Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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1971 – AB 2860 (Burton and Brown) Pages 2-28
1972 – AB 1199 (Speaker Moretti) Pages 29-30
1972 – SB 770 (Moscone) Pages 31-59
1978 – AB 1207 (Hart) Pages 60-97

October 2007
AMENDED IN ASSEMBLY SEPTEMBER 20, 1971
CALIFORNIA LEGISLATURE—1971 REGULAR SESSION

ASSEMBLY BILL
No. 2860

Introduced by Assemblymen Burton and Brown

April 16, 1971

REFERRED TO COMMITTEE ON HEALTH

An act to add Division 8 (commencing with Section 10000) to the Labor Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL’S DIGEST

AB 2860, as amended, Burton (Health). Health insurance. Adds Div. 8 (commencing with Sec. 10000), Lab.C. Enacts a program of comprehensive health insurance administered by the state.

Vote—%: Appropriation—Yes; Fiscal Committee—Yes.

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

SECTION 1. Division 8 (commencing with Section 10000) is added to the Labor Code, to read:

DIVISION 8. CALIFORNIA STATE COMPREHENSIVE HEALTH INSURANCE

CHAPTER 1. GENERAL PROVISIONS

10000. This division shall be known and may be cited as the Health Insurance Act.

10001. The Legislature hereby finds that the benefits
of the recent great advances in medical science have not
reached all the people in the state; that adequate hospital
and medical care is not available to all those who need it;
that only the highest-income groups and the poor who
are aided by public or private charity are relieved of the
ever-present concern over costs of personal health
services, while the vast middle-income and relatively low
income groups are left to cope with the shattering costs
of serious or prolonged illness; that the maldistribution of
available medical and hospital services causes, among
other things, wholly inadequate provision for the health
needs of families residing in our inner cities and rural
areas; that very few voluntary health insurance plans
provide adequate benefits and then at costs beyond the
reach of those families who most need such services; and
that medical and hospital services and facilities must be
expanded if the public health and welfare are to be
preserved and protected. The Legislature hereby
declares, as the public policy of the state, that adequate
medical and hospital care is a basic need and right of
every resident of the state, that fulfilling this need is a
duty and concern of the state and will best be
accomplished by the establishment of a comprehensive
statewide health insurance system which will make
preventive and curative health services and adequate
hospital facilities available to all.

CHAPTER 2. DEFINITIONS

10050. Wherever used in this division, the terms
hereinafter defined have the meanings ascribed to them
in this section except where the context requires a
different meaning.

10051. "Commission" means the Health Insurance
Commission.

10052. "Certified hospital" means any hospital
certified pursuant to this division and shall include a
nongeriatric facility or other facility designed primarily
for persons who are in need of acute medical or nursing
care and not for the senile aged who are in need only of
custodial care and maintenance.
10053. “Certified medical group” means any group of physicians or persons licensed under Sections 2943 or 9041 of the Business and Professions Code certified pursuant to this division as (a) having the necessary qualifications and engaged in the practice of the several specialties and areas of medicine prescribed by the commission and the necessary office space, equipment, facilities and medical apparatus required by the commission, (b) meeting the standards and other requirements established by the commission, and (c) affiliated with at least one certified hospital.

10054. “Comprehensive hospital services” means all services, as determined by the commission, performed in a certified hospital which are directly related to patient care, including, but not limited to, inpatient diagnostic, laboratory, medical and surgical care, ambulatory care in the hospital and in such decentralized care centers as the hospital may establish or designate and the furnishing of drugs and medicines prescribed pursuant to Section 10209.

10055. “Comprehensive medical services” means all medical services, as determined by the commission, including services performed by persons licensed under Sections 2943 or 9041 of the Business and Professions Code, except those performed by an optometrist, podiatrist, chiropractor or dentist (other than dental surgical care) and except for any service which an individual is eligible to receive from the United States, or in any institution, or from any provider of care, wholly supported by federal funds.

10056. “Scheduled hospital services” means those services directly related to patient care, performed in a duly licensed hospital, including but not limited to, inpatient diagnostic, laboratory, medical and surgical care, and ambulatory care, as determined and at the rate determined from time to time by the commission and the furnishing of drugs and medicines pursuant to Section 10210.

10057. “Scheduled medical services” means those medical services, except those performed by an
optometrist, podiatrist, chiropractor or dentist (other than dental surgical care), as determined and at the rate determined from time to time by the commission, but shall not include any service which an individual is eligible to receive from the United States or in any institution, or from any provider of care, wholly supported by federal funds.

10058. “Director” means the Director of the Health Insurance Commission.

10059. “Fund” means the Health Insurance Fund.

10060. “Employer” means any person, partnership, firm, association, public or private corporation, the legal representatives of a deceased person, or the receiver, trustee or successor of a person, partnership, firm, association, public or private corporation, including the state, municipal corporations, other governmental subdivisions, and all public agencies and authorities, who or whose agent or predecessor in interest has employed three or more persons in any employment subject to this division on each of 15 or more days within any calendar year.

Whenever any helper, assistant or employee of an employer engages any other person in the work which said helper, assistant or employee is doing for the employer, such employer shall for all purposes hereof be deemed the employer of such other person, whether such person is paid by the said helper, assistant or employee, or by the employer, provided the employment has been with the knowledge, actual, constructive or implied, of the employer.

In determining whether an employer is subject to this division, and in determining the taxes for which he is liable hereunder, such employer shall, whenever he contracts with any person for any work which is part of such employer’s usual trade, occupation, profession or enterprise be deemed to employ all employees employed by such person for such work, and he alone shall be liable for the taxes hereunder with respect to wages paid to such employees for such work, unless such person performs work or is in fact actually available to perform
work for anyone who may wish to contract with him and
is also found to be engaged in an independently
established trade, business, profession or enterprise.

10061. “Employee” means any person employed for
hire by an employer in an employment subject to this
division.

10062. “Employment” means any employment of an
employee by an employer in which all or the greater part
of the employee’s work is performed within the state
under any contract of hire, express or implied, oral or
written, and shall include any trade, occupation, service
or profession in which any person may engage; except
service for an employee by his spouse or minor child.

10063. “Employer’s contribution” means the taxes
due to the fund under this division from an employer on
account of and on behalf of each insured person
employed by him in an employment subject to this
division during the period of such employment.

10064. “Advisory council” means the State Advisory
Health Insurance Policy Council.

10065. “Year”, for the purposes of determining
liability for taxes and eligibility for benefits under this
division shall mean calendar year.

CHAPTER 3. HEALTH INSURANCE COMMISSION

Article 1. Administration

10100. There is in the Human Relations Agency the
Health Insurance Commission, under the control of an
executive officer known as the Director of the Health
Insurance Commission.

10101. The commission shall consist of the director
and eight members appointed by the Governor, subject
to confirmation by the Senate.

The terms of the eight members appointed by the
Governor shall be four years except that of the members
first appointed, two shall be appointed for terms of one
year, two for terms of two years, two for terms of three
years and two for terms of four years. Not more than four
of such members shall be of the same political party, and
no member may be a provider of medical or hospital
services under this division. The eight members
appointed by the Governor shall appoint a recognized
expert in the fields of public health and delivery of
medical and hospital services as director of the
commission, who shall be the chief executive and
operating officer and chairman of the commission and
shall serve for a term of four years. He shall devote his full
time and attention to the duties of his office and shall
receive the annual salary provided for in the
Government Code.

10102. Each of the appointed members shall receive
the sum of one hundred dollars ($100) for each day
engaged in the performance of his duties under this
division, not to exceed 100 days during any one calendar
year, and, in addition thereto, shall be entitled to
reimbursement for his traveling and other expenses
actually and necessarily incurred by him in the
performance of his duties hereunder.

10103. A majority of the commission shall constitute a
quorum to transact business. No vacancy shall impair the
rights of the remaining members to exercise all of the
powers of the commission so long as a majority remain.
Any investigation, inquiry, hearing or review which the
commission is authorized to hold or undertake may be
held or undertaken by or before any one member of the
commission, or by or before one or more of its deputies;
and every order made by a member thereof, or by one or
more of its duly authorized deputies, when approved and
confirmed by a majority of the commission, and so shown
on its record of proceedings, shall be deemed to be the
order of the commission. The commission may, by
majority vote of its membership, adopt such rules of
procedure for the conduct of its business, not inconsistent
with any of the provisions of this division, as it may deem
fit and it may from time to time, by like action of a
majority, supplement, amend, alter, modify or repeal its
rules of procedure in any respect.

10104. The commission may establish offices and hold
meetings in any place within the state.

Article 2. Powers and Duties

10125. The commission shall have the power to accept grants and donations of money for any of its purposes, to employ such persons as may be necessary to carry out the provisions of this division, to make such contracts and agreements as may be necessary to carry out the provisions of this division, to adopt and enforce such rules and regulations as may be necessary to accomplish the purposes of this division and to carry out its provisions, and to amend or repeal the same from time to time only in accordance with the provisions of Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code.

10126. The commission is hereby designated to act as the agent of the state or of the appropriate department thereof to submit the plan of statewide health insurance contemplated by this division for and obtain the approval of all federal agencies having jurisdiction and control over state plans for rendering medical and hospital services under federal laws, including Title XVIII and Title XIX of the Social Security Amendments of 1965 (Public Law 89-97), as now in force or hereafter amended, commonly known and referred to as the medicare and medicaid programs, and to accept and receive, and to deposit into the fund any and all grants of money available to the state under such laws, in reimbursement for the cost of such services or programs or otherwise. The commission shall act as the agent of the state or of the appropriate department thereof in any negotiations relative to the submission and approval of such plan and make any arrangement not inconsistent with law which may be required by or pursuant to such federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such federal laws.

10127. The commission shall require all providers of medical services and hospital services to render detailed
records of such services, including the person to whom
rendered, the person by whom rendered, and the total
fees therefor.

10129. The commission shall establish, by rule or
regulation, procedures to receive complaints in respect of
services and benefits furnished under this division, and
for appeals to the commission by persons aggrieved by
any determination made under this division.

10129. All records of the commission except the
personal medical records of persons receiving benefits
under the provisions of this act and all personnel records
of employees of the commission shall be deemed to be
public records for all purposes.

10130. In addition to all of the duties, powers and
authorities specifically imposed and conferred upon the
commission by this division, the commission shall serve
and function as a regulatory and policymaking body and
it shall have full power and authority:

(a) After consultation with the advisory council, to
establish standards of administration throughout the state,
to effect maximum efficiency and quality of medical and
hospital services and to prevent overutilization of such
services; such standards shall include provisions for
continuing medical education;

(b) To supervise and make inquiries and
investigations into the administration of this division and
the furnishing and payment of the benefits therein
provided and to do all things it deems necessary or
proper to improve the same throughout the state or in
any part thereof;

(c) If, after inquiry or investigation, it is satisfied that
the benefits provided by this division are not being
furnished adequately, properly or efficiently within any
local area, to authorize the director to make
arrangements and do all other things he deems fit or
necessary in order to insure the adequate, proper and
efficient furnishing of said benefits within said local area
including assistance in the establishment of certified
medical groups;

(d) After consultation with the advisory council as to
questions of general policy and administration, to study
and make recommendations as to the most effective
methods of providing benefits, and as to legislation and
matters of administrative policy concerning health and
related subjects;
(e) To delegate to any officer or employee of the
commission such of its powers and duties, except that of
prescribing rules and regulations, as it may consider
necessary and proper to carry out the purposes of this
division;
(f) To make inquiries into the causes and results of
sickness and injuries, the sources of mortality and the
effect of localities, employments and other conditions
upon the health of the persons entitled to the benefits
provided by this division and of the public generally; to
obtain, collect, preserve and, from time to time, publish
such information relating to mortality, sickness, injury
and health as may be useful in the administration of this
division or may contribute to the promotion of health or
the security of life;
(g) To promote the health and safety of the persons
entitled to the benefits provided by this division and to
take such steps within its means as it may deem feasible
and appropriate to reduce and prevent sickness, injury
and death among such persons;
(h) To cooperate with public health officers and all
other agencies, public and private, in the improvement
of public health and sanitation and in the promotion of
public education in all matters pertaining to health;
(i) To acquire, by purchase, exchange or otherwise,
personal and real property and to erect, construct and
equip buildings necessary to the proper administration of
this division and the exercise of its duties, powers and
authorities thereunder; and
(j) To make grants for medical research.
10130. It shall be the duty of the commission to make
a written report to the Governor and the Legislature not
later than December 1st of each year on the operation
and administration of this division in all its phases.
10132. The director shall be the chief executive and
operating officer under this division and he shall have all
the duties, powers and authorities imposed and granted
by this division or assigned to him by the commission. As
representative of the commission and under its direction,
he shall supervise, direct and control the administration
and enforcement of this division throughout the state,
and all administrative and executive powers and duties
needed for the proper administration and enforcement
of this division shall be vested in the director to be
exercised by him within the provisions of this division and
the rules and regulations adopted thereunder and subject
to the policies and in accordance with the principles
established by the commission. He shall have full power
and authority to appoint and employ such employees and
assistants as may be required for the administration
of the provisions of this division, to fix their compensation
within the amount available therefor, and to prescribe
their duties.

CHAPTER 4. ADVISORY HEALTH INSURANCE
POLICY COUNCIL

10150. There is hereby established in the commission
an advisory health insurance policy council to consist of
14 members. Two of such members shall be generally
representative of industry and two of such members shall
be generally representative of labor, three of such
members shall be generally representative of consumer
groups; one shall be a public member; one shall be
representative of government; one shall be generally
representative of the medical schools in the state and one
each shall be generally representative of providers of
comprehensive medical services, scheduled medical
services, comprehensive hospital services, and scheduled
hospital services under this division.

10151. The advisory council shall meet not less
frequently than twice a year and whenever at least six of
the members request a meeting.

10152. The commission shall appoint the members of
the advisory council who shall hold office for a term of
four years, except that any member appointed to fill a 
vacancy occurring prior to the expiration of the term for 
which his predecessor was appointed shall be appointed 
for the remainder of such term, and the terms of office 
of the members first taking office shall expire, as 
designated by the commission at the time of 
appointment, two at the end of the first year, four at the 
end of the second year, four at the end of the third year, 
and four at the end of the fourth year, after the date of 
appointment.

10153. Each appointed member shall receive 
compensation at the rate of seventy-five dollars ($75) per 
day for each day spent in attending meetings of the 
advisory council and for the time devoted to official 
business of the advisory council under this chapter, 
inclusive of travel time; and actual and necessary 
traveling and other expenses while away from his place 
of residence upon official business under this chapter.

10154. The advisory council, and each of its appointed 
members, may be provided by the commission with such 
secretarial, clerical or other assistants as the commission 
shall authorize.

10155. The commission, by a majority vote, may at 
any time remove any member of the council for cause 
after a hearing on written charges.

10156. The advisory council shall advise the board and 
the director with reference to all questions of general 
policy and administration in carrying out the provisions 
of this division.

10157. The advisory council may establish special 
advisory, technical, regional, or local committees or 
commissions for local areas or regions of the state whose 
membership may include members of the advisory 
council or other persons or both, to advise upon general 
or special questions, professional and technical subjects, 
questions concerning administration, problems affecting 
regions or localities, and related matters.

**Chapter 5. Health Insurance System**
Article 1. Eligibility and Coverage

10200. A statewide health insurance system is hereby established. Such system shall consist of Plan 1 and Plan 2, as hereinafter defined. Every person eligible for coverage under such system shall elect coverage under Plan 1 or Plan 2, in the manner hereinafter provided.

10201. Every bona fide resident of this state except those on active duty in the armed forces of the United States and those confined in federal, state and local penal institutions shall be eligible for the benefits of the health insurance system set forth in this division.

10202. A person electing coverage under Plan 1 may become a patient of any certified medical group in the state. As such patient he shall be entitled to receive comprehensive medical services from such group and comprehensive hospital services in the certified hospital with which such group is affiliated. If such person receives or is eligible to receive benefits under Title XVIII of the Social Security Amendments of 1965 (Public Law 89-97), as now in force or hereafter amended, commonly known as the medicare program, he shall be entitled to benefits under this division only after he has exhausted such benefits under such law or program, unless he assigns to the commission all of his right, title and interest in and to reimbursement for such benefits as may be provided under this division.

10203. (a) A person electing coverage under Plan 2 shall be entitled to receive reimbursement for scheduled medical services furnished to him, in accordance with the fee schedule promulgated by the commission and he shall also be entitled to receive scheduled hospital services, in accordance with the fee schedule promulgated by the commission. If such person receives or is eligible to receive benefits under Title XVIII of the Social Security Amendments of 1965 (Public Law 89-97), as now in force or hereafter amended, commonly known as the medicare program, he shall be entitled to benefits under this division only after he has exhausted such benefits under such law or program, unless he assigns to the corporation
all of his right, title, and interest in and to reimbursement for such benefits as may be provided under this division. 
(b) Such person shall pay in the first instance for all such medical services furnished to him and shall be entitled to be reimbursed therefor by the commission, in accordance with the fee schedules promulgated by the commission and the provisions of this division. 
(c) Before receiving reimbursement for medical services or hospital services furnished to such person, such person shall assume, bear and pay the first fifty dollars ($50) of the cost of such services rendered to such person in any one calendar year, not to exceed one hundred fifty dollars ($150) for a family group consisting of a person and his legal dependents for personal income tax purposes, and 20 per centum of the remainder of such costs. 
(d) The first fifty dollars ($50) of the cost of hospital services rendered to each such person shall be borne by and paid by such person directly to the hospital in which such services were rendered unless satisfactory proof is furnished to such hospital that such person has already paid such amount for such services in such calendar year. In addition thereto, such person shall bear and pay for such services 20 per centum of the remainder of such costs. The balance of such costs shall be paid by the commission directly to such hospital, in accordance with the rules and regulations of the commission.

10204. Every person electing coverage under either Plan 1 or Plan 2, who is receiving or is eligible to receive medical assistance under the provisions of the Medi-Cal Act, shall be entitled to additional benefits, as provided in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

10205. The corporation shall bill the Department of Health Care Services for the nonfederal share of the total cost of all services furnished by the commission pursuant to Section 10204, and the Department of Health Care Services shall pay to the commission the amount of all such bills out of any moneys available to such department for medical assistance at such times and in such
installments as the commission and such department may
mutually agree upon.

10206. Every person eligible for coverage under the
health insurance system shall apply to the commission for
coverage on forms to be furnished by the commission. If
electing Plan 1, he shall indicate on such application the
name of the certified medical group of which he chooses
to be a patient. The commission shall issue an appropriate
identification card to all eligible applicants. Eligible
applicants may also apply in behalf of their dependents
who must also qualify for eligibility under this division.

10207. Except in cases of change of residence, no
person may transfer from one plan to another or from one
certified medical group to another within Plan 1 except
during the third quarter of each year, to be effective on
the first day of January next succeeding.

10208. The commission shall publish and otherwise
make known in each local area the names and addresses
of certified medical groups and the names of the
physicians therein who have agreed to furnish services as
benefits under Plan 1.

10209. All prescriptions for drugs ordered by a
member of a certified medical group or by a certified
hospital for a patient electing coverage under Plan 1 who
is a patient of such group or who is being treated in such
hospital as a patient of such group shall be filled by the
pharmacy in such hospital and included as part of the
comprehensive hospital services furnished to such
patient. At the option of any such outpatient, such
prescriptions may be filled at any licensed or registered
pharmacy in this state, subject to the rules, regulations
and fee schedules promulgated by the commission. In the
event of the exercise of such option by such outpatient,
the pharmacy filling such prescriptions shall bill the
commission for the amounts due therefor, in accordance
with the fee schedule promulgated by the commission,
and the commission shall audit and pay to such pharmacy
the amount due on such bill and deduct the amount of
such payment from any moneys to which the certified
hospital, which would otherwise have filled such
prescription, shall be entitled to receive from the
commission under this division.

10210. All prescriptions for drugs ordered for a
patient electing coverage under Plan 2 who is being
treated in a hospital as a patient under such plan shall be
filled by the pharmacy in such hospital as part of the
scheduled hospital services furnished to such patient.

Article 2. Certification

10225. A group of physicians may apply to the
commission to be certified as a medical group under and
for the purposes of this division. Each such group shall be
composed of physicians having the necessary professional
qualifications and be engaged in the practice of the
several specialties and areas of medicine prescribed by
the commission. Each such group must be affiliated with
at least one certified hospital by contract in accordance
with this division and the rules and regulations of the
commission. Except for reasons satisfactory to the
commission, each such group shall accept as a patient any
person eligible for coverage under the health insurance
system who elects Plan 1 and applies for medical care by
such group. Each such group shall furnish such
comprehensive medical services to all of such persons as
may be necessary.

10226. Existing groups providing personal health
services on the effective date of this division may receive
interim certification as a certified medical group by the
commission under rules and regulations to be
promulgated by the commission; provided that such
interim certification shall not be for a period of more than
two years. During such period of interim certification the
commission may adjust payments to be made under the
provisions of this chapter.

10227. Any city or county medical society may qualify
as a certified medical group under Plan 1, provided it
meets the qualifications and standards established by the
commission.

10228. Certification of hospitals. 1. Any duly
approved and legally operated hospital in this state may apply to the commission for certification as a certified hospital under and for the purposes of this division. Such hospital shall comply in all respects with the requirements, qualifications and standards established and promulgated by the commission. Such hospital must have entered into an affiliation agreement with at least one certified medical group. Such agreement shall comply with the rules and regulations of the commission and copies of such agreement shall be filed with the board and such agreement shall be a public record. Such agreement must provide that the hospital will accept as patients therein all persons who are patients of the certified medical group making such agreement and allow all of the physicians constituting such group hospital privileges for the purpose of attending, treating and caring for such patients in such hospital. Every certified hospital shall furnish such comprehensive hospital services to all of the patients of the certified medical group or groups with which it is affiliated under and for the purposes of this division.

10229. The commission may, by order, require a certified hospital to enter into an affiliation agreement with one or more additional certified medical groups if the commission finds, that such requirement is in the public interest and that such certified hospital has adequate facilities and capacity to care for the patients of such group or groups; and failure to comply with such order shall be sufficient ground for the decertification of such hospital.

Article 3. Payments

10250. A per capita payment shall be made by the commission on behalf of each person electing coverage under Plan 1. Such payment shall be apportioned between the certified medical group chosen by such person and the certified hospital with which such group is affiliated. The amount of the payment and the dates of such payments shall be determined by the commission.
and shall be uniform throughout the state, except that it may vary from one geographic area to another, based on local cost differentials, as determined by the commission. The apportionment of the total payment among the certified medical group and the certified hospital shall be determined by agreement between such group, such hospital and the commission. Such agreements shall be public records.

10251. The commission shall from time to time establish and promulgate lists setting forth scheduled medical services and scheduled hospital services and payments to and on behalf of persons electing coverage under Plan 2 shall be made in accordance with such schedules.

Article 4. Extraordinary Medical Services

10275. (a) One per centum of the total per capita payments to be made to certified medical groups and certified hospitals in each calendar year for persons electing coverage under Plan 1 shall be withheld by the commission and paid into a special fund, which shall be subject to and governed by the same provisions of this division governing the health insurance fund.

(b) Such special fund shall be held for the purpose of making the payments required by this section.

(c) In the event that any person electing coverage under Plan 1 requires either medical services or hospital services of an extraordinary nature which cannot be provided by the certified medical group of which he is a patient or by the certified hospital with which such group is affiliated, the commission may authorize such services to be furnished by other physicians or hospitals and shall pay for such services from the special fund created by this section, in accordance with a special fee schedule established and promulgated by the commission.

10276. (a) The fees for the scheduled medical services and scheduled hospital services listed pursuant to Section 10251 shall be reduced by 1 per centum which shall be withheld by the commission and paid into a
special fund, which shall be subject to and governed by
the same provisions of this division governing the health
insurance fund.
(b) Such special fund shall be held for the purpose of
making the payments required by this section.
(c) In the event that any person electing coverage
under Plan 2 requires either medical services or hospital
services of an extraordinary nature, the commission may
authorize such services to be furnished by any physician
or hospital who or which can provide such services and
shall pay for such services from the special fund created
by this section, in accordance with special fee schedules
established and promulgated by the commission for such
extraordinary services.

Article 5. Subrogation

10300. (a) If any of the benefits provided by this
division are furnished in the event of sickness, injury or
disability to any person who by reason of such sickness,
injury or disability has a right to or claim for
compensation, benefits or damages against his employer
or any other person for causing such sickness, injury or
disability and for the damages resulting therefrom,
whether under any workmen’s compensation or
employers’ liability act, or otherwise under any statute,
ordinance, code, regulation or rule of law, the
commission shall, to the extent of the cost of the benefits
so furnished, be entitled to reimbursement out of any
sum or damages which said person receives by way of
compensation or benefits or through suit, settlement or
judgment and the commission shall, to said extent, be
subrogated to the said right or claim. Upon notice to the
one against whom said right or claim exists or is asserted,
the amount to which the commission is so entitled by way
of reimbursement shall be a lien upon said right or claim
and the said sum or damages paid or received
thereunder. Nothing in this section contained shall be
construed to prevent the prompt furnishing of any
benefits to any person pending the settlement or
determination of any such right or claim had or asserted by such person and the cost of any benefits so furnished shall, without prejudice to any other method of recovery, be recoverable by deduction from or suspension of any benefits to which such person may subsequently become entitled. If the benefits are so furnished to any person, the commission may give notice thereof to the one against whom such a right or claim exists or is asserted and the latter may repay to the commission the amount and cost of the benefits so furnished and such repayment shall, up to the amount thereof, be a full and valid discharge to him in respect of his liability to such person.

(b) If a person receiving the said benefits provided by this division for sickness, injury or disability has any such right or claim and fails, after a period of six months from the date such right or claim accrues, to take action or proceedings to enforce the same, it shall be lawful for the commission, at its own expense, to take such action or proceedings in the name and on behalf of such person, in which case any sum recovered by settlement or judgment in excess of the claim for reimbursement given to the commission and the reasonable expense of the action or proceedings shall be held by the commission as trustee for such person.

(c) A compromise of any such claim or cause of action by the employee in an amount less than the cost of the health insurance benefits furnished or to be furnished pursuant to this division shall be made only with the written consent of the commission.

(d) All moneys received pursuant to this section shall be deposited into the state health insurance fund for the purposes of such fund.

CHAPTER 6. FISCAL PROVISIONS

Article 1. Payroll Tax

10350. (a) A tax is hereby levied upon each employer in this state based upon his gross annual payroll. If such annual payroll is under one hundred thousand dollars,
1 ($100,000) the rate of the tax hereby imposed shall be 1½ percent. If such annual payroll is one hundred thousand dollars ($100,000) or more but less than five hundred thousand dollars ($500,000), the rate of the tax hereby imposed shall be 2 percent. If such annual payroll is five hundred thousand dollars ($500,000) or more, the rate of the tax hereby imposed shall be 2½ percent. The Franchise Tax Board shall adopt rules and regulations for the determination of an employer’s gross annual payroll, for the purposes of this section, based upon the projection of such employer’s gross weekly payroll or gross monthly payroll or other substantially similar factors.

(b) Such tax shall be due on the date when the wages or compensation of the employees on such payroll is due and payable to such employees and shall be payable to the Franchise Tax Board at such time, not less frequently than monthly, as the Franchise Tax Board may prescribe.

(c) The returns for such tax shall be in such form and shall contain such information as the Franchise Tax Board may prescribe. The Franchise Tax Board shall deposit all such taxes into the Health Insurance Fund.

(d) All of the provisions of the tax law relating to the imposition and collection of all other taxes administered by the Franchise Tax Board shall apply, insofar as practicable, to the tax imposition by this section.

Article 2. Health Insurance Tax

10375. A tax, to be known as the health insurance tax, is hereby imposed upon the personal income of every resident person who is subject to the tax on personal income imposed by the state tax law. The amount of such tax shall be calculated by applying the rate schedule set forth in Section 10376 to every resident taxpayer’s taxable income as shown on his personal income tax return required by and filed under the state tax law. The Franchise Tax Board shall require the annual income tax return filed by every resident taxpayer to show the amount of the tax imposed by this chapter and the calculation thereof. The Franchise Tax Board shall adopt
such rules and regulations as may be necessary to provide for estimating and withholding such tax throughout the year. For the purposes of administration, collection and enforcement, the tax imposed by this chapter shall be considered an additional income tax and shall be subject to all of the provisions of law governing the administration, collection and enforcement of the tax on personal incomes imposed by the state tax law. The Franchise Tax Board shall deposit all taxes, interest and penalties collected pursuant to this chapter into the Health Insurance Fund.

### Rate Schedule

If the California taxable income is: The tax is:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not over $5,000</td>
<td>0.2% of California taxable income</td>
</tr>
<tr>
<td>Over $5,000 but not over $10,000</td>
<td>$10 plus 0.6% of excess over $5,000</td>
</tr>
<tr>
<td>Over $10,000 but not over $15,000</td>
<td>$40 plus 1% of excess over $10,000</td>
</tr>
<tr>
<td>Over $15,000 but not over $20,000</td>
<td>$90 plus 1.5% of excess over $15,000</td>
</tr>
<tr>
<td>Over $20,000 but not over $25,000</td>
<td>$165 plus 2% of excess over $20,000</td>
</tr>
<tr>
<td>Over $25,000 but not over $30,000</td>
<td>$265 plus 2.5% of excess over $25,000</td>
</tr>
<tr>
<td>Over $30,000</td>
<td>$390 plus 3% of excess over $30,000</td>
</tr>
</tbody>
</table>

10377. A person electing coverage under Plan 2 who is 65 years of age or older shall have a credit against the tax due under this chapter for the amount of premiums paid by him during the taxable year for supplementary medical benefits under Part B of Title XVIII of the Social
Security Amendments of 1965 (Public Law 89-97), as now in force or hereafter amended.

10378. The employer of any person subject to the tax imposed by this chapter may agree with such person to assume, bear and pay all or any part of an amount equivalent to such part of such tax as would be due and payable by such employee if the compensation paid to him by his employer constituted his sole income. Such payment may be made by the employer to the employee in a lump sum or the employer may regard and treat such payment as additional withholding for personal income tax purposes and, in the latter event, the employer shall furnish the employee annually with a statement of the amounts so withheld.

Article 3. Health Insurance Fund

10400. There is hereby created in the State Treasury a fund to be known as the Health Insurance Fund. It shall consist of all taxes, contributions, interest, penalties and money paid into and received by the fund as provided by this division; of property and securities acquired by and through the use of moneys belonging to the fund; and of interest and other income earned by the fund. The taxes, contributions, interest, penalties and money paid into and received by the fund pursuant to this division, together with the interest and income earned thereon, shall be held in trust by the state and shall be used to pay the cost of all benefits provided by or pursuant to this division, the entire cost of administering such benefits, and such portion of all other expenditures necessary for the proper execution of the provisions of this division as is properly allocable to the administration of such benefits.

10401. The Director of Finance shall be the custodian of the fund and all disbursements therefrom shall be paid by him, after audit by and on the warrant of the Controller, on vouchers certified by or pursuant to the regulations of the commission, or by its duly authorized deputies or employees.
10402. The Director of Finance is hereby authorized to deposit any portion of the fund not needed for immediate use, in the same manner and subject to all provisions of law with respect to the deposit of other state funds held by him; and all interest earned by such portion of the fund as may be deposited by him in pursuance of the authority herein given shall be collected by him and placed to the credit of the fund.

10403. Any of the surplus or reserve belonging to the fund may, by order of the commission, as approved by the Controller, be invested in any obligations of the United States of America or in obligations of this state. All such securities shall be placed in the hands of the Director of Finance who shall be custodian thereof. He shall collect the principal, interest and other income thereof, when due, and pay the same into the fund. The Director of Finance shall pay all vouchers drawn on the fund for the making of such investments when signed by the commission, upon delivery of such securities to him, when there is attached to such vouchers the approval of the Controller. The commission may sell any of such securities, and the Director of Finance shall make delivery thereof upon the order of the commission, and the proceeds of any such sale shall be paid by the purchaser to the Director of Finance, upon delivery of said securities, and placed by him to the credit of the fund.

10404. The fund shall be the sole and exclusive source for the payment of benefits furnished under and the payment of expenses incurred in connection with the administration of this division and such benefits shall be due and payable only to the extent that the taxes, contributions and other moneys paid into the fund pursuant to this division article, with the increments thereon, actually collected and credited to the fund and not otherwise appropriated or allocated, are available therefor.

10405. All money in the fund is hereby appropriated for expenditure for the purposes specified in this division.
Article 4. Federal Grants

10425. In the interest of coordination and efficiency the commission is hereby designated as the agent of the state or of any department thereof to administer and expend any and all grants of money allocated or made available to the state under any act of Congress for grants-in-aid for health insurance or for any of the other purposes of this division to the extent that such benefits are provided by the corporation under this division. The commission is hereby authorized to do any and all things, not inconsistent with law, necessary to meet the requirements of any such act.

10426. The Director of Finance is hereby authorized to accept and receive on behalf of the state any and all grants or allotments of money made available to the state by or pursuant to any act of Congress for health insurance or for any of the other purposes of this division, to the extent that such benefits are provided by the commission under this division. All moneys so accepted and received shall be deposited by the Director of Finance in the fund for use exclusively for the purposes for which such grants or allotments were made.

10427. The commission is authorized to enter into any agreement with any agency of the federal government to receive any federal grant or subsidy which may be available for financing, in whole or in part, the cost of furnishing benefits under this division including any payments in lieu of the payroll tax imposed upon other employers pursuant to Chapter 6 (commencing with Section 1035) of this division. The commission is authorized to comply with any condition or requirement, not inconsistent with the provisions of this division or other provisions of law, imposed in connection with the receipt of any such grant or subsidy.

Sec. 2. The provisions of this act shall cease to be operative or have any force or effect if and as of the date when any act of Congress whereby and whereunder a federally administered nationwide system or plan of health insurance affording the same or substantially
similar benefits to the residents of this state as those
provided by this act, shall become operative and effective
within this state, except that such of the provisions of this
act as are deemed by the Health Insurance Commission
to be necessary for it to furnish or pay for benefits under
this act for which such commission became obligated
prior to such date or to collect taxes and contributions
which have theretofore accrued shall continue in force
and effect and such commission shall have full power and
authority to furnish and pay for such benefits and to
collect such taxes and contributions.

Sec. 3. Notwithstanding any other provision of law
no policy or contract of accident insurance, health
insurance, health and accident insurance, group health
insurance, group accident insurance, group accident and
health insurance, and no policy or group policy or
contract or group contract of medical expense indemnity
or hospital service indemnity insuring a person who is
eligible for coverage under this act shall be issued or
renewed for such coverage on or after the date when
such coverage and the benefits thereunder become
effective, but all such existing policies and contracts shall
continue in full force and effect until their respective
dates of expiration, unless the insurer issuing such policies
and contracts agrees with the Health Insurance
Commission for the transfer to it and the assumption by
it of all of the obligations of such insurer under such
policies and contracts for and during the unexpired terms
thereof.

Sec. 4. Notwithstanding any other provision of law
the operation and effectiveness of so much of the
provisions of Chapter 7 (commencing with Section
14000) of Part 3 of Division 9 of the Welfare and
Institutions Code, which establish, limit and define the
benefits under this act is hereby superseded and replaced
by the benefits provided for persons eligible for the
benefits set forth in this act; but if, for any reason, it is
determined that the state is ineligible to receive federal
reimbursement for medical services and hospital services
furnished under this act to persons for whom the state
would be eligible to receive such federal reimbursement if they had received medical assistance as needy persons under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code, then the provisions of such chapter shall be deemed to have continued in full force and effect so as to qualify the state for federal reimbursement for the cost and administration of the medical services and hospital services furnished to such persons under this act in the same manner and to the same extent as if such services had been furnished to such persons under and pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

Sec. 5. (a) The sum of five million dollars ($5,000,000), or so much thereof as may be necessary, is hereby appropriated in the first instance to the Health Insurance Commission out of any moneys in the State Treasury not otherwise appropriated and is hereby made available to such commission to defray its expenses, including personal service, maintenance and operation, traveling and other expenses, within and without the state, incurred by the commission in preparing and setting up the administrative machinery preparatory to carrying out the provisions of this act, and making the payments provided for thereunder.

(b) The moneys appropriated by this section shall be payable from the State Treasury on the audit and warrant of the Controller on vouchers certified or approved in the manner prescribed by law.

(c) The Health Insurance Commission shall reimburse the state for all moneys expended out of the appropriation made available for its use by this section and the state shall have a lien on the moneys deposited into the Health Insurance Fund pursuant to this act, to the extent necessary to assure such reimbursement. The time and manner of such reimbursement shall be agreed upon by such commission and the Controller.

Sec. 6. This act shall take effect July 1, 1972, except that Section 5 of this act and the administrative provisions of Section 1 of this act shall become operative on its
effective date, to the end that the statewide health insurance system provided by this act shall become fully operative and effective on July 1, 1972, and except that the taxes imposed by Article 1 (commencing with Section 10350) and Article 2 (commencing with Section 10375) of Chapter 6 of Division 8 as added by Section 1 of this act shall be due and payable from and after January 1, 1972.
An act to add Division 22 (commencing with Section 30000) to the Health and Safety Code, relating to health care services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1199, as introduced, Moretti (Health). Health care services.

Declares legislative intent to establish a statewide comprehensive health security program.

Vote—Majority; Appropriation—No; Fiscal Committee—No.

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

1 SECTION 1. Division 22 (commencing with Section 30000) is added to the Health and Safety Code, to read:

DIVISION 22. HEALTH CARE SERVICES

CHAPTER 1. GENERAL PROVISIONS

30000. This division shall be known as and may be cited as the Health Security Act. The program established by this act shall be known as and may be cited as the Health Security Program.

30001. The Legislature hereby finds that the benefits
of the recent great advances in medical science have not reached all the people in the state; that adequate hospital and medical care is not available to all those who need it; that only the highest-income groups and the poor who are aided by public or private charity are relieved of the ever-present concern over costs of personal health services, while the vast middle-income and relatively low income groups are left to cope with the shattering costs of serious or prolonged illness; that the maldistribution of available medical and hospital services causes, among other things, wholly inadequate provision for the health needs of families residing in our inner cities and rural areas; that very few voluntary health insurance plans provide adequate benefits and then at costs beyond the reach of those families who most need such services; and that medical and hospital services and facilities must be expanded if the public health and welfare are to be preserved and protected. The Legislature hereby declares, as the public policy of the state, that adequate medical and hospital care is a basic need and right of every resident of the state, that fulfilling this need is a duty and concern of the state and will best be accomplished by the establishment of a comprehensive statewide health security system which will make preventive and curative health care services available to all those who need them based upon their ability to reasonably pay for such services.
Amended in Senate July 3, 1972
Amended in Senate April 27, 1972

Senate Bill No. 770

Introduced by Senator Moscone

March 14, 1972

An act to add Section 15702.2 to the Government Code, to add Division 22 (commencing with Section 30000) to the Health and Safety Code, to add Sections 2151.1, 2151.2, 2151.3, 2151.4 and 17041.1 to AND 2151.4 to, and to add Part 10.7 (commencing with Section 19601) to Division 2 of the Revenue and Taxation Code, to amend Section 14005.6 of, and to repeal Sections 14132 and 14134 of, the Welfare and Institutions Code, relating to health protection.

Legislative Counsel's Digest

SB 770, as amended, Moscone. Health care services.
Provides for statewide compulsory comprehensive health insurance plan financed through payroll taxes with employer-employee contributions and statewide property tax, plus existing sources of funding for health care services. Establishes such plan basically through capitation contracts between the state and prepaid health plans, under which the state pays a specified amount per enrollee to the prepaid health plan; provides for a period during which transition to such system may occur. Specifies uniform comprehensive service benefits; includes Medi-Cal recipients in such uniform comprehensive services benefits, superseding the present basic schedule of benefits under Medi-Cal. Eliminates prior authorization, copayment, and relative's responsibility under Medi-Cal.

Creates a State Health Commission of 9 full-time members, a majority of whom are consumer representatives, and
creates 7 to 10 regional health jurisdictions in the state for planning, operations and evaluation of health services. Places under commission administration all state administrative entities related to health care services and included in the Governor’s Reorganization Plan No. 1 of 1970. Conveys broad powers on the commission to enter into prepaid health contracts with various classes of providers, to demand full fiscal disclosure of providers, to set rates of reimbursement, to adopt standards for various providers, and to administer a state health fund. Designates a percent of revenue for purposes of health resources development with priority to underserved communities and for developing health programs to meet special health problems, including those anticipated in prepaid plans developed for high-risk populations.

Makes legal residents of the state eligible, including Medi-Cal recipients and nonresident migrant agricultural workers employed in California agriculture. Excludes federal employees and armed services personnel, but permits federal employees to participate on a voluntary basis. Requires treatment plans for long-term care and excludes payments for residential and custodial care.

Vote—Majority: Appropriation—No; Fiscal Committee—Yes.

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

1  SECTION 1. Section 15702.2 is added to the Government Code, to read:
2  15702.2. The Franchise Tax Board is authorized to delegate to the Department of Human Resources Development which is authorized to accept, exercise, and perform, the powers and duties necessary to administer the reporting, collection, refunding, and enforcement of taxes imposed on the wages paid to employees by employers under Part 10.7 (commencing with Section 19601) of Division 2 of the Revenue and Taxation Code. The Franchise Tax Board is authorized to delegate to the California Unemployment Insurance Appeals Board which is authorized to accept, exercise,
and perform, under rules it adopts, the powers and duties
to administer appeals and petitions relating to such
provisions of Part 10.7. The delegation to the Department
of Human Resources Development shall not, however,
include the power and duty of the Franchise Tax Board
to adopt rules and regulations.

SEC. 1.5. Division 22 (commencing with Section
30000) is added to the Health and Safety Code, to read:

DIVISION 22. CONSUMER HEALTH
PROTECTION

CHAPTER 1. GENERAL

30000. This act shall be known and may be referred to
as the Consumer Health Protection Act of 1972.

30001. The Legislature hereby finds and declares that
the cost of health care now exceeds the ability to pay for
the average Californian. The rate of inflation of fees and
hospital charges has been twice as high as that indicated
by the consumer price index which led to the national
price freeze. Presently, hospital health insurance pays
only for about 35 percent of the medical cost of the
average citizen of the state. Expanded insurance
protection has been seriously retarded by uncontrollable
uncontrolled inflation in health care costs.

The Legislature can assure all citizens of the state that
they will be able to afford necessary health services on an
equitable basis only through compulsory statewide health
insurance accomplished through a payroll deduction
made by employers and employees, through a county
equalization tax for health care of medical indigents, and
through all present and future state and federal funding
for health care services. In addition to the financial issue,
the Legislature must also deal directly with those factors
responsible for the inflationary spiral in health costs.
These are unnecessary hospitalization services which are
performed without medical justification, with
inefficiency in the organization and management of
health services, unnecessary duplication of community
health facilities and services, and failure to place primary
emphasis on disease prevention and the maintenance of
health. The Legislature must also provide for the
protection of the consumer against hospitals and other
health care providers whose standards of care are below
accepted community practice. To accomplish these goals,
the Legislature must address itself to strengthening the
planning of health services, improving the efficiency of
operating health services, and the development of
standards of quality sufficient to adequately protect
patients.

The Legislature has determined, therefore, that
prepaid capitation contracts between the state and
organized providers shall be the sole method of
reimbursement to providers of health care services, after
the necessary transition period, which is estimated to be
three four years after the effective date of this act.

30002. As used in this division:
(a) "Prepaid health plan" means a plan which offers a
specified comprehensive scope of benefits to an enrolled
population for a predetermined prepaid annual
capitation rate.
(b) "Health maintenance organization" means any
organization of providers of health services with a
capacity to serve a given population enrolled in a prepaid
health plan. In addition, such organizations shall provide
preventive and health maintenance services, conduct
formalized peer review, medical audit, and utilization
review, and report annually to its membership the fiscal
and utilization data and the location of physicians and
facilities.
(c) "Medical care foundation" means a nonprofit
foundation whose physician membership is capable of
directly providing or arranging for the provision of
comprehensive services to patients enrolled in a prepaid
health plan.
(b) "Health maintenance organization" means any
organization of providers of health services with a
capacity to provide preventive and health maintenance
services to a given population of enrolled consumers in a
prepaid health plan. In addition, such organizations shall
conduct formalized peer review, medical audit and
utilization review and report annually to their
memberships the fiscal and utilization data as well as the
location of physicians and facilities. The definition of
health maintenance organization under this subdivision
shall include, but not be limited to, "medical care
foundations" and "health consumer organizations."
Medical care foundation means any nonprofit foundation
whose physician membership is capable of directly
providing or arranging for the provision of
comprehensive services to patients enrolled in a prepaid
health plan. Health consumer organization means any
incorporated organization of citizens whose primary
motive for organizing is to create a system of financing
and arranging for the delivery of personal health services
under circumstances which require sensitivity to the
consumer's desires in this field.
(c) "Fiscal intermediary" means any private
insurance company which performs fiscal and
administrative functions for any organization or provider
of health care, or on behalf of consumers through a
contract for health benefits.
(d) "Peer review—medical audit" means an
organized system for regular review of professional
performance in or out of the hospital by a committee of
peers. Such review is designed to judge the fairness of
charges and the medical justification for case
management to assure its quality.
(e) "Utilization review" means an organized
review by peers designed to control or eliminate
unnecessary admissions to hospitals, and unwarranted
length of stays in hospitals.
(f) "Provider profiles" means computer-assisted
files of the performance of a provider over an extended
period of time. Profiles assist peer review by the
identification of those providers whose patterns of
professional behavior do not conform to accepted
community standards defined by professional peers.
(g) "Provider" means any licensed individual or
organization engaged in the providing of personal health
service to the public.

(i) "State Health Commission" means that body
which under this legislation assumes broad powers and
responsibility for all the activities of the state government
related to providing personal health care to the public.

(j) "Accredited hospital" means a licensed hospital
accredited by the Joint Commission on Accreditation for
Hospitals and the Medical Staff Survey Committee.

(ii) "Approved hospital" means a licensed hospital
which meets the standards of performance as developed
by the State Health Commission to assure quality of care,
safety of the patient, and any other such criteria as the
commission deems necessary.

(k) "Health consumer organization" means any
incorporated organization of citizens whose primary
motive for organizing is to create a system of financing
and delivering personal health service under
circumstances which require sensitivity to the
consumer's desires in this field.

(l) "Health facility" means any licensed facility
whose primary function is to deliver personal health
service to the public. This includes but is not limited to
health departments, outpatient clinics, hospitals, clinics,
nursing homes, home care organizations and
intermediate care facilities.

(m) "Prepaid capitation" means an annual fixed
premium per person paid in advance for a specified set
of comprehensive health benefits.

(n) "Benefit period" means the period of time
during which an enrolled person is covered under a
prepaid health plan.

(o) "Open enrollment" means periods during the
year when prepaid plans with the capacity to serve new
enrollees open the plans to include new enrollment with
no policies to exclude enrollment for any reason. During
this open enrollment period, prepaid plans shall not
exclude any enrollee for any reason, and shall accept all
enrollees in their order of enrollment.

(p) "Allied health professional" means any
professional person involved in the provision of skilled
health service both directly and indirectly in support of
physicians and health institutions engaged in the delivery
of health care services.

(o) "Health surveyor" means a health professional
trained in the surveillance of the quality of care provided
by any provider or institution which is engaged in the
delivery of health care services.

(p) "Out of area emergency services" means medical
treatment for any sudden or unexpected illness, or the
medical treatment of an injury or injuries caused by an
accident. Such illnesses or injuries shall be those
requiring medical services at a location outside the
immediate area of the patient's own health maintenance
organization, and requiring the medical services of
another provider of health care services, so as to not
compromise the quality of care or safety of the patient by
delaying treatment.

(q) "Enrollee" means a person who has voluntarily
enrolled as a beneficiary of a health benefit plan.

CHAPTER 2. ADMINISTRATION

30020. There is in the state government the State
Health Commission, hereinafter referred to as the
commission, consisting of nine members appointed by
the Governor, with the advice and consent of the Senate,
who shall be full-time employees of the State of
California. Salaries of the commission shall be set,
regulated and adjusted by the Governor. A majority of
the commission members shall consist of bona fide
consumer members who have no direct or indirect
financial interest either in health insurance plans or the
provision of health services to the public. Of the initial
members appointed to the commission, five shall serve
for two years, and four shall serve for four years;
thereafter, the terms of the members shall be four years.
The commission shall be empowered to take appropriate
action as provided under this chapter upon a simple
majority vote of its members.
30021. The commission is hereby designated to act as
the agent of the state or of the appropriate department
thereof to submit the plan of statewide health insurance
contemplated by this division for, and obtain the
approval of, all federal agencies having jurisdiction and
control over state plans for rendering medical and
hospital services under federal laws, including Title
XVIII and Title XIX of the Social Security Act, and to
accept and receive and to deposit into the State Health
Care Trust Fund created under subdivision (g) of Section
30030, any and all grants of money available to the State
of California, under such laws, in reimbursement for the
cost of such services or programs or otherwise. The
commission shall act as the agent of the state or of the
appropriate department thereof in any negotiations
relative to the submission and approval of such plan and
make any arrangement not inconsistent with law which
may be required by or pursuant to such federal law to
obtain and retain such approval and to secure for the
state the benefits of the provisions of such federal laws.

30022. The commission, with recommendations from
the Health Planning Council, shall set boundaries for 7 to
10 regional health jurisdictions within the discretion of
the commission. Members of the governing body of each
such regional health jurisdiction shall conform to
requirements regarding membership stated in Public
Law 89/749 for membership in local health planning
councils. The commission may delegate to regional
jurisdictions such powers and duties as it deems necessary
for the improvement of planning and operation of health
services within each jurisdiction.

30023. The commission shall administer all state
administrative functions which relate to the planning,
operation, and evaluation of personal health service of all
kinds. Those administrative entities relating to provision
of health care services which are included within
Reorganization Plan No. 1 of 1970 (Chapter 1593 of the
Statutes of 1971) are transferred to the jurisdiction of the
commission. The jurisdiction of the commission over such
administrative entities shall include the hiring of
appropriate personnel, and the expansion or reduction of
powers and duties:
30022. The commission shall reorganize the voluntary
health planning councils formed and operating under
Public Law 89-749 and adhering to the requirements of
Public Law 89-749 into local commissions with
geographical and jurisdictional boundaries and such
powers and duties as set forth in regulations determined
by the State Health Commission.
30023. The commission shall be the regulatory body
which shall set policy and determine regulations which
relate to the planning, operation and evaluation of
personal health service of all kinds. The Director of the
State Health Department as set forth within
Reorganization Plan No. 1 of 1970 (Chapter 1593 of the
Statutes of 1971) shall be an ex officio member of the
State Health Commission without voting privileges, and
he shall be the chief administrative officer and shall carry
out the decisions, policies and regulations of the
commission. Those administrative entities relating to
provision of health care services which are included
within Reorganization Plan No. 1 of 1970 (Chapter 1593
of the Statutes of 1971) are transferred to the jurisdiction
of the commission.
30024. The Director of the State Department of
Health shall be an ex officio member of the commission
without a vote. He shall be the chief administrative
officer, and shall carry out the decisions and policies of
the commission.

Chapter 3. Powers and Duties

30030. The commission shall have the following
powers and duties.
(a) To enter into contracts with various health
maintenance organizations, health consumer
organizations or health facilities on behalf of those
persons eligible pursuant to Chapter 6, for their provision
of comprehensive health services as health maintenance
organizations receiving prepaid capitation payments.
1 Such contracts shall be subject to the requirements of
2 relevant provisions of the Insurance Code, but shall not
3 be subject to the requirements of Article 2.5
4 (commencing with Section 12530) of Chapter 6 of Part 2
5 of Division 3 of Title 2 of the Government Code, except
6 those health maintenance organizations that are at least
7 50 percent publicly funded shall not be subject to such
8 requirements of the Insurance Code and the
9 Government Code. Such contracts shall be for a specified
10 term set by the commission. Organizations which may
11 qualify as contractors shall include all health
12 maintenance organizations as defined in subdivision (b)
13 of Section 30002, and which meet the operating standards
14 as set forth in Chapter 4. Any provider who refuses to
15 participate in accordance with such operating standards,
16 and in accordance with further rules and regulations as
17 determined by the commission, shall not be entitled to
18 reimbursement pursuant to this division.
19 (b) To set rates of reimbursement based upon
20 geographical differences in costs of health care in the
21 state for various providers and based upon sound
22 actuarial data, after holding public hearings to ascertain
23 such differences.
24 (c) To hold public hearings pursuant to existing law
25 for purposes which shall include but not be limited to,
26 information gathering, grievance hearings for either
27 consumers or providers of health care, and rate setting.
28 (d) To develop the administrative capacity through
29 computer programs to set up a statewide information
30 system capable of collecting and analyzing fiscal and
31 program data from various providers relating to cost,
32 utilization review, peer review, provider profiles, quality
33 of care and consumer satisfaction.
34 (e) To employ trained health surveyors for the
35 purpose of making periodic visits to the direct operations
36 of various providers, to assure that the providers are in
37 compliance with the standards as determined by the
38 commission and as set forth in Chapter 4.
39 (f) To terminate the contract of a provider or health
40 maintenance organization for cause, and after public
hearings. Sufficient written notice of at least 15 days shall
be given to providers prior to termination pursuant to
this section. Providers shall, as a condition of their
contract, notify their enrollees of such termination.
(g) To designate a specified percent of the revenue
deposited in the State Health Care Trust Fund for a
development fund, both of which are hereby created, for
the purposes of this act. Disbursements from either fund
shall be subject to the management and control of the
State Controller in accordance with and not in conflict
with existing law.
(h) To enforce the standards set forth in Chapter 4
with regard to providers or health maintenance
organizations engaged in the delivery of services under
this act. The commission shall also have the power to
apply and enforce such standards with regard to fiscal
intermediaries during the transitional period.
(i) To reimburse providers of health care services on
a fee-for-service basis on behalf of consumers not yet
enrolled in a prepaid capitation plan with an approved
health maintenance organization, during the three-year
transitional period set forth under Section 30001 of this
act. No reimbursement shall be made to health benefit
plans established through fiscal intermediaries which do
not provide the benefits set forth under Chapter 7.
(j) To underwrite the costs of enrollment in a new
health maintenance organization for an enrollee of a
health maintenance organization which has become
insolvent, or is otherwise unable to fulfill its specific
contractual duties and functions as set forth in this act.
(k) To employ such persons as may be necessary to
carry out the provisions of this chapter.
(l) To enter into any agreement with any agency of
the federal government to receive any federal grant or
subsidy which may be available for financing, partially or
totally, the cost of carrying out the provisions of this act.
m) To delegate to regional commissioners such
powers and duties as the commission deems necessary to
the planning, operation, and evaluation of health
programs within each jurisdiction.
(n) To set reasonable standards relating to enrollment periods.

30031. Notwithstanding any other provision of law, no contract for provision of health care services executed after the effective date of this act between individuals and fiscal intermediaries or groups of any type and fiscal intermediaries, may be issued or renewed without approval of the commission and in compliance with the standards as set forth in Chapter 4, but all such existing benefit coverage shall remain in full force and effect until its date of expiration, provided that such time period does not exceed a date three years from the effective date of this act.

CHAPTER 4. STANDARDS OF PARTICIPATION

30040. The provisions of this chapter shall apply to health maintenance organizations, as defined in subdivision (b) of Section 30002, engaged in the delivery of health care services under this act.

30040.5. Each health maintenance organization shall be required to report annually to the commission on the cost of operation, the use of services, the current description of the location of physicians, allied health professional and health facilities, and the number of persons to whom service is rendered. Full fiscal disclosure by any and all providers of service shall be a condition of participation under this act.

Each health maintenance organization shall be required to furnish complete lists monthly to the commission or to the agency designated by the commission of those persons eligible to receive benefits under Title XVIII or XIX of the Social Security Act. This information is to be used solely for the purpose of receiving such federal reimbursement funds, and in no way is to be used to discriminate against the persons or the quality of health care to which they are entitled. All information obtained pursuant to this section shall be confidential.

30041. Laboratory services provided under the
provisions of this act are to be provided only in the
laboratories which are approved by the commission, or
the agency it so designates, in conformance with law.

30041.5. Health maintenance organizations shall be
certified by the commission, or the agency it so
designates, and shall at least meet the conditions of
participation under Title XVIII of the Social Security Act
federal law.

30042. Health maintenance organizations shall make
those services readily available at reasonable times to all
enrollees.

30042.5. Those health maintenance organizations
which are servicing a substantial patient/consumer
population of a particular social or ethnic group, or whose
primary language is other than English, shall employ
either a health professional from such social or ethnic
group or a designated person or persons able to
communicate with enrollees in such social or ethnic
groups.

30042.5. Those health maintenance organizations
which are serving a substantial enrollee population
whose primary language is other than English shall
employ adequate numbers of persons able to
communicate with the enrollees in their primary
language. Such employees shall be on duty at all locations
and during all hours when health care services are
provided.

30043. Health maintenance organizations shall
provide directly or through subcontractors, who also
conform to the requirements of this act, that scope of
benefits described in Chapter 7.

30043.5. Health maintenance organizations shall be
liable for payment at the prevailing and customary fee as
recognized by the commission, and in conformity with
law, for all out-of-area emergency services as defined in
subdivision (p) of Section 30002 rendered by another
provider which are required under the scope of benefits
pursuant to this act. Payment pursuant to this section
shall cover such emergency treatment as may be
reasonable and necessary until the patient enrollee can
be transferred to the provider group in which he is enrolled.

30044. Health maintenance organizations shall employ only those health professionals who are qualified and licensed under the law to perform specific acts of medical care for which they are qualified and licensed. Health maintenance organizations shall require continuing education for all professional personnel engaged in the delivery of health care services. Such continuing education shall be that which is recommended by the particular professional organization of which the professional is a member.

30044.5. Health maintenance organizations shall enroll no less than 10,000 or more than 50,000 consumers to whom services are to be provided. The ratio of physicians and other health professionals to consumers shall be set by regulation by the State Health Commission and subject to adjustment as deemed appropriate by the State Health Commission.

30044.5. The ratio of physicians and other allied health professionals to enrollees in health maintenance organizations shall be set pursuant to regulations adopted by the commission, and subject to adjustment as deemed appropriate by the commission.

30045. Health maintenance organizations shall furnish services in such a manner as to provide continuity of care, quality care and provision of services shall include ready referral of patients to such services at such times as may be medically appropriate. A managing physician or allied health professional shall supervise and coordinate each enrollee's care. A primary physician or primary health care team shall supervise and coordinate each enrollee's care. Such supervision and coordination shall be done in such a manner as to provide coordinated family care for enrolled families.

30045.5. Allied health professionals shall be employed to the maximum extent feasible to assist in the delivery of health care to the consumer.

30046. Health maintenance organizations shall accept, on behalf of their health professional members,
reimbursement on a prepaid capitation basis pursuant to
the contract between such health maintenance
organization and the commission, as payment in full for
services rendered.

30046.5. Health maintenance organizations shall
conduct an annual survey of their enrollees, designed to
ascertain the attitudes, concerns and wishes of the
consumer regarding the quality of health care he is
receiving. The findings of such an annual survey shall be
delivered to the commission no later than December 31
of each calendar year.

30047. Health maintenance organizations shall
provide a printed booklet that is available to all
consumers who demonstrate an interest. The booklet
shall contain a description of the available facilities, the
days and hours that medical service is available, public
and emergency transportation, a listing of all health
professionals employed or performing services on behalf
of the organization, and any such additional information
necessary to assist the consumer in making a rational,
reasonable choice of providers. In addition, such booklets
shall be printed in the primary language of all enrollees
whose primary language is other than English.

30047.5. Health maintenance organizations shall hold
periods of open enrollment when consumers who so
desire may enroll, unless a health maintenance
organization can demonstrate to the satisfaction of the
commission that it is operating at maximum enrollment
capacity.

30048. Health maintenance organizations shall
establish an enrollee grievance procedure which shall be
in conformity with such procedures as defined and
authorized by the commission.

30048.5. Health maintenance organizations shall be
subject to formalized peer review as established by the
commission.

30049. All eligible consumers, as set forth in Chapter
6, shall remain enrolled in the health maintenance
organization of their choice for a benefit period of one
year, with the following exceptions:

30049. Health maintenance organizations shall not disenroll any enrollee against his wishes without cause as determined by the commission, either through public hearings or by regulation. All eligible consumers, as set forth in Chapter 6, who become enrollees, shall remain enrolled in the health maintenance organization of their choice for a benefit period of one year, with the following exceptions:

(a) A consumer enrollee changes his residence for reasons of employment; or

(a) An enrollee who changes his residence; or

(b) The health maintenance organization is terminated pursuant to subdivision (f) of Section 30030; or

(c) The consumer enrollee declares his intent to disenroll through the grievance procedures established by the commission.

(d) The enrollee declares his intent to voluntarily disenroll at a cost to himself not to exceed the total premium as computed for one month.

30049.5. The commission shall have the power to modify or alter the standards set forth in this chapter if such modification or alteration is found to be necessary or in the public interest, as determined by the commission, with recommendations from the Health Planning Council.

30049.5. Health maintenance organizations, to the extent feasible, shall organize an advisory board of enrollees for the purpose of advising the health maintenance organization on matters of primary interest to the consumer.

Chapter 5. Development Fund

30050. Health maintenance organizations shall provide emergency medical services to their enrollees within the area of the enrollee's health maintenance organization either directly or by contracting for such
services in such locations as are readily available to the enrollees. Such emergency services shall include, but not be limited to:

(a) Hospital intensive and coronary care in the hospital;

(b) A team consisting of physicians, nurses and other allied health professionals on duty as necessary to provide 24-hour service;

(c) Equipment, facilities for electrocardiogram, transfusion, inhalation therapy, X-ray, and laboratory.

The Development Fund may be used for all of the following purposes:

(a) To provide financial and technical assistance for the development of health maintenance organizations and other types of prepaid plans. Priorities shall be given to city and county hospitals and underserved urban and rural communities.

(b) To provide financial and technical assistance for development of health maintenance organizations. Priorities shall be given to city, county and district hospitals and low-income, underserved urban and rural communities.

(b) The development and operation by contract of special purpose community health programs where the occurrence of disease is not evenly distributed in the community, including but not limited to control of alcoholism and drug abuse, the development and operation of emergency and trauma centers, programs for the control of venereal disease, medical disasters, and epidemics.

(c) The fund may make augmentation payments to prepaid health plans which can demonstrate valid evidence that they have incurred exceptional but legitimate costs in the care of such high-risk population as the poor, the aged, and the disabled and have continually been in conformance with peer review, utilization control, and other such standards established by the commission.

(d) The fund may make augmentation payments under special circumstances for prepaid health plans in
1 poverty communities to support specialized services, including but not limited to outreach community programs, medical-related language assistance, transportation and child care, nutrition education, medical social work, public health nursing and patient education.  
2 (e) The fund may contract for the purpose of demonstration, innovation, or experimentation of community health delivery systems. Pursuant to such purpose, the commission may seek federal waivers if necessary to obtain federal funds for such demonstration projects.

Chapter 6. Eligibility

30060. All legal residents of the State of California are eligible for enrollment, except for members of the armed forces serving in this state and federal employees who do not voluntarily enroll pursuant to the further provisions of this section. Medi-Cal recipients will continue to be identified for purposes of federal participation, and financed in the same manner as is currently provided for in Article 5 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, with federal funding to continue to the maximum possible extent in the future. The benefit plan shall be the equivalent of that stated in this chapter, and all regulations relating to prior authority, copayment, or relatives’ responsibility are rescinded. It is the intent of the Legislature that Medi-Cal recipients be treated for the purpose of medical care in a fashion which is indistinguishable from any other citizen, with the exception of the processes required for eligibility determination other than prior authorization, copayment and relatives’ responsibility.  
Migrant agricultural workers and their families who are not residents of California are eligible for service benefits if they can show evidence that they are currently engaged in or are seeking employment in agricultural labor in the State of California.  
Employees of the federal government are not eligible
for participation through payroll deduction. They may participate in prepaid plans by paying any difference in premium paid for current plans and those premiums set by the commission.

Chapter 7. Benefits

30070. (a) The full range of health services is covered to include prevention, screening, annual health assessment, diagnosis and treatment of illness, both in and out of hospitals, extended care, medical rehabilitation, medically justified nursing home care, and care provided in an organized home care program.

(b) No deductibles, copayments, waiting periods, cutoffs, or extra charges patient fees are permitted in approved prepaid health plans. Extra charges may be made by providers only upon written agreement between patient and provider which indicates clearly that patients understand that such charges are the responsibility of the patient and are not reimbursable under an approved prepaid plan.

(c) Reimbursement for extended or long-term care shall require a written and detailed treatment plan. Such a plan shall indicate that the treatment performed is in an environment which offers a level of care appropriate to the needs of the patient.

(d) No payments shall be made for custodial or residential care. Payments may be made for medical and nursing services performed in custodial or residential living arrangements.

(e) Citizens who enroll in a prepaid plan shall remain enrolled for a period of one year, except that disenrollment may take place upon change of residence at no cost; and voluntary disenrollment may take place at the enrollee's cost.

(f) Enrollees of any health maintenance organization may seek medical services outside their health maintenance organization, or services in addition to the scope of benefits set forth in this act; provided, however, that such enrollees shall be strictly and solely liable for
any such services requested and received. Such enrollee
liability shall include but is not limited to those benefits
specifically excluded in this act pursuant to Chapter 7,
and such extra medical care is not reimbursable under
approved prepaid plans.
30071. (a) Benefits under this chapter applying to
prepaid health plans, shall include:
(1) Outpatient services which are covered as follows:
Physician, hospital outpatient, optometric,
chiropractic, psychology, podiatric, occupational
therapy, physical therapy, speech therapy, audiology,
and services of persons rendering treatment by prayer or
healing by spiritual means in the practice of any church
or religious denomination insofar as these can be
encompassed by federal participation under an approved
plan.
(2) Hospital inpatient care.
(3) Nursing home care, including physician services
and prescription drugs.
(4) Purchase of prescription drugs prescribed by a
physician for the treatment of chronic disease only.
(5) Hospital outpatient dialysis services and home
hemodialysis services, including physician services,
medical supplies, drugs and equipment required for
dialysis.
(6) Outpatient laboratory and outpatient X-ray
services.
(7) Blood and blood derivatives are covered.
(8) Dental services.
(9) Medical transportation.
(10) Home health care services.
(11) Prosthetic and orthotic devices and eyeglasses.
(12) Hearing aids.
(13) Durable medical equipment and medical
supplies are covered.
(14) Physical therapy services, occupational therapy
services, speech therapy services and audiology services.
(15) Other diagnostic, screening or preventive
services.
(b) For providers who are not prepaid health plans,
the benefits of subdivision (a) shall apply, but such
benefits shall be subject to the following limitations:
(1) Nursing home care shall be limited to 120 days per
benefit period.
(2) Hospitalization for psychiatric diagnosis shall be
limited to 45 days per benefit period.
(3) Psychiatric visits shall be limited to 20 days per
benefit period.
(4) Prescription drugs shall be excluded, except those
required for long-term treatment of chronic disease.
(5) Medical rehabilitation shall not be covered.
(6) Cosmetic surgery shall be excluded unless
approved by psychiatric consultation or vocational
rehabilitation agency and related to employment.

SEC. 2. Section 2151.1 is added to the Revenue and
Taxation Code, to read:

2151.1. The board of supervisors of each county or city
and county shall annually, commencing with the
_______ fiscal year, at the time and in the manner of
levying other county taxes, levy and cause taxes to be
collected throughout the county for the purpose of
funding consumer health protection created pursuant to
Division 22 (commencing with Section 30000 of the
Health and Safety Code), as provided in this chapter.

SEC. 3. Section 2151.2 is added to the Revenue and
Taxation Code, to read:

2151.2. The additional taxes shall be levied and
collected throughout the territory of the county or city
and county at a rate of _______ dollars ($_______),
modified where necessary pursuant to Section 2151.4, on
each one hundred dollars ($100) of 100 percent of the
assessed valuation in the county as shown on the
equalized assessment roll for the current year. The
revenue so derived shall be paid into the Health Care
Trust Fund created pursuant to Health and Safety Code
Section 30026.

SEC. 4. Section 2151.3 is added to the Revenue and
Taxation Code, to read:

2151.3. On the basis of computations made by the
State Board of Equalization, the secretary of that board
shall certify on or before October 1 of each year to the
State Controller the factor, carried to three decimal
places, by which the total assessed value of all tangible
property on the current local roll of each county must be
modified to conform to the statewide average assessment
level; provided that property belonging to a county, city
and county, or municipal corporation which is taxable
under Section 1 of Article XIII of the Constitution and
constituting more than 10 percent of the total assessed
value of the taxable property within a school district shall
be excluded from the assessed value and the full cash
value that are used to compute such factor.

SEC. 5. Section 2151.4 is added to the Revenue and
Taxation Code, to read:

2151.4. The State Controller shall average the factor
certified for the current year under Section 2151.3 for the
local roll of the county with the factors so certified for the
two immediately preceding years. The three-year
average factor shall be applied to the tax rate in Section
2151.2 and the modified rate, which shall be transmitted
to the county assessor.

SEC. 6. Section 17041.1 is added to the Revenue and
Taxation Code, to read:

17041.1. (a) There shall be imposed for the purpose
of funding consumer health protection created pursuant
to Division 22 (commencing with Section 30000) of the
Health and Safety Code a payroll tax commencing with
the / / / / fiscal year and computed as follows:

<table>
<thead>
<tr>
<th>Gross salaries and wages</th>
<th>Tax rate on employee</th>
<th>Tax rate on employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 / $5,000:</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>$5,000 / $10,000:</td>
<td>2% plus 2% of any</td>
<td>$150 plus 6% of any</td>
</tr>
<tr>
<td></td>
<td>amount over $5,000</td>
<td>amount over $5,000</td>
</tr>
<tr>
<td>$10,000 /</td>
<td>$150 plus 3% of any</td>
<td>$150 plus 9% of any</td>
</tr>
<tr>
<td>$ /</td>
<td>amount over $10,000</td>
<td>amount over $10,000</td>
</tr>
</tbody>
</table>

Self-employed shall be taxed under this section at a rate
of / / / percent of their gross earnings.

(b) The tax imposed by this section shall be treated for
all purposes of this part as though it were imposed under Sections 17041 or 17048, except that no deductions, exclusions, or credits shall be allowed against the tax imposed under this section.

Sec. 6. Part 10.7 (commencing with Section 19601) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 10.7. CONSUMER HEALTH PROTECTION TAX LAW

Article 1. Definitions

19601. "Employer," as used in this part, means "employer" as defined in Section 18810.

19602. "Employee," as used in this part means "employee" as defined in Section 18803, except nonresident individuals are not employees for the purposes of this part.

19603. "Wages," as used in this part, means "wages" as defined in Section 18807.

19604. "Payroll period," as used in this part, means "payroll period" as defined in Section 18808.

19605. "Business income," as used in this part, means "adjusted gross income" as defined in Section 17072 minus

(a) Rental income, unless such income is received in a course of a trade or business:

(b) Dividends on any share of stock, and interest on any bond, debenture, note, or certificate, or other evidence of indebtedness issued with interest coupons or in regular form by any corporation, unless such dividends and interest are received in the course of a trade or business as a dealer in stocks or securities.

(c) Gains or losses

(1) From the sale or exchange of a capital asset,

(2) From the cutting of timber, or the disposal of timber, coal, or iron ore if Sections 17711 and 17712 apply to such gains or losses, or:

(3) From the sale, exchange, involuntary conversion,
or other disposition of property if such property is neither
(A) Stock in trade or other property of a kind which
would properly be included in inventory if on hand at the
close of taxable year, nor:
(B) Property held primarily for sale to customers in
the ordinary course of the trade or business;
(d) Royalties unless such royalties are received in the
course of a trade or business;
(e) Alimony and separate maintenance payments;
(f) Income in respect of a decedent;
(g) Income from an interest in an estate trust; and,
(h) Income from annuities, life insurance and
endowment contracts and pensions.

Article 2. Consumer Health Protection Tax

19610. (a) There shall be imposed for each taxable
year upon the wages paid every employee, subject to the
Consumers Health Protection Act of 1972, a consumer
health protection tax in the following amounts and at the
following rates:

The tax on the
employee is:
Not over $5,000 1 percent
Over $5,000 but not $50 plus 2 percent of
over $10,000 any amount over $5,000
Over $10,000 $150 plus 3 percent of
any amount over $10,000

(b) There shall be imposed for each taxable year upon
the wages paid by every employer to employees, subject
to the Consumers Health Protection Act of 1972, a
consumer health protection tax in the following amounts
and at the following rates:
The tax on the employer is:

If the wages are:

Not over $5,000 3 percent
Over $5,000 but not $150 plus 6 percent of any amount over $5,000
Over $10,000 $450 plus 9 percent of any amount over $10,000

(c) There shall be imposed for each taxable year upon the business income of every individual, subject to the Consumer Health Protection Act of 1972, from which the consumer health protection tax is not deducted and withheld pursuant to Section 19611, a consumer health protection tax at a rate of ____ percent of business income.

19611. Every employer making payment of any wages after _____ to an employee, who is subject to the provisions of the Consumer Health Protection Act of 1972, for services performed either within or without this state shall deduct and withhold from such wages for each payroll period an amount computed in such manner as to produce, so far as practicable, a sum which equals the amount of consumer health protection tax due from the employee under this part.

19612. The consumer health protection tax withheld pursuant to Section 19611 and the consumer health protection tax imposed upon the employer pursuant to Section 19610 shall be reported and paid in the manner and times specified in Section 18491 for the reporting and payment of withheld income taxes.

19613. Individuals subject to the provisions of Section 18415, pertaining to declarations of estimated tax, shall for taxable years beginning after _____ include within such declaration a declaration of consumer health protection tax imposed pursuant to subdivision (c) of Section 19610, estimated to be due and shall pay such tax in the manner and times specified in Section 18556 for the payment of estimated tax.

All other individuals subject to the consumer health protection tax imposed by subdivision (c) of Section
19610 shall report and pay such tax to the State Health
Commission on or before the 15th day of April following
the close of the calendar year or in such other manner
and at such times as may be prescribed.
19614 All individuals required to make and file
personal income tax returns pursuant to Chapter 17
(commencing with Section 18401) of Part 10 of Division
2, shall state therein the amount of consumer health
protection tax paid or withheld during the calendar or
fiscal year and shall pay the tax imposed by this part, less
the amount deducted and withheld pursuant to Section
19611 or previously paid as estimated tax pursuant to
Section 19613, on or before the 15th day of April following
the close of the calendar year or, if the return is made on
the basis of the fiscal year, on or before the 15th day of
the fourth month following the close of the fiscal year.
19615. (a) If the consumer health protection tax paid
by or withheld from an individual during the calendar or
fiscal year exceeds the tax due under Section 19610, the
individual shall be entitled to a refund or credit of the
amount of the excess.
(1) Individuals required to make and file personal
income tax returns shall claim the refund or credit on the
return for the year in which the excess tax was paid or
withheld. The excess tax shall be credited against the
personal income tax or if the personal income tax due
after deduction of all authorized credits is less than the
credit allowable pursuant to this section, the difference
shall be a tax refund. If the Franchise Tax Board disallows
the refund or credit provided for by this section, the
Franchise Tax Board shall notify the claimant
accordingly. The Franchise Tax Board action upon the
credit or refund is final unless the claimant files a protest
with the State Health Commission within 30 days of the
date of mailing of the notice of disallowance by the
Franchise Tax Board.
(2) Claimants not required to make and file personal
income tax returns shall file a claim for refund with the
State Health Commission on or before the 15th day of
April following the close of the calendar year or in such
other manner and at such time as may be prescribed. If
the State Health Commission denies the claim in whole
or in part filed under this paragraph or the protest filed
under paragraph (1) of subdivision (a), the claimant may
commence an action appealing such denial in the
Superior Court of the County of Sacramento, in the
County of Los Angeles, or in the City and County of San
Francisco.

19616. (a) Except for the limitations specified in this
part, all the provisions of Part 10 applicable to the
deduction and withholding from wages of personal
income taxes by employers shall apply, where applicable,
to the tax imposed by subdivisions (a) and (b) of Section
19610. If the Franchise Tax Board delegates its powers
and duties as provided in Section 15702.2 of the
Government Code, Section 18826 shall also apply to the
taxes imposed by subdivision (a) and (b) of Section
19610.

(b) Except for the limitations specified in this part, all
the provisions of Part 10, where applicable, shall apply to
the tax imposed by subdivision (c) of Section 19610,
insofar as such tax is required to be paid to the Franchise
Tax Board.

Sec. 6.5. No provision of this act, and no amendment
to the Government Code made by this act, shall affect or
alter any contractual or other nonstatutory obligation of
an employer to provide health services to his present and
former employees and their dependents, or to any such
persons, or the amount of any obligation for payment
(including any amount payable by an employer for
insurance premiums or into a fund to provide for any
such payment) toward all or any part of the cost of such
services. And, such employer-employee negotiated funds
as currently exist may be used to meet the obligation of
premiums on behalf of the employee.

Sec. 7. Section 14005.6 of the Welfare and
Institutions Code, as amended by Chapter 1685 of the
Statutes of 1971, is amended to read:

14005.6. (a) When a person is not eligible for aid
under any of the chapters set forth in Section 14005.1, but
meets all of the following conditions, he is eligible for health care benefits or services under Section 14005:
(1) He or his family meet the income and resource requirements for aid under Chapter 2 (commencing with Section 11200) of Part 3 of Division 9 of this code, except that the minimum basic standard of adequate care for a single person living alone shall be 75 percent of the standard for a two-person family under Section 11452;
(2) He resides within the state;
(3) He is a citizen of the United States, or has been legally present in the United States for a period of five years immediately preceding the date of application for Medi-Cal coverage, or who has applied for citizenship;
(4) He is 21 years of age or older, or has entered into a ceremonial marriage; and
(5) He is not receiving adequate financial contributions toward his support and cost of health care from a husband or wife or parent or adult child able to and responsible for support under the laws of this state.
SEC. 8. Section 14132 of the Welfare and Institutions Code, as amended by Chapter 1685 of the Statutes of 1971, is repealed.
SEC. 9. Section 14134 of the Welfare and Institutions Code, as amended by Chapter 1685 of the Statutes of 1971, is repealed.
SEC. 10. It is the intention of the Legislature that the funds derived under Revenue and Taxation Code Sections 2151.1 to 2151.4, inclusive, and 17041.1 shall be utilized to fund the provisions of this act. It is also the intention of the Legislature that the present funding structure for health care services of the county and state governments remain in effect, and such sources of funding shall be supplemented by the revenue derived under this act. It is not the intention of the Legislature to terminate existing federal funding and future federal funding available for provision of health care services in California.
SEC. 11. The provisions of this act shall continue to be operative, and shall be merged or rearranged in accordance with any federal legislation that provides
similar or equivalent benefits, if and when such federal legislation is enacted. Fiscal arrangements pursuant to such enacted federal law shall be accomplished by the commission in accordance with law.

SEC. 12. Notwithstanding any other provision of law, and according to customary budgetary procedures, the state share of employee health prepaid benefits, pursuant to this act, shall be funded in subsequent fiscal years.

SEC. 13. This act shall take effect July 1, 1974, except that the appointment of the commission shall become effective ______, and except that the collection of taxes imposed by ______ of this act shall commence on July 1, 1973. The transference of the various agencies and personnel as set forth in Section 30023 shall commence on ______.
An act to add Division 12.6 (commencing with Section 15500) to the Health and Safety Code, relating to medical and hospital services insurance, and making an appropriation therefor.

LEGISLATIVE COUNSEL’S DIGEST

AB 1207, as introduced, Hart (Fin., Ins., & Com.). Insurance: medical and hospital services.

There are no provisions of existing law which provide for a statewide medical and hospital services insurance operated by a state agency.

This bill would enact the California Voluntary Medical and Hospital Services Insurance Act which would create a California Voluntary Medical and Hospital Services Insurance Agency to operate a California Voluntary Medical and Hospital Services Insurance Plan. The agency would have a director appointed by the Governor and confirmed by the Senate, who would serve at the discretion of the Governor and who would appoint 6 assistant directors, at least 3 of whom would be medical doctors.

This bill would require the agency to make specified preparations for commencement of the plan within 2 years after the effective date of the bill, would provide for the payment of benefits by the plan to or on behalf of every enrollee for specified medical services, and would require premiums of
$216 per year for each adult and $108 per year for each child, with specified lower premiums for families with combined incomes of less than $12,000 per year.

This bill would require the agency to establish a trust fund for the deposit of all premiums received from subscribers, together with appropriations from the General Fund, from which shall be paid all claims for benefits of the plan and all operating and administrative costs.

This bill would provide that enrollment in the plan and the payment of premiums would be voluntary, but would permit an employer to enroll any employee and the employee's family, and would permit a public welfare agency to enroll any recipient of public assistance, provided that the employer or public welfare agency pays all or part of the premium for the person enrolled.

This bill would allow every medical service provider, laboratory, and hospital to apply to the agency for approval and listing as a participating provider of specified services as benefits of the plan, and would require the agency to compile and publish a schedule of fees in proportion to the usual, customary, and reasonable fee for each service provided in each general area of the state.

This bill would enact provisions relating to the method and form of making a claim for benefits, the auditing, payment, and assessment of claims, the offering of additional benefits to enrollees, and various related provisions.

This bill would specify that a prerequisite condition to the bill becoming operative would be an agreement by the United States government to permit the transfer to the agency of all funds, grants and sums of money which the state would ordinarily be entitled to receive from federal programs such as Medicare and Medicaid.

This bill would require, as a condition of enrollment in the plan, that every enrollee and provider agree to refer every claim for damages resulting from alleged negligence or malpractice in providing plan services to an arbitration board composed of 3 attorneys and 3 doctors, which would determine the degree and responsibility for negligence or malpractice, if any, and the amount of damages. The agency would be required to pay the amount of all damages, if any, in full
settlement of the claim.

This bill would appropriate an unspecified amount to the California Voluntary Medical and Hospital Services Insurance Agency to carry out specified functions, and to the agency trust fund for the payment of claims of benefits of the plan and operating and administrative costs.


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

SECTION 1. Division 12.6 (commencing with Section 15500) is added to the Health and Safety Code, to read:

DIVISION 12.6. MEDICAL AND HOSPITAL SERVICES INSURANCE

CHAPTER 1. FINDINGS AND PURPOSES

15500. This division shall be known and may be cited as the California Voluntary Medical and Hospital Services Insurance Act.

15501. The Legislature hereby finds that illness and accident are unpredictable hazards to all persons and that the financial cost of needed hospital and medical treatment may become a hardship upon any person or prevent their access to or receipt of needed hospital and medical treatment, and therefore a state agency shall be established to operate a medical and hospital services insurance plan, with funds supplied by voluntary subscriptions from subscribers, and matching state general funds, to pay all reasonable costs of all medically necessary, available, and appropriate medical and hospital services for all voluntary enrollees.

15502. The Legislature also finds that California has no precedent or experience with universal health insurance but takes note of the ten provinces and experience of the twenty-three million residents of Canada in evolving from conditions and methods of public and private health care financing closely paralleling existing conditions and
methods in the United States to an effective and
economical system of 10 autonomous and differently
structured provincial health insurance plans assisted
financially by the government of Canada, from which can
be drawn many valuable lessons and general principles to
guide us in planning to best meet our own particular
needs:
(a) Experience in Canada has demonstrated that the
total demand for medical and hospital services does not
increase significantly following introduction of universal
health insurance in a population already having an
adequate supply of hospital facilities and medical
personnel, whether such are uniformly distributed or not.
Experience in Canada has further demonstrated that the
actual utilization of medical and hospital insurance
benefits is almost entirely determined by decisions and
actions of physicians rather than by demands of patients
and all artificial regulatory mechanisms such as patient
copayments, deductibles, limits or exclusions are not only
unnecessary but tend to be strongly counter-productive
by greatly increasing administrative costs and
overburdening doctors and hospitals with paperwork and
also by deterring many persons from seeking early
diagnosis of disease and treatment which could be both
most effective and most economical.
(b) The medical profession itself is best qualified to
regulate the utilization and costs of insurance benefits
and can be relied on with confidence and held
accountable to perform this responsibility faithfully and
effectively in the best interests of the health of the people
of this state under a negotiated agreement with an
agency of the state without the necessity for a pervasive
and costly administrative and supervisory system.
(c) Compulsory enrollment or subscription by
individuals or employers to any health insurance plan is
undesirable because it grants an implied right to every
enrollee and subscriber to expect to receive health care
service whenever and wherever demanded, and such
expectations are clearly unrealizable and would impose
excessive demands on available medical manpower and
facilities, necessitating government intervention for the allocation of services; whereas universally affordable voluntary subscription may be predicated on a clear understanding and acceptance by all subscribers that the insurance benefits are intended only to pay for services which are medically necessary and readily available in the free marketplace.

(d) Experience in the various provinces of Canada has demonstrated that the total administrative cost of a single universal health insurance plan is likely to be substantially lower than under a system of multiple public and private plans and that the billing costs of providers are also substantially reduced by dealing with a single insurance carrier. It is further noted that Volume 5, entitled "Supplementary Health Insurance In Canada," of a study made for the Department of Health, Education and Welfare of the Canadian experience with government controls on the health care system (January, 1976), reports that private insurance companies in Canada (most of which are subsidiaries or affiliates of U. S. companies) are now enjoying increased sales of supplementary health insurance policies as well as life and disability income insurance since they have been relieved of underwriting medical and hospital insurance.

(e) The cost of professional malpractice litigation, settlements, insurance and defensive medicine is not a significant problem in Canada but it has become a major factor in the cost of health care in the United States and must be taken into account in any consideration or cost projection of any state health insurance program. There is general agreement that a speedy low-cost system of preliminary nonbinding arbitration could eliminate most protracted and expensive litigation and the unwarranted settlement of meritless claims. To achieve maximum economy and equity, however, such preliminary arbitration or adjudication of malpractice claims must be universal. A voluntary state health insurance plan, requiring as a condition of enrollment or participation an agreement to arbitrate all claims, would afford the most effective instrument or medium for universal arbitration
which could restrain or even reduce the ever-increasing
costs of malpractice defense.

CHAPTER 2. ORGANIZATION AND MANDATE

15505. (a) The California Voluntary Medical and
Hospital Services Insurance Act shall create a California
Voluntary Medical and Hospital Services Insurance
Agency to operate a California Voluntary Medical and
Hospital Services Insurance Plan. The agency shall have
a director appointed by the Governor to be confirmed by
the Senate, and he shall serve at the discretion of the
Governor. The director shall appoint six assistant
directors, of whom not less than three shall be medical
doctors, who together shall appoint or assemble such
deputy directors, staff, consultants, contractors, quarters,
and facilities as the directors shall deem necessary to
carry out the responsibilities and functions of the agency,
including the preparation of an annual budget and an
annual operations report and financial statement and
accounting of all receipts and expenditures, audited and
certified by the Auditor General, for the Governor and
the Legislature.

(b) The agency shall have two operational
subdivisions: one subdivision, hereafter referred to as
“Section I,” shall exclusively conduct all relations with
hospital service providers and the payment of hospital
service benefits of the plan; one subdivision, hereafter
referred to as “Section II,” shall exclusively conduct all
relations with medical and pathological laboratory
service providers and the payment of medical and
pathological laboratory benefits of the plan and such
additional benefits as may be provided by the plan in the
future.

(c) All operations of the plan shall be governed solely
by the provisions of this division. In recognition of the fact
that administrative rules and regulations respecting
ostensible financial transactions would be likely also to
adversely affect medical practice and hospital operation,
the agency shall issue or publish, or cause to issue or
publish, no rules or regulations. When particular or
general orders or directives are deemed necessary to
carry out the provisions and intentions of this division,
such shall be issued by the agency as memoranda, by
date, location, sequential number and reference to the
relevant section of this division. Whenever the agency
determines that amendment of this division is necessary,
the agency shall petition the Legislature to enact such
amendment.

CHAPTER 3. DEFINITIONS

15510. For purposes of this division:
(a) “Agency” means the California Voluntary Medical
and Hospital Services Insurance Agency created by this
division;
(b) “Plan” means the California Voluntary Medical
and Hospital Services Insurance Plan operated by the
agency;
(c) “Subscriber” means any adult person, 18 years of
age or older, who has enrolled himself or herself and his
or her spouse and dependent children and adult or child
wards, if any, in the plan and has paid the requisite
premium for each enrollee; or an employer or a public
agency that enrolls, and remits premiums to the plan on
behalf of one or more employees or clients;
(d) “Enrollee” means any person enrolled in the plan
by a subscriber and whose requisite premium has been
paid and is in force, and who has been assigned a plan
account number, which shall also identify the enrollee’s
subscriber;
(e) “Family” means any adult person 18 years of age or
older and spouse and all dependent children, adults, or
wards, if any, whether residing together in the same
household or not;
(f) “Adult” means any person 18 years of age or older;
(g) “Child” means any person under the age of 18
years;
(h) “Provider” means any person, partnership,
association, or corporation that provides and claims
payment for any medical, pathological laboratory or hospital service that is a benefit of the plan;
(i) "Doctor" means any person who is licensed as a medical doctor, doctor of osteopathic medicine, doctor of podiatric medicine, or doctor of dental surgery, who personally provides, performs, prescribes, orders, supervises, or certifies any medical service classified as a benefit of the plan, whether or not he or she has assigned any or all related fees to an employer, partnership, association, or corporation;
(j) "Hospital" means any establishment, with or without sleeping or feeding facilities, which provides patient diagnostic, therapeutic, or maintenance services or materials or staff for use only by or under the direction, supervision, and certification of a doctor, and for which a separate charge is made to the patient and which has been duly licensed and certified by all jurisdictional public health and safety agencies and which has been approved by the agency for participation in the plan;
(k) "Laboratory" means any separate establishment inside or outside of a hospital, a clinic, or a doctor's regular office and which is supervised at all times by a licensed medical doctor who is qualified as a specialist in pathology and which performs diagnostic pathological tests at the request only of doctors on behalf of patients who are charged separate fees for such services by the laboratory, and which has been duly licensed and certified by all jurisdictional public health, safety, and business regulatory agencies and which has been approved by the agency for participation in the plan for the provision of specified pathological tests;
(l) "Review organization" means a professional standard review organization.

Chapter 4. Initiation and Inception of the Plan

15515. The agency shall be charged with responsibility to make all necessary preparations to offer subscriptions and enrollments, and to commence payment of claims for benefits of the plan everywhere in the state within a
period of two years or less after the effective date of this
division, such preparations to include:
(a) The employment of staff;
(b) The occupation of quarters;
(c) The printing and distribution of informational and
operational material for and respecting subscription,
enrollment, premiums, benefits, claim forms, auditing
and processing and payment of claims;
(d) Establishment of medical and laboratory service
fee and hospital rate and charge schedules;
(e) Establishment of utilization review and control
procedures;
(f) Establishment of sanctions and disciplinary
procedures for illegal or unwarranted utilization of
benefits; and
(g) The preparation of a budget and projection of
operations to guide the Legislature in the appropriation
of funds to supplement subscribers’ premiums in
operating the plan for the succeeding calendar year.

15516. Not less than 90 days prior to the effective date
of inception of the plan, all persons who are enrolled in
or subscribers to or beneficiaries of the Medicare
program administered by the United States Social
Security Administration and the California Medi-Cal
program assisted by the United States Medicaid program
funds, shall be notified that all medical and hospital
service benefits provided by or through those programs
will cease on the effective date of inception of the plan;
and such notice shall be accompanied by an explanation
of the plan provided by this division and an application
form for enrollment in and subscription to the plan to
effectuate eligibility for the medical and hospital benefits
of the plan on the effective date of inception of the plan.

CHAPTER 5. DUPLICATION OF SERVICES AND
FUNCTIONS PROVIDED BY OTHER AGENCIES

15520. On the effective date of inception of the plan,
when the agency shall offer subscriptions and
enrollments and commence payment of claims for
benefits of the plan, the Legislature shall withhold all
appropriations for the funding of all similar or duplicate
hospital and medical service insurance benefits or
payments provided by any other agency of the state,
including but not necessarily limited to that program
known as Medi-Cal, and every such program operated by
any agency of the state, whether specified or not, shall
immediately cease providing or paying for medical or
hospital service for members of the general public on a
fee or charge-for-service basis.

15521. If the program specified in Section 15520 or any
other programs operated or administered by any agency
of the state provides any benefit, service or function
other than the direct provision of payment for medical
and hospital service for members of the general public
not enlisted or commissioned in the armed forces or
Coast Guard of the United States, entitled to such
benefits from the Department of Veterans Affairs,
residing in an Indian reservation or in the custody of a
penal or mental institution, such other benefit, service, or
function shall not be denied necessary operating funds by
the Legislature insofar as the purpose and intention of
this division are concerned.

CHAPTER 6. BENEFITS OF THE PLAN

15525. Payment shall be made by the plan to or on
behalf of every enrollee for all legal, appropriate,
professionally recognized and medically necessary
medical service provided as a personal professional
service by or under direct supervision of a licensed
medical doctor, wherever performed, including but not
necessarily limited to noncutting physical and psychiatric
medicine, surgery, obstetrics, radiological and electrical
procedures, pathology tests, transfusions, medication and
immunization, injections and anesthesia; and for the
same kind of services provided by a doctor of osteopathic
medicine.

15526. Payment shall be made by the plan to or on
behalf of every enrollee for all appropriate, professionally
recognized, and medically necessary reconstructive oral
surgery performed by a doctor of dental surgery in a
consenting hospital approved by the agency.
15527. Payment shall be made by the plan to or on
behalf of every enrollee for all appropriate, professionally
recognized and medically necessary foot surgery
performed by a doctor of podiatric medicine.
15528. Payment shall be made by the plan on behalf of
every enrollee for all professionally recognized
pathological tests performed at the request of the
enrollee’s doctor and under the direct supervision of a
medical doctor qualified as a specialist in pathology, by a
laboratory approved by the agency for participation in
the plan for specified pathological tests.
15529. Payment shall be made by the plan on behalf of
every enrollee for all legal, appropriate, professionally
recognized and medically necessary inpatient or
outpatient hospital service, supplies, medication,
transfusions and food provided by a hospital approved for
participation in the plan by the agency, including general
or special category hospitals, outpatient clinics,
emergency wards, convalescent hospitals, nursing homes
and acute alcohol or drug toxification treatment centers,
when the enrollee is admitted or attended by a licensed
doctor on the staff of the hospital.

CHAPTER 7. SERVICES EXCLUDED FROM BENEFITS OF
THE PLAN

15530. No payment shall be made by the plan on
account of:
(a) Any medical advice given to an enrollee by
telephone.
(b) Any cosmetic plastic surgery not deemed essential
to the physical and mental health of the enrollee and not
approved in advance by the agency.
(c) Any service or supplies or food provided by a
hospital at the request of the enrollee and which are not
medically necessary or prescribed by a doctor, such as but
not necessarily limited to private or semiprivate
accommodation, telephone, private nursing, and food not
ordinarily served or provided to all patients within the
hospital's basic per diem rate.
(d) Any medicolegal advice in connection with any
legal claim or suit other than as provided in Sections
15689 and 15691.
(e) Any service requested by or for the benefit of a
second party other than the enrollee, such as but not
necessarily limited to a life insurance application, a past,
present, or prospective employer, or any other party with
any legal or monetary interest in the health of the
enrollee.
(f) Any service that is the responsibility of an enrollee's
past or present employer or custodian, such as but not
necessarily limited to a workmen's compensation insurer,
the armed forces, Coast Guard, Veterans’ Administration,
penal or mental institutions.
(g) Any service that is a covered benefit of any other
public or private health insurance plan or prepaid
hospital or medical service plan, group or organization, in
which the enrollee is enrolled at his own or any other
party’s expense or is entitled to by any federal, state, or
municipal agency.
(h) Any hospital or laboratory service provided by a
hospital or laboratory not approved by the agency.
(i) Any medical service provided by a doctor who has
been excluded from the plan by unrevoked orders of the
directors of the agency, except in an emergency when
medically necessary service is not available from a
nonexcluded doctor.

CHAPTER 8. ASSIGNMENT OF BENEFITS

15535. It shall be a condition of enrollment in the plan
that every enrollee shall assign to the agency the full and
unreserved right to recover from any third party the full
amount of any benefits paid by the plan on account of
medical, laboratory or hospital service provided to the
enrollee, and necessitated by the culpable actions or
negligence of the third party and which are the liability
of the third party.

CHAPTER 9. PREMIUMS AND PREMIUM RECEIPTS

15540. Premiums shall be paid by every subscriber on account of each enrollee in his or her family or employ, in advance, monthly, quarterly, semianually, or annually in the amount of eighteen dollars ($18) per calendar month or two hundred sixteen dollars ($216) per year for each adult and one-half of that amount for each child.

15541. Subscribers who present valid evidence, in a form prescribed by the agency, showing that their enrollee’s total earned and unearned combined family income is less than twelve thousand dollars ($12,000) per year (one thousand dollars ($1,000) per month, average) shall be entitled to have their annual premiums for each adult enrollee calculated at the rate of 1.8 percent of total annual earned and unearned combined family income, or one-twelfth of 1.8 percent of that income monthly, and one-half of that amount for each child enrollee, but in no case shall the adult premium be less than three dollars ($3) per month or thirty-six dollars ($36) per year and one-half of that amount for each child.

15542. If an enrollee is employed by an employer who remits premiums to the plan on behalf of employees, it shall be the responsibility of the enrollee to advise the employer of the enrollee’s total annual earned and unearned combined family income on which the applicable premium is calculated, as provided in Section 15541.

15543. If two or more enrollees in a family are employed by the same or various employers who remit premiums to the plan on behalf of employees, it shall be the responsibility of each enrollee to advise their employer of any premiums being remitted to the plan by every other employer of every other enrollee in the enrollee’s family, so that there shall be no duplication in the applicable amount of premiums remitted.

15544. If employment contracts or agreements require
one or more employers to pay all or part of plan
premiums and remit such premiums to the plan on behalf
of one or more enrollees in the same family, the excess
amount of such premiums payable by the employer shall
be paid to the employee as wages and shall not be
remitted to the plan, after notification of the employer as
provided in Section 15543.

15545. Every subscriber shall be provided with a
receipt for premiums paid for each enrollee of the
subscriber, showing the enrollee’s name, address, plan
account number, and the calendar period covered by the
premium and if the subscriber is the employer of the
enrollee the receipt shall show the subscriber’s name,
address, and plan account number.

Chapter 10. Reinstatement of Coverage

15550. Enrollment in the plan shall be reinstated
without loss of coverage if any unpaid premiums on
account of any enrollees are paid within 60 days of their
due date but thereafter coverage shall not be effective
and benefits shall not be payable on account of any
enrollee for 45 days after a subscriber has reapplied for
enrollment and has paid any premiums then due in
advance; and the same shall apply with respect to an
enrollee separated from his or her subscriber.

Chapter 11. Trust Fund and Subsidy

15555. Upon the effective date of inception of the plan
and the offering of subscriptions to the public, the agency
shall establish a trust fund into which shall be deposited
all premiums received from subscribers together with an
at least equal amount of money appropriated from the
General Fund; from which shall be paid all claims for the
benefits of the plan and all operating and administrative
costs.

15556. During the first three years of operation of the
plan, the Legislature may increase the amount of money
appropriated from the General Fund, relative to
subscribers' premiums, to be deposited in the trust fund provided in Section 15555.

15557. Section 15556 notwithstanding, the amount of general funds appropriated by the Legislature and deposited in the trust fund provided in Section 15555 shall not exceed the amount of subscribers' premiums deposited in the trust fund during the fourth and succeeding years after the effective date of inception of the plan, except only as provided in Section 15561.

Chapter 12. Apportionment of Premiums and Subsidy

15560. Thirty-two percent of all premiums received from subscribers and deposited in the trust fund as provided in Section 15555 shall be reserved for the payment of medical and laboratory service benefits of the plan, and 65 percent of all such premiums shall be reserved for the payment of hospitalization benefits and 3 percent of all such premiums shall be reserved for the payment of operating and administrative costs and for unrecoverable arbitration costs and awards as provided in Sections 15689 and 15691.

15561. Appropriations from general funds shall be deposited in the plan trust fund and reserved in the same proportions as provided in Section 15560, but in no case shall the amounts appropriated from general funds and deposited in the trust fund be less than the difference between premiums paid by subscribers and the amount of twenty-four dollars ($24) per month or two hundred eighty-eight dollars ($288) per year per enrollee enrolled in the plan or any such amount as may be determined by the Legislature from time to time in the future with respect to the actual costs of the benefits provided by the plan; except that all amounts expended on administrative costs and unrecoverable arbitration costs and awards as provided in Section 15689 in excess of 3 percent subscribers' premiums shall be appropriated from general funds and deposited in the plan trust fund.
CHAPTER 13. VOLUNTARY ENROLLMENT AND SUBSCRIPTION

15565. Enrollment in the plan and the payment of applicable premiums shall be voluntary and the personal responsibility of every eligible adult resident of the state, except that nothing in this division shall be construed as preventing any adult subscriber from enrolling his or her spouse or child or adult dependents in the plan or any employer from enrolling any employee and the employee's family when the employer pays all or part of the employee's premiums, or the state, or any county, or municipal welfare agency from enrolling in the plan any person who is in receipt of public assistance when such public agency pays all or part of the applicable premium for that person.

CHAPTER 14. EFFECTIVE DATE OF BENEFITS AFTER ENROLLMENT

15570. All benefits of the plan shall become payable by the plan on the effective date of inception of the plan upon enrollment and payment of applicable premiums prior to the date of inception; and thereafter benefits shall become effective and payable 45 days after the date of enrollment and payment of applicable premiums, except that benefits shall be effective and payable from the date of birth when a parent or guardian has enrolled a child and paid the applicable premium within 30 days after the child's birth.

CHAPTER 15. REIMBURSEMENT OF FEES PAID TO NONPARTICIPATING PROVIDERS

15575. Every enrollee in the plan shall be entitled to reimbursement in the lesser amount of either the scheduled fee payable by the plan to a participating medical service provider for any service that is a benefit of the plan or the actual fee paid by the enrollee to any qualified nonexcluded and nonparticipating medical
service provider within the state for such service, upon submission to the plan by the enrollee of an explicit statement of the service provided together with a valid receipt for payment made or a valid assignment of payment due to the provider.

15576. Every nonexcluded and nonparticipating medical service provider within the state shall be required, in advance of providing any service that is a benefit of the plan to any identified enrollee in the plan, to inform the enrollee in writing that the provider is not a participant in the plan and that the enrollee may be entitled to receive full or partial reimbursement from the plan for fees paid to the provider; and shall at the same time inform the enrollee of the amount of such fees and the amount of the scheduled fees payable by the plan for the service; and to this end every nonexcluded and nonparticipating provider shall be supplied without charge with a copy of the current plan schedule of medical services and related fees as provided in Chapter 21 (commencing with Section 15610) of this division.

15577. Failure by any nonexcluded and nonparticipating medical service provider to inform any identified enrollee in the plan of all of the applicable information set out in Section 15576 shall discharge the enrollee and the plan of any and all obligation to pay any fees claimed by the provider for any service provided that otherwise would be a benefit of the plan.

CHAPTER 16. PARTICIPATION BY MEDICAL SERVICE PROVIDERS

15580. Every nonexcluded and licensed medical doctor, doctor of osteopathic medicine, doctor of podiatric medicine and doctor of dental surgery shall be entitled to be listed by the plan as a participating provider by making application to Section II of the agency 30 days in advance and shall be supplied by the agency without charge with an account number, all necessary claim submission forms, schedule of medical services and fees, informational material and two durable display signs at
least 6 by 12 inches in size stating his or her name, professional title, plan account number, and the following wording: "I am a participating medical service provider in the California Voluntary Medical and Hospital Services Insurance Plan. I will accept your valid plan premium payment receipt to submit my claim for payment to the plan. I may require the payment of an extra fee, which will be stipulated before I treat you, and which will be disclosed on my claim to the plan. You are entitled to know the amount of fee I will be paid by the plan for treating you."

15581. Any participating medical service provider may withdraw from the plan at any time upon giving notice to the agency in writing 30 days in advance.

15582. Any nonexcluded medical service provider who has voluntarily withdrawn from participation in the plan shall be entitled to be relisted by the plan as a participating provider upon giving notice to Section II of the agency in writing 30 days in advance and not less than 30 days after the effective date of prior withdrawal.

15583. Every participating medical service provider shall be required to submit a correctly completed official claim form to the plan on account of all services that are benefits of the plan that have been provided to any enrollee, and to disclose on such form the amount of any extra fees charged to the enrollee, or any portion of the scheduled fees payable by the plan that is remitted by the provider.

15584. Every participating medical service provider may at his or her own discretion advise any enrollee in advance of treatment that the provider will require the enrollee to pay a reasonable extra fee directly to the provider in addition to the fee payable by the plan; and no such extra fee shall be charged by the provider or payable by the enrollee unless consented to by the enrollee in advance of treatment or if such extra fee would effectively prevent access by the enrollee to necessary medical treatment.
CHAPTER 17. APPROVAL OF PATHOLOGICAL LABORATORIES

15590. Every pathological laboratory that provides services which are covered benefits of the plan and that desires to be listed by the agency as a participating laboratory shall submit to Section II of the agency in writing on an approved form an application for approval and listing, together with evidence of certification and licensure by all jurisdictional public health, safety and business regulatory agencies and evidence of professional competence in the specific services offered.

15591. Section II of the agency shall have final authority to issue a certificate of approval to a laboratory to provide specified services as benefits of the plan and to list the laboratory as a provider of those specified services as benefits of the plan.

15592. Any approved laboratory listed as a provider of specified services may from time to time request approval as a provider of other specific services or may request to be delisted as a provider of a specific service.

15593. Section II of the agency shall have authority to withdraw approval and listing of a laboratory as a provider of specified services at any time the section has evidence of a lack of professional competence by the laboratory in specified services.

CHAPTER 18. PARTICIPATION BY APPROVED LABORATORIES

15595. Every laboratory which is approved and listed by Section II of the agency as a provider of specified services shall be required to submit a correctly completed official claim form to the plan on account of all such specific services provided to an enrollee at the request of the enrollee’s doctor and shall not bill the enrollee for any additional fee for such service.

15596. Every laboratory which is approved and listed by Section II of the agency as a provider of specified services shall be supplied without charge by the section
1. with a plan account number, all necessary claim submission forms; a schedule of all professionally recognized pathological laboratory services and related usual, customary and reasonable fees; general informational material concerning the plan, and two durable display signs at least 24 by 14 inches in size stating the name of the laboratory, the name and professional title of the supervising medical doctor, and the following wording: “This laboratory is a participating provider in the California Voluntary Medical and Hospital Services Insurance Plan and your valid plan premium receipt will be accepted for submission of our claim for payment to the plan. No other charge will be made to you for any service we provide that is a covered benefit of the plan. We are approved by the plan to provide the following services only: ________.”

CHAPTER 19. APPROVAL OF HOSPITALS

15600. Every hospital that provides services which are classed as benefits of the plan shall be required to submit to Section I of the agency in writing on an approved form an application for approval as a provider together with evidence of certification and licensure by all public health, safety, and business regulatory agencies having jurisdiction and a certified statement of ownership, directors, and officers; a detailed certified inventory of all assets and facilities; certified statement of current financial condition and a summary of income, expenditures and operations for the preceding 48 calendar months, or since the commencement of operations, whichever is the shorter time; and the section shall have final authority to approve such hospital and list it as a provider.

CHAPTER 20. PARTICIPATION OF HOSPITALS

15605. Every hospital that is approved by Section I of the agency and listed as a provider of benefits of the plan shall be required to submit a correctly completed official
claim form to the plan on account of all services which are
covered benefits of the plan and provided to any enrollee
and shall not bill any enrollee for any additional charge
for such service but may bill any enrollee for additional
or optional services requested by the enrollee.

CHAPTER 21. MEDICAL SERVICES SCHEDULE AND FEES

15610. Section II of the agency shall compile and
publish a schedule of every professionally recognized and
defined physical and mental disease or disorder or the
symptoms or syndrome thereof, and every related
diagnostic and therapeutic service, procedure or
treatment; and affix to each such service a fee that is in
proportion to the usual, customary and reasonable fee for
such service in each general area of the state.

15611. Section II of the agency shall consult with the
medical professional association or society in each
general area in the compilation of the schedule and
affixing of fees as provided in Section 15610.

15612. Section II of the agency shall consult with the
medical professional association or society in each
general area in establishing the percentage of each
scheduled fee that will be paid by the plan for each
scheduled service that is a benefit of the plan.

15613. Section II of the agency shall provide a copy of
the medical service and fee schedule without charge to
every participating medical service provider and shall
make additional copies of the schedule available to
participating providers and to the medical profession in
general at reasonable charge.

15614. Section II of the agency shall consult with the
medical professional association or society in each area
from time to time with respect to making appropriate
revisions in the schedule of medical and laboratory
services and fees or the percentage of scheduled fees
payable by the plan in consideration of changed costs of
services or available plan trust funds.
CHAPTER 22. PATHOLOGICAL LABORATORY SERVICE
SCHEDULE AND FEES

15620. Section II of the agency shall compile and publish a schedule of every professionally recognized and defined laboratory pathological test and procedure and shall affix to each such service a fee that is in proportion to the usual, customary, and reasonable fee for such service in each general area of the state.

15621. Section II of the agency shall consult with the medical professional association or society, and with the pathological laboratory specialist association or society in each general area of the state in the compilation of the schedule of services and fees as provided in Section 15620.

15622. Section II of the agency shall consult with the medical professional association or society, and with the pathological laboratory specialist association or society in each general area in establishing the percentage of each scheduled fee that will be paid by the plan for each service that is a benefit of the plan.

15623. Section II of the agency shall provide a copy of the pathological laboratory service and fee schedule without charge to every approved and participating laboratory service provider and shall make additional copies of the schedule available to participating providers and to the medical profession in general at a reasonable charge.

15624. Section II of the agency shall consult with the medical professional association or society and with the pathological laboratory specialist association or society in each general area annually with respect to making appropriate revisions in the schedule of laboratory services and fees or the percentage of scheduled fees payable by the plan to laboratory service providers.

CHAPTER 23. HOSPITAL CHARGES AND RATES

15630. Section I of the agency shall provide each approved hospital with a schedule of per diem rates and charges that will be paid by the plan to that hospital for
each specified service or item that is a benefit of the plan
and which is ordered on behalf of an enrollee by an
attending medical doctor, doctor of osteopathic
medicine, doctor of podiatric medicine, or doctor of
dental surgery having staff privileges in the hospital with
the consent of the hospital, and who is attending the
enrollee with service which is a benefit of the plan.

15631. The per diem rates and charges for specified
services and items to be paid by the plan to each hospital
shall be set by Section I of the agency and shall be based
on each hospital’s certified annual financial and operating
cost statement, including the cost of amortizing every
capitalized asset owned or obligated by a hospital and
reasonable interest on all bonded and secured debt
obligated prior to the date of inception of the plan, and
a projected annual operating budget for each
forthcoming calendar year. Insofar as possible or practical
the per diem bed rate established and paid to each
hospital shall be for the lowest standard category of
accommodation in keeping with the medical
requirements of each patient and shall include an equal
share of all capital and operating costs of all facilities
within each hospital such as operating rooms,
laboratories, radiological equipment and the like; such
per diem bed rates to be subject to adjustment,
supplementation or reduction in relation to varying bed
utilization rates in each hospital and the length of
hospitalization of each patient. Rates payable for
outpatient visits shall include an equal share for each
patient of all capital and operating costs of all outpatient
or emergency ward facilities in each hospital.

15632. After the date of inception of the plan, the per
diem rates and charges for specific services and items to
be paid by the plan to each approved hospital shall not
include the cost of operation or amortization of any
capital expenditure that has not been specifically
approved in advance by Section I of the agency with
respect to the public interest that is likely to be served by
such capital expenditure.
CHAPTER 24. FORM OF CLAIM FOR BENEFITS OF PLAN

15635. All claims for service by participating medical
4 service, laboratory service, and hospital service providers
5 shall be submitted to the plan within 60 days of the last
6 day of the month in which the service was provided or
7 completed, and on a correctly completed form supplied
8 by the agency and which shall be printed on a standard
9 keypunch computer entry card approximately 7½ inches
10 by 3½ inches in size with a carbon insert and a tissue copy
11 for retention by the provider.
12 15636. All claims by all participating providers shall
13 state the following items of information:
14 (a) Provider’s name, address, and plan account
15 number.
16 (b) Provider’s assignee of payment, if any.
17 (c) Medical professional association or society, or
18 review organization having jurisdiction.
19 (d) Enrollee’s name, address, and plan account
20 number.
21 (e) Date of each separate service inclusive in time.
22 (f) Duration of each service in days, hours, and
23 minutes.
24 (g) Place of service as: office, home, hospital,
25 emergency room, outpatient clinic, or elsewhere.
26 (h) Sequential number of each separate service in
27 related treatment.
28 (i) Schedule number of service, procedure, or item.
29 (j) Related scheduled fee or charge for service,
30 procedure, or item.
31 (k) Percentage of scheduled fee payable by the plan.
32 (l) Medical diagnosis or description of patient’s
33 complaint.
34 (m) Name of referring or admitting doctor or
35 referred-to doctor.
36 (n) Certifying signature of attending doctor.
37 15637. In addition to the items of information specified
38 in Section 15636, all medical service providers shall be
39 required to state on their claim form the amount, if any,
40 of extra fees charged the enrollee, or any portion of the
scheduled fees payable by the plan that are remitted by the
a provider.
15638. All information on each claim submitted by each
participating provider shall be keypunched for entry into
a computer according to a program that will enable the
generation of the following output:
(a) Itemized monthly statement of all accepted claims
and a total payment check for each provider.
(b) Itemized cumulative statement for each enrollee
showing all claimed services and amounts paid to
providers on behalf of enrollees.
(c) Cumulative statements showing the quantity and
character of utilization of plan benefits by each provider
and each enrollee, for use by medical professional
associations or societies having jurisdiction in assessing
individual and general patterns of medical and hospital
practice and utilization of plan benefits on a continuing
basis, as provided in Sections 15651 and 15652.

CHAPTER 25. AUDITING OF CLAIMS

15640. Every claim for service submitted by a
participating provider and every claim by an enrollee for
reimbursement for payment to a nonexcluded and
nonparticipating medical service provider, as provided in
Section 15575, shall be audited by the agency or its agents
with respect to the validity of the information specified
and required in Section 15636 and when such information
is lacking or found to be incorrect or invalid or if the
claimed service is not a specified benefit of the plan, the
claim shall be so noted and returned to the claimant.

15641. The agency or its agents during the auditing of
any claim shall make no assessment of the medical
validity, necessity, or legality of the service claimed as a
benefit of the plan; but where there is reasonable doubt
of the medical validity, necessity, or legality of any such
claimed service the claim shall be referred to the
directors of the agency for assessment or reference to the
medical professional association or society or review
organization having jurisdiction for assessment and
recommendation respecting acceptance and payment of
the claim, as provided in Section 15650.

CHAPTER 26. PAYMENT OF CLAIMS

15645. Every submitted claim for service that is a
benefit of the plan and which has been approved for
payment by audit and which has not been referred for
assessment as provided in Section 15641, shall be paid by
the plan within 45 days after the last day of the calendar
month in which the claim was submitted by the provider
or enrollee.

15646. When more than one claim for service is
submitted by a participating provider or enrollee in any
one month, all approved claims shall be consolidated in
a single payment to the provider or enrollee within the
period specified in Section 15645.

CHAPTER 27. ASSESSMENT OF CLAIMS AND
UTILIZATION OF PLAN BENEFITS

15650. The directors of the agency shall make final
determination and assessment of the medical validity,
necessity, and legality of any claimed service that is a
benefit of the plan and to this end may enter into an
agreement from year to year with any medical
professional association or society or established review
organization having jurisdiction in any general area of
the state to consult with and advise the directors in
making such determinations and assessments and
approving or disapproving payment for claimed services.

15651. The agency may enter into an agreement from
year to year with any medical professional association or
society or review organization having jurisdiction in any
general area of the state to periodically or continuously
review and assess the cumulative and continuing
utilization of plan benefits by participating providers and
enrollees and to continuously advise the agency of any
utilization of plan benefits that appears to be illegal,
excessive, unwarranted, medically unnecessary, or
medically invalid, according to applicable laws and the normal and accepted standards of medical practice in the area.

15652. To effectuate any agreement provided in Section 15651, the agency shall provide the medical professional association or society or review organization having jurisdiction with cumulative summaries of all claims by each participating provider and enrollee for services that are benefits of the plan and which are categorized according to the type and nature of the service.

15653. A medical professional association or society or review organization having jurisdiction under agreement as provided in Sections 15650 and 15651 may recommend to the directors of the agency the application and nature of sanctions or disciplinary action against any participating provider or enrollee found to be utilizing the benefits of the plan illegally, excessively, unwarrantedly, or without medical necessity or validity.

15654. In response to the recommendations of any medical professional association or society or review organization having jurisdiction, as provided in Section 15653, the directors of the agency shall have authority to order a temporary or permanent reduction in the percentage of scheduled fees or rates payable in the future to a participating provider or to temporarily or permanently exclude a medical or laboratory service provider from future participation in the plan or to serve notice on an enrollee of a temporary or permanent reduction in the benefits of the plan that will be reimbursable to or payable on behalf of enrollees.

15655. The agency shall pay to any medical professional association or society or review organization having jurisdiction with which it has entered into an agreement as provided in Sections 15650 and 15651, a negotiated fee in the amount of 0.5 percent or more or less than 0.5 percent of the total dollar amount of providers' or enrollees' claims, reviewed during each three-month period.
CHAPTER 28. STATEMENT OF BENEFITS PAID

15660. The agency shall deliver to each enrollee a statement, as provided in subdivision (b) of Section 15638, listing every service claimed to have been provided to the enrollee and the amount paid to each provider on account of such claimed service during any period of time as may be determined by the agency with respect to any enrollee.

15661. As a condition of enrollment in the plan every enrollee shall be required to notify the agency of any claims for service by any provider which the enrollee has reason to believe were not, in fact, provided; and such obligation shall be noted on all statements furnished to enrollees.

CHAPTER 29. RIGHT OF RECOVERY

15665. Any other remedies or actions against providers and enrollees provided in this division notwithstanding, the agency shall have the right to proceed in law to recover from any provider or enrollee any amounts paid by the plan for services or benefits claimed but not, in fact, provided or received, or which are determined to be services or benefits excluded from the plan, or services provided by nonapproved or nonparticipating hospitals and laboratories, or by medical service providers excluded from the plan by the directors.

CHAPTER 30. EXCLUSION OF PARTICIPANTS

15670. The agency shall have authority to temporarily or permanently exclude from participation in the plan any enrollee or provider of laboratory or medical service found to have made, with intent to defraud the plan, any false claim for payment for service provided or received; or as provided in Section 15654, and in addition to the right of recovery as provided in Section 15665.

15671. The agency shall have authority to temporarily or permanently exclude from participation in the plan
any provider of medical services found to have charged
any enrollee an extra fee of such amount as to effectively
prevent that enrollee's access to medically necessary
service; or to have acted in concert or by prior agreement
with any other providers of medical service to regularly
and habitually charge enrollees a scale of extra fees in
excess of scheduled fees payable by the plan.

15672. Any exclusion order made by the agency under
Section 15654, 15670, or 15671 may be appealed by the
excluded party to the directors or the agency and
thereafter to any state court having jurisdiction at any
time within one year of the effective date of such order.

15673. The agency shall publish the names of every
medical and laboratory service provider excluded from
the plan, as provided in Sections 15654 and 15670 and shall
advise each enrollee that they will not be reimbursed by
the plan for any service received from any excluded
provider, except when such exclusion order is under
appeal or revoked as provided in Section 15671.

CHAPTER 31. ADDITIONAL BENEFITS

15675. Every paid-up enrollee in the plan shall be
entitled to reimbursement in the lesser amount of either
the scheduled fee or charge payable by the plan to a
participating provider in the area of residence of the
enrollee, or the actual fee or charge paid by the enrollee
to a medical doctor, pathological laboratory, or general
medical hospital outside of the state for any service that
ordinarily would be a benefit of the plan in the state while
the enrollee was traveling outside of the state or
temporarily living outside the state for a period not
exceeding one year from the enrollee's date of departure
from the state, upon submission to the agency of a valid
receipted statement of payment for such service within
30 days of the return to the state of the enrollee.

15676. The benefits provided in Section 15675 shall
apply to a child born outside of the state to a mother who
is an enrollee in the plan, and who would otherwise be
entitled to the benefits provided in Section 15675, if the
child is enrolled in the plan and the applicable premium
is paid on its behalf within 30 days of birth, as provided
in Section 15570.

15677. Not less than two years after the effective date
of inception of the plan, the agency directors shall
consider the advisability and feasibility of offering
additional benefits to enrollees, such as but not
necessarily including or limited to payment or
reimbursement for dental service, prescribed drugs,
prosthetics, home nursing; chiropractic treatment; and
Christian Science healing; on a basis of full or partial cost
or a scheduled annual amount; to be included within the
established premiums of the plan or in consideration of
additional and optional premiums; and shall bring their
recommendations before the Legislature for appropriate
amendment of this division.

15678. Any subscriber who has paid premiums on
account of any enrollee as provided in Chapter 9
(commencing with Section 15540) and with the mutual
consent and agreement of the enrollee shall be entitled
to enroll the enrollee as a member in any nonexcluded
and participating prepaid group medical practice
establishment or health maintenance organization
providing medical, hospital, or other health services to its
members, from which establishment or organization the
enrollee shall exclusively receive all necessary medical,
hospital, or other health services so long as the enrollee
elects to remain a member of that establishment or
organization. The plan shall pay the establishment or
organization on behalf of the enrollee a monthly or
annual payment not exceeding the average of the
monthly or annual premiums paid by all subscribers to
the plan together with general fund contributions to the
plan trust fund and no other payments shall be made by
the plan to or on behalf of the enrollee for benefits of the
plan. Any plan enrollee enrolled as a member of a
prepaid group medical practice establishment or health
maintenance organization may give the plan notice of
election to withdraw from such membership not less than
15 days in advance of the next due contractual payment
to be made by the plan on behalf of the enrollee to such
establishment or organization.

CHAPTER 32. AMENDMENT OF PREMIUMS AND
MATCHING FUNDS

15680. Not less than three years after the effective date
of inception of the plan, the directors of the agency may
recommend to the Legislature an appropriate increase in
the schedule of premiums set out in Sections 15540 and
15541, if it is then found that the actual costs of medical,
laboratory and hospital services that are benefits of the
plan exceed the apportioned and reserved income from
subscribers’ premiums, as provided in Section 15560, and
matching appropriations of funds, as provided in Section
15561.

CHAPTER 33. AMENDMENT OF THE SOCIAL SECURITY
AND MEDICAID ACTS

15685. As a prerequisite condition to this division
becoming operative, the State of California shall obtain
from the government of the United States an agreement
to amend the laws and acts governing those federal
programs generally known and referred to as Medicare
and Medicaid, enabling the transfer and application to
the California Voluntary Medical and Hospital Services
Insurance Agency Trust Fund, provided by Section
15555, all funds, grants and sums of money to which the
state and the residents of the state would ordinarily be
entitled to receive by agreement or statute under the
provisions and operation of those programs in payment
or reimbursement for medical and hospital services.

15681. In consideration of the agreement between the
State of California and the government of the United
States, as provided in Section 15680, every enrollee in the
plan shall assign, transfer or pay to the agency all medical
and hospital service benefits payments or reimbursement
to which the enrollee shall be entitled or receive under
the provisions and operation of the federal Medicare and
Medicaid programs.

CHAPTER 34. ARBITRATION

15690. It shall be a condition of enrollment and participation in the plan that every enrollee and provider shall agree to refer within the time allowed by any governing statute of limitation every claim or demand for damages resulting from alleged negligence or malpractice in the provision of any service that is a benefit of the plan, for arbitration to an arbitration board convened within 30 days of the date of filing of the claim and comprised of one licensed doctor and one licensed attorney nominated by the complainants together and severally, and one licensed doctor and one licensed attorney nominated by the defendants together and severally, and one licensed medical doctor nominated by the medical professional association or society having jurisdiction, and one licensed attorney nominated by the bar association or society having jurisdiction.

15691. All sessions of the board of arbitration provided in Section 15690 shall be chaired by the attorney nominated by the bar association or society having jurisdiction, and shall be held in quarters provided by the agency.

15692. The medical doctor nominated to the board of arbitration by the medical professional association or society having jurisdiction shall participate in the questioning and discussions of each session but shall not have a vote in any final decision or ruling by the board.

15693. A majority of the voting members of a board of arbitration, as provided in Sections 15691 and 15692 shall determine and assess the degree of and responsibility for negligence or culpable malpractice, if any, by the defendants together or severally and the amount of damages, if any, sustained by the complainants together or severally as a consequence of such negligence or culpable malpractice, if any, by the defendants together or severally.

15694. If a board of arbitration, as provided in Sections
1 15690, 15691, 15692, and 15693, finds that complainants
together or severally have sustained an amount of
damages as a consequence of the negligence or culpable
malpractice by the defendants together or severally, in
the provision of any service that is a benefit of the plan,
the agency shall pay to the complainants together or
severally the amount of all damages so determined and
assessed, in full settlement of the complainants’ claim,
unless the findings of the board of arbitration are
appealed as provided in Section 15698.

15695. The agency shall have the right to and shall
endeavor by every means and recourse provided by law
to recover from any defendants together or severally any
amounts of damages paid to any complainants together or
severally as provided in Section 15694, together with any
sessional fees paid to the members of the board of
arbitration as provided in Section 15696, subject to appeal
as provided in Section 15698; and to this end may
withhold all or any portion of any payments due the
defendants together or severally for past or future
services that are benefits of the plan.

15696. The agency shall enter into an agreement with
each member nominated to a board of arbitration, as
provided in Section 15690, to pay each such member a
sessional fee in the amount of thirty-five dollars ($35) per
hour or more or less than thirty-five dollars ($35) per
hour for each hour or portion of an hour devoted by each
member to his duties on the board of arbitration.

15697. If the majority of voting members of a board of
arbitration, as provided in Sections 15690 and 15692, find
that any allegation of negligence or malpractice or any
claim for damages by complainants together or severally
is wholly without merit or capricious or malicious, the
agency shall have the right to, and shall endeavor to,
recover by every means and recourse in law from the
complainants together or severally the amounts of all
sessional fees paid to members of the board of arbitration
as provided in Section 15696.

15698. Any finding or assessment by a board of
arbitration as provided in Sections 15693 and 15697 may
be appealed to any state court having jurisdiction by the
defendants together or severally or the complainants
together or severally or by the directors of the agency if
damages are assessed and payable to complainants
together or severally as provided in Section 15694.

CHAPTER 35. LIMITED SCOPE OF PLAN

15700. The purpose of this division is to provide only for
the establishment of a state voluntary insurance agency
and plan to pay all reasonable costs of all necessary and
appropriate medical, pathological laboratory and hospital
services, and such other additional benefits as may be
added in the future, as provided in Chapter 31
(commencing with Section 15675), for all enrollees when
and where such services are available from approved,
participating and nonexcluded providers; and the
resources of the agency and plan shall not be used in any
way directly to regulate the quality or availability of, or
to establish or operate, such services; and if adequate
services are not available when and where required by
enrollees, the agency and plan shall have no
responsibility or liability to provide such services; and in
consideration of the aforesaid limited scope and
purpose of this division, enrollment in and subscription to
the plan shall be voluntary for all enrollees and
subscribers as provided in Section 15565; and by so
limiting the scope and purpose of this division to the
providing of economic access to existing and available
health services any deficiencies in the quality, quantity,
 modes, methods, economics and distribution of those
services should be clearly revealed and may then be
corrected or improved by the health care profession or
appropriate public or private agencies, outside of an
independent of the California Voluntary Medical and
Hospital Services Insurance Plan and Agency.

CHAPTER 36. ESTIMATED COST OF PLAN

15705. The cost of medical and hospital service is
represented by the gross revenues of the physicians and hospitals that provide the service. The cost of the services that are benefits of the plan created by this division can be estimated as follows:

(a) The Internal Revenue Service publication numbered 438 (3/76) states that a total of 20,306 individual office-based physicians in California reported total gross income, including other than professional fees, of one billion one hundred fifty-two million eight hundred fifty-one thousand dollars ($1,152,851,000) or an average of fifty-six thousand seven hundred seventy-three dollars ($56,773) each, in 1972. In addition, approximately 6,000 other physicians as partners in partnerships reported average gross incomes of approximately eighty-two thousand dollars ($82,000) each (these latter figures are extrapolated from the IRS data which include physician partnership returns with those of other health service professionals such as dentists). The combined total of approximately 26,306 individual and partnership physicians reported average gross incomes of approximately sixty-two thousand five hundred dollars ($62,500) each or a total of approximately one billion six hundred forty-five million dollars ($1,645,000,000). If the average gross revenues of all office-based physicians increased to eighty-eight thousand dollars ($88,000) each and the number of physicians increased to 28,000 by fiscal year 1980, their total revenue would then amount to approximately two billion four hundred sixty-four million dollars ($2,464,000,000) or about one hundred seventeen dollars ($117) per capita for 21,000,000 residents of the state, of which approximately 75 percent or ninety dollars ($90) per capita would be payable as benefits of the plan for medically necessary medical services.

(b) The Social Security Bulletin (3/76) estimates that in 1975 the total expenses of all publicly and privately-owned acute and extended care community hospitals for all inpatient and outpatient services, including the salaries of approximately 70,000 staff physicians, were about thirty-five billion six hundred
1 million dollars ($35,600,000,000) or about one hundred
2 seventy dollars ($170) per capita for the U. S. civilian
3 population of 210,000,000. If national average hospital
4 expenses increase to about two hundred twenty-five
5 dollars ($225) per capita by 1980 and if California costs
6 exceed the national average by about 10 percent and are
7 approximately two hundred fifty dollars ($250) per
8 capita, approximately 75 percent or one hundred
9 eighty-nine dollars ($189) per capita would be payable as
10 benefits of the plan for medically necessary hospital
11 service.
12 (c) The combined cost of medical and hospital benefits
13 of the plan, as itemized above, would be about two
14 hundred seventy-nine dollars ($279) per capita or a total
15 of five billion eight hundred fifty-nine million dollars
16 ($5,859,000,000) if 21,000,000 residents of the state
17 enrolled in the plan in 1980.
18 15706. The premium schedule for subscribers to the
19 plan established by Chapter 9 (commencing with Section
20 15540) should result in an average income to the plan of
21 not less than twelve dollars ($12) a month or one hundred
22 forty-four dollars ($144) a year per enrollee or a total of
23 three billion twenty-four million dollars ($3,024,000,000)
24 if 21,000,000 residents enrolled in the plan, which,
25 together with matching state general funds, would
26 amount to a plan trust fund of six billion forty-eight
27 million dollars ($6,048,000,000).
28 15707. Chapter 12 (commencing with Section 15560)
29 restricts total administrative expenses and unrecoverable
30 arbitration award payments to 3 percent of available plan
31 trust funds or one hundred eighty-one million four
32 hundred forty thousand dollars ($181,440,000) or about
33 nine dollars ($9) a year per capita, if 21,000,000 residents
34 enrolled in the plan.
35 15708. If 21,000,000 residents enrolled in the plan by
36 1980 and medical and hospital benefits amounted to five
37 billion eight hundred fifty-nine million dollars
38 ($5,859,000,000), as postulated in subdivision (c) of
39 Section 15705, and administrative expenses amounted to
40 one hundred eighty-one million four hundred forty
thousand dollars ($181,440,000), as postulated in Section 13702, and total plan trust funds amounted to six billion forty-eight million dollars ($6,048,000,000), as postulated in Section 15707, the plan would have an operating surplus of seven million five hundred sixty thousand dollars ($7,560,000).

15709. Initial enrollment at inception of the plan probably would not exceed five million and probably not exceed 10 million by the end of the first two years of operation. The majority of initial enrollees would probably be in the lowest income categories, presently receiving medical and hospital care under either or both Medicare and Medi-Cal and therefore entitled to pay minimum premiums of three dollars ($3) per month and to receive the maximum general funds subsidy of twenty-one dollars ($21) per month. The general funds subsidy for five million enrollees would thereby possibly amount to one billion two hundred sixty million dollars ($1,260,000,000) per year. Such a subsidy would be some one hundred fifty-nine million four hundred sixty-six thousand eight hundred dollars ($159,466,800) less than estimated 1975 Medi-Cal expenditures of one billion four hundred nineteen million four hundred sixty-six thousand eight hundred dollars ($1,419,466,800) for medical and hospital services and associated administrative expenses that would be replaced by this plan.

15710. Approximately half or 2.5 million of the initial five million enrollees in the plan probably would be entitled to Medicare benefits for medical and hospital care, amounting to approximately one billion two hundred million dollars ($1,200,000,000), which would be available to the plan under agreement with the United States government as provided in Sections 15680 and 15681. These in-lieu Medicare funds would more than offset the higher medical and hospital expenses incurred by elderly and low-income patients.

15711. During subsequent years, the intake of enrollees would trend toward younger and higher-income categories who would pay higher premiums and require
less medical and hospital service. When 20 million
persons are enrolled, premiums would probably average
in excess of twelve dollars ($12) per capita per month, at
which point state general funds subsidies would amount
to approximately two hundred forty million dollars
($240,000,000) per month or two billion eight hundred
eighty million dollars ($2,880,000,000) per year, being
some two hundred sixty million five hundred thirty-three
thousand two hundred dollars ($260,533,200) more than
current Medi-Cal expenditures of one billion four
hundred nineteen million four hundred sixty-six
thousand eight hundred dollars ($1,419,466,800) and one
billion two hundred million dollars ($1,200,000,000) in
Medicare payments to California residents for medical
and hospital care.

SEC. 2. The sum of _______ dollars ($_______) is
hereby appropriated from the General Fund for
allocation in accordance with the following schedule:

(a) To the California Voluntary Medical
and Hospital Services Insurance Agency
to enable the agency to carry out the
responsibilities and functions specified
in Section 5510 within the time limits
specified.......................... $_____

(b) To the California Voluntary Medical
and Hospital Services Insurance
Agency Trust Fund for the payment of
claims for the benefits of the plan and
operating and administrative costs as
specified in Section 15555................ $_____

O