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Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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SENATE BILL No. 2868

Introduced by Senator Petris
(Coauthor: Senator Bill Greene)

March 2, 1990

An act to add Section 14005.45 to, and to add Division 13 (commencing with Section 20000) to, the Welfare and Institutions Code, relating to health care; ~~and making an appropriation therefor~~.

LEGISLATIVE COUNSEL'S DIGEST

SB 2868, as amended, Petris. Health insurance.

Existing law provides for the Medi-Cal program pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

This bill would provide that any medically indigent person or family, as defined, is eligible for Medi-Cal benefits.

Existing law provides various health care benefits to low-income persons.

This bill would require the provision of health care benefits to all residents of the state, to be administered by the California Health Care Commission, created by the bill, which would consist of 12 members, 6 of whom would be appointed by the Governor, 3 of whom would be appointed by the Speaker of the Assembly, and 3 of whom would be appointed by the Senate Committee on Rules. The bill would prescribe the duties of the commission and would prescribe

additional duties for the State Department of Health Services.

The bill would require the commission to appoint a Health Care Director to administer the universal health care program established by the bill.

The bill would establish the Right to Health Care Fund.

The bill would require the commission to phase in the implementation of the universal health care program according to a specified schedule.

The bill would require the commission, in consultation with the Legislative Analyst and such other experts deemed appropriate, to develop an evaluation and monitoring program which considers, at a minimum, the quality of care and access to care provided by the universal health care programs.

The bill would require the State Department of Health Services to report to the commission, no later than June 1, 1991, regarding federal financial participation and the integration of the Medi-Cal program into the universal health care program established pursuant to this bill.

The bill would transfer all moneys in the Hospital Services Account, Physician Services Account, and Unallocated Account in the Cigarette and Tobacco Products Surtax Fund to the Cigarette and Tobacco Products Surtax Account in the Right to Health Care Fund created by the bill ~~; and would continuously appropriate those moneys for purposes of the bill~~.

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

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

SECTION 1. This act shall be known and may be cited as the California Right to Health Care Act of 1990.

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

(a) All Californians have a right to medically necessary health care, including long-term services.

(b) Children, low-income working and unemployed persons, and persons with disabilities and chronic conditions, in particular, face deteriorating access to all

levels of medical care. Over five million Californians presently have no health insurance, and the number of these persons is growing at an alarming rate.

(c) It has been documented that the lack of access to medically necessary health care leads to a decline in health status including birth defects, lifelong disabilities, uncontrolled diabetes, hypertension and untreated chronic conditions.

(d) This lack of access to care results in unnecessary pain and suffering and leads to overuse of expensive emergency facilities.

(e) Providing preventive health care will efficiently and effectively improve the health of all Californians and can significantly reduce the need for more expensive long-term care later in life.

(f) The health and well-being of individuals is directly related to their ability to obtain necessary medical care and health-related support services for emergency, chronic, and long-term conditions.

(g) The integration of long-term care services with comprehensive health coverage is cost-effective, protects persons with disabilities from being impoverished by the cost of nursing facility care, and allows maximum independence for those who can remain safely at home.

SEC. 3. It is the intent of the Legislature to develop a comprehensive health care program to provide medically necessary care specific to individual needs, including preventive and long-term care, for all residents of California.

SEC. 4. Section 14005.45 is added to the Welfare and Institutions Code, to read:

14005.45. Any medically indigent resident or family of residents whose monthly income in excess of the amount required for maintenance established pursuant to Section 14005.12, exclusive of any amounts exempt under Chapter 2 (commencing with Section 11200), is not sufficient to provide for the costs of health care or coverage, less any amount by which the value of his or her other resources exceeds the value established in accordance with Section 14006, or a reasonable portion of

that value, as may be determined in accordance with standards established by the director, is eligible for health care services under Section 14005.

SEC. 5. Division 13 (commencing with Section 20000) is added to the Welfare and Institutions Code, to read:

DIVISION 13. RIGHT TO HEALTH CARE

CHAPTER 1. GENERAL

20000. The definitions contained in this chapter shall govern the construction of this division, unless the context requires otherwise.

20002. "Commission" means the California Health Care Commission.

20004. "Department" means the State Department of Health Services.

20006. "Dependent" means the spouse, minor child, permanently disabled child, or legal dependent of an eligible employee.

20008. "Director" means the Health Care Director appointed by the commission for the administration of this division.

20010. "Employee" means any person who works for any employer for wages.

20012. "Employer" means any person, partnership, corporation, association, or public or private agency employing, for wages, any person or persons to work in this state.

20014. "Federal poverty level" means the federal official poverty line, as defined by the federal Office of Management and Budget, based on Bureau of the Census data, and revised annually by the Secretary of Health and Human Services pursuant to Section 9902(2) of Title 42 of the United States Code.

20016. "Open plan" means that portion of the California Health Care Program in which eligible persons may elect to receive services either from a private or public provider on a fee-for-service basis or from a hospital, based on a negotiated annual budget.

20018. "Prepaid health plan" means any health maintenance organization, independent practice association, or any other mode of delivery of care approved by the commission to provide health care services to individuals in exchange for a prescribed capitated payment from the program.

20020. "Program" means the California Health Care Program.

20021. "Resident" means a resident as determined pursuant to Section 244 of the Government Code.

20022. "Self-employed" means an individual who is his or her own employer and employee.

20024. "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by an employer or a customer.

CHAPTER 2. ELIGIBILITY AND EXPENDITURE LIMITATIONS

20025. Any resident of this state is eligible for the services provided pursuant to this division.

20030. The amount which shall be used for the baseline for setting limits on expenditures for the first year of the operation of the program shall be the amount spent in California during the 1990 calendar year for all health care covered under this division.

20032. The Legislative Analyst shall determine the amount of statewide health care expenditures in the 1990 calendar year and shall report that amount to the commission by July 1, 1991.

CHAPTER 3. BENEFITS

Article 1. General

20050. (a) The benefits listed in this chapter shall be covered benefits under this division.

(b) The program shall provide all of the following:

(1) Comprehensive medical care benefits specified in

this chapter, including preventive care, primary and tertiary health care for acute and chronic conditions, rehabilitative care, and long-term services.

(c) Limited mental health services, dental care, and prescription drugs, as specified in this chapter.

(d) The program shall provide the benefits specified in this chapter through the open plan arrangement or by a prepaid health plan.

Article 2. Medical Benefits

20052. Covered benefits in this chapter shall include, but not be limited to, those benefits listed in this article, when determined to be medically necessary.

20054. Inpatient and outpatient hospital services.

20056. Inpatient and outpatient professional provider services.

20058. Diagnostic X-ray and laboratory services.

20060. Perinatal and maternity care.

20062. Children's preventive care, including, but not limited to, well-child care, routine dental checkups, and immunizations.

20064. Adult preventive care.

20066. Durable medical equipment.

20068. Podiatry.

20070. Unreplaced blood.

20072. Dialysis.

20074. Emergency transportation.

20076. Rehabilitative care.

20078. Alcohol and drug abuse or addiction treatment, or both.

20080. (a) Prescription drugs.

(b) In order to reduce the cost of prescription drugs, the commission shall use its buying power to purchase prescription drugs at the lowest possible prices directly from the manufacturers.

Article 2.5. Medigap Benefits

20090. Beneficiaries of Medicare, as defined by the federal Social Security Act, shall receive the benefits covered by the program.

20091. The program shall cover the difference between the Medicare allowable charge and the rate set or negotiated by the program.

Article 3. Long-Term Services

20100. (a) Long-term services which are necessary for the health, social, and personal needs of individuals with limited self-care capabilities are covered benefits under this division as provided in this section.

(b) Individual needs shall be determined through a standardized assessment of the individual's abilities for self-care and shall include all of the following:

(1) Medical examinations necessary to determine what, if any, level of medical care is required.

(2) Environmental and psychosocial evaluations to determine what the individual can and cannot do for himself or herself physically, as well as mentally.

(3) Services, service coordination, or case management, to ensure that necessary services are provided to enable the individual to remain safely in the least restrictive setting.

(c) Services may be provided in the individual's home, or through community-based, residential, or institutional programs.

(d) Reassessment shall be conducted at appropriate intervals.

20102. In providing long-term services under this division, the commission shall, to save program funds, encourage and reimburse noninstitutional long-term services where appropriate, as determined pursuant to the assessment process, to allow persons needing long-term services to remain safely in their homes to the maximum extent possible.

Article 4. Mental Health Benefits

machines and the expression of the voters' choice by means thereof are in compliance with this section.

20120. (a) All of the mental health benefits listed in this article are covered benefits under this chapter.

(b) To save program funds, the commission shall encourage the use of services, service coordination, and case management which will enable the individual to remain in the least restrictive setting. Services may be provided through community-based, residential, or institutional programs.

(c) The commission shall, by July 1, 1991, appoint an independent advisory board of mental health experts and representatives of health care consumers to develop a plan for providing all necessary mental health care through the program by January 1, 1997.

20122. Fifty-two visits per year.

20124. Inpatient care, other than for substance abuse, not exceeding 45 days per year.

Article 5. Dental Benefits

20130. (a) Dental benefits are a covered benefit under this chapter.

(b) All necessary dental care, including preventive care, shall initially be provided for individuals up to 18 years of age.

(c) Each year after the program becomes operational, the age limit for dental benefits shall be increased upward by one year.

Article 6. Expansion of Covered Benefits

20140. The commission may expand benefits beyond the minimum benefits described in this chapter, when expansion meets the intent of this division and there are sufficient revenues to cover the expansion.

CHAPTER 5. FREEDOM OF CHOICE OF HEALTH CARE PROVIDERS

20150. Any eligible individual may choose to receive services under this division either from a private or public provider or hospital on the open plan or enroll in a prepaid health plan.

20152. A prepaid health plan may use any of the following methods of service delivery:

(a) A staff model, in which services are provided by salaried health professionals, a group model, in which a professional group is paid a capitation rate by the prepaid health plan.

(b) An independent practice association model, in which professionals are paid fees.

(c) Any model not described in subdivision (a) or (b) for delivery of care approved by the director.

20154. (a) Annually, individuals enrolled in a prepaid health plan shall be entitled to an open enrollment period of not less than one month.

(b) During the open enrollment period, an individual may enroll in another prepaid health plan or change to the open plan option.

(c) A person enrolled in the open plan may enroll in any available prepaid health plan at any time.

20155. Individual providers under the open plan shall be bound by the Unruh Civil Rights Act.

20156. (a) Any prepaid health plans receiving payment from the program shall allow any eligible person to enroll in order of time of application, up to a reasonable limit determined by the capacity of the prepaid health plan to provide services.

(b) No prepaid health plan may refuse to enroll or serve any individual because of that individual's health history, preexisting health condition, age, sex, race, national origin, ancestry, sexual orientation, disability, ethnicity, or religion.

20158. Prepaid health plans, as a condition of approval to participate in the provision of benefits under this division, shall demonstrate they will provide, or arrange

and pay for, all of the benefits required for the capitation payment set by the commissioner.

20160. A prepaid health plan which does not have its own hospital facility shall contract with a hospital or hospitals for the provision of care for those enrolled in the health plan.

20162. A prepaid health plan shall demonstrate that the plan will do all of the following:

(a) Provide, or arrange and pay for, all the benefits required for the payment set by the program.

(b) Provide services of an acceptable level of quality.

(c) Charge no additional fees, premiums, or copayments other than those allowed by the commission for the provision of benefits under this division.

(d) Provide an approved grievance procedure for patients.

(e) Report to the program as required.

(f) Meet any other requirements the commission determines to be necessary to ensure that prepaid health plans are financially viable and will provide quality health care to their enrollees.

CHAPTER 6. ADMINISTRATION

Article 1. California Health Care Commission

20200. (a) There is in state government the California Health Care Commission.

(b) The commission shall administer this chapter.

20202. The commission shall consist of 12 members who shall be appointed as follows:

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

(1) One person, who shall be licensed as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who shall spend at least 20 hours per week caring for patients with health care coverage provided pursuant to this chapter.

(2) One person who shall be actively involved in the

administration of a hospital or other inpatient health facility which treats beneficiaries under this chapter.

(3) One person who represents businesses with 50 or more employees.

(4) Three persons representing the beneficiaries whose right to health care is guaranteed pursuant to this chapter, none of whom shall have any direct connection with the health care industry.

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

(1) One person who shall represent employee organizations.

(2) One academic expert in the field of health care delivery systems.

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

(c) Three persons appointed by the Senate Committee on Rules, for staggered six-year terms, as follows:

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

(2) One person who shall represent prepaid health plans.

(3) One person who shall represent nonprofit community clinics.

(d) The persons appointed pursuant to paragraphs (3) and (4) of subdivision (a), paragraph (1) of subdivision (b), and paragraph (1) of subdivision (c), shall be persons with no direct connection to the health industry.

20204. (a) Initial appointments to the commission shall be made by all appointing powers no later than May 1, 1991.

(b) Four of the initial appointees shall serve two-year terms.

(c) Four of the initial appointees shall serve four-year terms.

(d) Four of the initial appointees shall serve six-year terms.

(e) The term of ~~any of~~ each initial appointee shall be determined by lot.

Article 2. Commission Powers and Duties

20210. The powers and duties of the commission shall be as provided in this article.

20212. (a) The commission shall establish and maintain a system of universal access to covered medically necessary health care for all Californians, as required by this chapter.

(b) The commission's powers and duties shall include all of the following:

(1) Implementation of statutory eligibility standards.

(2) (A) Annual adoption of a benefits package which meets or exceeds the minimums required by law.

(B) The benefits package shall only exceed the minimums required by law when expansion of the package meets the intent of this division and there are sufficient revenues to adequately cover the expansion.

(3) Establishment of a ratesetting mechanism with annual review of sufficiency of rates.

(4) Acting directly, or through one or more contractors, as the single payor for all claims for services provided under this chapter.

(5) Establishment of an enrollment system which ensures that all eligible persons are aware of their right to health care and are formally enrolled.

(6) Maintenance of an evaluation mechanism which reviews access to care, quality of care, and provider participation.

20214. The commission shall implement statutory eligibility standards.

20216. The commission shall establish a ratesetting mechanism with an annual review of the sufficiency of the rates imposed pursuant to this division.

20218. The commission shall, either directly or through one or more contractors, act as the single agency to pay claims for services provided under this division.

20220. The commission shall establish an enrollment system which shall ensure that all eligible individuals are made aware of their right to health care benefits

provided under this chapter and which shall provide for the enrollment of any eligible individual under this division.

20222. The commission shall establish and maintain an evaluation system which reviews access to care, the quality of care, and provider participation under this division.

20224. The commission shall annually prepare a budget for the administration of this division, including the employment of staff.

20226. The commission shall have all authority and duties necessary for the administration of this division.

Article 3. Health Care Director

20230. (a) The commission shall appoint a Health Care Director, who shall function as the chief executive officer for the administration of this division.

(b) The director shall serve a minimum of four years, unless he or she receives a vote of no confidence by not less than two-thirds of the membership of the commission.

(c) The director shall be exempt from civil service.

(d) The director may employ appropriate staff necessary to implement this division.

Article 4. Program Implementation

20240. The commission shall establish and maintain a system of universal health care to cover medically necessary health care for all Californians pursuant to this division.

20242. (a) The commission shall ensure that the program established pursuant to this division shall use the most efficient structure and means of administration.

Article 5. Implementation Schedule

20245. (a) The commission shall establish a schedule for the implementation of this division.

(b) (1) The commission may phase in the implementation of the program prior to July 1, 1996.

(2) The commission, in phasing in the implementation of the program, shall focus on ensuring that services are expanded for underserved populations.

20246. It is the intent of the Legislature to appropriate funds for the purposes of the program which are sufficient to ensure the program has the capacity to become fully operational on July 1, 1996.

CHAPTER 7. MONITORING

20250. The commission, in consultation with the Legislative Analyst and such other experts as it may deem appropriate, shall develop an evaluation and monitoring program which considers, at a minimum, the quality of care and access to care provided by the program, including geographic distribution of health care resources.

CHAPTER 8. EFFICIENCY OF OPERATIONS

20260. The director shall set standards and conduct the retrospective review of the utilization of benefits under this division to ensure that effective, cost efficient, and appropriate services are rendered under this division.

20262. The director shall make timely payments to providers, including prepaid health plans and hospitals, and shall establish a system which is efficient for health care providers and the commission to administer, which eliminates unnecessary administrative costs. The cost of administration shall not exceed the limits set in Section 20280.

20264. (a) The director shall establish uniform reporting requirements for all health care providers.

(b) To the extent permitted by federal law, the director shall implement standardized claims and reporting methods under this division.

(c) (1) The director shall require all recipients of

funds under this division to periodically report information which the director determines to be necessary for the planning, budgeting, and quality assurance of care provided under this division.

(2) The director shall make any information and reports submitted pursuant to this section, and the analysis of the data contained in those reports, available to the public.

CHAPTER 9. CONFIDENTIALITY OF RECORDS

20270. This division shall not affect any provision of law in effect regarding the confidentiality of communications between a recipient of services under this division and the health care provider, and existing provisions of law regarding the confidentiality of medical records and patient-health care provider communications shall apply to this division.

CHAPTER 10. ALLOCATION OF FUNDS

20280. Not more than 4 percent of the funds appropriated for the program shall be used for the administration of the program.

20282. The director shall consolidate all programs in effect on the effective date of this division, and any program effected on or after that date, which provides, directs, monitors, or facilitates health care services provided by the program, and shall eliminate duplication of administration to the greatest extent possible.

20284. That amount of any appropriation for the purposes of this division remaining after appropriate funds are allocated for administrative costs, capital expenditures, and reserves shall be divided, based on the geographic variations in costs of services and the proportion of individuals, adjusted for health risk variations, enrolled in the open plan, prepaid health plans, and hospitals.

CHAPTER 11. PROVIDER REIMBURSEMENT

20290. Prepaid health plans may reimburse providers by any method of reimbursement authorized by Section 20152.

20291. Providers shall not charge any fee for services covered under Chapter 3 (commencing with Section 20050) which exceeds the rate set or negotiated by the program.

20292. Providers shall be reimbursed for services provided under this division as follows:

(a) The program shall reimburse individual providers, other than hospitals, for the provision of covered services in the open plan pursuant to a resource-based relative value fee schedule established by the director, based on the total amount of funds available to the open plan.

(b) (1) Hospitals shall be reimbursed on the basis of a global annual budget for all covered services rendered under the program to eligible individuals, based on its census, location, the acuity of its patient population, and other relevant factors.

(2) The director shall negotiate the budget specified in paragraph (1) with each participating hospital on an annual basis, with adjustments made for epidemics and other unforeseen catastrophic changes in the general health status of a patient population.

(c) (1) The director shall reimburse prepaid health plans on a capitated basis, for each patient, based on the total funds available to all prepaid health plans reimbursed under this division, the number of persons enrolling in the prepaid health plans, adjusted for health risk variations of enrollees, and geographical variations in costs of services.

(2) If a prepaid health plan does not have its own hospital facility, the total capitated payment to the prepaid health plan shall be reduced, based on the cost of hospital care delivered to enrollees.

CHAPTER 12. CAPITAL EXPENDITURES AND ALLOCATIONS

Article 1. Capital Allocations

20300. (a) The commission shall annually adopt a capital expenditure budget.

(b) Allocations to geographic areas and to individual provider facilities shall be based on need and shall be calculated so that the minimum access standards adopted by the commission will be met in all areas of the state, and shall ensure the efficient development and operation of necessary facilities.

20302. (a) No later than January 1, 1992, the commission shall report to the appropriate committees of the Legislature on the capital needs of California health facilities, including county facilities, with a focus on underserved geographic areas with substantially below average health facilities and investment per capita as compared to the state average.

(b) The report required by subdivision (a) shall also address geographic areas where the distance to health facilities imposes a barrier to care.

Article 2. Capital Expenditures

20310. During the period commencing on the operative date of this section and ending July 1, 1995, no capital investment in health care facilities in excess of two hundred thousand dollars ($200,000) shall be made without prior approval of the commission.

20312. Commencing July 1, 1995, the commission shall approve any capital investment in health care facilities in excess of the amount determined by the commission.

20314. The approval of any capital investment by the commission shall be based on efforts to do all of the following:

(a) Fulfill unmet needs.

(b) Preclude unnecessary expansion of facilities and services.

(c) Ensure the efficient development of health care facilities that are appropriate to the services provided.

(d) Ensure sufficient access to health care facilities.

(e) Ensure access to efficacious new technologies.

20316. The commission, in approving any capital investment under this article, shall consider the level of cost control which can be attained through control over capital expenditures, administrative efficiency, unmet capital needs, and any other relevant factors.

CHAPTER 13. RESERVES

20320. The director shall retain a portion of funds appropriated for the purposes of this division in reserve, for use in unexpected budgetary shortfalls or epidemics.

20322. The commission shall review and adjust its budget, fee schedules, and capitation rates on a regular basis, according to a schedule established by the commission, to ensure that the program remains solvent and that the payments to health care providers are equitable, prompt, and within the program budget.

CHAPTER 14. RIGHT TO HEALTH CARE FUND

20330. There is in the State Treasury the Right to Health Care Fund.

20332. (a) There is in the Right to Health Care Fund the Cigarette and Tobacco Products Surtax Account.

(b) All funds deposited in the Hospital Services Account, Physician Services Account, and the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund shall be transferred on a quarterly basis to the Cigarette and Tobacco Products Surtax Account in the Right to Health Care Fund.

~~(c) The Cigarette and Tobacco Products Surtax Account in the Right to Health Care Fund is continuously appropriated, without regard to fiscal years, to the commission, for the purposes of this division.~~

~~(d)~~

(c) Those funds appropriated by this section which

have been transferred from the Cigarette and Tobacco Products Surtax Fund shall be used only to the extent authorized by Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code.

20334. All funds appropriated for the purposes of this division are not subject to the expenditure limitation provisions of Article XIII B of the California Constitution.

CHAPTER 15. REPORTS

Article 1. Legislative Analyst Reports

20350. The Legislative Analyst shall, by January 1, 1992, calculate the amount of funds saved by the state due to the elimination of state obligations or expenditures resulting from the implementation of the program.

20352. The Legislative Analyst shall, by January 1, 1992, calculate the amount of expenditures paid in 1989 for the benefit of California residents for health care and related expenses, including health, workers' compensation, auto insurance, and benefits administration.

20354. The Legislative Analyst shall report the calculations made pursuant to this chapter to the commission, the appropriate committees of the Legislature, and the Governor.

Article 2. Commission Reports

20360. (a) Commencing January 1, 1995, the commission shall make a report to the public, the appropriate committees of the Legislature, and the Governor every five years, which shall contain an evaluation of the program.

(b) The report required by subdivision (a) shall include all of the following:

(1) A description of the commission's evaluation and monitoring program.

(2) A description of the successes and problems in the

areas of access and quality.

(3) The results of surveys of consumer and provider satisfaction with the program.

20362. (a) The commission shall make a report, annually, to the appropriate committees of the Legislature and the Governor, which summarizes information about health needs, health services, health expenditures, revenues, and other relevant issues relating to the program.

(b) The report required by subdivision (a) shall contain the commission's recommendations for any legislation necessary to maintain or improve the efficient performance of the program.

CHAPTER 16. MISCELLANEOUS

20370. (a) The commission shall seek all necessary federal waivers, exemptions, agreements, or legislation which will allow that all federal payments for health care made to this state will be paid directly to the commission for the purposes of the program, and for the assumption, by the program, of the responsibility for all benefits previously paid for by the federal government.

(b) The commission shall, in all cases, seek to maximize federal contributions and payments for health care services provided in this state, and, in obtaining the waivers, exemptions, agreements, or legislation required by subdivision (a), the commission shall ensure that the contributions of the federal government for health care services in California will not decrease in relation to other states as a result of the waivers, exemptions, agreements, or legislation.

20380. (a) The director may require copayments for services of not more than 10 percent of the cost of the services, not to exceed two hundred fifty dollars ($250) per year in copayments for individuals, and five hundred dollars ($500) for families.

(b) Persons who have income below 250 percent of federal poverty guidelines shall not be required to pay any copayments.

(c) No copayments may be required that create a barrier to medically necessary care.

20382. (a) A prepaid health plan may impose copayments from its members no greater than 5 percent of the cost of services, and not more than one hundred dollars ($100) per year per individual or two hundred fifty dollars ($250) per year for families.

(b) Persons who have incomes below 250 percent of the federal poverty guidelines shall not be required to pay any copayments. No copayments may be required that create a barrier to necessary care.

(c) No individual in either the open plan or a prepaid health plan shall be required to meet a deductible as a condition for receiving health care services.

20384. The cost of any necessary research and education related to medicine and health, other than patient and consumer education, shall not be paid by the program, but shall be separately funded by the State Legislature, except as specified below. The cost of medical and health research and education other than patient and consumer education shall therefore not be included in the Legislative Analyst's calculation of the costs of health care services in 1989 pursuant to Section 20352.

20386. Insurance companies may sell, subject to the approval of the Insurance Commissioner, health insurance to cover benefits not provided by the program. However, no private insurance may be sold to cover benefits which individuals are entitled to receive from the program.

20387. The department shall report to the commission, no later than June 1, 1991, regarding all of the following:

(a) All federal medicaid options and other federal options which the state has not exercised but would allow greater federal participation in the provision of health care services pursuant to this division.

(b) The amount of potential federal participation relating to each option.

(c) The amount of expanded federal participation

which could be expected if outreach and other efforts were initiated to expand participation in present programs, including the medically needy program.

(d) A process by which the Medi-Cal program could be transferred to the commission and integrated into the universal health care system by July 1, 1993.

20388. The commission shall implement the report of the department to take advantage of all federal medicaid options to maximize eligibility and services, and shall take steps to maximize participation in all programs with federal participation, as soon as possible after the issuance of the department's report. Payment for those services shall come from the Right to Health Care Fund.

20389. The department shall conduct a vigorous outreach campaign to notify potentially eligible persons, including the medically needy, of their eligibility.

CHAPTER 17. SEVERABILITY

20430. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

CHAPTER 18. ENFORCEMENT

20440. Any person who is eligible for health care services under this division has the right to equitable access to medically necessary health care, and shall have standing to enforce this division.

SEC. 6. It is the intent of the Legislature that the program established pursuant to this act shall be financed through the redirection of existing state revenues and supplemental funding.

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AMENDED IN SENATE JANUARY 14, 1992

AMENDED IN SENATE JANUARY 6, 1992

AMENDED IN SENATE APRIL 4, 1991

SENATE BILL No. 36

Introduced by Senator Petris
(Principal coauthor: Senator Torres)
(Coauthors: Senators Alquist, Deddeh, Dills, ~~and Bill Greene~~) ***Bill Greene, and Rosenthal)***
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December 3, 1990

An act to add Section 17222.5 to the Revenue and Taxation Code, to add Section 17000.1 to, and to add Division 13 (commencing with Section 20000) to, the Welfare and Institutions Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 36, as amended, Petris. Health coverage.

(1) Existing law provides for the Medi-Cal program pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

This bill would require the provision of health care benefits, as described, to all residents of the state, to be administered by the California Health Care Commission, created by the bill, which would consist of 15 members, 4 of whom would be appointed by the Governor, 4 of whom would be appointed by the Speaker of the Assembly, 4 of whom would be appointed by the Senate Committee on Rules, and 3 of whom would be appointed by the State Insurance Commissioner. The bill would prescribe the duties of the commission and

would prescribe additional duties for the State Department of Health Services.

The bill would authorize the commission to impose an income-based sliding fee applicable to recent arrivals in the state, and to impose an income-based sliding fee scale for long-term care services on certain individuals who have not lived, worked, or paid state income or property taxes in the state for a period of 5 years, under certain conditions.

The bill would require the commission to appoint a Health Care Director, to administer the universal health care program established by the bill.

The bill would require the commission to phase in the implementation of the universal health care program according to a specified schedule.

The bill would require the commission, in consultation with the Legislative Analyst and such other experts deemed appropriate, to develop an evaluation and monitoring program which considers, at a minimum, the quality of care and access to care provided by the universal health care program.

The bill would set forth a plan for the reimbursement of health care providers.

The bill would require the commission to adopt an annual capital expenditure budget and would require approval of the commission for certain capital investment in health facilities, as specified.

The bill would require the State Department of Health Services to report to the commission, no later than July 1, 1993, regarding federal financial participation and the integration of the Medi-Cal program into the universal health care program established pursuant to this bill.

The bill would establish the Right to Health Care Fund, and would continuously appropriate the fund for the purposes of the universal health care program established by the bill. The bill would continuously appropriate all moneys in the Hospital Services Account, Physician Services Account, and Unallocated Account in the Cigarette and Tobacco Products Surtax Fund to the Cigarette and Tobacco Products Surtax Account or the Right to Health Care Fund, commencing January 1, 1995.

The bill would continuously appropriate from the General Fund to the Right to Health Care Fund an amount equal to the state allocation for the Medi-Cal program for the 1990–91 fiscal year, adjusted for increases in caseload and the cost of living, upon notification of the Department of Finance by the commission as to the date the Medi-Cal program has merged with the program established by this bill.

For income years commencing on and after January 1, 1995, the bill would impose a surcharge of 10% of the gross payroll of every employer in the state and 10% of net earnings from self-employment on self-employed individuals. The bill would impose on each resident a surcharge of 1.5% of the sum of his or her California adjusted gross income, plus social security, Tier 1 railroad retirement benefits, California unemployment compensation, and California lottery winnings, in excess of 250% of the federal poverty guidelines, but not less than a specified amount.

The bill would require the Franchise Tax Board to be responsible for the administration of the surcharge of 10% of net earnings from self-employment and the surcharge of 1.5% on each resident. The bill would require the Employment Development Department to be responsible for the administration of the surcharge of 10% of the gross payroll of every employer in the state. The bill would require all surcharges to be deposited in the continuously appropriated Right to Health Care Fund. The surcharges constitute a tax for the purpose of increasing state revenue pursuant to Article XIII B of the California Constitution, thereby requiring a ⅔ vote of each house of the Legislature for passage.

(2) Existing law requires each county, and city and county, to relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident who lawfully reside in the county, when such persons are not supported in a prescribed manner.

This bill would terminate the counties' duty to provide health care services pursuant to that provision upon full implementation of the universal health care program described in (1), but not later than January 1, 1995, and upon the appropriate transfer of funds by the Legislature.

(3) This bill would appropriate $1,000,000 from the General Fund to the commission for the purpose of starting the program described in (1).

(4) This bill would provide that the provisions described in (1), (2), and (3) shall not take effect until passage of SCA 5 by the voters.

(5) This bill would provide that if any of its provisions are invalid, that invalidity shall not affect other provisions or applications of the bill.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. This act shall be known and may be cited as the California Right to Health Care Act of 1992.

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

(a) All Californians have a right to medically necessary health care, including long-term services.

(b) Children, low-income working and unemployed persons, and persons with disabilities and chronic conditions, in particular, face deteriorating access to all levels of medical care. Over five million Californians presently have no health insurance, and the number of these persons is growing at an alarming rate.

(c) It has been documented that the lack of access to medically necessary health care leads to a decline in health status including birth defects, lifelong disabilities, uncontrolled diabetes, hypertension and untreated chronic conditions.

(d) This lack of access to care results in unnecessary pain and suffering and leads to overuse of expensive emergency facilities.

(e) Providing preventive health care will efficiently and effectively improve the health of all Californians and can significantly reduce the need for more expensive long-term care later in life.

(f) The health and well-being of individuals is directly related to their ability to obtain necessary medical care

and health-related support services for emergency, chronic, and long-term conditions.

(g) The integration of long-term care services with comprehensive health coverage is cost-effective, protects persons with disabilities from being impoverished by the cost of nursing facility care, and allows maximum independence for those who can remain safely at home.

SEC. 3. It is the intent of the Legislature to do all of the following:

(a) Develop a comprehensive health care program to provide medically necessary care specific to individual needs, including preventive and long-term care, for all residents of California.

(b) Provide a financing plan for this system which will capture the money that is now being spent on health care by the public and private sectors.

(c) Provide financing for this system which is progressive and spread the burden among Californians based on ability to pay. The allocation of moneys shall be in an efficient and equitable fashion.

SEC. 4. Section 17222.5 is added to the Revenue and Taxation Code, to read:

17222.5. The surcharge amount imposed on a self-employed individual pursuant to subdivision (b) of Section 20400 of the Welfare and Institutions Code shall be deductible as a trade or business expense in determining adjusted gross income.

SEC. 5. Section 17000.1 is added to the Welfare and Institutions Code, to read:

17000.1. Upon full implementation of Division 13 (commencing with Section 20000), but not later than January 1, 1995, and upon the appropriate, as determined by the Legislature, transfer of funds by the Legislature as described in Section 20225, the counties' responsibility to provide health care services pursuant to Section 17000 shall be terminated and that responsibility shall be transferred to the California Health Care Commission.

SEC. 6. Division 13 (commencing with Section 20000) is added to the Welfare and Institutions Code, to read:

DIVISION 13. RIGHT TO HEALTH CARE

CHAPTER 1. GENERAL

20000. The definitions contained in this chapter shall govern the construction of this division, unless the context requires otherwise.

20002. "Commission" means the California Health Care Commission.

20004. "Department" means the State Department of Health Services.

20006. "Dependent" means the spouse, minor child, permanently disabled child, or legal dependent of an eligible employee.

20008. "Director" means the Health Care Director appointed by the commission for the administration of this division.

20010. "Employee" means any person who works for any employer for wages.

20012. "Employer" means any person, partnership, corporation, association, or public or private agency employing, for wages, any person or persons to work in this state.

20014. "Federal poverty level" means the federal official poverty line, as defined by the federal Office of Management and Budget, based on Bureau of the Census data, and revised annually by the Secretary of Health and Human Services pursuant to Section 9902(2) of Title 42 of the United States Code.

20016. "Open plan" means that portion of the California Health Care Program in which eligible persons may elect to receive services either from a private or public provider on a fee-for-service basis or from a hospital, based on a negotiated annual budget.

20018. "Prepaid health plan" means any health maintenance organization, independent practice association, or any other mode of delivery of care approved by the commission to provide health care services to individuals in exchange for a prescribed capitated payment from the program.

20020. "Program" means the California Health Care Program.

20021. "Resident" means a resident as determined pursuant to Section 244 of the Government Code.

20022. "Self-employed" means an individual who is his or her own employer and employee.

20024. "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by an employer or a customer.

CHAPTER 2. ELIGIBILITY AND EXPENDITURE LIMITATIONS

20025. Any resident of this state is eligible for the services provided pursuant to this division.

20026. (a) For residents eligible for the federal Medicare program, as defined by the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), and for persons on active military duty or otherwise receiving benefits under the CHAMPUS program (10 U.S.C.A. Sec. 1071 et seq.) and their dependents, and for federal employees entitled to health care benefits and their dependents, benefits under this division shall be secondary to any health care benefits for which those persons are eligible, or to which those persons are entitled. The health care benefits provided pursuant to this division shall be supplemental to benefits provided under Medicare Parts A and B and shall include health care benefits not provided by Medicare Parts A and B, including long-term care, prescription drugs, preventive care, and Medigap benefits.

(b) Coverage provided under this division shall be secondary to any retirement health coverage for which a resident, or the resident's dependents, are eligible. The commission shall hold public hearings regarding the integration of benefits provided under this division with retirement health benefit plans in the private and public sectors. Based on the hearings, the commission shall conduct a comparison of the benefits available to

residents under this division with those typically available to retirees and their dependents and shall adopt regulations defining benefits under this division which residents with retiree health coverage are entitled to receive. In adopting regulations, the commission shall consider establishing a maintenance of effort for private and public retiree health benefit plans in order to avoid creating incentives for private and public employers to reduce retiree health benefits.

(c) The commission shall be authorized to negotiate with private and public employers for the transfer of responsibility for providing health benefits to retirees and their dependents from the employer to the commission. Any private or public employer may negotiate with the commission for the transfer of the responsibility for providing retiree health benefits to the commission to the extent allowed by retiree health benefit agreements.

20030. The amount that shall be used for the baseline for setting limits on expenditures for the first year of the operation of the program shall be the amount spent in California during the 1990 calendar year for all health care covered under this division.

20032. The commission shall estimate the expenditures and revenues required to provide services under this division and report that information to the Legislature on or before July 1, 1993, and annually thereafter.

CHAPTER 3. BENEFITS

Article 1. General

20050. (a) The benefits listed in this chapter shall be covered benefits under this division.

(b) The program shall provide all of the following:

(1) Comprehensive medical care benefits specified in this chapter, including preventive care, primary and tertiary health care for acute and chronic conditions, rehabilitative care, and long-term services.

(c) Limited mental health services, dental care, and prescription drugs, as specified in this chapter.

(d) The program shall provide the benefits specified in this chapter through the open plan arrangement or by a prepaid health plan.

Article 2. Medical Benefits

20060. Covered benefits in this chapter shall include, but not be limited to, the following when determined to be medically necessary.

(a) Inpatient and outpatient hospital services.

(b) Inpatient and outpatient professional provider services, including home health care.

(c) Diagnostic X-ray and laboratory services.

(d) Perinatal and maternity care.

(e) Children's preventive care, including, but not limited to, well-child care, routine dental checkups, and immunizations.

(f) Adult preventive care.

(g) Durable medical equipment.

(h) Podiatry.

(i) Unreplaced blood.

(j) Dialysis.

(k) Emergency transportation.

(*l*) Rehabilitative care.

(m) Alcohol and drug abuse or addiction treatment, or both.

(n) (1) Prescription drugs.

(2) In order to reduce the cost of prescription drugs, the commission shall use its buying power to purchase prescription drugs at the lowest possible prices directly from the manufacturers.

20061. Nothing in this article shall preclude the direct reimbursement of nurse practitioners or other advanced practice nurses in providing covered services or benefits within the scope of their practice.

20062. The commission may, at its discretion, include coverage for any service or benefit that is not listed as a covered benefit that the commission determines is of

equivalent therapeutic value or that is a less costly treatment alternative to a listed service, if the service or benefit is provided by a licensed professional acting within the scope of his or her practice.

Article 3. Long-Term Services

20100. (a) Long-term services which are necessary for the health, social, and personal needs of individuals with limited self-care capabilities are covered benefits under this division as provided in this section.

(b) Long-term services shall include all of the following:

(1) Institutional and residential care.

(2) Home health care.

(3) Hospice care.

(4) Home- and community-based services, including personal assistance and attendant care.

(c) Individual needs shall be determined through a standardized assessment of the individual's abilities for self-care and shall include all of the following:

(1) Medical examinations necessary to determine what, if any, level of medical care is required.

(2) Environmental and psychosocial evaluations to determine what the individual can and cannot do for himself or herself physically, as well as mentally.

(3) Services, service coordination, or case management, to ensure that necessary services are provided to enable the individual to remain safely in the least restrictive setting.

(d) Services may be provided in the individual's home, or through community-based, residential, or institutional programs.

(e) Reassessment shall be conducted at appropriate intervals, but not less than once a year.

20102. In providing long-term services under this division, the commission shall, to save program funds, encourage and reimburse noninstitutional long-term services where appropriate, as determined pursuant to the assessment process, to allow persons needing

long-term services to remain safely in their homes to the maximum extent possible.

Article 4. Mental Health Benefits

20120. (a) All of the mental health benefits listed in this article are covered benefits under this chapter.

(b) To save program funds, the commission shall encourage the use of services, service coordination, and case management which will enable the individual to remain in the least restrictive setting. Services may be provided through community-based, residential, or institutional programs.

(c) The commission shall, by July 1, 1993, appoint an independent advisory board of mental health experts and representatives of health care consumers to develop a plan for providing all necessary mental health care through the program by January 1, 1998.

20122. Fifty-two out-patient visits per year are covered benefits under this chapter.

20124. Inpatient care, other than for substance abuse, not exceeding 45 days per year is a covered benefit under this chapter.

Article 5. Dental Benefits

20130. (a) Dental benefits are a covered benefit under this chapter.

(b) All necessary dental care, including preventive care, shall initially be provided for individuals up to 18 years of age.

(c) Each year after the program becomes operational, the age limit for dental benefits shall be increased upward by one year.

Article 6. Expansion of Covered Benefits

20140. The commission may expand benefits beyond the minimum benefits described in this chapter, when expansion meets the intent of this division and there are

sufficient revenues to cover the expansion.

CHAPTER 5. FREEDOM OF CHOICE OF HEALTH CARE PROVIDERS

20150. Any eligible individual may choose to receive services under this division either from a private or public provider or hospital on the open plan or enroll in a prepaid health plan.

20152. A prepaid health plan may use any of the following methods of service delivery:

(a) A staff model, in which services are provided by salaried health professionals.

(b) A group model, in which a professional group is paid a capitation rate.

(c) An independent practice association model, in which professionals are paid fees.

(d) Any other model for delivery of care approved by the director.

20154. (a) Annually, individuals enrolled in a prepaid health plan shall be entitled to an open enrollment period of not less than one month.

(b) During the open enrollment period, an individual may enroll in another prepaid health plan or change to the open plan option.

(c) A person enrolled in the open plan may enroll in any available prepaid health plan at any time.

20155. All providers, including health plans, which receive funds or provide care pursuant to this division, shall be bound by the Unruh Civil Rights Act (Sec. 51, CCC).

20156. (a) Any prepaid health plan receiving payment from the program shall allow any eligible person to enroll in order of time of application, up to a reasonable limit determined by the capacity of the prepaid health plan to provide services.

(b) No prepaid health plan may refuse to enroll or serve any individual because of that individual's health history, preexisting health condition, age, sex, race, national origin, ancestry, sexual orientation, disability,

ethnicity, or religion.

20158. Prepaid health plans, as a condition of approval to participate in the provision of benefits under this division, shall demonstrate they will provide, or arrange and pay for, all of the benefits required for the capitation payment set by the commissioner.

20160. A prepaid health plan which does not have its own hospital facility shall contract with a hospital or hospitals for the provision of care for those enrolled in the health plan.

20162. A prepaid health plan shall demonstrate that the plan will do all of the following:

(a) Provide, or arrange and pay for, all the benefits required for the payment set by the program.

(b) Provide services of an acceptable level of quality.

(c) Charge no additional fees, premiums, or copayments other than those allowed by the commission for the provision of benefits under this division.

(d) Provide an approved grievance procedure for patients.

(e) Report to the program as required.

(f) Meet any other requirements the commission determines to be necessary to ensure that prepaid health plans are financially viable and will provide quality health care to their enrollees.

CHAPTER 6. ADMINISTRATION

Article 1. California Health Care Commission

20200. (a) There is in state government the California Health Care Commission.

(b) The commission shall administer this chapter.

20202. The commission shall consist of 15 members who shall be appointed as follows:

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

(1) One person, who shall be licensed as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions

Code, who shall spend at least 20 hours per week caring for patients with health care coverage provided pursuant to this chapter.

(2) One person who shall be actively involved in the administration of a hospital or other inpatient health facility which treats beneficiaries under this chapter.

(3) One person who represents businesses with 50 or more employees.

(4) One person representing the beneficiaries whose right to health care is guaranteed pursuant to this chapter.

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

(1) One person who shall represent nurses.

(2) One person who shall represent prepaid health plans.

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

(4) One person who shall represent the beneficiaries whose right to health care is guaranteed pursuant to this division.

(c) Four persons appointed by the Senate Committee on Rules, for staggered six-year terms, as follows:

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

(2) One person who shall represent labor.

(3) One academic expert in the field of health care delivery systems.

(4) One person who shall represent the beneficiaries whose right to health care is guaranteed pursuant to this division.

(d) Three persons appointed by the State Insurance Commissioner, for staggered six-year terms, as follows:

(1) Two persons who shall represent the beneficiaries whose right to health care is guaranteed pursuant to this division.

(2) One person who shall represent nonprofit community clinics.

(e) The beneficiary representatives and the persons appointed pursuant to paragraph (3) of subdivision (a),

and paragraphs (1), (2), and (3) of subdivision (c), shall be persons with no direct connection to the health industry.

20204. (a) Initial appointments to the commission shall be made by all appointing powers no later than July 1, 1993.

(b) Five of the initial appointees shall serve two-year terms.

(c) Five of the initial appointees shall serve four-year terms.

(d) Five of the initial appointees shall serve six-year terms.

(e) The term of any of each initial appointee shall be determined by lot.

Article 2. Commission Powers and Duties

20210. The powers and duties of the commission shall be as provided in this article.

20212. (a) The commission shall establish and maintain a system of universal access to covered medically necessary health care for all Californians, as required by this chapter.

(b) The commission's powers and duties shall include all of the following:

(1) Implementation of statutory eligibility standards.

(2) (A) Annual adoption of a benefits package which meets or exceeds the minimums required by law.

(B) The benefits package shall only exceed the minimums required by law when expansion of the package meets the intent of this division and there are sufficient revenues to adequately cover the expansion.

(3) Establishment of a ratesetting mechanism with annual review of sufficiency of rates.

(4) Acting directly, or through one or more contractors, as the single payor for all claims for services provided under this chapter.

(5) Establishment of an enrollment system which ensures that all eligible persons are aware of their right to health care and are formally enrolled.

(6) Maintenance of an evaluation mechanism which reviews access to care, quality of care, and provider participation.

20214. The commission shall implement statutory eligibility standards.

20216. The commission shall establish a ratesetting mechanism with an annual review of the sufficiency of the rates imposed pursuant to this division.

20218. The commission shall, either directly or through one or more contractors, act as the single agency to pay claims for services provided under this division.

20220. The commission shall establish an enrollment system which shall ensure that all eligible individuals are made aware of their right to health care benefits provided under this chapter and which shall provide for the enrollment of any eligible individual under this division.

20221. (a) The commission shall periodically study the impact of migration to the state on the ability of the program to provide necessary health and long-term care for beneficiaries.

(b) If the commission finds, based on credible evidence, that migration to the state is imposing a significant financial burden on the program, the commission shall make recommendations to the Legislature on mitigating the financial burden.

(c) If the commission finds, pursuant to subdivision (a), that migration to the state is imposing a significant financial burden on the program, the commission may impose an income-based sliding fee applicable to recent arrivals in the state. No share-of-cost shall be required under this subdivision for an individual whose family income is 250 percent or less of the federal poverty level, or who is employed, or who is a dependent of an employed person, in the state.

(d) If the commission finds that the number of individuals migrating to the state primarily to utilize the long-term care benefits provided by the program is imposing a significant financial burden on the program, the commission may impose an income-based sliding fee

scale for long-term care services on individuals with income over 250 percent of the federal poverty level who have not lived, worked, or paid state income or property taxes in the state for a period of five years, with the period to begin no earlier than January 1, 1992. The share-of-cost shall not be imposed upon any individual for more than five years from the date that the individual moved to the state.

20222. The commission shall establish and maintain an evaluation system which reviews access to care, the quality of care, and provider participation under this division.

20224. The commission shall annually prepare a budget for the administration of this division, including the employment of staff.

20225. On or before January 1, 1994, the commission shall identify state-administered health, mental health, and long-term health care programs whose benefits and services substantially duplicate those provided under this division and shall make recommendations to the Legislature for the transfer of funding for those programs to the Right to Health Care Fund.

20226. The commission shall study the feasibility of integrating health benefits provided under workers' compensation, auto, homeowners', and other liability coverages with the benefits provided under this division and shall submit a report of its findings to the Legislature on or before July 1, 1994.

20227. The commission shall have all authority and duties necessary for the administration of this division.

Article 3. Health Care Director

20230. (a) The commission shall appoint a Health Care Director, who shall function as the chief executive officer for the administration of this division.

(b) The director shall serve a minimum of four years, unless he or she receives a vote of no confidence by not less than two-thirds of the membership of the commission.

(c) The director shall be exempt from civil service.

(d) The director may employ appropriate staff necessary to implement this division.

Article 4. Program Implementation

20240. The commission shall establish and maintain a system of universal health care to cover medically necessary health care for all Californians pursuant to this division.

20242. (a) The commission shall ensure that the program established pursuant to this division shall use the most efficient structure and means of administration.

Article 5. Implementation Schedule

20245. (a) The commission shall establish a schedule for the implementation of this division.

(b) (1) The commission shall phase in the implementation of the program by January 1, 1995.

(2) The commission, in phasing in the implementation of the program, shall focus on ensuring that services are expanded for underserved populations.

20246. It is the intent of the Legislature to appropriate funds for the purposes of the program which are sufficient to ensure the program has the capacity to become operational on January 1, 1995.

CHAPTER 7. MONITORING

20250. The commission, in consultation with the Legislative Analyst and such other experts as it may deem appropriate, shall develop an evaluation and monitoring program which considers, at a minimum, the quality of care and access to care provided by the program, including geographic distribution of health care resources.

CHAPTER 8. EFFICIENCY OF OPERATIONS

20260. The director shall set standards and conduct the retrospective review of the utilization of benefits under this division to ensure that effective, cost efficient, and appropriate services are rendered under this division.

20262. The director shall make timely payments to providers, including prepaid health plans and hospitals, and shall establish a system which is efficient for health care providers and the commission to administer, which eliminates unnecessary administrative costs. The cost of administration shall not exceed the limits set in Section 20280.

20264. (a) The director shall establish uniform reporting requirements for all health care providers.

(b) To the extent permitted by federal law, the director shall implement standardized claims and reporting methods under this division.

(c) (1) The director shall require all recipients of funds under this division to periodically report information which the director determines to be necessary for the planning, budgeting, and quality assurance of care provided under this division.

(2) The director shall make any information and reports submitted pursuant to this section, and the analysis of the data contained in those reports, available to the public.

CHAPTER 9. CONFIDENTIALITY OF RECORDS

20270. This division shall not affect any provision of law in effect regarding the confidentiality of communications between a recipient of services under this division and the health care provider, and existing provisions of law regarding the confidentiality of medical records and patient-health care provider communications shall apply to this division.

CHAPTER 10. ALLOCATION OF FUNDS

20280. Not more than 4 percent of the funds appropriated for the program shall be used for the administration of the program.

20282. The director shall consolidate all programs in effect on the effective date of this division, and any program effected on or after that date, which provides, directs, monitors, or facilitates health or long-term care services provided by the program, and shall eliminate duplication of administration to the greatest extent possible.

20284. That amount of any appropriation for the purposes of this division remaining after appropriate funds are allocated for administrative costs, capital expenditures, and reserves shall be divided, based on the geographic variations in costs of services and the proportion of individuals, adjusted for health risk variations, enrolled in the open plan, prepaid health plans, and hospitals.

CHAPTER 11. PROVIDER REIMBURSEMENT

20290. Prepaid health plans may reimburse providers by any method of reimbursement authorized by Section 20152.

20291. Providers shall not charge any fee for services covered under Chapter 3 (commencing with Section 20050) which exceeds the rate set or negotiated by the program.

20292. Providers shall be reimbursed for services provided under this division as follows:

(a) The program shall reimburse individual providers, other than hospitals, for the provision of covered services in the open plan pursuant to a resource-based relative value fee schedule established by the director, based on the total amount of funds available to the open plan.

(b) (1) Hospitals shall be reimbursed on the basis of a global annual budget for all covered services rendered under the program to eligible individuals, based on its

census, location, the acuity of its patient population, and other relevant factors.

(2) The director shall negotiate the budget specified in paragraph (1) with each participating hospital on an annual basis, with adjustments made for epidemics and other unforeseen catastrophic changes in the general health status of a patient population.

(c) (1) The director shall reimburse prepaid health plans on a capitated basis, for each patient, based on the total funds available to all prepaid health plans reimbursed under this division, the number of persons enrolling in the prepaid health plans, adjusted for health risk variations of enrollees, and geographical variations in costs of services.

(2) If a prepaid health plan does not have its own hospital facility, the total capitated payment to the prepaid health plan shall be reduced, based on the cost of hospital care delivered to enrollees.

CHAPTER 12. CAPITAL EXPENDITURES AND ALLOCATIONS

Article 1. Capital Allocations

20300. (a) The commission shall annually adopt a capital expenditure budget.

(b) Allocations to geographic areas and to individual provider facilities shall be based on need and shall be calculated so that the minimum access standards adopted by the commission will be met in all areas of the state, and shall ensure the efficient development and operation of necessary facilities.

20302. (a) No later than January 1, 1994, the commission shall report to the appropriate committees of the Legislature on the capital needs of California health facilities, including county facilities, with a focus on underserved geographic areas with substantially below average health facilities and investment per capita as compared to the state average.

(b) The report required by subdivision (a) shall also

address geographic areas where the distance to health facilities imposes a barrier to care.

Article 2. Capital Expenditures

20310. During the period commencing on the operative date of this section and ending July 1, 1996, no capital investment in health care facilities in excess of five hundred thousand dollars ($500,000) shall be made without prior approval of the commission.

20312. Commencing July 1, 1996, the commission shall approve any capital investment in health care facilities in excess of the amount determined by the commission.

20314. The approval of any capital investment by the commission shall be based on efforts to do all of the following:

(a) Fulfill unmet needs.

(b) Preclude unnecessary expansion of facilities and services.

(c) Ensure the efficient development of health care facilities that are appropriate to the services provided.

(d) Ensure sufficient access to health care facilities.

(e) Ensure access to efficacious new technologies.

20316. The commission, in approving any capital investment under this article, shall consider the level of cost control which can be attained through control over capital expenditures, administrative efficiency, unmet capital needs, and any other relevant factors.

CHAPTER 13. RESERVES

20320. The director shall establish and retain a reserve account of 1 percent of the total revenues collected for the support of this program during budgetary shortfalls or epidemics as defined by the commission.

20321. Whenever the director determines that the reserve account exceeds 1 percent of the total revenues collected for the support of this program, he or she shall report to the commission and the Legislature on

appropriate options, including, but not limited to, increasing benefits, adjusting rates of reimbursement, improving access, reducing payroll tax rates, and expanding the reserve.

20322. The commission shall review and adjust its budget, fee schedules, and capitation rates on a regular basis, according to a schedule established by the commission, to ensure that the program remains solvent and that the payments to health care providers are equitable, prompt, and within the program budget.

CHAPTER 14. RIGHT TO HEALTH CARE FUND

20330. (a) There is in the State Treasury the Right to Health Care Fund.

(b) All funds in the Right to Health Care Fund are continuously appropriated to the commission, without regard to fiscal years, for the purposes of this division.

20332. (a) There is in the Right to Health Care Fund the Cigarette and Tobacco Products Surtax Account.

(b) Commencing January 1, 1995, all funds deposited in the Hospital Services Account, Physician Services Account, and the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund shall be transferred on a quarterly basis to the Cigarette and Tobacco Products Surtax Account in the Right to Health Care Fund.

(c) The Cigarette and Tobacco Products Surtax Account in the Right to Health Care Fund is continuously appropriated, without regard to fiscal years, to the commission, for the purposes of this division.

(d) Those funds appropriated by this section which have been transferred from the Cigarette and Tobacco Products Surtax Fund shall be used only to the extent authorized by Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code.

20333.5. After receipt of the appropriate federal waivers pursuant to Section 20390, the commission shall notify the Department of Finance regarding the date

when the Medical Assistance Program (Medi-Cal) will be merged with the universal health care system. As of that date, there is continuously appropriated from the General Fund and without regard to fiscal years, to the Right to Health Care Fund an amount equal to the General Fund allocation to the Medi-Cal program, for the 1990–91 fiscal year, adjusted annually for increases in caseload and for increases in the cost of living, as measured by the Consumer Price Index for the State of California, as determined by the United States Bureau of Labor Statistics.

CHAPTER 15. FRANCHISE TAX BOARD AND EMPLOYMENT DEVELOPMENT DEPARTMENT ADMINISTRATIVE COSTS

20340. The commission shall reimburse the Franchise Tax Board and Employment Development Department for the cost of administering Chapter 18 (commencing with Section 20400).

20342. Upon the request of the director, the Franchise Tax Board shall make any aggregated relevant information available to the director.

CHAPTER 16. REPORTS

20360. (a) Commencing January 1, 1996, the commission shall make a report to the public, the appropriate committees of the Legislature, and the Governor every five years, which shall contain an evaluation of the program.

(b) The report required by subdivision (a) shall include all of the following:

(1) A description of the commission's evaluation and monitoring program.

(2) A description of the successes and problems in the areas of access and quality.

(3) The results of surveys of consumer and provider satisfaction with the program.

20362. (a) The commission shall make a report, annually, to the appropriate committees of the

Legislature and the Governor, which summarizes information about health needs, health services, health expenditures, revenues, and other relevant issues relating to the program.

(b) The report required by subdivision (a) shall contain the commission's recommendations for any legislation necessary to maintain or improve the efficient performance of the program.

CHAPTER 17. MISCELLANEOUS

20370. (a) The commission shall seek all necessary federal waivers, exemptions, agreements, or legislation which will allow that all federal payments for health, mental health, and long-term care made to this state will be paid directly to the commission for the purposes of the program, and for the assumption, by the program, of the responsibility for all benefits previously paid for by the federal government.

(b) The commission shall, in all cases, seek to maximize federal contributions and payments for health, mental health, and long-term care services provided in this state, and, in obtaining the waivers, exemptions, agreements, or legislation required by subdivision (a), the commission shall ensure that the contributions of the federal government for health, mental health, and long-term care services in California will not decrease in relation to other states as a result of the waivers, exemptions, agreements, or legislation.

20375. Coverage and benefits provided under this division shall be secondary to any coverage provided under any workers' compensation, automobile insurance, or liability insurance policy.

20380. (a) The director may require copayments for services of not more than 10 percent of the cost of the services, not to exceed two hundred fifty dollars ($250) per year in copayments for individuals, and five hundred dollars ($500) for families.

(b) Persons who have income below 250 percent of federal poverty guidelines shall not be required to pay

any copayments.

(c) No copayments may be required that create a barrier to medically necessary care.

20382. (a) A prepaid health plan may impose copayments from its members no greater than 5 percent of the cost of services, and not more than one hundred dollars ($100) per year per individual or two hundred fifty dollars ($250) per year for families.

(b) Persons who have incomes below 250 percent of the federal poverty guidelines shall not be required to pay any copayments. No copayments may be required that create a barrier to necessary care.

(c) No individual in either the open plan or a prepaid health plan shall be required to meet a deductible as a condition for receiving health care services.

20384. The cost of any necessary research and education related to medicine and health, other than patient and consumer education, shall not be paid by the program.

20386. Insurance companies may sell, subject to the approval of the Insurance Commissioner, health insurance to cover benefits not provided by the program. However, no private insurance may be sold to cover benefits which individuals are entitled to receive from the program.

20387. The department shall report to the commission, no later than July 1, 1993, regarding all of the following:

(a) All federal medicaid options and other federal options which the state has not exercised but would allow greater federal participation in the provision of health care services pursuant to this division.

(b) The amount of potential federal participation relating to each option.

(c) The amount of expanded federal participation which could be expected if outreach and other efforts were initiated to expand participation in present programs, including the medically needy program.

(d) A process by which the Medi-Cal program could be transferred to the commission and integrated into the

universal health care system by July 1, 1994.

20388. The commission shall implement the report of the department to take advantage of all federal medicaid options to maximize eligibility and services, and shall take steps to maximize participation in all programs with federal participation, as soon as possible after the issuance of the department's report. Payment for those services shall come from the Right to Health Care Fund.

20389. The department shall conduct a vigorous outreach campaign to notify potentially eligible persons, including the medically needy, of their eligibility.

20390. When directed to do so by the commission, the director shall petition the federal government for a waiver pursuant to Section 1315 of Title 42 of the United States Code for the purpose of providing medical services to medicaid beneficiaries. The state shall, at a minimum, continue to match federal financial participation at the same rate at which the match was made during the 1990–91 fiscal year.

CHAPTER 18. HEALTH CARE SURCHARGES

20400. (a) Commencing January 1, 1995, there shall be imposed on the gross payroll of every employer in the state a surcharge at the rate of 10 percent of the amount of the gross payroll, including remunerations to employees as defined in Section 13004 of the Unemployment Insurance Code.

(b) Self-employed individuals shall be subject to the surcharge rate of 10 percent of the amount of net earnings from self-employment. This surcharge amount shall be deductible as a trade or business expense in determining adjusted gross income.

20402. Employers in business for less than three years subject to the surcharge imposed by Section 20400 shall be subject to a graduated surcharge.

20404. (a) There is hereby imposed a surcharge on each resident at the rate of 1.5 percent of the sum of his or her California adjusted gross income plus social security, Tier 1 railroad retirement benefits, California

unemployment compensation, and California lottery winnings, in excess of 250 percent of the federal poverty guidelines. To the extent a surcharge is imposed under this section, in no event shall the amount be less than one hundred dollars ($100) per California income tax return or fifty dollars ($50) per California income tax return for a married person filing separately from his or her spouse.

20406. (a) The Franchise Tax Board shall be responsible for the administration of the surcharges imposed by Section 20404 and subdivision (b) of Section 20400.

(b) The Employment Development Department shall be responsible for the administration of the surcharge imposed by subdivision (a) of Section 20400.

(c) The surcharges imposed by Section 20404 and subdivision (a) of Section 20400 shall be withheld by the employer and transmitted to the Employment Development Department at the same time and in the same manner as other payroll taxes.

(d) The surcharges imposed by subdivision (b) of Section 20400 shall be paid at the same time and in the same manner as other taxes imposed on self-employed individuals.

(e) All funds collected pursuant to this chapter shall be transferred to, or deposited in, the Right to Health Care Fund.

20408. The Franchise Tax Board and Employment Development Department shall administer this chapter pursuant to regulations adopted by the Franchise Tax Board and Employment Development Department in accordance with the personal income tax and withholding tax on wages laws.

20409. (a) The commission shall obtain and maintain information regarding covered individuals and furnish that information to the Franchise Tax Board or Employment Development Department, upon request, for purposes of administering the surcharges imposed by this chapter and for administering the tax laws.

(b) The Franchise Tax Board and Employment Development Department shall disclose tax return

information to the commission upon request, for purposes of administering this division.

20410. This chapter shall be operative for income years beginning on or after January 1, 1995.

~~CHAPTER 20. SEVERABILITY~~

~~20430. If any provision of this division or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.~~

~~CHAPTER 21.~~

CHAPTER 20. ENFORCEMENT

20440. Any person who is eligible for health care services under this division has the right to equitable access to medically necessary health care, and shall have standing to enforce this division.

SEC. 7. (a) The sum of one million dollars ($1,000,000) is appropriated from the General Fund to the commission for the purposes of starting the program established by Division 13 (commencing with Section 20000) of the Welfare and Institutions Code.

(b) The commission shall repay the amount appropriated by subdivision (a) to the General Fund on or before December 31, 1995, with interest at the rate earned by the Pooled Money Investment Fund.

SEC. 8. Sections 4, 5, 6, and 7 of this bill shall not take effect until Senate Constitutional Amendment 5 of the 1991–92 Regular Session is approved by the voters.

SEC. 9. If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

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AMENDED IN ASSEMBLY APRIL 4, 1990

CALIFORNIA LEGISLATURE—1989–90 REGULAR SESSION

ASSEMBLY BILL No. 3032

Introduced by Assembly ~~Member~~ ~~Willie~~ ~~Brown~~ *Members Willie Brown and Margolin*

February 20, 1990

~~An act to amend Section 2533 of the Labor Code, relating to employee health care coverage.~~ *An act to amend Sections 2395.5 and 2400 of the Business and Professions Code, to add Section 411.30 to the Code of Civil Procedure, to add Part 8.5 (commencing with Section 2100) to Division 2 of the Labor Code, to amend Sections 17053.20 and 23615 of, and to add Section 17096 to, the Revenue and Taxation Code, relating to health care, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 3032, as amended, W. Brown. ~~Employee health~~ *Health* care coverage.

~~Under the existing Tucker Health Care Coverage Act of 1989, which will become operative on January 1, 1992, an employer may select health care coverage required to be provided by purchasing coverage authorized by any statute, including a specified provision in the Insurance Code.~~

~~This bill would delete the reference to this specified Insurance Code provision.~~

Under existing law, basic health care services are provided to certain qualified low-income individuals through the Medi-Cal program which is administered by the State Department of Health Services. However, existing law does not require an employer to provide health care insurance for employees.

This bill would enact the Health Insurance Act of 1990, which would require every employer to provide health care

coverage to all employees. The bill would require that this mandatory health care coverage include a specified minimum list of benefits and services, and would exclude certain benefits and services from coverage as minimum mandatory benefits.

The bill would require that employers pay 75% of the cost of the least costly available health care coverage for employees, and 50% of the cost of that coverage for dependents of employees. The bill would state the intent of the Legislature that where coverage which exceeds the minimum benefits required by the bill has been or is provided by an employer, that coverage and the method of payment for the coverage shall continue as established by employer practices.

The bill would allow employers to select coverage from any insurance carrier, or to provide coverage through self-funded employer-sponsored plans. The bill would also permit employers to form associations for the purpose of pooling employees to obtain group coverage at lower rates.

The bill would require any employer who fails to provide the required coverage to pay for the health care costs incurred by an employee during the period that employee did not have employer provided coverage.

This bill would also establish the Cal-Care program under which specified eligible employers and employees could obtain the minimum required coverage. Those eligible employers and employees who opt to purchase coverage through Cal-Care would pay a specified monthly premium through the withholding of health premium surcharges of an unspecified percent of gross payroll or wages. The Cal-Care premium would be subsidized for those employers and employees who meet specified requirements.

The bill would provide for the administration of the collection of surcharges by the Franchise Tax Board. The Franchise Tax Board would be authorized to contract with the Employment Development Department for the collection of these amounts.

The bill would require the California Medical Assistance Commission to negotiate the rates at which providers of hospital services to Cal-Care enrollees would be reimbursed.

The rates would be based on the rates negotiated by the California Medical Assistance Commission for reimbursement of Medi-Cal providers increased by specified percentages for targeted service categories. The bill would state the intent of the Legislature that funds for the increases in provider reimbursement rates come from future appropriations.

The bill would require all health care insurance carriers doing business in the state to provide coverage for the basic minimum required benefits, and would establish some requirements regarding the underwriting practices of health care insurance carriers.

This bill would provide for the review and modification of this plan for mandatory health insurance coverage by the Secretaries of Business, Transportation and Housing, and Health and Welfare, for purposes of monitoring and responding to the effect of the program on cost containment and medical cost inflation.

The bill would further provide for cost containment by requiring drug utilization review, and copayments of specified amounts for specified services by enrollees.

The bill would require the Office of Statewide Health Planning and Development to develop an outpatient data system to collect provider specific data from providers and insurance carriers.

The bill would create the California Health Plan Fund which would be continuously appropriated for the purposes of this bill. Money in the fund would be derived from the Cal-Care health premium surcharges, and 50% of the money in the Hospital Services Account, Physician Services Account, and the Unallocated Account of the Cigarette and Tobacco Products Surtax Fund.

The bill would further provide for an annual appropriation to the California Health Plan Fund from the General Fund, in an amount equal to 50% of the amount of General Fund spending on the medically indigent services program and the county health services program during the 1988–89 fiscal year, increased as specified.

The provisions of this bill that are part of the Health Insurance Act of 1990 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. These provisions 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.

Existing Personal Income Tax Law and Bank and Corporation Tax Law authorize tax credits against the taxes imposed by those laws of the greater of $25 per covered individual or 25% per month of the costs paid or incurred during the taxable year or income year by an eligible employer to provide health coverage, as defined. These existing provisions do not become operative until January 1, 1992.

This bill would provide that these tax credits shall be the greater of $15 per covered individual or 10% per month of the costs paid or incurred to provide health coverage as specified.

Under the existing Personal Income Tax Law, gross income of an employee does not include employer-provided coverage under an accident or health insurance plan.

This bill would make an exception to that exclusion, by expressly including in gross income amounts paid or incurred by a taxpayer's employer for basic minimum coverage, as defined, where the taxpayer elects multiple coverage, as specified.

Existing law provides that corporations and other artificial legal entities have no professional rights or privileges. Existing law allows charitable institutions, foundations, or clinics to employ physician licensees on a salaried basis, but does not allow these entities to charge patients for professional services rendered by the employed licensee.

This bill would expand the authorization to hospitals, skilled nursing facilities, and other entities and would remove the prohibition on charging for professional services rendered.

Existing law provides for immunity from liability for civil damages for negligent acts or omissions of a physician licensee when serving on an on-call basis to a hospital emergency room and providing emergency obstetrical services. These provisions do not apply when consideration in any form was paid for the services rendered, and in certain other

circumstances.

This bill would expand the immunity from liability for civil damages for negligent acts or omissions to any physician licensee who provides emergency services, rather than emergency obstetrical services, in a hospital emergency room.

Existing law does not specifically require an attorney representing a plaintiff in a professional negligence action to review the facts of a case or to consult with a licensed physician regarding the merits of the case before filing a complaint.

This bill would require attorneys to file a certificate declaring that they have reviewed the facts of the case and consulted with at least one physician regarding the case. The certificate would have to be filed on or before service of the complaint on any defendant.

Vote: ~~majority~~ *⅔*. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

~~SECTION 1. Section 2533 of the Labor Code is amended to read:~~

~~2533. For purposes of this chapter, an employer may select health care coverage required to be provided by purchasing coverage authorized by any statute.~~

~~SEC. 2. This act shall become operative on January 1, 1992.~~

SECTION 1. The Legislature finds and declares all of the following:

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

(b) 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.

(c) In the last 10 years, the total number of uninsured persons in California has grown by 50 percent as a result of decreased employer coverage, more restrictive public

program eligibility, and a system of competitive health care pricing.

(d) The uninsured population of California is over five 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 the number of persons with no health insurance continues to grow significantly.

(e) In addition, 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.

(f) This lack of basic minimum health insurance for the 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, disability, and restricted ability to perform daily activities, birth defects and lifelong disabilities, uncontrolled diabetes, hypertension, and untreated chronic conditions.

(3) Increasing financial problems among those providers which continue to treat 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.

(g) 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 in any other industrialized country.

The cost of health insurance has increased at a significantly greater rate than the costs of medical care.

(h) 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. However, competitive pricing has made it more difficult to pass on the cost of treatment for uninsured persons to payers for insured persons.

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

(j) 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.

(k) Although state and local governments have provided, and continue to provide, a medical care system to serve indigent and low-income persons, due to 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.

(l) Uniform employer coverage would substantially reduce the number of Californians without health insurance.

SEC. 2. It is the intent of the Legislature to:

(a) Build on existing health insurance and health care service delivery systems, and preserve and expand the capacity of the existing public and private delivery systems.

(b) Provide incentives for the health care system to provide expanded, affordable coverage through the expansion of managed care systems.

(c) Provide for a series of evolutionary steps to modify the current system of private insurance and provider rate

setting if goals regarding access and price stability are not met within a reasonable time frame.

(d) Maximize federal participation in health care funding.

(e) Provide a minimum health care benefit package to all Californians, including those that are currently uninsured.

(f) Identify an affordable, medically viable, and actuarially sound package of minimum benefits, or a minimum benefits package defined by a cost limit.

(g) Be fair to businesses by:

(1) Assuring that businesses have a primary fiscal and managerial role in providing health coverage for employees.

(2) Assuring that coverage is affordable and available to all businesses.

(h) Avoid nonproductive employment incentives, enable employers to make employment and personnel decisions based on productivity rather than on avoiding the costs of health care coverage, and retain current flexibility in benefits for both employers and employees.

(i) Provide coverage to dependents of employees, as well as employees, in a cost-effective manner through the economies of scale associated with large risk pools and reduced per capita costs for dependent coverage.

(j) Control future year costs in order to prevent unwarranted future cost increases, and accentuate positive cost containment incentives.

(k) Take into consideration the ability of low-income employees to share the burden of health care coverage.

(l) Take into consideration the resources available to businesses, particularly small businesses, for their share of the burden.

(m) Prudently allocate and reallocate resources within the health care insurance and delivery systems.

(n) Combine cost containment, systems reform, and resource allocation to provide for the structural and fiscal integrity of the health care system.

(o) Maintain and stablilize the existing publicly supported "safety net" health care system, and provide

needed health care services to the remaining uninsured population.

(p) Hold the increases in individual and group health insurance and health care coverage to no more than the increase in the cost of living.

(q) Protect the public from unfair pricing 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.

(r) Implement all the necessary changes in the health care system in a cost-effective and administratively streamlined fashion.

SEC. 3. Section 2395.5 of the Business and Professions Code is amended to read:

2395.5. (a) A licensee who ~~serves on an on/call basis to~~ *provides services in* a hospital emergency room, who in good faith renders emergency ~~obstetrical~~ services to a person while ~~serving on/call~~ *providing services*, shall not be liable for any civil damages as a result of any negligent act or omission by the licensee in rendering the emergency ~~obstetrical~~ services. The immunity granted by this section shall not apply to acts or omissions constituting gross negligence, recklessness, or willful misconduct.

(b) The protections of subdivision (a) shall not apply to the licensee in any of the following cases:

(1) Consideration in any form was provided to the licensee for serving, or the licensee was required to ~~serve, on an on/call basis to~~ *provide services in* the hospital emergency room. In either event, the protections of subdivision (a) shall not apply unless the hospital expressly, in writing, accepts liability for the licensee's negligent acts or omissions.

(2) The licensee had provided prior medical diagnosis or treatment to the same patient for a condition having a bearing on or relevance to the treatment of the ~~obstetrical~~ condition which required emergency services.

(3) Before rendering emergency ~~obstetrical~~ services, the licensee had a contractual obligation or agreement

with the patient, another licensee, or a third-party payer on the patient's behalf to provide ~~obstetrical~~ care for the patient, or the licensee had a reasonable expectation of payment for the emergency services provided to the patient.

(c) Except as provided in subdivision (b), nothing in this section shall be construed to affect or modify the liability of the hospital for ordinary or gross negligence.

SEC. 4. Section 2400 of the Business and Professions Code is amended to read:

2400. *(a)* Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed *hospitals, skilled nursing facilities,* charitable institutions, foundations, or clinics; ~~if no charge for professional services rendered patients is made by any such institution, foundation, or clinic~~.

(b) Notwithstanding subdivision (a):

(1) Hospitals, skilled nursing facilities, and other institutions, may employ physicians as directors of patient care services for management of medical services provided by independent medical staff.

(2) Hospitals may pay malpractice insurance premiums for physicians employed full-time by the hospital, with offices in or adjacent to the hospital, as part of the hospital's liability coverage.

(c) It is the intent of the Legislature to provide for:

(1) Improved competition among hospitals for preferred provider designation from insurance carriers and large businesses who are endeavoring to maintain low health insurance premium costs.

(2) An increase in the number of hospitals who implement staff model health maintenance organization structure.

SEC. 5. Section 411.30 is added to the Code of Civil Procedure, to read:

411.30. (a) In any action for damages arising out of the professional negligence of a person holding a valid physician's and surgeon's certificate issued pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or of a person holding a valid dentist's license issued pursuant to Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code, or of a person holding a valid podiatrist's certificate issued pursuant to Article 22 (commencing with Section 2460) of Chapter 5 of Division 2 of the Business and Professions Code, or of a person licensed pursuant to the Chiropractic Act, on or before the date of service of the complaint on any defendant, the plaintiff's attorney shall file the certificate specified in subdivision (b).

(b) A certificate shall be executed by the attorney for the plaintiff declaring one of the following:

(1) That the attorney has reviewed the facts of the case, that the attorney has consulted with at least one physician and surgeon, dentist, podiatrist, or chiropractor who is licensed to practice and practices in this state or any other state or teaches at an accredited college or university and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action, and that the attorney has concluded on the basis of that review and consultation that there is reasonable and meritorious cause for the filing of the action.

(2) That the attorney was unable to obtain the consultation required by paragraph (1) because a statute of limitations, including the provisions of Article 2 (commencing with Section 583.210) of Chapter 1.5 of Title 8, would impair the action and that the certificate required by paragraph (1) could not be obtained before the impairment of the action. If a certificate is executed pursuant to this paragraph, the certificate required by paragraph (1) shall be filed within 60 days after service of the complaint.

(3) That the attorney was unable to obtain the consultation required by paragraph (1) because the

attorney had made three separate good faith attempts with three separate physicians and surgeons, dentists, podiatrists, or chiropractors to obtain the consultation and none of those contacted would agree to the consultation.

(c) Where a certificate is required pursuant to this section, only one certificate shall be filed notwithstanding that multiple defendants have been named in the complaint or may be named at a later time.

(d) Where the attorney intends to rely solely on the doctrine of "res ipsa loquitur", as defined in Section 646 of the Evidence Code, or exclusively on a failure to inform of the consequences of a procedure, or both, this section shall be inapplicable. The attorney shall certify upon filing of the complaint that the attorney is solely relying on the doctrines of "res ipsa loquitur" or failure to inform of the consequences of a medical procedure or both, and for that reason is not filing a certificate required by this section.

(e) If a request by the plaintiff for the defendant's records has been made pursuant to Section 1158 of the Evidence Code, and if the defendant has failed to produce the records within the time limits specified by that section, the time for filing the certificate of merit shall be extended for the period by which the time for furnishing records set forth in Section 1158 of the Evidence Code is exceeded by the defendant to a maximum of 60 days after which the requirement for the certificate is voided.

(f) For purposes of this section, and subject to Section 912 of the Evidence Code, an attorney who submits a certificate as required by paragraph (1) or (2) of subdivision (b) has a privilege to refuse to disclose the identity of the physician or surgeon, dentist, podiatrist, or chiropractor consulted and the contents of the consultation. The privilege shall also be held by the physician or surgeon, dentist, podiatrist, or chiropractor so consulted, provided that when the attorney makes a claim under paragraph (3) of subdivision (b) that he or she was unable to obtain the required consultation with

the physician and surgeon, dentist, podiatrist, or chiropractor, the court may require the attorney to divulge the names of physicians and surgeons, dentists, podiatrists, or chiropractors refusing the consultation.

(g) The court may impose monetary sanctions against an attorney who fails to comply with this section.

(h) A violation of this section may constitute unprofessional conduct and be grounds for discipline against the attorney.

(i) The failure to file a certificate required by this section shall be grounds for a demurrer pursuant to Section 430.10.

(j) This section shall not be applicable to a plaintiff who is not represented by an attorney.

SEC. 6. Part 8.5 (commencing with Section 2100) is added to Division 2 of the Labor Code, to read:

PART 8.5. EMPLOYEE HEALTH INSURANCE

CHAPTER 1. GENERAL PROVISIONS

Article 1. Title and Purpose

2100. This part shall be known and may be cited as the Health Insurance Act of 1990.

2101. It is the purpose of this part 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, it is intended that this part 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.

2102. This part 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 part.

Article 2. Definitions

2110. Unless the context requires otherwise, the definitions set forth in this article govern the construction of this part.

2111. "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, "administering agency" means the Employment Development Department.

2112. "Cal-Care" means a program to provide access to Cal-Care benefits for Cal-Care eligible individuals.

2113. "Cal-Care benefits" means those basic minimum benefits provided for pursuant to subdivision (b) of Section 2160.

2114. "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.

2115. "Department" means the State Department of Health Services.

2116. "Dependent" means the spouse, dependent child up to age 22, permanently disabled child, or legally dependent parent of a covered employee.

2117. "Employee" means any person who works for any employer.

2118. "Employer" means any person, partnership, corporation, association, or public or private agency employing for wages or salary one or more persons to work in this state, and includes self-employed persons.

2119. "Fund" means the California Health Plan Fund.

2120. "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 Chapter 3 (commencing with Section 2150).

2121. "Low profit employer" means an employer

whose profit per full-time-equivalent employee is below two thousand dollars ($2,000) per annum.

2122. "Other available health coverage" means any of the following:

(a) Insurance available at the place of employment

(b) Medi-Cal.

(c) Medicare.

(d) Other state and federal health care coverage provided through other provisions of law.

(e) Health insurance policies purchased by the insured individual.

2123. "Physician and surgeon," for purposes of this part, means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, or a podiatrist with a certificate to practice podiatric medicine issued pursuant to Article 22 (commencing with Section 2460) of Chapter 5 of Division 2 of the Business and Professions Code.

2124. "Principal employer" means the employer for whom any employee works the largest number of hours in any month.

2125. "Taxable gross payroll" means that portion of an employer's gross payroll attributable to those employees who are not covered by a health benefits plan.

2126. "Wages" means all renumeration 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.

CHAPTER 2. COVERAGE

2130. Every employer shall provide basic minimum health care coverage for each employee and his or her dependents pursuant to this part.

2131. Every employer required to provide health care coverage pursuant to this part may do either of the following:

(a) Select that coverage from any carrier.

(b) Provide coverage through self-funded

employer-sponsored plans.

2132. (a) Every employer shall pay at least the following:

(1) Seventy-five percent of the cost of the least costly available health care coverage for each employee of the employer.

(2) Fifty percent of the cost of the least costly available health care coverage for each of the employee's dependents.

(b) It is the intent of the Legislature that where an employer provides or has provided coverage which exceeds the minimum benefits required by this part, the coverage and method of payment for that coverage shall continue as established by employer practices.

(c) To the extent that the employee is responsible for paying all or a part of the cost of health care coverage required by this part, the employer shall withhold those amounts from the employee's salary and wages.

2133. 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.

2134. Each 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.

2135. This part does not require an employer to provide health care coverage for any employee who 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 part.

2136. This part does 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.

2137. Employers may form associations for the purpose of providing the health care coverage required by this part. Employers who form associations may do the following:

(a) Pool their employees in order to obtain group, rather than small-group or individual, rates and coverage.

(b) Provide for self-funded employer-sponsored health care coverage.

2138. Any employer who fails to provide the health care coverage required by this part shall be liable to pay for all health care costs incurred by an eligible employee during the period in which the employer failed to provide coverage.

2139. Employers providing coverage pursuant to this part shall not be required to pay for benefits when the beneficiary is entitled to receive those benefits under any workers' compensation or employers' liability law for the injury or illness.

CHAPTER 3. HEALTH CARE BENEFITS

Article 1. Covered Benefits

2150. The basic minimum health care coverage required by this part shall include all of the benefits and services listed in this article.

2150.1. Hospital inpatient care for a period of at least 30 days in each calendar year, in a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, including all of the following benefits and services:

(a) Semi-private room, including meals, general nursing services, and private room and special diets when prescribed as medically necessary.

(b) Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room, anesthesia, radiology, laboratory, and other diagnostic services.

(c) Drugs and medications administered while an

inpatient.

(d) Dressings, casts, equipment, oxygen services, and radiation therapy.

(e) Inhalation therapy following prior authorization.

2150.3. Medical and surgical services, provided on an outpatient basis whenever medically appropriate, including all of the following:

(a) Surgical services performed by a physician and surgeon.

(b) Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.

(c) Dressings, casts and use of castroom, anesthesia, and oxygen services when medically necessary.

(d) Blood derivatives and their administration, and whole blood when a volunteer blood program is not available to the enrollee.

(e) Home, office, and hospital visits by a physician and surgeon.

(f) Radiation therapy, and chemotherapy of proven benefit.

(g) Preventive services for health maintenance of minors, including well-child examinations, health evaluations, physical examinations for early detection and diagnosis of disease or other conditions, and immunizations and vaccinations in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987.

(h) Medical and surgical consultation by a physician and surgeon.

(i) Sterilization.

(j) Nothing in this section shall preclude the use of nurse practitioners or other advanced practice nurses in providing covered services.

2150.5. Comprehensive maternity and perinatal care, including the services of a physician and surgeon, and all necessary hospital services are covered services. Nothing in this section shall preclude the use of nurse practitioners or other advanced practice nurses in providing covered services.

2150.7. Emergency care, including emergency ambulance transportation is a covered service.

2150.9. One hundred days of skilled nursing, and home health care benefits limited to skilled home nursing services provided on a part-time, intermittent basis as prescribed by the patient's physician is a covered benefit.

2151.1. Hospice services are a covered service.

2151.3. Covered services include plastic and reconstructive surgical services limited to the following:

(a) Surgery to correct a physical functional disorder resulting from a congenital disease or anomaly.

(b) Surgery to correct a physical functional disorder following an injury, or incidental to surgery covered by the minimum basic health care coverage.

(c) Reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury. Internal breast prosthesis required incidental to the surgery is a covered service.

2151.5. Preventive care including periodic routine physical exams and proven preventive procedures and screenings for well-children in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987, when prescribed by a physician and surgeon is a covered benefit.

2151.7. Mental health benefits, including all of the following are covered benefits:

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

(b) At least 15 outpatient visits in each calendar year.

2151.9. (a) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration for approved indications, generic equivalents listed as substitutable in the federal Food and Drug Administration publication, "Approved Drug Products With Therapeutic Equivalence Evaluation", are covered benefits.

(b) Health benefit plans may impose cost-containment measures, including, but not limited to, requiring the use of generic drugs, or the use of a drug

formulary.

2152.1. At least 10 outpatient visits in each calendar year for speech, occupational, or physical therapy is a covered benefit.

2152.3. Preventive child dental services is a covered service.

2153. This part shall not be construed to prohibit an insurance carrier's ability to impose cost-control mechanisms, including, but not limited to, prior authorization.

Article 2. Excluded Benefits

2155. The benefits and services listed in this article shall not be included as part of the basic minimum health care coverage required by this part. Coverage of these services shall remain subject to labor negotiations, individual choice, or individual payment by patients.

2155.1. Services which are not medically necessary for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though the services are not specifically listed as exclusions, are excluded.

2155.3. Any services which are received prior to the enrollee's effective date of coverage are excluded.

2155.5. Custodial, domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required are excluded. Custodial care is care that does not require the regular services of trained medical or allied health professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.

2155.7. Personal or comfort items, or a private room in a hospital unless medically necessary, are excluded.

2155.9. Emergency facility services for non-emergency conditions are excluded.

2156.1. Excluded services include those medical,

surgical (including implants and transplants), or other health care procedures, services, drugs, or devices which are either:

(a) Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(b) Outmoded, not efficacious or not sufficiently cost-effective to be covered by the minimum basic benefit package.

2156.3. Transportation except as specified in Section 2150.7 of listed benefits is excluded.

2156.5. Implants, except pacemakers, intraocular lenses, and artificial hips are excluded.

2156.7. Any transplants and directly associated services for the patient and donor, including, but not limited to, organ, bone marrow, skin, and cornea transplants are excluded.

2156.9. Prescription and nonprescription drugs, except those provided as an inpatient hospital benefit and as specified in Section 2151.9 of listed benefits are excluded. This exclusion of drugs and medicines also excludes their administration.

2157.1. Sex change operations, investigation of or treatment for infertility, reversal of sterilization, conception by artificial means, and contraceptive supplies and devices are excluded.

2157.3. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery), routine eye examinations, including eye refractions, except when provided as part of a routine examination under "preventive care," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care are excluded.

2157.5. Speech, occupational, and physical therapy except as specified in Section 2152.1 of listed benefits are excluded.

2157.7. Durable medical equipment, including, but not limited to, hospital beds, wheelchairs, walk-aids, or other medical equipment and supplies not specifically listed in the schedule of benefits, except while in the

hospital, are excluded.

2157.9. Dental services and services for temporomandibular joint problems are excluded, except as specified in Section 2152.3, and for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within 90 days of the accidental injury or as soon thereafter as is medically feasible and provided the enrollee is eligible for covered services at the time that services are provided.

2158.1. Mental health services are excluded except as specified in Section 2151.7.

2158.3. Treatment of chemical dependency is excluded, except for acute inpatient detoxification.

2158.5. Obesity treatment and weight loss programs are excluded.

2158.7. Cosmetic surgery, including treatment for complications of cosmetic surgery is excluded, except as specifically provided in Section 2151.3.

2158.9. Excluded benefits include medical services received from or paid for by the Veterans' Administration, benefits or services that are covered under the terms of any automobile medical, automobile no fault or liability, underinsured or uninsured motorist, or similar contract of insurance, and benefits paid under Division 4 (commencing with Section 3200) or Division 4.5 (commencing with Section 6100) or any employers' liability law or federal law which provides benefit payments for the injury or illness.

2159.1. Conditions resulting from acts of war (declared or not) are excluded.

2159.3. Any service or supply not specifically listed as a covered service is excluded.

CHAPTER 4. CAL-CARE

Article 1. Benefits

2160. (a) The Cal-Care program, which shall be known and may be cited as Cal-Care, is hereby established.

(b) Cal-Care benefits shall include the following:

(1) The benefits and services listed as the basic minimum required health care coverage in Article 1 (commencing with Section 2150) of Chapter 3.

(2) The following services as provided for pursuant to Section 14132 of the Welfare and Institutions Code:

(A) All medically necessary hospitalization.

(B) Long-term care.

(C) Durable medical equipment.

(D) Short-Doyle mental health services.

Article 2. Eligibility

2160.1. Employees and self-employed persons with incomes below 200 percent of the federal poverty level are eligible for Cal-Care benefits for themselves and their dependents.

2160.2. Charitable corporations organized pursuant to Section 501(c)(3) of the Internal Revenue Code, and low-profit employers may purchase basic health care coverage through Cal-Care for their employees and employees' dependents under the premium schedule set forth in Section 2166.

2160.3. Part-time and seasonal employees are eligible for Cal-Care benefits for themselves and their dependents.

Article 3. Fiscal Provisions

2161. There is hereby established the California Health Plan Fund.

2161.5. Notwithstanding Section 13340 of the Government Code, all money in the fund is continuously appropriated to the commission for the purposes of this part. 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.

2162. All premiums and other payments collected under Section 2170 shall be deposited in the fund.

2162.5. Fifty percent of all the 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. However, if any portion of the funds received cannot be used for purposes consistent with 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.

2163. There shall be an annual appropriation from the General Fund to the fund in an amount equal to 50 percent of the 1988–89 General Fund spending on the Medically Indigent Services Program and the county health services program provided for by Section 16700 of the Welfare and Institutions Code, increased annually by the percentage increase in the California Necessities Index.

2163.5. (a) The State Department of Health Services shall seek federal approval for the inclusion of Medi-Cal recipients 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.

(b) The State Department of Health Services shall seek all appropriate federal waivers to maximize federal financial participation. The department shall report to the appropriate committees of the Legislature on any waivers received.

Article 4. Health Premium Surcharges

2165. Eligible employers and employees who opt to purchase health care coverage through the Cal-Care program shall each pay their portion of the premium by paying the health premium surcharge as provided in Section 2170.

2166. (a) The monthly premium for participation of

eligible employees in the Cal-Care plan shall be:

(1) For a single adult	*$ 84.80*
(2) For a two person family	*$168.11*
(3) For a family group of three or more	*$278.11*

(b) The premiums shall cover the cost of providing Cal-Care benefits, and shall cover administrative costs including a sales commission component. Program administrative costs shall account for no more than 6 percent of the total premiums collected.

(c) The department shall adjust these premiums annually by the increase in the Consumer Price Index.

2167. Employer and employee contributions toward the Cal-Care premium shall be in the same ratio as provided in Section 2132.

2168. Employer and employee contributions toward the Cal-Care premium for part-time employees shall be prorated to reflect the percentage of full-time (40 hours per week) work performed by that employee.

2169. The employer and employee contributions toward the Cal-Care premium shall be subsidized according to the following schedule:

(a) A 60 percent subsidy for:

(1) Employers with annual profits from zero dollars ($0) up to one thousand dollars ($1,000) per full-time-equivalent employee.

(2) Employees and self-employed persons with income below the federal poverty level.

(b) A 40 percent subsidy for:

(1) Employers with annual profits from one thousand dollars ($1,000) up to two thousand dollars ($2,000) per full-time-equivalent employee.

(2) Employees and self-employed persons with salaries between 100 and 200 percent of the federal poverty level.

2170. For those employers and employees who opt to obtain coverage for the minimum basic benefits by purchasing Cal-Care coverage, a health premium surcharge is hereby imposed as follows:

(a) On that portion of the employer's gross payroll that is attributable to employees who are not covered by a health benefits plan, a surcharge of _____ percent.

(b) On the taxable income of every self-employed individual who is not covered by a health benefits plan, a surcharge of _____ percent.

(c) On the gross wages of each employee who is not covered by a health benefits plan, a surcharge of _____ percent.

Article 5. Administration

2175. The Franchise Tax Board may contract with the Employment Development Department for the collection of those health premium surcharges imposed on the gross payroll and wages of employers and employees pursuant to Section 2170.

2176. (a) The surcharge imposed on gross payrolls by this part 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 part 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.

2177. 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.

2178. Any other taxpayer subject to taxes under this part 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.

2179. (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 part.

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

2180. The administering agency, in the enforcement of this part, shall, as soon as practicable after a return is filed under this part, examine it and determine the correct amount of the tax.

2181. 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.

2182. 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.

2183. Each notice shall set forth the reasons for the proposed additional assessment and the computation thereof.

2184. 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.

2185. If no protest is filed, the amount of the deficiency assessed becomes final upon the expiration of 60 days.

2186. 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.

2187. (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.

2188. 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.

2189. 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.

2190. 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.

2191. 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.

Article 6. Reimbursement of Cal-Care Providers

2195. (a) The California Medical Assistance Commission shall negotiate the rates, terms, and conditions for hospital contracts with providers for

services to be rendered to Cal-Care beneficiaries in conjunction with the negotiations for Medi-Cal selective provider contracts.

(b) The commission shall have all the same powers and authority to carry out the provisions of this Section as are granted to the commission under Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

2196. (a) In order to ensure that adequate access to services is available for Cal-Care enrollees throughout the state, the department shall reimburse providers of services under the Cal-Care program in the following targeted service categories at the rates negotiated by the California Medical Assistance Commission for the reimbursement of providers under the Medi-Cal program pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, increased by the following amounts:

Service Category	*Full Year Cost*	*% Adjustment*
Physicians (specific specialties to receive higher or lower percents)	*$253,631,500*	*35%*
Other Medical	*$ 37,902,175*	*25%*
Emergency Medical Transportation	*$ 1,834,500*	*30%*
Other Services	*$ 19,916,090*	*10%*
Home Health Agencies	*$ 4,125,000*	*30%*
Dental Services	*$ 20,837,600*	*40%*
Prepaid Health Plans	*$ 24,732,000*	*15%*
Child Health Disability Prevention	*$ 19,156,000*	*40%*
County Organized Health Systems	*$ 8,382,000*	*15%*
Hospital Inpatient/ Outpatient fixed		

dollar amount to be distributed via C MAC negotiations....	*$200,000,000*	*fixed*
Managed care incentives	*$ 49,753,135*	*fixed*

(b) It is the intent of the Legislature that the increases in provider reimbursement rates provided for in this section shall serve to realign reimbursement rates toward a resource based relative value scale.

(c) It is the further intent of the Legislature that funding for the increases in provider reimbursement rates provided for in this Section shall come from future appropriations.

2197. (a) Prepaid health plans which serve Cal-Care enrollees may, at their option, contract with the department to purchase hospital coverage using the rates negotiated by the California Medical Assistance Commission for Cal-Care enrollees.

(b) The purpose of this section is to help ensure the financial viability of prepaid health plans and to encourage the expansion of managed health care arrangements for Cal-Care enrollees.

CHAPTER 5. REGULATION OF HEALTH CARE INSURANCE

Article 1. General Provisions

2200. (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 practices among entities providing health insurance or health coverage which result in adverse selection, severe financial difficulties for the plans and their subscribers, and the unavailability of, and extremely high premiums for, small group health insurance.

2201. Any entity offering or providing health coverage or insurance in the state shall provide a minumum basic benefit package covering the services specified in Article 1 (commencing with Section 2150) of Chapter 3.

2202. Any insurance carrier doing business in the state may not impose preexisting condition exclusions of longer than six months. Persons changing plans after six months will be considered to have met the preexisting condition waiting period.

2203. Notwithstanding any other provision of law, any health insurance carrier doing business in this state may, as a condition of providing health insurance coverage, mediation or arbitration of a dispute of a claim prior to commencement of litigation relating to covered services.

Article 2. Regulation of Health Insurance Underwriting Practices

2205. For purposes of this article, a small group is 25 or fewer employees. Insurance carriers writing small group coverage shall be required to:

(a) Accept all small groups on a guaranteed issue and guaranteed renewable basis unless the carrier demonstrates a lack of delivery system capacity to do so.

(b) Elect a rating method for small groups as either an "A" carrier as provided in Section 2206, or a "B" carrier as provided in Section 2207.

2206. "A" carriers shall limit the number of geographic rating areas to four, and shall meet the requirements of either subdivision (a) or subdivision (b).

(a) (1) Provide no more than four family size categories.

(2) Contain no more than nine occupational categories.

(3) Contain no more than five age categories.

(4) Contain rate differences between the lowest and highest cost occupational category of no more than 30 percent, adjusted for the benefit package, age, family size, and area.

(b) Contain rates consistent with the federal law regulating health maintenance organizations, with maximum rates which do not exceed any of the following:

(1) Thirty percent of the difference between the lowest and highest small group rates, adjusted for the benefit package, age, family size, and area.

(2) A 110 percent of the carrier's community rate for the benefit package.

2207. (a) "B" carriers may do both of the following:

(1) Charge small group rates up to maximum rates. These may not exceed the lowest small group rates issued by the carrier by more than 40 percent adjusted for the benefit package, age, family size, and area.

(2) Cede up to 85 percent of the cost of a high-risk small group to the "B" carrier reinsurance board under ceding criteria acceptable to the board.

(b) "B" carriers shall pay assessments to the board based on their percentage of small group business to cover the costs of the reinsurance program. Assessments shall not exceed 5 percent of total "B" carrier small group premium.

2208. Each carrier not writing small group coverage (including self-insured plans) shall pay reinsurance assessments where the Secretary of Business, Transportation and Housing, upon the request of a "B" carrier or the reinsurance board, finds one of the following:

(a) Assessments for "B" carriers exceed 5 percent of "B" carrier small group premium.

(b) Inadequate financial capacity among "B" carriers to support the reinsurance program.

(c) Adverse impact upon a "B" carrier's large group rates because of assessments or rate limits.

2209. Health care insurance carriers shall establish the reinsurance board provided for in this article.

2210. The Insurance Commissioner shall enforce this chapter, and may adopt any regulations necessary for enforcement purposes.

CHAPTER 6. COST CONTAINMENT PROVISIONS

Article 1. Review and Modification of Health Insurance Program

2215. It is the intent of this article to ensure the long-term and ongoing affordability of mandated health care coverage costs to employees, employers, and the state's taxpayers.

2216. Each year, beginning in the third year of implementation of the programs provided for in this part, an average of the three preceding fiscal years of California's medical cost inflation rate shall be compared with the overall California Consumer Price Index. If the medical inflation rate exceeds the California Consumer Price Index, then one of the following options shall be adopted as determined by the Secretary of Health and Welfare after consultation with the Secretary of the Business, Transportation and Housing:

(a) The Cal-Care program may be made available to any person or entity wishing to purchase it.

(b) The mandate for provision of coverage by employers pursuant to Section 2130 may be made inoperative.

(c) The employer mandate may be redefined to require payment of a specific dollar amount which would be adjusted periodically. Under this option, employers share this cost with employees, and the benefit package includes the benefits chosen by employers and employees within the dollars available to purchase coverage.

(d) A fee may be charged based on the gross receipts of all providers who benefit from an excessive medical inflation rate. The fee charged shall be proportional to the degree of the medical cost inflation. Proceeds of the fee may be redistributed either to payers of health care costs, or to the subsidy system operated by the state for qualifying businesses and employees.

2217. In selecting the option to be followed pursuant to Section 2216, the secretary shall consider the following

criteria:

(a) _____.

(b) _____.

(c) _____.

Article 2. Drug Utilization Review

2218. The Legislature finds that the inappropriate use of prescription drugs is a significant factor contributing to the cost of increasing health care expenditures, and that there are severe adverse health consequences of drug interactions.

2219. Each health insurance plan shall maintain an effective prescription drug utilization review program.

Article 3. Copayments, Deductibles, and Coinsurance

2220. The Department of Corporations or the Insurance Commissioner 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 Article 2 (commencing with Section 2150) of Chapter 3.

2221. Except as otherwise provided by an employer-employee collective bargaining agreement, employee cost sharing through copayments shall be required as part of the minimum basic plan. The copayments shall include the following:

(a) Five dollars ($5) per primary care office visit, except for referral visits, preventive care, or maternity care.

(b) Two dollars ($2) per outpatient prescription for generic drugs.

(c) Five dollars ($5) per outpatient prescription for brand name drugs.

(d) Fifty dollars ($50) for inpatient hospital admission, except for maternity care, readmission for the same condition within 90 days, or for hospital outpatient

(except emergency) services.

(e) Twenty-five dollars ($25) per emergency room visit, unless admitted to the hospital, in which case, the hospital copayment shall apply.

CHAPTER 7. DATA BASE FOR MANAGEMENT AND EVALUATION

2240. The Office of Statewide Health Planning and Development shall develop a provider specific outpatient data collection system (similar to the hospital discharge data currently collected by that office) to assist payers in managing their health care resources. Information shall be collected from insurance carriers and individual providers.

CHAPTER 8. OPERATIVE DATE

2250. This part 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 part 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 part, as determined by the Director of Industrial Relations.

2251. The Secretary of Health and Welfare and the Secretary of Business, Transportation and Housing, or their designees, shall seek the necessary waiver or exemption from the federal Employee Retirement Income Security Act of 1974 in order that this part becomes operative. The secretaries shall report to the Legislature regarding any waiver or exemption received.

SEC. 7. Section 17053.20 of the Revenue and Taxation Code is amended to read:

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.

(b) The amount of the credit allowed by subdivision (a) shall be ~~twenty/five dollars ($25)~~ *fifteen dollars ($15)* per month per covered individuals or ~~25~~ *10* 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)~~ *fifteen dollars ($15)* per month or ~~25~~ *10* 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.~~ *the act which amended this section during the 1990 portion of the 1989–90 Regular Session of this Legislature.*

(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 Pediatrics.

(B) Mental health benefits consisting of at least:

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

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

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

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

(k) To be eligible for the credit under this section, each disability insurance policy, health care service plan contract, or nonprofit hospital service plan contract shall be certified as providing the basic health care services described in paragraph (4) of subdivision (h), and, if applicable, either or both of the supplemental benefits of

paragraph (6) of subdivision (h), by legal opinion of the plan's counsel, a copy of which shall be provided to each eligible employer to be retained for submission to the Franchise Tax Board upon request.

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

SEC. 8. Section 17096 is added to the Revenue and Taxation Code, to read:

17096. Notwithstanding Section 106 of the Internal Revenue Code, gross income of a taxpayer includes the amount paid or incurred by a taxpayer's employer for basic minimum health care coverage, as defined by Article 1 (commencing with Section 2150) of Chapter 3 of this part of the Labor Code, if the taxpayer elects to accept multiple employer-paid basic minimum health care coverage under any circumstance in which the employer is not required to provide coverage pursuant to Section 2135 of the Labor Code.

SEC. 9. 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)~~ *fifteen dollars ($15)* per month per covered individual or ~~25~~ *10* 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)~~ *fifteen dollars ($15)* per month or ~~25~~ *10* 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~~ *the act which amended this section during the 1990 portion of the 1989–90 Regular Session of the Legislature.*

(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 Pediatrics.

(B) Mental health benefits consisting of at least:

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

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

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

(j) The Department of Corporations shall forward to the Franchise Tax Board at least annually, or more frequently upon request, a list of all health care services plans licensed under Section 1353 of the Health and Safety Code which are required to provide the basic

health care services defined in subdivision (b) of Section 1345 of the Health and Safety Code. The Department of Insurance shall forward to the Franchise Tax Board at least annually, or more frequently upon request, a list of all insurers authorized to transact disability insurance in this state and nonprofit hospital service plan corporations holding the certificate of authority required by Section 11504 of the Insurance Code.

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

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

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