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California Research Bureau

Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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1992 – SB 248	Pages 2-34
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1994 – AB 16 (Margolin), Proposed Conference Committee Report	Pages 89-93

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AMENDED IN ASSEMBLY FEBRUARY 25, 1992

AMENDED IN ASSEMBLY JUNE 27, 1991

AMENDED IN ASSEMBLY JUNE 18, 1991

AMENDED IN SENATE APRIL 24, 1991

SENATE BILL No. 248

Introduced by Senator ~~Robbins~~ *Maddy*
(Principal coauthor: Assembly Member Brown)

January 29, 1991

~~An act to add Chapter 9 (commencing with Section 10700) to Part 2 of Division 2 of the Insurance Code, relating to insurance.~~ *An act to add Section 3700.2 to, and to add Chapter 1.5 (commencing with Section 2445) to Part 9 of Division 2 of, the Labor Code, and to add Sections 17053.21 and 23615.1 to the Revenue and Taxation Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

SB 248, as amended, ~~Robbins~~ *Maddy*. ~~Insurance: health benefits~~ *Health care.*

(1) Existing law establishes the Tucker Health Care Coverage Act of 1989, which authorizes every employer, as defined, to provide health care coverage with prescribed benefits to each employee, as defined, in a certain manner.

This bill would enact the Affordable Basic Health Care Act of 1992. Under the act, every employer, as defined, not exempt, as specified, would be required to provide basic health care coverage, as defined, to each employee, as defined, and dependent, as defined, including payment of at least 75% of the lowest premium, as defined, for basic health care coverage the employer offers each covered employee and dependent of a covered employee, basic health care coverage to each employee and his or her dependents, and

prescribed continuation of payments for health care for any employee, and his or her dependent, who is hospitalized or otherwise prevented by sickness or injury from working and earning wages and for whom sick leave benefits are exhausted.

The bill would require all health insurers, as defined, to offer to all employers with 100 employees or fewer, within the service area of the health insurer, basic health care coverage. The bill would require the health insurer to charge a single community rate, as defined, in the same geographic region for basic health care coverage, except that the premium rate offered to those employers would be prohibited from exceeding by more than 30% the community rate for basic health care coverage in the same geographic region, as described. The bill would exempt a health insurer from any law mandating benefits or mandating the offering of benefits to the extent the health insurer is offering to provide or is providing basic health care coverage, except as required by the bill.

The bill would establish the Health Care Coverage Commission with a prescribed membership and duties.

The bill would require the commission, on or before January 1, 1996, to file a comprehensive report with the Legislature, including a specific legislative proposal (a) to establish a pooling mechanism to provide basic health care coverage for every employee and dependent of an employee, including certain part-time employees, to take effect, if enacted, on or before January 1, 1997; and (b) to establish a mechanism to provide basic health care coverage for every person not otherwise covered by a private health plan, Medicare, or Medi-Cal, to take effect, if enacted, on or before January 1, 1998.

The bill would require the commission to make available to employers with 25 employees or fewer, a minimum of 6 regional small employer health benefits purchasing pools, as described.

The bill would require the Governor to appoint a Medical Policy Panel, Cost Containment Panel, and Technology Panel, with prescribed membership and duties, including advising the commission.

The bill would require the commission to determine the percentage of employers that voluntarily extend coverage equal to or greater than the coverage provided under the act, and, if the commission determines that at least 90% of the employers have voluntarily extended coverage prior to a certain date, the provisions of the act would be inoperative with respect to employers.

(2) Existing law requires every employer except the state to secure the payment of workers' compensation.

This bill would authorize any employer or association of employers, in complying with the requirements described in (1), to provide health care coverage and the obligation to provide health benefits for workers' compensation coverage in the same contract or policy. The bill would authorize any carrier to provide that consolidated coverage.

(3) Existing law provides for certain employer tax credits.

This bill would allow an employer providing basic health care coverage under prescribed conditions to receive the credits.

(4) The bill would provide that its provisions shall become operative on the day federal legislation is enacted that exempts the bill from preemption by the federal Employee Retirement Income Security Act of 1974, but in no case before January 1, 1993.

~~Under existing law, any person or entity that provides coverage for certain health benefits, and any person or entity organized for the purpose of offering or providing health coverage for employees of 2 or more employers, is presumed to be subject to the jurisdiction of the Department of Insurance, except that those provisions do not apply to health care service plans.~~

~~This bill would provide that all master group insurance policies and master group nonprofit hospital service plan contracts providing hospital, medical, or surgical benefits, regardless of the situs of their contracts or policies, coverage under which is solicited in any manner in this state to employers of 25 or fewer employees shall provide a written disclosure to be delivered at the time of solicitation, in a specified form, and containing specified information concerning the rating and renewal practices of the entity, and~~

~~a statement that a technical description of the entity's rating and renewal practices is available.~~

~~The bill would require those entities to obtain an actuarial opinion on the soundness of its rating and renewal practices.~~

~~The bill would impose requirements in the use of rating and renewal practices of those entities for small group employers. It would limit the maximum spread for all business to 175% of the lowest rate level available, and would limit premium rate increases. It would restrict transfer of participating units, as specified. It would prohibit termination of a risk due to excessive claims history or health deterioration. The bill would permit the Insurance Commissioner to waive compliance with these requirements, as specified.~~

~~The bill would provide for administrative penalties for violations, as specified.~~

~~These provisions would become operative on July 1, 1992.~~

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

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

~~SECTION 1.~~ ~~Chapter~~ ~~9 (commencing with Section~~

SECTION 1. It is the intent of the Legislature to ensure access to affordable medically necessary health care to all the people of California by the year 2000.

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

(a) Over 6,000,000 people in California have no health care coverage. Approximately two-thirds of these people are employed or are dependents of employed persons. Most of these people are working at jobs where health care coverage is not provided and at wages which make it impracticable for them to purchase private health care coverage.

(b) State and local governments have provided, and must continue to provide, a health care system to serve indigent and low-income persons. It is the intent of the people that the public safety net institutions shall have sufficient revenue to remain economically viable and to provide care that is fully equal to community standards.

However, because of public revenue constraints at both the state and local level, the ability of that system to meet California's need to make health care accessible to its uninsured is wholly inadequate.

(c) The lack of health care coverage for large numbers of Californians is causing the following very serious problems:

(1) Decreasing access to inpatient care, prenatal care, and outpatient care for the uninsured, and decreasing availability of emergency and trauma care for all Californians.

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

(3) Increasingly severe financial problems among those health care providers who continue to care for persons without health coverage, potentially resulting in the closing of emergency departments, trauma centers and hospitals, and the reduction in the availability of health care professionals so as to substantially worsen the quality of health care available to the citizens of this state.

(4) Steadily increasing health care costs and health insurance premiums for the decreasing number of consumers who pay full charges for health services.

(d) The only practical way of making affordable, quality health care available to everyone in California is to maximize the availability of employer-sponsored health care coverage, strengthen the public safety net, and ensure that all parties assume responsibility for containing health care costs, including health care providers, insurers and health care plans, consumers, employers, and government. This will permit the provision of health care through a pluralistic, market-oriented health care system, strengthened by balanced incentives, roles and responsibilities among payors, providers, patients, and government.

(e) The health delivery system in the State of California is on the verge of collapse as a result of the high demand for health care services, the lack of affordable

health care coverage, and the increasing burden of uncompensated and undercompensated care. The remedy provided herein is the only adequate and reasonable remedy within the limits of what the foregoing public health safety considerations permit now and into the forseeable future.

SEC. 3. Chapter 1.5 (commencing with Section 2445) is added to Part 9 of Division 2 of the Labor Code, to read:

CHAPTER 1.5. AFFORDABLE BASIC HEALTH CARE ACT OF 1992

Article 1. Title

2445. This chapter shall be known and may be cited as the Affordable Basic Health Care Act of 1992.

Article 2. Definitions

2445.5. Unless the context requires otherwise, the definitions set forth in this article shall govern the construction and meaning of the terms and phrases used in this chapter.

2446. "Basic health care coverage" means a health plan that provides basic health care services as set forth in this chapter.

2446.5. "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 (42 U.S.C., Sec. 186), authorized to administer, provide, or pay for health care services in this state.

2447. "Catastrophic health care coverage" means a health plan that provides coverage for catastrophic health care expenses as defined by the commission.

2447.5. "Commission" means the Health Care Coverage Commission.

2447.6. "Community rate" means the premium determined for basic health care coverage in each geographic region on a per person or per family basis and

may vary with the number of persons in a family, but the premium shall be equivalent for all individuals and for all families of similar composition, regardless of the sex, occupation, or other factor that has, or might, affect the cost of providing services to an enrollee, other than age.

2448. "Cost-sharing" means any deductible, copayment, coinsurance, or any other mechanism other than a premium payment whereby an employee pays for a portion of the cost of health services provided to the employee or the employee's dependent.

2448.5. "Dependent" means the spouse, child, or adopted child up to age 22 and permanently disabled child of the covered employee.

2449. "Employee" means any person who works at least 17.5 hours per week or 70 hours per month for any single employer in a bona fide employer-employee relationship, more than 60 days in any calendar year. "Employee" shall not include an independent contractor or any registered student in a postsecondary educational institution who is working for the institution and who is covered by student health services sponsored by the institution.

2449.5. "Employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary 25 or more employees at any one time to work in this state. Effective January 1, 1995, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary 10 or more employees at any one time to work in this state. Effective January 1, 1996, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary five or more employees at any one time to work in this state. Effective January 1, 1997, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary one or more employees at any one time to work in this state.

2451. "Enrollee" means each individual with at least basic health care coverage.

2451.5. "Health insurer" means any insurer or health care service plan authorized to provide or pay for health care services in this state and regulated by the Department of Corporations or the Department of Insurance.

2452. "Health plan" means a program providing health care services directly or through insurance, reimbursement or otherwise.

2452.5. "Pool" means a regional small employer health benefits purchasing pool as set forth in Section 2482.5.

2452.6. "Practice parameter" means a strategy for patient management developed to assist physicians, in clinical decisionmaking, and includes standards, guidelines, and other patient management strategies. Only practice parameters that have been developed in conformance with the "Attributes to Guide the Development of Practice Parameters" published by the American Medical Association/Specialty Society Practice Parameters Partnership may be approved by the commission pursuant to subdivision (e) of Section 2480.5.

2453. "Premium" means the monthly per enrollee amount that the carrier charges for providing basic health care coverage, or for self-insured plans, the monthly per enrollee amount that the Health Care Coverage Commission determines to be the actuarially sound cost of the basic health care coverage, or for carriers providing partial insurance to self-insured plans, the total of the monthly per enrollee amount which the carrier charges for providing basic health care coverage and the monthly per enrollee amount that the Health Care Coverage Commission determines to be the actuarially sound cost of the self-insured portion of the basic health care coverage.

2453.5. "Supplemental policy" means health care coverage for services not included in the basic health care coverage as provided by Article 4 (commencing with Section 2460).

2454. "Wages" means all remuneration for services from whatever source, including commissions, bonuses,

and tips and gratuities paid directly to any individual by his or her employer or a customer.

Article 3. Employee Health Care Coverage

2455. On and after January 1, 1994, every employer shall provide basic health care coverage to each employee and his or her dependents, including all of the following:

(a) Payment of at least 75 percent of the lowest premium for basic health care coverage the employer offers for each covered employee and dependent of a covered employee.

(b) Basic health care coverage to every employee and his or her dependents, effective no later than the first day of the calendar month following the employee's 60-day anniversary.

(c) Continuation of 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, and for the dependents of the employee. This obligation shall continue for three calendar months following the month during which the employee became hospitalized or disabled from working, or until the month the employee becomes eligible for other public or private coverage, whichever occurs first.

(d) The commission may delay the phase-in of employer coverage by no more than two years for employers with fewer than 25 employees if the commission determines that the economic condition of the state would place an undue hardship on those employers.

2455.5. (a) No new employer shall be required to provide basic health care coverage until 27 months after the date the new employer first received an employer tax identification number from the Employment Development Department. The commission shall adopt regulations designed to ensure that this exemption applies only to bona fide start-up enterprises and not to

businesses resulting from the sale, reorganization, or other alteration of an existing enterprise.

(b) A new employer may waive the exemption set forth in subdivision (a) by submitting a written waiver on a form prescribed by the Franchise Tax Board.

2456. Nothing in this chapter shall be construed to limit the right of employees to bargain collectively for different health care coverage, if the protection provided by the negotiated plan is at least actuarially equivalent to the protection afforded by this chapter. This chapter shall be applicable with respect to any employees who do not receive at least this level of protection or who are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party.

2456.5. An employer shall not be required to provide health care coverage pursuant to this article with respect to any employee or dependent if the employee waives enrollment of the employee or the employee's dependent in writing pursuant to Section 2458.

2457. An employer shall deduct from the wages owed to any employee the amount sufficient to cover the employee's contribution, if any, to the premium required by Section 2457.5.

2457.5. An employee shall pay for any portion of the premium not covered by the employee's employer or the commission.

2458. (a) An employee shall not waive basic health care coverage for the employee or the employee's dependents except as provided in this section, which requires an employee to waive basic health care coverage as necessary to avoid duplicate coverage. The employee shall have the right to elect which coverage to waive should a waiver be required by this section.

(b) An employee that has basic health care coverage for the employee or his or her dependents, or both, shall waive any duplicate coverage, but only for the period that the employee or the dependent, or both, has at least basic health care coverage.

(c) A dependent minor who is employed, or a parent

or guardian on the behalf of a dependent minor under 12 years of age, shall waive basic health care coverage provided by the dependent minor's employer, but only if and for the period that the dependent minor, or parent or guardian on behalf of the dependent minor, has at least basic health care coverage.

(d) If an individual is an employee of more than one employer, the employee shall waive basic health care coverage from all but one employer, such that the employee and each dependent has only one basic health care coverage.

(e) An employee who waives health care coverage pursuant to this section shall notify his or her employer immediately if the duplicate coverage is terminated, and shall enroll in the employer's health care plan effective not later than the first day of a calendar month following 30 days from the date of the termination of coverage.

2458.5. An employer shall not fail or refuse to hire, and shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child or other dependent and the employer would be required by this article to provide basic health care coverage for the spouse or child or other dependent. A violation of this section constitutes unlawful discrimination within the meaning of Section 51 of the Civil Code, and an unfair business practice within the meaning of Section 17200 of the Business and Professions Code.

2459. Any employer who fails to provide basic health care coverage as required by this act shall be liable for twice the health care costs incurred by an employee or that employee's dependent during the period in which the employer failed to provide coverage and the employee's reasonable attorney's fees.

Article 4. Basic Health Care Benefits

2460. Basic health care coverage provided in accordance with this chapter shall include the provision of or payment for all of the following in each calendar

year that are medically necessary for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member of an enrollee, except as otherwise provided in this article:

(a) Hospital inpatient care for a period of at least 45 days in a hospital licensed pursuant to subdivision (a) or (b) of Section 1250 of the Health and Safety Code including all of the following:

(1) Room and board, including private room and special diets when prescribed as medically necessary, and general nursing services.

(2) 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.

(3) Drugs and medications administered while an inpatient.

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

(5) Respiratory and physical therapy following prior authorization.

(b) Medical and surgical services, which shall be provided on an outpatient basis when medically appropriate, including all of the following:

(1) Surgical services.

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

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

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

(5) Hospital visits, and at least 20 home or office visits.

(6) Radiation therapy and chemotherapy of proven benefit.

(7) Pap smears and mammograms under the periodicity schedules approved by the commission.

(8) Medical and surgical consultation.

(9) Sterilization, but not including sex change operations, investigation of or treatment for infertility,

reversal of sterilization, conception by artificial means, and contraceptive supplies and devices.

(c) Comprehensive maternity and perinatal care.

(d) Emergency and necessary followup care, including emergency ambulance transportation.

(e) Long-term care benefits, including home care, skilled nursing care, respite, and hospice care, to the extent the carrier determines they are less costly alternatives to covered inpatient care.

(f) Plastic and reconstructive services limited to the following:

(1) To correct a physical functional disorder resulting from a congenital disease or anomaly.

(2) To correct a physical functional disorder following an injury or incidental to surgery covered by the basic health care coverage.

(3) For reconstructive surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury. Internal breast prostheses required incidental to the surgery shall be provided.

(g) Child preventive care including periodic routine physical examinations, and proven preventive procedures, immunizations, vaccinations, 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.

(h) Mental health benefits, including both of the following or their actuarial equivalent:

(1) Inpatient care or acute residential care for a period of at least 15 days in each calendar year.

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

(i) At least 10 outpatient visits in each calendar year for speech, occupational, and physical therapy.

(j) Durable medical equipment.

(k) 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," and those additional

nonapproved indications as approved by the commission pursuant to Section 2480.5.

(l) Nothing in this chapter shall be construed as expanding or restricting the scope of practice conferred upon any person licensed, certified, or registered pursuant to the Business and Professions Code or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act.

2460.5. Basic health care coverage provided in accordance with this chapter shall not include any of the following:

(a) Anything that is either of the following:

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

(2) Determined by the commission to be outmoded, not efficacious, outside a practice parameter, or not sufficiently cost-effective pursuant to paragraph (7) of subdivision (a) of Section 2480.5.

(b) Implants, except pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips.

(c) Eyeglasses, contact lenses (except lenses for keratoconus, or following cataract surgery, or corneal transplantation), radial or hexagonal keratotomy, routine eye examinations, including eye refractions, except provided as part of a routine examination under "preventive care," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care.

(d) Prescription and nonprescription drugs, except those provided as an inpatient hospital benefit and as specified in subdivision (k) of Section 2460. Any exclusion of drugs and medicines also excludes their administration.

(e) Treatment of chemical dependency, except for acute inpatient detoxification.

(f) Obesity treatment or weight loss programs.

(g) Health care services received from or paid for by the Veterans' Administration, benefits paid under any

workers' compensation or any employers' liability law or federal law for injury or illness, or any accident insurance.

(h) Conditions resulting from acts of war whether declared or not.

(i) Any service or supply not specifically listed as a covered service or supply.

2461. Notwithstanding Sections 2460 and 2460.5, health plans meeting the minimum requirements for benefits mandated for federally qualified health maintenance organizations or for health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that provide at least the basic health care coverage specified in Section 2460 shall be deemed to constitute basic health care coverage as long as they otherwise comply with the requirements of this chapter.

2461.5. (a) Basic health care coverage may include provisions for cost sharing if the cost sharing is the same as or actuarially equivalent to all of the following:

(1) The employee's total annual out-of-pocket expenses for copayments and deductibles shall not exceed one-quarter of the annual premium for the employee and the employee's dependents, if any.

(2) Deductibles shall not exceed two hundred fifty dollars ($250) annually for an individual or five hundred dollars ($500) annually for a family, adjusted annually by a percentage equal to the percentage change, if any, in the federal minimum wage commencing January 1, 1994.

(3) No copayment shall exceed 20 percent of the charge of a covered service.

(b) Notwithstanding subdivision (a), basic health care coverage may provide for a deductible for prescription drugs provided on an outpatient basis of up to two hundred dollars ($200) annually for an individual or four hundred dollars ($400) for a family, adjusted annually by a percentage equal to the percentage change, if any, in the federal minimum wage commencing January 1, 1994.

2462. Basic health care coverage may exclude, or provide for a copayment in excess of that set forth in

Section 2461.5 for any item or services that an individual obtains without complying with any reasonable procedures established by the carrier, and approved by the licensing agency of the carrier or authorized by the commission, to ensure the efficient and appropriate utilization of nonemergency covered services, or to encourage or require the use of providers contracting with the carrier for nonemergency services.

2462.5. Basic health care coverage shall not include a lifetime policy limit of less than five hundred thousand dollars ($500,000) per enrollee, and shall not include an annual policy limit of less than the lifetime limit.

2463. Basic health care coverage shall be administered in compliance with the following minimum requirements:

(a) No contract for, or advertising of, basic health care coverage shall misrepresent the terms of any contract for basic health care coverage.

(b) Claims shall be submitted on the Uniform Claim Form or the Uniform Capitated Health Care Encounter Form approved by the commission.

Article 5. Health Insurers

2464. All health insurers shall offer to all employers with 100 employees or less within the service area of the health insurer a basic health care coverage option. Health insurers shall charge a single community rate in the same geographic region for basic health care coverage, except that the premium rate offered to any employer with 100 employees or less shall not exceed that insurer's community rate for basic health care coverage in that geographic region by more than 30 percent. Geographic underwriting standards shall be limited to six California regions as determined by the commission, reflecting geographic variations in practice costs. Health insurers may enter into subcontracts with other entities in carrying out the requirements of this section.

2464.5. Notwithstanding Section 2464, where it maintains a network, a health insurer may cease to offer

coverage to employers not already contracting with it if the health insurer reasonably anticipates that it will not have the capacity within its network of associated health providers to deliver services adequately to additional enrollees because of its obligations to existing group contractholders and enrollees. A health insurer that ceases to offer coverage pursuant to this section shall not enroll new groups of employers unless it resumes offering coverage pursuant to Section 2464. Any health insurer that offers health care coverage shall accept every employer with 100 employees or fewer that requests a rate quote and accepts the rate quote received, provided the employer complies with the requirements of the group contract or policy.

2465. Carriers shall not exclude or otherwise limit any individual from group coverage under any plan of basic health care coverage on the basis that the individual has, or at any time has had, any disease, disorder, or condition.

2465.5. Coverage accepted by employers shall be renewable with respect to all eligible employees or dependents at the option of the policyholder or contractholder except as follows:

(a) For nonpayment of the required premiums by the policyholder or contractholder.

(b) For fraud or misrepresentation of the policyholder or contractholder.

(c) For material noncompliance with plan provisions.

2466. Carriers shall enroll, not later than the first day of the calendar month following 30 days from the termination date of coverage, any individual who would otherwise be covered by a group coverage and whose duplicate coverage is terminated as set forth in subdivision (d) of Section 2458.

2466.5. To the extent they are offering to provide or are providing basic health care coverage, carriers are exempt from any law mandating benefits or mandating the offering of benefits except as specifically provided in this article.

2467. A carrier may offer and provide health care coverage that exceeds the requirements established for

basic health care coverage through a supplemental policy. Sections 2464 to 2466, inclusive, shall apply to the basic health care coverage portion of that coverage, but shall not apply to the supplemental policy providing coverage which exceeds that required for basic health care coverage.

2467.3. Carriers that provide basic health care coverage shall make available catastrophic health care coverage to retired employees not eligible for Medicare at rates based on sound actuarial principles, provided, however, that a carrier which is a federally qualified health maintenance organization may meet this requirement by offering basic health care coverage.

2467.5. Any carrier that violates any provision of this chapter shall be deemed to have committed a violation of its enabling or licensing statutes, subjecting it to all enforcement actions available to the Insurance Commissioner or Commissioner of Corporations, as applicable. Carriers not subject to the jurisdiction of the Insurance Commissioner or Commissioner of Corporations shall be subject to all the enforcement powers of the commission.

2468. Carriers may combine to establish and participate in a reinsurance program, subject to the requirements established by the commission. Carriers participating in a reinsurance program shall comply with Sections 2464 to 2466, inclusive, but may cede that portion of the risk agreed to by the reinsurance entity to the reinsurance entity. The reinsurance entity shall provide for the proper funding of the program, including actuarially sound reserves for unpaid losses, by charging the member carriers a reinsurance contribution and, as necessary, by assessing and collecting from the member carriers in proportion to their participation in the program. Any unsatisfied net liability or outstanding assessment owed by an insolvent carrier participating in the reinsurance program shall be assumed by and apportioned among the remaining carriers in the reinsurance program in the same manner in which assessments are levied by the reinsurance entity. The

reinsurance entity shall have all rights allowed by law on behalf of the remaining carriers against the insolvent carrier for sums due the program.

2468.5. This article shall be binding on carriers only with respect to basic health care coverage offered or provided to employers, as defined in Section 2449.5.

Article 7. Health Care for Every Californian

2473. On or before January 1, 1996, the commission shall file a comprehensive report with the Legislature, including a specific legislative proposal for establishing a pooling mechanism to provide basic health care coverage for all employees in the state and their dependents, including those persons who work fewer than 17.5 hours per week or 70 hours per month, or 60 days or fewer in any calendar year, and those persons who work for employers that employ fewer than five employees, to take effect, if enacted, no later than January 1, 1997.

2473.5. On or before January 1, 1997, the commission shall file a comprehensive report with the Legislature, including a specific legislative proposal for establishing a mechanism to provide basic health care coverage for every Californian not otherwise covered by a private health plan, Medicare, or Medi-Cal, to take effect if enacted no later than January 1, 1998.

2474. The commission shall study the feasibility of extending basic health care coverage to every Californian eligible for Medi-Cal. The commission shall report its findings to the Legislature on or before January 1, 1995.

Article 8. Health Care Coverage Commission

2475. There is in state government the Health Care Coverage Commission.

2475.5. The commission shall consist of 12 members appointed as follows:

(a) Six members appointed by the Governor as follows:

(1) One member who shall represent business, who

shall be experienced in the administration of, and knowledgeable about, employee health benefit plans.

(2) One member who shall represent the general public, who shall be a recipient of basic health care coverage.

(3) One member who shall represent prepaid health plans, who shall be experienced in the administration of, and knowledgeable about, prepaid health plans.

(4) One member 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 no less than 20 hours per week caring for patients with basic health care coverage.

(5) One member who shall represent general acute care hospitals, who shall be actively involved in the administration of a general acute care hospital which treats patients with basic health care coverage.

(6) One member who shall represent labor, who shall be knowledgeable about employee health benefit plans.

(b) Three members appointed by the Speaker of the Assembly as follows:

(1) One member who shall represent disability insurers, who shall be experienced in the administration of and knowledgeable about the provision of basic health care coverage.

(2) One member who shall represent general acute care hospitals, who shall be actively involved in the administration of a general acute care hospital that treats patients with basic health care coverage.

(3) One member who shall represent the general public, who shall be a recipient of basic health care coverage.

(c) Three members appointed by the Senate Rules Committee as follows:

(1) One member representing labor organizations, who shall be experienced in the administration of, and knowledgeable about, health plans.

(2) One member 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 no fewer than 20 hours per week caring for patients with basic health care coverage.

(3) One member who shall represent business, who shall be experienced in the administration of, and knowledgeable about, employee health benefit plans.

2476. The members of the commission shall serve for staggered six-year terms. The initial appointments to the commission shall be for the following terms:

(a) The Governor shall appoint two members for two-year terms, two members for four-year terms, and two members for six-year terms.

(b) The Speaker of the Assembly shall appoint one member for a two-year term, one member for a four-year term, and one member for a six-year term.

(c) The Senate Committee on Rules shall appoint one member for a two-year term, one member for a four-year term, and one member for a six-year term.

(d) The term for each of the initial appointments to the commission shall commence on January 1, 1993.

2476.5. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified.

2477. Appointments to fill vacancies on the commission shall be for the unexpired term.

2477.5. The Legislature shall determine the compensation to be paid to members of the commission. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2478. The members of the commission shall select two of its members to be chairperson and vice chairperson.

2478.5. Seven members of the commission shall constitute a quorum for the transaction of any business, for the performance of any duty, or for the exercise of any power of the commission.

2479. The commission shall appoint an executive officer who shall be exempt from civil service pursuant to subdivision (e) of Section 4 of Article VII of the California Constitution. The executive officer shall serve at the pleasure of the commission.

2479.5. The executive officer shall perform and discharge under the direction and control of the commission, the powers, duties, purposes, functions, and jurisdiction delegated to him or her by the commission.

2480. The commission shall do all of the following:

(a) File a comprehensive report with the Legislature, including a specific legislative proposal for establishing a mechanism to provide sliding-scale subsidies for low-income employees and their dependents. The commission shall identify savings to existing programs, including, but not limited to, Medi-Cal, that would accrue as a result of full implementation of this act. The commission, after identification of these savings, shall submit to the Governor and the Legislature recommendations for utilization of these savings to offset the cost of health care coverage to low-income employees and small employers.

(b) Establish any requirements the commission determines to be reasonably necessary to maximize the access to necessary health care for those carriers not regulated by the Department of Insurance or the Department of Corporations.

(c) Develop and maintain a method of responding to employers' inquiries relating to general health care coverage options, and provide comparative information on the costs, benefits, and services of all certified basic health care coverage options and those supplemental policies of which the commission is aware.

(d) Collect and refer to the Medical Policy, Cost Containment, and Technology Panels data on the utilization of health care services from carriers. The commission shall require reporting only as necessary to accomplish its purposes with respect to cost containment, access, quality, and control of expensive technology, and shall establish reporting mechanisms designed to minimize the administrative burden and cost to health care providers and carriers. Information that individually identifies patients, health care providers or carriers shall be kept confidential.

(e) Monitor the access that California residents have

to necessary health care services, determine the extent of any unmet needs for these services or lack of access or quality that may exist from time to time, and make an annual report to the Governor and the Legislature, including recommendations it deems appropriate to maximize the availability of quality health care. The report shall include the major causes of health care cost escalation, including at least the following: insurance administration, cost shifting by government, increased utilization, increased technology, the tort system, the aging population, biological epidemics, including, but not limited to, AIDS, drug abuse, and tobacco use, and other increases in practice costs. The report shall include a recommendation on the scope of basic health care benefits. Any recommendations for an increase in benefits shall include an explanation of the projected annual financial effect of the amendment expressed both in the aggregate and the amount of increase in the average premium and cost-sharing expense the average employer and employee would bear. The report shall also include recommendations the commission deems appropriate to contain health care costs, and, if the rate of premium increases has not stabilized by the time Article 3 (commencing with Section 2455) has been implemented, a recommendation of the feasibility and advisability of capping future premium increases.

(f) Monitor compliance with this chapter, and report annually to the Legislature its findings and recommendations, including any specific legislative proposal for penalties or other enforcement mechanisms as it finds are warranted.

(g) Develop a uniform claim form for use by all carriers providing basic health care coverage on a fee-for-service basis and a uniform capitated health care encounter form for all carriers providing basic health care coverage on a capitated basis. These forms shall be as similar as possible, and shall include all of the information required to be reported pursuant to subdivision (a) of Section 2480.5.

(h) Exercise all powers reasonably necessary to carry

out the powers and responsibilities granted or imposed upon it under this chapter.

2480.5. The commission shall adopt pursuant to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1, of Division 3, of Title 2, of the Government Code), all necessary rules and regulations to carry out this chapter, including, but not limited to, the following:

(a) Establishing requirements for reporting by carriers of data on the utilization of health care services to the Office of Statewide Health Planning and Development. This data collection system shall meet the following criteria:

(1) Protect the confidentiality of personal and private patient information.

(2) Preserve incentives for physicians to make diagnostic and treatment decisions based on medical necessity rather than cost alone.

(3) Avoid duplication of costs by requiring carriers rather than health care providers to submit data.

(4) Adopt safeguards to ensure that the data collected is interpreted by experienced, practicing physicians and surgeons licensed to practice medicine in California.

(5) Assure that the data collected are valid, useful, and appropriate for comparison.

(6) Afford all interested professional medical and hospital associations a minimum of 30 days to comment before any data is released to the public.

(7) Assure that data collection requirements are adequate but not onerous, cost-effective, and related to a valid and achievable purpose.

(b) Establishing procedures for appealing to the Cost Containment Panel disputes over excessive charges for health care services, as recommended by the Cost Containment Panel. These procedures shall encourage the resolution of these disputes by nonprofit medical and other professional societies that are exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code and are composed of at least 25 percent of the eligible licentiates in the geographic area served by the

society.

(c) Determining and adjudicating disputes concerning whether a health care procedure, service, drug, or device is experimental, investigational, outmoded, not efficacious, outside a practice parameter approved pursuant to subdivision (e) or otherwise not sufficiently cost-effective to be included in basic health care coverage as recommended by the Medical Policy Panel.

(d) Establishing the indications for prescription drugs that, although not approved by the federal Food and Drug Administration, are included in basic health care coverage as recommended by the Medical Policy Panel.

(e) Adopting the practice parameters that may be used by carriers providing basic health care coverage to deny payment as recommended by the Medical Policy Panel. Beneficiaries shall not be required to pay for services denied pursuant to this paragraph.

(f) Determining when the referral by health care providers to facilities in which they have an ownership interest is permitted and when such self-referral is prohibited.

2481. The commission shall hire staff and may contract with any public agency, including any agency of the state government or with any private person, as necessary to carry out its duties.

2482.5. (a) The commission shall make available to employers with 25 employees or fewer a minimum of six regional small employer health benefits purchasing pools. The commission shall contract with a minimum of six private not-for-profit corporations to administer these pools. The contractors shall not be carriers and shall have experience in the administration of health benefits programs or shall have the present or reasonably anticipated capability to administer the pool in a geographic area.

(b) Each contractor shall contract with a minimum of three carriers to make available health plans certified as basic health care coverage pursuant to Article 4 (commencing with Section 2460) and Article 5

(commencing with Section 2464).

(c) The commission shall adopt, pursuant to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1, of Division 2, of Title 2, of the Government Code), all rules and regulations necessary to implement the small employer health benefits purchasing pools, including, but not limited to, the following:

(1) Marketing and recruitment of potential enrollees.

(2) Determining eligibility for pool participation.

(3) Data collection, analysis, and reporting.

(4) Financial solvency of participating carriers.

(5) Methods of collecting premiums and available subsidies.

(d) Employers that participate in a pool shall purchase basic health care coverage for all of its employees and their dependents who have not waived coverage pursuant to Section 2458.

(e) Costs for the administration of the purchasing pools may be borne by carriers that make available basic health care coverage to employers in the pool.

Article 9. Medical Policy Panel

2484. Upon the nomination of the commission, the Governor shall appoint a Medical Policy Panel which shall be composed of seven physicians and surgeons licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, as set forth in Chapter 8 (commencing with Section 3600) of Division 2 of the Business and Professions Code), and in the active practice of medicine, and one member representing each of the following: hospitals, nursing, labor, business and carriers providing basic health care coverage. The physician panel members shall be nominated by the commission after it has consulted with the statewide and local associations of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide

association of hospitals. The person representing nursing shall be nominated by the commission after consultation with the statewide association of nursing. No physician member of the panel shall practice in the same medical specialty as any other physician member nor conduct his or her primary practice in the same county, as any other physician member. At least two members of the panel shall have experience in the administration of utilization review systems.

2484.5. Members of the panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2485. The Medical Policy Panel shall have the authority to do all of the following:

(a) Recommend to the commission those health care procedures, services, drugs or devices that are experimental, investigational, outmoded, not efficacious, or otherwise not sufficiently cost-effective to be included in basic health care coverage. In making these determinations, the panel shall consider the opinions of the state and national medical and specialty organizations, the National Institutes of Health, the Agency for Health Care Policy and Research, and other interested parties.

(b) Recommend to the commission those indications for prescription drugs that although not approved by the federal Food and Drug Administration, are sufficiently efficacious and cost-effective to be included in basic health care coverage.

(c) Analyze the utilization data collected by the commission for patterns of practice and report annually

to the commission its recommendations for improving the quality and availability of care.

(d) Contract with nonprofit professional medical, osteopathic, podiatric, hospital, and health facility societies exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code for peer review to evaluate aberrant patterns of practice of providers discovered in the course of the panel's duties set forth in subdivision (c) or brought to the attention of the commission by carriers. These contracts shall allow for reimbursement by the commission or the parties seeking the review of the costs of the review, but shall provide no profit to the professional association. Results of the review shall be used solely for peer education of the health care provider or education of the carrier as indicated. If the panel determines that educational efforts have failed, the panel shall refer the matter to the appropriate licensing agency. The records and proceedings of the panel and the contracting organizations shall be confidential unless and until a licensing agency takes formal action.

(e) Review the practice parameters developed by state and national medical and specialty organizations, the National Institutes of Health, and other interested parties and recommend to the commission those practice parameters that may be authorized for use by carriers providing basic health care coverage to deny payment.

(f) Recommend to the commission the scope of basic health care benefits. Any recommendation for a change in the scope of benefits shall include an explanation of the health impact on enrollees.

2485.5. The Medical Policy Panel may establish subcommittees of its members as it deems necessary to assist the panel in the performance of its duties, and may delegate the performance of its peer review duty set forth in subdivision (d) of Section 2485 to any subcommittee that has a minimum of two panel members. The panel may request the assistance of physician and surgeon members of a medical quality review committee established pursuant to Article 13

(commencing with Section 2320) of Chapter 5 of Division 2 of the Business and Professions Code, as it deems necessary to assist the panel or its subcommittees in the performance of its duties, and each committee member who agrees to serve shall be subject to applicable laws, rules and regulations as if he or she were a member of the panel.

Article 10. Cost Containment Panel

2486. Upon the nomination of the commission, the Governor shall appoint a Cost Containment Panel that shall be composed of one person representing businesses with 50 or more employees, one person representing business with fewer than 50 employees, one person representing employee organizations, one person representing hospitals, one physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, one person representing registered nurses, one person representing a health care service plan regulated under the Knox-Keene Health Care Services Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), one person representing disability insurers providing coverage of hospital, medical and surgical expenses, and one person representing consumers at large. The physician panel member shall be in the active practice of medicine and shall be nominated by the commission after consultation with the statewide association of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals. The person representing nursing shall be nominated by the commission after consultation with the statewide association of nursing.

2486.5. Members of the Cost Containment Panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed

and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2487. The Cost Containment Panel shall have the authority to do all of the following:

(a) Act as an appellate body for any beneficiary, physician, other health care provider or carrier who wishes to dispute whether a charge for health care services is excessive. In determining whether a charge is excessive, the panel shall consider the fees charged by other providers in the area for the same procedure, practice costs, and the Harvard Resource Based Relative Value Scale approved by the Physician Payment Review Commission. A panel member who will gain a direct financial benefit from the outcome of the dispute shall not participate in, hear, comment, or advise other members upon, or decide, any appeal under this subdivision.

(b) Analyze the utilization data collected by the commission for patterns of practice and report annually to the commission its recommendations for improving the quality and availability of care.

(c) Report to the commission on the major causes of health care cost escalation, including, but not limited to, the following:

(1) Insurance administration.

(2) Cost shifting by government.

(3) Increased utilization.

(4) Increased technology.

(5) The tort system.

(6) The aging population.

(7) Biological epidemics, including, but not limited to, AIDS, drug abuse, and tobacco use.

(8) Other increases in practice costs.

(d) Recommend to the commission the scope of basic health care benefits. Any recommendations for an

increase in benefits shall include an explanation of the projected annual financial effect of the amendment expressed both in the aggregate and the amount of increase in the average premium and cost-sharing expense the average employer and employee would bear.

(e) Recommend to the commission specific cost-containment provisions to be considered by the Legislature.

Article 11. Technology Panel

2488. Upon nomination of the commission, the Governor shall appoint a Technology Panel which shall be composed of one member representing each of the following: carriers, medical researchers, physicians, hospitals, consumers, and business. The physician panel member shall be licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or the Osteopathic Initiative Act and shall be nominated by the commission after it has consulted with the statewide and local associations of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals.

2488.5. Members of the Technology Panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the Technology Panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2489. The Technology Panel shall have authority to do all of the following:

(a) Monitor the development of new health care

technology and conduct cost/benefit analyses specific to California's population and health care financing mechanisms while this technology is still in its experimental phases.

(b) Publish recommendations concerning rational dissemination of technology, taking into consideration the beneficial effects of competition.

(c) Publish recommendations concerning the circumstances under which new health care technology should be available and rates that will promote appropriate use of new technology.

Article 12. Inoperative

2490. The commission shall determine the percentage of employers in California that voluntarily extend coverage equal to or greater than that provided for in this chapter, and if the commission determines that at least 90 percent of employers have voluntarily extended this coverage prior to the date the employer would be responsible to provide the coverage, this chapter shall become inoperative with respect to employers, so long as voluntary participation remains at that level.

SEC. 4. Section 3700.2 is added to the Labor Code, to read:

3700.2. Any employer, or association of employers, in complying with this chapter, may arrange to provide health care coverage and the obligation to provide health benefits for workers' compensation coverage in the same contract or policy. Any carrier may provide that consolidated coverage. This section shall not be administered or interpreted to reduce benefits to injured employees.

SEC. 5. Section 17053.21 is added to the Revenue and Taxation Code, to read:

17053.21. An eligible employer providing basic health care coverage pursuant to Chapter 1.5 (commencing with Section 2445) of Part 9 of Division 2 of the Labor Code shall receive the credit allowed by Section 17053.20.

SEC. 6. Section 23615.1 is added to the Revenue and Taxation Code, to read:

23615.1. An eligible employer providing basic health care coverage pursuant to Chapter 1.5 (commencing with Section 2445) of Part 9 of Division 2 of the Labor Code shall receive the credit allowed by Section 23615.

SEC. 7. This act shall become operative on the day federal legislation is enacted that exempts this act from preemption by the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.), but in no case shall this act become operative before January 1, 1993.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly, June 27, 1991 (J.R. 11).

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Proposition #
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PROPOSED LAW

AFFORDABLE BASIC HEALTH CARE INITIATIVE OF 1992

Section 1. This measure shall be known and may be cited as the Affordable Basic Health Care Initiative of 1992.

Section 2. It is the intent of this measure to ensure that all Californian's [sic] have access to affordable medically necessary health care by the year 2000.

Section 3. The people find and declare as follows:

(a) Over 6,000,000 people in California have no health care coverage. Approximately two-thirds of these people are employed or are dependents of employed persons. Most of these people are working at jobs where health care coverage is not provided and at wages which make it impracticable for them to purchase private health care coverage.

(b) State and local governments have provided, and must continue to provide, a health care system to serve indigent and low-income persons. It is the intent of the people that the public safety net institutions shall have sufficient revenue to remain economically viable and to provide care that is fully equal to community standards. However, because of public revenue constraints at both the state and local level, the ability of that system to meet California's need to make health care accessible to its uninsured is wholly inadequate.

(c) The lack of health care coverage for large numbers of Californians is

causing the following very serious problems:

(1) Decreasing access to inpatient care, prenatal care, and outpatient care for the uninsured, and decreasing availability of emergency and trauma care for all Californians.

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

(3) Increasingly severe financial problems among those health care providers who continue to care for persons without health coverage, potentially resulting in the closing of emergency departments, trauma centers and hospitals, and the reduction in the availability of health care professionals so as to substantially worsen the quality of health care available to the citizens of this state.

(4) Steadily increasing health care costs and health insurance premiums for the decreasing number of consumers who pay full charges for health services.

(d) The only practical way of making affordable, quality health care available to everyone in California is to maximize the availability of employer-sponsored health care coverage, strengthen the public safety net, and ensure that all parties assume responsibility for containing health care costs, including health care providers, insurers and health care plans, consumers, employers, and government. This will permit the provision of health care through a pluralistic, market-oriented health care system, strengthened by balanced incentives, roles and responsibilities among payers, providers, patients and government.

(e) The health delivery system in the State of California is on the verge of

collapse as a result of the high demand for health care services, the lack of affordable health care coverage, and the increasing burden of uncompensated and undercompensated care. The remedy provided by this act is the only adequate and reasonable remedy within the limits of what the foregoing public health safety considerations permit now and into the foreseeable future.

Section 4. Chapter 0.5 (commencing with Section 2100) is added to Part 9 of Division 2 of the Labor Code, to read:

CHAPTER 0.5 AFFORDABLE BASIC HEALTH CARE ACT OF 1992

Article 1. Title

2100. This chapter shall be known and may be cited as the Affordable Basic Health Care Act of 1992.

Article 2. Definitions

2101. Unless the context requires otherwise, the definitions set forth in this article shall govern the construction and meaning of the terms and phrases used in this chapter.

2102. "Basic health care coverage" means a health plan that provides basic health care services meeting the standards set forth in this chapter.

2103. "Carrier" means any insurer, health care service plan, self-funded employer-sponsored plan, multiple employer trust, multiple employer welfare arrangement as defined by federal law (29 U.S.C. Section 1002(40)(A)), Taft-Hartley Trust as defined by federal law (42 U.S.C. Section 186), or other entity which writes, issues, administers, provides or pays for health care services in this state.

2104. "Catastrophic health care coverage" means a health plan that provides coverage for catastrophic health care expenses as defined by the

commission.

2105. "Commission" means the Health Care Coverage Commission.

2106. "Community rate" means the premium determined for basic health care coverage in each geographic region on a per person or per family basis and may vary with the number of persons in a family, but the premium must be equivalent for all individuals and for all families of similar composition, regardless of the sex, occupation or other factor which has or might affect the cost experience of an enrollee, other than age.

2107. "Cost-sharing" means any deductible, copayment, coinsurance, or any other mechanism other than a premium payment whereby an employee pays for a portion of the cost of health services provided to the employee or the employee's dependent.

2108. "Dependent" means the spouse, child or adopted child up to age 22, and permanently disabled child of the covered employee.

2109. "Employee" means any person who works at least 17.5 hours per week or 70 hours per month for any single employer in a bona fide employer-employee relationship, more than 60 days in any calendar year. "Employee" shall not include an independent contractor, or any registered student in a postsecondary educational institution working for that institution and who is covered under institutionally sponsored student health services.

2110. "Employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary 25 or more employees at any one time to work in this state. Effective January 1, 1995, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary 10 or more employees at any one time to work in this state. Effective

January 1, 1996, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary five or more employees at any one time to work in this state. Effective January 1, 1997, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary one or more employees at any one time to work in this state.

2111. "Enrollee" means each individual with at least basic health care coverage.

2112. "Health insurer" means any insurer or health care service plan authorized to provide or pay for health care services in this state and regulated by the Department of Corporations or the Department of Insurance.

2113. "Health plan" means a program providing health care services directly or through insurance, reimbursement or otherwise.

2114. "Pool" means a regional small employer health benefits purchasing pool as set forth in Section 2183.

2115. "Practice parameter" means a strategy for patient management developed to assist physicians in clinical decisionmaking, and includes standards, guidelines and other patient management strategies. Only practice parameters which have been developed in conformance with the "Attributes to Guide the Development of Practice Parameters" published by the American Medical Association/Specialty Society Practice Parameters Partnership may be approved by the commission pursuant to subdivision (e) of Section 2181.

2116. "Premium" means the monthly per enrollee amount which the carrier charges for providing basic health care coverage, or, for self-insured plans, the monthly per enrollee amount which the commission determines to be the actuarially sound cost of the basic health care coverage, or for carriers

providing partial insurance to self-insured plans, the total of the monthly per enrollee amount which the carrier charges for providing basic health care coverage and the monthly per enrollee amount which the commission determines to be the actuarially sound cost of the self-insured portion of the basic health care coverage.

2117. "Supplemental policy" means health care coverage for services not included in the basic health care coverage as provided by Article 4 (commencing with Section 2130).

2118. "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by his or her employer or a customer.

Article 3. Employee Health Care Coverage

2120. Effective January 1, 1994, every employer shall provide basic health care coverage to each of that employer's employees and their dependents, including all of the following:

(a) Payment of at least 75 percent of the lowest premium for basic health care coverage the employer offers for each covered employee and dependent of a covered employee.

(b) Basic health care coverage to every employee and that employee's dependents, effective no later than the first day of the calendar month following the employee's 60-day anniversary.

(c) Continuation of 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, and for that employee's dependents. This obligation shall continue for three calendar months following the month during which the employee became hospitalized or

disabled from working or until the month the employee becomes eligible for other public or private coverage, whichever occurs first.

(d) The commission may delay the phase-in of employer coverage by no more than two years for employers with fewer than 25 employees if the state's economic condition would place an undue hardship on the state's small employers.

2121. (a) No new employer shall be required to provide basic health care coverage until 27 months after the date the new employer first received an employer tax identification number from the Employment Development Department. The commission shall adopt regulations designed to ensure that this exemption applies only to bona fide start-up enterprises and not to businesses resulting from the sale, reorganization or other alteration of an existing enterprise.

(b) A new employer may waive the exemption set forth in subdivision (a) by submitting a written waiver on a form prescribed by the Franchise Tax Board.

2122. Nothing in this chapter shall be construed to limit the right of employees to bargain collectively for different health care coverage, if the protection provided by the negotiated plan is at least actuarially equivalent to the protection afforded by this chapter. This chapter shall be applicable with respect, to any employees who do not receive at least this level of protection or who are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party.

2123. An employer shall not be required to provide health care coverage pursuant to this article with respect to any employee or dependent if the employee waives enrollment of the employee or the employee's dependent in

writing pursuant to Section 2126.

2124. Employers shall deduct from the wages owed to any employee the amount sufficient to cover the employee's contribution, if any, to the premium required by Section 2125, except that an employee's contribution shall not exceed two percent of that employee's wages.

2125. An employee shall pay for any portion of the premium not covered by the employee's employer or the commission.

2126. (a) An employee may not waive basic health care coverage for the employee or the employee's dependents except as provided in this section, which requires an employee to waive basic health care coverage as necessary to avoid duplicate coverage. The employee shall have the right to elect which coverage to waive should a waiver be required by this section.

(b) An employee that has basic health care coverage for the employee or the employee's dependent(s) or both must waive any duplicate coverage, but only for the period that the employee or the dependent, or both, has at least basic health care coverage.

(c) A dependent minor who is employed (or a parent or guardian on the behalf of a dependent minor under 12 years of age) must waive basic health care coverage provided by the dependent minor's employer, but only if and for the period that the dependent minor (or parent or guardian on behalf of the dependent minor) has at least basic health care coverage.

(d) In the case of an individual who is an employee with respect to more than one employer, the employee shall waive basic health care coverage from all but one employer, such that the employee and each dependent has only one basic health care coverage.

(e) An employee who waives health care coverage pursuant to this section

shall notify his or her employer immediately if the duplicate coverage is terminated, and shall enroll in the employer's health care plan effective not later than the first day of a calendar month following 30 days from the date of the termination of coverage.

2127. An employer shall not fail or refuse to hire, and shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child or other dependent and the employer would be required by this article to provide basic health care coverage for the spouse or child or other dependent. A violation of this section constitutes unlawful discrimination within the meaning of Section 51 of the Civil Code, and an unfair business practice within the meaning of Section 17200 of the Business and Professions Code.

2128. Any employer who fails to provide basic health care coverage as required by this Act shall be liable for twice the health care costs incurred by an employee or that employee's dependent during the period in which the employer failed to provide coverage, and the employee's reasonable attorney's fees.

Article 4. Basic Health Care Benefits

2130. Basic health care coverage provided in accordance with this chapter shall include the provision of or payment for all of the following in each calendar year which are medically necessary for the diagnosis, treatment or prevention of injury or illness, or to improve the functioning of a malformed body member of an enrollee, except as otherwise provided in this article:

(a) Hospital inpatient care for a period of at least 45 days in a hospital licensed pursuant to subdivision (a) or (b) of Section 1250 of the Health and Safety Code, including all of the following:

(1) Room and board, including private room and special diets when

prescribed as medically necessary, and general nursing services.

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

(3) Drugs and medications administered while an inpatient.

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

(5) Respiratory and physical therapy following prior authorization.

(b) Medical and surgical services, which shall be provided on an outpatient basis when medically appropriate, including all of the following:

(1) Surgical services

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

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

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

(5) Hospital visits, and at least 20 home or office visits.

(6) Radiation therapy and chemotherapy of proven benefit.

(7) Pap smears and mammograms under the periodicity schedules approved by the commission.

(8) Medical and surgical consultation.

(9) Sterilization, but not including sex change operations, investigation of or treatment for infertility, reversal of sterilization, conception by artificial means, or contraceptive supplies and devices.

(c) Comprehensive maternity and perinatal care.

(d) Emergency and necessary followup care, including emergency ambulance transportation.

(e) Long-term care benefits including home care, skilled nursing care, respite, and hospice care, to the extent the carrier determines they are less costly alternatives to covered inpatient care.

(f) Plastic and reconstructive services limited to the following:

(1) To correct a physical functional disorder resulting from a congenital disease or anomaly.

(2) To correct a physical functional disorder following an injury or incidental to surgery covered by the basic health care coverage.

(3) For reconstructive surgery and associated procedures following a mastectomy which resulted from disease, illness, or injury. Internal breast prostheses required incidental to the surgery will be provided.

(g) Child preventive care including periodic routine physical examinations, and proven preventive procedures, immunizations, vaccinations, 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.

(h) Mental health benefits, including both of the following or actuarial equivalent:

(i) Inpatient care or acute residential care for a period of at least 15 days.

(2) At least 15 outpatient visits.

(i) At least 10 outpatient visits for speech, occupational and physical therapy.

(j) Durable medical equipment.

(k) 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," and those additional nonapproved indications as approved by the Health Care Coverage Commission pursuant to Section 2181.

(l) Nothing in this chapter shall be construed as expanding or restricting the scope of practice conferred upon any person licensed, certified, or registered pursuant to the Business and Professions Code or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act.

2131. Basic health care coverage provided in accordance with this chapter is not required to include any of the following:

(a) Anything which is either of the following:

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

(2) Determined by the commission to be outmoded, not efficacious, outside a practice parameter or not sufficiently cost-effective pursuant to subdivision (c) of Section 2181.

(b) Implants, except pacemakers, intraocular lenses, screws, nuts, bolts,

bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips.

(c) Eyeglasses, contact lenses (except lenses for keratoconus, or following cataract surgery, or corneal transplantation), radial or hexagonal keratotomy, routine eye examinations, including eye refractions, except provided as part of a routine examination under "preventive care," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care.

(d) Prescription and nonprescription drugs, except those provided as an inpatient hospital benefit and as specified in subdivision (k) of Section 2130. Any exclusion of drugs and medicines also excludes their administration.

(e) Treatment of chemical dependency, except for acute inpatient detoxification.

(f) Obesity treatment or weight loss programs.

(g) Health care services received from or paid for by the Veterans' Administration, benefits paid under any workers' compensation or any employers' liability law or federal law for injury or illness, or any accident insurance.

(h) Conditions resulting from acts of war whether declared or not.

(i) Any service or supply not specifically listed as a covered service or supply.

2132. Notwithstanding Sections 2130 and 2131, health plans providing the minimum requirements for benefits mandated for federally qualified health maintenance organizations established by Title XIII of the United States Public Health Service Act (42 U.S.C. Sec. 300e and following) or for health care service plans by the Knox-Keene Health Care Service Plan Act of 1975

(Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) which provide at least the basic health care coverage specified in Section 2130 shall be deemed to constitute basic health care coverage as long as they otherwise comply with the requirements of this article.

2133. (a) Basic health care coverage may include provisions for cost sharing which is the same as or actuarially equivalent to all of the following:

(1) The employee's total annual out of pocket expenses for copayments and deductibles shall not exceed one-quarter of the annual premium for the employee and the employee's dependents, if any.

(2) Deductibles shall not exceed two hundred fifty dollars ($250) annually for an individual or five hundred dollars ($500) annually for a family, adjusted annually by a percentage equal to the percentage change, if any, in the federal minimum wage commencing January I, 1994.

(3) No copayment shall exceed 20 percent of the charge of a covered service.

(b) Notwithstanding subdivision (a), basic health care coverage may provide for a deductible for prescription drugs provided on an outpatient basis of up to two hundred dollars ($200) annually for an individual or four hundred dollars ($400) for a family, adjusted annually by a percentage equal to the percentage change, if any, in the federal minimum wage commencing January 1, 1994.

2134. Basic health care coverage may exclude, or provide for a copayment in excess of that set forth in Section 2133 for, any item or services that an individual obtains without complying with any reasonable procedures established by the carrier and approved by the carrier's licensing agency or authorized by the commission to ensure the efficient and appropriate utilization

of nonemergency covered services, or to encourage or require the use of providers contracting with the carrier for nonemergency services.

2135. Basic health care coverage shall not include a lifetime policy limit of less than five hundred thousand dollars ($500,000) per enrollee, and shall not include an annual policy limit of less than the lifetime limit.

2136. Basic health care coverage shall be administered in compliance with the following minimum requirements:

(a) No contract for, or advertising of, basic health care coverage shall misrepresent the terms of any contract for basic health care coverage.

(b) Claims shall be submitted on the uniform claim form or the uniform capitated health care encounter form approved by the commission. Article 5. Health Insurers

2140. All health insurers shall offer to all employers with 100 employees or less within the service area of the health insurer a basic health care coverage option. Health insurers shall charge a single community rate in the same geographic region for basic health care coverage, except that the premium rate offered to any employer with 100 employees or less shall not exceed that insurer's community rate for basic health care coverage in that geographic region by more than 30 percent. Geographic underwriting standards shall be limited to six California regions as determined by the commission, reflecting geographic variations in practice costs. Health insurers may enter into subcontracts with other entities in carrying out the requirements of this section.

2141. Notwithstanding Section 2140, where it maintains a network, a health insurer may cease to offer coverage to employers not already contracting with it when the health insurer reasonably anticipates that it will not have the capacity within its network of associated health providers to deliver

services adequately to additional enrollees because of its obligations to existing group contract holders and enrollees. A health insurer which ceases to offer coverage pursuant to this section, may not enroll new groups of employers unless it resumes offering coverage pursuant to Section 2140. Any health insurer which is offering health care coverage shall accept every employer with 100 employees or less that requests a rate quote and accepts the rate quote received, provided the employer complies with the requirements of the group contract or policy.

2142. Carriers shall not exclude or otherwise limit any individual from group coverage under any plan of basic health care coverage on the basis that the individual has, or at any time has had, any disease, disorder, or condition.

2143. Coverage accepted by employers shall be renewable with respect to all eligible employees or dependents at the option of the policy-holder or contract holder except as follows:

(a) For non payment of the required premiums by the policy-holder or contract holder.

(b) For fraud or misrepresentation of the policy-holder or contract holder.

(c) For material noncompliance with plan provisions.

2144. Carriers shall enroll, not later than the first day of the calendar month following 30 days from the termination date of coverage, any individual who would otherwise be covered by a group coverage and whose duplicate coverage is terminated as set forth in subdivision (e) of Section 2126.

2145. To the extent they are offering to provide or are providing basic health care coverage, carriers shall be exempt from any law mandating benefits or mandating the offering of benefits except as specifically provided in

this article.

2146. A carrier may offer and provide health care coverage which exceeds the requirements established for basic health care coverage through a supplemental policy. Sections 2140 to 2144, inclusive, shall apply to the basic health care coverage portion of that coverage, but shall not apply to the supplemental policy providing coverage which exceeds that required for basic health care coverage.

2147. Carriers which provide basic health care coverage shall make available catastrophic health care coverage to retired employees not eligible for Medicare at rates based on sound actuarial principles, provided, however that a carrier which is a federally qualified health maintenance organization may meet this requirement by offering basic health care coverage.

2148. Any carrier that violates any provision of this chapter shall be deemed to have committed a violation of its enabling or licensing statutes, subjecting it to all enforcement actions available to the Insurance Commissioner or Commissioner of Corporations, as applicable. Carriers not subject to the jurisdiction of the Insurance Commissioner or the Commissioner of Corporations, shall be subject to all the enforcement powers of the commission.

2149. Carriers may combine to establish and participate in a reinsurance program, subject to the requirements established by the commission. Carriers participating in a reinsurance program shall comply with Sections 2140 to 2144, inclusive, but may cede that portion of the risk agreed to by the reinsurance entity to the reinsurance entity. The reinsurance entity shall provide for the proper funding of the program, including actuarially sound reserves for unpaid losses, by charging the member carriers a reinsurance contribution and, as necessary, by assessing and collecting from the member carriers in proportion to their participation in the program. Any unsatisfied net

liability or outstanding assessment owed by an insolvent carrier participating in the reinsurance program shall be assumed by and apportioned among the remaining carriers in the reinsurance program in the same manner in which assessments are levied by the reinsurance entity. The reinsurance entity shall have all rights allowed by law on behalf of the remaining carriers in the reinsurance program against the insolvent carrier for sums due the program.

2150. The provisions of this article shall be binding on carriers only with respect to basic health care coverage offered or provided to employers as defined in Section 2110.

Article 6. Health Care for Every Californian

2160. No later than January 1, 1996, the commission shall file a comprehensive report with the Legislature, including a specific legislative proposal for establishing a pooling mechanism to provide basic health care coverage for every employee in the state and their dependents, including those persons who work less than 17.5 hours per week or 70 hours per month, or 60 days or less in any calendar year, and those persons who work for employers that employ fewer than 5 employees, to take effect if enacted no later than January 1, 1997.

2161. No later than January 1 1997, the commission shall file a comprehensive report with the Legislature, including a specific legislative proposal for establishing a mechanism to provide basic health care coverage for every Californian not otherwise covered by a private health plan, Medicare or Medi-Cal, to take effect if enacted no later than January 1, 1998.

2162. The commission shall study the feasibility of extending basic health care coverage to every Californian eligible for Medi-Cal. The commission shall report its findings to the Legislature no later than January 1, 1995.

Article 7. Health Care Coverage Commission

2170. There is in state government the Health Care Coverage Commission.

2171. The commission shall consist of 12 members appointed as follows:

(a) Six members appointed by the Governor as follows:

(1) One member who shall represent business, who shall be experienced in the administration of, and knowledgeable about, employee health benefit plans.

(2) One member who shall represent the general public, who shall be a recipient of basic health care coverage.

(3) One member who shall represent prepaid health plans, who shall be experienced in the administration of, and knowledgeable about, prepaid health plans.

(4) One member 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 or the Osteopathic Initiative Act, who shall spend no less than 20 hours per week caring for patients with basic health care coverage.

(5) One member who shall represent general acute care hospitals, who shall be actively involved in the administration of a general acute care hospital which treats patients with basic health care coverage.

(6) One member who shall represent labor, who shall be knowledgeable about employee health benefit plans.

(b) Three members appointed by the Speaker of the Assembly as follows:

(1) One member who shall represent disability insurers, who shall be experienced in the administration of, and knowledgeable about, the provision of basic health care coverage.

(2) One member who shall represent general acute cure hospitals, who shall be actively involved in the administration of a general acute care hospital which treats patients with basic health care coverage.

(3) One member who shall represent the general public, who shall be a recipient of basic health care coverage.

(c) Three members appointed by the Senate Committee on Rules as follows:

(1) One member representing labor organizations, who shall be experienced in the administration of, and knowledgeable about, health plans.

(2) One member 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 or the Osteopathic Initiative Act, who shall spend no less than 20 hours per week caring for patients with basic health care coverage.

(3) One member who shall represent business, who shall be experienced in the administration of, and knowledgeable about, employee health benefit plans.

2172. The members of the commission shall serve for staggered six-year terms. The initial appointments to the commission shall be for the following terms:

(a) The Governor shall appoint two members for two-year terms, two members for a four-year term, and two members for six-year terms.

(b) The Speaker of the Assembly shall appoint one member for a two-year term, one member for a four-year term, and one member for a six-year term.

(c) The Senate Committee on Rules shall appoint one member for a two-year term, one member for a four-year term, and one member for a six-year term.

(d) The term for each of the initial appointments to the commission will commence on January 1, 1993.

2173. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified.

2174. Appointments to fill vacancies on the commission shall be for the unexpired term.

2175. The Legislature shall determine the compensation to be paid members of the commission. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2176. The members of the commission shall select two of its members to be chairperson and vice chairperson.

2177. Seven members of the commission shall constitute a quorum for the transaction of any business, for the performance of any duty, or for the exercise of any power of the commission.

2178. The commission shall appoint an executive officer who shall be exempt from civil service pursuant to subdivision (e) of Section 4 of Article VII

of the California Constitution. The executive officer shall serve at the pleasure of the commission.

2179. The executive officer shall perform and discharge under the direction and control of the commission, the powers, duties, purposes, functions and jurisdiction delegated to him or her by the commission.

2180. The commission shall do all of the following:

(a) File a comprehensive report with the Legislature, including a specific legislative proposal for establishing a mechanism to provide slidingscale subsidies for low income employees and their dependents. The commission shall identify savings to existing programs, including but not limited to Medi-Cal, that would accrue as a result of full implementation of this act. The commission, after identification of these savings, shall submit to the Governor and the Legislature recommendations for utilization of these savings to offset the cost of health care coverage to low income employees and small employers.

(b) Establish such requirements the commission determines to be reasonably necessary to maximize the access to necessary health care for those carriers not regulated by the Department of Insurance or the Department of Corporations.

(c) Develop and maintain a method of responding to employers' inquiries relating to general health care coverage options, and provide comparative information on the costs, benefits, and services of all health plans providing basic health care coverage and those supplemental policies of which the commission is aware.

(d) Collect from carriers and refer to the Medical Policy, Cost Containment and Technology Panels data on the utilization of health care services. The

commission shall require reporting only as necessary to accomplish its purposes with respect to cost-containment, access, quality, and control of expensive technology, and shall establish reporting mechanisms designed to minimize the administrative burden and cost of health care providers and carriers. Information which individually identifies patients, health care providers, or carriers shall be kept confidential except as provided in subdivision (d) of Section 2187.

(e) Monitor the access that California residents have to necessary health care services, determine the extent of any unmet needs for these services or lack of access or quality that may exist from time to time, and make an annual report to the Governor and the Legislature, including recommendations it deems appropriate to maximize the availability of quality health care. The report shall include the major causes of health care cost escalation, including at least the following: insurance administration, cost shifting by government, increased utilization, increased technology, the tort system, the aging population, biological epidemics, including, but not limited to, AIDS, drug abuse, and tobacco use, and other increases in practice costs. The report shall include a recommendation on the scope of basic health care benefits. Any recommendations for an increase in benefits shall include an explanation of the projected annual financial effect of the amendment expressed both in the aggregate and the amount of increase in the average premium and cost-sharing expense the average employer and employee would bear. The report shall also include recommendations it deems appropriate to contain health care costs, and, if the rate of premium increases has not stabilized by the time Article 3 (commencing with Section 2120) has been implemented, a recommendation on the feasibility and advisability of capping future premium increases.

(f) Monitor the compliance with this chapter, and report annually to the Legislature in findings and recommendations, including such specific

legislative proposals for penalties or other enforcement mechanisms as it finds are warranted.

(g) Develop a uniform claim form for use by all carriers providing basic health care coverage on a fee-for-service basis and a uniform capitated health care encounter form for all carriers providing the basic health care coverage on a capitated basis. These forms shall be as similar as possible, and shall include all of the information required to be reported pursuant to subdivision (a) of Section 2181.

(h) Provide adequate funding and administrative support for the Medical Policy Panel, Cost Containment Panel, and Technology Panel.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities granted or imposed upon it under this chapter.

2181. The commission shall adopt pursuant to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), all necessary rules and regulations to carry out this chapter including, but not limited to, the following:

(a) Establishing requirements for reporting by carriers of data on the utilization of health care services to the Office of Statewide Health Planning and Development. This data collection system shall meet the following criteria:

(1) Protect the confidentiality of personal and private patient information.

(2) Preserve incentives for physicians to make diagnostic and treatment decisions based on medical necessity rather than cost alone.

(3) Avoid duplication of costs by requiring carriers rather than health care providers to submit data.

(4) Adopt safeguards to ensure that the data collected is interpreted by experienced, practicing physicians and surgeons licensed to practice medicine in California.

(5) Ensure that the data collected are valid, useful, and appropriate for comparison.

(6) Afford all interested professional medical and hospital associations a minimum of 30 days to comment before any data is released to the public.

(7) Ensure that data collection requirements are adequate but not onerous, cost effective, and related to a valid and achievable purpose.

(b) Establishing procedures for appealing to the Cost Containment Panel disputes over excessive charges for health care services, as recommended by the Cost Containment Panel. These procedures shall encourage the resolution of these disputes by nonprofit medical and other professional societies which are exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code and are comprised of at least 25 percent of the eligible licentiates in the geographic area served by the society.

(c) Determining and adjudicating disputes concerning whether a health care procedure, service, drug, or device is experimental, investigational, outmoded, not efficacious, outside a practice parameter approved pursuant to subdivision (e) or otherwise not sufficiently cost-effective to be included in basic health care coverage as recommended by the Medical Policy Panel.

(d) Establishing the indications for prescription drugs which, although not approved by the federal Food and Drug Administration, are included in basic health care coverage as recommended by the Medical Policy Panel.

(e) Adoption of the practice parameters which may be used by carriers providing basic health care coverage to deny payment as recommended by the

Medical Policy Panel. Beneficiaries may not be required to pay for services denied pursuant to this subdivision.

(f) Determining when the referral by health care providers to facilities in which they have an ownership interest is permitted and when such self-referral is prohibited.

2182. The commission shall hire staff and may contract with any public agency, including any agency of the state government or with any private person, as necessary to carry out its duties.

2183. (a) The commission shall make available to employers with 25 employees or less a minimum of six regional small employer health benefits purchasing pools. The commission shall contract with a minimum of six private not-for-profit corporations to administer these pools. The contractors shall not be carriers and shall have experience in the administration of health benefits programs or shall have the present or reasonably anticipated capability to administer the pool in a geographic area.

(b) Each contractor shall contract with a minimum of three carriers to make available basic health care coverage to all employers in the pool on terms consistent with Article 4 (commencing with Section 2130) and Article 5 (commencing with Section 2140).

(c) The commission shall adopt pursuant to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), all rules and regulations necessary to implementation of the small employer health benefits purchasing pools, including, but not limited to, the following:

(1) Marketing and recruitment of potential employers.

(2) Determining eligibility for pool participation.

(3) Data collection, analysis and reporting.

(4) Financial solvency of participating carriers.

(5) Methods of collecting premiums and available subsidies.

(d) Employers that participate in a pool shall purchase basic health care coverage for each of their employees and their dependents who have not waived coverage pursuant to Section 2126.

(e) Costs for the administration of the purchasing pools may be borne by the carriers which make available basic health care coverage to employers in the pool.

Article 8. Medical Policy Panel

2185. Upon the nomination of the commission, the Governor shall appoint a Medical Policy Panel which shall be composed of seven physicians and surgeons licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act and in the active practice of medicine, and one member representing each of the following: hospitals, nursing, labor, business and carriers providing basic health care coverage. The physician panel members shall be nominated by the commission after it has consulted with the statewide and local associations of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals. The person representing nursing shall be nominated by the commission after consultation with the statewide association of nursing. No physician member of the panel shall practice in the same medical specialty as any other physician member nor conduct his or her primary practice in the same county as any other physician member. At least two members of the panel shall have

experience in the administration of utilization review systems.

2186. Members of the panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2187. The Medical Policy Panel shall have the authority to do all of the following:

(a) Recommend to the commission those health care procedures, services, drugs or devices which are experimental, investigational, outmoded, not efficacious, or otherwise not sufficiently cost-effective to be included in basic health care coverage. In making these determinations, the panel shall consider the opinions of the state and national medical and specialty organizations, the National Institutes of Health, the Agency for Health Care Policy and Research, and other interested parties.

(b) Recommend to the commission those indications for prescription drugs which, although not approved by the federal Food and Drug Administration, are sufficiently efficacious and cost-effective to be included in basic health care coverage.

(c) Analyze the utilization data collected by the commission for patterns of practice and report annually to the commission its recommendations for improving the quality and availability of care.

(d) Contact with nonprofit professional medical, osteopathic, podiatric, hospital, and health facility societies exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code for peer review to evaluate aberrant patterns of practice of providers discovered in the course of the panel's duties set forth in subdivision (c) or brought to the attention of the commission by carriers. These contracts shall allow for the reimbursement by the commission or the parties seeking the review of the costs of such review, but shall provide no profit to the professional association. Results of the review shall be used solely for peer education of the health care provider or education of the carrier as indicated. If the panel determines that educational efforts have failed, the panel shall refer the matter to the appropriate licensing agency. The records and proceedings of the panel and the contracting organizations shall be confidential unless and until a licensing agency takes formal action.

(e) Review the practice parameters developed by state and national medical and specialty organizations. The National Institutes of Health, and other interested parties and recommend to the commission those practice parameters which may be authorized for use by carriers providing basic health care coverage to deny payment.

(f) Recommend to the commission the scope of basic health care benefits. Any recommendations for a change in the scope of benefits shall include an explanation of the health impact on enrollees.

2188. The Medical Policy Panel may establish subcommittees of its members it deems necessary to assist the panel in the performance of its duties, and may delegate the performance of its peer review duty set forth in subdivision (d) of Section 2187 to any such subcommittee which has a minimum of two panel members. The panel may request the assistance of physician and surgeon members of a medical quality review committee established pursuant to Article 13 (commencing with Section 2320) of Chapter

5 of Division 2 of the Business and Professions Code, as it deems necessary to assist the panel or its subcommittees in the performance of its duties, and each committee member who agrees to serve shall be subject to applicable laws, rules and regulations as if he or she were a member of the panel.

Article 9. Cost Containment Panel

2190. Upon the nomination of the commission, the Governor shall appoint a Cost Containment Panel which shall be composed of one person representing businesses with 50 or more employees, one person representing businesses with less than 50 employees, one person representing employee organizations, one person representing hospitals, one physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, one person representing registered nurses, one person representing a health care service plan regulated under the Knox-Keene Health Care Services Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), one person representing disability insurers providing coverage of hospital, medical and surgical expenses, and one person representing consumers at large. The physician panel member shall be in the active practice of medicine and shall be nominated by the commission after consultation with the statewide association of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals. The person representing nursing shall be nominated by the commission after consultation with the statewide association of nursing.

2191. Members of the panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies

shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2192. The Cost Containment Panel shall have the authority to do all of the following:

(a) Act as an appellate body for any beneficiary, physician, other health care provider or carrier who wishes to dispute whether a charge for health care services is excessive. In determining whether a charge is excessive, the panel shall consider the fees charged by other providers in the area for the same procedure, practice costs, and the Harvard Resource Based Relative Value Scale approved by the Physician Payment Review Commission. A panel member who will gain a direct financial benefit from the outcome of the dispute may not participate in, hear, comment, or advise other members upon, or decide any appeal under this subdivision.

(b) Analyze the utilization data collected by the commission for patterns of practice and report annually to the commission its recommendations for improving the quality and availability of care.

(c) Report to the commission on the major causes of health care cost escalation, including, but not limited to, insurance administration, cost shifting by government, increased utilization, increased technology, the tort system, the aging population, biological epidemics, including, but not limited to AIDS, drug abuse, and tobacco use, and other increases in practice costs.

(d) Recommend to the commission the scope of basic health care benefits. Any recommendations for an increase in benefits shall include an explanation of the projected annual financial effect of the amendment

expressed both in the aggregate and the amount of increase in the average premium and cost-sharing expense the average employer and employee would bear.

(e) Recommend to the commission specific cost containment provisions which should be considered by the Legislature.

Article 10. Technology Panel

2195. Upon nomination of the commission, the Governor shall appoint a Technology Panel which shall be composed of one member representing each of the following: carriers, medical researchers, physicians, hospitals, consumers, and business. The physician panel member shall be licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act and shall be nominated by the commission after it has consulted with the statewide and local associations of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals.

2196. Members of the panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2197. The Technology Panel shall have authority to do all of the following:

2197. (a) Monitor the development of new health care technology and conduct cst-benefit analyses specific to California's population and health care financing mechanisms while this technology is still in its experimental phases.

(b) Publish recommendations concerning rational dispersion of technology, taking into consideration the beneficial effects of competition.

(c) Publish recommendations concerning the circumstances under which new health care technology should be available and rates which will promote appropriate use of new technology.

Article 11. Voluntary Employer Participation

2210. The commission shall determine the percentage of employers in California that voluntarily extend coverage equal to or greater than that provided for in this chapter, and if the commission determines that at least ninety percent (90%) of the employers have voluntarily extended this coverage prior to the date the employers would be responsible to provide this coverage, this chapter shall become inoperative with respect to employers, so long as voluntary participation remains at that level.

Article 12. Amendments

2215. The provisions of Article 4 (commencing with Section 2130) of this chapter may be amended by a statute passed by a vote of four-fifths of the membership of each house of the Legislature in furtherance of its purposes. The other provisions of this chapter, except for this section, may be amended by a statute passed by a vote of two-thirds of the membership of each house of the Legislature in furtherance of its purposes.

Section 5. Section 3700 of the Labor Code is amended to read:

3700. Every employer except the state shall secure the payment of

compensation in one or more of the following ways:

(a) By being insured against liability to pay compensation in one or more insurers duly authorized to write compensation insurance in this state.

(b) By securing from the Director of Industrial Relations a certificate of consent to self-insure, which may be given upon furnishing proof satisfactory to the Director of Industrial Relations of ability to self-insure and to pay any compensation that may become due to his employees.

(c) For any county, city, city and county, municipal corporation, public district, public agency, or any political subdivision of the state, including each member of a pooling arrangement under a joint exercise of powers agreement (but not the state itself), by securing from the Director of Industrial Relations a certificate of consent to self-insure against workers' compensation claims, which certificate may be given upon furnishing proof satisfactory to the director of ability to administer workers' compensation claims properly, and to pay workers' compensation claims that may become due to its employees. On or before March 31, 1979, a political subdivision of the state which, on December 31, 1978, was uninsured for its liability to pay compensation, shall file a properly completed and executed application for a certificate of consent to self-insure against workers' compensation claims. The certificate shall be issued and be subject to the provisions of Section 3702.

(d) Any employer, or association of employers, in complying with this chapter, may arrange to provide health care coverage and the obligation to provide health benefits in workers' compensation coverage in the same contract or policy. Any carrier may provide that consolidated coverage. This subdivision shall not be administered or interpreted to reduce benefits to injured employees.

Section 6. Section 17053.21 of the Revenue and Taxation Code is added

to read:

17053.21. An eligible employer, as defined in Section 17053.20, providing basic health care coverage pursuant to Chapter 0.5 (commencing with Section 2100) of Part 9 of Division 2 of the Labor Code shall receive the credit allowed by Section 17053.20.

Section 7. Section 23615.1 of the Revenue and Taxation Code is added to read:

23615.1. An eligible employer, as defined in Section 23615, providing basic health care coverage pursuant to Chapter 0.5 (commencing with Section 2100) of Part 9 of Division 2 of the Labor Code shall receive the credit allowed by Section 23615.

Section 8. (a) Notwithstanding any other provision of law, for the 1992-93 fiscal year, the sum of one million, five hundred thousand dollars ($1,500,000) is appropriated from the Cigarette and Tobacco Products Surtax Fund for support of the Health Care Coverage Commission created by Section 2170 of the Labor Code according to the following schedule:

(1) Five hundred thousand dollars ($500,000) from the Hospital Services Account.

(2) Five hundred thousand dollars ($500,000) from the Physician Services Account.

(3) Five hundred thousand dollars ($500,000) from the Unallocated Account.

(b) Notwithstanding any other provision of law, for the 1993- 94 fiscal year and each fiscal year thereafter, the sum of three million dollars ($3,000,000) is appropriated from the Cigarette and Tobacco Products Surtax Fund for support

of the Health Care Coverage Commission created by Section 2170 of the Labor Code according to the following schedule:

(1) One million dollars ($1,000,000) from the Hospital Services Account.

(2) One million dollars ($1,000,000) from the Physician Services Account.

(3) One million dollars ($1,000,000) from the Unallocated Account.

Section 9. The Legislature may amend Sections 5, 6, 7 and 8 of this measure in accordance with Article IV of the California Constitution.

Section 10. If any section, part, clause, or phrase of this measure is for any reason held to be invalid or unconstitutional, the invalid or unconstitutional provision shall be severed and the remaining provisions shall not be affected but shall remain in full force and effect.

Section 11. This measure shall become effective on January 1, 1993, except that Section 2120 of the Labor Code shall not be operative until January 1, 1994 or 90 days after the effective date of federal legislation which exempts Section 4 of this measure from preemption by the federal Employee Retirement Income Security Act of 1974, whichever occurs later. In the event the effective date of federal legislation which exempts Section 4 of this measure from preemption by the federal Employee Retirement Income Security Act of 1974 occurs after October 3, 1993, then all the dates in Section 4 of this measure are extended for a period of time equal to the number of days between October 3, 1993 and the effective date of this federal legislation.

AMENDED IN ASSEMBLY MAY 1, 1991

CALIFORNIA LEGISLATURE—1991–92 REGULAR SESSION

ASSEMBLY BILL No. 1672

Introduced by Assembly Member Margolin

March 8, 1991

An act to amend ~~Section 500 of~~ *Sections 663, 675, 675.5, 677, 10291.5, and 10350.3 of, to add Article 5.5 (commencing with Section 10370) to Chapter 4 of Part 2 of Division 2 of, to add Section 10113.7 to, and to repeal and add Section 666 of,* the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 1672, as amended, Margolin. Insurance: ~~renewal notices.~~

~~Existing law provides that whenever any insurer has, as a regular course of conduct, sent renewal premium notices to an insured, and intends to discontinue that practice, it shall notify the insured of that intention.~~

~~This bill would qualify that requirement by requiring that notice unless that notice to policyholders is otherwise required by statute.~~

Existing law requires, as to certain policies of automobile insurance, an insurer at least 20 days prior to policy expiration shall deliver or mail to the named insured at the address shown in the policy either a written or verbal offer of renewal of the policy contingent upon payment of premium as stated in the offer, or a notice of nonrenewal of the policy containing or accompanied by a statement that upon written request by the named insured made not later than one month following the expiration of the policy period, or delivered to the insurer, the insurer will notify the insured in writing, within 20 days of his or her request the reason or reasons for that

nonrenewal.

This bill would require the offer of renewal to be written and delete the requirement that the notice of nonrenewal contain or be accompanied by the above statement, as specified.

Existing law provides that when an automobile insurance policy is canceled and the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer is required upon written request of the named insured, mailed or delivered to the insurer not less than 15 days prior to the affected date of cancellation, to specify in writing the reason for the cancellation. A statement of that reason is required to be mailed or delivered to the named insured within 5 days after receipt of the written request.

This bill would delete that provision. It would require instead any notice of cancellation or nonrenewal of automobile insurance, as specified, to include a written statement of the reason or reasons for the cancellation or nonrenewal. It would require any offer to renew, which includes a price increase or change in coverage, to be in writing and to include a statement of the reasons for that price increase or change in coverage. It would also require those notices to include specified addresses and telephone numbers.

Existing law sets forth various provisions with respect to cancellation and failure to renew certain property insurance. Specifically exempted from these provisions are automobile insurance and workers' compensation insurance. With respect to those provisions "commercial insurance" is defined to not include workers' compensation insurance.

This bill would delete the exemption of workers' compensation insurance from those provisions.

Existing law requires notices of cancellation of certain noncommercial property insurance, to be in writing, and to be mailed to the named insured at the address shown on the policy and to contain, among other things, a statement that upon written request to the named insured mailed and delivered to the insurer within 15 days of the date of cancellation, the insurer shall specify the reason of cancellation.

This bill would delete the written request provision and make those other provisions applicable to the nonrenewal of policies as well, and would require those notices to include a statement of the reason or reasons for the nonrenewal or cancellation, except as specified. It would also require any offer to renew, which includes a price increase or change in coverage, to be in writing and to include a statement of the reason or reasons for the increase or change. It would also require those notices to include certain addresses and telephone numbers, as specified.

The bill would also provide that no increase of premium on any individual life insurance policy which provides for premium changes by the insurer shall be effective unless written notice is delivered to the policyholder, or mailed to his or her last address as shown by the records of the insurer, not less than 30 days prior to the effective date of the increase, as specified.

Existing law authorizes a disability policy to contain provisions which reserve the right to refuse any renewal, as specified.

This bill would provide that any notice of nonrenewal delivered or mailed as required in a situation where an insurer reserves that right, shall include a statement of the reason or reasons for the nonrenewal.

Existing law requires a policy of disability insurance to contain one of either of 2 forms. Form A is required when an insurer does not reserve the right to refuse any renewal, and Form B is applicable where that right is reserved.

Existing law sets forth certain grace period provisions relative to both Form A and Form B, of not less than 7 days for weekly premium provision payments, 10 days for monthly premium policies, and 31 days for all other policies.

This bill would instead specify a 31-day grace period for the payment of each premium falling due after the first premium with respect to both Form A and Form B, and would increase from 5 to 31 days prior to the premium due date, the time for which the insurer must deliver to the insured written notice of its intention not to renew, with respect to Form B.

The bill would also provide, with respect to application for and underwriting of any policy of individual disability

insurance, that unless a policy is unconditionally delivered when an application is taken, an insurer shall not require, and may not accept, an amount greater than 3 months' premium to be submitted with an application for the policy, as specified. When a policy is not issued, an insurer would be liable for interest, as specified, on funds submitted with an application.

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

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

~~SECTION 1.~~ ~~Section 500 of the Insurance Code is amended to read:~~

~~500. Unless notice to policyholders is otherwise required by statute, whenever any insurer has, as a regular course of conduct, sent renewal premium notices to an insured, and intends to discontinue that practice, it shall notify the insured of its intention not to send those notices.~~

SECTION 1. Section 663 of the Insurance Code is amended to read:

663. At least 20 days prior to policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(a) A written ~~or verbal~~ offer of renewal of the policy contingent upon payment of premium as stated in the offer.

(b) A notice of nonrenewal of the policy. ~~That notice shall contain or be accompanied by a statement that upon written request by the named insured, made not later than one month following the expiration of the policy period, or delivered to the insurer, the insurer will notify the insured in writing, within 20 days of his request, the reason or reasons for such nonrenewal.~~

(c) In the event that an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall

remain in effect for 30 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal. Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other replacement or succeeding automobile insurance policy procured by the insured, or his agent or broker, with respect to any automobile designated in both policies.

(d) The insurer shall not be required to notify the named insured, or any other insured, of nonrenewal of the policy if the insurer has mailed or delivered a notice of expiration or cancellation, on or prior to the 20th day preceding expiration of the policy period.

SEC. 2. Section 666 of the Insurance Code is repealed.

~~666. Where the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer shall upon written request of the named insured, mailed or delivered to the insurer not less than 15 days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.~~

SEC. 3. Section 666 is added to the Insurance Code, to read:

666. (a) Any notice of cancellation or nonrenewal required by this chapter, or by Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1 for a policy described in Section 660, shall include a written statement of the reason or reasons for the cancellation or nonrenewal.

(b) Any offer to renew a policy subject to this chapter which includes a price increase or change in the coverage shall be in writing and shall include a statement of reasons for the price increase or change in coverage.

(c) A notice subject to subdivision (a) or (b) shall include the addresses and telephone numbers referred to in Section 510.

SEC. 4. Section 675 of the Insurance Code is amended to read:

675. Except as provided in Section 679.6, this chapter shall apply to policies of insurance, other than automobile insurance ~~and workmen's compensation insurance~~, on risks located or resident in this state which are issued and take effect or which are renewed after the effective date of this chapter and insuring any of the following contingencies:

(a) Loss of or damage to real property which is used predominantly for residential purposes and which consists of not more than four dwelling units.

(b) Loss of or damage to personal property in which natural persons resident in specifically described real property of the kind described in subdivision (a) have an insurable interest, except personal property used in the conduct of a commercial or industrial enterprise.

(c) Legal liability of a natural person or persons for loss of, damage to, or injury to, persons or property, but not including policies primarily insuring risks arising from the conduct of a commercial or industrial enterprise.

This chapter shall not be construed so as to modify or negate any of the provisions of Chapter 3 (commencing with Section 330) of Part 1 of Division 1, nor to destroy any rights or remedies therein provided.

SEC. 5. Section 675.5 of the Insurance Code is amended to read:

675.5. (a) In addition to any policy of insurance specified in Section 675, this chapter shall apply to policies of commercial insurance issued or issued for delivery in this state which are issued and take effect or are renewed on or after January 1, 1987.

(b) As used in this section, commercial insurance means commercial multiperil, commercial property, commercial liability, commercial special multiperil, commercial comprehensive multiperil, errors and omissions liability, and professional liability insurance, and any other insurance not included in subdivision (d) which covers any of the following contingencies:

(1) Loss of or damage to real property used or owned

by a commercial or industrial enterprise.

(2) Loss of or damage to personal property, except personally owned motor vehicles, used in the conduct of a commercial or industrial enterprise.

(3) Legal liability of any person for loss of, damage to, or injury to persons or property, arising from the conduct of a commercial or industrial enterprise.

(c) As used in this section, the term commercial or industrial enterprise includes a business operated for profit, a professional practice, a nonprofit organization, or a governmental entity.

(d) As used in this section, the term commercial insurance does not include any of the following:

~~(1) Worker's compensation insurance.~~

~~(2)~~

(1) Insurance provided pursuant to the California FAIR plan or the California automobile assigned risk plan.

~~(3)~~

(2) Disability insurance.

~~(4)~~

(3) Automobile insurance covered by Section 660 and property insurance covered by Section 675.

~~(5)~~

(4) Ocean marine insurance.

~~(6)~~

(5) Fidelity and surety insurance.

~~(7)~~

(6) Surplus line insurance.

~~(8)~~

(7) Reinsurance.

~~(9)~~

(8) Any insurance, other than professional liability insurance for malpractice, errors, or omissions, for which premiums are determined on a retrospective rating basis.

~~(10)~~

(9) Nuclear liability insurance.

~~(11)~~

(10) Nuclear property insurance.

SEC. 6. Section 677 of the Insurance Code is amended

to read:

677. *(a)* All notices of cancellation *or nonrenewal of policies* shall be in writing, mailed to the named insured at the address shown in the policy, or to his or her last known address, and shall state, with respect to *cancellation of* policies in effect after the time limits specified in Section 676, ~~(a)~~ which of the grounds set forth in Section 676 is relied upon ; ~~and (b) that, upon written request of the named insured, mailed or delivered to the insurer within 15 days of the date of cancellation, the insurer shall specify the reason for the cancellation~~ . *The notice shall include a statement of the reason or reasons for the nonrenewal or cancellation,* except where the reason *for cancellation* is for nonpayment of premium and *this ground* is so stated in the cancellation notice.

(b) Any offer to renew a policy subject to this chapter which includes a price increase or change in the coverage shall be in writing and shall include a statement of the reason or reasons for the price increase or change in coverage.

(c) Any notice subject to subdivision (a) or (b) shall include the addresses and telephone numbers referred to in Section 510.

SEC. 7. Section 10113.7 is added to the Insurance Code, to read:

10113.7. (a) No increase of premium on any individual life insurance policy which provides for premium changes by the insurer shall be effective unless written notice is delivered to the policyowner, or mailed to his or her last address as shown by the records of the insurer, not less than 30 days prior to the effective date of the increase. If the notice is sent with or contained as part of an ordinary premium or renewal invoice or payment request, the notice of increase shall be stated separately from the ordinary statement of the amount due, and shall be in 10-point boldface type.

(b) This section shall not apply to premium increases resulting directly from changes in coverage requested by the policyowner.

(c) Nothing in this section shall be deemed to relieve the insurer of any other obligation imposed by any other provision of law.

SEC. 8. Section 10291.5 of the Insurance Code is amended to read:

10291.5. (a) The purpose of this section is to achieve both of the following:

(1) Prevent, in respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Assure that the language of all insurance policies can be readily understood and interpreted.

(b) The commissioner shall not approve any disability policy for insurance or delivery in this state in any of the following circumstances:

(1) If the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(2) If it contains any provision for payment at a rate, or in an amount (other than the product of rate times the periods for which payments are promised) for loss caused by particular event or events (as distinguished from character of physical injury or illness of the insured) more than triple the lowest rate, or amount, promised in the policy for the same loss caused by any other event or events (loss caused by sickness, loss caused by accident, and different degrees of disability each being considered, for the purpose of this paragraph, a different loss); or if it contains any provision for payment for any confining loss of time at a rate more than six times the least rate payable for any partial loss of time or more than twice the least rate payable for any nonconfining total loss of time; or if it contains any provision for payment for any nonconfining total loss of time at a rate more than three times the least rate payable for any partial loss of time.

(3) If it contains any provision for payment for disability caused by particular event or events (as

distinguished from character of physical injury or illness of the insured) payable for a term more than twice the least term of payment provided by the policy for the same degree of disability caused by any other event or events; or if it contains any benefit for total nonconfining disability payable for lifetime or for more than 12 months and any benefit for partial disability, unless the benefit for partial disability is payable for at least three months; or if it contains any benefit for total confining disability payable for lifetime or for more than 12 months, unless it also contains benefit for total nonconfining disability caused by the same event or events payable for at least three months, and, if it also contains any benefit for partial disability, unless the benefit for partial disability is payable for at least three months. The provisions of this paragraph shall apply separately to accident benefits and to sickness benefits.

(4) If it contains provision or provisions which would have the effect, upon any termination of the policy, of reducing or ending the liability as the insurer would have, but for the termination, for loss of time resulting from accident occurring while the policy is in force or for loss of time commencing while the policy is in force and resulting from sickness contracted while the policy is in force or for other losses resulting from accident occurring or sickness contracted while the policy is in force, and also contains provision or provisions reserving to the insurer the right to cancel or refuse to renew the policy, unless it also contains other provision or provisions the effect of which is that termination of the policy as the result of the exercise by the insurer of any such right shall not reduce or end the liability in respect to the hereinafter specified losses as the insurer would have had under the policy, including its other limitations, conditions, reductions, and restrictions, had the policy not been so terminated.

The specified losses referred to in the preceding paragraph are:

(i) Loss of time which commences while the policy is in force and results from sickness contracted while the policy is in force.

(ii) Loss of time which commences within 20 days following and results from accident occurring while the policy is in force.

(iii) Losses which result from accident occurring or sickness contracted while the policy is in force and arise out of the care or treatment of illness or injury and which occur within 90 days from the termination of the policy or during a period of continuous compensable loss or losses which period commences prior to the end of such 90 days.

(iv) Losses other than those specified in clause (i), (ii), or (iii) of this paragraph which result from accident occurring or sickness contracted while the policy is in force and which losses occur within 90 days following the accident or the contraction of the sickness.

(5) If by any caption, label, title, or description of contents the policy states, implies, or infers without reasonable qualification that it provides loss of time indemnity for lifetime, or for any period of more than two years, if the loss of time indemnity is made payable only when house confined or only under special contingencies not applicable to other total loss of time indemnity.

(6) If it contains any benefit for total confining disability payable only upon condition that the confinement be of an abnormally restricted nature unless the caption of the part containing any such benefit is accurately descriptive of the nature of the confinement required and unless, if the policy has a description of contents, label, or title, at least one of them contain reference to the nature of the confinement required.

(7) (A) If, irrespective of the premium charged therefor, any benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured.

(B) In determining whether benefits are of real economic value to the insured, the commissioner shall not differentiate between insureds of the same or similar economic or occupational classes and shall give due consideration to all of the following:

(i) The right of insurers to exercise sound

underwriting judgment in the selection and amounts of risks.

(ii) Amount of benefit, length of time of benefit, nature or extent of benefit, or any combination of those factors.

(iii) The relative value in purchasing power of the benefit or benefits.

(iv) Differences in insurance issued on an industrial or other special basis.

(C) To be of real economic value, it shall not be necessary that any benefit or benefits cover the full amount of any loss which might be suffered by reason of the occurrence of any hazard or event insured against.

(8) If it substitutes a specified indemnity upon the occurrence of accidental death for any benefit of the policy, other than a specified indemnity for dismemberment, which would accrue prior to the time of that death or if it contains any provision which has the effect, other than at the election of the insured exercisable within not less than 20 days in the case of benefits specifically limited to the loss by removal of one or more fingers or one or more toes or within not less than 90 days in all other cases, of doing any of the following:

(A) Of substituting, upon the occurrence of the loss of both hands, both feet, one hand and one foot, the sight of both eyes or the sight of one eye and the loss of one hand or one foot, some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than the total of the benefit or benefits for which such specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of such dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(B) Of substituting, upon the occurrence of any other dismemberment some specified indemnity for any or all benefits under the policy unless the indemnity so

specified is equal to or greater than one-fourth of the total of the benefit or benefits for which the specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of the dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(C) Of substituting a specified indemnity upon the occurrence of any dismemberment for any benefit of the policy which would accrue prior to the time of dismemberment.

As used in this section, loss of a hand shall be severance at or above the wrist joint, loss of a foot shall be severance at or above the ankle joint, loss of an eye shall be the irrecoverable loss of the entire sight thereof, loss of a finger shall mean at least one entire phalanx thereof and loss of a toe the entire toe.

(9) If it contains provision, other than as provided in Section 10370, reducing any original benefit more than 50 percent on account of age of the insured.

(10) If the insuring clause or clauses contain no reference to the exceptions, limitations, and reductions (if any) or no specific reference to, or brief statement of, each abnormally restrictive exception, limitation, or reduction.

(11) If it contains benefit or benefits for loss or losses from specified diseases only unless:

(A) All of the diseases so specified in each provision granting the benefits fall within some general classification based upon the following:

(i) The part or system of the human body principally subject to all such diseases.

(ii) The similarity in nature or cause of such diseases.

(iii) In case of diseases of an unusually serious nature and protracted course of treatment, the common characteristics of all such diseases with respect to severity of affliction and cost of treatment.

(B) The policy is entitled and each provision granting

the benefits is separately captioned in clearly understandable words so as to accurately describe the classification of diseases covered and expressly point out, when that is the case, that not all diseases of the classification are covered.

~~(12) If it does not contain provision for a grace period of at least the number of days specified below for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force provided, that the grace period to be included in the policy shall be not less than seven days for policies providing for weekly payment of premium, not less than 10 days for policies providing for monthly payment of premium and not less than 31 days for all other policies.~~

~~(13)~~

(12) If it fails to conform in any respect with any law of this state.

(c) The commissioner may, from time to time as conditions warrant, after notice and hearing, promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient, to establish, in advance of the submission of policies, the standard or standards conforming to subdivision (b), by which he or she shall disapprove or withdraw approval of any disability policy.

In promulgating any such rule or regulation the commissioner shall give consideration to the criteria herein established and to the desirability of approving for use in policies in this state uniform provisions, nationwide or otherwise, and is hereby granted the authority to consult with insurance authorities of any other state and their representatives individually or by way of convention or committee, to seek agreement upon those provisions.

Any such rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) The commissioner may withdraw approval of

filing of any policy or other document or matter required to be approved by the commissioner, or filed with him or her, by this chapter when the commissioner would be authorized to disapprove or refuse filing of the same if originally submitted at the time of the action of withdrawal.

Any such withdrawal shall be in writing and shall specify reasons. An insurer adversely affected by any such withdrawal may, within a period of 30 days following mailing or delivery of the writing containing the withdrawal, by written request secure a hearing to determine whether the withdrawal should be annulled, modified, or confirmed. Unless, at any time, it is mutually agreed to the contrary, a hearing shall be granted and commenced within 30 days following filing of the request and shall proceed with reasonable dispatch to determination. Unless the commissioner in writing in the withdrawal, or subsequent thereto, grants an extension, any such withdrawal shall, in the absence of any such request, be effective, prospectively and not retroactively, on the 91st day following the mailing or delivery of the withdrawal, and, if request for the hearing is filed, on the 91st day following mailing or delivery of written notice of the commissioner's determination.

(e) No proceeding under this section is subject to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) Except as provided in subdivision (i), any action taken by the commissioner under this section is subject to review by the courts of this state and proceedings on review shall be in accordance with the Code of Civil Procedure.

Notwithstanding any other provision of law to the contrary, petition for any such review may be filed at any time before the effective date of the action taken by the commissioner. No action of the commissioner shall become effective before the expiration of 20 days after written notice and a copy thereof are mailed or delivered to the person adversely affected, and any action so submitted for review shall not become effective for a

further period of 15 days after the filing of the petition in court. The court may stay the effectiveness thereof for a longer period.

(g) This section shall be liberally construed to effectuate the purpose and intentions herein stated; but shall not be construed to grant the commissioner power to fix or regulate rates for disability insurance or prescribe a standard form of disability policy, except that the commissioner shall prescribe a standard supplementary disclosure form for presentation with all disability insurance policies, pursuant to Section 10603.

(h) This section shall be effective on and after July 1, 1950, as to all policies thereafter submitted and on and after January 1, 1951, the commissioner may withdraw approval pursuant to subdivision (d) of any policy thereafter issued or delivered in this state irrespective of when its form may have been submitted or approved, and prior to those dates the provisions of law in effect on January 1, 1949, shall apply to those policies.

(i) Any such policy issued by an insurer to an insured on a form approved by the commissioner, and in accordance with the conditions, if any, contained in the approval, at a time when that approval is outstanding shall, as between the insurer and the insured, or any person claiming under the policy, be conclusively presumed to comply with, and conform to, this section.

SEC. 9. Section 10350.3 of the Insurance Code is amended to read:

10350.3. A disability policy shall contain a provision which shall be in one of the two forms set forth herein. Form A shall be used in a policy in which the insurer does not reserve the right to refuse any renewal. Form B shall be used in a policy in which an insurer reserves the right to refuse any renewal. *Any notice of nonrenewal delivered or mailed as required by Form B shall include a statement of the reason or reasons for the nonrenewal.* The clause in parentheses may only be added if the policy contains a cancellation provision. ~~In the blank in each such form shall be inserted a number; not less than "7" for weekly premium policies, "10" for monthly premium~~

~~policies; and "31" for all other policies.~~

Form A.

Grace Period: A grace period of */ /* *31* days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

Form B.

Grace Period: Unless not less than ~~five~~ *31* days prior to the premium due date the insurer has delivered to the ~~insurer~~ *insured* or has mailed to his *or her* last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted, a grace period of */ /* *31* days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

SEC. 10. Article 5.5 (commencing with Section 10370) is added to Chapter 4 of Part 2 of Division 2 of the Insurance Code, to read:

Article 5.5. Special Provisions

10370. In addition to any other requirement of law, the following shall apply to application for and underwriting of any policy of individual disability insurance issued in this state:

(a) Unless a policy is unconditionally delivered when an application is taken, an insurer shall not require, and may not accept, an amount greater than three months' premium to be submitted with an application for the policy. No further premium shall be collected until the policy is delivered to the applicant.

(b) The insurer shall notify the applicant, within 60

days from the date the insurer or the insurer's authorized representative or producer receives the application and accompanying premium, as to whether or not the policy will be issued. If the applicant is not so notified, the insurer shall pay interest to the applicant on the funds submitted with the application, at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure, from the date the insurer or insurer's authorized representative or producer received those funds until they are refunded to the applicant or are applied toward the premium.

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BILL NUMBER: AB 16 AMENDED 07/15/93
BILL TEXT

AMENDED IN SENATE JULY 15, 1993
AMENDED IN ASSEMBLY JUNE 7, 1993
AMENDED IN ASSEMBLY MAY 13, 1993

INTRODUCED BY Assembly Member Margolin
(Principal coauthor: Senator Torres)

DECEMBER 7, 1992

An act to add Division 9 (commencing with Section 20000) to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 16, as amended, Margolin. Health care.

Under existing law, basic health care services are provided to certain low-income individuals through the Medi-Cal program which is administered by the State Department of Health Services. However, there is no entity within state government that regulates the provision of health care insurance coverage or services to all citizens of the state, nor does existing law require employers to provide health care insurance coverage for their employees.

This bill would state the intent of the Legislature regarding provision of health care services.

The bill would create the California Health Plan Commission, with specified powers and duties, which would establish and maintain a program of universal health coverage to be known as the California Health Plan. The bill would require that, under the plan, all California residents would be eligible for the same federally required package of comprehensive health care services, health care coverage currently provided through workers' compensation and automobile insurance would be provided through the plan, {-and -} all California residents would be eligible to participate without regard to employment status or place of employment in accordance with applicable federal requirements {+ , and the commission would create a modified managed care system to serve rural communities throughout California +} .

The bill would require the commission to establish and fund regional health insurance purchasing corporations, with certain duties. The bill would require, on or after January 1, 1995, the corporations, the commission, or another agency designated by the commission, to enter into contracts with health plans for the purpose of providing health benefits coverage to all eligible persons. The bill would require, on or before January 1, 1995, the commission to adopt regulations to implement these provisions and to prepare a plan, budget, and timetable for the transfer of funds and entitlements under the Medi-Cal program, as required by federal law, to the commission.

This bill would provide that these provisions are to become operative upon the enactment of federal legislation requiring or authorizing any state to adopt a comprehensive health care plan with similar provisions to this bill.

Vote: majority. Appropriation: no. Fiscal committee:

yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. It is the intent of the Legislature to do all of the following:

(a) Establish a system of universal health coverage in accordance with federal law that guarantees access to quality affordable health care for every Californian.

(b) Create a health commission to implement the requirements of federal law regarding the purchase of health care coverage.

(c) Implement the elements of the federal standard benefit package including 24-hour care as it will be applied in this state.

(d) Establish a state health budget in conformance with federal law governing the maximum health care expenditures within the state.

(e) Establish health insurance purchasing corporations as permitted or required by federal law.

(f) Prepare a plan, budget, and timetable for the phased transfer of Medi-Cal funded health coverage to the commission in accordance with federal law.

SEC. 2. Division 9 (commencing with Section 20000) is added to the Insurance Code, to read:

DIVISION 9. CALIFORNIA HEALTH PLAN

CHAPTER 1. DEFINITIONS

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 Plan Commission.

20004. "HIPC" means a regional health insurance purchasing corporation established pursuant to Section 20060.

20006. "Program" means the California Health Plan.

CHAPTER 2. CALIFORNIA HEALTH PLAN COMMISSION

20020. There is in the state government the California Health Plan Commission, that shall be an independent authority composed of seven members.

CHAPTER 3. CALIFORNIA HEALTH PLAN

20030. The commission shall establish and maintain, for all California residents, a program of universal health coverage to be known as the California Health Plan, under which all of the following shall be provided:

(a) All California residents shall be eligible for the same federally required package of comprehensive health care services, provided through competing health plans that shall accept all eligible individuals regardless of health status and without individual medical underwriting, preexisting condition exclusions, or waiting periods.

(b) Health care shall be provided to all California residents through a cost-effective system of coverage regardless of the

cause or site of injury or illness, and under which the health care coverage currently provided through workers' compensation and automobile insurance shall be provided through the California Health Plan.

(c) All California residents shall be eligible to participate without regard to employment status or place of employment in accordance with applicable federal requirements. {+

(d) The commission shall create a modified managed care system to serve rural communities throughout California. +}

20031. To establish and maintain the program, the commission shall do all of the following:

(a) Establish health insurance purchasing corporations (HIPCs) pursuant to Section 20060.

(b) Appoint committees, as necessary, to provide technical assistance in the operation of the program.

(c) Undertake activities necessary to administer the program, including marketing and publicizing the program, and assuring health plan, employer, and enrollee compliance with program requirements.

(d) Establish rules, conditions, and procedures for participation of eligible persons.

(e) Establish rules, conditions, and procedures for participation of health plans.

(f) Issue rules and regulations as necessary to administer the program.

(g) In conjunction with HIPCs, as appropriate, collect data from all private health plans and sponsor research into health outcomes and practice guidelines in order to facilitate fair competition and cost containment.

20034. (a) Notwithstanding any other provision of law, the commission shall not be subject to licensure or regulation by the Department of Insurance or the Department of Corporations.

(b) Participating health plans that contract with the program shall be licensed and in good standing with their licensing agencies.

20035. The commission shall develop and make available objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the commission.

20036. The commission shall use appropriate and efficient means to notify eligible persons of the availability of sponsored health coverage from the program.

CHAPTER 4. GLOBAL BUDGETING

20040. The commission shall develop a statewide global budget for health service expenditures by benefit type based on estimated expenses and utilization data prepared by the commission.

CHAPTER 5. TWENTY-FOUR HOUR COMPREHENSIVE COVERAGE

20050. Health plans offering benefits through the California Health Plan shall include federally required medical, surgical, and hospital treatment, without regard to the cause or site of

the injury or illness.

CHAPTER 6. REGIONAL HEALTH INSURANCE PURCHASING CORPORATIONS

20060. Regional health insurance purchasing corporations (HIPCs) shall be established and funded by the commission.

20061. The HIPCs, the commission, or another agency designated by the commission, where no HIPC is established, shall do all of the following in accordance with state and federal standards:

(a) On or after January 1, 1995, enter into contracts with health plans for the purpose of providing health coverage to all eligible persons. Participating health plans shall have all of the following operating characteristics satisfactory to the commission as well as meeting other applicable criteria established by the commission:

(1) The ability to deliver the federally required package of comprehensive health services in accordance with defined criteria for quality and service, and cost-sharing.

(2) Strong financial condition, including the ability to assume the risk of providing and paying for covered services.

(3) A satisfactory grievance procedure.

(4) Participating health plans that contract with, or employ, health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the commission, in consultation with the health plan's licensing agency:

(A) Review the quality of care covered.

(B) Review the appropriateness of care covered.

(C) Provide accessible health care services.

(b) Ensure that all consumers have a choice among private health plans that will provide the federally required package of comprehensive health services for no additional premium above that paid on their behalf by the HIPC.

(c) Make provision to assist all California residents in choosing among contracting private health plans by providing consumer education, including uniform information about all the certified private health plans in a given region.

(d) Provide a mechanism for enrolling all eligible persons in their chosen private health plans.

(e) Monitor and enforce standards concerning access and quality of care in all private health plans.

(f) Make available consumer information that accurately summarizes the benefit plans that are offered by the health plans through the program and the terms on which the plans are available.

CHAPTER 7. PLAN IMPLEMENTATION

20070. The commission shall, on or before January 1, 1995, adopt regulations to fully implement this act.

20071. The commission shall, on or before January 1, 1995, prepare a plan, budget, and timetable for the transfer of funds and entitlements under the Medi-Cal program to the commission, as required by federal law, for the purpose of providing health coverage for persons who would otherwise be eligible for Medi-Cal.

SEC. 3. Section 2 of this act shall become operative upon the enactment of federal legislation requiring or authorizing any state to adopt a comprehensive health care plan that contains

provisions that are similar to the provisions of this act.