Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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1980 – AB 3068 (Bannai) Pages 2-26
1982 – AB 1262 (Torres) Pages 27-76
1988 – AB 2647 (Campbell) Pages 77-79

October 2007
Introduced by Assemblyman Bannai

March 7, 1980

REFERRED TO COMMITTEE ON FINANCE, INSURANCE, AND COMMERCE

An act to add Part 6.5 (commencing with Section 12700) to Division 2 of the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL’S DIGEST

AB 3068, as introduced, Bannai (Fin., Ins., & Com.). Comprehensive health insurance.

The existing law has no provisions relating to qualified comprehensive health insurance.

This bill would enact provisions relating to comprehensive health insurance which would, among other things, do all of the following:

1. Require, as a condition to transacting health insurance business in this state, a carrier offering group or individual policies of health insurance, to offer qualified comprehensive health insurance through group policies and through individual policies and by participating in the California Comprehensive Health Insurance Association, created by the bill.

2. Require every employer with respect to any group health insurance policy delivered or issued for delivery in this state, or a self-insured employee welfare benefit plan established in this state, with specified exceptions, to offer to its employees a plan of coverage providing health benefits, as specified.

3. Specify those individuals eligible to be covered under
a group comprehensive health insurance plan offered pursuant to the bill.

(4) Establish a nonprofit legal entity to be known as the California Comprehensive Health Insurance Association, for the purpose of assuring that qualified comprehensive health insurance is made available throughout the year to each California resident applying for such coverage.

(5) Require that each carriers, health maintenance organizations and self-insurers providing health insurance or health care services in this state be a member of such association.

(6) Provide for the establishment of a board of directors of the association to be selected by the members of the association subject to the approval of the insurance commissioner.

(7) Require such association to submit to the commissioner a plan of operation for the association.

(8) Provide that the association be subject to examination by the commissioner.

(9) Require the State Department of Social Services to secure qualified comprehensive health insurance coverage for all eligible recipients and to enter into contractual agreements with carriers of the association to perform physical intermediary functions.

(10) Make various technical and conforming changes.

Under existing law, Sections 2231 and 2234 of the Revenue and Taxation Code require the state to reimburse local agencies and school districts for certain costs mandated by the state. Other provisions require the Department of Finance to review statutes disclaiming these costs and provide, in certain cases, for making claims to the State Board of Control for reimbursement.

This bill provides that no appropriation is made by this act pursuant to Section 2231 or 2234, but recognizes that local agencies and school districts may pursue their other available remedies to seek reimbursement for these costs.

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

SECTION 1. Part 6.5 (commencing with Section 12700) is added to Division 2 of the Insurance Code, to read:

PART 6.5. COMPREHENSIVE HEALTH INSURANCE.

12700. As used in this part:
(a) "Association" means the California Comprehensive Health Insurance Association established under Section 12712.
(b) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.
(c) "Commissioner" means the Insurance Commissioner.
(d) "Eligible expenses" means those charges for health care services and articles provided for in Section 12703.
(e) "Employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or legal representative, trustee in bankruptcy, receiver or trustee, or the legal representative of a deceased person, including the State of California and each county, city, and city and county therein, which has in its regular employ one or more employees during any calendar year after the effective date of this part.
(f) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing facility, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity
hospital, outpatient clinic, home health care agency,
bioanalytical laboratory, or central services facility
servicing one or more such institutions, but excluding
institutions that provide healing solely by prayer.
(g) “Health care institutions” means skilled nursing
facilities, home health agencies, and hospitals.
(h) “Health care provider” means any physician,
hospital, or other person who is licensed in this state to
furnish health care services.
i) “Health care services” means any services or
products included in the furnishing to any individual of
medical or dental care, or hospitalization, or incident to
the furnishing of such care or hospitalization, as well as
the furnishing to any person of any other services or
products for the purpose of preventing, alleviating,
curing, or healing human illness or injury.
(j) “Health insurance” means hospital, surgical, and
medical expense incurred policies, nonprofit hospital
service plans, and self-insured employee welfare benefit
plans; however, the term “health insurance” does not
include short-term travel accident policies, accident only
policies, fixed indemnity policies, automobile medical
payment, or incidental coverage issued with or as a
supplement to liability insurance.
(k) “Health maintenance organization” means any
person or entity who undertakes to provide for, arrange
for, pay for, or reimburse any part of the cost of any
health care services, and at least a part of such
arrangement consists of arranging for or the provision of
health care services, as distinguished from
indemnification against the cost of such services, on a
prepaid basis.
(l) “Insured” means all individuals who are provided
qualified comprehensive health insurance coverage
under an individual or group policy, including all
dependents and other insured persons, if any.
m) “Medical” means medical assistance funded by
state and federal agencies.
n) “Medicare” means Title XVIII of the Social
Security Act (42 U.S.C. 1395 et seq.).
(o) "Policy" means a contract, policy, or plan of health insurance.
(p) "Policy year" means a 12-month period during which a policy provides coverage or obligates the carrier to provide health care services.
(q) "Qualified comprehensive health insurance" means the coverage specified in Section 12708 of this part.
(r) "Qualified psychologist" means a person who:
(1) Is licensed or certified as a psychologist;
(2) Has a doctoral degree in clinical psychology; and
(3) Has at least two years of supervised experience in clinical psychology in a licensed hospital or mental health center.
(s) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier.
(t) "Services of a skilled nursing facility" means that such services must commence within 14 days following a confinement of at least three consecutive days in a hospital for the same condition.
(u) "Skilled nursing facility," "home health agency," "hospital," and "home health services" have the meanings assigned to them pursuant to federal law (42 U.S.C. 1395).
12701. (a) As a condition to transacting health insurance business in this state, a carrier shall, in connection with the offering of every individual or group health insurance policy to be issued for delivery in California, offer qualified comprehensive health insurance through group policies, through individual policies, and by participating in the California Comprehensive Health Insurance Association under Section 12712; or by a combination of any of the methods specified herein.
Such obligation to offer qualified comprehensive health insurance required shall not arise due to the fact that a carrier issues short term, travel accident policies, accident policies, accident only policies, fixed indemnity policies, automobile medical payment, or incidental
coverages issued with or as a supplement to liability policies.
(b) Any health maintenance organization or self-insurance plan shall include a conversion privilege for its members, covered employees, and other covered individuals under which qualified comprehensive health insurance coverage is available immediately upon termination of coverage under the health maintenance organization or self-insurance plans. Conversion benefits shall be made available through the association or otherwise.
12 12702. (a) Every employer with respect to any group health insurance policy delivered or issued for delivery in this state, or a self-insured employee welfare benefit plan established in this state, except as provided below, shall offer to its employees a plan of coverage which provides benefits equivalent to those enumerated in subdivision (a) of Section 12703, subject to the exclusions permitted by subdivision (c) of Section 12703. Employers shall inform their employees of the availability of qualified comprehensive health insurance. The employer’s obligation to make such coverage available shall arise when the employer has either:
12 (1) Twenty-five or more employees and 50 percent or more of them apply for coverage; or
12 (2) Less than 25 employees and 10 employees apply for such coverage.
If more than 50 percent of the employees apply for qualified comprehensive health insurance coverage, an employer shall make available the qualified comprehensive coverage to all of its covered employees. However, an employer or carrier may discontinue a plan providing qualified comprehensive health insurance or equivalent benefits when enrollment drops below 50 percent of the employees or less than 10 if there are less than 25 total employees. No other provision of this part may be construed to limit the ability of employees to select among different health insurance options offered by employers at any time. The term “employee” shall not include employees who work less than 20 hours per week
and 26 weeks per year.

(b) The plan shall be financed from funds solely contributed by the employer or solely by the employees or any combination thereof, subject to the condition that the employer contribute at least the same absolute dollar amount for purchase or provision of the coverage on behalf of each employee as the employer pays or would pay for any other health benefit plan continued or made available to employees.

(c) The requirements of this section shall not apply to:

(1) Employers providing employees with health benefits coverage under terms of a collectively bargained agreement of the employer and the employees' union representatives;

(2) Employers with fewer than 10 employees; or

(3) Employers that demonstrate compliance with the purpose of this part by submitting to the commissioner a plan of employee coverage that is determined by the commissioner to be no less favorable to the insured or covered member than the qualified comprehensive coverage required to be made available hereunder. Employers demonstrating such compliance shall not be required to meet any other requirements of this section. The commissioner may adopt appropriate equivalency tables or guidelines to be used in determining whether the employer's plan of coverage is no less favorable to the insured or covered member than qualified comprehensive coverage.

(d) An employer may offer qualified comprehensive health insurance coverage even though the employer is not be obligated to do so.

12703. (a) Qualified comprehensive health insurance shall pay reasonable and customary charges for necessary health care services rendered or furnished for the diagnosis or treatment of illness or injury, which exceed the deductible and copayment amounts applicable under Section 12704, when such charges are eligible expenses. "Eligible expenses" means the charges for the following health care services and articles to the extent furnished by a health care provider in an
1 emergency situation or furnished or prescribed by a
2 physician:
3 (1) Hospital services, including charges for the
4 institution's most common semi-private room, and for
5 private room only when medically necessary;
6 (2) Professional services for the diagnosis or treatment
7 of injuries, illnesses, or conditions, other than mental or
8 dental, which are rendered by a physician, or, at his or
9 her direction, by his or her staff of registered graduate
10 nurses and allied health professionals;
11 (3) The first 20 professional visits for the diagnosis or
12 treatment of one or more mental conditions rendered
13 during the year by one or more physicians, or, at the
14 direction by their staff of registered graduate nurses and
15 allied health professionals;
16 (4) Drugs and contraceptive devices requiring a
17 physician's prescription;
18 (5) Services of a skilled nursing facility for not more
19 than 180 days per year;
20 (6) Services of a home health agency up to 270 days of
21 service per year;
22 (7) Use of radium or other radioactive materials;
23 (8) Oxygen;
24 (9) Anesthetics;
25 (10) Prostheses, other than dental;
26 (11) Rental of durable medical equipment which has
27 no personal use in the absence of the condition for which
28 prescribed;
29 (12) Diagnostic x-rays and laboratory tests;
30 (13) Oral surgery for:
31 (A) Excision of partially or completely erupted
32 impacted teeth;
33 (B) Excision of a tooth root without the extraction of
34 the entire tooth; or
35 (C) The gums and tissues of the mouth when not
36 performed in connection with the extraction or repair of
37 teeth;
38 (14) Services of a physical therapist and services of a
39 speech therapist; and
40 (15) Professional ambulance services to the nearest
health care facility qualified to treat the illness or injury.
(b) For purposes of this section, if benefits are
provided in the form of services rather than cash
payments, their value shall be determined on the basis of
their monetary equivalency.
(c) The following do not constitute eligible expenses
in any qualified comprehensive health insurance plan
within the scope of this section:
(1) Services for which a charge is not made in the
absence of insurance or for which there is no legal
obligation on the part of the patient to pay;
(2) Services and charges made for benefits provided
under the laws of the United States including medicare,
military service-connected disabilities, medical services
provided for members of the armed forces and their
dependents or for employees of the armed forces of the
United States, medical services financed in the future on
behalf of all citizens by the United States, but not
including medicaid;
(3) Benefits which would duplicate the provision of
services or payment of charges for any care for injury or
disease either:
(A) Arising out of and in the course of an employment
subject to a worker's compensation or similar law; or
(B) For which benefits are payable without regard to
fault under a coverage statutorily required to be
contained in any motor vehicle or other liability
insurance policy or equivalent self-insurance.
However, such provision shall not authorize exclusion
of charges that exceed the benefits payable under the
applicable workers' compensation or no-fault coverage;
(4) Care which is primarily for custodial or domiciliary
purpose;
(5) Cosmetic surgery unless provided as result of an
injury or medically necessary surgical procedure; and
(6) Any charge for services or articles, the provision of
which is not within the scope of the license or certificate
of the institution or individual rendering such services.
12704. (a) Subject to the limitation provided in
subdivision (c), a qualified comprehensive health
insurance policy offered in accordance with this chapter
shall impose a two hundred dollar ($200) deductible on
a per person, per policy year basis. The deductible shall
be applied to the first two hundred dollars ($200) of
eligible expenses incurred by the covered person.
(b) Subject to the limitation provided in subdivision
(c), a mandatory copayment requirement shall be
imposed at the rate of 20 percent of eligible expenses in
excess of the mandatory deductible.
(c) The maximum aggregate out-of-pocket payments
for eligible expenses by the insured in the form of
deductibles and copayments shall not exceed two
hundred dollars ($200) or 10 percent of the insured’s
adjusted gross income, whichever is greater. Such
limitation shall be applied on a per insured, per policy
year basis. The maximum out-of-pocket expense limit
shall not apply to any insured that fails to provide the
carrier with adequate evidentiary information on
adjusted gross income.
The amount of the out-of-pocket expense limitation for
an insured shall be administratively determined annually
by the carrier according to information provided by the
insured. The maximum out-of-pocket expense limit shall
be based upon the insured’s adjusted gross income in the
last full tax year immediately preceding the
comprehensive health insurance policy year. The insured
shall provide information reasonably satisfactory to the
carrier disclosing the required adjusted gross income
amounts. Submission of information on income through a
sworn affidavit or a notarized statement shall be accepted
by carriers as satisfactory disclosure of income. If a policy
or certificate of coverage covers more than one family
member or dependent, the applicable adjusted gross
income figure shall be the aggregate adjusted gross
income of all the covered individuals. The information
furnished by the insured under this section or the fact
that it is not provided shall remain confidential and shall
not be used by the carrier for any other purpose.
(d) Except for coverages in effect on December 31,
1980, carriers providing qualified comprehensive health
insurance shall be prohibited from including therein any
form of health insurance primarily designed to
supplement qualified comprehensive plan coverage by
providing coverage for the deductible, copayment, or
exclusion amounts under a qualified comprehensive plan
unless such coverage is provided through a separate
policy and purchased by the insured.

12705. (a) No person shall be eligible for qualified
comprehensive health insurance coverage who, at the
effective date of coverage, has or would have coverage
under a qualified comprehensive plan either
individually, through a group, or as a dependent.
(b) Coordination of benefit provisions may be
included in a group qualified comprehensive health
insurance plan, if such benefits are not less favorable to
the insured. Benefits provided by qualified
comprehensive health insurance shall be secondary to
any health insurance provided under any other state or
federal law, except Medi-Cal. Notwithstanding any
contrary requirement of state law, benefits of a qualified
comprehensive health insurance plan shall not be
coordinated with or reduced by reason of any separate
coverage of the deductible or copayment amounts
permitted by subdivision (d) of Section 12704.
(c) Qualified comprehensive health insurance,
whether issued by carriers or issued or reinsured by the
association under Section 12712 shall conform to all of the
requirements enumerated herein. No qualified
comprehensive health plan contract shall be delivered or
issued for delivery until approved by the commissioner.
(d) If a qualified comprehensive health insurance
policy provides that coverage of a dependent unmarried
child terminates when the child becomes 19 years of age
(or 25 years of age if he or she is enrolled full time in an
accredited educational institution), the policy shall also
provide in substance that attainment of the limiting age
shall not operate to terminate his or her coverage while
he or she is, and continues to be, both:
(1) Incapable of self-sustaining employment by the
reason of mental retardation or physical handicap; and
(2) Chiefly dependent upon the person in whose name the contract is issued, or the insured member, in the case of a group policy, for support and maintenance. However, proof of such incapacity and dependency shall be furnished to the carrier within 30 days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(e) Any qualified comprehensive health insurance policy that provides coverage for a family member of the person in whose name the contract is issued shall, as to the family member's coverage, also provide that the health insurance benefits applicable for children be payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children shall consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child the contract shall require that notification of the birth of a child and payment of the required premium be furnished to the carrier within 31 days after the date of birth so that such coverage may be continued beyond the 31-day period.

(f) Qualified comprehensive health insurance plans may contain provisions under which coverage is excluded during a period of six months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as:

(1) The condition manifested itself within a period of six months before the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment; or

(2) Medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

This subdivision may not be construed to prohibit preexisting condition provisions in an insurance policy.
which are more favorable to the insured.

(g) Any individual qualified comprehensive health insurance plan issued as a result of conversion from group health insurance, from a health maintenance organization plan, or from a self-insured group shall credit the time covered under a group or individual plan to the durational requirements of this section.

(h) Any individual qualified health insurance plan issued as a result of the withdrawal of a carrier from the individual health insurance market under paragraph (2) of subdivision (a) of Section 12707 shall credit the time covered under the termination policy to the durational requirements of this section.

12706. (a) A group comprehensive health insurance plan offered pursuant to this part shall be one under which the individuals eligible to be covered include:

(1) Each qualified employee or member of the group policyholder;

(2) The spouse of each qualified employee or member; and

(3) The dependent unmarried children of the qualified employee or member who are:

(A) Under 19 years of age; or

(B) Under 25 years of age and are full-time students in accredited educational institutions.

(b) The group comprehensive health insurance plan shall also provide for the continuation of coverage in accordance with each of the following circumstances:

(1) Upon layoff, leave of absence, or termination of employment, other than as a result of death of the employee, continuation of the coverage for such employee and his covered dependents to the end of the second calendar month following the calendar month in which such layoff, leave of absence, or termination commenced.

(2) Upon the death of the employee, continuation of coverage for the covered dependents of such employee to the end of the second calendar month following the calendar month in which death occurred;

(3) During an employee’s absence due to illness or
injury, continuation of coverage for such employee and
his or her covered dependents for at least 30 months from
the beginning of such absence; or
(4) Upon termination of the group plan, coverage for
covered individuals who were totally disabled on the date
of termination, shall be continued for a period of 12
calendar months following the calendar month in which
the plan was terminated, provided that a claim is
submitted therefor within two years of the termination of
the plan. Such continued coverage shall also include
pregnancy benefits, provided the covered individual was
pregnant on the date the plan was terminated.
(c) The coverage of any covered individual
terminates:
(1) As to a child, at the end of the premium period in
which the child marries, ceases to be a dependent of the
employee, or attains the age of 19, whichever occurs first,
except that if the child is a full-time student at an
accredited institution, such coverage shall be continued
while the child remains unmarried and a full-time
student, but not beyond the premium period in which
the child attains the age of 25;
(2) As to the employee's spouse, at the end of the
premium period in which a divorce, annulment, or legal
separation is obtained; and
(3) As to the employee or employee's spouse, the date
preceding such person's eligibility for medicare benefits
under Title XVIII of the Social Security Act (42 U.S.C.
1395 et seq.).
(d) Any employee or dependent entitled to a
continuation of coverage under this section at a time
when the employer changes plans, and who would
thereby lose his or her continuation of coverage, shall be
eligible under any successor plan for not less than the
continuation of the coverage that would have been
required had the prior plan remained unchanged.
(e) Any continuation of coverage required by this
section, other than that required in subsection (4) of
subdivision (b), shall be subject to the requirement on
the part of the individual whose coverage is to be
continued, that the individual contribute the part of the
premium he or she would have been required to
contribute had the employee remained an active covered
employee.
(f) The group comprehensive health insurance plan
shall permit an employee required to be made eligible for
coverage thereunder to elect instead, to apply for
coverage from any licensed health maintenance
organization and to have the employer pay toward the
cost of coverage by such organization an amount equal to
the amount the employer would pay toward the cost of
coverage of such employee under the employer’s plan.
(g) The group comprehensive health insurance plan
shall make available to any eligible person covered under
the plan, a conversion privilege under which qualified
comprehensive health insurance shall be available
immediately upon termination of coverage under the
group plan; however, the conversion coverage shall not
duplicate any coverages continued under the terminated
group plan.
(h) No group qualified comprehensive health
insurance plan shall exclude any individual member who
would otherwise be eligible for coverage under a group
plan solely on the basis that the individual is either:
(1) Eligible for coverage under the state Medi-Cal
program; or
(2) Uninsurable under individually underwritten
health standards.
12707. (a) The individual qualified comprehensive
health insurance policy shall contain provisions under
which the carrier or association shall be obligated to
renew the contract until the earlier of:
(1) The day on which the individual in whose name
the contract is issued first becomes eligible for medicare
coverage, except that in a family policy covering both
husband and wife, the age of the younger spouse shall be
used as the basis for meeting the age or such durational
requirement; or
(2) The next anniversary date which has been
preceded by at least 120 days before notice from the
carrier that is refusing to renew on the next policy
anniversaries of all individual qualified comprehensive
health insurance plans in force in this state and that it
shall no longer issue individual health insurance in this
state, except conversion policies required under the
terms of group or individual policies. As a condition
precedent to a carrier’s refusal to renew, it shall arrange
for the availability of qualified comprehensive health
insurance for all of the individual policyholders which
shall credit the time covered under the terminating
policy to any durational requirement for coverage of
preexisting conditions under the new policy.
(b) The carrier or association shall not change the
rates for individual qualified comprehensive health
insurance, except on a class basis with a clear disclosure
in the policy of the carrier’s or association’s right to do so.
(c) The individual qualified comprehensive health
insurance policy shall provide that upon the death of the
individual in whose name the contract is issued, every
other individual then covered under the contract may
elect, within a period specified in the contract, to
continue coverage under the same or a different contract
until such time as he would have ceased to be entitled to
coverage had the individual in whose name the contract
was issued lived.
12708. On and after September 1, 1981, every health
care provider shall make reasonable efforts before
providing services to determine whether the recipient of
the provider’s health care services is covered under
qualified comprehensive health insurance, and shall
make a reasonable effort to advise the recipient, upon
request, of any health care expenses rendered by the
provider that are not eligible for reimbursement under
qualified comprehensive health insurance.
12709. Carriers, the association, and health care
providers may enter into negotiations and agreements
for the establishment of direct payment plans, automatic
assignments, or other mechanisms under which carrier
payments shall be accepted as complete fulfillment of
charges made by the provider for eligible expenses or
expenses covered under a health insurance plan. Any
reduction in charges of health care providers shall apply
to all purchasers and third party purchasers of health care
services, and no health care provider shall discriminate in
its charges as to any purchaser of health care services.
12710. Benefits payable under qualified
comprehensive health insurance policies shall be
necessary for care and treatment, and for reasonable and
customary charges. Charges payable under qualified
comprehensive health insurance shall be subject to
review by mechanisms to be determined by the carrier
or association in accordance with regulations adopted by
the commissioner. Any such charges determined shall be
furnished to the insured upon written request.
12711. A health care provider shall not refuse to
render health care services to any person covered under
qualified comprehensive health insurance because of the
scope of the insured’s coverage. Any violation of Sections
12708, 12709, or 12710 shall be grounds for suspension or
revocation of the provider’s license in accordance with
procedures established by the appropriate state licensing
agency.
12712. There is hereby established a nonprofit legal
entity to be known as the California Comprehensive
Health Insurance Association, which shall assure that
qualified comprehensive health insurance is made
available throughout the year to each California resident
applying for such coverage. All carriers, health
maintenance organizations, and self-insurers providing
health insurance or health care services in this state shall
be members of the association. Each carrier, in meeting
its obligation under this section, may elect to issue a
qualified comprehensive health insurance policy in its
own name, may reinsure the policy with the association,
or may refer the risk to the association which will provide
the qualified comprehensive health insurance in the
name of the association. The association shall operate
under a plan of operation established and approved
under Section 12714 and shall exercise its powers through
a board of directors established pursuant to section 12713.
12713. The board of directors of the association shall be selected by the members of the association subject to approval by the commissioner. To select the initial board of directors and to initially organize the association, the commissioner shall give notice to all members in this state of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not be otherwise compensated by the association for their services.

12714. (a) The association shall submit to the commissioner a plan of operation for the association and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation shall become effective upon approval, in writing, by the commissioner, consistent with the date on which the coverage is to be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable proportionate basis among the member carriers, health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt appropriate rules necessary or advisable to implement this section. Such rules shall be effective until modified by the commissioner or superseded by a plan submitted by the
association and approved by the commissioner.

(b) The plan of operation shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the association;

(2) Establish the amount and method of reimbursing members of the board;

(3) Establish regular times and places for meetings of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the commissioner;

(5) Establish procedures whereby selections for the board of directors are to be made and submitted to the commissioner for his approval;

(6) Contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) Establish procedures for the periodic advertising on behalf of all member carriers of the general availability of the qualified comprehensive health insurance coverages from individual carriers and the association.

c) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association, or its equivalent, in two or more states. A delegation shall take effect only with the approval of both the board of directors and the commissioner. The commissioner shall not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided herein. If the commissioner determines that participation of association members doing business in this state in a multistate organization is not in the best interest of the citizens of this state, the commissioner may require those members to establish and operate a state comprehensive health insurance association solely in this state as required herein.

12715. (a) The association shall have the general powers and authority enumerated by this subdivision in
accordance with the plan of operation approved by the
commissioner under subdivision (a) of Section 12714. The
association shall have the general powers and authority
granted under the laws of this state to carriers licensed to
transact the kinds of health service or insurance included
under Section 12700.
The association shall have the specific authority and
duty to:
(1) Enter into contracts as are necessary or proper to
carry out the provisions of this part;
(2) Sue or be sued, including taking any legal actions
necessary or proper for recovery of any assessments for
or on behalf of, or against participating carriers;
(3) Take legal action necessary to avoid the payment
of improper claims against the association or the coverage
provided by or through the association;
(4) Establish appropriate rates, scales of rates, rate
classifications, and rating adjustments, such rates not to
be unreasonable in relation to the coverage provided and
the reasonable operational expenses of the association;
(5) Administer any type of reinsurance program for or
on behalf of members;
(6) Pool risks among members;
(7) Issue policies of insurance on an indemnity or
provision of service basis providing the coverage
required by this part in its own name or on behalf of
members, including the provision of conversion policies
for persons covered under group health insurance
policies, health maintenance organization plans, and
self-insurer plans;
(8) Issue policies to individuals whose coverage is
otherwise terminated under Section 12707;
(9) Administer separate pools, separate accounts, or
other plans or arrangements considered appropriate for
separate members or groups of members;
(10) Operate and administer any combination of
plans, pools, reinsurance arrangements, or other
mechanisms as deemed appropriate to best accomplish
the fair and equitable operation of the association; and
(11) Appoint from among members appropriate legal,
actuarial, and other committees as necessary to provide
technical assistance in the operation of the association,
policy, and other contract design, and any other function
within the authority of the association.

12716. (a) Every member shall participate in the
association. A member shall determine the particular
risks it elects to reinsure in the association or have
coverage issued by the association on its behalf. The
election of particular risks shall be made from the
following risk classes the member underwrites in
California:

1 (1) Individual, excluding group conversions;
(2) Group conversions; and
(3) Groups with fewer than 50 employees or
members.
(b) A member or group policyholder may not select
out individual eligible lives from a group and reinsure
them in the association. Members electing to administer
risks which are reinsured in the association shall comply
with the benefit determination guidelines and the
accounting procedures established by the association. A
risk reinsured by the association shall not be withdrawn
by the participating carrier except in accordance with
the rules established by the association.
(c) Rates for coverages issued by the association or
reinsured through the association shall not be
unreasonable in relation to the benefits provided, the risk
experience, and the reasonable expenses of providing the
coverage. Separate scales of premium rates shall apply for
individual risks and group risks, consisting of one rate for
each of a number of age brackets of insured individuals
and one rate for all eligible dependents. Rates shall be
adjusted for area variations in health care provider costs.
Premium rates shall take into consideration the extra
morbidity and administration expenses, if any, for risks
reinsured in the association, reasonable expense
allowances to members reinsuring risks, and the level of
rates charged by carriers for groups of 50 or fewer lives.
All rates adopted by the association shall be submitted to
the commissioner for approval. Rates for coverages issued
by the association shall be subject to the requirements of
Section 12723.
12717. Following the close of the association’s fiscal
year, the association shall determine the net premiums
(reinsurance premiums less administrative expense
allowance), the expenses of administration pertaining to
the reinsurance operations of the association, and the
incurred losses for the year. Any net loss shall be assessed
by the association to all members in proportion to their
respective shares of total health insurance premiums
received in this state during the calendar year (or with
paid losses in the year) coinciding with or ending during
the fiscal year of the association or any other equitable
basis as may be provided in the plan of operation. For
self-insurer and health maintenance organization
members of the association, the proportionate share of
losses shall be determined through the application of an
equitable formula based upon claims paid or the value of
services provided. In sharing losses, the association may
abate or defer in any part the assessment of a member,
if, in the opinion of the board, payment of the assessment
would endanger the ability of the member to fulfill its
contractual obligations. Net gains, if any, shall be held at
interest to offset future losses or allocated to reduce
future premiums.
12718. Expense allowances referred to in Section
12717 shall also be applicable to risks for which particular
members do not elect to administer one or more classes
or risks reinsured in the association. Any net loss to the
association represented by the excess of its actual
expenses of administering policies issued by the
association over the applicable expense allowance shall
be separately assessed to the members. All assessments
shall be on an equitable formula established by the
association.
12719. The association shall conduct periodic audits to
assure the general accuracy of the financial data
submitted to the association and the association shall have
an annual audit of its operations by an independent
certified public accountant.
12720. The association shall be subject to examination by the commissioner. The board of directors shall submit, not later than March 30th of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

12721. All policy forms issued by the association or reinsured through the association shall conform in substance to prototype forms developed by the association, and shall in all other respects conform to the requirements enumerated herein, including the requirement that such forms shall be filed with and approved by the commissioner before use.

12722. The association shall not issue or reinsure qualified comprehensive health insurance plan coverage to any individual or group, which on the effective date of coverage applied for or reinsured, already has or would have qualified comprehensive health insurance coverage as an insured or covered dependent.

12723. (a) Rates established by carriers for qualified comprehensive health insurance shall be reasonable in relation to benefits provided.

(b) Every carrier shall file with the commissioner all rates and supplementary rate information and all changes and amendments thereof made by it for use in this state applicable to qualified comprehensive health insurance coverages on or before the date the rates become effective.

(c) Each filing and any supporting information filed under this section shall be open to public inspection. Copies may be obtained by any person upon request and upon payment of a reasonable charge.

(d) If the commissioner determines that a rate is not reasonable in relation to benefits provided, he or she shall order that its use be discontinued for any policy issued or renewed after a date specified in the order.

(e) Within one year after the effective date of an order under subdivision (d), no rate promulgated to replace a disapproved rate shall be used until it has been filed with the commissioner and not disapproved within 30 days thereafter.
(f) Whenever a carrier has no legally effective rates as a result of the commissioner's disapproval of rates or other action, the commissioner shall, upon request, specify interim rates for the carrier which are substantial enough to protect the interests of all parties. Additionally, the commissioner may order that a specified portion of the premiums be placed in an approved escrow account. Whenever new rates become legally effective, the commissioner shall order the escrowed funds or any change in the interim rates to be distributed appropriately, except that de minimus refunds to policyholders shall not be required.

(g) The premium charged for a plan of coverage not issued by or reinsured through the association shall not exceed the premium that would be applicable for the same plan of coverage issued by or reinsured in the association.

12724. The State Department of Social Services shall secure qualified comprehensive health insurance coverage for all eligible recipients; and the department shall enter into contractual agreements with carriers of the association to perform fiscal intermediary functions. The State Department of Social Services may contract with one or more insurers offering qualified comprehensive health insurance coverage or the association for the provision of such coverages, as modified by this section, to persons eligible for medical assistance. Notwithstanding any provision to the contrary, the State Department of Social Services shall modify any coverages contracted for under this section to conform to federal and state medicare or Medi-Cal requirements, including revisions of health care benefits as necessary. Any insurer or the association entering into an agreement with the State Department of Social Services for the provisions of coverage under this section may be authorized by that department to undertake such activities as a fiscal agent or intermediary as necessary and appropriate in the administration of the State Department of Social Services program.

12725. The commissioner may adopt the appropriate
rules and regulations necessary to implement the
provisions of this part.

SEC. 2. Notwithstanding Section 2231 or 2234 of the
Revenue and Taxation Code, no appropriation is made by
this act pursuant to these sections. It is recognized,
however, that a local agency or school district may pursue
any remedies to obtain reimbursement available to it
under Chapter 3 (commencing with Section 2201) of Part
4 of Division 1 of that code.
AN ACT TO ADD PART 6.5 (COMMENCING WITH SECTION 12700) TO DIVISION 2 OF THE INSURANCE CODE, RELATING TO HEALTH INSURANCE, AND MAKING AN APPROPRIATION THEREFOR.

LEGISLATIVE COUNSEL'S DIGEST

AB 1262, AS AMENDED, TORRES. COMPREHENSIVE AND CATASTROPHIC HEALTH INSURANCE.

THE EXISTING LAW HAS NO PROVISIONS RELATING TO HEALTH INSURANCE FOR COMPREHENSIVE AND CATASTROPHIC ILLNESS AND INJURY.

THIS BILL WOULD ENACT THE CALIFORNIA COMPREHENSIVE HEALTH INSURANCE ACT TO DO, AMONG OTHER THINGS, ALL OF THE FOLLOWING:

(1) ESTABLISH A JOINT UNDERWRITING ASSOCIATION OF HEALTH INSURERS UNDER STATE AUSPICES TO MARKET STANDARD POLICIES OF INSURANCE TO SMALL GROUPS AND INDIVIDUALS AT ACTUARILY SOUND RATES WITHOUT PROHIBITING THE SALE OF SUCH POLICIES BY INDIVIDUAL UNDERWRITERS.

(2) ESTABLISH AN INSURANCE POLICY GRADING SYSTEM WHICH CLASSIFIES POLICIES WITH RESPECT TO CERTAIN STANDARDS.

(3) MANDATE THAT ALL EMPLOYERS IN THIS STATE WHO MAKE INSURANCE AVAILABLE TO EMPLOYEES OFFER AT LEAST ONE QUALIFIED PLAN, AS DEFINED.

(4) REQUIRE ALL HEALTH INSURERS TO OFFER A QUALIFIED PLAN TO ELIGIBLE GROUPS OR INDIVIDUAL APPLICANTS.

(5) REQUIRE ALL HEALTH INSURERS IN THIS STATE TO AFFIRMATIVELY OFFER MAJOR MEDICAL COVERAGE IN THEIR POLICIES OF INSURANCE WHICH ARE NOT QUALIFIED PLANS.
(6) Require insurance and health and hospital service plan contracts to include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions.

(7) Establish a California Catastrophic Health Expense Protection Fund to pay the expense of individuals who incur medical costs over prescribed amounts.

The bill would also define covered expenses to include specified services and benefits. It would provide for certification of a qualified Medicare supplement plan for persons over the age of 65 years, with such plan to supplement Medicare, as specified. The bill would also specify the duties of the Insurance Commissioner.

The bill would establish a Comprehensive Health Insurance Association of all insurers, self-insurers, fraternals and health or hospital care service plans who are authorized to transact insurance in this state, and exempt such association from taxation under the laws of this state including all property owned by the association. The bill would specify powers and duties of the association.

The bill would also enact the California Catastrophic Health Expense Protection Act, under the direction of the Director of the Department of Health Services. The act would provide for state assistance to eligible persons, as determined by the director.

The bill would also create in the State Treasury the California Catastrophic Health Expense Protection Fund with an initial appropriation from the General Fund of $10,000,000. The appropriation would be used without regard to fiscal year for the purpose of funding specified activities of the Department of Health Services.

Existing law contains no provision directly relating to comprehensive health insurance. However, existing law contains numerous provisions relating to various forms of health insurance, including individual and group insurance, employee welfare benefit plans, nonprofit hospital service plans, and health care service plans. Among other things, existing law regulates, in various ways, required provisions and coverage, rights of conversion upon termination of coverage, and coordination with other sources of health
benefits.

This bill would require every carrier offering individual health insurance to make a qualified individual comprehensive health care plan available to every resident of the state who is not eligible for Medicare.

It would require every self-insurer whose plan covers 3 or more employees to make an individual comprehensive health care plan available as a conversion privilege.

It would require every carrier offering group health insurance to make a group comprehensive plan available to every employer of 3 or more employees.

It would require every carrier offering a Medicare supplement plan to make a Medicare supplement plan available to every eligible person.

The bill would specify the required minimum standard of the various forms of comprehensive coverage.

Required coverage could be provided by the California Comprehensive Health Insurance Association, which would be created by the bill. Insurers transacting health insurance would be required to be members.

Coverage could also be provided by a residual market mechanism.

Rates for coverage could not exceed that established by the California Comprehensive Health Insurance Association.

The bill would provide for the establishment of regulations by the Insurance Commissioner of standards for policy provisions and for coverage for individual policies of health insurance.

The bill would specify required provisions for all group health policies or contracts.

The bill would contain various other provisions.


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

1 SECTION 1. Part 6.5 (commencing with Section 12700) is added to Division 2 of the Insurance Code, to read:
PART 6.5. COMPREHENSIVE AND
CATASTROPHIC HEALTH INSURANCE

CHAPTER 1. FINDINGS

12700. The Legislature finds that the lack of
reasonably priced comprehensive and catastrophic
health insurance coverage places many Californians at
risk of pauperization in the event of serious illness. The
Legislature further finds a substantial number of
Californians are not able to acquire adequate health
insurance because of circumstances related to:

(a) The size of their employing firm;
(b) Preexisting conditions of illness;
(c) Low cash incomes above public assistance levels.

In addition, current trends in medical care costs
threaten the financial stability of more and more
Californians as copayments, deductibles, expenses of
uncovered services and premiums increase at a faster
rate than income.

It is the intent of the Legislature, therefore, in the
passage of this act enactment of this part, to accomplish
the following purposes:

(a) Establish a joint underwriting association of health
insurers under state auspices to market standard policies
of insurance to small groups and individuals at actuarily
sound rates without prohibiting the sale of such policies
by individual underwriters;

(b) Establish an insurance policy grading system
which shall classify policies with respect to certain
standards. Such policies will be called “qualified plans”;

(c) Mandate that all employers in the state, who make
insurance available to employees, offer at least one
qualified plan;

(d) Require all health insurers in the state to offer a
qualified plan to eligible groups or individual applicants;

(e) Require all health insurers in the state to
affirmatively offer major medical coverage in their
policies of insurance which are not qualified plans;

(b) Require all carriers and self-insurers in the state
who issue comprehensive and Medicare supplement
plans to offer comprehensive and Medicare supplement plans to eligible groups or individual applicants.

(c) Require insurance, and health and hospital service plan contracts to include the right to convert to an individual coverage qualified plan without the addition of plan underwriting restrictions;

(g) Establish a state catastrophic health expense protection fund to pay the expense of individuals who incur medical care costs over prescribed amounts.

This act shall be known and may be cited as the California Comprehensive Health Insurance Act.

CHAPTER 2. DEFINITIONS

12702. For the purposes of this part, the terms and phrases used herein shall have the following meanings:

(a) "Employer" means any person, partnership, association, trust, estate or corporation, or political subdivision, which employs ten or more individuals who are residents of this state.

(b) "Health or hospital care service plan" means an entity licensed, or exempted, as provided in applicable provisions of the Health and Safety Code with the exception of specialized health care service plans and nonprofit hospital service plans contained in Chapter 11 (commencing with Section 11491).

(c) "Qualified "Comprehensive Health Insurance plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required under this part or the actuarial equivalent of those benefits.

(d) "Qualified Medicare Plan "Medicare Supplement Plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required under this part or the actuarial equivalent of those benefits.

(e) "Commissioner" means the Insurance Commissioner.
(f) "Dependent" means a spouse or unmarried child
under the age of 19 years, a dependent child who is a
student under the age of 25 and financially dependent
upon the parent, or a dependent child of any age who is
disabled.

(g) "Employee" means any California resident who
has entered into the employment of or works under
contract or service or apprenticeship with any employer.
"Employee" does not include a person who has been
employed for less than 30 days by his present employer,
or one who is employed less than 30 hours per week by
his present employer, nor an independent contractor.

(h) "Plan of health coverage" means any plan or
combination of plans of coverage, including
combinations of self-insurance, individual accident and
health insurance policies, group accident and health
insurance policies, coverage under a nonprofit hospital or
medical service plan or coverage under a health or
hospital care service plan subscriber contract.

(i) "Insurer" means those companies operating in the
state offering or selling policies or contracts of accident
and health insurance. "Insurer" does not include health
or hospital care service plans.

(j) "Accident and health insurance policy" or "policy"
means insurance or nonprofit hospital or medical service
plan contracts providing benefits for hospital, surgical
and medical care. "Policy" does not include coverage
which is (1) limited to disability or income protection
coverage, (2) automobile medical payment coverage, (3)
supplemental or liability insurance, (4) designed solely to
provide payments on a per diem, fixed indemnity or
nonexpense incurred basis, (5) credit accident and health
insurance, (6) designed solely to provide dental or vision
care, (7) blanket accident and sickness insurance, (8)
accident only coverage issued by licensed insurance
agents or solicitors which provides reasonable benefits in
relation to the cost of services.

(k) "Health benefits" means benefits offered to
employees on an indemnity or prepaid basis which pay
the costs of or provide medical, surgical or hospital care.
(l) "Eligible person" means an individual who is a resident of California and meets the enrollment requirements specified in this part.

(m) "California Comprehensive Health Insurance Association" or "association" means the association created by this part which shall include all insurers and fraternals.

(n) "Medicare" means Part A and Part B of the United States Social Security Act, Title XVIII, as amended, 42 U.S.C.A. Sections 1394, et seq.

(o) "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical, or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare.

(p) "State plan premium" means the premium determined pursuant to this part.

(q) "Writing carrier" means the insurer or insurers and health or hospital care service plan or plans selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

(r) "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with applicable provisions of law governing such associations.

(s) "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health or hospital care service plan coverage offered by the association through the writing carrier.

(t) "Self-insurer" means an employer or an employee welfare benefit plan which directly or indirectly provides a plan of health coverage to its employees and administers the plan of health coverage or through an insurer, trust, or agent except to the extent of accident and health premium, subscriber contract charges or health or hospital service plan contract charges. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public who provides health care services directly to his
employees at no charge to them.
(u) "Self-insurance" means a plan of health coverage
offered by a self-insurer.
(v) "Medi-Cal" means those benefits offered pursuant
to Chapter 7 (commencing with Section 14000) or
Chapter 8 (commencing with Section 14500) of Part 3 of
Division 9 of the Welfare and Institutions Code.
(w) "Carrier" means an insurer, a nonprofit hospital
service plan, a health care service plan regulated by the
Department of Corporations, or a fraternal beneficiary
association.
(x) "Residual market association" means an
association of nonprofit hospital and health care service
plans organized in the same manner as the
Comprehensive Health Insurance Association.

CHAPTER 3. COVERAGE

12703. (a) Every carrier offering individual health
insurance in this state shall, as a condition of transacting
health insurance, make a qualified individual
comprehensive health care plan described in Section
12704 available to every resident of this state who is not
eligible for Medicare. An individual shall have a choice of
a qualified plan of insurance with a low, middle, or high
deductible option as described in subdivision (b) of
Section 12704. Individual comprehensive health care
plans may be made available through participation in the
California Comprehensive Health Insurance Association
in accordance with Section 12709, or a residual market
association in accordance with Section 12710.
(b) The premium charged for a plan which is not
insured by or through the California Comprehensive
Health Insurance Association or any other residual
market association, may not exceed the premium which
would be applicable for participation in those
associations. The premium charged for a plan insured by
or through the California Comprehensive Health
Insurance Association shall be precisely the premium
established for that classification under the California
Comprehensive Health Insurance Association.

(c) Every self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan, described in Section 12708, available under a conversion privilege to every person covered by the plan who is a resident of this state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of layoff, death or termination of employment. An individual shall have the choice of the low option or middle option or high option deductible described in Subdivision (b) of Section 12704. The individual comprehensive health care plans may be provided through a carrier or through participation in the Health Insurance Association in accordance with Section 12709. The premium charged for a plan which is not insured by or through the California Comprehensive Health Insurance Association may not exceed the premium established for that particular classification under the California Comprehensive Health Insurance Association. The premium charged for a plan which is insured by or through the California Comprehensive Health Insurance Association shall be precisely the premium established for that particular classification under the California Comprehensive Health Insurance Association.

(d) Every carrier offering group health insurance in this state shall, as a condition of transacting that health insurance, make a group comprehensive health care plan, as described in Section 12705, available to every employer of three or more eligible employees. An employer shall have the choice of the low option or middle option or high option deductible described in subdivision (b) of Section 12704. Group comprehensive health care plans may be made available to employers of between 3 and 25 eligible employees through participation in the Health Insurance Association, in accordance with Section 12709 or the residual market association, in accordance with Section 12710. The premium charged for a plan on groups of between 3 and 25 eligible employees which is not insured by or through
the California Comprehensive Health Insurance Association or a residual market association may not exceed the premium which would be applicable through participation in these associations. The premium charged for a plan which is insured by or through the California Comprehensive Health Insurance Association shall be precisely the premium established for that particular classification under the California Comprehensive Health Insurance Association.

(e) Every carrier offering Medicare supplement plans in this state shall as a condition of transacting that health insurance make a Medicare supplement plan described in subdivision (f) of Section 12704 available to each person who is eligible for Medicare coverage and who applies for a Medicare supplement plan. Medicare supplement plans may be made available through participation in the California Comprehensive Health Insurance Association in accordance with Section 12709 or a residual market association, in accordance with Section 12710. The premium charged for a plan, which is not insured by or through the California Comprehensive Health Insurance Association or any other residual market association, may not exceed the premium which would be applicable through participation in those associations. The premium charged for a plan which is insured by or through the California Comprehensive Health Insurance Association shall be precisely the premium established for that particular classification under the California Comprehensive Health Insurance Association.

(f) Except as provided in Subdivision (c) of Section 12711 nothing in this chapter shall preclude the right of carriers to transact other kinds of insurance for which they are authorized, nor preclude the right of carriers to transact any other lawful kind of health insurance.

(g) Nothing in this chapter shall require a carrier to make available coverage under a group or individual comprehensive health care plan or Medicare supplement plan to any person or group who is already covered under such a plan.
12704. All individual and all group comprehensive
health care plans shall include minimum standard
benefits as described in this section.
(a) Except as provided in subdivisions (b) and (c),
minimum standard benefits shall be benefits, including
coverage for catastrophic illness, with a life-time
maximum of one million dollars ($1,000,000) per
individual, for reasonable charges or, the allowance
agreed upon between a provider and a carrier for the
following health care services, rendered to an individual
covered by the plan for the diagnosis or treatment of
nonoccupational disease or injury: (1) hospital services;
(2) professional services which are rendered by a
physician, or by a registered nurse in accordance with
standardized procedures, other than services for mental
or dental conditions; (3) the diagnosis or treatment of
mental conditions, as defined by the commissioner,
rendered during the year by one or more physicians on
other than an inpatient basis, or by their staffs of
registered nurses, in accordance with standardized
procedures, up to a yearly maximum benefit of one
thousand dollars ($1,000); (4) legend drugs requiring a
physician’s prescription; (5) services of a skilled nursing
facility for not more than 120 days in a calendar year,
provided such services commence within 14 days
following a confinement of at least three consecutive days
in a hospital for the same condition; (6) home health
agency services, as defined by the commissioner, up to a
maximum of 180 visits in a calendar year, provided those
services commence within seven days following
confinement in a hospital or skilled nursing facility of at
least three consecutive days for the same conditions,
provided further, in the case of an individual diagnosed
by a physician as terminally ill with a prognosis of six
months or less to live, such home health agency services
may commence irrespective of whether that covered
person was so confined, or, if the covered person was so
confined, irrespective of the seven-day period, and the
yearly benefit for medical social services, as hereinafter
defined, shall not exceed two hundred dollars ($200); (7)
use of radium or other radioactive materials; (8) outpatient chemotherapy for the removal of tumors and treatment of leukemia, including outpatient chemotherapy; (9) oxygen; (10) anesthetics; (11) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis; (12) rental of durable medical equipment which has no personal use in the absence of the condition for which prescribed; (13) diagnostic X-rays and laboratory tests as defined by the commissioner; (14) oral surgery for: (A) excision of partially or completely unerupted impacted teeth, or (B) excision of a tooth root without the extraction of the entire tooth; (15) services of a licensed physical therapist, rendered under the direction of a physician; (16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury; (17) certain other services which are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the insurance commissioner; (18) confinement in a facility established primarily for the treatment of alcoholism and licensed for such care by the state, or in a part of a hospital used primarily for such treatment, shall be a covered expense for a period of at least 45 days within any calendar year. "Medical social services" as used in paragraph (6) means services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of the covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving those problems; (C) participation in the development of treatment for such covered persons.

(b) Minimum standard benefits may include one or more of the following provisions: (1) Subject to the provisions of paragraph (3) the plan may require deductibles. The "low option deductible" shall be two
hundred dollars ($200) per person, the "middle option
deductible" shall be five hundred dollars ($500) per
person, the "high option deductible" shall be seven
hundred fifty dollars ($750) per person. The amount of
the deductible may not be greater when a service is
rendered on an outpatient basis than when that service
is offered on an inpatient basis. Expenses incurred during
the last three months of a calendar year and actually
applied to an individual's deductible for that year shall be
applied to that individual's deductible in the following
calendar year. The two hundred dollar ($200) maximum,
the five hundred dollar ($500) maximum and the seven
hundred fifty dollar ($750) maximum may be adjusted
yearly to correspond with the change in the medical care
component of the consumer price index, as adjusted by
the commissioner. The base year for that computation
shall be the first full year of operation of the plan. (2).
Subject to the provisions of paragraph (3), the plan shall
require a maximum copayment of 20 percent for charges
for all types of health care in excess of the deductible and
50 percent for services listed in paragraph (3) of
subdivision (a) in excess of the deductible. (3) The sum
of the deductible and copayments required in any
calendar year under any option may not exceed a
maximum limit of one thousand dollars ($1,000) per
covered individual, or two thousand dollars ($2,000) per
covered family; provided, covered expenses incurred
after the applicable maximum limit has been reached
shall be paid at the rate of 100 percent, except that
expenses incurred for treatment of mental and nervous
conditions may be paid at the rate of 50 percent as
specified in paragraph (3) of subdivision (a). The one
thousand dollar ($1,000) and two thousand dollar
($2,000) maximums shall be adjusted yearly to
correspond with the change in the medical care
component of the consumer price index as adjusted by
the commissioner. (4) The plan may limit lifetime
benefits to a maximum of not less than one million dollars
($1,000,000) per covered individual. (5) No preexisting
condition exclusion shall exclude coverage of any
preexisting conditions unless: (A) The condition first
manifested itself within the period of six months
immediately prior to the effective date of coverage in
such a manner as would cause a reasonably prudent
person to seek diagnosis, care or treatment; (B) medical
advice or treatment was recommended or received
within the period of six months immediately prior to the
effective date of coverage, or (C) the condition is
pregnancy existing on the effective date of coverage. No
policy shall exclude coverage for a loss due to preexisting
conditions for a period greater than six months following
the effective date of coverage. Any individual
comprehensive health care plan issued as a result of
conversion from group health insurance or from a
self-insured group shall credit the time covered under
the group health insurance toward any exclusion.

(c) Plans providing minimum standard benefits need
not provide benefits for the following: (1) Any charge for
any care, for any injury, or disease either (A) arising out
of and in the course of an employment subject to a
workers’ compensation or similar law or (B) to the extent
benefits are payable without regard to fault under a
coverage statutorily required to be contained in any
motor vehicle or other liability insurance policy or
equivalent self-insurance; (2) any charge for treatment
for cosmetic purposes other than surgery for the prompt
repair of an accidental injury sustained while covered;
provided “cosmetic” shall not mean replacement of any
anatomic structure removed during treatment of tumors;
(3) any charge for travel, other than transportation by
local professional ambulance to the nearest health care
institution qualified to treat the illness or injury; (4) any
charge for private room accommodations to the extent it
is in excess of the institution’s most common charge for
a semiprivate room; (5) any charge by health care
institutions to the extent that it is determined by the
carrier that the charge exceeds the reasonable charge in
the locality for the service, or an agreed upon allowance;
(6) any charge for services or articles to the extent that
it exceeds the reasonable charge in the locality for the
service, or an agreed upon allowance; (7) any charge for
services or articles which are determined not to be
medically necessary, except that this shall not apply to
the fabrication or placement of the prosthesis as specified
in paragraph (11) of subdivision (a) and paragraph (2);
(8) any charge for services or articles the provision of
which is not within the scope of the license or certificate
of the institution or individual rendering such services or
articles; (9) any charge for services or articles furnished,
paid for or reimbursed directly by or under any law of a
government, except as otherwise provided herein; (10)
any charge for services or articles for custodial care or
designed primarily to assist an individual in meeting his
activities of daily living; (11) any charge for services
which would not have been made if no insurance existed
or for which the covered individual is not legally
obligated to pay; (12) any charge for eyeglasses, contact
lenses or hearing aids or the fitting thereof; (13) any
charge for dental care not specifically covered by this
part; and (14) any charge for services of a registered
nurse who ordinarily resides in the covered individual's
home, or who is a member of the covered individual's
family or the family of the covered individual's spouse.
(d) Whenever a covered individual who receives
benefits for an injury has a right of recovery against any
person or organization, a carrier that has paid those
benefits to or for the insured person shall be subrogated
to all such rights of recovery to the extent of its payments.
(e) The minimum standard benefits of any individual
or group comprehensive health care plan may be
satisfied by catastrophic coverage offered in conjunction
with basic hospital or medical-surgical plans on an
expense incurred or service basis as approved by the
commissioner as providing at least equivalent benefits.
(f) All Medicare supplement plans offered pursuant to
this part to persons over the age of 65 years shall provide
coverage of 50 percent of the deductible and copayment
required under Medicare and 80 percent of the charges
for covered services described in this section which
charges are not paid by Medicare. The coverage shall
include a limitation of one thousand dollars ($1,000) per person in total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than one hundred thousand dollars ($100,000).

12705. A group comprehensive health care plan shall contain the minimum standard benefits prescribed in Section 12704, including the choice of the low option, middle option or high option deductible, and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) each eligible employee; (2) the spouse of each eligible employee; and (3) dependent unmarried children, who are under the age of 19 or are full-time students under the age of 23 at an accredited institution of higher learning.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until eligible for other group insurance: (1) Upon layoff or leave of absence, or termination of employment, other than as a result of death of the employee, continuation of coverage for such employee and his covered dependents to the end of the 39th week following the day on which the employee lost eligibility to participate in the group; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee to the end of the 39th week following the day on which the employee lost eligibility to participate in the group; (3) during an employee's absence due to illness or injury, continuation of coverage for such employee and his covered dependents during continuance of such illness or injury or for up to 12 months from the beginning of such absence; (4) upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination, shall be continued without premium payment during the continuance of such disability for a period of 12 calendar months following the calendar month in which the plan was terminated, provided a claim is submitted therefor within one year of the termination of the plan; (5) the
coverage of any covered individual shall terminate: (A) as to a child, at the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of 19, whichever occurs first, except that if the child is a full-time student at an accredited institution, the coverage may be continued while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of 23. If on the date specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within 31 days of the date on which the child’s coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child’s continued incapacity and dependency but not more often than once a year thereafter; (B) as to the employee’s spouse, at the end of the month following the month in which a divorce, annulment or legal separation is obtained; and (C) as to the employee or dependent as of midnight of the day preceding such person’s eligibility for benefits under Title XVIII of the Social Security Act; (6) any continuation of coverage required by this section except paragraph (4) of subdivision (b) may be subject to the requirement, on the part of the individual whose coverage is to be continued, that the individual contribute that portion of the premium he would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay the entire premium at the group rate if coverage is continued in accordance with paragraph (1) of subdivision (b) above, provided the employer shall not be legally obligated by this part to pay that premium if not paid timely by the employee.

(c) The commissioner shall promulgate regulations
concerning coordination of benefits between the plan
and other health insurance plans.

(d) The plan shall make available to California
residents, in addition to any other conversion privilege
available, a conversion privilege under which coverage
shall be available immediately upon termination of
coverage under the group plan. The terms and benefits
offered under the conversion benefits shall be at least
equal to the terms and benefits of an individual
comprehensive health care plan.

12708. An individual comprehensive health care plan
shall contain the minimum standard benefits prescribed
in Section 12704, including the choice of the low option,
middle option or high option deductible, and shall also
conform in substance to the requirements of this section.
Each individual comprehensive health care plan shall
contain provisions:

(a) Which obligate the carrier to continue the
contract until the earlier of the following:

(1) The date on which the individual in whose name
the contract was issued first becomes eligible for
coverage under Title XVIII of the Social Security Act or
under a group comprehensive health care plan.

(2) The plan anniversary date at least 60 days prior to
which the carrier has mailed to the individual at his last
address shown on the carrier’s records written notice of
its decision not to continue coverage on a class basis only.

The carrier may reserve the right to adjust premiums
by classes in accordance with its experience for policies
or contracts not written by or through the California
Comprehensive Health Insurance Association, provided
that premium may not exceed the premium established
for that particular class by the California Comprehensive
Health Insurance Association.

(b) Which, upon the death of the individual in whose
name the contract was issued, permits every other
individual then covered under the contract to elect
within such period as shall be specified in the contract, to
continue the same coverage until such time as he would
have ceased to be entitled to coverage had the individual
in whose name the contract was issued lived.

(c) Under which the benefits payable shall be excess to all other sources of health insurance benefits, including benefits provided pursuant to any state or federal law other than Medicaid.

12709. There is hereby created a nonprofit legal entity to be known as the California Comprehensive Health Insurance Association. All insurers and self-insurers doing business in the state, as a condition to their authority to transact the applicable kinds of health insurance defined in Section 12702, shall be members of the association if not otherwise prohibited by federal law. The association shall perform its functions under a plan of operation established and approved under subdivision (a), and shall exercise its powers through a board of directors established under this section.

(a) (1) The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the net health insurance policy premium derived from this state in the previous calendar year. If the board of directors is not selected within 60 days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner may consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

(2) The board shall submit to the commissioner, a plan of operation for the association necessary or suitable to assure the fair, reasonable and equitable administration
of the association. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation provided such plan is determined to be suitable to assure the fair, reasonable and equitable administration of the association, and provides for the sharing of association gains or losses on an equitable proportionate basis. If the board fails to submit a suitable plan of operation within 180 days after its appointment, or if at any time thereafter the board fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate those reasonable rules as are necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated in Sections 12702 to 12713, inclusive, do all the following:

(A) Establish procedures for the handling and accounting of assets and moneys of the association.

(B) Establish regular times and places for meetings of the board of directors.

(C) Establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner.

(D) Establish procedures whereby selections for the board of directors shall be made and submitted to the commissioner.

(E) Establish procedures to amend, subject to the approval of the commissioner, the plan of operations.

(F) Establish procedures for the selection of an administering carrier and set forth the powers and duties of the administering carrier.

(G) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(H) Establish procedures for the advertisement of
behalf of all participating carriers of the general
availability of the comprehensive and Medicare
supplement coverage under Sections 12702 to 12713.
(b) The association shall have the general powers and
authority granted under the laws of this state to carriers
to transact the kinds of plans of health coverage defined
under Section 12702, and in addition thereto, the specific
authority to do all the following:
(1) Enter into contracts necessary or proper to carry
out the provisions and purposes of Sections 12702 to
12713.
(2) Sue or be sued, including taking any legal actions
necessary or proper for recovery of any assessments for,
on behalf of, or against participating members.
(3) Take such legal action necessary to avoid the
payment of improper claims against the association or the
coverage provided by or through the association.
(4) Establish, with respect to health insurance
provided by or on behalf of the association, appropriate
rates, scales of rates, rate classifications and rating
adjustments, such rates not to be unreasonable in relation
to the coverage provided and the operational expenses of
the association.
(5) Administer any type of reinsurance program, for
or on behalf of participating members.
(6) Pool risks among participating members.
(7) Issue policies of insurance on an indemnity or
provision of service basis providing the coverage
required by Sections 12702 to 12713 in its own name or on
behalf of participating members.
(8) Administer separate pools, separate accounts or
other plans as deemed appropriate for separate members
or groups of members.
(9) Operate and administer any combination of plans,
pools, reinsurance arrangements or other mechanisms as
deemed appropriate to best accomplish the fair and
 equitable operation of the association.
(10) Set limits on the amounts of reinsurance which
may be ceded to the association by its members.
(11) Appoint from among participating members
appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(c) Every member shall participate in the association in accordance with the provisions of this subdivision.

(1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state from which classes of risk it may elect to reinsure selected risks:

(A) Individual, excluding group conversion.

(B) Individual, including group conversion.

(C) Groups of between 3 and 25 employees or members.

(D) Medicare supplement plans.

(2) No member or employer shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the participating member except in accordance with the rules established by the association.

(3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply for individual risks and group risks. Group rates may be adjusted for area variations in provider costs, but individual rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of 10 lives. In no event shall the rate for a given classification or group be less than 125 percent.
nor more than 150 percent of the average group rate
charged for that classification or group with similar
characteristics under a policy covering 10 lives. All rates
shall be promulgated by the association through an
actuarial committee consisting of five persons who are
members of the American Academy of Actuaries, shall be
filed with the commissioner and may be disapproved
within 60 days from the filing thereof if excessive,
inadequate, or unfairly discriminatory.

(d)(1) Following the close of each fiscal year, the
administering carrier shall determine the net premiums,
reinsurance premiums less administrative expense
allowance, the expense of administration pertaining to
the reinsurance operations of the association and the
incurred losses for the year. Any net loss shall be assessed
to all participating members in proportion to their
respective shares of the total health insurance policy
premiums earned in this state during the calendar year,
or with paid losses in the year, coinciding with or ending
during the fiscal year of the association or on any other
equitable basis as may be provided in the plan of
operations. For self-insured members of the association,
health insurance premiums earned shall be established
by dividing the amount of paid health losses for the
applicable period by 85 percent. Net gains, if any, shall be
held at interest to offset future losses or allocated to
reduce future premiums.

(2) Any net loss to the association represented by the
excess of its actual expenses of administering policies
issued by the association over the applicable expense
allowance shall be separately assessed to those
participating members who do not elect to administer
their plans. All assessments shall be on an equitable
formula established by the board.

(3) The association shall conduct periodic audits to
assure the general accuracy of the financial data
submitted to the association, and the association shall
have an annual audit of its operations by an independent
certified public accountant. The annual audit shall be
filed with the commissioner for his review.
(e) All policy forms issued by or through the association shall conform in substances to prototype forms developed by the association, shall in all other respects conform to the requirements of this act, and shall be approved by the commissioner. The commissioner may disapprove any such form if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy.

(f) The association shall not issue nor reissue comprehensive health care plan coverage with respect to any person who is already covered under an individual or group comprehensive health care plan, or who is eligible for Medicare or who is not a resident of this state.

(g) Benefits payable under a comprehensive health care plan insured by or reinsured through the association shall be paid net of all other health insurance benefits paid or payable through any other source, and net of all health insurance coverages provided by or pursuant to any other state or federal law including Title XVIII of the Social Security Act, Medicare, but excluding Medi-Cal.

(h) There shall be no liability on the part of and no cause of action of any nature shall arise against any carrier or its agents or its employees, the California Comprehensive Health Insurance Association or its agents or its employees or the residual market mechanism established under the provisions of Section 12710 or its agents or its employees, or the commissioner or his representatives for any action taken by them in the performance of their duties under Sections 12702 to 12713. This provision shall not apply to the obligations of a carrier, a self-insurer, the California Comprehensive Health Insurance Association or the residual market mechanism for payment of benefits provided under a comprehensive health care or Medicare supplement plan.

12710. (a) Hospital and health care service plans may elect to meet the obligations of Section 12703 by participating in the California Comprehensive Health Insurance Association established in Section 12709 as a full member thereof, or by making comprehensive health
care or Medicare supplement plans available directly through a subscriber contract or combination of contracts or by forming a separate residual market mechanism substantially similar to the association established in Section 12709.

(b) In the event that hospital and health care service plans choose to form a separate residual market mechanism, the commissioner shall have the same regulatory powers over that residual market mechanism as he or she has over the California Comprehensive Health Insurance Association, and that residual market mechanism shall have the same powers and duties as the association. Rating classifications under a residual market mechanism established under this section need not be the same as the classifications established under this association, but any rates established by the residual market mechanism shall be approved by the commissioner. The commissioner shall promulgate regulations to carry out the requirements of this section.

(c) If the hospital and health care service plans do not elect to participate in the California Comprehensive Health Insurance Association those hospital and health care service plans shall be required to make available an individual comprehensive health care plan to every resident of the state whose coverage under a group or individual contract issued by the hospital and health care service plan has terminated. That coverage may be made available through a separate residual market mechanism established under this section.

12711. In order to provide reasonable simplification of terms and coverages of individual accident and sickness insurance policies and contracts, to facilitate public understanding and comparison, to eliminate provisions which may be misleading or unreasonably confusing in connection with either the purchase of such coverage or with the settlement of claims and to provide for full disclosure in the sale of such coverages:

(a) The commissioner shall issue regulations to establish specific standards for policy provisions used in individual health insurance policies or contracts, but not
including group conversion policies or contracts, which
shall be in addition to other applicable laws of this state
which may cover the terms of renewability, initial and
subsequent conditions of eligibility, non-duplication of
coverage provisions, coverage of dependents,
termination of insurance, probationary periods,
limitations, exceptions, reductions, elimination periods,
requirements for replacements, recurrent conditions,
pre-existing conditions, and the definition of the terms
hospital, accident, sickness, injury, physician, accidental
means, total disability, permanent disability, partial
disability, nervous disorders, guaranteed renewable, and
noncancelable.

(b) The commissioner shall adopt regulations that
specify prohibit policy provisions not otherwise
specifically authorized by statute which in the opinion of
the commissioner are unjust, unfair or unfairly
discriminatory to the policyholder, any person insured
under the policy, or any beneficiary.

(c) The commissioner shall adopt regulations, to
establish minimum standards for benefits under each of
the following categories of coverage in individual
policies, other than conversion policies issued pursuant to
a contractual conversion privilege under a group policy:
basic hospital expense coverage, basic medical-surgical
depense coverage, hospital confinement indemnity
coverage, major medical expense coverage, disability
income protection coverage, accident only coverage and
specified accident coverage. Specified disease policies,
riders and benefits shall be prohibited whether issued on
a group or individual basis.

(d) Nothing in this section shall preclude the issuance
of any policy which combines two or more of the
categories of coverage enumerated in subdivision (c),
except that specified accident coverage shall not be
combined with any other category of coverage. The
commissioner shall prescribe the method of
identification of policies based upon coverage provided.

(e) No policy shall be delivered or issued for delivery
in this state which does not meet the prescribed
minimum standards for the categories of coverage listed
in subdivision (c), provided nothing in this section shall
preclude the issuance or delivery of any policy which
does not meet such prescribed minimum standards of
coverage so long as such policy is clearly identified as not
meeting such prescribed standards.

(f) No such policy or contract shall be delivered in this
state unless:

(1) An outline of coverage described herein
accompanies the policy or (2) the outline of coverage
described in this section is delivered to the applicant at
the time application is made and acknowledgement of
receipt of certificate of delivery of such outline is
provided the carrier with the application. In the event
the policy or contract is issued on a basis other than that
applied for, the outline of coverage properly describing
the policy shall accompany the policy when it is
delivered. The outline of coverage shall include: (A) a
statement identifying the applicable category or
categories of coverage provided by the policy in
accordance with this section; (B) a description of the
principal benefits and coverage provided in the policy;
(C) a statement of the exceptions, reductions and
limitations contained in the policy or contract; (D) a
statement of the renewal provisions including any
reservation by the carrier of a right to change premiums;
and (E) a statement that the outline is a summary of the
policy issued or applied for and that the policy should be
consulted to determine governing contractual provision.

(g) If a carrier elects to use a simplified application
form, with or without any questions as to the applicant’s
health at the time of application, but without any
questions concerning the insured’s health history or
medical treatment history, the policy shall cover loss
developing after six months from any pre-existing
condition not specifically excluded from coverage by the
terms of the policy and, except as so provided, the policy
shall not include wording that would permit a defense
based upon pre-existing conditions.

(h) Regulations promulgated pursuant to this section
shall specify an effective date applicable to policy and
benefit riders delivered or issued for delivery in this state
on and after such effective date which shall not be less
than 180 days after the date of adoption or promulgation.

12712. (a) In order to assure reasonable continuation
of coverage and extension of benefits to the citizens of
this state, all group health policies or contracts delivered
or issued for delivery or renewal in this state on or after
April 1, 1983, shall, subject to the provisions of subdivision
(c), contain those provisions described in subdivisions
(b) and (d) of Section 12705.

(b) The commissioner shall, within 180 days after April
1, 1983, adopt regulations covering group coverage
discontinuance and replacement.

(c) Nothing in this section shall alter or impair existing
group policies or contracts which have been established
pursuant to an agreement which resulted from collective
bargaining, and the provisions required by this section
shall become effective upon the next regular renewal and
completion of the collective bargaining agreement.

CHAPTER 3. COVERAGE

12700.2. Every employer who provides or makes
available to his employees a plan of health insurance
coverage shall make available to such employees
employed in this state a plan or combination of plans
which have been certified by the commissioner as a Class
B qualified plan. If such plan does not meet the
requirements of this part for a Class B qualified plan, the
employer shall make available a supplemental plan of
health benefits which, when combined with the existing
plan of health benefits, constitutes a Class B coverage
plan. The plan or combinations of plans may be financed
from funds contributed solely by the employer or solely
by the employees or any combination thereof. The plans
may consist of self-insurance, health or hospital care
service plan contracts, group policies or individual
policies or any combination thereof.

12700.3. In the event that an employer fails to comply
with the provisions of Section 12700.2; none of the employer’s costs for health benefits shall qualify as an income tax deduction for purposes of state taxation. In the case of an employer who qualifies as a nonprofit tax exempt organization for purposes of taxation, if the employer fails to make available at least a Class B qualified plan to his employees, the employer shall lose his status as an exempt organization.

12700.4. For each type of qualified plan described in this part, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

12700.5. An insurer or fraternal issuing Medicare supplement plans in this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

12700.6. For each type of qualified plan described in Section 12700.12; an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

12700.7. Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every
applicant for a new unqualified policy at the time of
application and annually to every holder of an
unqualified policy of accident and health insurance. The
coverage shall provide that when a covered individual
incurs out-of-pocket expenses of five thousand dollars
($5,000) or more within a calendar year for services
covered in Section 12700.12, benefits shall be payable;
subject to any copayment authorized by the
commissioner, up to a maximum lifetime limit of two
hundred fifty thousand dollars ($250,000).

12700.8. No policy of accident and health insurance
may be issued or renewed in this state 180 days after the
effective date of this chapter by an insurer or a fraternal
which has not complied with the requirements of this
chapter.

12700.9. An insurer or fraternal may fulfill its
obligations under this chapter by issuing the required
coverages in their own name and reinsuring the risk and
administration of the coverages with the association in
accordance with this part.

12700.10. Nothing in this part shall require an insurer
or fraternal to offer or issue a policy to any person who
does not meet the underwriting or membership
requirements of the insurer or fraternal.

12700.11. Upon application by an insurer, fraternal, or
employers for certification of a plan of health coverage as
a qualified plan or a qualified Medicare supplement plan
for the purposes of this part, the commissioner shall make
determination within 90 days as to whether the plan is
qualified. All plans of health coverage shall be labeled as
"qualified" or "nonqualified" on the front of the policy or
evidence of insurance. All qualified plans shall indicate
whether they are Class A, B, or C coverage plans.

12700.12. A plan of health coverage shall be certified
as a Class A qualified plan if it otherwise meets the
applicable requirements of law in this state, whether or
not the policy is issued in California, and meets or exceeds
the following minimum standards:

(a) The minimum benefits for a covered individual
shall, subject to the other provisions of this subdivision, be
equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed one hundred fifty dollars ($150) per person. The coverage shall include a limitation of three thousand dollars ($3,000) per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars ($250,000).

Such limitation on total annual out-of-pocket expenses and the maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary and reasonable charges for the following services and articles when prescribed by a physician:

(1) Hospital services;
(2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;
(3) Drugs requiring a physician's prescription;
(4) Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under MediCal;
(5) Services of a home health agency if the services would qualify as reimbursable services under MediCal;
(6) Use of radium or other radioactive materials;
(7) Oxygen;
(8) Anesthetics;
(9) Prostheses, other than dental;
(10) Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
(11) Diagnostic X-rays and laboratory tests;
(12) Oral surgery for partially or completely unerupted impacted teeth; a tooth root without the extraction of the entire tooth; or the gums and tissues of the mouth when not performed in connection with the extraction of repair of teeth;
(13) Rehabilitative services if the services would qualify as reimbursable under Medi-Cal;
(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;
(c) Covered expenses for the services and articles specified in this subdivision do not include the following:
(1) Any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self/insurance or (iii) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program except as otherwise provided by law.
(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;
(3) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medi-Cal;
(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi/private room; unless a private room is prescribed as medically necessary by a physician; if the institution does not have semi/private rooms its most common semi/private room charge shall be considered to be 90 percent of its current private room charge;
(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided;
(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles; and
(7) Any charge for services or articles deemed not to be medically necessary.
12700.13. A plan of health coverage shall be certified as a Class B qualified plan if it meets the requirements established by Section 12700.12, except that the deductible shall not exceed five hundred dollars ($500) per person.

12700.14. A plan of health coverage shall be certified as a Class C qualified plan if it meets the requirements established by Section 12712, except that the deductible shall not exceed one thousand dollars ($1,000) per person.

12700.15. A health or hospital/care service plan which provides the comprehensive services required by the Knox/Keene Act and is a qualified health maintenance organization pursuant to federal law shall be deemed to be providing a Class A qualified plan.

12700.16. Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 50 percent of the deductible and copayment required under Medicare and 80 percent of the charges for covered services described in Section 12700.12 which charges are not paid by Medicare. The coverage shall include a limitation of one thousand dollars ($1,000) per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than one hundred thousand dollars ($100,000).

12700.17. For the first 18 months of operation of the comprehensive health insurance plan, the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(a) The premium for the Class C qualified plan shall be the average of rates charged by the five insurers with the largest number of individuals in a Class C individual qualified plan of insurance in force in California;

(b) The premium for the Class B qualified plan shall be the average rates charged by the five insurers with the largest number of individuals in a Class B individual qualified plan of insurance in force in California;

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(e) The premium for a qualified Medicare supplement plan shall be the average of rates charged by the five insurers with the largest number of individuals enrolled in a qualified Medicare supplement plan; and,

(d) The charge for health or hospital care service plan coverage shall be based on generally accepted actuarial principles appropriate to organized prepayment systems.

12700.18. For subsequent enrollees or renewals of membership, the schedule of premiums for membership in the health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Chapter 4. Duties of the Commissioner

12700.19. The commissioner may do all of the following:

(a) Formulate general policies to advance the purposes of this part;

(b) Supervise the creation of the California Comprehensive Health Association within the limits described in Section 12700.20;

(c) Approve the selection of the writing carrier by the association and approve the association’s contract with the writing carrier including the state plan coverage and premiums to be charged;

(d) Appoint advisory committees;

(e) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;

(g) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits specified in this part so that the residents of this state may best avail themselves of the health care benefits provided herein; and,

(h) Contract with insurers and others for
administrative services and adopt, amend, suspend, and
repeal rules as reasonably necessary to carry out and
make effective the provisions and purposes of this part.

CHAPTER 5. COMPREHENSIVE HEALTH INSURANCE
ASSOCIATION

12700.20. There is hereby established a
Comprehensive Health Insurance Association to
promote the public health and welfare of the people of
the State of California, with membership consisting of all
insurers, self-insurers, fraternals and health or hospital
care service plans authorized to transact business in this
state. The Comprehensive Health Insurance Association
shall be exempt from taxation under the laws of this state
and all property owned by the association shall be exempt
from taxation.

12700.21. (a) The board of directors of the association
shall be made up of seven individuals selected by
participating members, subject to approval by the
commissioner. To select the initial board of directors, and
to initially organize the association, the commissioner
shall give notice to all members of the time and place of
the organizational meeting. In determining voting rights
at the organizational meeting, each member shall be
entitled to vote in person or proxy. The vote shall be a
weighted vote based upon the member's cost of
self-insurance, accident and health insurance premium,
subscriber contract charges, or health or hospital care
service plan contract payment derived from or on behalf
of California residents in the previous calendar year, as
determined by the commissioner. If the board of
directors is not selected within 60 days after notice of the
organizational meeting, the commissioner may appoint
the initial board. In approving or selecting members of
the board, the commissioner shall consider, among other
things, whether all types of members are fairly
represented. Members of the board may be reimbursed
from the moneys of the association for expenses incurred
by them as members, but shall not otherwise be
compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(b) All members shall maintain their membership in the association as a condition of transacting accident and health insurance, self/insurance, or health or hospital care service plan business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

12700.22 All meetings of the association; its board, and any committees of the association, shall be open to the public.

12700.23 All members shall enter into a contract with the association according to terms specified in Section 12700.26. The contract of reinsurance shall be executed on or before July 1, 1982, for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

12700.24 In the performance of their duties as members of the association, the members shall be exempt from the provisions of any law prohibiting combinations in restraint of trade.

12700.25 The association may:

(a) Exercise the power granted to insurers under the laws of this state;

(b) Sue or be sued;

c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in subdivisions (e) and (f);

d) Establish administrative and accounting procedures for the operation of the association;

e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by this part by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the
association. The categories of coverage are:

(1) Individual qualified plans, excluding group conversions;
(2) Group conversions;
(3) Group qualified plans with fewer than 50 employees or members; and
(4) Major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every individual covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of member’s risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred or estimated to be incurred in the operation of the reinsurance plan. The reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance;

(f) Provide for the administration by the association of policies which are reinsured pursuant to subdivision (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member’s behalf. If a member elects to have the association administer the categories of coverage, it must do so for every individual covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for
the administration.
12700.26. Upon certification as an eligible person in
the manner provided by this chapter, an eligible person
may enroll in the comprehensive health insurance plan
by payment of the state plan premium to the writing
carrier.
12700.27. Any employer which has in its employ one
or more eligible persons enrolled in the comprehensive
health insurance plan may make all or any portion of the
state plan premium payment to the state plan directly to
the writing carrier.
12700.28. Not less than 87½ percent of the state plan
premium paid to the writing carrier shall be used to pay
claims, and not more than 12½ percent shall be used for
the payment of agent referral fees as authorized in
Section 12700.46 and for payment of the writing carrier’s
direct and indirect expenses, as specified in Section
12700.38.
12700.29. Any income in excess of the costs incurred
by the association in providing reinsurance or
administrative services pursuant to this part shall be held
at interest and used by the association to offset losses due
to claims expenses of the state plan or allocated to reduce
state plan premiums.
12700.30. Each member of the association shall share
the losses due to claims expenses of the comprehensive
health insurance plan for plans issued or approved for
issuance by the association, and shall share in the
operating and administrative expenses incurred or
estimated to be incurred by the association incident to
the conduct of its affairs, pursuant to the terms of the
individual reinsurance contracts executed by the
association with each member. Deviations in the claims
experience of the state plan from the premium payments
allocated to the payment of benefits shall be the liability
of the association members. Association members shall
share in the claims expense of the state plan and
operating and administrative expenses of the association
in an amount equal to the ratio of the member’s total cost
of self-insurance, accident and health insurance
premium, subscriber contract charges, or health or hospital care service plan contract charges received from or on behalf of California residents as divided into the total cost of self/insurance; accident and health or hospital insurance premium; subscriber contract charges; and health care service plan contract charges received by all association members from or on behalf of California residents, as determined by the commissioner. The reinsurance contract shall provide for an annual determination and assessment of each member's liability; if any. Payment of the assessment shall be due within 30 days after the end of the association's fiscal year. Subject to the approval of the commissioner, the reinsurance contract may provide for interim assessments as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claim expenses of the state plan and operating and administrative expenses of the association, until the association's next annual fiscal year end assessment. Failure by a member to tender to the association, the assessed reinsurance payment within 30 days of notification by the association shall be grounds for termination of the member's membership.

Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

12700.31: The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a Class C qualified plan, a Class B qualified plan, a Class A qualified plan, and a qualified Medicare supplement plan. They shall offer health or hospital care service plan contracts in those areas of the state where a health or hospital care service plan has agreed to make the coverage available and has been selected as a writing carrier.

12700.32: Any member of the association may submit to the commissioner the policies of accident and health insurance or the health or hospital care service plan contracts which are being proposed to serve in the
comprehensive health insurance plan. The time and
manner of the submission shall be prescribed by rule of
the commissioner.

12700.33. Upon the commissioner’s approval of the
policy forms and contracts submitted, the association
shall select policies and contracts submitted by a member
or members of the association to be the comprehensive
health insurance plan. This selection shall be based upon
criteria including the member’s proven ability to handle
large group accident and health insurance cases, efficient
claim paying capacity, and the estimate of total charges
for administering the plan. The association may select
separate writing carriers for the three types of qualified
plans; the qualified Medicare supplement plan; and the
health or hospital service plan contract.

12700.34. The writing carrier shall perform all
administrative and claims payment functions. The
writing carrier shall provide these services for a period of
three years, unless a request to terminate is approved by
the commissioner. The commissioner shall approve or
deny a request to terminate within 90 days of its receipt.
A failure to make a final decision on a request to
terminate within the specified period shall be deemed to
be an approval. Six months prior to the expiration of each
three/year period, the association shall invite submissions
of policy forms from members of the association;
including the writing carrier. The association shall follow
the provisions of Section 12700.33 in selecting a writing
carrier for the subsequent three/year period.

12700.35. The writing carrier shall provide to all
eligible persons enrolled in the plan an individual policy
or certificate, setting forth a statement as to the insurance
protection to which the person is entitled, with whom
claims are to be filed and to whom benefits are payable.
The policy or certificate shall indicate that coverage was
obtained through the association.

12700.36. The writing carrier shall submit to the
association and the commissioner on a monthly basis a
report on the operation of the state plan. Specific
information to be contained in this report shall be
determined by the association prior to the effective date of the state plan.

12700.37. All claims shall be paid by the writing carrier. Such claims shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

12700.38. The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing/Carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

12700.39. The writing carrier shall at all times when carrying out its duties under this part be considered an agent of the association and the commissioner with civil liability subject to applicable provisions of law regulating contract claims against the state by a party to a state contract.

12700.40. Premiums received by the writing carrier for the comprehensive health insurance plan are specifically exempted from paying any state/imposed gross premiums tax.

12700.41. The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate may provide the following:

(a) Name; address; age; and length of time at residence of the applicant;

(b) Name; address and age of spouse and children, if any, if they are to be insured;
(c) Evidence of rejection; or a requirement of restrictive riders; or a pre-existing/conditions limitation on a qualified plan; the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least two association members within six months of the date of the certificate; and

(d) A designation of the coverage desired.

An eligible person may not purchase more than one policy from the state plan.

12700.42: Within 30 days of receipt of the certificate described in Section 12700.41, the writing carrier shall either reject the application for failing to comply with the requirements in Section 12700.41 or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date of the application, if the applicant otherwise complies with the requirements of this part.

12700.43: No person who obtains coverage pursuant to this part shall be covered for any pre-existing condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days immediately preceding the filing of an application.

12700.44: The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio and television, as well as publication in appropriate state offices and publications.

12700.45: The association shall devise and implement means of maintaining public awareness of the provisions of this chapter and shall administer such provisions in a manner that facilitates public participation in the state plan.

12700.46: The writing carrier shall pay an agent's referral fee of twenty-five dollars ($25) to each insurance
agent who refers an applicant to the state plan; if the
application is accepted. Selling or marketing of qualified
state plans shall not be limited to the writing carrier or
its agents. The referral fees shall be paid by the writing
carrier from money received as premiums for the state
plan.

12700-47. Every insurer which rejects or applies
underwriting restrictions to an applicant for accident and
health insurance shall notify the applicant of the
existence of the state plan, the requirements for being
accepted in it, and the procedure for applying to it.

12700-48. Every program of self/insurance; policy of
group accident and health insurance or contract of
coverage by a health or hospital care service plan written
or renewed in this state, shall include, in addition to
existing provisions of law relating to continuation of
coverage after termination of employment; the right to
convert to an individual coverage qualified plan without
the addition of underwriting restrictions regardless of the
reason for leaving the group. The person leaving the
group may exercise his right to conversion within 30 days
of leaving the group. Plans of health coverage shall also
include a provision which, upon the death of the
individual in whose name the contract was issued;
permits every other individual then covered under the
contract to elect, within the period specified in the
contract, to continue coverage under the same or a
different contract without the addition of underwriting
restrictions until the person would have ceased to have
been entitled to coverage; had the individual in whose
name the contract was issued lived. An individual
conversion contract issued by a health or hospital care
service plan shall not be deemed to be an individual
enrollment contract for the purposes of individual
enrollment provisions of the Knox/Keene Act.

12700-49. An employer who employs in this state, on
the average during a calendar quarter, 100 employees or
more; other than employees engaged in seasonal
employment and who offers a health benefits plan to
employees, whether (a) purchased from an insurer or a
health or hospital care service plan, or (b) provided on a self insured basis; shall; upon the next renewal of the health benefits plan contract offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health or hospital care service plan contract if one is available. An option need not be provided if less than 25 employees select such option.

12700.50. An employer may make the dual offers specified in Section 12700.49 through an insurer, a health or hospital care service plan or on a self/insured basis. If an offer is made on a self/insured basis, the accident and health insurance type of coverage or health or hospital care service plan type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided.

12700.51. No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health or hospital care service plan coverage by a particular health or hospital care service plan. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single/price package.

CHAPTER 6. CALIFORNIA CATASTROPHIC HEALTH EXPENSE PROTECTION ACT

12701. This chapter may be cited as the California Catastrophic Health Expense Protection Act.

12702. For the purposes of this chapter:
(a) "Eligible person" means any person who is a resident of California and who, while a resident of California, has been found by the director to have incurred an obligation to pay qualified expenses for himself or herself and any dependents in any 13 consecutive months exceeding:
(1) 40 percent of his or her household income up to fifteen thousand dollars ($15,000); plus 50 percent of his or her household income between fifteen thousand dollars ($15,000) and twenty-five thousand dollars ($25,000); plus 60 percent of his or her household income in excess of twenty-five thousand dollars ($25,000); or;

(2) Two thousand five hundred dollars ($2,500), whichever is greater except that the level of required obligation shall be reduced by an amount equal to three times the out-of-pocket expense for health insurance premiums incurred by an eligible person.

(b) "Qualified expense" means any charge incurred subsequent to July 1, 1982, for a health service which is included in the list of covered services described in Section 25700.12 of this part, and for which no third party is liable.

(c) "Dependent" means a spouse or unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(d) "Gross income" means federally adjusted gross income and the sums of the following to the extent not included in this subdivision:

(1) Additions to federally adjusted gross income as provided by state revenue and taxation provision relating to:

(A) Federally, but not state, exempt interest;

(B) Federally deductible state income tax;

(C) Disallowed depreciation;

(D) Federally exempt interest and dividends; and the

(E) Amount of excluded gain realized by a trust or sale or exchange of property;

(2) All nontaxable income;

(3) Recognized long/term capital gains;

(4) Dividends excluded from federal adjusted gross income pursuant to Section 116 of the Internal Revenue Code of 1954;

(5) Public assistance and relief;

(6) Any pension or annuity, including railroad
retirement benefits; all payments received under the
federal Social Security Act (26 U.S.C.A. Section 1394 et
seq.) supplemental security income and veteran's
disability pensions, which was not exclusively funded by
the applicant or spouse; or which was funded exclusively
by applicant or spouse and which funding payments were
excluded from federal adjusted gross income in the years
when the payments were made;

(7) Nonstate taxable interest received from the state
or federal government or any instrumentality or political
subdivision thereof;
(8) Workers' compensation;
(9) Unemployment benefits;
(10) Nontaxable strike benefits; and
(11) The gross amounts of payments received in the
nature of disability income or sick pay as a result of
accident, sickness or other disability, whether funded
through insurance or otherwise. In the case of an
individual who files an income tax return on a fiscal year
basis; the term "federal adjusted gross income" shall
mean federal adjusted gross income reflected in the fiscal
year ending in the calendar year. "Income" does not
include:

(i) Amounts excluded pursuant to Section 101 of the
Internal Revenue Code; subdivision (a) of Section 102;
and Sections 117 and 121 (26 U.S.C.; Sections 102; 117;
121);
(ii) Amounts of any pension or annuity which was
exclusively funded by the applicant or spouse and which
funding payments were not excluded from federal
adjusted gross income in the years when the payments
were made;
(iii) Gifts from nongovernmental sources;
(iv) Surplus food or other relief in kind supplied by a
governmental agency or relief granted pursuant to any
federal or state or local tax credits;
(v) "Household income" means the gross income of an
eligible person and all of his or her dependents for the
calendar year preceding the year in which an application
is filed pursuant to Section 12703.
(f) "Director" means the Director of the Department of Health Services.

(g) "Third party" means any person other than the eligible person or his or her dependents.

12703. Any person who believes that they are or will become an eligible person may submit an application for state assistance to the director. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12/month period for computing expenses began.

12704. If the director determines that an applicant is an eligible person, the director shall pay 95 percent of all qualified expenses of the eligible person and his or her dependents in excess of:

(a) Forty percent of his or her household income under fifteen thousand dollars ($15,000) plus 50 percent of his or her household income between fifteen thousand dollars ($15,000) and twenty/five thousand dollars ($25,000) plus 60 percent of his or her household income in excess of twenty/five thousand dollars ($25,000); or,

(b) Two thousand five hundred dollars ($2,500), whichever is greater for the 12/month period in which the applicant becomes an eligible person. The director shall by regulation establish procedures for determining whether, and to what extent, qualified expenses are reasonable charges; unless otherwise provided for by regulation, charge shall be reviewed for reasonableness by the same procedures used to review and limit reimbursement under MediCal. If the director determines that the charge for a health service is excessive, the director may limit payment to the reasonable charge for that service. If the director determines that a health service provided to an eligible person was not medically necessary, the director may refuse to pay for the service. The director may contract with a review organization (as defined in 42 U.S.C., Section 1320, et seq.), in making any determination as to whether or not a service was medically necessary. If the director in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid
portion of the charge shall be deemed to be an
unconscionable fee, against the public policy of this state,
and unenforceable in any action brought for the recovery
of moneys owed.

12705. Whenever the director pays for or becomes
liable for payments for health services under the
provisions of this chapter, the director shall have a lien for
payments and liabilities for the services upon any and all
causes of action which accrue to the person to whom the
services were furnished, or his legal representatives, as a
result of injuries which directly or indirectly led to the
incurring of qualified expenses.

12706. The director may perfect and enforce his or
her lien by following applicable procedures of law except
that the director shall have one year from the date when
the last item of health service was furnished in which to
file his or her verified lien statement. The statement shall
be filed with the appropriate clerk of court in the county
in which the recipient of the services resides or in the
county in which the action was filed.

12707. Where a third party may be liable in whole or
in part for payment for health services, the director may
consider the charges for the health services to be
qualified expenses if the eligible person assigns any right
accruing by virtue of any third party liability to the
director to the extent necessary to reimburse the state for
any payments made under the provisions of this section.

12708. Upon furnishing assistance under the
provisions of this chapter, the Department of Health
Services shall be subrogated, to the extent of its payments
for health services, to any rights the eligible person or his
or her dependent may have under the terms of any plan
of health coverage. The right of subrogation shall not
attach prior to written notice of the exercise of
subrogation rights to the issuer of the plan of health
coverage.

The Attorney General, or the appropriate city
attorney, acting upon direction from the Attorney
General, may institute or join a civil action against the
issuer of the plan of health coverage to recover under this
12700. The director shall:
   (a) Promulgate reasonable rules to implement this chapter;
   (b) Establish application forms and procedures for the use of persons seeking to be declared an eligible person; and,
   (c) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

12710. The director may:
   (a) Enter into contracts with the United States or any state agency, instrumentality or political subdivision thereof for the purpose of coordinating the program established by this chapter with other programs which provide or pay for the delivery of health services;
   (b) Enter into contracts with third parties to perform some or all of the duties imposed on the director by this chapter.

12711. The final decision of the director denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to the Administrative Procedure Act (Chapter 4 (commencing with Section 11370); Chapter 4.5 (commencing with Section 11371); Chapter 5 (commencing with Section 11500); of Division 3 of Title 2 of the Government Code), as amended.

12712. There is hereby created in the State Treasury, the California Catastrophic Health Expense Protection Fund. There is initially appropriated from the General Fund for deposit in the California Catastrophic Health Expense Protection Fund, the sum of ten million dollars ($10,000,000). The appropriation is to be used without regard to fiscal year for the purpose of funding the activities of the Department of Health Services as are authorized by the provisions of this part and the administration thereof.

SEC. 2. Sections 12700.2, 12700.26, 12700.31, 12700.41,
1. Sections 48 and 49 of this act shall become operative July 1, 1982.
AMENDED IN ASSEMBLY SEPTEMBER 10, 1987
AMENDED IN ASSEMBLY APRIL 20, 1987
CALIFORNIA LEGISLATURE—1987-88 REGULAR SESSION

ASSEMBLY BILL No. 2647

Introduced by Assembly Member Campbell

March 10, 1987

An act relating to national health program.

LEGISLATIVE COUNSEL'S DIGEST

AB 2647, as amended, Campbell. National health program.

Under existing law there is no national health program.

This act would submit to the voters at the next statewide election a measure requiring the Governor to request the President and the Congress to enact a national health program.


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

1 SECTION 1. At the next statewide election in accordance with the provisions of the Government Code and the Elections Code governing the submission of statewide measures to the voters the following measure shall be submitted to the voters:

National Health Program

9 We, the people of the State of California, do hereby find and declare as follows:
10 The United States through public and private sources
will expend in 1987 10 times the amount spent on health
care 20 years ago.
The dramatic rise in health care expenditures has both
played a major role in fueling inflation and still left
millions of Americans without needed health services
and without protection against the catastrophic costs of
acute and long-term care.
The State of California and other states have limited
ability to control and shape policy for health care
programs that transcend state boundaries and are, most
often, national in scope.
The trend in health care costs predicts both a greater
share of the nation's limited resources going into health
care and less health care coverage and protection being
afforded the people of the United States.
The Governor shall prepare and transmit on or before
December 31, 1988, a request to the President and all
members of the Congress of the United States to enact by
January 1, 1990, legislation establishing a national health
program, providing accessibility for all Americans;
freedom of choice; a comprehensive range of services;
fiscally sound financing through the private and public
sectors; allowance for innovation in delivery systems;
provision for pilot projects; incorporation of professional
standards; and decisionmaking with reliance on
professional judgement and sensitivity to consumer
input.

SEC. 2. Notwithstanding any other provision of law,
all ballots of the election shall have printed thereon and
in a square thereof, the words: "National Health
Program," and in the same square under those words, the
following in eight-point type: "This act requires the
Governor to request the President and the Congress to
enact a national health program." Opposite the square,
there shall be left spaces in which the voters may place
a cross in the manner required by law to indicate whether
they vote for or against the act.
Where the voting in the election is done by means of
voting machines used pursuant to law in the manner that
carries out the intent of this section, the use of the voting
machines and the expression of the voters' choice by means thereof are in compliance with this section.