Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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October 2007
ASSEMBLY BILL  

No. 350

Introduced by Assembly Member Willie Brown

January 25, 1989

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


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.


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

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

   CHAPTER 2. EMPLOYEE HEALTH INSURANCE

   Article 1. Findings and Purposes

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

   2501. The Legislature hereby finds and declares as follows:

   (a) While a significant majority of Californians receive health insurance through their employers as a result of employment, fewer employers in California provide this coverage than the nationwide average.
(b) In the last 10 years, the total number of uninsured in California has grown by more than 25 percent as a result of decreased employer coverage, more restrictive public program eligibility, and a system of competitive health care pricing.

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

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

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

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

2502. It is the purpose of this chapter to ensure that nearly all employed persons in California are provided basic health care coverage. Further, it is intended that employer-sponsored health care programs offer employees coverage for dependents; the costs of which would be determined through employer-employee agreements. Finally, this chapter will encourage methods whereby employees of small firms can be included in risk-sharing pools so that the cost of health insurance to small businesses is equalized.
2503. This chapter shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that are more favorable to the employees than the basic benefits required by this chapter.

Article 2. Definitions

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

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

2514. “Dependent” means the spouse, minor child, permanently disabled child, or legally dependent parent of a covered employee.

2516. “Employee” means any person who works at least 86.67 hours per month for any single employer.

2518. “Employer” means any person, partnership, corporation, association, or public or private agency employing for wages or salary five or more persons to work in this state.

2520. “Principal employer” means the employer for whom any employee works the largest number of hours in any month.

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

Article 3. Coverage

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

2532. Every employer required to provide health care coverage pursuant to this chapter may select that
coverage from any carrier. Employers may also provide
coverage through self-funded employer-sponsored plans.

2534. Every employer shall be responsible for at least
75 percent of the cost of health care coverage. However,
where coverage exceeds the minimum benefits required
by this chapter, or where coverage includes an
employee's dependents, the payment for that coverage
shall be consistent with established practices. To the
extent that the employee is responsible for paying all or
a part of these costs, an employer shall withhold those
amounts from the employee's salary and wages.

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

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

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

(a) The employer is not the principal employer of the
employee in terms of monthly hours worked.
(b) The employee is covered as a dependent under a
health care plan, health insurance plan, hospital service
plan, or self-funded employer-sponsored plan which has
benefits meeting the requirements of this chapter.

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

2544. Employers may form associations for the
purpose of providing health care coverage under this
chapter. These associations may pool their employees in
order to obtain group, rather than small-group or individual, rates and coverage, and these associations may also provide for self-funded employer-sponsored health care coverage.

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

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

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

(1) Retail trade.
(2) Manufacturing.
(3) Agriculture.
(4) Transportation.
(5) Wholesale trade.
(6) Services industries.
(7) Professions.
(8) Construction.
(9) Miscellaneous.

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

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

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

2547. All carriers licensed or authorized to underwrite health care coverage in California who offer group health insurance to employers with fewer than 50 employees shall only use the underwriting criteria
described in Section 2546 with regard to groups containing fewer than 50 employees. Carriers offering health insurance to groups containing fewer than 50 employees, and not conforming to the criteria described in Section 2546 with regard to those groups, shall not be permitted to underwrite health care coverage in California.

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

Article 4. Health Care Benefits

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

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

(1) Room accommodations.
(2) Regular and special diets.
(3) General nursing services.
(4) Use of operating rooms, surgical supplies, anesthesia services, and supplies.
(5) Drugs, dressing, oxygen, antibiotics, and blood transfusion services.

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

(1) Hospital outpatient services.
(2) Facilities for surgical procedures or health care of an emergency nature.

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

(1) Surgical services performed by a licensed physician and surgeon.
(2) Aftercare visits for a reasonable period.
(3) Anesthesiologist services.

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

(1) Necessary home, office, and hospital visits by a licensed physician and surgeon.
(2) Intensive medical care while hospitalized
(3) Medical or surgical consultation.
(e) Diagnostic laboratory services, X-ray, and
radio-therapeutic services necessary for diagnosis or
treatment of injury or disease.
(f) Maternity benefits.
(g) Mental health benefits, including all of the
following:
(1) Inpatient care or acute residential care for a period
of at least 20 days in each calendar year.
(2) At least 25 outpatient visits in each calendar year.
2552. (a) Health care coverage pursuant to this
chapter shall not include a copayment or deductible
expense to the beneficiary for any of the following:
(1) Hospital inpatient services, including care in a
psychiatric facility or acute residential treatment facility.
(2) Physician and surgeon services provided in the
hospital.
(3) Laboratory and other services.
(4) Ambulatory surgical benefits.
(b) Health care coverage pursuant to this chapter may
require a copayment, not to exceed 25 percent of the
charges, for all other benefits.
2554. Employers providing services pursuant to this
chapter shall not be required to pay for benefits when the
beneficiary is entitled to receive disability benefits or
compensation under any workers' compensation or
employers' liability law for the injury or illness.

Article 5. Operative Date

2560. This chapter shall become operative on January
1, 1993, or on the effective date of federal legislation
which exempts this chapter from preemption by the
federal Employee Retirement Income Security Act of
1974, whichever occurs sooner, as determined by the
Director of Industrial Relations. However, this chapter
shall 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 chapter, as determined by the Director of Industrial Relations.
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 enacted becomes operative.


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

1. SECTION 1. Section 17053.20 of the Revenue and Taxation Code is amended to read:

2. 17053.20. (a) There shall be allowed as a credit against the amount of "net tax" (as defined in Section 17039) an amount equal to the amount determined in subdivision (b) for payments by an eligible employer to provide health coverage for eligible individuals and their dependents.

3. (b) The amount of the credit allowed by subdivision (a) shall be twenty-five dollars ($25) per month per covered individuals or 25 percent per month of the total amount paid or incurred for such health coverage by the employer during the taxable year, whichever is more,
plus twenty-five dollars ($25) per month or 25 percent of
the total amount paid or incurred per month per covered
individual’s dependent or dependents, whichever is
more.
(c) To qualify for the credit provided in subdivision
(b), an eligible employer must pay or incur at least 75
percent of the monthly premium for health coverage for
eligible individuals who elect to have that coverage, or at
least 75 percent per month towards health coverage for
an eligible individual’s dependent or dependents and for
which the individual does not pay more than 25 percent,
or both. At least annually, the employer shall make
participation available to all eligible individuals and to all
newly hired individuals within 60 days of the date of
employment. Nothing in this section shall require an
eligible employer to pay for dependent health coverage
in order to qualify for the eligible individual health
coverage credit provided herein. Nothing in this section
shall prohibit employers from making additional health
benefits available to an eligible individual at the
employer’s or eligible individual’s expense.
(d) The credit allowed by this section shall be in lieu
of any deduction to which the taxpayer otherwise may be
entitled for expenses on which a credit under this section
is claimed.
(e) If the credit allowed under this section exceeds the
“net tax” for the taxable year, that portion of the credit
which exceeds the “net tax” may be carried over to the
“net tax” in succeeding taxable years until the credit is
used. The credit shall be applied first to the earliest
taxable years possible.
(f) Any amount of expenses paid by an employer
under this section shall not be included as income to the
eligible individual for purposes of the Personal Income
Tax Law. If those expenses have been included in
arriving at federal adjusted gross income of the eligible
individual, the amount included shall be subtracted in
arriving at state adjusted gross income. As used in Section
17071 with respect to the eligible individual,
“compensation for services” does not include expenses
paid under this section.

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

(h) For purposes of this section:

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

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

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

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

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

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

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

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

(B) Inpatient and outpatient physician services.

(C) Diagnostic and screening tests.

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

(6) "Supplemental benefits" means:

(A) Prenatal and well-baby care which meets 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.
SEC. 2. Section 23615 of the Revenue and Taxation Code is amended to read:

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

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

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

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

(e) If two or more taxpayers share in the expenses eligible for the credit provided by this section, each taxpayer shall be eligible to receive the tax credit in
proportion to its respective share of the expenses paid or
incurred.
(f) If the credit allowed under this section exceeds the
taxes imposed by this part (except the minimum
franchise tax and the alternative minimum tax) for the
income year, that portion of the credit which exceeds
those taxes may be carried over to the tax (as defined by
Section 23036) in succeeding income years until the
credit is used. The credit shall be applied first to the
earliest income years possible.
(g) Any amount of expenses paid by an employer
under this section shall not be included as income to the
eligible individual for purposes of the Personal Income
Tax Law. If those expenses have been included in
arriving at federal taxable income of the eligible
individual, the amount included shall be subtracted in
arriving at state taxable income. As used in Section 17071
with respect to the eligible individual, “compensation for
services” does not include expenses paid under this
section.
(h) For purposes of this section:
(1) “Eligible employer” means a taxpayer which
employs on the average during the income year no more
than 25 employees including owner-operators and which
makes the minimum contribution required by this
section on behalf of an eligible individual. An “eligible
employer” is not a taxpayer who liquidates the assets of
or dissolves the organization of a business, for tax
purposes only, in anticipation of becoming eligible for the
credit allowed under this section and then subsequently
reorganizes the business.
(2) “Eligible individual” means an individual who, on
a form prescribed by the Franchise Tax Board and
retained by the qualified employer, certifies that he or
she is a resident of California (within the meaning of
Section 17014), and who:
(A) Performs services for an eligible employer for an
average of at least 35 hours per week for remuneration,
or
(B) Performs services for an eligible employer for less
than 35 hours if the eligible employer provides health  
coverage for that individual and meets all other  
requirements for the credit under this section, or  
(C) As an owner-operator or shareholder, provides at  
least an average of 35 hours per week in personal services  
to the business for which health coverage is contracted.  
(3) "Health coverage" means health coverage that at  
a minimum, includes basic health care services for illness  
or injury provided by a private insurance company  
holding a valid outstanding certificate of authority from  
the Insurance Commissioner, a nonprofit hospital service  
plan qualifying under Chapter 11A (commencing with  
Section 11491) of Part 2 of Division 2 of the Insurance  
Code, or a health care service plan as defined under  
subdivision (f) of Section 1345 of the Health and Safety  
Code, which is lawfully engaged in providing, arranging,  
paying for, or reimbursing the cost of personal health  
services under insurance policies or contracts, medical or  
hospital service agreements, or membership contracts in  
consideration of premiums or other periodic charges  
payable to it. "Health coverage" may include provisions  
for cost sharing if the total cost sharing does not exceed  
200 percent of the annual premium, and no copayment  
exceeds 50 percent of the cost of a covered service.  
(4) "Basic health care services" means the services  
defined in subdivision (b) of Section 1345 of the Health  
and Safety Code, or those benefits and provisions as may  
be required of employers in this state by the enactment  
of Assembly Bill 350 of the 1989-90 Regular Session, or all  
of the following benefits:  
(A) Inpatient and outpatient hospital services,  
including inpatient care for a period of at least 120 days  
of confinement in each calendar year and ancillary  
services.  
(B) Inpatient and outpatient physician services.  
(C) Diagnostic and screening tests.  
(5) "Dependent" means any person who qualifies as a  
dependent of the eligible individual for purposes of a  
health care service plan certified to qualify for the credit  
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 16800) to Part 6 of Division 9 of the Welfare and Institutions Part 8.5 (commencing with Section 2100) to Division 2 of, and 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

Signed 7-14-89, Governor.
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 of 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.


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

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

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

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

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

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

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

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

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

(f) The cost of health care has risen sharply in excess
of all other components of the Consumer Price Index and
at a rate higher than any other industrialized country. The cost of health insurance has increased at a significantly greater rate than the costs of medical care.

(g) While the “competition experiment” in delivering health care has reduced the rate of increase in hospital and other providers’ rates, fees, and charges; other problems in the delivery of basic health services persist or have been exacerbated:

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

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

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

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

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

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

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

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

(l) The annual costs of long/term care in a nursing home typically exceed twenty thousand dollars ($20,000) per individual.
(m) The recently enacted catastrophic coverage under Medicare will finance very little of the long/term care needs of California's seniors. The catastrophic health expenses associated with long/term care affect 3 percent of persons over 65 years of age.

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

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

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

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

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

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

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

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

CHAPTER 9.5: HEALTH INSURANCE

Article 1. General

18800. Unless the context requires otherwise, the definitions set forth in this article govern the construction of this chapter:
18800.1. "Commission" means the California Health Plan Commission.
18800.2. "Department" means the State Department of Health Services.
18800.3. "Other available health coverage" means insurance available at the place of employment; Medi-Cal, except as provided pursuant to this chapter; Medicare, other state and federal health care coverage; and individually purchased health insurance policies.
18800.4. "Employee" means an individual described in Article 1.5 (commencing with Section 621) of Chapter 3 of Part 1 of Division 1 of the Unemployment Insurance Code.
18800.5. "Employer" means an individual described in Article 3 (commencing with Section 675) of Chapter 3 of Part 1 of Division 1 of the Unemployment Insurance Code.

Article 2. Basic Health Care

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

PART 8.5. HEALTH INSURANCE

CHAPTER 1. GENERAL

2100. Unless the context requires otherwise, the definitions set forth in this chapter govern the construction of this division.
2102. "Administering agency" means the Franchise Tax Board, and, if the Franchise Tax Board has contracted with the Employment Development Department for the enforcement of the tax on gross payrolls, with respect to provisions relating to those taxes, it means the Employment Development Department.
2104. "Department" means the State Department of Health Services.
2105. "Dependent" means the spouse or child of the employee.

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

2107. "Employer" means an individual described in Article 3 (commencing with Section 675) of Chapter 3 of Part 1 of Division 1 of the Unemployment Insurance Code.

2108. "Fund" means the California Health Plan Fund.

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

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

2111. "Taxable gross payroll" means that portion of an employer's gross payroll attributable to those employees who are not offered a health benefits plan.

CHAPTER 2. BASIC HEALTH CARE

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

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

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

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

(B) One person who shall represent county governments.

(C) One person who shall represent health care providers.
(D) Three persons with no direct connection with the health care industry.

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

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

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

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

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

(A) One person who shall represent employee organizations.

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

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

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

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

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

(a) The commission shall provide basic health coverage to persons receiving unemployment insurance benefits either by exercising the continuation options for employee’s group health coverage or by purchasing or providing basic minimum health coverage.

(b) Basic health insurance provided pursuant to this article shall include all of the following:
(1) Inpatient and outpatient hospital care.
(2) Professional services as determined by the commission.
(3) Preventive services.
(4) Children's dental care.
(5) Prescription drugs.
(6) X-ray services.
(7) Laboratory services.
(8) Other services comparable to the benefits offered by the average group employer.

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

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

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

2126. (a) The commission shall, wherever possible, contract for delivery of health care at negotiated amounts.
(b) The commission shall give preference in contracting to plans which offer subscribers the broadest choice of and access to doctors, dentists, and pharmacies best possible health care at the lowest possible cost.
(c) Health maintenance organizations, prepaid health plans, independent practice associations, county organized health systems, and other qualified health systems under the Knox-Keene Act (Chapter 2.2 commencing with Section 1340) of Division 2 of the Health and Safety Code, prudent purchaser organizations, and other health insurance plans certified by the Department of Insurance or Department of Corporations may bid for contracts with the commission.
(d) In areas where there are no qualified plans, the commission may contract for care with local medical societies, hospitals, counties, or community clinics or make such other alternative arrangements for basic health coverage as it finds feasible.

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

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

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

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

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

(d) All services covered under a contracting plan shall be readily available and reasonably accessible to all enrollees.
2129. Plans which contract with the commission shall have open enrollment for persons eligible under the plan, may not impose waiting periods, and may not deny coverage or participation based upon the medical or demographic characteristics of the subscriber.

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

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

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

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

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

1. A gross payroll tax on all employers equal to the average percentage expenditure from gross payroll of all employers on health insurance or coverage for their employees and dependents. Employers shall receive credit against this tax for the amount of their current payroll spending on health insurance or health coverage for their employees and dependents.

(A) Every new small business employer's gross payroll tax shall be calculated at the following rates:
(i) During the first year following the employer's commencement of business, 30 percent of the full rate.
(ii) During the second year following the employer's commencement of business, 60 percent of the full rate.
(iii) During the third year following the employer's commencement of business, 90 percent of the full rate.
(B) Every small business employer with eight employees or less, and with an average annual employee salary of $12,000 or less, shall be subject to the gross payroll tax at the following rates:
(i) During the first year of operation of the plan, 50 percent of the full rate.
(ii) During the second year of operation of the plan, 75 percent of the full rate.
(iii) During the third year of operation of the plan, 100 percent of the full rate.
(1) The gross payroll tax imposed pursuant to Chapter 5 (commencing with Section 2715)
(2) The allocation of seventy percent of the revenues generated by the imposition of taxes pursuant to Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code. These funds shall be spent only on hospital and physician services.
(3) An amount equal to the 1988–89 General Fund spending on the Medically Indigent Services Program adjusted annually by the percentage increase in the California Necessities Index.
(4) An unemployment health insurance tax calculated in an amount sufficient to provide basic minimum health coverage for individuals or families with no health insurance who receive unemployment insurance.
18823.5. (a) Any employer with 50 or more employees, and who, after January 1, 1990, without good cause ceases to offer a health benefits plan and does not within 30 days thereof, offer a health benefits plan which meets the minimum requirements of Section 18840, shall pay a penalty in an amount equal to 50 percent of the amount of gross payroll tax imposed pursuant to paragraph (1) of subdivision (b) of Section 18823, for a
period of three years following the date of termination of
the plan.
(b) This section shall remain in effect only until
January 1, 1997, and as of that date is repealed, unless a
later enacted statute, which is enacted before January 1,
1997, deletes or extends that date.

2134. (a) A health insurance premium shall be
withheld from all persons not covered by health
insurance at their place of employment covering 25
percent of the cost of the basic minimum health
coverage. For persons with incomes below 300 percent of
the federal poverty level, the premium shall be on a
sliding fee scale as determined by the commission.
(b) (1) If the necessary federal waivers are secured,
the federal and state contributions for Medi-Cal
medically needy coverage for care and services to
families who shall be eligible for and receive coverage
under this plan shall be applied to the plan.
(2) If the necessary federal waivers are secured,
federal and state contributions for all Medi-Cal families
who shall be eligible for and receive coverage under this
plan shall be applied to the plan.
(3) The Director of Health Services shall seek the
appropriate federal waivers.

2135. The Legislative Analyst shall study and report
to the Legislature by July 1, 1990, on both of the following:
(a) The average expenditure from gross payroll of
employers to provide health insurance or health
coverage for their employees and dependents.
(b) The amount of health unemployment insurance
tax necessary to provide basic minimum health coverage
for individuals with no health insurance who receive
unemployment insurance.

2136. Funding from existing programs and revenue
streams shall be phased into this program with the
minimum feasible disruption in existing programs and
services. No revenues designated to the plan may be used
for any other governmental purpose.
18827.
2137. The plan shall begin July 1, 1992, and the
commission may phase in its operation if it deems this
appropriate.

Chapter 3. Regulation of Health Insurance and
Delivery of Health Care

Chapter 3. Regulation of Health Insurance

18830.
2150. (a) It is the intent of the Legislature to reduce
the rate of inflation in medical care and services to a rate
no higher than the Consumer Price Index for all
commodities.
(b) It is the intent of the Legislature to prevent unfair
and deceptive business and trade practice among entities
providing health insurance or health coverage resulting
in adverse selection, and severe financial difficulties for
the plans and their subscribers.

18831.
2151. (a) No rate increase in health insurance or
health coverage provided by any entity doing business in
the State of California shall take effect unless it is
approved by the Insurance Commissioner. The
Insurance Commissioner may determine that annualized
increases below the Consumer Price Index shall not be
reviewed.
(b) A rate increase shall be deemed approved 90 days
after public notice to the Insurance Commissioner unless
the Insurance Commissioner decides within that time
period to hold a hearing.
(c) Any request for a rate increase in excess of the
Consumer Price Index shall be deemed presumed to be
excessive and unfairly discriminatory and the burden of
proof of justifying that increase shall be on the entity
seeking it.

18832.
2152. (a) No insurer shall charge a rate that is
excessive, inadequate, or unfairly discriminatory, or otherwise in violation of this chapter. The Insurance Commissioner shall consider whether that rate reflects the insurance company’s investment income.

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

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

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

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

Whenever the Insurance Commissioner holds a hearing, the hearing shall be conducted in accordance with the following:

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

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

(c) Oral evidence shall be only on oath or affirmation.
(d) An administrative record shall be compiled, containing all evidence upon which the decision is based, all admissible evidence offered by any party, all documents required by law to be filed with regard to the subject of the hearing, and all comments made by any person.

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

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

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

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

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

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

2159. The Insurance Commissioner may order any adjustment in rates necessary to prevent rates or practices from being excessive, inadequate, or unfairly discriminatory and may require the refund of any portion
of any premiums collected pursuant to an excessive or
unfairly discriminatory rate.

Moreover,

2160. Any entity offering or providing health
coverage or insurance in the state shall provide a
minimum basic benefit package covering the following
services determined to be medically necessary:
(a) Hospital inpatient services and ambulatory care
services.
(b) Professional services as defined in the Insurance
Code.
(c) Diagnostic laboratory and diagnostic and
therapeutic radiologic services.
(d) Preventive health services, including perinatal
services and well-child services.
(e) Emergency services, including ambulance
services and out-of-plan coverage.
(f) Prescription drugs.
(g) Children’s dental care.

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

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

In accordance with the Unruh Civil Rights Act,
contained in Section 51 of the Civil Code, an insurer or
provider of health coverage shall not arbitrarily
discriminate against individuals in the setting of
insurance rates or in the denial of insurance coverage.
2164. The Insurance Commissioner may disapprove the use of any advertising or solicitation which is untrue, misleading, or deceptive.

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

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

2167. The Insurance Commissioner may disapprove the form and content of contracts for health services which are determined to be a deceptive or unfair business practice or have the effect of defrauding plan subscribers of medically necessary basic health services.

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

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

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

(b) For purposes of judicial review:

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

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

2171. The Office of Statewide Health Planning and
Development shall adopt guidelines governing
unnecessary and duplicative capital spending on special
services for inpatient hospital care.

2172. (a) The department, the commission, and the
Insurance Commissioner shall conduct small area analysis
review of provider practice patterns in health plans
under their jurisdiction, and shall publicize and
disseminate the results of the review among consumers,
subscribers, physicians, and hospitals.
(b) Plans subject to this chapter shall cooperate in
furnishing data necessary for that analysis and review.

CHAPTER 4. REGULATION OF HEALTH CARE DELIVERY

2190. (a) No rate increase in health coverage
provided by any health care service plan doing business
in the State of California shall take effect unless it is
approved by the Department of Corporations. The
Department of Corporations may determine that
annualized increases below the Consumer Price Index
shall not be reviewed.
(b) A rate increase shall be deemed approved 90 days
after public notice to the Department of Corporations
unless the Department of Corporations decides within
that time period to hold a hearing.
(c) Any request for a rate increase in excess of the
Consumer Price Index shall be presumed to be excessive
and unfairly discriminatory and the burden of proof of
justifying that increase shall be on the entity seeking it.

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

2192. (a) No health care service plan provider shall
charge a rate that is excessive, inadequate, or unfairly
discriminatory, or otherwise in violation of this chapter.
The Department of Corporations shall consider whether
that rate reflects the investment income of the health
care service plan coverage provider.
(b) Any proposals to increase rates above the
Consumer Price Index shall be filed no later than 90 days
before the proposed effective date of the increase and
shall not be imposed without the prior approval of the
Department of Corporations.
(c) Every proposal filed pursuant to subdivision (b)
shall be accompanied by sufficient supporting data to
establish that the rates are not excessive, inadequate, or
unfairly discriminatory.
(d) The Department of Corporations shall schedule a
hearing no later than 60 days after public notice of the
hearing except where extended for good cause. A written
decision shall be issued promptly upon completion of a
hearing. The decision shall be solely on the basis of the
record, approving or disapproving the filing, in whole or
in part. No portion of a filing shall be approved unless its
rates are neither excessive, inadequate, nor unfairly
discriminatory. A decision shall be adopted, amended, or
rejected only under subdivisions (c) and (e) of Section
11517 of the Government Code and solely on the basis of
the record.
2193. Whenever the Department of Corporations
holds a hearing, the hearing shall be conducted in
accordance with the following:
(a) Reasonable public notice shall be given of the
purpose and nature of the hearing and the opportunity
for public participation.
(b) All parties shall be provided with a reasonable
opportunity to present their views.
(c) Oral evidence shall be only on oath or affirmation.
(d) An administrative record shall be compiled,
containing all evidence upon which the decision is based,
all admissible evidence offered by any party, all
documents required by law to be filed with regard to the
subject of the hearing, and all comments made by any
person.
2194. (a) Any entity which purchases health
coverage or a plan subscriber of the health care service
plan seeking a rate increase, or his or her representative, may petition the commission to hold a hearing on a proposed rate increase.

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

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

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

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

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

(b) For purposes of judicial review:

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

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

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

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

(a) Hospital inpatient services and ambulatory care services.

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

(c) Diagnostic laboratory and diagnostic and
therapeutic radiologic services.
(d) Preventive health services, including perinatal
services and well-child services.
(e) Emergency services, including ambulance
services and out-of-plan coverage.
(f) Prescription drugs.
(g) Children’s dental care.

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 5. FISCAL PROVISIONS

Article 1. General

2215. (a) There is established the California Health
Plan Fund.

(b) For purposes of this article, “fund” means the
California Health Plan Fund.

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

2217. All premiums and other payments received by
the commission shall be deposited in the fund.
Article 2. Imposition of Tax

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

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

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

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

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

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

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

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

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

2226. Every very small business employer with low
average salaries shall be phased into the plan during the first two years of the plan’s operations by having the tax required under Section 2220, subject to the reduction under Section 2225 if applicable, reduced to the following amounts:

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

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

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

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

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

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

2229. The commission and the State Department of
Health Services shall seek federal approval for the inclusion of the Medi-Cal medically needy as participants in the plan, and the use of federal and state funds devoted to that program by the plan. If approval is received, it is the intent of the Legislature that money that would otherwise be spent on that program shall be used by the fund.

Article 3. Exemptions and Adjustments

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

Article 4. Administration

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

CHAPTER 6. PAYMENTS, RETURNS, AND ASSESSMENTS

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

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

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

2242. Any other taxpayer subject to taxes under this
division shall file with the administering agency a return
of taxes at the same time the taxpayer is required to file
a return of taxes under Part 10 (commencing with
Section 17001) of Division 2 of the Revenue and Taxation
Code.
2243. (a) All revenues collected pursuant to taxes
imposed by this chapter shall be transferred to the
California Health Plan Gross Payroll and Income Tax
Fund, which is hereby established.
(b) All moneys in the fund created by subdivision (a)
are hereby continuously appropriated, without regard to
fiscal years, for the following purposes:
(1) For refunds and credits under this division.
(2) The balance shall be allocated to the California
Health Plan Fund.
2244. The administering agency, in the enforcement
of this division, shall, as soon as practicable after a return
is filed under this division, examine it and determine the
correct amount of the tax.
2245. If the administering agency determines that the
tax disclosed by the original return is less than the tax
disclosed by its examination, it shall mail a notice or
notices to the taxpayer of the deficiency proposed to be
assessed.
2246. Notwithstanding any provision to the contrary,
any interest, penalty, or addition to any tax imposed
under this division may be assessed and collected in the
same manner as if it were a deficiency.
2247. Each notice shall set forth the reasons for the
proposed additional assessment and the computation
thereof.
2248. Within 60 days after the mailing of each notice
of additional tax proposed to be assessed, the taxpayer
may file with the administering agency a written protest
against the proposed additional tax, specifying in the
protest the grounds upon which it is based.
2249. If no protest is filed, the amount of the
deficiency assessed becomes final upon the expiration of
60 days.
2250. If a protest is filed, the administering agency
shall reconsider the assessment of the deficiency and, if
the taxpayer has so requested in the protest, shall grant
the taxpayer or the taxpayer’s authorized representative
or representatives an oral hearing. The administering
agency may act upon the protest in whole or in part. If
the administering agency acts on the protest in part only,
the remaining protest shall continue to be under protest
until the administering agency acts on that part.

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

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

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

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

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