

# CRB

California Research Bureau



## Ninety Years of Health Insurance Reform Efforts in California

### Bill and Proposition Files

#### California Research Bureau

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**CRB 07-013-06**

1989 – AB 350 (Speaker Brown, Keene)

Pages 2-10

1989 – SB 1207 (Keene, Maddy)

Pages 11-19

1989 – AB 328 (Margolin)

Pages 20-48

October 2007

AMENDED IN ASSEMBLY MAY 30, 1989  
AMENDED IN ASSEMBLY MAY 15, 1989  
AMENDED IN ASSEMBLY MARCH 28, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 350**

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**Introduced by Assembly Member Willie Brown**

January 25, 1989

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An act to add Chapter 2 (commencing with Section 2500) to Part 9 of Division 2 of the Labor Code, relating to employee health insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 350, as amended, W. Brown. Employee health care insurance.

Existing law does not require an employer to provide health care insurance for employees.

This bill would enact the Tucker Health Insurance Act of 1989, which would require every employer which employs 5 or more persons to provide specified health care coverage to every employee who works at least 86.67 hours per month for any single employer. Coverage would begin at the earliest time at which coverage can be provided after the employee has been employed for 2 calendar months.

This bill would require the employer to continue payments for health care coverage for up to 3 calendar months if an employee is prevented by sickness from working and earning wages, and sick leave benefits are exhausted.

This bill would permit employers to form associations for the purpose of providing health care coverage by pooling employees in order to obtain group rates and coverage, and by providing for self-funded employer-sponsored health care

coverage.

This bill would require any employer who fails to provide health care coverage for employees to pay for the health care costs incurred by an eligible employee during the period in which the employer failed to provide coverage.

*This bill would require that group insurance plans available to employers with fewer than 50 eligible employees comply with specified underwriting criteria, and would provide that insurance carriers offering these group insurance plans and not conforming to the underwriting criteria with regard to these groups shall not be permitted to underwrite health care coverage in California.*

This bill would become operative on January 1, 1993, or on the effective date of federal legislation which exempts the bill from preemption by the federal Employee Retirement Income Security Act of 1974, whichever occurs sooner.

This bill would not become operative if federal legislation is enacted to provide equal or superior health care coverage to all eligible employees prior to the operative date of this bill.

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

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

1 SECTION 1. Chapter 2 (commencing with Section  
2 2500) is added to Part 9 of Division 2 of the Labor Code,  
3 to read:

4  
5 CHAPTER 2. EMPLOYEE HEALTH INSURANCE

6  
7 Article 1. Findings and Purposes

8  
9 2500. This chapter shall be known and may be cited  
10 as the Tucker Health Insurance Act of 1989.

11 2501. The Legislature hereby finds and declares as  
12 follows:

13 (a) While a significant majority of Californians receive  
14 health insurance through their employers as a result of  
15 employment, fewer employers in California provide this  
16 coverage than the nationwide average.

1 (b) In the last 10 years, the total number of uninsured  
2 in California has grown by more than 25 percent as a  
3 result of decreased employer coverage, more restrictive  
4 public program eligibility, and a system of competitive  
5 health care pricing.

6 (c) State and local governments have provided, and  
7 continue to provide, a medical care system to serve  
8 indigent and low-income persons. However, because of  
9 public revenue constraints at both the state and local  
10 level, the ability of that system to meet the needs of the  
11 uninsured is wholly inadequate.

12 (d) According to recent studies conducted by the  
13 University of California at Los Angeles and the Rand  
14 Corporation, the competitive pricing system in California  
15 has generated lower health care cost increases than in  
16 those states with traditional pricing mechanisms.  
17 Competitive pricing, however, has made it more difficult  
18 to pass on the cost of treatment for uninsured persons to  
19 payers for insured persons.

20 (e) To a large extent, those employers who provide for  
21 their employees' health care are also absorbing the costs  
22 of the uninsured. If economic competition is to be fair  
23 and equitable, all employers should absorb these costs  
24 equally.

25 (f) The uninsured comprise over 20 percent of  
26 California's population. Approximately two-thirds of the  
27 uninsured are employed or are dependents of employed  
28 persons. Uniform employer coverage would substantially  
29 reduce the number of Californians without health  
30 insurance.

31 2502. It is the purpose of this chapter to ensure that  
32 nearly all employed persons in California are provided  
33 basic health care coverage. Further, it is intended that  
34 employer-sponsored health care programs offer  
35 employees coverage for dependents, the costs of which  
36 would be determined through employer-employee  
37 agreements. Finally, this chapter will encourage methods  
38 whereby employees of small firms can be included in  
39 risk-sharing pools so that the cost of health insurance to  
40 small businesses is equalized.

1 2503. This chapter shall not be construed to diminish  
2 any protection already provided pursuant to collective  
3 bargaining agreements or employer-sponsored plans that  
4 are more favorable to the employees than the basic  
5 benefits required by this chapter.

6

7

## Article 2. Definitions

8

9 2510. Unless the context requires otherwise, the  
10 definitions set forth in this article shall govern the  
11 construction and meaning of the terms and phrases used  
12 in this chapter.

13 2512. "Carrier" means any insurer, health care  
14 service plan, nonprofit hospital service plan, self-funded  
15 employer-sponsored plan, multiple employer trust, or  
16 Taft-Hartley Trust as defined by federal law, authorized  
17 to pay for health care services in this state.

18 2514. "Dependent" means the spouse, minor child,  
19 permanently disabled child, or legally dependent parent  
20 of a covered employee.

21 2516. "Employee" means any person who works at  
22 least 86.67 hours per month for any single employer.

23 2518. "Employer" means any person, partnership,  
24 corporation, association, or public or private agency  
25 employing for wages or salary five or more persons to  
26 work in this state.

27 2520. "Principal employer" means the employer for  
28 whom any employee works the largest number of hours  
29 in any month.

30 2522. "Wages" means all remuneration for services  
31 from whatever source, including commissions, bonuses,  
32 and tips and gratuities paid directly to any individual by  
33 a customer or his or her employer.

34

35

## Article 3. Coverage

36

37 2530. Every employer shall provide health care  
38 coverage to each employee pursuant to this chapter.

39 2532. Every employer required to provide health  
40 care coverage pursuant to this chapter may select that

1 coverage from any carrier. Employers may also provide  
2 coverage through self-funded employer-sponsored plans.  
3 2534. Every employer shall be responsible for at least  
4 75 percent of the cost of health care coverage. However,  
5 where coverage exceeds the minimum benefits required  
6 by this chapter, or where coverage includes an  
7 employee's dependents, the payment for that coverage  
8 shall be consistent with established practices. To the  
9 extent that the employee is responsible for paying all or  
10 a part of these costs, an employer shall withhold those  
11 amounts from the employee's salary and wages.

12 2536. Every employer shall provide health care  
13 coverage to every employee who has been employed for  
14 three calendar months by the employer, at the earliest  
15 time thereafter at which coverage can be provided.

16 2538. An employer shall continue payments for health  
17 care coverage for any employee who is hospitalized or  
18 otherwise prevented by sickness or injury from working  
19 and earning wages, and for whom sick leave benefits are  
20 exhausted. This obligation shall continue for three  
21 calendar months following the month during which the  
22 employee became hospitalized or disabled from working,  
23 or the month the employee becomes eligible for other  
24 public or private coverage, whichever occurs first.

25 2540. An employer shall not be required to provide  
26 health care coverage pursuant to this chapter with  
27 respect to any employee if any of the following occur:

28 (a) The employer is not the principal employer of the  
29 employee in terms of monthly hours worked.

30 (b) The employee is covered as a dependent under a  
31 health care plan, health insurance plan, hospital service  
32 plan, or self-funded employer-sponsored plan which has  
33 benefits meeting the requirements of this chapter.

34 2542. This chapter shall not apply to any employee  
35 who, pursuant to the teachings, faith, or belief of any  
36 group, depends for healing upon prayer or other spiritual  
37 means.

38 2544. Employers may form associations for the  
39 purpose of providing health care coverage under this  
40 chapter. These associations may pool their employees in

1. order to obtain group, rather than small-group or  
2. individual, rates and coverage, and these associations may  
3. also provide for self-funded employer-sponsored health  
4. care coverage.

5. 2546. Group health insurance for employers with  
6. fewer than 50 eligible employees shall be available only  
7. if the plan complies with the following underwriting  
8. rules:

9. (a) Geographic underwriting standards shall be  
10. limited to two California regions. A carrier may divide  
11. the state according to reasonable criteria fully disclosed  
12. to prospective group contractors.

13. (b) Within each geographic region established by a  
14. carrier, underwriting groups shall be established by  
15. classes of enterprise, to which each contracting employer  
16. group shall be assigned. A carrier shall maintain an  
17. enterprise group in each of the following classes:

18. (1) Retail trade.

19. (2) Manufacturing.

20. (3) Agriculture.

21. (4) Transportation.

22. (5) Wholesale trade.

23. (6) Services industries.

24. (7) Professions.

25. (8) Construction.

26. (9) Miscellaneous.

27. (c) The age and sex of every covered person may be  
28. ascertained and given full actuarial weight in  
29. determining insurance rates for the class to which his or  
30. her group is assigned.

31. (d) A carrier's premium rates for all groups and  
32. persons in the same class, within the same geographic  
33. region, shall be identical.

34. (e) Additional underwriting criteria shall not be  
35. applied to individuals or groups eligible for coverage  
36. under this section.

37. 2547. All carriers licensed or authorized to  
38. underwrite health care coverage in California who offer  
39. group health insurance to employers with fewer than 50  
40. employees shall only use the underwriting criteria

1 *described in Section 2546 with regard to groups*  
2 *containing fewer than 50 employees. Carriers offering*  
3 *health insurance to groups containing fewer than 50*  
4 *employees, and not conforming to the criteria described*  
5 *in Section 2546 with regard to those groups, shall not be*  
6 *permitted to underwrite health care coverage in*  
7 *California.*

8 2548. Any employer who fails to provide health care  
9 coverage as required by this chapter shall be liable to pay  
10 for the health care costs incurred by an eligible employee  
11 during the period in which the employer failed to  
12 provide coverage.

13  
14 Article 4. Health Care Benefits

15  
16 2550. Health care benefits provided in accordance  
17 with this chapter shall include all of the following:

18 (a) Hospital inpatient care for a period of at least 120  
19 days of hospitalization in each calendar year, including all  
20 of the following:

21 (1) Room accommodations.

22 (2) Regular and special diets.

23 (3) General nursing services.

24 (4) Use of operating rooms, surgical supplies,  
25 anesthesia services, and supplies.

26 (5) Drugs, dressing, oxygen, antibiotics, and blood  
27 transfusion services.

28 (b) Hospital outpatient care, including all of the  
29 following:

30 (1) Hospital outpatient services.

31 (2) Facilities for surgical procedures or health care of  
32 an emergency nature.

33 (c) Surgical benefits, including all of the following:

34 (1) Surgical services performed by a licensed  
35 physician and surgeon.

36 (2) Aftercare visits for a reasonable period.

37 (3) Anesthesiologist services.

38 (d) Medical benefits, including all of the following:

39 (1) Necessary home, office, and hospital visits by a  
40 licensed physician and surgeon.

1 (2) Intensive medical care while hospitalized.

2 (3) Medical or surgical consultation.

3 (e) Diagnostic laboratory services, X-ray, and  
4 radio-therapeutic services necessary for diagnosis or  
5 treatment of injury or disease.

6 (f) Maternity benefits.

7 (g) Mental health benefits, including all of the  
8 following:

9 (1) Inpatient care or acute residential care for a period  
10 of at least 20 days in each calendar year.

11 (2) At least 25 outpatient visits in each calendar year.

12 2552. (a) Health care coverage pursuant to this  
13 chapter shall not include a copayment or deductible  
14 expense to the beneficiary for any of the following:

15 (1) Hospital inpatient services, including care in a  
16 psychiatric facility or acute residential treatment facility.

17 (2) Physician and surgeon services provided in the  
18 hospital.

19 (3) Laboratory and other services.

20 (4) Ambulatory surgical benefits.

21 (b) Health care coverage pursuant to this chapter may  
22 require a copayment, not to exceed 25 percent of the  
23 charges, for all other benefits.

24 2554. Employers providing services pursuant to this  
25 chapter shall not be required to pay for benefits when the  
26 beneficiary is entitled to receive disability benefits or  
27 compensation under any workers' compensation or  
28 employers' liability law for the injury or illness.

29

### 30 Article 5. Operative Date

31

32 2560. This chapter shall become operative on January  
33 1, 1993, or on the effective date of federal legislation  
34 which exempts this chapter from preemption by the  
35 federal Employee Retirement Income Security Act of  
36 1974, whichever occurs sooner, as determined by the  
37 Director of Industrial Relations. However, this chapter  
38 shall not become operative if federal legislation is  
39 enacted to provide equal or superior health care  
40 coverage to all eligible employees prior to the operative

- 1 date of this chapter, as determined by the Director of
- 2 Industrial Relations.

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AMENDED IN ASSEMBLY SEPTEMBER 14, 1989

AMENDED IN ASSEMBLY AUGUST 21, 1989

AMENDED IN SENATE MAY 1, 1989

**SENATE BILL**

**No. 1207**

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**Introduced by Senator Keene  
(Principal coauthor: Senator Maddy)  
(Coauthor: Senator Stirling)**

March 8, 1989

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An act to amend ~~and repeal~~ Sections 17053.20 and 23615 of the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

SB 1207, as amended, Keene. Income taxes: bank and corporation taxes: credits: health coverage.

The existing Personal Income Tax Law and Bank and Corporation Tax Law authorize for a specified 5-year period, a tax credit against the taxes imposed by those laws for the greater of \$25 per month per covered individual or 25% per month of the costs paid or incurred during the taxable or income year by an eligible employer to provide health coverage, as defined, for an eligible individual and the individual's dependents. An additional \$5 per month tax credit is authorized with respect to specified supplemental benefits. The term "eligible employer" means a taxpayer which employs on the average during the tax year no more than 25 eligible individuals, as defined, in California and makes a minimum required contribution on behalf of an eligible individual. Excluded from the term "eligible employer" is a taxpayer who subsidized or provided health insurance to eligible individuals in 1986 and 1987. The tax credit provisions do not become operative until specified

conditions exist, and then remain in effect for a 5-year period thereafter.

This bill would, under those laws, eliminate the exclusion from the term "eligible employer" of a taxpayer who subsidized or provided health insurance to eligible individuals in 1986 and 1987. It would provide that, in addition to existing requirements, an "eligible individual" means an individual who makes a specified certification on a form prescribed by the Franchise Tax Board. It would delete the requirement that specified conditions must exist before the tax credit provisions become operative. It would also delete the specification that the tax credits are to remain in effect only for a 5-year period after they become operative. ~~However, it would repeal the tax credits on January 1, 1993, if the Tucker Health Insurance Act of 1989 (proposed by AB 350) does not become operative on or before January 1, 1993.~~ It would also modify the definition of health coverage.

This bill would also make clarifying nonsubstantive changes to those laws.

This bill would take effect immediately as a tax levy, but *the substantive provisions* would become operative ~~only if on the date AB 350 is chaptered becomes operative.~~

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

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

- 1- SECTION 1. Section 17053.20 of the Revenue and
- 2 Taxation Code is amended to read:
- 3 17053.20. (a) There shall be allowed as a credit
- 4 against the amount of "net tax" (as defined in Section
- 5 17039) an amount equal to the amount determined in
- 6 subdivision (b) for payments by an eligible employer to
- 7 provide health coverage for eligible individuals and their
- 8 dependents.
- 9 (b) The amount of the credit allowed by subdivision
- 10 (a) shall be twenty-five dollars (\$25) per month per
- 11 covered individuals or 25 percent per month of the total
- 12 amount paid or incurred for such health coverage by the
- 13 employer during the taxable year, whichever is more;

1 plus twenty-five dollars (\$25) per month or 25 percent of  
2 the total amount paid or incurred per month per covered  
3 individual's dependent or dependents, whichever is  
4 more.

5 (c) To qualify for the credit provided in subdivision  
6 (b), an eligible employer must pay or incur at least 75  
7 percent of the monthly premium for health coverage for  
8 eligible individuals who elect to have that coverage, or at  
9 least 75 percent per month towards health coverage for  
10 an eligible individual's dependent or dependents and for  
11 which the individual does not pay more than 25 percent,  
12 or both. At least annually, the employer shall make  
13 participation available to all eligible individuals and to all  
14 newly hired individuals within 60 days of the date of  
15 employment. Nothing in this section shall require an  
16 eligible employer to pay for dependent health coverage  
17 in order to qualify for the eligible individual health  
18 coverage credit provided herein. Nothing in this section  
19 shall prohibit employers from making additional health  
20 benefits available to an eligible individual at the  
21 employer's or eligible individual's expense.

22 (d) The credit allowed by this section shall be in lieu  
23 of any deduction to which the taxpayer otherwise may be  
24 entitled for expenses on which a credit under this section  
25 is claimed.

26 (e) If the credit allowed under this section exceeds the  
27 "net tax" for the taxable year, that portion of the credit  
28 which exceeds the "net tax" may be carried over to the  
29 "net tax" in succeeding taxable years until the credit is  
30 used. The credit shall be applied first to the earliest  
31 taxable years possible.

32 (f) Any amount of expenses paid by an employer  
33 under this section shall not be included as income to the  
34 eligible individual for purposes of the Personal Income  
35 Tax Law. If those expenses have been included in  
36 arriving at federal adjusted gross income of the eligible  
37 individual, the amount included shall be subtracted in  
38 arriving at state adjusted gross income. As used in Section  
39 17071 with respect to the eligible individual,  
40 "compensation for services" does not include expenses

1 paid under this section.

2 (g) With the exception of a husband and wife, if two  
3 or more taxpayers share in the expenses eligible for the  
4 credit provided by this section, each taxpayer shall be  
5 eligible to receive the tax credit in proportion to his or  
6 her respective share of the expenses paid or incurred. In  
7 the case of a partnership, the tax credit may be divided  
8 between the partners pursuant to a written partnership  
9 agreement in accordance with Chapter 10 (commencing  
10 with Section 17851), which includes Section 704 of the  
11 Internal Revenue Code concerning substantial economic  
12 effect, relating to partner's distributive share. In the case  
13 of a husband or wife who files a separate return, the  
14 credit may be taken by either or equally divided between  
15 them.

16 (h) For purposes of this section:

17 (1) "Eligible employer" means a taxpayer which  
18 employs on the average during the taxable year no more  
19 than 25 employees including owner-operators and which  
20 makes the minimum contribution required by this  
21 section on behalf of an eligible individual. An "eligible  
22 employer" is not a taxpayer who liquidates the assets of  
23 or dissolves the organization of a business, for tax  
24 purposes only, in anticipation of becoming eligible for the  
25 credit allowed under this section and then subsequently  
26 reorganizes the business.

27 (2) "Eligible individual" means an individual who, on  
28 a form prescribed by the Franchise Tax Board and  
29 retained by the qualified employer, certifies that he or  
30 she is a resident of California (within the meaning of  
31 Section 17014), and who:

32 (A) Performs services for an eligible employer for an  
33 average of at least 35 hours per week for remuneration,  
34 or

35 (B) Performs services for an eligible employer for less  
36 than 35 hours per week for remuneration, if the eligible  
37 employer provides health coverage for that individual  
38 and meets all other requirements for the credit under  
39 this section, or

40 (C) As owner-operator or a managing partner,

1 provides at least an average of 35 hours per week in  
2 personal services to the business for which health  
3 coverage is contracted.

4 (3) "Health coverage" means health coverage that, at  
5 a minimum, includes basic health care services for illness  
6 or injury provided by a private insurance company  
7 holding a valid outstanding certificate of authority from  
8 the Insurance Commissioner, a nonprofit hospital service  
9 plan qualifying under Chapter 11A (commencing with  
10 Section 11491) of Part 2 of Division 2 of the Insurance  
11 Code, or a health care service plan as defined under  
12 subdivision (f) of Section 1345 of the Health and Safety  
13 Code, which is lawfully engaged in providing, arranging,  
14 paying for, or reimbursing the cost of personal health  
15 services under insurance policies or contracts, medical  
16 and hospital service agreements, membership contracts,  
17 in consideration of premiums or other periodic charges  
18 payable to it. "Health coverage" may include provisions  
19 for cost sharing if the total cost sharing does not exceed  
20 200 percent of the annual premium, and no copayment  
21 exceeds 50 percent of the cost of a covered service.

22 (4) "Basic health care services" means the services  
23 defined in subdivision (b) of Section 1345 of the Health  
24 and Safety Code, or those benefits and provisions as may  
25 be required of employers in this state by the enactment  
26 of Assembly Bill 350 of the 1989-90 Regular Session, or all  
27 of the following benefits:

28 (A) Inpatient and outpatient hospital services,  
29 including inpatient care for a period of at least 120 days  
30 of confinement in each calendar year and ancillary  
31 services.

32 (B) Inpatient and outpatient physician services.

33 (C) Diagnostic and screening tests.

34 (5) "Dependent" means any person who qualifies as a  
35 dependent of the eligible individual for purposes of a  
36 health care service plan certified to qualify for the credit  
37 allowed under this section.

38 (6) "Supplemental benefits" means:

39 (A) Prenatal and well-baby care which meets  
40 guidelines established by the American Academy of

1 Pediatrics.

2 (B) Mental health benefits consisting of at least:

3 (i) Inpatient hospital care for a mental disorder for not  
4 less than 45 days per year.

5 (ii) Outpatient psychotherapy and counseling for a  
6 mental disorder for not less than 20 visits per year.

7 (i) An eligible employer shall be entitled to an  
8 additional five dollar (\$5) tax credit per month per  
9 covered employee for each of the two supplemental  
10 benefits.

11 (j) The Department of Corporations shall forward to  
12 the Franchise Tax Board at least annually, or more  
13 frequently upon request, a list of all health care services  
14 plans licensed under Section 1353 of the Health and  
15 Safety Code which are required to provide the basic  
16 health care services defined in subdivision (b) of Section  
17 1345 of the Health and Safety Code. The Department of  
18 Insurance shall forward to the Franchise Tax Board at  
19 least annually, or more frequently upon request, a list of  
20 all insurers authorized to transact disability insurance in  
21 this state and nonprofit hospital service plan corporations  
22 holding the certificate of authority required by Section  
23 11504 of the Insurance Code.

24 (k) To be eligible for the credit under this section,  
25 each disability insurance policy, health care service plan  
26 contract, or nonprofit hospital service plan contract shall  
27 be certified as providing the basic health care services  
28 described in paragraph (4) of subdivision (h), and, if  
29 applicable, either or both of the supplemental benefits of  
30 paragraph (6) of subdivision (h), by legal opinion of the  
31 plan's counsel, a copy of which shall be provided to each  
32 eligible employer to be retained for submission to the  
33 Franchise Tax Board upon request.

34 ~~(l) If the Tucker Health Insurance Act of 1989 does~~  
35 ~~not become operative on or before January 1, 1993, then~~  
36 ~~this section shall remain in effect only until January 1,~~  
37 ~~1993, and as of that date is repealed.~~

38 *(l) Subdivisions (a) to (k), inclusive, shall become*  
39 *operative on the date that the Tucker Health Insurance*  
40 *Act of 1989 becomes operative.*

1 SEC. 2. Section 23615 of the Revenue and Taxation  
2 Code is amended to read:

3 23615. (a) There shall be allowed as a credit against  
4 the tax (as defined by Section 23036), an amount equal to  
5 the amount determined in subdivision (b) for payments  
6 made by an eligible employer to provide health coverage  
7 for an eligible individual and that individual's dependent.

8 (b) The amount of the credit allowed by subdivision  
9 (a) shall be twenty-five dollars (\$25) per month per  
10 covered individual or 25 percent of the total amount paid  
11 or incurred per month for such health coverage by the  
12 employer during the taxable year, whichever is more,  
13 plus twenty-five dollars (\$25) per month or 25 percent of  
14 the total amount paid or incurred per month per covered  
15 individual's dependent or dependents.

16 (c) To qualify for the credit provided in subdivision  
17 (b), an eligible employer must pay or incur at least 75  
18 percent of the monthly premium for health coverage for  
19 eligible individuals who elect to have that coverage  
20 and/or at least 75 percent per month towards health  
21 coverage for an eligible individual's dependent or  
22 dependents and for which the individual does not pay  
23 more than 25 percent. At least annually, the employer  
24 shall make participation available to all eligible  
25 individuals and to all newly hired individuals within 60  
26 days of the date of employment. Nothing in this section  
27 shall require an eligible employer to pay for dependent  
28 health coverage in order to qualify for the eligible  
29 individual health coverage credit provided herein.  
30 Nothing in this section shall prohibit employers from  
31 making additional health benefits available to an eligible  
32 individual at the employer's or eligible individual's  
33 expense.

34 (d) The credit allowed by this section shall be in lieu  
35 of any deduction to which the taxpayer otherwise may be  
36 entitled for expenses on which a credit under this section  
37 is claimed.

38 (e) If two or more taxpayers share in the expenses  
39 eligible for the credit provided by this section, each  
40 taxpayer shall be eligible to receive the tax credit in

1 proportion to its respective share of the expenses paid or  
2 incurred.

3 (f) If the credit allowed under this section exceeds the  
4 taxes imposed by this part (except the minimum  
5 franchise tax and the alternative minimum tax) for the  
6 income year, that portion of the credit which exceeds  
7 those taxes may be carried over to the tax (as defined by  
8 Section 23036) in succeeding income years until the  
9 credit is used. The credit shall be applied first to the  
10 earliest income years possible.

11 (g) Any amount of expenses paid by an employer  
12 under this section shall not be included as income to the  
13 eligible individual for purposes of the Personal Income  
14 Tax Law. If those expenses have been included in  
15 arriving at federal taxable income of the eligible  
16 individual, the amount included shall be subtracted in  
17 arriving at state taxable income. As used in Section 17071  
18 with respect to the eligible individual, "compensation for  
19 services" does not include expenses paid under this  
20 section.

21 (h) For purposes of this section:

22 (1) "Eligible employer" means a taxpayer which  
23 employs on the average during the income year no more  
24 than 25 employees including owner-operators and which  
25 makes the minimum contribution required by this  
26 section on behalf of an eligible individual. An "eligible  
27 employer" is not a taxpayer who liquidates the assets of  
28 or dissolves the organization of a business, for tax  
29 purposes only, in anticipation of becoming eligible for the  
30 credit allowed under this section and then subsequently  
31 reorganizes the business.

32 (2) "Eligible individual" means an individual who, on  
33 a form prescribed by the Franchise Tax Board and  
34 retained by the qualified employer, certifies that he or  
35 she is a resident of California (within the meaning of  
36 Section 17014), and who:

37 (A) Performs services for an eligible employer for an  
38 average of at least 35 hours per week for remuneration,  
39 or

40 (B) Performs services for an eligible employer for less

1 than 35 hours if the eligible employer provides health  
2 coverage for that individual and meets all other  
3 requirements for the credit under this section, or

4 (C) As an owner-operator or shareholder, provides at  
5 least an average of 35 hours per week in personal services  
6 to the business for which health coverage is contracted.

7 (3) "Health coverage" means health coverage that at  
8 a minimum, includes basic health care services for illness  
9 or injury provided by a private insurance company  
10 holding a valid outstanding certificate of authority from  
11 the Insurance Commissioner, a nonprofit hospital service  
12 plan qualifying under Chapter 11A (commencing with  
13 Section 11491) of Part 2 of Division 2 of the Insurance  
14 Code, or a health care service plan as defined under  
15 subdivision (f) of Section 1345 of the Health and Safety  
16 Code, which is lawfully engaged in providing, arranging,  
17 paying for, or reimbursing the cost of personal health  
18 services under insurance policies or contracts, medical or  
19 hospital service agreements, or membership contracts in  
20 consideration of premiums or other periodic charges  
21 payable to it. "Health coverage" may include provisions  
22 for cost sharing if the total cost sharing does not exceed  
23 200 percent of the annual premium, and no copayment  
24 exceeds 50 percent of the cost of a covered service.

25 (4) "Basic health care services" means the services  
26 defined in subdivision (b) of Section 1345 of the Health  
27 and Safety Code, or those benefits and provisions as may  
28 be required of employers in this state by the enactment  
29 of Assembly Bill 350 of the 1989-90 Regular Session, or all  
30 of the following benefits:

31 (A) Inpatient and outpatient hospital services,  
32 including inpatient care for a period of at least 120 days  
33 of confinement in each calendar year and ancillary  
34 services.

35 (B) Inpatient and outpatient physician services.

36 (C) Diagnostic and screening tests.

37 (5) "Dependent" means any person who qualifies as a  
38 dependent of the eligible individual for purposes of a  
39 health care service plan certified to qualify for the credit  
40 allowed under this section.

AMENDED IN SENATE JULY 10, 1989  
AMENDED IN ASSEMBLY MAY 17, 1989  
AMENDED IN ASSEMBLY MARCH 28, 1989  
AMENDED IN ASSEMBLY MARCH 6, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 328**

**Introduced by Assembly Members Margolin and Hauser**

January 23, 1989

An act to add Chapter 9.5 (commencing with Section 18800) to Part 6 of Division 9 of the Welfare and Institutions Code, to add and repeal Section 2226.1 of the Labor Code, relating to health insurance care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 328, as amended, Margolin. Health insurance.

Existing law provides basic health care to certain qualified low-income persons pursuant to the Medi-Cal program, which is administered by the State Department of Health Services.

This bill would establish the California Health Plan Commission, with 12 members, appointed by the Speaker of the Assembly, the President pro Tempore of the Senate, and the Governor, and would authorize it to establish a system of subsidized basic health insurance, including self-insurance if the commission determines it is cost-effective, to be available to persons with no other available health insurance or health coverage. It would state the Legislature's intent that the subsidized health insurance would be funded through premiums, as determined by the California Health Plan

Commission, and the imposition of various taxes, as specified, and allocations from other state funds.

The bill would prohibit any rate increase in health insurance ~~or health coverage~~ provided by any entity doing business in the state unless it is approved by the Insurance Commissioner, and would provide procedures for the review of the proposed rate increases.

*The bill would also prohibit any increase in health coverage provided by any health care service plan provider doing business in the state unless it is approved by the Department of Corporations, and would provide procedures for the review of the proposed increases.*

*The bill would establish the California Health Plan Fund, which would be continuously appropriated for the purposes of the bill. Money in the fund would be derived from premiums, a gross payroll tax on employers, a payroll tax on certain employees, from an appropriation from money in the Cigarette and Tobacco Products Surtax Fund, a tax on certain self-employed persons, and from other specified sources. Taxes would be deposited into the California Health Plan Gross Payroll and Income Tax Fund, which would be established and continuously appropriated for refunds and credits, with the balance to be allocated to the California Health Plan Fund. The bill would impose a penalty on employers who cease to offer a basic health plan, but that provision would be repealed on January 1, 1997.*

Vote: ~~majority~~  $\frac{2}{3}$ . Appropriation: ~~no~~ yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. It is the intent of this act to provide basic  
2 minimum health coverage for all Californians.

3 SEC. 2. The Legislature finds and declares all of the  
4 following:

5 (a) All Californians have a right to affordable, and  
6 reasonably priced health care and to nondiscriminatory  
7 treatment by health insurers and providers.

8 (b) The uninsured population of California is over five  
9 million persons, and well over 80 percent of the

1 uninsured are working persons and their family  
2 members, primarily working in small businesses, the  
3 service industry, agriculture, fishing, and other jobs  
4 where health insurance is not provided and at wages  
5 which make it impracticable to purchase private health  
6 insurance, and that the number of persons with no health  
7 insurance is growing significantly.

8 (c) The lack of basic minimum health insurance for  
9 this population is causing the following very serious  
10 problems:

11 (1) Low and decreasing access to inpatient care,  
12 prenatal care, emergency care, and outpatient care.

13 (2) A greater incidence of fair to poor health, bed  
14 disability, and restricted activity days, birth defects and  
15 lifelong disabilities, uncontrolled diabetes and  
16 hypertension, and untreated chronic conditions.

17 (3) Increasing financial problems among those  
18 providers which continue to see a disproportionate share  
19 of persons without health coverage.

20 (4) Steadily increasing health insurance premiums for  
21 those decreasing numbers of payers who pay full charges  
22 for health services.

23 (5) Reliance on the government funded Medi-Cal and  
24 county health programs as catastrophic health insurer of  
25 last resort.

26 (d) Millions of Californians have inadequate health  
27 insurance which either does not protect them from the  
28 catastrophic health expenses accompanying serious  
29 illness, accident, or disabling condition or does not ensure  
30 financial access to basic health services. Many  
31 Californians are denied health coverage because of  
32 preexisting conditions.

33 (e) Small businesses employing low-wage workers,  
34 and self-employed persons experience severe financial  
35 disincentives to purchasing health insurance since the  
36 premiums for these plans are as much as 30 to 50 percent  
37 higher than premiums for health policies sold to large  
38 groups.

39 (f) The cost of health care has risen sharply in excess  
40 of all other components of the Consumer Price Index and

1 at a rate higher than any other industrialized country.  
2 The cost of health insurance has increased at a  
3 significantly greater rate than the costs of medical care.

4 (g) While the "competition experiment" in delivering  
5 health care has reduced the rate of increase in hospital  
6 and other providers' rates, fees, and charges; other  
7 problems in the delivery of basic health services persist  
8 or have been exacerbated:

9 (1) It has not increased the coverage of basic  
10 minimum health insurance at the workplace.

11 (2) It has not reduced the rate of increase in health  
12 care spending to the level of Consumer Price Index.

13 (3) It has reduced access to health care services for the  
14 uninsured and increased the financial difficulties of those  
15 institutions serving large numbers of the poor and the  
16 uninsured.

17 (4) The rate of capital spending on unnecessary and  
18 duplicative services has increased substantially;  
19 corrective actions are necessary to protect the public  
20 health and safety.

21 (h) State government through Medi/Cal, In/Home  
22 Supportive Services, and other state or state and federal  
23 programs is the predominant purchaser of long-term care  
24 services to persons over 65 years of age paying for over  
25 half of all long-term care. Medicare and private  
26 insurance, pay for very little (approximately 3 percent)  
27 of long-term care services.

28 (i) Elderly individuals, spouses, and children are the  
29 second largest purchasers of long-term care services  
30 paying for almost half of all long-term care, directly  
31 out/of/pocket.

32 (j) Persons over 65 years of age use almost 90 percent  
33 of all long-term institutional services in California.

34 (k) The state programs covering long-term care  
35 require elderly persons seeking state financial assistance  
36 for long-term care services to impoverish themselves and  
37 to a significant degree their spouses.

38 (l) The annual costs of long-term care in a nursing  
39 home typically exceed twenty thousand dollars (\$20,000)  
40 per individual.

1     (m) The recently enacted catastrophic coverage  
2 under Medicare will finance very little of the long-term  
3 care needs of California's seniors. The catastrophic health  
4 expenses associated with long-term care affect 3 percent  
5 of persons over 65 years of age.

6     (n) Over the next 30 years, the numbers of  
7 Californians over 65 years of age who are at risk for the  
8 catastrophic expenses of long-term care and the need for  
9 long-term care services are projected to increase at over  
10 twice the rate of the overall population.

11     SEC. 3. (a) It is the intent of the Legislature to hold  
12 the increases in individual and group health insurance  
13 and health coverage to no more than the increase in the  
14 cost of living.

15     (b) It is the intent of the Legislature to protect the  
16 public from deceptive practices, unfair pricing, abuse,  
17 fraud, and substandard quality in the coverage of health  
18 care costs by health insurers and in the delivery of health  
19 care services by health care providers.

20     (c) It is the intent of the Legislature to accomplish all  
21 of the following:

22     (1) Provide basic health insurance coverage to the  
23 uninsured comparable and equivalent to the benefits  
24 offered by the average group employer.

25     (2) Implement those measures in a cost-effective and  
26 administratively streamlined fashion.

27     (3) Preserve and expand the capacity of existing  
28 public and private systems to deliver care to the  
29 uninsured.

30     SEC. 4. Chapter 9.5 (commencing with Section  
31 18800) is added to Part 6 of Division 9 of the Welfare and  
32 Institutions Code, to read:

33  
34                   CHAPTER 9.5. HEALTH INSURANCE

35  
36                           Article 1. General

37  
38     18800. Unless the context requires otherwise, the  
39 definitions set forth in this article govern the construction  
40 of this chapter.

1 18800.1. "Commission" means the California Health  
2 Plan Commission.

3 18800.2. "Department" means the State Department  
4 of Health Services.

5 18800.3. "Other available health coverage" means  
6 insurance available at the place of employment;  
7 Medi-Cal, except as provided pursuant to this chapter;  
8 Medicare; other state and federal health care coverage;  
9 and individually purchased health insurance policies.

10 18800.4. "Employee" means an individual described  
11 in Article 1.5 (commencing with Section 621) of Chapter  
12 3 of Part 1 of Division 1 of the Unemployment Insurance  
13 Code.

14 18800.5. "Employer" means an individual described  
15 in Article 3 (commencing with Section 675) of Chapter  
16 3 of Part 1 of Division 1 of the Unemployment Insurance  
17 Code.

18

19 Article 2. Basic Health Care

20

21 SEC. 4. Part 8.5 (commencing with Section 2100) is  
22 added to Division 2 of the Labor Code, to read:

23

24 PART 8.5. HEALTH INSURANCE

25

26 CHAPTER 1. GENERAL

27

28 2100. Unless the context requires otherwise, the  
29 definitions set forth in this chapter govern the  
30 construction of this division.

31 2102. "Administering agency" means the Franchise  
32 Tax Board, and, if the Franchise Tax Board has  
33 contracted with the Employment Development  
34 Department for the enforcement of the tax on gross  
35 payrolls, with respect to provisions relating to those taxes,  
36 it means the Employment Development Department.

37 2103. "Commission" means the California Health  
38 Plan Commission.

39 2104. "Department" means the State Department of  
40 Health Services.

1     2105. “Dependent” means the spouse or child of the  
2 employee.

3     2106. “Employee” means an individual described in  
4 Article 1.5 (commencing with Section 621) of Chapter 3  
5 of Part 1 of Division 1 of the Unemployment Insurance  
6 Code.

7     2107. “Employer” means an individual described in  
8 Article 3 (commencing with Section 675) of Chapter 3 of  
9 Part 1 of Division 1 of the Unemployment Insurance  
10 Code.

11     2108. “Fund” means the California Health Plan Fund.

12     2109. “Health benefits plan” means health insurance  
13 or other health coverage on a group plan, or both, which  
14 provides benefits equal to those provided pursuant to  
15 Article 2 (commencing with Section 2120).

16     2110. “Other available health coverage” means  
17 insurance available at the place of employment;  
18 Medi-Cal, except as provided pursuant to this chapter;  
19 Medicare, other state and federal health care coverage;  
20 and individually purchased health insurance policies.

21     2111. “Taxable gross payroll” means that portion of an  
22 employer’s gross payroll attributable to those employees  
23 who are not offered a health benefits plan.

24

25                   CHAPTER 2. BASIC HEALTH CARE

26

27     ~~18810.~~

28     2120. (a) There is in the state government, the  
29 California Health Plan Commission, which shall be an  
30 independent authority.

31     (b) Membership of the commission shall include all of  
32 the following:

33     (1) Six persons appointed by the Governor, for  
34 staggered six-year terms, as follows:

35     (A) One person who shall represent businesses with 50  
36 or more employees.

37     (B) One person who shall represent county  
38 governments.

39     (C) One person who shall represent health care  
40 providers.

1 (D) Three persons with no direct connection with the  
2 health care industry.

3 (2) Three persons appointed by the Speaker of the  
4 Assembly, for staggered six-year terms, as follows:

5 (A) One person who shall represent businesses with  
6 fewer than 50 employees.

7 (B) One person who shall represent health care  
8 service plans.

9 (C) One person who shall represent health care  
10 providers.

11 (3) Three persons appointed by the President pro  
12 Tempore of the Senate, for staggered six-year terms, as  
13 follows:

14 (A) One person who shall represent employee  
15 organizations.

16 (B) One person who shall represent health care  
17 insurers.

18 (C) One person who shall represent health care  
19 providers.

20 (c) At least 50 percent of the membership of the  
21 commission shall be persons with no direct connection to  
22 the health industry.

23 ~~18811.~~

24 2121. California residents with no other available  
25 health insurance or coverage are eligible for basic health  
26 insurance under the plan established by this chapter for  
27 themselves and their dependents.

28 ~~18812.~~

29 2122. Small businesses, self-employed persons, and  
30 partnerships with less than 50 employees may purchase  
31 basic health insurance through the commission for their  
32 employees and dependents.

33 ~~18813.~~

34 2123. (a) The commission shall provide basic health  
35 coverage to persons receiving unemployment insurance  
36 benefits either by exercising the continuation options for  
37 employee's group health coverage or by purchasing or  
38 providing basic minimum health coverage.

39 (b) Basic health insurance provided pursuant to this  
40 article shall include all of the following:

- 1 (1) Inpatient and outpatient hospital care.
- 2 (2) Professional services as determined by the
- 3 commission.
- 4 (3) Preventive services.
- 5 (4) Children's dental care.
- 6 (5) Prescription drugs.
- 7 (6) X-ray services.
- 8 (7) Laboratory services.
- 9 (8) Other services comparable to the benefits offered
- 10 by the average group employer.

11 (c) The plan shall also include other less expensive  
12 alternatives to the basic services specified in subdivision  
13 (b) which the commission determines can be provided at  
14 lower cost through a cost-controlled system.

15 ~~18814.~~

16 2124. The commission may fulfill any of its  
17 responsibilities by hiring staff or contracting with any  
18 qualified third parties as it shall determine.

19 ~~18815.~~

20 2125. The costs of the premium for basic minimum  
21 health coverage shall be as determined by the  
22 commission and shall be no higher than the premiums for  
23 state employees for comparable coverage.

24 ~~18816.~~

25 2126. (a) The commission shall, wherever possible,  
26 contract for delivery of health care at negotiated  
27 amounts.

28 (b) The commission shall give preference in  
29 contracting to plans which offer subscribers the broadest  
30 choice of and access to doctors, dentists, and pharmacies.  
31 *best possible health care at the lowest possible cost.*

32 (c) Health maintenance organizations, prepaid health  
33 plans, independent practice associations, county  
34 organized health systems, and other qualified health  
35 systems under the Knox-Keene Act (Chapter 2.2  
36 (commencing with Section 1340) of Division 2 of the  
37 Health and Safety Code), prudent purchaser  
38 organizations, and other health insurance plans certified  
39 by the Department of Insurance or Department of  
40 Corporations may bid for contracts with the commission.

1 (d) In areas where there are no qualified plans, the  
2 commission may contract for care with local medical  
3 societies, hospitals, counties, or community clinics or  
4 make such other alternative arrangements for basic  
5 health coverage as it finds feasible.

6 (e) The commission may provide for self-insurance  
7 where it determines it is cost-effective.

8 ~~18817.~~

9 2127. The commission shall give priority in  
10 contracting to those plans which have established  
11 methods for preventing and controlling overutilization of  
12 services including utilization review, case management,  
13 and small area analysis, which emphasize delivery of  
14 preventive and primary care services through  
15 appropriate rate structures and service delivery, and  
16 which have established reimbursement structures, and  
17 delivery mechanisms which minimize the duplication of  
18 costly specialized medical services *and which minimize*  
19 *financial out-of-pocket expenses for covered medical*  
20 *services to persons with limited capacity to pay for*  
21 *medical care.*

22 ~~18818.~~

23 2128. (a) Where possible, the commission shall offer  
24 a choice of at least three alternative plans. The  
25 commission shall provide each eligible person with a fair  
26 and accurate summary of the alternative plans. The  
27 commission shall also prescreen for accuracy and  
28 completeness the marketing and advertising materials of  
29 all participating plans.

30 (b) Plans shall be actuarially sound, self-supporting,  
31 and at risk.

32 (c) Plans which contract with the commission shall not  
33 charge subscribers for any additional premiums for the  
34 basic coverage of this chapter. ~~Providers participating in~~  
35 ~~a plan shall accept the payment from the plan as payment~~  
36 ~~in full.~~

37 (d) *All services covered under a contracting plan shall*  
38 *be readily available and reasonably accessible to all*  
39 *enrollees.*

40 ~~18819.~~

1 2129. Plans which contract with the commission shall  
2 have open enrollment for persons eligible under the plan,  
3 may not impose waiting periods, and may not deny  
4 coverage or participation based upon the medical or  
5 demographic characteristics of the subscriber.

6 ~~18820.~~

7 2130. The commission shall develop and implement  
8 with the assistance of the Departments of Corporations,  
9 Health Services, and Insurance a mechanism for  
10 monitoring the quality and accessibility of the plans.

11 ~~18821.~~

12 2131. The commission may, for cause and after notice  
13 and hearing, declare that a provider is outside the plan,  
14 and the provider shall not be reimbursed by any  
15 participating plan for services provided after the  
16 determination except emergency services, as  
17 determined by the commission.

18 ~~18822.~~

19 2132. Each participating plan shall have a grievance  
20 resolution procedure approved by the commission and an  
21 advisory committee on the quality and accessibility of  
22 care and comprised of subscriber representatives.

23 ~~18823.~~

24 2133. (a) Financing and expenditures for the costs of  
25 the program shall be outside the limits of Article XIII B  
26 of the Constitution and shall be deposited and expended  
27 from a special trust fund devoted exclusively to the  
28 purposes of this program.

29 (b) It is the intent of the Legislature that the revenues  
30 necessary to pay for the program shall be provided as  
31 follows:

32 ~~(1) A gross payroll tax on all employers equal to the~~  
33 ~~average percentage expenditure from gross payroll of all~~  
34 ~~employers on health insurance or coverage for their~~  
35 ~~employees and dependents. Employers shall receive~~  
36 ~~credit against this tax for the amount of their current~~  
37 ~~payroll spending on health insurance or health coverage~~  
38 ~~for their employees and dependents.~~

39 ~~(A) Every new small business employer's gross payroll~~  
40 ~~tax shall be calculated at the following rates:~~

1 (i) During the first year following the employer's  
2 commencement of business, 30 percent of the full rate.

3 (ii) During the second year following the employer's  
4 commencement of business, 60 percent of the full rate.

5 (iii) During the third year following the employer's  
6 commencement of business, 90 percent of the full rate.

7 (B) Every small business employer with eight  
8 employees or less, and with an average annual employee  
9 salary of \$12,000 or less, shall be subject to the gross  
10 payroll tax at the following rates:

11 (i) During the first year of operation of the plan, 50  
12 percent of the full rate.

13 (ii) During the second year of operation of the plan, 75  
14 percent of the full rate.

15 (iii) During the third year of operation of the plan, 100  
16 percent of the full rate.

17 (1) *The gross payroll tax imposed pursuant to Chapter*  
18 *5 (commencing with Section 2715)*

19 (2) The allocation of seventy percent of the revenues  
20 generated by the imposition of taxes pursuant to Article  
21 2 (commencing with Section 30121) of Chapter 2 of Part  
22 13 of Division 2 of the Revenue and Taxation Code. These  
23 funds shall be spent only on hospital and physician  
24 services.

25 (3) An amount equal to the 1988-89 General Fund  
26 spending on the Medically Indigent Services Program  
27 adjusted annually by the percentage increase in the  
28 California Necessities Index.

29 (4) An unemployment health insurance tax calculated  
30 in an amount sufficient to provide basic minimum health  
31 coverage for individuals or families with no health  
32 insurance who receive unemployment insurance.

33 18823.5. (a) Any employer with 50 or more  
34 employees, and who, after January 1, 1990, without good  
35 cause ceases to offer a health benefits plan and does not,  
36 within 30 days thereof, offer a health benefits plan which  
37 meets the minimum requirements of Section 18840, shall  
38 pay a penalty in an amount equal to 50 percent of the  
39 amount of gross payroll tax imposed pursuant to  
40 paragraph (1) of subdivision (b) of Section 18823, for a

1 period of three years following the date of termination of  
2 the plan.

3 ~~(b) This section shall remain in effect only until~~  
4 ~~January 1, 1997, and as of that date is repealed, unless a~~  
5 ~~later enacted statute, which is enacted before January 1,~~  
6 ~~1997, deletes or extends that date.~~

7 ~~18824.~~

8 2134. (a) A health insurance premium shall be  
9 withheld from all persons not covered by health  
10 insurance at their place of employment covering 25  
11 percent of the cost of the basic minimum health  
12 coverage. For persons with incomes below 300 percent of  
13 the federal poverty level, the premium shall be on a  
14 sliding fee scale as determined by the commission.

15 (b) (1) If the necessary federal waivers are secured,  
16 the federal and state contributions for Medi-Cal  
17 medically needy coverage for care and services to  
18 families who shall be eligible for and receive coverage  
19 under this plan shall be applied to the plan.

20 (2) If the necessary federal waivers are secured,  
21 federal and state contributions for all Medi-Cal families  
22 who shall be eligible for and receive coverage under this  
23 plan shall be applied to the plan.

24 (3) The Director of Health Services shall seek the  
25 appropriate federal waivers.

26 ~~18825.~~

27 2135. The Legislative Analyst shall study and report  
28 to the Legislature by July 1, 1990, on both of the following:

29 (a) The average expenditure from gross payroll of  
30 employers to provide health insurance or health  
31 coverage for their employees and dependents.

32 (b) The amount of health unemployment insurance  
33 tax necessary to provide basic minimum health coverage  
34 for individuals with no health insurance who receive  
35 unemployment insurance.

36 ~~18826.~~

37 2136. Funding from existing programs and revenue  
38 streams shall be phased into this program with the  
39 minimum feasible disruption in existing programs and  
40 services. No revenues designated to the plan may be used

1 for any other governmental purpose.

2 ~~18827.~~

3 2137. The plan shall begin July 1, 1992, and the  
4 commission may phase in its operation if it deems this  
5 appropriate.

6  
7 **Article 3. Regulation of Health Insurance and**  
8 **Delivery of Health Care**

9  
10 **CHAPTER 3. REGULATION OF HEALTH INSURANCE**

11  
12 ~~18830.~~

13 2150. (a) It is the intent of the Legislature to reduce  
14 the rate of inflation in medical care and services to a rate  
15 no higher than the Consumer Price Index for all  
16 commodities.

17 (b) It is the intent of the Legislature to prevent unfair  
18 and deceptive business and trade practice among entities  
19 providing health insurance or health coverage resulting  
20 in adverse selection, and severe financial difficulties for  
21 the plans and their subscribers.

22 ~~18831.~~

23 2151. (a) No rate increase in health insurance or  
24 ~~health coverage~~ provided by any entity doing business in  
25 the State of California shall take effect unless it is  
26 approved by the Insurance Commissioner. The  
27 Insurance Commissioner may determine that annualized  
28 increases below the Consumer Price Index shall not be  
29 reviewed.

30 (b) A rate increase shall be deemed approved 90 days  
31 after public notice to the Insurance Commissioner unless  
32 the Insurance Commissioner decides within that time  
33 period to hold a hearing.

34 (c) Any request for a rate increase in excess of the  
35 Consumer Price Index shall be ~~deemed~~ *presumed* to be  
36 excessive and unfairly discriminatory and the burden of  
37 proof of justifying that increase shall be on the entity  
38 seeking it.

39 ~~18832.~~

40 2152. (a) No insurer shall charge a rate that is

1 excessive, inadequate, or unfairly discriminatory, or  
2 otherwise in violation of this chapter. The Insurance  
3 Commissioner shall consider whether that rate reflects  
4 the insurance company's investment income.

5 (b) Any proposals to increase rates above the  
6 Consumer Price Index shall be filed no later than 90 days  
7 before the proposed effective date of the increase and  
8 shall not be imposed without the prior approval of the  
9 Insurance Commissioner.

10 (c) Every proposal filed pursuant to subdivision (b)  
11 shall be accompanied by sufficient supporting data to  
12 establish that the rates are not excessive, inadequate, or  
13 unfairly discriminatory.

14 (d) A hearing shall be scheduled no later than 60 days  
15 after public notice of the hearing except where extended  
16 for good cause. A written decision shall be issued  
17 promptly upon completion of a hearing. The decision  
18 shall be solely on the basis of the record, approving or  
19 disapproving the filing, in whole or in part. No portion of  
20 a filing shall be approved unless its rates are neither  
21 excessive, inadequate, nor unfairly discriminatory. A  
22 decision shall be adopted, amended or rejected only  
23 under subdivisions (c) and (e) of Section 11517 of the  
24 Government Code and solely on the basis of the record.

25 ~~18833.~~

26 *2153.* Every insurer shall file with the Insurance  
27 Commissioner its health insurance rating plan and all  
28 amendments thereto. The plan shall include, but not be  
29 limited to, rate schedules, and the coverage of each  
30 health plan.

31 ~~18834.~~

32 *2154.* Whenever the Insurance Commissioner holds a  
33 hearing, the hearing shall be conducted in accordance  
34 with the following:

35 (a) Reasonable public notice shall be given of the  
36 purpose and nature of the hearing and the opportunity  
37 for public participation.

38 (b) All parties shall be provided with a reasonable  
39 opportunity to present their views.

40 (c) Oral evidence shall be only on oath or affirmation.

1 (d) An administrative record shall be compiled,  
2 containing all evidence upon which the decision is based,  
3 all admissible evidence offered by any party, all  
4 documents required by law to be filed with regard to the  
5 subject of the hearing, and all comments made by any  
6 person.

7 ~~18835.~~

8 2155. Any information provided to the Insurance  
9 Commissioner pursuant to this article shall be available  
10 for public inspection and shall not be subject to  
11 subdivision (d) of Section 6254 of the Government Code  
12 and Section 1857.9 of the Insurance Code.

13 ~~18836.~~

14 2156. (a) Any entity which purchases health  
15 insurance or health coverage or a plan subscriber of the  
16 entity seeking a rate increase, or his or her  
17 representative, may petition the commission to hold a  
18 hearing on a proposed rate increase.

19 (b) The Insurance Commissioner shall state, in  
20 writing, the reasons for holding a hearing or denying a  
21 petition for a hearing.

22 (c) Failure to file a petition shall not preclude any  
23 payer or subscriber from participating in any hearing if  
24 one is ordered.

25 ~~18837.~~

26 2157. The Insurance Commissioner shall have all  
27 powers necessary to carry out the purposes of this chapter  
28 including the authority to promulgate all necessary  
29 regulations.

30 ~~18838.~~

31 2158. The Insurance Commissioner may hold a  
32 hearing at any time, before or after a request for filing  
33 becomes effective, when it appears to him or her that the  
34 rates or practices specified in the filing are excessive,  
35 inadequate, or unfairly discriminatory.

36 ~~18839.~~

37 2159. The Insurance Commissioner may order any  
38 adjustment in rates necessary to prevent rates or  
39 practices from being excessive, inadequate, or unfairly  
40 discriminatory and may require the refund of any portion

1 of any premiums collected pursuant to an excessive or  
2 unfairly discriminatory rate.

3 ~~18840.~~

4 2160. Any entity offering or providing health  
5 coverage or insurance in the state shall provide a  
6 minimum basic benefit package covering the following  
7 services determined to be medically necessary:

8 (a) Hospital inpatient services and ambulatory care  
9 services.

10 (b) Professional services as defined in the Insurance  
11 Code.

12 (c) Diagnostic laboratory and diagnostic and  
13 therapeutic radiologic services.

14 (d) Preventive health services, including perinatal  
15 services and well-child services.

16 (e) Emergency services, including ambulance  
17 services and out-of-plan coverage.

18 (f) Prescription drugs.

19 (g) Children's dental care.

20 ~~18841.~~

21 2161. The Insurance Commissioner may disapprove  
22 any exclusion, reduction, or other limitations as to  
23 coverage, deductibles, or coinsurance provisions which  
24 have the direct or indirect effect of denying reasonable  
25 access to the health services covered under minimum  
26 basic benefit package.

27 ~~18842.~~

28 2162. Entities which offer health insurance or provide  
29 health coverage in the State of California shall have at  
30 least a 30 consecutive day open enrollment period  
31 annually, and may not deny coverage or participation  
32 based upon the medical or demographics characteristics  
33 of the subscriber.

34 ~~18843.~~

35 2163. In accordance with the Unruh Civil Rights Act,  
36 contained in Section 51 of the Civil Code, an insurer or  
37 provider of health coverage shall not arbitrarily  
38 discriminate against individuals in the setting of  
39 insurance rates or in the denial of insurance coverage.

40 ~~18844.~~

1 2164. The Insurance Commissioner may disapprove  
2 the use of any advertising or solicitation which is untrue,  
3 misleading, or deceptive.

4 ~~18845.~~

5 2165. The Insurance Commissioner shall not permit  
6 the use of any health insurance rating plan that  
7 discriminates on the basis of race, language, color,  
8 religion, ancestry, national origin, or health status.

9 ~~18846.~~

10 2166. The Insurance Commissioner may disapprove  
11 any marketing or advertising plan or plan of selective  
12 enrollments or terminations which is determined to be a  
13 deceptive or unfair business practice or have the effect of  
14 defrauding the public.

15 ~~18847.~~

16 2167. The Insurance Commissioner may disapprove  
17 the form and content of ~~contracts~~ *any contract* for health  
18 ~~services insurance~~ which are determined to be a  
19 deceptive or unfair business practice or have the effect of  
20 defrauding plan subscribers of medically necessary basic  
21 health services.

22 ~~18848.~~

23 2168. The Insurance Commissioner may examine  
24 policy forms used by insurers and may prohibit the use of  
25 any form found to be deceptive, misleading, or contrary  
26 to the public interest.

27 ~~18849.~~

28 2169. Hearings under this chapter shall be conducted  
29 pursuant to Sections 11500 to 11528, inclusive, of the  
30 Government Code.

31 ~~18850.~~

32 2170. (a) Judicial review of the commissioner's  
33 decision pursuant to this article shall be by petition for a  
34 writ of mandate.

35 (b) For purposes of judicial review:

36 (1) A decision to hold a hearing is not a final order or  
37 decision.

38 (2) A decision to hold a hearing is final.

39 ~~18851.~~

40 2171. The Office of Statewide Health Planning and

1 Development shall adopt guidelines governing  
2 unnecessary and duplicative capital spending on special  
3 services for inpatient hospital care.

4 ~~18852.~~

5 2172. (a) The department, the commission, and the  
6 Insurance Commissioner shall conduct small area analysis  
7 review of provider practice patterns in health plans  
8 under their jurisdiction, and shall publicize and  
9 disseminate the results of the review among consumers,  
10 subscribers, physicians, and hospitals.

11 (b) Plans subject to this chapter shall cooperate in  
12 furnishing data necessary for that analysis and review.

13

14 **CHAPTER 4. REGULATION OF HEALTH CARE**  
15 **DELIVERY**

16

17 2190. (a) *No rate increase in health coverage*  
18 *provided by any health care service plan doing business*  
19 *in the State of California shall take effect unless it is*  
20 *approved by the Department of Corporations. The*  
21 *Department of Corporations may determine that*  
22 *annualized increases below the Consumer Price Index*  
23 *shall not be reviewed.*

24 (b) *A rate increase shall be deemed approved 90 days*  
25 *after public notice to the Department of Corporations*  
26 *unless the Department of Corporations decides within*  
27 *that time period to hold a hearing.*

28 (c) *Any request for a rate increase in excess of the*  
29 *Consumer Price Index shall be presumed to be excessive*  
30 *and unfairly discriminatory and the burden of proof of*  
31 *justifying that increase shall be on the entity seeking it.*

32 2191. *Every health care service plan shall file with the*  
33 *Department of Corporations its health coverage plan and*  
34 *all amendments thereto. The plan shall include, but not*  
35 *be limited to, rate schedules, and the coverage of each*  
36 *health plan.*

37 2192. (a) *No health care service plan provider shall*  
38 *charge a rate that is excessive, inadequate, or unfairly*  
39 *discriminatory, or otherwise in violation of this chapter.*  
40 *The Department of Corporations shall consider whether*

1 that rate reflects the investment income of the health  
2 care service plan coverage provider.

3 (b) Any proposals to increase rates above the  
4 Consumer Price Index shall be filed no later than 90 days  
5 before the proposed effective date of the increase and  
6 shall not be imposed without the prior approval of the  
7 Department of Corporations.

8 (c) Every proposal filed pursuant to subdivision (b)  
9 shall be accompanied by sufficient supporting data to  
10 establish that the rates are not excessive, inadequate, or  
11 unfairly discriminatory.

12 (d) The Department of Corporations shall schedule a  
13 hearing no later than 60 days after public notice of the  
14 hearing except where extended for good cause. A written  
15 decision shall be issued promptly upon completion of a  
16 hearing. The decision shall be solely on the basis of the  
17 record, approving or disapproving the filing, in whole or  
18 in part. No portion of a filing shall be approved unless its  
19 rates are neither excessive, inadequate, nor unfairly  
20 discriminatory. A decision shall be adopted, amended, or  
21 rejected only under subdivisions (c) and (e) of Section  
22 11517 of the Government Code and solely on the basis of  
23 the record.

24 2193. Whenever the Department of Corporations  
25 holds a hearing, the hearing shall be conducted in  
26 accordance with the following:

27 (a) Reasonable public notice shall be given of the  
28 purpose and nature of the hearing and the opportunity  
29 for public participation.

30 (b) All parties shall be provided with a reasonable  
31 opportunity to present their views.

32 (c) Oral evidence shall be only on oath or affirmation.

33 (d) An administrative record shall be compiled,  
34 containing all evidence upon which the decision is based,  
35 all admissible evidence offered by any party, all  
36 documents required by law to be filed with regard to the  
37 subject of the hearing, and all comments made by any  
38 person.

39 2194. (a) Any entity which purchases health  
40 coverage or a plan subscriber of the health care service

1 plan seeking a rate increase, or his or her representative,  
2 may petition the commission to hold a hearing on a  
3 proposed rate increase.

4 (b) The Department of Corporations shall state, in  
5 writing, the reasons for holding a hearing or denying a  
6 petition for a hearing.

7 (c) Failure to file a petition shall not preclude any  
8 payer or subscriber from participating in any hearing if  
9 one is ordered.

10 2195. The Department of Corporations may hold a  
11 hearing at any time, before or after a request for filing  
12 becomes effective, when the Department of  
13 Corporations determines that the rates or practices  
14 specified in the filing are excessive, inadequate, or  
15 unfairly discriminatory.

16 2196. Hearings under this article shall be conducted  
17 pursuant to Sections 11500 to 11528, inclusive, of the  
18 Government Code.

19 2197. (a) Judicial review of a hearing decision  
20 pursuant to this article shall be by petition for a writ of  
21 mandate.

22 (b) For purposes of judicial review:

23 (1) A decision to hold a hearing is not a final order or  
24 decision.

25 (2) A decision to hold a hearing is final.

26 2198. The Department of Corporations may order  
27 any adjustment in rates necessary to prevent rates or  
28 practices from being excessive, inadequate, or unfairly  
29 discriminatory and may require the refund of any portion  
30 of any premiums collected pursuant to an excessive or  
31 unfairly discriminatory rate.

32 2199. Any health care service plan offering or  
33 providing health coverage in the state shall provide a  
34 minimum basic benefit package covering the following  
35 services determined to be medically necessary:

36 (a) Hospital inpatient services and ambulatory care  
37 services.

38 (b) Professional services as defined in the Insurance  
39 Code.

40 (c) Diagnostic laboratory and diagnostic and

1 therapeutic radiologic services.

2 (d) Preventive health services, including perinatal  
3 services and well-child services.

4 (e) Emergency services, including ambulance  
5 services and out-of-plan coverage.

6 (f) Prescription drugs.

7 (g) Children's dental care.

8 2200. The Department of Corporations may  
9 disapprove any exclusion on reduction, or any other  
10 limitation, as to coverage, deductibles, or coinsurance  
11 provisions which have the direct or indirect effect of  
12 denying reasonable access to the health services covered  
13 as minimum basic benefits, as specified in Section 18869.

14 2201. Any health care service plan which provides  
15 health coverage in the State of California shall have at  
16 least a 30 consecutive day open enrollment period  
17 annually, and may not deny coverage or participation  
18 based upon the medical or demographic characteristics  
19 of the subscriber.

20 2202. In accordance with the Unruh Civil Rights Act,  
21 contained in Section 51 of the Civil Code, a provider of  
22 health coverage shall not arbitrarily discriminate against  
23 individuals in the denial of health coverage.

24 2203. The Department of Corporations may  
25 disapprove the use of any advertising or solicitation  
26 which is untrue, misleading, or deceptive.

27 2204. The Department of Corporations shall not  
28 permit the use of any health care service plan that  
29 discriminates on the basis of race, language, color,  
30 religion, ancestry, national origin, or health status.

31 2205. The Department of Corporations may  
32 disapprove any marketing or advertising plan or plan of  
33 selective enrollments or terminations which is  
34 determined to be a deceptive or unfair business practice  
35 or have the effect of defrauding the public.

36 2206. The Department of Corporations may  
37 disapprove the form and content of any contract for  
38 health services which the department determines to be  
39 a deceptive or unfair business practice or have the effect  
40 of defrauding plan subscribers of medically necessary

1 *basic health services.*

2 2207. *The Department of Corporations may examine*  
3 *forms used by health coverage providers and may*  
4 *pronibit the use of any form found to be deceptive,*  
5 *misleading, or contrary to the public interest.*

6 2208. *(a) The department, the commission, and the*  
7 *Department of Corporations shall conduct small area*  
8 *analysis review of provider practice patterns in health*  
9 *plans under their jurisdiction, and shall publicize and*  
10 *disseminate the results of the review among consumers,*  
11 *subscribers, physicians, and hospitals.*

12 *(b) Providers of health coverage subject to this*  
13 *chapter shall cooperate in furnishing data necessary for*  
14 *that analysis and review.*

15 2209. *Any information provided to the Department of*  
16 *Corporations pursuant to this article shall be available for*  
17 *public inspection and shall not be subject to subdivision*  
18 *(e) of Section 6254 of the Government Code.*

19 2210. *The Department of Corporations shall have all*  
20 *powers necessary to carry out the purposes of this article*  
21 *including the authority to adopt all necessary regulations.*

22  
23 **CHAPTER 5. FISCAL PROVISIONS**

24  
25 **Article 1. General**

26  
27 2215. *(a) There is established the California Health*  
28 *Plan Fund.*

29 *(b) For purposes of this article, "fund" means the*  
30 *California Health Plan Fund.*

31 2216. *Notwithstanding Section 13340 of the*  
32 *Government Code, all money in the fund is continuously*  
33 *appropriated to the commission for the purposes of this*  
34 *division. Money in the fund shall be used exclusively for*  
35 *the purposes of this part. Appropriations from the fund*  
36 *shall not be included in the appropriations limit*  
37 *established by Article XIII B of the California*  
38 *Constitution.*

39 2217. *All premiums and other payments received by*  
40 *the commission shall be deposited in the fund.*

1  
2                   Article 2. Imposition of Tax  
3

4     2220. A tax is hereby imposed upon the payroll of  
5 each employer, at the rate of 8 percent of the gross  
6 payroll attributable to employees in this state who are not  
7 covered by a health benefits plan.

8     2221. A tax is hereby imposed on the taxable income  
9 of every self-employed individual who is not covered by  
10 a health benefits plan in the state at a rate which shall be  
11 calculated by multiplying by 86 percent the combined  
12 rate of tax imposed on the gross payroll of each employer  
13 in the state under this division plus the rate of tax  
14 imposed on the gross wages of each uninsured employee  
15 under this division.

16     2222. A tax is hereby imposed on the gross wages of  
17 each employee in this state who is not covered by a health  
18 benefits plan, at the rate of 2 percent of the employee's  
19 gross wages.

20     2223. A tax, at the rate of 2 percent, is hereby imposed  
21 on the taxable income, as determined pursuant to  
22 Chapter 1 (commencing with Section 17001) of Part 10 of  
23 Division 2 of the Revenue and Taxation Code, of every  
24 individual who is neither an employee nor employer and  
25 is not covered by a health benefits plan in this state.

26     2224. The maximum tax imposed pursuant to this  
27 article on any employee shall not exceed 25 percent of  
28 the average health insurance premium pursuant to this  
29 part.

30     2225. During its first three years of business, every  
31 small business employer's tax imposed under Section 2220  
32 shall be reduced to the following amounts:

33     (a) During the first year following commencement of  
34 business, 30 percent of the amount specified in Section  
35 2220.

36     (b) During the second year, 60 percent of the amount  
37 specified in Section 2220.

38     (c) During the third year, 90 percent of the amount  
39 specified in Section 2220.

40     2226. Every very small business employer with low

1 average salaries shall be phased into the plan during the  
2 first two years of the plan's operations by having the tax  
3 required under Section 2220, subject to the reduction  
4 under Section 2225 if applicable, reduced to the following  
5 amounts:

6 (a) During the first year of the plan's operation, 50  
7 percent of the amount otherwise due.

8 (b) During the second year of the plan's operation, 75  
9 percent of the amount otherwise due.

10 2226.1. (a) Any employer with 50 or more employees  
1 who, after January 1, 1990, without good cause, ceases to  
2 offer a health benefits plan and does not, within 30 days  
3 thereafter, offer a health benefits plan that meets the  
4 minimum requirements for a basic health plan shall pay  
5 a penalty on the tax imposed by Section 2203 in an  
6 amount equal to 50 percent of the tax otherwise due for  
7 the period in which the employer does not provide a  
8 basic health plan.

9 (b) This section shall remain in effect only until  
10 January 1, 1997, and as of that date is repealed, unless a  
11 later enacted statute, which is enacted before January 1,  
12 1997, deletes or extends that date.

13 2227. All money in the Hospital Service Account,  
14 Physician Service Account, and the Unallocated Account  
15 of the Cigarette and Tobacco Products Surtax Fund  
16 created by Section 30122 of the Revenue and Taxation  
17 Code is appropriated to the fund, provided, however,  
18 that if any portion of the funds received cannot be used  
19 for purposes consistent with the provisions of Section  
20 30122 of the Revenue and Taxation Code that are  
21 applicable to the money, the commission shall return the  
22 appropriation to the appropriate account of the Cigarette  
23 and Tobacco Products Surtax Fund.

24 2228. It is the intent of the Legislature that there shall  
25 be an annual appropriation from the General Fund to the  
26 fund in an amount equal to the 1988-89 General Fund  
27 spending on the Medically Indigent Services Program,  
28 increased annually by the percentage increase in the  
29 California Necessities Index.

30 2229. The commission and the State Department of

1 *Health Services shall seek federal approval for the*  
2 *inclusion of the Medi-Cal medically needy as participants*  
3 *in the plan, and the use of federal and state funds devoted*  
4 *to that program by the plan. If approval is received, it is*  
5 *the intent of the Legislature that money that would*  
6 *otherwise be spent on that program shall be used by the*  
7 *fund.*

8  
9 **Article 3. Exemptions and Adjustments**

10  
11 **2230.** *The gross wages of any employee whose*  
12 *adjusted gross income, as defined in Section 17052 of the*  
13 *Revenue and Taxation Code, does not exceed 100 percent*  
14 *of the federal poverty level for California, as determined*  
15 *by the United States Department of Commerce, are*  
16 *exempt from the tax imposed by this chapter.*

17  
18 **Article 4. Administration**

19  
20 **2235.** *The Franchise Tax Board may contract with the*  
21 *Employment Development Department for the*  
22 *collection of those taxes imposed on the gross payroll of*  
23 *employers and employees pursuant to Article 2*  
24 *(commencing with Section 2220).*

25  
26 **CHAPTER 6. PAYMENTS, RETURNS, AND ASSESSMENTS**

27  
28 **2240.** (a) *The tax imposed on gross payrolls by this*  
29 *division shall be paid on the 15th day of the second month*  
30 *following the month for which the taxable payroll is*  
31 *computed.*

32 (b) *All other taxes imposed under this division shall be*  
33 *paid on the same day that taxes are required to be paid*  
34 *under Part 10 (commencing with Section 17001) of*  
35 *Division 2 of the Revenue and Taxation Code.*

36 **2241.** *Any taxpayer subject to a tax on employer gross*  
37 *payrolls shall file with the administering agency a return*  
38 *of taxes on or before the 15th day of the month following*  
39 *the month for which the payroll is computed.*

40 **2242.** *Any other taxpayer subject to taxes under this*

1 division shall file with the administering agency a return  
2 of taxes at the same time the taxpayer is required to file  
3 a return of taxes under Part 10 (commencing with  
4 Section 17001) of Division 2 of the Revenue and Taxation  
5 Code.

6 2243. (a) All revenues collected pursuant to taxes  
7 imposed by this chapter shall be transferred to the  
8 California Health Plan Gross Payroll and Income Tax  
9 Fund, which is hereby established.

10 (b) All moneys in the fund created by subdivision (a)  
11 are hereby continuously appropriated, without regard to  
12 fiscal years, for the following purposes:

13 (1) For refunds and credits under this division.

14 (2) The balance shall be allocated to the California  
15 Health Plan Fund.

16 2244. The administering agency, in the enforcement  
17 of this division, shall, as soon as practicable after a return  
18 is filed under this division, examine it and determine the  
19 correct amount of the tax.

20 2245. If the administering agency determines that the  
21 tax disclosed by the original return is less than the tax  
22 disclosed by its examination, it shall mail a notice or  
23 notices to the taxpayer of the deficiency proposed to be  
24 assessed.

25 2246. Notwithstanding any provision to the contrary,  
26 any interest, penalty, or addition to any tax imposed  
27 under this division may be assessed and collected in the  
28 same manner as if it were a deficiency.

29 2247. Each notice shall set forth the reasons for the  
30 proposed additional assessment and the computation  
31 thereof.

32 2248. Within 60 days after the mailing of each notice  
33 of additional tax proposed to be assessed, the taxpayer  
34 may file with the administering agency a written protest  
35 against the proposed additional tax, specifying in the  
36 protest the grounds upon which it is based.

37 2249. If no protest is filed, the amount of the  
38 deficiency assessed becomes final upon the expiration of  
39 60 days.

40 2250. If a protest is filed, the administering agency

1 shall reconsider the assessment of the deficiency and, if  
2 the taxpayer has so requested in the protest, shall grant  
3 the taxpayer or the taxpayer's authorized representative  
4 or representatives an oral hearing. The administering  
5 agency may act upon the protest in whole or in part. If  
6 the administering agency acts on the protest in part only,  
7 the remaining protest shall continue to be under protest  
8 until the administering agency acts on that part.

9 2251. (a) The administering agency's action upon  
10 the protest, whether in whole or in part, is final upon the  
11 expiration of 30 days from the date when it mails notice  
12 of its action to the taxpayer, unless the taxpayer appeals  
13 in writing from the action to the State Board of  
14 Equalization.

15 (b) The appeal shall be addressed and mailed to the  
16 State Board of Equalization at Sacramento, California,  
17 and a copy of the appeal shall be addressed and mailed  
18 at the same time to the administering agency.

19 2252. The State Board of Equalization shall hear and  
20 determine the appeal and thereafter shall forthwith  
21 notify the taxpayer and the administering agency of its  
22 determination and the reasons therefor.

23 2253. The State Board of Equalization's  
24 determination becomes final upon the expiration of 30  
25 days from the time of the determination, unless within  
26 the 30-day period, the taxpayer or the administering  
27 agency files a petition for a rehearing with the State  
28 Board of Equalization. In that event, the determination  
29 becomes final upon the expiration of 30 days from the  
30 time the State Board of Equalization issues its opinion on  
31 the petition.

32 2254. When a deficiency is determined and the  
33 assessment becomes final, the administering agency shall  
34 mail notice and demand to the taxpayer for the payment  
35 thereof. The deficiency assessed is due and payable at the  
36 expiration of 10 days from the date of the notice and  
37 demand.

Article 7. Jeopardy Assessments

2255. If the administering agency finds that the assessment or collection of a tax or deficiency for any current taxable period, current or past, will be jeopardized in whole or in part by delay, it may mail or issue notice of its findings to the taxpayer, together with a demand for immediate payment of the tax or deficiency declared to be in jeopardy, including interest and penalties and additions thereto.

**CORRECTIONS**

Text—Pages 6, 14, and 23.