason and remain eligible for this discount.

Proposition 33 will result in more competition between insurance companies and better insurance rates because you will be able to shop around for insurance without losing your discount.

In California, you must have automobile insurance. You deserve a reward for following the law. VOTE YES ON PROPOSITION 33.

According to the opponents:[10]

Consumer advocates agree: NO ON PROPOSITION 33 —It's another deceptive insurance company trick to raise auto insurance rates for millions of responsible drivers in California.

Mercury Insurance spent $16 million on a similar initiative in 2010. Californians rejected it.

Now they're at it again. Mercury Insurance's billionaire chairman George Joseph has already spent $8 million to fund Proposition 33. When was the last time an insurance company billionaire spent a fortune to save you money?

Proposition 33 unfairly punishes anyone who stopped driving for a good reason but now needs insurance to get back behind the wheel. Proposition 33 "will allow insurance companies to increase cost of insurance," according to the Attorney General's Official

Summary—even on motorists with perfect driving records.

Proposition 33 is a cleverly worded initiative that says one thing and does another. Beware: the California Department of Insurance has said the so-called "continuous coverage discount" scheme "will result in a surcharge" for many California drivers. That's why Consumers Union, the policy and advocacy division of Consumer Reports, opposes Prop. 33.

Proposition 33 raises insurance rates for students completing college who now need to drive to a new job.

Proposition 33 raises insurance rates for people who dropped their coverage while recuperating from a serious illness or injury that kept them off the road.

Prop. 33 deregulates the insurance industry, making big insurance companies less accountable—which is why this measure is 99% funded by an insurance billionaire whose company, Mercury Insurance, has a record of overcharging consumers. The California Department of Insurance says Mercury has "a deserved reputation for abusing its customers and intentionally violating the law with arrogance and indifference." No on 33: It penalizes responsible drivers who did not need auto insurance in the past. Prop. 33 allows insurance companies to charge dramatically higher rates to customers with perfect driving records, just because they had not purchased auto insurance at

some point during the past five years. Drivers must pay this unfair penalty even if they did not own a car or need insurance at the time. No on 33: It hurts California's middle-class families.

In states where the Proposition 33 surcharge is legal, the result is HIGHER PREMIUMS:
- Texans can pay 61% more.
- Nevadans, 79% more.
- Floridians, 103% more.

No on 33: It leads to more uninsured motorists, costing us all more.

According to the California Department of Insurance, the financial penalty insurance companies want to impose "discourages [people] from buying insurance, which may add to the number of uninsured motorists and ultimately drives up the cost of the uninsured motorist coverage for every insured."

MORE UNINSURED DRIVERS hurts taxpayers and the state. No on Prop. 33: Californians already rejected a nearly identical proposal in 2010. Let's make it clear to these powerful special interests that No means No.

Don't give insurance companies more power to raise our rates. VOTE NO on PROP. 33. It's too good to be true.

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[1] As printed in the official Voter Information Guide.
[2]The New York Times, November 18, 1988, Editorial, "The Only Real Fix for Auto Insurance"
[3] "What We Know About Uninsured Motorists and How Well We Know What We Know", J. Daniel Khazzoom, December 1997 Discussion Paper, Revised April 2000, published by Resources for the Future, p. 21, footnote 23.
[4] See California Insurance Code Section 1861.02, subdivision (c).
[5] Prior to Proposition 103, there was not requirement that auto insurers issue policies to drivers with clean driving safety records, and there was minimal regulation of the factors that could be used to rate drivers.
[6] See uncodified Section 8 of Proposition 103 as approved by voters November 8, 1988. The state constitution provides that initiatives placed on the ballot by the voters are not amendable at all by the Legislature, except to the extent that the initiative itself confers that authority. The courts have ruled that the authority can be conditioned, such as a "further the purposes" clause, and that it is the courts' role, not the Legislature's role, to ascertain whether a particular amendment in fact "furthers the purposes."
[7] A copy of the report is attached.
[8] A copy of the Proposition is attached.
[9] As printed in the official Voter Information Guide.
[10] As printed in the official Voter Information Guide.