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Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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1971 – AB 2860 (Burton and Brown)

Pages 2-28

1972 – AB 1199 (Speaker Moretti)

Pages 29-30

1972 – SB 770 (Moscone)

Pages 31-59

1978 – AB 1207 (Hart)

Pages 60-97

October 2007

AMENDED IN ASSEMBLY SEPTEMBER 20, 1971

CALIFORNIA LEGISLATURE—1971 REGULAR SESSION

ASSEMBLY BILL

No. 2860

Introduced by Assemblymen Burton and Brown

April 16, 1971

REFERRED TO COMMITTEE ON HEALTH

An act to add Division 8 (commencing with Section 10000) to the Labor Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2860, as amended, Burton (Health). Health insurance. Adds Div. 8 (commencing with Sec. 10000), Lab.C.

Enacts a program of comprehensive health insurance administered by the state.

Vote— $\frac{2}{3}$; Appropriation—Yes; Fiscal Committee—Yes.

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

1 SECTION 1. Division 8 (commencing with Section
2 10000) is added to the Labor Code, to read:

3

4

DIVISION 8. CALIFORNIA STATE
5 COMPREHENSIVE HEALTH INSURANCE

6

7

CHAPTER 1. GENERAL PROVISIONS

8

9 10000. This division shall be known and may be cited
10 as the Health Insurance Act.

11 10001. The Legislature hereby finds that the benefits

1 of the recent great advances in medical science have not
2 reached all the people in the state; that adequate hospital
3 and medical care is not available to all those who need it;
4 that only the highest-income groups and the poor who
5 are aided by public or private charity are relieved of the
6 ever-present concern over costs of personal health
7 services, while the vast middle-income and relatively low
8 income groups are left to cope with the shattering costs
9 of serious or prolonged illness; that the maldistribution of
10 available medical and hospital services causes, among
11 other things, wholly inadequate provision for the health
12 needs of families residing in our inner cities and rural
13 areas; that very few voluntary health insurance plans
14 provide adequate benefits and then at costs beyond the
15 reach of those families who most need such services; and
16 that medical and hospital services and facilities must be
17 expanded if the public health and welfare are to be
18 preserved and protected. The Legislature hereby
19 declares, as the public policy of the state, that adequate
20 medical and hospital care is a basic need and right of
21 every resident of the state, that fulfilling this need is a
22 duty and concern of the state and will best be
23 accomplished by the establishment of a comprehensive
24 statewide health insurance system which will make
25 preventive and curative health services and adequate
26 hospital facilities available to all.

27 CHAPTER 2. DEFINITIONS

28
29 10050. Wherever used in this division, the terms
30 hereinafter defined have the meanings ascribed to them
31 in this section except where the context requires a
32 different meaning.

33 10051. "Commission" means the Health Insurance
34 Commission.

35 10052. "Certified hospital" means any hospital
36 certified pursuant to this division and shall include a
37 nongeriatric facility or other facility designed primarily
38 for persons who are in need of acute medical or nursing
39 care and not for the senile aged who are in need only of
40 custodial care and maintenance.

1 10053. "Certified medical group" means any group of
2 physicians *or persons licensed under Sections 2943 or*
3 *9041 of the Business and Professions Code* certified
4 pursuant to this division as (a) having the necessary
5 qualifications and engaged in the practice of the several
6 specialties and areas of medicine prescribed by the
7 commission and the necessary office space, equipment,
8 facilities and medical apparatus required by the
9 commission, (b) meeting the standards and other
10 requirements established by the commission, and (c)
11 affiliated with at least one certified hospital.

12 10054. "Comprehensive hospital services" means all
13 services, as determined by the commission, performed in
14 a certified hospital which are directly related to patient
15 care, including, but not limited to, inpatient diagnostic,
16 laboratory, medical and surgical care, ambulatory care in
17 the hospital and in such decentralized care centers as the
18 hospital may establish or designate and the furnishing of
19 drugs and medicines prescribed pursuant to Section
20 10209.

21 10055. "Comprehensive medical services" means all
22 medical services, as determined by the commission,
23 *including services performed by persons licensed under*
24 *Sections 2943 or 9041 of the Business and Professions*
25 *Code*, except those performed by an optometrist,
26 podiatrist, chiropractor or dentist (other than dental
27 surgical care) and except for any service which an
28 individual is eligible to receive from the United States, or
29 in any institution, or from any provider of care, wholly
30 supported by federal funds.

31 10056. "Scheduled hospital services" means those
32 services directly related to patient care, performed in a
33 duly licensed hospital, including but not limited to,
34 inpatient diagnostic, laboratory, medical and surgical
35 care, and ambulatory care, as determined and at the rate
36 determined from time to time by the commission and the
37 furnishing of drugs and medicines pursuant to Section
38 10210.

39 10057. "Scheduled medical services" means those
40 medical services, except those performed by an

1 optometrist, podiatrist, chiropractor or dentist (other
2 than dental surgical care), as determined and at the rate
3 determined from time to time by the commission, but
4 shall not include any service which an individual is
5 eligible to receive from the United States or in any
6 institution, or from any provider of care, wholly
7 supported by federal funds.

8 10058. "Director" means the Director of the Health
9 Insurance Commission.

10 10059. "Fund" means the Health Insurance Fund.

11 10060. "Employer" means any person, partnership,
12 firm, association, public or private corporation, the legal
13 representatives of a deceased person, or the receiver,
14 trustee or successor of a person, partnership, firm,
15 association, public or private corporation, including the
16 state, municipal corporations, other governmental
17 subdivisions, and all public agencies and authorities, who
18 or whose agent or predecessor in interest has employed
19 three or more persons in any employment subject to this
20 division on each of 15 or more days within any calendar
21 year.

22 Whenever any helper, assistant or employee of an
23 employer engages any other person in the work which
24 said helper, assistant or employee is doing for the
25 employer, such employer shall for all purposes hereof be
26 deemed the employer of such other person, whether
27 such person is paid by the said helper, assistant or
28 employee, or by the employer, provided the employment
29 has been with the knowledge, actual, constructive or
30 implied, of the employer.

31 In determining whether an employer is subject to this
32 division, and in determining the taxes for which he is
33 liable hereunder, such employer shall, whenever he
34 contracts with any person for any work which is part of
35 such employer's usual trade, occupation, profession or
36 enterprise be deemed to employ all employees employed
37 by such person for such work, and he alone shall be liable
38 for the taxes hereunder with respect to wages paid to
39 such employees for such work, unless such person
40 performs work or is in fact actually available to perform

1 work for anyone who may wish to contract with him and
2 is also found to be engaged in an independently
3 established trade, business, profession or enterprise.

4 10061. "Employee" means any person employed for
5 hire by an employer in an employment subject to this
6 division.

7 10062. "Employment" means any employment of an
8 employee by an employer in which all or the greater part
9 of the employee's work is performed within the state
10 under any contract of hire, express or implied, oral or
11 written, and shall include any trade, occupation, service
12 or profession in which any person may engage; except
13 service for an employee by his spouse or minor child.

14 10063. "Employer's contribution" means the taxes
15 due to the fund under this division from an employer on
16 account of and on behalf of each insured person
17 employed by him in an employment subject to this
18 division during the period of such employment.

19 10064. "Advisory council" means the State Advisory
20 Health Insurance Policy Council.

21 10065. "Year", for the purposes of determining
22 liability for taxes and eligibility for benefits under this
23 division shall mean calendar year.

24

25 CHAPTER 3. HEALTH INSURANCE COMMISSION

26

27 Article 1. Administration

28

29 10100. There is in the Human Relations Agency the
30 Health Insurance Commission, under the control of an
31 executive officer known as the Director of the Health
32 Insurance Commission.

33 10101. The commission shall consist of the director
34 and eight members appointed by the Governor, subject
35 to confirmation by the Senate.

36 The terms of the eight members appointed by the
37 Governor shall be four years except that of the members
38 first appointed, two shall be appointed for terms of one
39 year, two for terms of two years, two for terms of three
40 years and two for terms of four years. Not more than four

1 of such members shall be of the same political party, and
2 no member may be a provider of medical or hospital
3 services under this division. The eight members
4 appointed by the Governor shall appoint a recognized
5 expert in the fields of public health and delivery of
6 medical and hospital services as director of the
7 commission, who shall be the chief executive and
8 operating officer and chairman of the commission and
9 shall serve for a term of four years. He shall devote his full
10 time and attention to the duties of his office and shall
11 receive the annual salary provided for in the
12 Government Code.

13 10102. Each of the appointed members shall receive
14 the sum of one hundred dollars (\$100) for each day
15 engaged in the performance of his duties under this
16 division, not to exceed 100 days during any one calendar
17 year, and, in addition thereto, shall be entitled to
18 reimbursement for his traveling and other expenses
19 actually and necessarily incurred by him in the
20 performance of his duties hereunder.

21 10103. A majority of the commission shall constitute a
22 quorum to transact business. No vacancy shall impair the
23 rights of the remaining members to exercise all of the
24 powers of the commission so long as a majority remain.
25 Any investigation, inquiry, hearing or review which the
26 commission is authorized to hold or undertake may be
27 held or undertaken by or before any one member of the
28 commission, or by or before one or more of its deputies;
29 and every order made by a member thereof, or by one or
30 more of its duly authorized deputies, when approved and
31 confirmed by a majority of the commission, and so shown
32 on its record of proceedings, shall be deemed to be the
33 order of the commission. The commission may, by
34 majority vote of its membership, adopt such rules of
35 procedure for the conduct of its business, not inconsistent
36 with any of the provisions of this division, as it may deem
37 fit and it may from time to time, by like action of a
38 majority, supplement, amend, alter, modify or repeal its
39 rules of procedure in any respect.

40 10104. The commission may establish offices and hold

1 meetings in any place within the state.

2

3

Article 2. Powers and Duties

4

5 10125. The commission shall have the power to accept
6 grants and donations of money for any of its purposes, to
7 employ such persons as may be necessary to carry out the
8 provisions of this division, to make such contracts and
9 agreements as may be necessary to carry out the
10 provisions of this division, to adopt and enforce such rules
11 and regulations as may be necessary to accomplish the
12 purposes of this division and to carry out its provisions,
13 and to amend or repeal the same from time to time only
14 in accordance with the provisions of Chapter 4.5
15 (commencing with Section 11371) of Part 1 of Division 3
16 of Title 2 of the Government Code.

17 10126. The commission is hereby designated to act as
18 the agent of the state or of the appropriate department
19 thereof to submit the plan of statewide health insurance
20 contemplated by this division for and obtain the approval
21 of all federal agencies having jurisdiction and control
22 over state plans for rendering medical and hospital
23 services under federal laws, including Title XVIII and
24 Title XIX of the Social Security Amendments of 1965
25 (Public Law 89-97), as now in force or hereafter
26 amended, commonly known and referred to as the
27 medicare and medicaid programs, and to accept and
28 receive, and to deposit into the fund any and all grants of
29 money available to the state under such laws, in
30 reimbursement for the cost of such services or programs
31 or otherwise. The commission shall act as the agent of the
32 state or of the appropriate department thereof in any
33 negotiations relative to the submission and approval of
34 such plan and make any arrangement not inconsistent
35 with law which may be required by or pursuant to such
36 federal law to obtain and retain such approval and to
37 secure for the state the benefits of the provisions of such
38 federal laws.

39 10127. The commission shall require all providers of
40 medical services and hospital services to render detailed

1 records of such services, including the person to whom
2 rendered, the person by whom rendered, and the total
3 fees therefor.

4 10128. The commission shall establish, by rule or
5 regulation, procedures to receive complaints in respect of
6 services and benefits furnished under this division, and
7 for appeals to the commission by persons aggrieved by
8 any determination made under this division.

9 10129. All records of the commission except the
10 personal medical records of persons receiving benefits
11 under the provisions of this act and all personnel records
12 of employees of the commission shall be deemed to be
13 public records for all purposes.

14 10130. In addition to all of the duties, powers and
15 authorities specifically imposed and conferred upon the
16 commission by this division, the commission shall serve
17 and function as a regulatory and policymaking body and
18 it shall have full power and authority:

19 (a) After consultation with the advisory council, to
20 establish standards of administration throughout the state
21 to effect maximum efficiency and quality of medical and
22 hospital services and to prevent overutilization of such
23 services; such standards shall include provisions for
24 continuing medical education;

25 (b) To supervise and make inquiries and
26 investigations into the administration of this division and
27 the furnishing and payment of the benefits therein
28 provided and to do all things it deems necessary or
29 proper to improve the same throughout the state or in
30 any part thereof;

31 (c) If, after inquiry or investigation, it is satisfied that
32 the benefits provided by this division are not being
33 furnished adequately, properly or efficiently within any
34 local area, to authorize the director to make
35 arrangements and do all other things he deems fit or
36 necessary in order to insure the adequate, proper and
37 efficient furnishing of said benefits within said local area
38 including assistance in the establishment of certified
39 medical groups;

40 (d) After consultation with the advisory council as to

1 questions of general policy and administration, to study
2 and make recommendations as to the most effective
3 methods of providing benefits, and as to legislation and
4 matters of administrative policy concerning health and
5 related subjects;

6 (e) To delegate to any officer or employee of the
7 commission such of its powers and duties, except that of
8 prescribing rules and regulations, as it may consider
9 necessary and proper to carry out the purposes of this
10 division;

11 (f) To make inquiries into the causes and results of
12 sickness and injuries, the sources of mortality and the
13 effect of localities, employments and other conditions
14 upon the health of the persons entitled to the benefits
15 provided by this division and of the public generally; to
16 obtain, collect, preserve and, from time to time, publish
17 such information relating to mortality, sickness, injury
18 and health as may be useful in the administration of this
19 division or may contribute to the promotion of health or
20 the security of life;

21 (g) To promote the health and safety of the persons
22 entitled to the benefits provided by this division and to
23 take such steps within its means as it may deem feasible
24 and appropriate to reduce and prevent sickness, injury
25 and death among such persons;

26 (h) To cooperate with public health officers and all
27 other agencies, public and private, in the improvement
28 of public health and sanitation and in the promotion of
29 public education in all matters pertaining to health;

30 (i) To acquire, by purchase, exchange or otherwise,
31 personal and real property and to erect, construct and
32 equip buildings necessary to the proper administration of
33 this division and the exercise of its duties, powers and
34 authorities thereunder; and

35 (j) To make grants for medical research.

36 10130. It shall be the duty of the commission to make
37 a written report to the Governor and the Legislature not
38 later than December 1st of each year on the operation
39 and administration of this division in all its phases.

40 10132. The director shall be the chief executive and

1 operating officer under this division and he shall have all
2 the duties, powers and authorities imposed and granted
3 by this division or assigned to him by the commission. As
4 representative of the commission and under its direction,
5 he shall supervise, direct and control the administration
6 and enforcement of this division throughout the state,
7 and all administrative and executive powers and duties
8 needed for the proper administration and enforcement
9 of this division shall be vested in the director to be
10 exercised by him within the provisions of this division and
11 the rules and regulations adopted thereunder and subject
12 to the policies and in accordance with the principles
13 established by the commission. He shall have full power
14 and authority to appoint and employ such employees and
15 assistants as may be required for the the administration
16 of the provisions of this division, to fix their compensation
17 within the amount available therefor, and to prescribe
18 their duties.

19

20 CHAPTER 4. ADVISORY HEALTH INSURANCE
21 POLICY COUNCIL
22

23 10150. There is hereby established in the commission
24 an advisory health insurance policy council to consist of
25 14 members. Two of such members shall be generally
26 representative of industry and two of such members shall
27 be generally representative of labor, three of such
28 members shall be generally representative of consumer
29 groups; one shall be a public member; one shall be
30 representative of government; one shall be generally
31 representative of the medical schools in the state and one
32 each shall be generally representative of providers of
33 comprehensive medical services, scheduled medical
34 services, comprehensive hospital services, and scheduled
35 hospital services under this division.

36 10151. The advisory council shall meet not less
37 frequently than twice a year and whenever at least six of
38 the members request a meeting.

39 10152. The commission shall appoint the members of
40 the advisory council who shall hold office for a term of

1 four years, except that any member appointed to fill a
2 vacancy occurring prior to the expiration of the term for
3 which his predecessor was appointed shall be appointed
4 for the remainder of such term, and the terms of office
5 of the members first taking office shall expire, as
6 designated by the commission at the time of
7 appointment, two at the end of the first year, four at the
8 end of the second year, four at the end of the third year,
9 and four at the end of the fourth year, after the date of
10 appointment.

11 10153. Each appointed member shall receive
12 compensation at the rate of seventy-five dollars (\$75) per
13 day for each day spent in attending meetings of the
14 advisory council and for the time devoted to official
15 business of the advisory council under this chapter,
16 inclusive of travel time; and actual and necessary
17 traveling and other expenses while away from his place
18 of residence upon official business under this chapter.

19 10154. The advisory council, and each of its appointed
20 members, may be provided by the commission with such
21 secretarial, clerical or other assistants as the commission
22 shall authorize.

23 10155. The commission, by a majority vote, may at
24 any time remove any member of the council for cause
25 after a hearing on written charges.

26 10156. The advisory council shall advise the board and
27 the director with reference to all questions of general
28 policy and administration in carrying out the provisions
29 of this division.

30 10157. The advisory council may establish special
31 advisory, technical, regional, or local committees or
32 commissions for local areas or regions of the state whose
33 membership may include members of the advisory
34 council or other persons or both, to advise upon general
35 or special questions, professional and technical subjects,
36 questions concerning administration, problems affecting
37 regions or localities, and related matters.

38
39
40

CHAPTER 5. HEALTH INSURANCE SYSTEM

1 Article 1. Eligibility and Coverage

2

3 10200. A statewide health insurance system is hereby
4 established. Such system shall consist of Plan 1 and Plan
5 2, as hereinafter defined. Every person eligible for
6 coverage under such system shall elect coverage under
7 Plan 1 or Plan 2, in the manner hereinafter provided.

8 10201. Every bona fide resident of this state except
9 those on active duty in the armed forces of the United
10 States and those confined in federal, state and local penal
11 institutions shall be eligible for the benefits of the health
12 insurance system set forth in this division.

13 10202. A person electing coverage under Plan 1 may
14 become a patient of any certified medical group in the
15 state. As such patient he shall be entitled to receive
16 comprehensive medical services from such group and
17 comprehensive hospital services in the certified hospital
18 with which such group is affiliated. If such person
19 receives or is eligible to receive benefits under Title
20 XVIII of the Social Security Amendments of 1965 (Public
21 Law 89-97), as now in force or hereafter amended,
22 commonly known as the medicare program, he shall be
23 entitled to benefits under this division only after he has
24 exhausted such benefits under such law or program,
25 unless he assigns to the commission all of his right, title
26 and interest in and to reimbursement for such benefits as
27 may be provided under this division.

28 10203. (a) A person electing coverage under Plan 2
29 shall be entitled to receive reimbursement for scheduled
30 medical services furnished to him, in accordance with the
31 fee schedule promulgated by the commission and he shall
32 also be entitled to receive scheduled hospital services, in
33 accordance with the fee schedule promulgated by the
34 commission. If such person receives or is eligible to
35 receive benefits under Title XVIII of the Social Security
36 Amendments of 1965 (Public Law 89-97), as now in force
37 or hereafter amended, commonly known as the medicare
38 program, he shall be entitled to benefits under this
39 division only after he has exhausted such benefits under
40 such law or program, unless he assigns to the corporation

1 all of his right, title, and interest in and to reimbursement
2 for such benefits as may be provided under this division.

3 (b) Such person shall pay in the first instance for all
4 such medical services furnished to him and shall be
5 entitled to be reimbursed therefor by the commission, in
6 accordance with the fee schedules promulgated by the
7 commission and the provisions of this division.

8 (c) Before receiving reimbursement for medical
9 services or hospital services furnished to such person,
10 such person shall assume, bear and pay the first fifty
11 dollars (\$50) of the cost of such services rendered to such
12 person in any one calendar year, not to exceed one
13 hundred fifty dollars (\$150) for a family group consisting
14 of a person and his legal dependents for personal income
15 tax purposes, and 20 per centum of the remainder of such
16 costs.

17 (d) The first fifty dollars (\$50) of the cost of hospital
18 services rendered to each such person shall be borne by
19 and paid by such person directly to the hospital in which
20 such services were rendered unless satisfactory proof is
21 furnished to such hospital that such person has already
22 paid such amount for such services in such calendar year.
23 In addition thereto, such person shall bear and pay for
24 such services 20 per centum of the remainder of such
25 costs. The balance of such costs shall be paid by the
26 commission directly to such hospital, in accordance with
27 the rules and regulations of the commission.

28 10204. Every person electing coverage under either
29 Plan 1 or Plan 2, who is receiving or is eligible to receive
30 medical assistance under the provisions of the Medi-Cal
31 Act, shall be entitled to additional benefits, as provided in
32 Chapter 7 (commencing with Section 14000) of Part 3 of
33 Division 9 of the Welfare and Institutions Code.

34 10205. The corporation shall bill the Department of
35 Health Care Services for the nonfederal share of the total
36 cost of all services furnished by the commission pursuant
37 to Section 10204, and the Department of Health Care
38 Services shall pay to the commission the amount of all
39 such bills out of any moneys available to such department
40 for medical assistance at such times and in such

1 installments as the commission and such department may
2 mutually agree upon.

3 10206. Every person eligible for coverage under the
4 health insurance system shall apply to the commission for
5 coverage on forms to be furnished by the commission. If
6 electing Plan 1, he shall indicate on such application the
7 name of the certified medical group of which he chooses
8 to be a patient. The commission shall issue an appropriate
9 identification card to all eligible applicants. Eligible
10 applicants may also apply in behalf of their dependents
11 who must also qualify for eligibility under this division.

12 10207. Except in cases of change of residence, no
13 person may transfer from one plan to another or from one
14 certified medical group to another within Plan 1 except
15 during the third quarter of each year, to be effective on
16 the first day of January next succeeding.

17 10208. The commission shall publish and otherwise
18 make known in each local area the names and addresses
19 of certified medical groups and the names of the
20 physicians therein who have agreed to furnish services as
21 benefits under Plan 1.

22 10209. All prescriptions for drugs ordered by a
23 member of a certified medical group or by a certified
24 hospital for a patient electing coverage under Plan 1 who
25 is a patient of such group or who is being treated in such
26 hospital as a patient of such group shall be filled by the
27 pharmacy in such hospital and included as part of the
28 comprehensive hospital services furnished to such
29 patient. At the option of any such outpatient, such
30 prescriptions may be filled at any licensed or registered
31 pharmacy in this state, subject to the rules, regulations
32 and fee schedules promulgated by the commission. In the
33 event of the exercise of such option by such outpatient,
34 the pharmacy filling such prescriptions shall bill the
35 commission for the amounts due therefor, in accordance
36 with the fee schedule promulgated by the commission,
37 and the commission shall audit and pay to such pharmacy
38 the amount due on such bill and deduct the amount of
39 such payment from any moneys to which the certified
40 hospital, which would otherwise have filled such

1 prescription, shall be entitled to receive from the
2 commission under this division.

3 10210. All prescriptions for drugs ordered for a
4 patient electing coverage under Plan 2 who is being
5 treated in a hospital as a patient under such plan shall be
6 filled by the pharmacy in such hospital as part of the
7 scheduled hospital services furnished to such patient.

8

9

Article 2. Certification

10

11 10225. A group of physicians may apply to the
12 commission to be certified as a medical group under and
13 for the purposes of this division. Each such group shall be
14 composed of physicians having the necessary professional
15 qualifications and be engaged in the practice of the
16 several specialties and areas of medicine prescribed by
17 the commission. Each such group must be affiliated with
18 at least one certified hospital by contract in accordance
19 with this division and the rules and regulations of the
20 commission. Except for reasons satisfactory to the
21 commission, each such group shall accept as a patient any
22 person eligible for coverage under the health insurance
23 system who elects Plan 1 and applies for medical care by
24 such group. Each such group shall furnish such
25 comprehensive medical services to all of such persons as
26 may be necessary.

27 10226. Existing groups providing personal health
28 services on the effective date of this division may receive
29 interim certification as a certified medical group by the
30 commission under rules and regulations to be
31 promulgated by the commission; provided that such
32 interim certification shall not be for a period of more than
33 two years. During such period of interim certification the
34 commission may adjust payments to be made under the
35 provisions of this chapter.

36 10227. Any city or county medical society may qualify
37 as a certified medical group under Plan 1, provided it
38 meets the qualifications and standards established by the
39 commission.

40 10228. Certification of hospitals. 1. Any duly

1 approved and legally operated hospital in this state may
2 apply to the commission for certification as a certified
3 hospital under and for the purposes of this division. Such
4 hospital shall comply in all respects with the
5 requirements, qualifications and standards established
6 and promulgated by the commission. Such hospital must
7 have entered into an affiliation agreement with at least
8 one certified medical group. Such agreement shall
9 comply with the rules and regulations of the commission
10 and copies of such agreement shall be filed with the
11 board and such agreement shall be a public record. Such
12 agreement must provide that the hospital will accept as
13 patients therein all persons who are patients of the
14 certified medical group making such agreement and
15 allow all of the physicians constituting such group
16 hospital privileges for the purpose of attending, treating
17 and caring for such patients in such hospital. Every
18 certified hospital shall furnish such comprehensive
19 hospital services to all of the patients of the certified
20 medical group or groups with which it is affiliated under
21 and for the purposes of this division.

22 10229. The commission may, by order, require a
23 certified hospital to enter into an affiliation agreement
24 with one or more additional certified medical groups if
25 the commission finds, that such requirement is in the
26 public interest and that such certified hospital has
27 adequate facilities and capacity to care for the patients of
28 such group or groups; and failure to comply with such
29 order shall be sufficient ground for the decertification of
30 such hospital.

31

32

Article 3. Payments

33

34 10250. A per capita payment shall be made by the
35 commission on behalf of each person electing coverage
36 under Plan 1. Such payment shall be apportioned
37 between the certified medical group chosen by such
38 person and the certified hospital with which such group
39 is affiliated. The amount of the payment and the dates of
40 such payments shall be determined by the commission

1 and shall be uniform throughout the state, except that it
2 may vary from one geographic area to another, based on
3 local cost differentials, as determined by the commission.
4 The apportionment of the total payment among the
5 certified medical group and the certified hospital shall be
6 determined by agreement between such group, such
7 hospital and the commission. Such agreements shall be
8 public records.

9 10251. The commission shall from time to time
10 establish and promulgate lists setting forth scheduled
11 medical services and scheduled hospital services and
12 payments to and on behalf of persons electing coverage
13 under Plan 2 shall be made in accordance with such
14 schedules.

15
16 Article 4. Extraordinary Medical Services

17
18 10275. (a) One per centum of the total per capita
19 payments to be made to certified medical groups and
20 certified hospitals in each calendar year for persons
21 electing coverage under Plan 1 shall be withheld by the
22 commission and paid into a special fund, which shall be
23 subject to and governed by the same provisions of this
24 division governing the health insurance fund.

25 (b) Such special fund shall be held for the purpose of
26 making the payments required by this section.

27 (c) In the event that any person electing coverage
28 under Plan 1 requires either medical services or hospital
29 services of an extraordinary nature which cannot be
30 provided by the certified medical group of which he is a
31 patient or by the certified hospital with which such group
32 is affiliated, the commission may authorize such services
33 to be furnished by other physicians or hospitals and shall
34 pay for such services from the special fund created by this
35 section, in accordance with a special fee schedule
36 established and promulgated by the commission.

37 10276. (a) The fees for the scheduled medical
38 services and scheduled hospital services listed pursuant
39 to Section 10251 shall be reduced by 1 per centum which
40 shall be withheld by the commission and paid into a

1 special fund, which shall be subject to and governed by
2 the same provisions of this division governing the health
3 insurance fund.

4 (b) Such special fund shall be held for the purpose of
5 making the payments required by this section.

6 (c) In the event that any person electing coverage
7 under Plan 2 requires either medical services or hospital
8 services of an extraordinary nature, the commission may
9 authorize such services to be furnished by any physician
10 or hospital who or which can provide such services and
11 shall pay for such services from the special fund created
12 by this section, in accordance with special fee schedules
13 established and promulgated by the commission for such
14 extraordinary services.

15
16 Article 5. Subrogation

17
18 10300. (a) If any of the benefits provided by this
19 division are furnished in the event of sickness, injury or
20 disability to any person who by reason of such sickness,
21 injury or disability has a right to or claim for
22 compensation, benefits or damages against his employer
23 or any other person for causing such sickness, injury or
24 disability and for the damages resulting therefrom,
25 whether under any workmen's compensation or
26 employers' liability act, or otherwise under any statute,
27 ordinance, code, regulation or rule of law, the
28 commission shall, to the extent of the cost of the benefits
29 so furnished, be entitled to reimbursement out of any
30 sum or damages which said person receives by way of
31 compensation or benefits or through suit, settlement or
32 judgment and the commission shall, to said extent, be
33 subrogated to the said right or claim. Upon notice to the
34 one against whom said right or claim exists or is asserted,
35 the amount to which the commission is so entitled by way
36 of reimbursement shall be a lien upon said right or claim
37 and the said sum or damages paid or received
38 thereunder. Nothing in this section contained shall be
39 construed to prevent the prompt furnishing of any
40 benefits to any person pending the settlement or

1 determination of any such right or claim had or asserted
2 by such person and the cost of any benefits so furnished
3 shall, without prejudice to any other method of recovery,
4 be recoverable by deduction from or suspension of any
5 benefits to which such person may subsequently become
6 entitled. If the benefits are so furnished to any person, the
7 commission may give notice thereof to the one against
8 whom such a right or claim exists or is asserted and the
9 latter may repay to the commission the amount and cost
10 of the benefits so furnished and such repayment shall, up
11 to the amount thereof, be a full and valid discharge to him
12 in respect of his liability to such person.

13 (b) If a person receiving the said benefits provided by
14 this division for sickness, injury or disability has any such
15 right or claim and fails, after a period of six months from
16 the date such right or claim accrues, to take action or
17 proceedings to enforce the same, it shall be lawful for the
18 commission, at its own expense, to take such action or
19 proceedings in the name and on behalf of such person, in
20 which case any sum recovered by settlement or
21 judgment in excess of the claim for reimbursement given
22 to the commission and the reasonable expense of the
23 action or proceedings shall be held by the commission as
24 trustee for such person.

25 (c) A compromise of any such claim or cause of action
26 by the employee in an amount less than the cost of the
27 health insurance benefits furnished or to be furnished
28 pursuant to this division shall be made only with the
29 written consent of the commission.

30 (d) All moneys received pursuant to this section shall
31 be deposited into the state health insurance fund for the
32 purposes of such fund.

33

34

CHAPTER 6. FISCAL PROVISIONS

35

36

Article 1. Payroll Tax

37

38 10350. (a) A tax is hereby levied upon each employer
39 in this state based upon his gross annual payroll. If such
40 annual payroll is under one hundred thousand dollars,

1 (\$100,000) the rate of the tax hereby imposed shall be 1½
2 percent. If such annual payroll is one hundred thousand
3 dollars (\$100,000) or more but less than five hundred
4 thousand dollars (\$500,000), the rate of the tax hereby
5 imposed shall be 2 percent. If such annual payroll is five
6 hundred thousand dollars (\$500,000) or more, the rate of
7 the tax hereby imposed shall be 2½ percent. The
8 Franchise Tax Board shall adopt rules and regulations for
9 the determination of an employer's gross annual payroll,
10 for the purposes of this section, based upon the projection
11 of such employer's gross weekly payroll or gross monthly
12 payroll or other substantially similar factors.

13 (b) Such tax shall be due on the date when the wages
14 or compensation of the employees on such payroll is due
15 and payable to such employees and shall be payable to
16 the Franchise Tax Board at such time, not less frequently
17 than monthly, as the Franchise Tax Board may prescribe.

18 (c) The returns for such tax shall be in such form and
19 shall contain such information as the Franchise Tax Board
20 may prescribe. The Franchise Tax Board shall deposit all
21 such taxes into the Health Insurance Fund.

22 (d) All of the provisions of the tax law relating to the
23 imposition and collection of all other taxes administered
24 by the Franchise Tax Board shall apply, insofar as
25 practicable, to the tax imposition by this section.

26

27

Article 2. Health Insurance Tax

28

29 10375. A tax, to be known as the health insurance tax,
30 is hereby imposed upon the personal income of every
31 resident person who is subject to the tax on personal
32 income imposed by the state tax law. The amount of such
33 tax shall be calculated by applying the rate schedule set
34 forth in Section 10376 to every resident taxpayer's taxable
35 income as shown on his personal income tax return
36 required by and filed under the state tax law. The
37 Franchise Tax Board shall require the annual income tax
38 return filed by every resident taxpayer to show the
39 amount of the tax imposed by this chapter and the
40 calculation thereof. The Franchise Tax Board shall adopt

1 such rules and regulations as may be necessary to provide
 2 for estimating and withholding such tax throughout the
 3 year. For the purposes of administration, collection and
 4 enforcement, the tax imposed by this chapter shall be
 5 considered an additional income tax and shall be subject
 6 to all of the provisions of law governing the
 7 administration, collection and enforcement of the tax on
 8 personal incomes imposed by the state tax law. The
 9 Franchise Tax Board shall deposit all taxes, interest and
 10 penalties collected pursuant to this chapter into the
 11 Health Insurance Fund.

12 10376. Rate Schedule

| | | |
|----|-------------------------|-------------------------------|
| 13 | | |
| 14 | If the California | |
| 15 | taxable income is: | The tax is: |
| 16 | Not over \$5,000 | 0.2% of the California |
| 17 | | taxable income |
| 18 | Over \$5,000 but | |
| 19 | not over \$10,000 | \$10 plus 0.6% of excess over |
| 20 | | \$5,000 |
| 21 | Over \$10,000 but | |
| 22 | not over \$15,000 | \$40 plus 1% of excess over |
| 23 | | \$10,000 |
| 24 | Over \$15,000 but | |
| 25 | not over \$20,000 | \$90 plus 1.5% of excess over |
| 26 | | \$15,000 |
| 27 | Over \$20,000 but | |
| 28 | not over \$25,000 | \$165 plus 2% of excess over |
| 29 | | \$20,000 |
| 30 | Over \$25,000 but | |
| 31 | not over \$30,000 | \$265 plus 2.5% of excess |
| 32 | | over \$25,000 |
| 33 | Over \$30,000..... | \$390 plus 3% of excess over |
| 34 | | \$30,000 |

35

36 10377. A person electing coverage under Plan 2 who
 37 is 65 years of age or older shall have a credit against the
 38 tax due under this chapter for the amount of premiums
 39 paid by him during the taxable year for supplementary
 40 medical benefits under Part B of Title XVIII of the Social

1 Security Amendments of 1965 (Public Law 89-97), as now
2 in force or hereafter amended.

3 10378. The employer of any person subject to the tax
4 imposed by this chapter may agree with such person to
5 assume, bear and pay all or any part of an amount
6 equivalent to such part of such tax as would be due and
7 payable by such employee if the compensation paid to
8 him by his employer constituted his sole income. Such
9 payment may be made by the employer to the employee
10 in a lump sum or the employer may regard and treat such
11 payment as additional withholding for personal income
12 tax purposes and, in the latter event, the employer shall
13 furnish the employee annually with a statement of the
14 amounts so withheld.

15

16 Article 3. Health Insurance Fund

17

18 10400. There is hereby created in the State Treasury
19 a fund to be known as the Health Insurance Fund. It shall
20 consist of all taxes, contributions, interest, penalties and
21 money paid into and received by the fund as provided by
22 this division; of property and securities acquired by and
23 through the use of moneys belonging to the fund; and of
24 interest and other income earned by the fund. The taxes,
25 contributions, interest, penalties and money paid into
26 and received by the fund pursuant to this division,
27 together with the interest and income earned thereon,
28 shall be held in trust by the state and shall be used to pay
29 the cost of all benefits provided by or pursuant to this
30 division, the entire cost of administering such benefits,
31 and such portion of all other expenditures necessary for
32 the proper execution of the provisions of this division as
33 is properly allocable to the administration of such
34 benefits.

35 10401. The Director of Finance shall be the custodian
36 of the fund and all disbursements therefrom shall be paid
37 by him, after audit by and on the warrant of the
38 Controller, on vouchers certified by or pursuant to the
39 regulations of the commission, or by its duly authorized
40 deputies or employees.

1 10402. The Director of Finance is hereby authorized
2 to deposit any portion of the fund not needed for
3 immediate use, in the same manner and subject to all
4 provisions of law with respect to the deposit of other state
5 funds held by him; and all interest earned by such portion
6 of the fund as may be deposited by him in pursuance of
7 the authority herein given shall be collected by him and
8 placed to the credit of the fund.

9 10403. Any of the surplus or reserve belonging to the
10 fund may, by order of the commission, as approved by the
11 Controller, be invested in any obligations of the United
12 States of America or in obligations of this state. All such
13 securities shall be placed in the hands of the Director of
14 Finance who shall be custodian thereof. He shall collect
15 the principal, interest and other income thereof, when
16 due, and pay the same into the fund. The Director of
17 Finance shall pay all vouchers drawn on the fund for the
18 making of such investments when signed by the
19 commission, upon delivery of such securities to him,
20 when there is attached to such vouchers the approval of
21 the Controller. The commission may sell any of such
22 securities, and the Director of Finance shall make
23 delivery thereof upon the order of the commission, and
24 the proceeds of any such sale shall be paid by the
25 purchaser to the Director of Finance, upon delivery of
26 said securities, and placed by him to the credit of the
27 fund.

28 10404. The fund shall be the sole and exclusive source
29 for the payment of benefits furnished under and the
30 payment of expenses incurred in connection with the
31 administration of this division and such benefits shall be
32 due and payable only to the extent that the taxes,
33 contributions and other moneys paid into the fund
34 pursuant to this division article, with the increments
35 thereon, actually collected and credited to the fund and
36 not otherwise appropriated or allocated, are available
37 therefor.

38 10405. All money in the fund is hereby appropriated
39 for expenditure for the purposes specified in this division.

Article 4. Federal Grants

1
2
3 10425. In the interest of coordination and efficiency
4 the commission is hereby designated as the agent of the
5 state or of any department thereof to administer and
6 expend any and all grants of money allocated or made
7 available to the state under any act of Congress for
8 grants-in-aid for health insurance or for any of the other
9 purposes of this division to the extent that such benefits
10 are provided by the corporation under this division. The
11 commission is hereby authorized to do any and all things,
12 not inconsistent with law, necessary to meet the
13 requirements of any such act.

14 10426. The Director of Finance is hereby authorized
15 to accept and receive on behalf of the state any and all
16 grants or allotments of money made available to the state
17 by or pursuant to any act of Congress for health insurance
18 or for any of the other purposes of this division, to the
19 extent that such benefits are provided by the commission
20 under this division. All moneys so accepted and received
21 shall be deposited by the Director of Finance in the fund
22 for use exclusively for the purposes for which such grants
23 or allotments were made.

24 10427. The commission is authorized to enter into any
25 agreement with any agency of the federal government to
26 receive any federal grant or subsidy which may be
27 available for financing, in whole or in part, the cost of
28 furnishing benefits under this division including any
29 payments in lieu of the payroll tax imposed upon other
30 employers pursuant to Chapter 6 (commencing with
31 Section 1035) of this division. The commission is
32 authorized to comply with any condition or requirement,
33 not inconsistent with the provisions of this division or
34 other provisions of law, imposed in connection with the
35 receipt of any such grant or subsidy.

36 SEC. 2. The provisions of this act shall cease to be
37 operative or have any force or effect if and as of the date
38 when any act of Congress whereby and whereunder a
39 federally administered nationwide system or plan of
40 health insurance affording the same or substantially

1 similar benefits to the residents of this state as those
2 provided by this act, shall become operative and effective
3 within this state, except that such of the provisions of this
4 act as are deemed by the Health Insurance Commission
5 to be necessary for it to furnish or pay for benefits under
6 this act for which such commission became obligated
7 prior to such date or to collect taxes and contributions
8 which have theretofore accrued shall continue in force
9 and effect and such commission shall have full power and
10 authority to furnish and pay for such benefits and to
11 collect such taxes and contributions.

12 SEC. 3. Notwithstanding any other provision of law
13 no policy or contract of accident insurance, health
14 insurance, health and accident insurance, group health
15 insurance, group accident insurance, group accident and
16 health insurance, and no policy or group policy or
17 contract or group contract of medical expense indemnity
18 or hospital service indemnity insuring a person who is
19 eligible for coverage under this act shall be issued or
20 renewed for such coverage on or after the date when
21 such coverage and the benefits thereunder become
22 effective, but all such existing policies and contracts shall
23 continue in full force and effect until their respective
24 dates of expiration, unless the insurer issuing such policies
25 and contracts agrees with the Health Insurance
26 Commission for the transfer to it and the assumption by
27 it of all of the obligations of such insurer under such
28 policies and contracts for and during the unexpired terms
29 thereof.

30 SEC. 4. Notwithstanding any other provision of law
31 the operation and effectiveness of so much of the
32 provisions of Chapter 7 (commencing with Section
33 14000) of Part 3 of Division 9 of the Welfare and
34 Institutions Code, which establish, limit and define the
35 benefits under this act is hereby superseded and replaced
36 by the benefits provided for persons eligible for the
37 benefits set forth in this act; but if, for any reason, it is
38 determined that the state is ineligible to receive federal
39 reimbursement for medical services and hospital services
40 furnished under this act to persons for whom the state

1 would be eligible to receive such federal reimbursement
2 if they had received medical assistance as needy persons
3 under Chapter 7 (commencing with Section 14000) of
4 Part 3 of Division 9 of the Welfare and Institutions Code,
5 then the provisions of such chapter shall be deemed to
6 have continued in full force and effect so as to qualify the
7 state for federal reimbursement for the cost and
8 administration of the medical services and hospital
9 services furnished to such persons under this act in the
10 same manner and to the same extent as if such services
11 had been furnished to such persons under and pursuant
12 to Chapter 7 (commencing with Section 14000) of Part 3
13 of Division 9 of the Welfare and Institutions Code.

14 SEC. 5. (a) The sum of five million dollars
15 (\$5,000,-000), or so much thereof as may be necessary, is
16 hereby appropriated in the first instance to the Health
17 Insurance Commission out of any moneys in the State
18 Treasury not otherwise appropriated and is hereby made
19 available to such commission to defray its expenses,
20 including personal service, maintenance and operation,
21 traveling and other expenses, within and without the
22 state, incurred by the commission in preparing and
23 setting up the administrative machinery preparatory to
24 carrying out the provisions of this act, and making the
25 payments provided for thereunder.

26 (b) The moneys appropriated by this section shall be
27 payable from the State Treasury on the audit and warrant
28 of the Controller on vouchers certified or approved in the
29 manner prescribed by law.

30 (c) The Health Insurance Commission shall reimburse
31 the state for all moneys expended out of the
32 appropriation made available for its use by this section
33 and the state shall have a lien on the moneys deposited
34 into the Health Insurance Fund pursuant to this act, to
35 the extent necessary to assure such reimbursement. The
36 time and manner of such reimbursement shall be agreed
37 upon by such commission and the Controller.

38 SEC. 6. This act shall take effect July 1, 1972, except
39 that Section 5 of this act and the administrative provisions
40 of Section 1 of this act shall become operative on its

1 effective date, to the end that the statewide health
2 insurance system provided by this act shall become fully
3 operative and effective on July 1, 1972, and except that
4 the taxes imposed by Article 1 (commencing with Section
5 10350) and Article 2 (commencing with Section 10375) of
6 Chapter 6 of Division 8 as added by Section 1 of this act
7 shall be due and payable from and after January 1, 1972.

O

Introduced by Assemblyman Moretti

March 14, 1972

REFERRED TO COMMITTEE ON HEALTH

An act to add Division 22 (commencing with Section 30000) to the Health and Safety Code, relating to health care services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1199, as introduced, Moretti (Health). Health care services.

Declares legislative intent to establish a statewide comprehensive health security program.

Vote—Majority; Appropriation—No; Fiscal Committee—No.

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

1 SECTION 1. Division 22 (commencing with Section
2 30000) is added to the Health and Safety Code, to read:

3

4 DIVISION 22. HEALTH CARE SERVICES

5

6 CHAPTER 1. GENERAL PROVISIONS

7

8 30000. This division shall be known as and may be
9 cited as the Health Security Act. The program established
10 by this act shall be known as and may be cited as the
11 Health Security Program.

12 30001. The Legislature hereby finds that the benefits

1 of the recent great advances in medical science have not
2 reached all the people in the state; that adequate hospital
3 and medical care is not available to all those who need it;
4 that only the highest-income groups and the poor who
5 are aided by public or private charity are relieved of the
6 ever-present concern over costs of personal health
7 services, while the vast middle-income and relatively low
8 income groups are left to cope with the shattering costs
9 of serious or prolonged illness; that the maldistribution of
10 available medical and hospital services causes, among
11 other things, wholly inadequate provision for the health
12 needs of families residing in our inner cities and rural
13 areas; that very few voluntary health insurance plans
14 provide adequate benefits and then at costs beyond the
15 reach of those families who most need such services; and
16 that medical and hospital services and facilities must be
17 expanded if the public health and welfare are to be
18 preserved and protected. The Legislature hereby
19 declares, as the public policy of the state, that adequate
20 medical and hospital care is a basic need and right of
21 every resident of the state, that fulfilling this need is a
22 duty and concern of the state and will best be
23 accomplished by the establishment of a comprehensive
24 statewide health security system which will make
25 preventive and curative health care services available to
26 all those who need them based upon their ability to
27 reasonably pay for such services.

O

AMENDED IN SENATE JULY 3, 1972
AMENDED IN SENATE APRIL 27, 1972

SENATE BILL

No. 770

Introduced by Senator Moscone

March 14, 1972

An act to add SECTION 15702.2 TO THE GOVERNMENT CODE, TO ADD Division 22 (commencing with Section 30000) to the Health and Safety Code, to add Sections 2151.1, 2151.2, 2151.3, ~~2151.4~~ and ~~17041.1~~ to AND 2151.4 TO, AND TO ADD PART 10.7 (COMMENCING WITH SECTION 19601) TO DIVISION 2 OF, the Revenue and Taxation Code, to amend Section 14005.6 of, and to repeal Sections 14132 and 14134 of, the Welfare and Institutions Code, relating to health protection.

LEGISLATIVE COUNSEL'S DIGEST

SB 770, as amended, Moscone. Health care services.

Provides for statewide compulsory comprehensive health insurance plan financed through payroll taxes with employer-employee contributions and statewide property tax, plus existing sources of funding for health care services. Establishes such plan basically through capitation contracts between the state and prepaid health plans, under which the state pays a specified amount per enrollee to the prepaid health plan; provides for a period during which transition to such system may occur. Specifies uniform comprehensive service benefits; includes Medi-Cal recipients in such uniform comprehensive services benefits, superseding the present basic schedule of benefits under Medi-Cal. Eliminates prior authorization, copayment, and relative's responsibility under Medi-Cal.

Creates a State Health Commission of 9 full-time members, a majority of whom are consumer representatives, and

creates 7 to 10 regional health jurisdictions in the state for planning, operations and evaluation of health services. Places under commission administration all state administrative entities related to health care services and included in the Governor's Reorganization Plan No. 1 of 1970. Conveys broad powers on the commission to enter into prepaid health contracts with various classes of providers, to demand full fiscal disclosure of providers, to set rates of reimbursement, to adopt standards for various providers, and to administer a state health fund. Designates a percent of revenue for purposes of health resources development with priority to underserved communities and for developing health programs to meet special health problems, including those anticipated in prepaid plans developed for high-risk populations.

Makes legal residents of the state eligible, including Medi-Cal recipients and nonresident migrant agricultural workers employed in California agriculture. Excludes federal employees and armed services personnel, but permits federal employees to participate on a voluntary basis. Requires treatment plans for long-term care and excludes payments for residential and custodial care.

Vote—Majority; Appropriation—No;
Fiscal Committee—Yes.

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

1 SECTION 1. *Section 15702.2 is added to the*
2 *Government Code, to read:*
3 *15702.2. The Franchise Tax Board is authorized to*
4 *delegate to the Department of Human Resources*
5 *Development which is authorized to accept, exercise,*
6 *and perform, the powers and duties necessary to*
7 *administer the reporting, collection, refunding, and*
8 *enforcement of taxes imposed on the wages paid to*
9 *employees by employers under Part 10.7 (commencing*
10 *with Section 19601) of Division 2 of the Revenue and*
11 *Taxation Code. The Franchise Tax Board is authorized to*
12 *delegate to the California Unemployment Insurance*
13 *Appeals Board which is authorized to accept, exercise,*

1 *and perform, under rules it adopts, the powers and duties*
2 *to administer appeals and petitions relating to such*
3 *provisions of Part 10.7. The delegation to the Department*
4 *of Human Resources Development shall not, however,*
5 *include the power and duty of the Franchise Tax Board*
6 *to adopt rules and regulations.*

7 SEC. 1.5. Division 22 (commencing with Section
8 30000) is added to the Health and Safety Code, to read:

9

10

DIVISION 22. CONSUMER HEALTH
PROTECTION

11

12

13

CHAPTER 1. GENERAL

14

15 30000. This act shall be known and may be referred to
16 as the Consumer Health Protection Act of 1972.

17 30001. The Legislature hereby finds and declares that
18 the cost of health care now exceeds the ability to pay for
19 the average Californian. The rate of inflation of fees and
20 hospital charges has been twice as high as that indicated
21 by the consumer price index which led to the national
22 price freeze. Presently, ~~hospital~~ *health* insurance pays
23 only for about 35 percent of the medical cost of the
24 average citizen of the state. Expanded insurance
25 protection has been seriously retarded by ~~uncontrollable~~
26 *uncontrolled* inflation in health care costs.

27 The Legislature can assure all citizens of the state that
28 they will be able to afford necessary health services on an
29 equitable basis only through compulsory statewide health
30 insurance accomplished through a payroll deduction
31 made by employers and employees, through a county
32 equalization tax for health care of medical indigents, and
33 through all present and future state and federal funding
34 for health care services. In addition to the financial issue,
35 the Legislature must also deal directly with those factors
36 responsible for the inflationary spiral in health costs.
37 These are unnecessary hospitalization services which are
38 performed without medical justification, with
39 inefficiency in the organization and management of
40 health services, unnecessary duplication of community

1 health facilities and services, and failure to place primary
2 emphasis on disease prevention and the maintenance of
3 health. The Legislature must also provide for the
4 protection of the consumer against hospitals and other
5 health care providers whose standards of care are below
6 accepted community practice. To accomplish these goals,
7 the Legislature must address itself to strengthening the
8 planning of health services, improving the efficiency of
9 operating health services, and the development of
10 standards of quality sufficient to adequately protect
11 patients.

12 The Legislature has determined, therefore, that
13 prepaid capitation contracts between the state and
14 organized providers shall be the sole method of
15 reimbursement to providers of health care services, after
16 the necessary transition period, which is estimated to be
17 ~~three~~ *four* years after the effective date of this act.

18 30002. As used in this division:

19 (a) "Prepaid health plan" means a plan which offers a
20 specified comprehensive scope of benefits to an enrolled
21 population for a predetermined prepaid annual
22 capitation rate.

23 ~~(b) "Health maintenance organization" means any~~
24 ~~organization of providers of health services with a~~
25 ~~capacity to serve a given population enrolled in a prepaid~~
26 ~~health plan. In addition, such organizations shall provide~~
27 ~~preventive and health maintenance services, conduct~~
28 ~~formalized peer review, medical audit, and utilization~~
29 ~~review, and report annually to its membership the fiscal~~
30 ~~and utilization data and the location of physicians and~~
31 ~~facilities.~~

32 ~~(c) "Medical care foundation" means a nonprofit~~
33 ~~foundation whose physician membership is capable of~~
34 ~~directly providing or arranging for the provision of~~
35 ~~comprehensive services to patients enrolled in a prepaid~~
36 ~~health plan.~~

37 ~~(b) "Health maintenance organization" means any~~
38 ~~organization of providers of health services with a~~
39 ~~capacity to provide preventive and health maintenance~~
40 ~~services to a given population of enrolled consumers in a~~

1 prepaid health plan. In addition, such organizations shall
2 conduct formalized peer review, medical audit and
3 utilization review and report annually to their
4 memberships the fiscal and utilization data as well as the
5 location of physicians and facilities. The definition of
6 health maintenance organization under this subdivision
7 shall include, but not be limited to, "medical care
8 foundations" and "health consumer organizations."
9 Medical care foundation means any nonprofit foundation
10 whose physician membership is capable of directly
11 providing or arranging for the provision of
12 comprehensive services to patients enrolled in a prepaid
13 health plan. Health consumer organization means any
14 incorporated organization of citizens whose primary
15 motive for organizing is to create a system of financing
16 and arranging for the delivery of personal health services
17 under circumstances which require sensitivity to the
18 consumer's desires in this field.

19 ~~(d)~~ (c) "Fiscal intermediary" means any private
20 insurance company which performs fiscal and
21 administrative functions for any organization or provider
22 of health care, or on behalf of consumers through a
23 contract for health benefits.

24 ~~(e)~~ (d) "Peer review—medical audit" means an
25 organized system for regular review of professional
26 performance in or out of the hospital by a committee of
27 peers. Such review is designed to judge the fitness of
28 charges and the medical justification for case
29 management to assure its quality.

30 ~~(f)~~ (e) "Utilization review" means an organized
31 review by peers designed to control or eliminate
32 unnecessary admissions to hospitals, and unwarranted
33 length of stays in hospitals.

34 ~~(g)~~ (f) "Provider profiles" means computer-assisted
35 files of the performance of a provider over an extended
36 period of time. Profiles assist peer review by the
37 identification of those providers whose patterns of
38 professional behavior do not conform to accepted
39 community standards defined by professional peers.

40 ~~(h)~~ (g) "Provider" means any licensed individual or

1 organization engaged in the providing of personal health
2 service to the public.

3 ~~(i)~~ (h) "State Health Commission" means that body
4 which under this legislation assumes broad powers and
5 responsibility for all the activities of the state government
6 related to providing personal health care to the public.

7 ~~(j)~~ "Accredited hospital" means a licensed hospital
8 accredited by the Joint Commission on Accreditation for
9 Hospitals and the Medical Staff Survey Committee.

10 (i) "Approved hospital" means a licensed hospital
11 which meets the standards of performance as developed
12 by the State Health Commission to assure quality of care,
13 safety of the patient, and any other such criteria as the
14 commission deems necessary.

15 ~~(k)~~ "Health consumer organization" means any
16 incorporated organization of citizens whose primary
17 motive for organizing is to create a system of financing
18 and delivering personal health service under
19 circumstances which require sensitivity to the
20 consumer's desires in this field.

21 ~~(l)~~ (j) "Health facility" means any licensed facility
22 whose primary function is to deliver personal health
23 service to the public. This includes but is not limited to
24 health departments, outpatient clinics, hospitals, clinics,
25 nursing homes, home care organizations and
26 intermediate care facilities.

27 ~~(m)~~ (k) "Prepaid capitation" means an annual fixed
28 premium per person paid in advance for a specified set
29 of comprehensive health benefits.

30 ~~(n)~~ (l) "Benefit period" means the period of time
31 during which an enrolled person is covered under a
32 prepaid health plan.

33 ~~(o)~~ (m) "Open enrollment" means periods during the
34 year when prepaid plans with the capacity to serve new
35 enrollees open the plans to include new enrollment ; with
36 no policies to exclude enrollment for any reason. During
37 this open enrollment period, prepaid plans shall not
38 exclude any enrollee for any reason, and shall accept all
39 enrollees in their order of enrollment.

40 ~~(p)~~ (n) "Allied health professional" means any

1 professional person involved in the provision of skilled
2 health service both directly and indirectly in support of
3 physicians and health institutions engaged in the delivery
4 of health care services.

5 ~~(q)~~ (o) "Health surveyor" means a health professional
6 trained in the surveillance of the quality of care provided
7 by any provider or institution which is engaged in the
8 delivery of health care services.

9 (p) "*Out of area emergency services*" means medical
10 treatment for any sudden or unexpected illness, or the
11 medical treatment of an injury or injuries caused by an
12 accident. Such illnesses or injuries shall be those
13 requiring medical services at a location outside the
14 immediate area of the patient's own health maintenance
15 organization, and requiring the medical services of
16 another provider of health care services, so as to not
17 compromise the quality of care or safety of the patient by
18 delaying treatment.

19 (q) "*Enrollee*" means a person who has voluntarily
20 enrolled as a beneficiary of a health benefit plan.

21

22

CHAPTER 2. ADMINISTRATION

23

24 30020. There is in the state government the State
25 Health Commission, hereinafter referred to as the
26 commission, consisting of nine members appointed by
27 the Governor, *with the advice and consent of the Senate*,
28 who shall be full-time employees of the State of
29 California. Salaries of the commission shall be set,
30 regulated and adjusted by the Governor. A majority of
31 the commission members shall consist of bona fide
32 consumer members who have no direct or indirect
33 financial interest either in health insurance plans or the
34 provision of health services to the public. Of the initial
35 members appointed to the commission, five shall serve
36 for two years, and four shall serve for four years;
37 thereafter, the terms of the members shall be four years.
38 The commission shall be empowered to take appropriate
39 action as provided under this chapter upon a simple
40 majority vote of its members.

1 30021. The commission is hereby designated to act as
2 the agent of the state or of the appropriate department
3 thereof to submit the plan of statewide health insurance
4 contemplated by this division for, and obtain the
5 approval of, all federal agencies having jurisdiction and
6 control over state plans for rendering medical and
7 hospital services under federal laws, including Title
8 XVIII and Title XIX of the Social Security Act, and to
9 accept and receive and to deposit into the State Health
10 Care Trust Fund created under subdivision (g) of Section
11 30030, any and all grants of money available to the State
12 of California, under such laws, in reimbursement for the
13 cost of such services or programs or otherwise. The
14 commission shall act as the agent of the state or of the
15 appropriate department thereof in any negotiations
16 relative to the submission and approval of such plan and
17 make any arrangement not inconsistent with law which
18 may be required by or pursuant to such federal law to
19 obtain and retain such approval and to secure for the
20 state the benefits of the provisions of such federal laws.

21 ~~30022. The commission, with recommendations from~~
22 ~~the Health Planning Council, shall set boundaries for 7 to~~
23 ~~10 regional health jurisdictions within the discretion of~~
24 ~~the commission. Members of the governing body of each~~
25 ~~such regional health jurisdiction shall conform to~~
26 ~~requirements regarding membership stated in Public~~
27 ~~Law 89/749 for membership in local health planning~~
28 ~~councils. The commission may delegate to regional~~
29 ~~jurisdictions such powers and duties as it deems necessary~~
30 ~~for the improvement of planning and operation of health~~
31 ~~services within each jurisdiction.~~

32 30023. The commission shall administer all state
33 administrative functions which relate to the planning,
34 operation, and evaluation of personal health service of all
35 kinds. Those administrative entities relating to provision
36 of health care services which are included within
37 Reorganization Plan No. 4 of 1970 (Chapter 1593 of the
38 Statutes of 1971) are transferred to the jurisdiction of the
39 commission. The jurisdiction of the commission over such
40 administrative entities shall include the hiring of

1 appropriate personnel, and the expansion or reduction of
2 powers and duties.

3 30022. The commission shall reorganize the voluntary
4 health planning councils formed and operating under
5 Public Law 89-749 and adhering to the requirements of
6 Public Law 89-749 into local commissions with
7 geographical and jurisdictional boundaries and such
8 powers and duties as set forth in regulations determined
9 by the State Health Commission.

10 30023. The commission shall be the regulatory body
11 which shall set policy and determine regulations which
12 relate to the planning, operation and evaluation of
13 personal health service of all kinds. The Director of the
14 State Health Department as set forth within
15 Reorganization Plan No. 1 of 1970 (Chapter 1593 of the
16 Statutes of 1971) shall be an ex officio member of the
17 State Health Commission without voting privileges, and
18 he shall be the chief administrative officer and shall carry
19 out the decisions, policies and regulations of the
20 commission. Those administrative entities relating to
21 provision of health care services which are included
22 within Reorganization Plan No. 1 of 1970 (Chapter 1593
23 of the Statutes of 1971) are transferred to the jurisdiction
24 of the commission.

25 ~~30024. The Director of the State Department of~~
26 ~~Health shall be an ex officio member of the commission~~
27 ~~without a vote. He shall be the chief administrative~~
28 ~~officer, and shall carry out the decisions and policies of~~
29 ~~the commission.~~

30

31 CHAPTER 3. POWERS AND DUTIES

32

33 30030. The commission shall have the following
34 powers and duties.

35 (a) To enter into contracts with various health
36 maintenance organizations, health consumer
37 organizations or health facilities on behalf of those
38 persons eligible pursuant to Chapter 6, for their provision
39 of comprehensive health services as health maintenance
40 organizations receiving prepaid capitation payments.

1 Such contracts shall be subject to the requirements of
2 relevant provisions of the Insurance Code, but shall not
3 be subject to the requirements of Article 2.5
4 (commencing with Section 12530) of Chapter 6 of Part 2
5 of Division 3 of Title 2 of the Government Code, except
6 those health maintenance organizations that are at least
7 50 percent publicly funded shall not be subject to such
8 requirements of the Insurance Code and the
9 Government Code. Such contracts shall be for a specified
10 term set by the commission. Organizations which may
11 qualify as contractors shall include all health
12 maintenance organizations as defined in subdivision (b)
13 of Section 30002, and which meet the operating standards
14 as set forth in Chapter 4. Any provider who refuses to
15 participate in accordance with such operating standards,
16 and in accordance with further rules and regulations as
17 determined by the commission, shall not be entitled to
18 reimbursement pursuant to this division.

19 (b) To set rates of reimbursement based upon
20 geographical differences in costs of health care in the
21 state for various providers and based upon sound
22 actuarial data, after holding public hearings to ascertain
23 such differences.

24 (c) To hold public hearings pursuant to existing law
25 for purposes which shall include but not be limited to,
26 information gathering, grievance hearings for either
27 consumers or providers of health care, and rate setting.

28 (d) To develop the administrative capacity through
29 computer programs to set up a statewide information
30 system capable of collecting and analyzing fiscal and
31 program data from various providers relating to cost,
32 utilization review, peer review, provider profiles, quality
33 of care and consumer satisfaction.

34 (e) To employ trained health surveyors for the
35 purpose of making periodic visits to the direct operations
36 of various providers, to assure that the providers are in
37 compliance with the standards as determined by the
38 commission and as set forth in Chapter 4.

39 (f) To terminate the contract of a provider or health
40 maintenance organization for cause, and after public

1 hearings. Sufficient written notice of at least 15 days shall
2 be given to providers prior to termination pursuant to
3 this section. Providers shall, as a condition of their
4 contract, notify their enrollees of such termination.

5 (g) To designate a specified percent of the revenue
6 deposited in the State Health Care Trust Fund for a
7 development fund, both of which are hereby created, for
8 the purposes of this act. Disbursements from either fund
9 shall be subject to the management and control of the
10 State Controller in accordance with and not in conflict
11 with existing law.

12 (h) To enforce the standards set forth in Chapter 4
13 with regard to providers or health maintenance
14 organizations engaged in the delivery of services under
15 this act. The commission shall also have the power to
16 apply and enforce such standards with regard to fiscal
17 intermediaries during the transitional period.

18 (i) To reimburse providers of health care services on
19 a fee-for-service basis on behalf of consumers not yet
20 enrolled in a prepaid capitation plan with an approved
21 health maintenance organization, during the three-year
22 transitional period set forth under Section 30001 of this
23 act. No reimbursement shall be made to health benefit
24 plans established through fiscal intermediaries which do
25 not provide the benefits set forth under Chapter 7.

26 (j) To underwrite the costs of enrollment in a new
27 health maintenance organization for an enrollee of a
28 health maintenance organization which has become
29 insolvent, or is otherwise unable to fulfill its specific
30 contractual duties and functions as set forth in this act.

31 (k) To employ such persons as may be necessary to
32 carry out the provisions of this chapter.

33 (l) To enter into any agreement with any agency of
34 the federal government to receive any federal grant or
35 subsidy which may be available for financing, partially or
36 totally, the cost of carrying out the provisions of this act.

37 (m) To delegate to regional commissioners such
38 powers and duties as the commission deems necessary to
39 the planning, operation, and evaluation of health
40 programs within each jurisdiction.

1 (n) To set reasonable standards relating to enrollment
2 periods.

3 30031. Notwithstanding any other provision of law, no
4 contract for provision of health care services executed
5 after the effective date of this act between individuals
6 and fiscal intermediaries or groups of any type and fiscal
7 intermediaries, may be issued or renewed without
8 approval of the commission and in compliance with the
9 standards as set forth in Chapter 4, but all such existing
10 benefit coverage shall remain in full force and effect until
11 its date of expiration, provided that such time period does
12 not exceed a date three years from the effective date of
13 this act.

14

15 CHAPTER 4. STANDARDS OF PARTICIPATION

16

17 30040. The provisions of this chapter shall apply to
18 health maintenance organizations, *as defined in*
19 *subdivision (b) of Section 30002*, engaged in the delivery
20 of health care services under this act.

21 30040.5. Each health maintenance organization shall
22 be required to report annually to the commission on the
23 cost of operation, the use of services, the current
24 description of the location of physicians, allied health
25 professional and health facilities, and the number of
26 persons to whom service is rendered. Full fiscal
27 disclosure by any and all providers of service shall be a
28 condition of participation under this act.

29 Each health maintenance organization shall be
30 required to furnish complete lists monthly to the
31 commission or to the agency designated by the
32 commission of those persons eligible to receive benefits
33 under Title XVIII or XIX of the Social Security Act. This
34 information is to be used solely for the purpose of
35 receiving such federal reimbursement funds, and in no
36 way is to be used to discriminate against the persons or
37 the quality of health care to which they are entitled. All
38 information obtained pursuant to this section shall be
39 confidential.

40 30041. Laboratory services provided under the

1 provisions of this act are to be provided only in the
2 laboratories which are approved by the commission, or
3 the agency it so designates, in conformance with law.

4 30041.5. Health maintenance organizations shall be
5 certified by the commission, or the agency it so
6 designates, and shall at least meet the conditions of
7 participation under ~~Title XVIII of the Social Security Act~~
8 *federal law*.

9 30042. Health maintenance organizations shall make
10 those services readily available at reasonable times to all
11 enrollees.

12 ~~30042.5. Those health maintenance organizations~~
13 ~~which are servicing a substantial patient/consumer~~
14 ~~population of a particular social or ethnic group, or whose~~
15 ~~primary language is other than English, shall employ~~
16 ~~either a health professional from such social or ethnic~~
17 ~~group or a designated person or persons able to~~
18 ~~communicate with enrollees in such social or ethnic~~
19 ~~groups.~~

20 *30042.5. Those health maintenance organizations*
21 *which are serving a substantial enrollee population*
22 *whose primary language is other than English shall*
23 *employ adequate numbers of persons able to*
24 *communicate with the enrollees in their primary*
25 *language. Such employees shall be on duty at all locations*
26 *and during all hours when health care services are*
27 *provided.*

28 30043. Health maintenance organizations shall
29 provide directly or through subcontractors, who also
30 conform to the requirements of this act, that scope of
31 benefits described in Chapter 7.

32 30043.5. Health maintenance organizations shall be
33 liable for payment at the prevailing and customary fee as
34 recognized by the commission, and in conformity with
35 law, for all out-of-area emergency services *as defined in*
36 *subdivision (p) of Section 30002* rendered by another
37 provider which are required under the scope of benefits
38 pursuant to this act. Payment pursuant to this section
39 shall cover such emergency treatment as may be
40 reasonable and necessary until the ~~patient~~ enrollee can

1 be transferred to the provider group in which he is
2 enrolled.

3 30044. Health maintenance organizations shall
4 employ only those health professionals who are qualified
5 and licensed under the law to perform specific acts of
6 medical care for which they are qualified and licensed.
7 *Health maintenance organizations shall require*
8 *continuing education for all professional personnel*
9 *engaged in the delivery of health care services. Such*
10 *continuing education shall be that which is*
11 *recommended by the particular professional*
12 *organization of which the professional is a member.*

13 ~~30044.5. Health maintenance organizations shall~~
14 ~~enroll no less than 10,000 or more than 30,000 consumers~~
15 ~~to whom services are to be provided. The ratio of~~
16 ~~physicians and other health professionals to consumers~~
17 ~~shall be set by regulation by the State Health Commission~~
18 ~~and subject to adjustment as deemed appropriate by the~~
19 ~~State Health Commission.~~

20 *30044.5. The ratio of physicians and other allied*
21 *health professionals to enrollees in health maintenance*
22 *organizations shall be set pursuant to regulations adopted*
23 *by the commission, and subject to adjustment as deemed*
24 *appropriate by the commission.*

25 30045. Health maintenance organizations shall
26 furnish services in such a manner as to provide continuity
27 of care, quality care and provision of services shall include
28 ready referral of patients to such services at such times as
29 may be medically appropriate. ~~A managing physician or~~
30 ~~allied health professional shall supervise and coordinate~~
31 ~~each enrollee's care. A primary physician or primary~~
32 ~~health care team shall supervise and coordinate each~~
33 ~~enrollee's care. Such supervision and coordination shall~~
34 ~~be done in such a manner as to provide coordinated~~
35 ~~family care for enrolled families.~~

36 30045.5. Allied health professionals shall be employed
37 to the maximum extent feasible to assist in the delivery
38 of health care to the consumer.

39 30046. Health maintenance organizations shall
40 accept, on behalf of their health professional members,

1 reimbursement on a prepaid capitation basis pursuant to
2 the contract between such health maintenance
3 organization and the commission, as payment in full for
4 services rendered.

5 ~~30046.5. Health maintenance organizations shall~~
6 ~~conduct an annual survey of their enrollees, designed to~~
7 ~~ascertain the attitudes, concerns and wishes of the~~
8 ~~consumer regarding the quality of health care he is~~
9 ~~receiving. The findings of such an annual survey shall be~~
10 ~~delivered to the commission no later than December 31~~
11 ~~of each calendar year.~~

12 30047. Health maintenance organizations shall
13 provide a printed booklet that is available to all
14 consumers who demonstrate an interest. The booklet
15 shall contain a description of the available facilities, the
16 days and hours that medical service is available, public
17 and emergency transportation, a listing of all health
18 professionals employed or performing services on behalf
19 of the organization, and any such additional information
20 necessary to assist the consumer in making a rational,
21 reasonable choice of providers. *In addition, such booklets*
22 *shall be printed in the primary language of all enrollees*
23 *whose primary language is other than English.*

24 30047.5. Health maintenance organizations shall hold
25 periods of open enrollment when consumers who so
26 desire may enroll, unless a health maintenance
27 organization can demonstrate to the satisfaction of the
28 commission that it is operating at maximum enrollment
29 capacity.

30 30048. Health maintenance organizations shall
31 establish an enrollee grievance procedure which shall be
32 in conformity with such procedures as defined and
33 authorized by the commission.

34 30048.5. Health maintenance organizations shall be
35 subject to formalized peer review as established by the
36 commission.

37 ~~30049. All eligible consumers, as set forth in Chapter~~
38 ~~6, shall remain enrolled in the health maintenance~~
39 ~~organization of their choice for a benefit period of one~~

1 year, with the following exceptions:

2 30049. Health maintenance organizations shall not
3 disenroll any enrollee against his wishes without cause as
4 determined by the commission, either through public
5 hearings or by regulation. All eligible consumers, as set
6 forth in Chapter 6, who become enrollees, shall remain
7 enrolled in the health maintenance organization of their
8 choice for a benefit period of one year, with the following
9 exceptions:

10 ~~(a)~~ A consumer enrollee changes his residence for
11 reasons of employment; or

12 (a) An enrollee who changes his residence; or

13 (b) The health maintenance organization is
14 terminated pursuant to subdivision (f) of Section 30030;
15 or

16 (c) The ~~consumer~~ enrollee declares his intent to
17 disenroll through the grievance procedures established
18 by the commission.

19 (d) The enrollee declares his intent to voluntarily
20 disenroll at a cost to himself not to exceed the total
21 premium as computed for one month.

22 30049.5. The ~~commission~~ shall have the power to
23 ~~modify or alter~~ the standards set forth in this chapter if
24 ~~such modification or alteration is found to be necessary or~~
25 ~~in the public interest, as determined by the commission,~~
26 ~~with recommendations from the Health Planning~~
27 ~~Council.~~

28 30049.5. Health maintenance organizations, to the
29 extent feasible, shall organize an advisory board of
30 enrollees for the purpose of advising the health
31 maintenance organization on matters of primary interest
32 to the consumer.

33

34 CHAPTER 5. DEVELOPMENT FUND

35

36

37 30050. Health maintenance organizations shall
38 provide emergency medical services to their enrollees
39 within the area of the enrollee's health maintenance
40 organization either directly or by contracting for such

1 *services in such locations as are readily available to the*
2 *enrollees. Such emergency services shall include, but not*
3 *be limited to:*

4 *(a) Hospital intensive and coronary care in the*
5 *hospital;*

6 *(b) A team consisting of physicians, nurses and other*
7 *allied health professionals on duty as necessary to provide*
8 *24-hour service;*

9 *(c) Equipment, facilities for electrocardiogram,*
10 *transfusion, inhalation therapy, X-ray, and laboratory.*

11 ~~30050~~ 30051. The Development Fund may be used
12 for all of the following purposes:

13 ~~(a) To provide financial and technical assistance for~~
14 ~~the development of health maintenance organizations~~
15 ~~and other types of prepaid plans. Priorities shall be given~~
16 ~~to city and county hospitals and underserved urban and~~
17 ~~rural communities.~~

18 *(a) To provide financial and technical assistance for*
19 *development of health maintenance organizations.*
20 *Priorities shall be given to city, county and district*
21 *hospitals and low-income, underserved urban and rural*
22 *communities.*

23 *(b) The development and operation by contract of*
24 *special purpose community health programs where the*
25 *occurrence of disease is not evenly distributed in the*
26 *community, including but not limited to control of*
27 *alcoholism and drug abuse, the development and*
28 *operation of emergency and trauma centers, programs*
29 *for the control of venereal disease, medical disasters, and*
30 *epidemics.*

31 *(c) The fund may make augmentation payments to*
32 *prepaid health plans which can demonstrate valid*
33 *evidence that they have incurred exceptional but*
34 *legitimate costs in the care of such high-risk population*
35 *as the poor, the aged, and the disabled and have*
36 *continually been in conformance with peer review,*
37 *utilization control, and other such standards established*
38 *by the commission.*

39 *(d) The fund may make augmentation payments*
40 *under special circumstances for prepaid health plans in*

1 poverty communities to support specialized services,
2 including but not limited to outreach community
3 programs, medical-related language assistance,
4 transportation and child care, nutrition education,
5 medical social work, public health nursing and patient
6 education.

7 (e) The fund may contract for the purpose of
8 demonstration, innovation, or experimentation of
9 community health delivery systems. Pursuant to such
10 purpose, the commission may seek federal waivers if
11 necessary to obtain federal funds for such demonstration
12 projects.

13

14

CHAPTER 6. ELIGIBILITY

15

16 30060. All legal residents of the State of California are
17 eligible for enrollment, except for members of the armed
18 forces serving in this state and federal employees who do
19 not voluntarily enroll pursuant to the further provisions
20 of this section. Medi-Cal recipients will continue to be
21 identified for purposes of federal participation, and
22 financed in the same manner as is currently provided for
23 in Article 5 of Chapter 7 of Part 3 of Division 9 of the
24 Welfare and Institutions Code, with federal funding to
25 continue to the maximum possible extent in the future.
26 The benefit plan shall be the equivalent of that stated in
27 this chapter, and all regulations relating to prior
28 authority, copayment, or relatives' responsibility are
29 rescinded. It is the intent of the Legislature that Medi-Cal
30 recipients be treated for the purpose of medical care in
31 a fashion which is indistinguishable from any other
32 citizen, with the exception of the processes required for
33 eligibility determination other than prior authorization,
34 copayment and relatives' responsibility.

35 Migrant agricultural workers *and their families* who
36 are not residents of California are eligible for service
37 benefits if they can show evidence that they are currently
38 engaged in or are seeking employment in agricultural
39 labor in the State of California.

40 Employees of the federal government are not eligible

1 for participation through payroll deduction. They may
2 participate in prepaid plans by paying any difference in
3 premium paid for current plans and those premiums set
4 by the commission.

5
6 CHAPTER 7. BENEFITS
7

8 30070. (a) The full range of health services is covered
9 to include prevention, screening, annual health
10 assessment, diagnosis and treatment of illness, both in and
11 out of hospitals, extended care, medical rehabilitation,
12 medically justified nursing home care, and care provided
13 in an organized home care program.

14 (b) No deductibles, copayments, waiting periods,
15 cutoffs, or ~~extra charges patient fees~~ are permitted in
16 approved prepaid health plans. ~~Extra charges may be~~
17 ~~made by providers only upon written agreement~~
18 ~~between patient and provider which indicates clearly~~
19 ~~that patients understand that such charges are the~~
20 ~~responsibility of the patient and are not reimbursable~~
21 ~~under an approved prepaid plan.~~

22 (c) Reimbursement for extended or long-term care
23 shall require a written and detailed treatment plan. Such
24 a plan shall indicate that the treatment performed is in
25 an environment which offers a level of care appropriate
26 to the needs of the patient.

27 (d) No payments shall be made for custodial or
28 residential care. Payments may be made for medical and
29 nursing services performed in custodial or residential
30 living arrangements.

31 ~~(e) Citizens who enroll in a prepaid plan shall remain~~
32 ~~enrolled for a period of one year, except that~~
33 ~~disenrollment may take place upon change of residence~~
34 ~~at no cost, and voluntary disenrollment may take place at~~
35 ~~the enrollee's cost.~~

36 (e) *Enrollees of any health maintenance organization*
37 *may seek medical services outside their health*
38 *maintenance organization, or services in addition to the*
39 *scope of benefits set forth in this act; provided, however,*
40 *that such enrollees shall be strictly and solely liable for*

1 *any such services requested and received. Such enrollee*
2 *liability shall include but is not limited to those benefits*
3 *specifically excluded in this act pursuant to Chapter 7,*
4 *and such extra medical care is not reimbursable under*
5 *approved prepaid plans.*

6 30071. (a) Benefits under this chapter applying to
7 prepaid health plans, shall include:

8 (1) Outpatient services which are covered as follows:

9 Physician, hospital outpatient, optometric,
10 chiropractic, psychology, podiatric, occupational
11 therapy, physical therapy, speech therapy, audiology,
12 and services of persons rendering treatment by prayer or
13 healing by spiritual means in the practice of any church
14 or religious denomination insofar as these can be
15 encompassed by federal participation under an approved
16 plan.

17 (2) Hospital inpatient care.

18 (3) Nursing home care, including physician services
19 and prescription drugs.

20 (4) Purchase of prescription drugs prescribed by a
21 physician for the treatment of chronic disease only.

22 (5) Hospital outpatient dialysis services and home
23 hemodialysis services, including physician services,
24 medical supplies, drugs and equipment required for
25 dialysis.

26 (6) Outpatient laboratory and outpatient X-ray
27 services.

28 (7) Blood and blood derivatives are covered.

29 (8) Dental services.

30 (9) Medical transportation.

31 (10) Home health care services.

32 (11) Prosthetic and orthotic devices and eyeglasses.

33 (12) Hearing aids.

34 (13) Durable medical equipment and medical
35 supplies are covered.

36 (14) Physical therapy services, occupational therapy
37 services, speech therapy services and audiology services.

38 (15) Other diagnostic, screening or preventive
39 services.

40 (b) For providers who are not prepaid health plans,

1 the benefits of subdivision (a) shall apply, but such
2 benefits shall be subject to the following limitations:

3 (1) Nursing home care shall be limited to 120 days per
4 benefit period.

5 (2) Hospitalization for psychiatric diagnosis shall be
6 limited to 45 days per benefit period.

7 (3) Psychiatric visits shall be limited to 20 days per
8 benefit period.

9 (4) Prescription drugs shall be excluded, except those
10 required for long-term treatment of chronic disease.

11 (5) Medical rehabilitation shall not be covered.

12 (6) Cosmetic surgery shall be excluded unless
13 approved by psychiatric consultation or vocational
14 rehabilitation agency and related to employment.

15 SEC. 2. Section 2151.1 is added to the Revenue and
16 Taxation Code, to read:

17 2151.1. The board of supervisors of each county or city
18 and county shall annually, commencing with the
19 _____ fiscal year, at the time and in the manner of
20 levying other county taxes, levy and cause taxes to be
21 collected throughout the county for the purpose of
22 funding consumer health protection created pursuant to
23 Division 22 (commencing with Section 30000 of the
24 Health and Safety Code), as provided in this chapter.

25 SEC. 3. Section 2151.2 is added to the Revenue and
26 Taxation Code, to read:

27 2151.2. The additional taxes shall be levied and
28 collected throughout the territory of the county or city
29 and county at a rate of _____ dollars (\$_____),
30 modified where necessary pursuant to Section 2151.4, on
31 each one hundred dollars (\$100) of 100 percent of the
32 assessed valuation in the county as shown on the
33 equalized assessment roll for the current year. The
34 revenue so derived shall be paid into the Health Care
35 Trust Fund created pursuant to Health and Safety Code
36 Section 30026.

37 SEC. 4. Section 2151.3 is added to the Revenue and
38 Taxation Code, to read:

39 2151.3. On the basis of computations made by the
40 State Board of Equalization, the secretary of that board

1 shall certify on or before October 1 of each year to the
 2 State Controller the factor, carried to three decimal
 3 places, by which the total assessed value of all tangible
 4 property on the current local roll of each county must be
 5 modified to conform to the statewide average assessment
 6 level; provided that property belonging to a county, city
 7 and county, or municipal corporation which is taxable
 8 under Section 1 of Article XIII of the Constitution and
 9 constituting more than 10 percent of the total assessed
 10 value of the taxable property within a school district shall
 11 be excluded from the assessed value and the full cash
 12 value that are used to compute such factor.

13 SEC. 5. Section 2151.4 is added to the Revenue and
 14 Taxation Code, to read:

15 2151.4. The State Controller shall average the factor
 16 certified for the current year under Section 2151.3 for the
 17 local roll of the county with the factors so certified for the
 18 two immediately preceding years. The three-year
 19 average factor shall be applied to the tax rate in Section
 20 2151.2 and the modified rate, which shall be transmitted
 21 to the county assessor.

22 SEC. 6. Section ~~17041.1~~ is added to the Revenue and
 23 Taxation Code, to read:

24 ~~17041.1. (a) There shall be imposed for the purpose~~
 25 ~~of funding consumer health protection created pursuant~~
 26 ~~to Division 22 (commencing with Section 30000) of the~~
 27 ~~Health and Safety Code a payroll tax commencing with~~
 28 ~~the / / / / fiscal year and computed as follows:~~
 29

| 30 | Gross salaries | Tax rate | Tax rate |
|----|--------------------|----------------------|----------------------|
| 31 | and wages | on employee | on employer |
| 32 | \$0 / \$5,000.... | 1% | 3% |
| 33 | 5,000 / 10,000.... | \$50 plus 2% of any | \$150 plus 6% of any |
| 34 | | amount over \$5,000 | amount over \$5,000 |
| 35 | 10,000 / /.... | \$150 plus 3% of any | \$450 plus 9% of any |
| 36 | | amount over \$10,000 | amount over \$10,000 |

37
 38 Self-employed shall be taxed under this section at a rate
 39 of / / percent of their gross earnings.

40 (b) The tax imposed by this section shall be treated for

1 all purposes of this part as though it were imposed under
2 Sections ~~17041~~ or ~~17048~~, except that no deductions,
3 exclusions, or credits shall be allowed against the tax
4 imposed under this section.

5 *SEC. 6. Part 10.7 (commencing with Section 19601) is*
6 *added to Division 2 of the Revenue and Taxation Code,*
7 *to read:*

8

9 *PART 10.7. CONSUMER HEALTH PROTECTION*
10 *TAX LAW*

11

12 *Article 1. Definitions*

13

14 *19601. "Employer," as used in this part, means*
15 *"employer" as defined in Section 18810.*

16 *19602. "Employee," as used in this part means*
17 *"employee" as defined in Section 18809, except*
18 *nonresident individuals are not employees for the*
19 *purposes of this part.*

20 *19603. "Wages," as used in this part, means "wages"*
21 *as defined in Section 18807.*

22 *19604. "Payroll period," as used in this part, means*
23 *"payroll period" as defined in Section 18808.*

24 *19605. "Business income," as used in this part, means*
25 *"adjusted gross income" as defined in Section 17072*
26 *minus*

27 *(a) Rental income, unless such income is received in*
28 *a course of a trade or business;*

29 *(b) Dividends on any share of stock, and interest on*
30 *any bond, debenture, note, or certificate, or other*
31 *evidence of indebtedness issued with interest coupons or*
32 *in regular form by any corporation, unless such dividends*
33 *and interest are received in the course of a trade or*
34 *business as a dealer in stocks or securities.*

35 *(c) Gains or losses*

36 *(1) From the sale or exchange of a capital asset,*

37 *(2) From the cutting of timber, or the disposal of*
38 *timber, coal, or iron ore if Sections 17711 and 17712 apply*
39 *to such gains or losses, or;*

40 *(3) From the sale, exchange, involuntary conversion,*

- 1 or other disposition of property if such property is neither
 2 (A) Stock in trade or other property of a kind which
 3 would properly be included in inventory if on hand at the
 4 close of taxable year, nor:
 5 (B) Property held primarily for sale to customers in
 6 the ordinary course of the trade or business;
 7 (d) Royalties unless such royalties are received in the
 8 course of a trade or business;
 9 (e) Alimony and separate maintenance payments;
 10 (f) Income in respect of a decedent;
 11 (g) Income from an interest in an estate trust; and,
 12 (h) Income from annuities, life insurance and
 13 endowment contracts and pensions.

14

15 *Article 2. Consumer Health Protection Tax*

16

17 19610. (a) There shall be imposed for each taxable
 18 year upon the wages paid every employee, subject to the
 19 Consumers Health Protection Act of 1972, a consumer
 20 health protection tax in the following amounts and at the
 21 following rates:

22

23

24 *If the wages are:*25 *Not over \$5,000*26 *Over \$5,000 but not*
27 *over \$10,000*28 *Over \$10,000*

29

30

The tax on the
employee is:

1 percent

\$50 plus 2 percent of
any amount over \$5,000\$150 plus 3 percent of
any amount over \$10,000

31 (b) There shall be imposed for each taxable year upon
 32 the wages paid by every employer to employees, subject
 33 to the Consumers Health Protection Act of 1972, a
 34 consumer health protection tax in the following amounts
 35 and at the following rates:

| | | |
|---|-----------------------------|---------------------------------|
| 1 | | <i>The tax on the</i> |
| 2 | <i>If the wages are:</i> | <i>employer is:</i> |
| 3 | <i>Not over \$5,000</i> | <i>3 percent</i> |
| 4 | <i>Over \$5,000 but not</i> | <i>\$150 plus 6 percent of</i> |
| 5 | <i>over \$10,000</i> | <i>any amount over \$5,000</i> |
| 6 | <i>Over \$10,000</i> | <i>\$450 plus 9 percent of</i> |
| 7 | | <i>any amount over \$10,000</i> |

8
9 (c) *There shall be imposed for each taxable year upon*
10 *the business income of every individual, subject to the*
11 *Consumer Health Protection Act of 1972, from which the*
12 *consumer health protection tax is not deducted and*
13 *withheld pursuant to Section 19611, a consumer health*
14 *protection tax at a rate of ____ percent of business*
15 *income.*

16 19611. *Every employer making payment of any*
17 *wages after _____ to an employce, who is subject to*
18 *the provisions of the Consumer Health Protection Act of*
19 *1972, for services performed either within or without this*
20 *state shall deduct and withhold from such wages for each*
21 *payroll period an amount computed in such manner as to*
22 *produce, so far as practicable, a sum which equals the*
23 *amount of consumer health protection tax due from the*
24 *employee under this part.*

25 19612. *The consumer health protection tax withheld*
26 *pursuant to Section 19611 and the consumer health*
27 *protection tax imposed upon the employer pursuant to*
28 *Section 19610 shall be reported and paid in the manner*
29 *and times specified in Section 18491 for the reporting and*
30 *payment of withheld income taxes.*

31 19613. *Individuals subject to the provisions of Section*
32 *18415, pertaining to declarations of estimated tax, shall,*
33 *for taxable years beginning after _____ include within*
34 *such declaration, a declaration of consumer health*
35 *protection tax imposed pursuant to subdivision (c) of*
36 *Section 19610, estimated to be due and shall pay such tax*
37 *in the manner and times specified in Section 18556 for the*
38 *payment of estimated tax.*

39 *All other individuals subject to the consumer health*
40 *protection tax imposed by subdivision (c) of Section*

1 19610 shall report and pay such tax to the State Health
2 Commission on or before the 15th day of April following
3 the close of the calendar year or in such other manner
4 and at such times as may be prescribed.

5 19614 All individuals required to make and file
6 personal income tax returns pursuant to Chapter 17
7 (commencing with Section 18401) of Part 10 of Division
8 2, shall state therein the amount of consumer health
9 protection tax paid or withheld during the calendar or
10 fiscal year and shall pay the tax imposed by this part, less
11 the amount deducted and withheld pursuant to Section
12 19611 or previously paid as estimated tax pursuant to
13 Section 19613, on or before the 15th day of April following
14 the close of the calendar year or, if the return is made on
15 the basis of the fiscal year, on or before the 15th day of
16 the fourth month following the close of the fiscal year.

17 19615. (a) If the consumer health protection tax paid
18 by or withheld from an individual during the calendar or
19 fiscal year exceeds the tax due under Section 19610, the
20 individual shall be entitled to a refund or credit of the
21 amount of the excess.

22 (1) Individuals required to make and file personal
23 income tax returns shall claim the refund or credit on the
24 return for the year in which the excess tax was paid or
25 withheld. The excess tax shall be credited against the
26 personal income tax or if the personal income tax due
27 after deduction of all authorized credits is less than the
28 credit allowable pursuant to this section, the difference
29 shall be a tax refund. If the Franchise Tax Board disallows
30 the refund or credit provided for by this section, the
31 Franchise Tax Board shall notify the claimant
32 accordingly. The Franchise Tax Board action upon the
33 credit or refund is final unless the claimant files a protest
34 with the State Health Commission within 30 days of the
35 date of mailing of the notice of disallowance by the
36 Franchise Tax Board.

37 (2) Claimants not required to make and file personal
38 income tax returns shall file a claim for refund with the
39 State Health Commission on or before the 15th day of
40 April following the close of the calendar year or in such

1 other manner and at such time as may be prescribed. If
2 the State Health Commission denies the claim in whole
3 or in part filed under this paragraph or the protest filed
4 under paragraph (1) of subdivision (a), the claimant may
5 commence an action appealing such denial in the
6 Superior Court of the County of Sacramento, in the
7 County of Los Angeles, or in the City and County of San
8 Francisco.

9 19616. (a) Except for the limitations specified in this
10 part, all the provisions of Part 10 applicable to the
11 deduction and withholding from wages of personal
12 income taxes by employers shall apply, where applicable,
13 to the tax imposed by subdivisions (a) and (b) of Section
14 19610. If the Franchise Tax Board delegates its powers
15 and duties as provided in Section 15702.2 of the
16 Government Code, Section 18826 shall also apply to the
17 taxes imposed by subdivision (a) and (b) of Section
18 19610.

19 (b) Except for the limitations specified in this part, all
20 the provisions of Part 10, where applicable, shall apply to
21 the tax imposed by subdivision (c) of Section 19610,
22 insofar as such tax is required to be paid to the Franchise
23 Tax Board.

24 SEC. 6.5. No provision of this act, and no amendment
25 to the Government Code made by this act, shall affect or
26 alter any contractual or other nonstatutory obligation of
27 an employer to provide health services to his present and
28 former employees and their dependents, or to any such
29 persons, or the amount of any obligation for payment
30 (including any amount payable by an employer for
31 insurance premiums or into a fund to provide for any
32 such payment) toward all or any part of the cost of such
33 services. And, such employer-employee negotiated funds
34 as currently exist may be used to meet the obligation of
35 premiums on behalf of the employee.

36 SEC. 7. Section 14005.6 of the Welfare and
37 Institutions Code, as amended by Chapter 1685 of the
38 Statutes of 1971, is amended to read:

39 14005.6. (a) When a person is not eligible for aid
40 under any of the chapters set forth in Section 14005.1, but

1 meets all of the following conditions, he is eligible for
2 health care benefits or services under Section 14005:

3 (1) He or his family meet the income and resource
4 requirements for aid under Chapter 2 (commencing with
5 Section 11200) of Part 3 of Division 9 of this code, except
6 that the minimum basic standard of adequate care for a
7 single person living alone shall be 75 percent of the
8 standard for a two-person family under Section 11452;

9 (2) He resides within the state;

10 (3) He is a citizen of the United States, or has been
11 legally present in the United States for a period of five
12 years immediately preceding the date of application for
13 Medi-Cal coverage, or who has applied for citizenship;

14 (4) He is ~~21~~ 18 years of age or older, or has entered into
15 a ceremonial marriage; and

16 (5) He is not receiving adequate financial
17 contributions toward his support and cost of health care
18 from a husband or wife or parent or adult child able to
19 and responsible for support under the laws of this state.

20 SEC. 8. Section 14132 of the Welfare and Institutions
21 Code, as amended by Chapter 1685 of the Statutes of 1971,
22 is repealed.

23 SEC. 9. Section 14134 of the Welfare and Institutions
24 Code, as amended by Chapter 1685 of the Statutes of 1971,
25 is repealed.

26 SEC. 10. It is the intention of the Legislature that the
27 funds derived under Revenue and Taxation Code
28 Sections 2151.1 to 2151.4, inclusive, and 17041.1 shall be
29 utilized to fund the provisions of this act. It is also the
30 intention of the Legislature that the present funding
31 structure for health care services of the county and state
32 governments remain in effect, and such sources of
33 funding shall be supplemented by the revenue derived
34 under this act. It is not the intention of the Legislature to
35 terminate existing federal funding and future federal
36 funding available for provision of health care services in
37 California.

38 SEC. 11. The provisions of this act shall continue to be
39 operative, and shall be merged or rearranged in
40 accordance with any federal legislation that provides

1 similar or equivalent benefits, if and when such federal
2 legislation is enacted. Fiscal arrangements pursuant to
3 such enacted federal law shall be accomplished by the
4 commission in accordance with law.

5 SEC. 12. Notwithstanding any other provision of law,
6 and according to customary budgetary procedures, the
7 state share of employee health prepaid benefits, pursuant
8 to this act, shall be funded in subsequent fiscal years.

9 SEC. 13. This act shall take effect July 1, 1974, except
10 that the appointment of the commission shall become
11 effective _____, and except that the collection of taxes
12 imposed by _____ of this act shall commence on July
13 1, 1973.

14 The transference of the various agencies and personnel
15 as set forth in Section 30023 shall commence on _____.

ASSEMBLY BILL

No. 1207

Introduced by Assemblyman Hart

March 30, 1977

REFERRED TO COMMITTEE ON FINANCE, INSURANCE, AND COMMERCE

An act to add Division 12.6 (commencing with Section 15500) to the Health and Safety Code, relating to medical and hospital services insurance, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1207, as introduced, Hart (Fin., Ins., & Com.). Insurance: medical and hospital services.

There are no provisions of existing law which provide for a statewide medical and hospital services insurance operated by a state agency.

This bill would enact the California Voluntary Medical and Hospital Services Insurance Act which would create a California Voluntary Medical and Hospital Services Insurance Agency to operate a California Voluntary Medical and Hospital Services Insurance Plan. The agency would have a director appointed by the Governor and confirmed by the Senate, who would serve at the discretion of the Governor and who would appoint 6 assistant directors, at least 3 of whom would be medical doctors.

This bill would require the agency to make specified preparations for commencement of the plan within 2 years after the effective date of the bill, would provide for the payment of benefits by the plan to or on behalf of every enrollee for specified medical services, and would require premiums of

\$216 per year for each adult and \$108 per year for each child, with specified lower premiums for families with combined incomes of less than \$12,000 per year.

This bill would require the agency to establish a trust fund for the deposit of all premiums received from subscribers, together with appropriations from the General Fund, from which shall be paid all claims for benefits of the plan and all operating and administrative costs.

This bill would provide that enrollment in the plan and the payment of premiums would be voluntary, but would permit an employer to enroll any employee and the employee's family, and would permit a public welfare agency to enroll any recipient of public assistance, provided that the employer or public welfare agency pays all or part of the premium for the person enrolled.

This bill would allow every medical service provider, laboratory, and hospital to apply to the agency for approval and listing as a participating provider of specified services as benefits of the plan, and would require the agency to compile and publish a schedule of fees in proportion to the usual, customary, and reasonable fee for each service provided in each general area of the state.

This bill would enact provisions relating to the method and form of making a claim for benefits, the auditing, payment, and assessment of claims, the offering of additional benefits to enrollees, and various related provisions.

This bill would specify that a prerequisite condition to the bill becoming operative would be an agreement by the United States government to permit the transfer to the agency of all funds, grants and sums of money which the state would ordinarily be entitled to receive from federal programs such as Medicare and Medicaid.

This bill would require, as a condition of enrollment in the plan, that every enrollee and provider agree to refer every claim for damages resulting from alleged negligence or malpractice in providing plan services to an arbitration board composed of 3 attorneys and 3 doctors, which would determine the degree and responsibility for negligence or malpractice, if any, and the amount of damages. The agency would be required to pay the amount of all damages, if any, in full

settlement of the claim.

This bill would appropriate an unspecified amount to the California Voluntary Medical and Hospital Services Insurance Agency to carry out specified functions, and to the agency trust fund for the payment of claims of benefits of the plan and operating and administrative costs.

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

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

1 SECTION 1. Division 12.6 (commencing with Section
2 15500) is added to the Health and Safety Code, to read:

3
4 DIVISION 12.6. MEDICAL AND HOSPITAL
5 SERVICES INSURANCE

6
7 CHAPTER 1. FINDINGS AND PURPOSES

8
9 15500. This division shall be known and may be cited as
10 the California Voluntary Medical and Hospital Services
11 Insurance Act.

12 15501. The Legislature hereby finds that illness and
13 accident are unpredictable hazards to all persons and that
14 the financial cost of needed hospital and medical
15 treatment may become a hardship upon any person or
16 prevent their access to or receipt of needed hospital and
17 medical treatment, and therefore a state agency shall be
18 established to operate a medical and hospital services
19 insurance plan, with funds supplied by voluntary
20 subscriptions from subscribers, and matching state
21 general funds, to pay all reasonable costs of all medically
22 necessary, available, and appropriate medical and
23 hospital services for all voluntary enrollees.

24 15502. The Legislature also finds that California has no
25 precedent or experience with universal health insurance
26 but takes note of the ten provinces and experience of the
27 twenty-three million residents of Canada in evolving
28 from conditions and methods of public and private health
29 care financing closely paralleling existing conditions and

1 methods in the United States to an effective and
2 economical system of 10 autonomous and differently
3 structured provincial health insurance plans assisted
4 financially by the government of Canada, from which can
5 be drawn many valuable lessons and general principles to
6 guide us in planning to best meet our own particular
7 needs:

8 (a) Experience in Canada has demonstrated that the
9 total demand for medical and hospital services does not
10 increase significantly following introduction of universal
11 health insurance in a population already having an
12 adequate supply of hospital facilities and medical
13 personnel, whether such are uniformly distributed or not.
14 Experience in Canada has further demonstrated that the
15 actual utilization of medical and hospital insurance
16 benefits is almost entirely determined by decisions and
17 actions of physicians rather than by demands of patients
18 and all artificial regulatory mechanisms such as patient
19 copayments, deductibles, limits or exclusions are not only
20 unnecessary but tend to be strongly counter-productive
21 by greatly increasing administrative costs and
22 overburdening doctors and hospitals with paperwork and
23 also by deterring many persons from seeking early
24 diagnosis of disease and treatment which could be both
25 most effective and most economical.

26 (b) The medical profession itself is best qualified to
27 regulate the utilization and costs of insurance benefits
28 and can be relied on with confidence and held
29 accountable to perform this responsibility faithfully and
30 effectively in the best interests of the health of the people
31 of this state under a negotiated agreement with an
32 agency of the state without the necessity for a pervasive
33 and costly administrative and supervisory system.

34 (c) Compulsory enrollment or subscription by
35 individuals or employers to any health insurance plan is
36 undesirable because it grants an implied right to every
37 enrollee and subscriber to expect to receive health care
38 service whenever and wherever demanded, and such
39 expectations are clearly unrealizable and would impose
40 excessive demands on available medical manpower and

1 facilities, necessitating government intervention for the
2 allocation of services; whereas universally affordable
3 voluntary subscription may be predicated on a clear
4 understanding and acceptance by all subscribers that the
5 insurance benefits are intended only to pay for services
6 which are medically necessary and readily available in
7 the free marketplace.

8 (d) Experience in the various provinces of Canada has
9 demonstrated that the total administrative cost of a single
10 universal health insurance plan is likely to be
11 substantially lower than under a system of multiple
12 public and private plans and that the billing costs of
13 providers are also substantially reduced by dealing with
14 a single insurance carrier. It is further noted that Volume
15 5, entitled "Supplementary Health Insurance In
16 Canada," of a study made for the Department of Health,
17 Education and Welfare of the Canadian experience with
18 government controls on the health care system (January,
19 1976), reports that private insurance companies in
20 Canada (most of which are subsidiaries or affiliates of U.
21 S. companies) are now enjoying increased sales of
22 supplementary health insurance policies as well as life
23 and disability income insurance since they have been
24 relieved of underwriting medical and hospital insurance.

25 (e) The cost of professional malpractice litigation,
26 settlements, insurance and defensive medicine is not a
27 significant problem in Canada but it has become a major
28 factor in the cost of health care in the United States and
29 must be taken into account in any consideration or cost
30 projection of any state health insurance program. There
31 is general agreement that a speedy low-cost system of
32 preliminary nonbinding arbitration could eliminate most
33 protracted and expensive litigation and the unwarranted
34 settlement of meritless claims. To achieve maximum
35 economy and equity, however, such preliminary
36 arbitration or adjudication of malpractice claims must be
37 universal. A voluntary state health insurance plan,
38 requiring as a condition of enrollment or participation an
39 agreement to arbitrate all claims, would afford the most
40 effective instrument or medium for universal arbitration

1 which could restrain or even reduce the ever-increasing
2 costs of malpractice defense.

3

4 CHAPTER 2. ORGANIZATION AND MANDATE

5

6 15505. (a) The California Voluntary Medical and
7 Hospital Services Insurance Act shall create a California
8 Voluntary Medical and Hospital Services Insurance
9 Agency to operate a California Voluntary Medical and
10 Hospital Services Insurance Plan. The agency shall have
11 a director appointed by the Governor to be confirmed by
12 the Senate, and he shall serve at the discretion of the
13 Governor. The director shall appoint six assistant
14 directors, of whom not less than three shall be medical
15 doctors, who together shall appoint or assemble such
16 deputy directors, staff, consultants, contractors, quarters,
17 and facilities as the directors shall deem necessary to
18 carry out the responsibilities and functions of the agency,
19 including the preparation of an annual budget and an
20 annual operations report and financial statement and
21 accounting of all receipts and expenditures, audited and
22 certified by the Auditor General, for the Governor and
23 the Legislature.

24 (b) The agency shall have two operational
25 subdivisions: one subdivision, hereafter referred to as
26 "Section I," shall exclusively conduct all relations with
27 hospital service providers and the payment of hospital
28 service benefits of the plan; one subdivision, hereafter
29 referred to as "Section II," shall exclusively conduct all
30 relations with medical and pathological laboratory
31 service providers and the payment of medical and
32 pathological laboratory benefits of the plan and such
33 additional benefits as may be provided by the plan in the
34 future.

35 (c) All operations of the plan shall be governed solely
36 by the provisions of this division. In recognition of the fact
37 that administrative rules and regulations respecting
38 ostensible financial transactions would be likely also to
39 adversely affect medical practice and hospital operation,
40 the agency shall issue or publish, or cause to issue or

1 publish, no rules or regulations. When particular or
2 general orders or directives are deemed necessary to
3 carry out the provisions and intentions of this division,
4 such shall be issued by the agency as memoranda, by
5 date, location, sequential number and reference to the
6 relevant section of this division. Whenever the agency
7 determines that amendment of this division is necessary,
8 the agency shall petition the Legislature to enact such
9 amendment.

10

11

CHAPTER 3. DEFINITIONS

12

13 15510. For purposes of this division:

14 (a) "Agency" means the California Voluntary Medical
15 and Hospital Services Insurance Agency created by this
16 division;

17 (b) "Plan" means the California Voluntary Medical
18 and Hospital Services Insurance Plan operated by the
19 agency;

20 (c) "Subscriber" means any adult person, 18 years of
21 age or older, who has enrolled himself or herself and his
22 or her spouse and dependent children and adult or child
23 wards, if any, in the plan and has paid the requisite
24 premium for each enrollee; or an employer or a public
25 agency that enrolls, and remits premiums to the plan on
26 behalf of one or more employees or clients;

27 (d) "Enrollee" means any person enrolled in the plan
28 by a subscriber and whose requisite premium has been
29 paid and is in force, and who has been assigned a plan
30 account number, which shall also identify the enrollee's
31 subscriber;

32 (e) "Family" means any adult person 18 years of age or
33 older and spouse and all dependent children, adults, or
34 wards, if any, whether residing together in the same
35 household or not;

36 (f) "Adult" means any person 18 years of age or older;

37 (g) "Child" means any person under the age of 18
38 years;

39 (h) "Provider" means any person, partnership,
40 association, or corporation that provides and claims

1 payment for any medical, pathological laboratory or
2 hospital service that is a benefit of the plan;

3 (i) "Doctor" means any person who is licensed as a
4 medical doctor, doctor of osteopathic medicine, doctor of
5 podiatric medicine, or doctor of dental surgery, who
6 personally provides, performs, prescribes, orders,
7 supervises, or certifies any medical service classified as a
8 benefit of the plan, whether or not he or she has assigned
9 any or all related fees to an employer, partnership,
10 association, or corporation;

11 (j) "Hospital" means any establishment, with or
12 without sleeping or feeding facilities, which provides
13 patient diagnostic, therapeutic, or maintenance services
14 or materials or staff for use only by or under the direction,
15 supervision, and certification of a doctor, and for which
16 a separate charge is made to the patient and which has
17 been duly licensed and certified by all jurisdictional
18 public health and safety agencies and which has been
19 approved by the agency for participation in the plan;

20 (k) "Laboratory" means any separate establishment
21 inside or outside of a hospital, a clinic, or a doctor's
22 regular office and which is supervised at all times by a
23 licensed medical doctor who is qualified as a specialist in
24 pathology and which performs diagnostic pathological
25 tests at the request only of doctors on behalf of patients
26 who are charged separate fees for such services by the
27 laboratory, and which has been duly licensed and
28 certified by all jurisdictional public health, safety, and
29 business regulatory agencies and which has been
30 approved by the agency for participation in the plan for
31 the provision of specified pathological tests;

32 (l) "Review organization" means a professional
33 standard review organization.

34

35 CHAPTER 4. INITIATION AND INCEPTION OF THE PLAN

36

37 15515. The agency shall be charged with responsibility
38 to make all necessary preparations to offer subscriptions
39 and enrollments, and to commence payment of claims for
40 benefits of the plan everywhere in the state within a

1 period of two years or less after the effective date of this
2 division, such preparations to include:
3 (a) The employment of staff;
4 (b) The occupation of quarters;
5 (c) The printing and distribution of informational and
6 operational material for and respecting subscription,
7 enrollment, premiums, benefits, claim forms, auditing
8 and processing and payment of claims;
9 (d) Establishment of medical and laboratory service
10 fee and hospital rate and charge schedules;
11 (e) Establishment of utilization review and control
12 procedures;
13 (f) Establishment of sanctions and disciplinary
14 procedures for illegal or unwarranted utilization of
15 benefits; and
16 (g) The preparation of a budget and projection of
17 operations to guide the Legislature in the appropriation
18 of funds to supplement subscribers' premiums in
19 operating the plan for the succeeding calendar year.
20 15516. Not less than 90 days prior to the effective date
21 of inception of the plan, all persons who are enrolled in
22 or subscribers to or beneficiaries of the Medicare
23 program administered by the United States Social
24 Security Administration and the California Medi-Cal
25 program assisted by the United States Medicaid program
26 funds, shall be notified that all medical and hospital
27 service benefits provided by or through those programs
28 will cease on the effective date of inception of the plan;
29 and such notice shall be accompanied by an explanation
30 of the plan provided by this division and an application
31 form for enrollment in and subscription to the plan to
32 effectuate eligibility for the medical and hospital benefits
33 of the plan on the effective date of inception of the plan.

34
35 CHAPTER 5. DUPLICATION OF SERVICES AND
36 FUNCTIONS PROVIDED BY OTHER AGENCIES
37

38 15520. On the effective date of inception of the plan,
39 when the agency shall offer subscriptions and
40 enrollments and commence payment of claims for

1 benefits of the plan, the Legislature shall withhold all
2 appropriations for the funding of all similar or duplicate
3 hospital and medical service insurance benefits or
4 payments provided by any other agency of the state,
5 including but not necessarily limited to that program
6 known as Medi-Cal, and every such program operated by
7 any agency of the state, whether specified or not, shall
8 immediately cease providing or paying for medical or
9 hospital service for members of the general public on a
10 fee or charge-for-service basis.

11 15521. If the program specified in Section 15520 or any
12 other programs operated or administered by any agency
13 of the state provides any benefit, service or function
14 other than the direct provision of payment for medical
15 and hospital service for members of the general public
16 not enlisted or commissioned in the armed forces or
17 Coast Guard of the United States, entitled to such
18 benefits from the Department of Veterans Affairs,
19 residing in an Indian reservation or in the custody of a
20 penal or mental institution, such other benefit, service, or
21 function shall not be denied necessary operating funds by
22 the Legislature insofar as the purpose and intention of
23 this division are concerned.

24

25

CHAPTER 6. BENEFITS OF THE PLAN

26

27 15525. Payment shall be made by the plan to or on
28 behalf of every enrollee for all legal, appropriate,
29 professionally recognized and medically necessary
30 medical service provided as a personal professional
31 service by or under direct supervision of a licensed
32 medical doctor, wherever performed, including but not
33 necessarily limited to noncutting physical and psychiatric
34 medicine, surgery, obstetrics, radiological and electrical
35 procedures, pathology tests, transfusions, medication and
36 immunization, injections and anesthesia; and for the
37 same kind of services provided by a doctor of osteopathic
38 medicine.

39 15526. Payment shall be made by the plan to or on
40 behalf of every enrollee for all appropriate, professionally

1 recognized, and medically necessary reconstructive oral
2 surgery performed by a doctor of dental surgery in a
3 consenting hospital approved by the agency.

4 15527. Payment shall be made by the plan to or on
5 behalf of every enrollee for all appropriate, professionally
6 recognized and medically necessary foot surgery
7 performed by a doctor of podiatric medicine.

8 15528. Payment shall be made by the plan on behalf of
9 every enrollee for all professionally recognized
10 pathological tests performed at the request of the
11 enrollee's doctor and under the direct supervision of a
12 medical doctor qualified as a specialist in pathology, by a
13 laboratory approved by the agency for participation in
14 the plan for specified pathological tests.

15 15529. Payment shall be made by the plan on behalf of
16 every enrollee for all legal, appropriate, professionally
17 recognized and medically necessary inpatient or
18 outpatient hospital service, supplies, medication,
19 transfusions and food provided by a hospital approved for
20 participation in the plan by the agency, including general
21 or special category hospitals, outpatient clinics,
22 emergency wards, convalescent hospitals, nursing homes
23 and acute alcohol or drug toxification treatment centers,
24 when the enrollee is admitted or attended by a licensed
25 doctor on the staff of the hospital.

26

27 CHAPTER 7. SERVICES EXCLUDED FROM BENEFITS OF
28 THE PLAN

29

30 15530. No payment shall be made by the plan on
31 account of:

32 (a) Any medical advice given to an enrollee by
33 telephone.

34 (b) Any cosmetic plastic surgery not deemed essential
35 to the physical and mental health of the enrollee and not
36 approved in advance by the agency.

37 (c) Any service or supplies or food provided by a
38 hospital at the request of the enrollee and which are not
39 medically necessary or prescribed by a doctor, such as but
40 not necessarily limited to private or semiprivate

1 accommodation, telephone, private nursing, and food not
2 ordinarily served or provided to all patients within the
3 hospital's basic per diem rate.

4 (d) Any medicolegal advice in connection with any
5 legal claim or suit other than as provided in Sections
6 15689 and 15691.

7 (e) Any service requested by or for the benefit of a
8 second party other than the enrollee, such as but not
9 necessarily limited to a life insurance application, a past,
10 present, or prospective employer, or any other party with
11 any legal or monetary interest in the health of the
12 enrollee.

13 (f) Any service that is the responsibility of an enrollee's
14 past or present employer or custodian, such as but not
15 necessarily limited to a workmen's compensation insurer,
16 the armed forces, Coast Guard, Veterans' Administration,
17 penal or mental institutions.

18 (g) Any service that is a covered benefit of any other
19 public or private health insurance plan or prepaid
20 hospital or medical service plan, group or organization, in
21 which the enrollee is enrolled at his own or any other
22 party's expense or is entitled to by any federal, state, or
23 municipal agency.

24 (h) Any hospital or laboratory service provided by a
25 hospital or laboratory not approved by the agency.

26 (i) Any medical service provided by a doctor who has
27 been excluded from the plan by unrevoked orders of the
28 directors of the agency, except in an emergency when
29 medically necessary service is not available from a
30 nonexcluded doctor.

31

32 CHAPTER 8. ASSIGNMENT OF BENEFITS

33

34 15535. It shall be a condition of enrollment in the plan
35 that every enrollee shall assign to the agency the full and
36 unreserved right to recover from any third party the full
37 amount of any benefits paid by the plan on account of
38 medical, laboratory or hospital service provided to the
39 enrollee, and necessitated by the culpable actions or
40 negligence of the third party and which are the liability

1 of the third party.

2

3 CHAPTER 9. PREMIUMS AND PREMIUM RECEIPTS

4

5 15540. Premiums shall be paid by every subscriber on
6 account of each enrollee in his or her family or employ,
7 in advance, monthly, quarterly, semiannually, or
8 annually in the amount of eighteen dollars (\$18) per
9 calendar month or two hundred sixteen dollars (\$216)
10 per year for each adult and one-half of that amount for
11 each child.

12 15541. Subscribers who present valid evidence, in a
13 form prescribed by the agency, showing that their
14 enrollee's total earned and unearned combined family
15 income is less than twelve thousand dollars (\$12,000) per
16 year (one thousand dollars (\$1,000) per month, average)
17 shall be entitled to have their annual premiums for each
18 adult enrollee calculated at the rate of 1.8 percent of total
19 annual earned and unearned combined family income, or
20 one-twelfth of 1.8 percent of that income monthly, and
21 one-half of that amount for each child enrollee, but in no
22 case shall the adult premium be less than three dollars
23 (\$3) per month or thirty-six dollars (\$36) per year and
24 one-half of that amount for each child.

25 15542. If an enrollee is employed by an employer who
26 remits premiums to the plan on behalf of employees, it
27 shall be the responsibility of the enrollee to advise the
28 employer of the enrollee's total annual earned and
29 unearned combined family income on which the
30 applicable premium is calculated, as provided in Section
31 15541.

32 15543. If two or more enrollees in a family are
33 employed by the same or various employers who remit
34 premiums to the plan on behalf of employees, it shall be
35 the responsibility of each enrollee to advise their
36 employer of any premiums being remitted to the plan by
37 every other employer of every other enrollee in the
38 enrollee's family, so that there shall be no duplication in
39 the applicable amount of premiums remitted.

40 15544. If employment contracts or agreements require

1 one or more employers to pay all or part of plan
2 premiums and remit such premiums to the plan on behalf
3 of one or more enrollees in the same family, the excess
4 amount of such premiums payable by the employer shall
5 be paid to the employee as wages and shall not be
6 remitted to the plan, after notification of the employer as
7 provided in Section 15543.

8 15545. Every subscriber shall be provided with a
9 receipt for premiums paid for each enrollee of the
10 subscriber, showing the enrollee's name, address, plan
11 account number, and the calendar period covered by the
12 premium and if the subscriber is the employer of the
13 enrollee the receipt shall show the subscriber's name,
14 address, and plan account number.

15 16 CHAPTER 10. REINSTATEMENT OF COVERAGE

17
18 15550. Enrollment in the plan shall be reinstated
19 without loss of coverage if any unpaid premiums on
20 account of any enrollees are paid within 60 days of their
21 due date but thereafter coverage shall not be effective
22 and benefits shall not be payable on account of any
23 enrollee for 45 days after a subscriber has reapplied for
24 enrollment and has paid any premiums then due in
25 advance; and the same shall apply with respect to an
26 enrollee separated from his or her subscriber.

27 28 CHAPTER 11. TRUST FUND AND SUBSIDY

29
30 15555. Upon the effective date of inception of the plan
31 and the offering of subscriptions to the public, the agency
32 shall establish a trust fund into which shall be deposited
33 all premiums received from subscribers together with an
34 at least equal amount of money appropriated from the
35 General Fund; from which shall be paid all claims for the
36 benefits of the plan and all operating and administrative
37 costs.

38 15556. During the first three years of operation of the
39 plan, the Legislature may increase the amount of money
40 appropriated from the General Fund, relative to

1 subscribers' premiums, to be deposited in the trust fund
2 provided in Section 15555.

3 15557. Section 15556 notwithstanding, the amount of
4 general funds appropriated by the Legislature and
5 deposited in the trust fund provided in Section 15555 shall
6 not exceed the amount of subscribers' premiums
7 deposited in the trust fund during the fourth and
8 succeeding years after the effective date of inception of
9 the plan, except only as provided in Section 15561.

10

11 CHAPTER 12. APPORTIONMENT OF PREMIUMS AND
12 SUBSIDY

13

14 15560. Thirty-two percent of all premiums received
15 from subscribers and deposited in the trust fund as
16 provided in Section 15555 shall be reserved for the
17 payment of medical and laboratory service benefits of the
18 plan, and 65 percent of all such premiums shall be
19 reserved for the payment of hospitalization benefits and
20 3 percent of all such premiums shall be reserved for the
21 payment of operating and administrative costs and for
22 unrecoverable arbitration costs and awards as provided
23 in Sections 15689 and 15691.

24 15561. Appropriations from general funds shall be
25 deposited in the plan trust fund and reserved in the same
26 proportions as provided in Section 15560, but in no case
27 shall the amounts appropriated from general funds and
28 deposited in the trust fund be less than the difference
29 between premiums paid by subscribers and the amount
30 of twenty-four dollars (\$24) per month or two hundred
31 eighty-eight dollars (\$288) per year per enrollee enrolled
32 in the plan or any such amount as may be determined by
33 the Legislature from time to time in the future with
34 respect to the actual costs of the benefits provided by the
35 plan; except that all amounts expended on administrative
36 costs and unrecoverable arbitration costs and awards as
37 provided in Section 15689 in excess of 3 percent
38 subscribers' premiums shall be appropriated from
39 general funds and deposited in the plan trust fund.

1 service provider within the state for such service, upon
2 submission to the plan by the enrollee of an explicit
3 statement of the service provided together with a valid
4 receipt for payment made or a valid assignment of
5 payment due to the provider.

6 15576. Every nonexcluded and nonparticipating
7 medical service provider within the state shall be
8 required, in advance of providing any service that is a
9 benefit of the plan to any identified enrollee in the plan,
10 to inform the enrollee in writing that the provider is not
11 a participant in the plan and that the enrollee may be
12 entitled to receive full or partial reimbursement from the
13 plan for fees paid to the provider; and shall at the same
14 time inform the enrollee of the amount of such fees and
15 the amount of the scheduled fees payable by the plan for
16 the service; and to this end every nonexcluded and
17 nonparticipating provider shall be supplied without
18 charge with a copy of the current plan schedule of
19 medical services and related fees as provided in Chapter
20 21 (commencing with Section 15610) of this division.

21 15577. Failure by any nonexcluded and
22 nonparticipating medical service provider to inform any
23 identified enrollee in the plan of all of the applicable
24 information set out in Section 15576 shall discharge the
25 enrollee and the plan of any and all obligation to pay any
26 fees claimed by the provider for any service provided
27 that otherwise would be a benefit of the plan.

28
29 CHAPTER 16. PARTICIPATION BY MEDICAL SERVICE
30 PROVIDERS

31
32 15580. Every nonexcluded and licensed medical doctor,
33 doctor of osteopathic medicine, doctor of podiatric
34 medicine and doctor of dental surgery shall be entitled to
35 be listed by the plan as a participating provider by
36 making application to Section II of the agency 30 days in
37 advance and shall be supplied by the agency without
38 charge with an account number, all necessary claim
39 submission forms, schedule of medical services and fees,
40 informational material and two durable display signs at

1 least 6 by 12 inches in size stating his or her name,
2 professional title, plan account number, and the following
3 wording: "I am a participating medical service provider
4 in the California Voluntary Medical and Hospital Services
5 Insurance Plan. I will accept your valid plan premium
6 payment receipt to submit my claim for payment to the
7 plan. I may require the payment of an extra fee, which
8 will be stipulated before I treat you, and which will be
9 disclosed on my claim to the plan. You are entitled to
10 know the amount of fee I will be paid by the plan for
11 treating you."

12 15581. Any participating medical service provider may
13 withdraw from the plan at any time upon giving notice
14 to the agency in writing 30 days in advance.

15 15582. Any nonexcluded medical service provider who
16 has voluntarily withdrawn from participation in the plan
17 shall be entitled to be relisted by the plan as a
18 participating provider upon giving notice to Section II of
19 the agency in writing 30 days in advance and not less than
20 30 days after the effective date of prior withdrawal.

21 15583. Every participating medical service provider
22 shall be required to submit a correctly completed official
23 claim form to the plan on account of all services that are
24 benefits of the plan that have been provided to any
25 enrollee, and to disclose on such form the amount of any
26 extra fees charged to the enrollee, or any portion of the
27 scheduled fees payable by the plan that is remitted by the
28 provider.

29 15584. Every participating medical service provider
30 may at his or her own discretion advise any enrollee in
31 advance of treatment that the provider will require the
32 enrollee to pay a reasonable extra fee directly to the
33 provider in addition to the fee payable by the plan; and
34 no such extra fee shall be charged by the provider or
35 payable by the enrollee unless consented to by the
36 enrollee in advance of treatment or if such extra fee
37 would effectively prevent access by the enrollee to
38 necessary medical treatment.

1 **CHAPTER 17. APPROVAL OF PATHOLOGICAL**
2 **LABORATORIES**

3
4 15590. Every pathological laboratory that provides
5 services which are covered benefits of the plan and that
6 desires to be listed by the agency as a participating
7 laboratory shall submit to Section II of the agency in
8 writing on an approved form an application for approval
9 and listing, together with evidence of certification and
10 licensure by all jurisdictional public health, safety and
11 business regulatory agencies and evidence of professional
12 competence in the specific services offered.

13 15591. Section II of the agency shall have final authority
14 to issue a certificate of approval to a laboratory to provide
15 specified services as benefits of the plan and to list the
16 laboratory as a provider of those specified services as
17 benefits of the plan.

18 15592. Any approved laboratory listed as a provider of
19 specified services may from time to time request
20 approval as a provider of other specific services or may
21 request to be delisted as a provider of a specific service.

22 15593. Section II of the agency shall have authority to
23 withdraw approval and listing of a laboratory as a
24 provider of specified services at any time the section has
25 evidence of a lack of professional competence by the
26 laboratory in specified services.

27
28 **CHAPTER 18. PARTICIPATION BY APPROVED**
29 **LABORATORIES**

30
31 15595. Every laboratory which is approved and listed
32 by Section II of the agency as a provider of specified
33 services shall be required to submit a correctly
34 completed official claim form to the plan on account of
35 all such specific services provided to an enrollee at the
36 request of the enrollee's doctor and shall not bill the
37 enrollee for any additional fee for such service.

38 15596. Every laboratory which is approved and listed
39 by Section II of the agency as a provider of specified
40 services shall be supplied without charge by the section

1 with a plan account number, all necessary claim
2 submission forms; a schedule of all professionally
3 recognized pathological laboratory services and related
4 usual, customary and reasonable fees; general
5 informational material concerning the plan, and two
6 durable display signs at least 24 by 14 inches in size stating
7 the name of the laboratory, the name and professional
8 title of the supervising medical doctor, and the following
9 wording: "This laboratory is a participating provider in
10 the California Voluntary Medical and Hospital Services
11 Insurance Plan and your valid plan premium receipt will
12 be accepted for submission of our claim for payment to
13 the plan. No other charge will be made to you for any
14 service we provide that is a covered benefit of the plan.
15 We are approved by the plan to provide the following
16 services only: _____."

18 CHAPTER 19. APPROVAL OF HOSPITALS

19
20 15600. Every hospital that provides services which are
21 classed as benefits of the plan shall be required to submit
22 to Section I of the agency in writing on an approved form
23 an application for approval as a provider together with
24 evidence of certification and licensure by all public
25 health, safety, and business regulatory agencies having
26 jurisdiction and a certified statement of ownership,
27 directors, and officers; a detailed certified inventory of all
28 assets and facilities; certified statement of current
29 financial condition and a summary of income,
30 expenditures and operations for the preceding 48
31 calendar months, or since the commencement of
32 operations, whichever is the shorter time; and the section
33 shall have final authority to approve such hospital and list
34 it as a provider.

36 CHAPTER 20. PARTICIPATION OF HOSPITALS

37
38 15605. Every hospital that is approved by Section I of
39 the agency and listed as a provider of benefits of the plan
40 shall be required to submit a correctly completed official

1 claim form to the plan on account of all services which are
2 covered benefits of the plan and provided to any enrollee
3 and shall not bill any enrollee for any additional charge
4 for such service but may bill any enrollee for additional
5 or optional services requested by the enrollee.

6

7 CHAPTER 21. MEDICAL SERVICES SCHEDULE AND FEES

8

9 15610. Section II of the agency shall compile and
10 publish a schedule of every professionally recognized and
11 defined physical and mental disease or disorder or the
12 symptoms or syndrome thereof, and every related
13 diagnostic and therapeutic service, procedure or
14 treatment; and affix to each such service a fee that is in
15 proportion to the usual, customary and reasonable fee for
16 such service in each general area of the state.

17 15611. Section II of the agency shall consult with the
18 medical professional association or society in each
19 general area in the compilation of the schedule and
20 affixing of fees as provided in Section 15610.

21 15612. Section II of the agency shall consult with the
22 medical professional association or society in each
23 general area in establishing the percentage of each
24 scheduled fee that will be paid by the plan for each
25 scheduled service that is a benefit of the plan.

26 15613. Section II of the agency shall provide a copy of
27 the medical service and fee schedule without charge to
28 every participating medical service provider and shall
29 make additional copies of the schedule available to
30 participating providers and to the medical profession in
31 general at reasonable charge.

32 15614. Section II of the agency shall consult with the
33 medical professional association or society in each area
34 from time to time with respect to making appropriate
35 revisions in the schedule of medical and laboratory
36 services and fees or the percentage of scheduled fees
37 payable by the plan in consideration of changed costs of
38 services or available plan trust funds.

1 CHAPTER 22. PATHOLOGICAL LABORATORY SERVICE
2 SCHEDULE AND FEES

3
4 15620. Section II of the agency shall compile and
5 publish a schedule of every professionally recognized and
6 defined laboratory pathological test and procedure and
7 shall affix to each such service a fee that is in proportion
8 to the usual, customary, and reasonable fee for such
9 service in each general area of the state.

10 15621. Section II of the agency shall consult with the
11 medical professional association or society, and with the
12 pathological laboratory specialist association or society in
13 each general area of the state in the compilation of the
14 schedule of services and fees as provided in Section 15620.

15 15622. Section II of the agency shall consult with the
16 medical professional association or society, and with the
17 pathological laboratory specialist association or society in
18 each general area in establishing the percentage of each
19 scheduled fee that will be paid by the plan for each
20 service that is a benefit of the plan.

21 15623. Section II of the agency shall provide a copy of
22 the pathological laboratory service and fee schedule
23 without charge to every approved and participating
24 laboratory service provider and shall make additional
25 copies of the schedule available to participating providers
26 and to the medical profession in general at a reasonable
27 charge.

28 15624. Section II of the agency shall consult with the
29 medical professional association or society and with the
30 pathological laboratory specialist association or society in
31 each general area annually with respect to making
32 appropriate revisions in the schedule of laboratory
33 services and fees or the percentage of scheduled fees
34 payable by the plan to laboratory service providers.

35
36 CHAPTER 23. HOSPITAL CHARGES AND RATES

37
38 15630. Section I of the agency shall provide each
39 approved hospital with a schedule of per diem rates and
40 charges that will be paid by the plan to that hospital for

1 each specified service or item that is a benefit of the plan
2 and which is ordered on behalf of an enrollee by an
3 attending medical doctor, doctor of osteopathic
4 medicine, doctor of podiatric medicine, or doctor of
5 dental surgery having staff privileges in the hospital with
6 the consent of the hospital, and who is attending the
7 enrollee with service which is a benefit of the plan.

8 15631. The per diem rates and charges for specified
9 services and items to be paid by the plan to each hospital
10 shall be set by Section I of the agency and shall be based
11 on each hospital's certified annual financial and operating
12 cost statement, including the cost of amortizing every
13 capitalized asset owned or obligated by a hospital and
14 reasonable interest on all bonded and secured debt
15 obligated prior to the date of inception of the plan, and
16 a projected annual operating budget for each
17 forthcoming calendar year. Insofar as possible or practical
18 the per diem bed rate established and paid to each
19 hospital shall be for the lowest standard category of
20 accommodation in keeping with the medical
21 requirements of each patient and shall include an equal
22 share of all capital and operating costs of all facilities
23 within each hospital such as operating rooms,
24 laboratories, radiological equipment and the like; such
25 per diem bed rates to be subject to adjustment,
26 supplementation or reduction in relation to varying bed
27 utilization rates in each hospital and the length of
28 hospitalization of each patient. Rates payable for
29 outpatient visits shall include an equal share for each
30 patient of all capital and operating costs of all outpatient
31 or emergency ward facilities in each hospital.

32 15632. After the date of inception of the plan, the per
33 diem rates and charges for specific services and items to
34 be paid by the plan to each approved hospital shall not
35 include the cost of operation or amortization of any
36 capital expenditure that has not been specifically
37 approved in advance by Section I of the agency with
38 respect to the public interest that is likely to be served by
39 such capital expenditure.

1 CHAPTER 24. FORM OF CLAIM FOR BENEFITS OF PLAN

2

3 15635. All claims for service by participating medical
4 service, laboratory service, and hospital service providers
5 shall be submitted to the plan within 60 days of the last
6 day of the month in which the service was provided or
7 completed, and on a correctly completed form supplied
8 by the agency and which shall be printed on a standard
9 keypunch computer entry card approximately 7³/₈ inches
10 by 3¹/₄ inches in size with a carbon insert and a tissue copy
11 for retention by the provider.

12 15636. All claims by all participating providers shall
13 state the following items of information:

14 (a) Provider's name, address, and plan account
15 number.

16 (b) Provider's assignee of payment, if any.

17 (c) Medical professional association or society, or
18 review organization having jurisdiction.

19 (d) Enrollee's name, address, and plan account
20 number.

21 (e) Date of each separate service inclusive in time.

22 (f) Duration of each service in days, hours, and
23 minutes.

24 (g) Place of service as: office, home, hospital,
25 emergency room, outpatient clinic, or elsewhere.

26 (h) Sequential number of each separate service in
27 related treatment.

28 (i) Schedule number of service, procedure, or item.

29 (j) Related scheduled fee or charge for service,
30 procedure, or item.

31 (k) Percentage of scheduled fee payable by the plan.

32 (l) Medical diagnosis or description of patient's
33 complaint.

34 (m) Name of referring or admitting doctor or
35 referred-to doctor.

36 (n) Certifying signature of attending doctor.

37 15637. In addition to the items of information specified
38 in Section 15636, all medical service providers shall be
39 required to state on their claim form the amount, if any,
40 of extra fees charged the enrollee, or any portion of the

1 scheduled fees payable by the plan that are remitted by
2 a provider.

3 15638. All information on each claim submitted by each
4 participating provider shall be keypunched for entry into
5 a computer according to a program that will enable the
6 generation of the following output:

7 (a) Itemized monthly statement of all accepted claims
8 and a total payment check for each provider.

9 (b) Itemized cumulative statement for each enrollee
10 showing all claimed services and amounts paid to
11 providers on behalf of enrollees.

12 (c) Cumulative statements showing the quantity and
13 character of utilization of plan benefits by each provider
14 and each enrollee, for use by medical professional
15 associations or societies having jurisdiction in assessing
16 individual and general patterns of medical and hospital
17 practice and utilization of plan benefits on a continuing
18 basis, as provided in Sections 15651 and 15652.

19

20 CHAPTER 25. AUDITING OF CLAIMS

21

22 15640. Every claim for service submitted by a
23 participating provider and every claim by an enrollee for
24 reimbursement for payment to a nonexcluded and
25 nonparticipating medical service provider, as provided in
26 Section 15575, shall be audited by the agency or its agents
27 with respect to the validity of the information specified
28 and required in Section 15636 and when such information
29 is lacking or found to be incorrect or invalid or if the
30 claimed service is not a specified benefit of the plan, the
31 claim shall be so noted and returned to the claimant.

32 15641. The agency or its agents during the auditing of
33 any claim shall make no assessment of the medical
34 validity, necessity, or legality of the service claimed as a
35 benefit of the plan; but where there is reasonable doubt
36 of the medical validity, necessity, or legality of any such
37 claimed service the claim shall be referred to the
38 directors of the agency for assessment or reference to the
39 medical professional association or society or review
40 organization having jurisdiction for assessment and

1 recommendation respecting acceptance and payment of
2 the claim, as provided in Section 15650.

3
4 CHAPTER 26. PAYMENT OF CLAIMS

5
6 15645. Every submitted claim for service that is a
7 benefit of the plan and which has been approved for
8 payment by audit and which has not been referred for
9 assessment as provided in Section 15641, shall be paid by
10 the plan within 45 days after the last day of the calendar
11 month in which the claim was submitted by the provider
12 or enrollee.

13 15646. When more than one claim for service is
14 submitted by a participating provider or enrollee in any
15 one month, all approved claims shall be consolidated in
16 a single payment to the provider or enrollee within the
17 period specified in Section 15645.

18
19 CHAPTER 27. ASSESSMENT OF CLAIMS AND
20 UTILIZATION OF PLAN BENEFITS

21
22 15650. The directors of the agency shall make final
23 determination and assessment of the medical validity,
24 necessity, and legality of any claimed service that is a
25 benefit of the plan and to this end may enter into an
26 agreement from year to year with any medical
27 professional association or society or established review
28 organization having jurisdiction in any general area of
29 the state to consult with and advise the directors in
30 making such determinations and assessments and
31 approving or disapproving payment for claimed services.

32 15651. The agency may enter into an agreement from
33 year to year with any medical professional association or
34 society or review organization having jurisdiction in any
35 general area of the state to periodically or continuously
36 review and assess the cumulative and continuing
37 utilization of plan benefits by participating providers and
38 enrollees and to continuously advise the agency of any
39 utilization of plan benefits that appears to be illegal,
40 excessive, unwarranted, medically unnecessary, or

1 medically invalid, according to applicable laws and the
2 normal and accepted standards of medical practice in the
3 area.

4 15652. To effectuate any agreement provided in
5 Section 15651, the agency shall provide the medical
6 professional association or society or review organization
7 having jurisdiction with cumulative summaries of all
8 claims by each participating provider and enrollee for
9 services that are benefits of the plan and which are
10 categorized according to the type and nature of the
11 service.

12 15653. A medical professional association or society or
13 review organization having jurisdiction under agreement
14 as provided in Sections 15650 and 15651 may recommend
15 to the directors of the agency the application and nature
16 of sanctions or disciplinary action against any
17 participating provider or enrollee found to be utilizing
18 the benefits of the plan illegally, excessively,
19 unwarrantedly, or without medical necessity or validity.

20 15654. In response to the recommendations of any
21 medical professional association or society or review
22 organization having jurisdiction, as provided in Section
23 15653, the directors of the agency shall have authority to
24 order a temporary or permanent reduction in the
25 percentage of scheduled fees or rates payable in the
26 future to a participating provider or to temporarily or
27 permanently exclude a medical or laboratory service
28 provider from future participation in the plan or to serve
29 notice on an enrollee of a temporary or permanent
30 reduction in the benefits of the plan that will be
31 reimbursable to or payable on behalf of enrollees.

32 15655. The agency shall pay to any medical professional
33 association or society or review organization having
34 jurisdiction with which it has entered into an agreement
35 as provided in Sections 15650 and 15651, a negotiated fee
36 in the amount of 0.5 percent or more or less than 0.5
37 percent of the total dollar amount of providers' or
38 enrollees' claims, reviewed during each three-month
39 period.

1 CHAPTER 28. STATEMENT OF BENEFITS PAID

2
3 15660. The agency shall deliver to each enrollee a
4 statement, as provided in subdivision (b) of Section
5 15638, listing every service claimed to have been
6 provided to the enrollee and the amount paid to each
7 provider on account of such claimed service during any
8 period of time as may be determined by the agency with
9 respect to any enrollee.

10 15661. As a condition of enrollment in the plan every
11 enrollee shall be required to notify the agency of any
12 claims for service by any provider which the enrollee has
13 reason to believe were not, in fact, provided; and such
14 obligation shall be noted on all statements furnished to
15 enrollees.

16
17 CHAPTER 29. RIGHT OF RECOVERY

18
19 15665. Any other remedies or actions against providers
20 and enrollees provided in this division notwithstanding,
21 the agency shall have the right to proceed in law to
22 recover from any provider or enrollee any amounts paid
23 by the plan for services or benefits claimed but not, in
24 fact, provided or received, or which are determined to be
25 services or benefits excluded from the plan, or services
26 provided by nonapproved or nonparticipating hospitals
27 and laboratories, or by medical service providers
28 excluded from the plan by the directors.

29
30 CHAPTER 30. EXCLUSION OF PARTICIPANTS

31
32 15670. The agency shall have authority to temporarily
33 or permanently exclude from participation in the plan
34 any enrollee or provider of laboratory or medical service
35 found to have made, with intent to defraud the plan, any
36 false claim for payment for service provided or received;
37 or as provided in Section 15654, and in addition to the
38 right of recovery as provided in Section 15665.

39 15671. The agency shall have authority to temporarily
40 or permanently exclude from participation in the plan

1 any provider of medical services found to have charged
2 any enrollee an extra fee of such amount as to effectively
3 prevent that enrollee's access to medically necessary
4 service; or to have acted in concert or by prior agreement
5 with any other providers of medical service to regularly
6 and habitually charge enrollees a scale of extra fees in
7 excess of scheduled fees payable by the plan.

8 15672. Any exclusion order made by the agency under
9 Section 15654, 15670, or 15671 may be appealed by the
10 excluded party to the directors or the agency and
11 thereafter to any state court having jurisdiction at any
12 time within one year of the effective date of such order.

13 15673. The agency shall publish the names of every
14 medical and laboratory service provider excluded from
15 the plan, as provided in Sections 15654 and 15670 and shall
16 advise each enrollee that they will not be reimbursed by
17 the plan for any service received from any excluded
18 provider, except when such exclusion order is under
19 appeal or revoked as provided in Section 15671.

20

21

CHAPTER 31. ADDITIONAL BENEFITS

22

23 15675. Every paid-up enrollee in the plan shall be
24 entitled to reimbursement in the lesser amount of either
25 the scheduled fee or charge payable by the plan to a
26 participating provider in the area of residence of the
27 enrollee, or the actual fee or charge paid by the enrollee
28 to a medical doctor, pathological laboratory, or general
29 medical hospital outside of the state for any service that
30 ordinarily would be a benefit of the plan in the state while
31 the enrollee was traveling outside of the state or
32 temporarily living outside the state for a period not
33 exceeding one year from the enrollee's date of departure
34 from the state, upon submission to the agency of a valid
35 receipted statement of payment for such service within
36 30 days of the return to the state of the enrollee.

37 15676. The benefits provided in Section 15675 shall
38 apply to a child born outside of the state to a mother who
39 is an enrollee in the plan, and who would otherwise be
40 entitled to the benefits provided in Section 15675, if the

1 child is enrolled in the plan and the applicable premium
2 is paid on its behalf within 30 days of birth, as provided
3 in Section 15570.

4 15677. Not less than two years after the effective date
5 of inception of the plan, the agency directors shall
6 consider the advisability and feasibility of offering
7 additional benefits to enrollees, such as but not
8 necessarily including or limited to payment or
9 reimbursement for dental service, prescribed drugs,
10 prosthetics, home nursing; chiropractic treatment; and
11 Christian Science healing; on a basis of full or partial cost
12 or a scheduled annual amount; to be included within the
13 established premiums of the plan or in consideration of
14 additional and optional premiums; and shall bring their
15 recommendations before the Legislature for appropriate
16 amendment of this division.

17 15678. Any subscriber who has paid premiums on
18 account of any enrollee as provided in Chapter 9
19 (commencing with Section 15540) and with the mutual
20 consent and agreement of the enrollee shall be entitled
21 to enroll the enrollee as a member in any nonexcluded
22 and participating prepaid group medical practice
23 establishment or health maintenance organization
24 providing medical, hospital, or other health services to its
25 members, from which establishment or organization the
26 enrollee shall exclusively receive all necessary medical,
27 hospital, or other health services so long as the enrollee
28 elects to remain a member of that establishment or
29 organization. The plan shall pay the establishment or
30 organization on behalf of the enrollee a monthly or
31 annual payment not exceeding the average of the
32 monthly or annual premiums paid by all subscribers to
33 the plan together with general fund contributions to the
34 plan trust fund and no other payments shall be made by
35 the plan to or on behalf of the enrollee for benefits of the
36 plan. Any plan enrollee enrolled as a member of a
37 prepaid group medical practice establishment or health
38 maintenance organization may give the plan notice of
39 election to withdraw from such membership not less than
40 15 days in advance of the next due contractual payment

1 to be made by the plan on behalf of the enrollee to such
2 establishment or organization.

3

4 CHAPTER 32. AMENDMENT OF PREMIUMS AND
5 MATCHING FUNDS
6

7 15680. Not less than three years after the effective date
8 of inception of the plan, the directors of the agency may
9 recommend to the Legislature an appropriate increase in
10 the schedule of premiums set out in Sections 15540 and
11 15541, if it is then found that the actual costs of medical,
12 laboratory and hospital services that are benefits of the
13 plan exceed the apportioned and reserved income from
14 subscribers' premiums, as provided in Section 15560, and
15 matching appropriations of funds, as provided in Section
16 15561.

17

18 CHAPTER 33. AMENDMENT OF THE SOCIAL SECURITY
19 AND MEDICAID ACTS
20

21 15685. As a prerequisite condition to this division
22 becoming operative, the State of California shall obtain
23 from the government of the United States an agreement
24 to amend the laws and acts governing those federal
25 programs generally known and referred to as Medicare
26 and Medicaid, enabling the transfer and application to
27 the California Voluntary Medical and Hospital Services
28 Insurance Agency Trust Fund, provided by Section
29 15555, all funds, grants and sums of money to which the
30 state and the residents of the state would ordinarily be
31 entitled to receive by agreement or statute under the
32 provisions and operation of those programs in payment
33 or reimbursement for medical and hospital services.

34 15681. In consideration of the agreement between the
35 State of California and the government of the United
36 States, as provided in Section 15680, every enrollee in the
37 plan shall assign, transfer or pay to the agency all medical
38 and hospital service benefits payments or reimbursement
39 to which the enrollee shall be entitled or receive under
40 the provisions and operation of the federal Medicare and

1 Medicaid programs.

2

3

CHAPTER 34. ARBITRATION

4

5 15690. It shall be a condition of enrollment and
6 participation in the plan that every enrollee and provider
7 shall agree to refer within the time allowed by any
8 governing statute of limitation every claim or demand for
9 damages resulting from alleged negligence or
10 malpractice in the provision of any service that is a
11 benefit of the plan, for arbitration to an arbitration board
12 convened within 30 days of the date of filing of the claim
13 and comprised of one licensed doctor and one licensed
14 attorney nominated by the complainants together and
15 severally, and one licensed doctor and one licensed
16 attorney nominated by the defendants together and
17 severally, and one licensed medical doctor nominated by
18 the medical professional association or society having
19 jurisdiction, and one licensed attorney nominated by the
20 bar association or society having jurisdiction.

21 15691. All sessions of the board of arbitration provided
22 in Section 15690 shall be chaired by the attorney
23 nominated by the bar association or society having
24 jurisdiction, and shall be held in quarters provided by the
25 agency.

26 15692. The medical doctor nominated to the board of
27 arbitration by the medical professional association or
28 society having jurisdiction shall participate in the
29 questioning and discussions of each session but shall not
30 have a vote in any final decision or ruling by the board.

31 15693. A majority of the voting members of a board of
32 arbitration, as provided in Sections 15691 and 15692 shall
33 determine and assess the degree of and responsibility for
34 negligence or culpable malpractice, if any, by the
35 defendants together or severally and the amount of
36 damages, if any, sustained by the complainants together
37 or severally as a consequence of such negligence or
38 culpable malpractice, if any, by the defendants together
39 or severally.

40 15694. If a board of arbitration, as provided in Sections

1 15690, 15691, 15692, and 15693, finds that complainants
2 together or severally have sustained an amount of
3 damages as a consequence of the negligence or culpable
4 malpractice by the defendants together or severally, in
5 the provision of any service that is a benefit of the plan,
6 the agency shall pay to the complainants together or
7 severally the amount of all damages so determined and
8 assessed, in full settlement of the complainants' claim,
9 unless the findings of the board of arbitration are
10 appealed as provided in Section 15698.

11 15695. The agency shall have the right to and shall
12 endeavor by every means and recourse provided by law
13 to recover from any defendants together or severally any
14 amounts of damages paid to any complainants together or
15 severally as provided in Section 15694, together with any
16 sessional fees paid to the members of the board of
17 arbitration as provided in Section 15696, subject to appeal
18 as provided in Section 15698; and to this end may
19 withhold all or any portion of any payments due the
20 defendants together or severally for past or future
21 services that are benefits of the plan.

22 15696. The agency shall enter into an agreement with
23 each member nominated to a board of arbitration, as
24 provided in Section 15690, to pay each such member a
25 sessional fee in the amount of thirty-five dollars (\$35) per
26 hour or more or less than thirty-five dollars (\$35) per
27 hour for each hour or portion of an hour devoted by each
28 member to his duties on the board of arbitration.

29 15697. If the majority of voting members of a board of
30 arbitration, as provided in Sections 15690 and 15692, find
31 that any allegation of negligence or malpractice or any
32 claim for damages by complainants together or severally
33 is wholly without merit or capricious or malicious, the
34 agency shall have the right to, and shall endeavor to,
35 recover by every means and recourse in law from the
36 complainants together or severally the amounts of all
37 sessional fees paid to members of the board of arbitration
38 as provided in Section 15696.

39 15698. Any finding or assessment by a board of
40 arbitration as provided in Sections 15693 and 15697 may

1 be appealed to any state court having jurisdiction by the
2 defendants together or severally or the complainants
3 together or severally or by the directors of the agency if
4 damages are assessed and payable to complainants
5 together or severally as provided in Section 15694.

6 7 CHAPTER 35. LIMITED SCOPE OF PLAN

8
9 15700. The purpose of this division is to provide only for
10 the establishment of a state voluntary insurance agency
11 and plan to pay all reasonable costs of all necessary and
12 appropriate medical, pathological laboratory and hospital
13 services, and such other additional benefits as may be
14 added in the future, as provided in Chapter 31
15 (commencing with Section 15675), for all enrollees when
16 and where such services are available from approved,
17 participating and nonexcluded providers; and the
18 resources of the agency and plan shall not be used in any
19 way directly to regulate the quality or availability of, or
20 to establish or operate, such services; and if adequate
21 services are not available when and where required by
22 enrollees, the agency and plan shall have no
23 responsibility or liability to provide such services; and in
24 consideration of the aforestated limited scope and
25 purpose of this division, enrollment in and subscription to
26 the plan shall be voluntary for all enrollees and
27 subscribers as provided in Section 15565; and by so
28 limiting the scope and purpose of this division to the
29 providing of economic access to existing and available
30 health services any deficiencies in the quality, quantity,
31 modes, methods, economics and distribution of those
32 services should be clearly revealed and may then be
33 corrected or improved by the health care profession or
34 appropriate public or private agencies, outside of an
35 independent of the California Voluntary Medical and
36 Hospital Services Insurance Plan and Agency.

37 38 CHAPTER 36. ESTIMATED COST OF PLAN

39
40 15705. The cost of medical and hospital service is

1 represented by the gross revenues of the physicians and
2 hospitals that provide the service. The cost of the services
3 that are benefits of the plan created by this division can
4 be estimated as follows:

5 (a) The Internal Revenue Service publication
6 numbered 438 (3/76) states that a total of 20,306
7 individual office-based physicians in California reported
8 total gross income, including other than professional fees,
9 of one billion one hundred fifty-two million eight
10 hundred fifty-one thousand dollars (\$1,152,851,000) or an
11 average of fifty-six thousand seven hundred
12 seventy-three dollars (\$56,773) each, in 1972. In addition,
13 approximately 6,000 other physicians as partners in
14 partnerships reported average gross incomes of
15 approximately eighty-two thousand dollars (\$82,000)
16 each (these latter figures are extrapolated from the IRS
17 data which include physician partnership returns with
18 those of other health service professionals such as
19 dentists). The combined total of approximately 26,306
20 individual and partnership physicians reported average
21 gross incomes of approximately sixty-two thousand five
22 hundred dollars (\$62,500) each or a total of
23 approximately one billion six hundred forty-five million
24 dollars (\$1,645,000,000). If the average gross revenues of
25 all office-based physicians increased to eighty-eight
26 thousand dollars (\$88,000) each and the number of
27 physicians increased to 28,000 by fiscal year 1980, their
28 total revenue would then amount to approximately two
29 billion four hundred sixty-four million dollars
30 (\$2,464,000,000) or about one hundred seventeen dollars
31 (\$117) per capita for 21,000,000 residents of the state, of
32 which approximately 75 percent or ninety dollars (\$90)
33 per capita would be payable as benefits of the plan for
34 medically necessary medical services.

35 (b) The Social Security Bulletin (3/76) estimates that
36 in 1975 the total expenses of all publicly and
37 privately-owned acute and extended care community
38 hospitals for all inpatient and outpatient services,
39 including the salaries of approximately 70,000 staff
40 physicians, were about thirty-five billion six hundred

1 million dollars (\$35,600,000,000) or about one hundred
2 seventy dollars (\$170) per capita for the U. S. civilian
3 population of 210,000,000. If national average hospital
4 expenses increase to about two hundred twenty-five
5 dollars (\$225) per capita by 1980 and if California costs
6 exceed the national average by about 10 percent and are
7 approximately two hundred fifty dollars (\$250) per
8 capita, approximately 75 percent or one hundred
9 eighty-nine dollars (\$189) per capita would be payable as
10 benefits of the plan for medically necessary hospital
11 service.

12 (c) The combined cost of medical and hospital benefits
13 of the plan, as itemized above, would be about two
14 hundred seventy-nine dollars (\$279) per capita or a total
15 of five billion eight hundred fifty-nine million dollars
16 (\$5,859,000,000) if 21,000,000 residents of the state
17 enrolled in the plan in 1980.

18 15706. The premium schedule for subscribers to the
19 plan established by Chapter 9 (commencing with Section
20 15540) should result in an average income to the plan of
21 not less than twelve dollars (\$12) a month or one hundred
22 forty-four dollars (\$144) a year per enrollee or a total of
23 three billion twenty-four million dollars (\$3,024,000,000)
24 if 21,000,000 residents enrolled in the plan, which,
25 together with matching state general funds, would
26 amount to a plan trust fund of six billion forty-eight
27 million dollars (\$6,048,000,000).

28 15707. Chapter 12 (commencing with Section 15560)
29 restricts total administrative expenses and unrecoverable
30 arbitration award payments to 3 percent of available plan
31 trust funds or one hundred eighty-one million four
32 hundred forty thousand dollars (\$181,440,000) or about
33 nine dollars (\$9) a year per capita, if 21,000,000 residents
34 enrolled in the plan.

35 15708. If 21,000,000 residents enrolled in the plan by
36 1980 and medical and hospital benefits amounted to five
37 billion eight hundred fifty-nine million dollars
38 (\$5,859,000,000), as postulated in subdivision (c) of
39 Section 15705, and administrative expenses amounted to
40 one hundred eighty-one million four hundred forty

1 thousand dollars (\$181,440,000), as postulated in Section
2 13702, and total plan trust funds amounted to six billion
3 forty-eight million dollars (\$6,048,000,000), as postulated
4 in Section 15707, the plan would have an operating
5 surplus of seven million five hundred sixty thousand
6 dollars (\$7,560,000).

7 15709. Initial enrollment at inception of the plan
8 probably would not exceed five million and probably not
9 exceed 10 million by the end of the first two years of
10 operation. The majority of initial enrollees would
11 probably be in the lowest income categories, presently
12 receiving medical and hospital care under either or both
13 Medicare and Medi-Cal and therefore entitled to pay
14 minimum premiums of three dollars (\$3) per month and
15 to receive the maximum general funds subsidy of
16 twenty-one dollars (\$21) per month. The general funds
17 subsidy for five million enrollees would thereby possibly
18 amount to one billion two hundred sixty million dollars
19 (\$1,260,000,000) per year. Such a subsidy would be some
20 one hundred fifty-nine million four hundred sixty-six
21 thousand eight hundred dollars (\$159,466,800) less than
22 estimated 1975 Medi-Cal expenditures of one billion four
23 hundred nineteen million four hundred sixty-six
24 thousand eight hundred dollars (\$1,419,466,800) for
25 medical and hospital services and associated
26 administrative expenses that would be replaced by this
27 plan.

28 15710. Approximately half or 2.5 million of the initial
29 five million enrollees in the plan probably would be
30 entitled to Medicare benefits for medical and hospital
31 care, amounting to approximately one billion two
32 hundred million dollars (\$1,200,000,000), which would be
33 available to the plan under agreement with the United
34 States government as provided in Sections 15680 and
35 15681. These in-lieu Medicare funds would more than
36 offset the higher medical and hospital expenses incurred
37 by elderly and low-income patients.

38 15711. During subsequent years, the intake of enrollees
39 would trend toward younger and higher-income
40 categories who would pay higher premiums and require

1 less medical and hospital service. When 20 million
 2 persons are enrolled, premiums would probably average
 3 in excess of twelve dollars (\$12) per capita per month, at
 4 which point state general funds subsidies would amount
 5 to approximately two hundred forty million dollars
 6 (\$240,000,000) per month or two billion eight hundred
 7 eighty million dollars (\$2,880,000,000) per year, being
 8 some two hundred sixty million five hundred thirty-three
 9 thousand two hundred dollars (\$260,533,200) more than
 10 current Medi-Cal expenditures of one billion four
 11 hundred nineteen million four hundred sixty-six
 12 thousand eight hundred dollars (\$1,419,466,800) and one
 13 billion two hundred million dollars (\$1,200,000,000) in
 14 Medicare payments to California residents for medical
 15 and hospital care.

16 SEC. 2. The sum of _____ dollars (\$_____) is
 17 hereby appropriated from the General Fund for
 18 allocation in accordance with the following schedule:

- 19
- 20 (a) To the California Voluntary Medical
 21 and Hospital Services Insurance Agency
 22 to enable the agency to carry out the
 23 responsibilities and functions specified
 24 in Section 5510 within the time limits
 25 specified..... \$_____
 - 26 (b) To the California Voluntary Medical
 27 and Hospital Services Insurance
 28 Agency Trust Fund for the payment of
 29 claims for the benefits of the plan and
 30 operating and administrative costs as
 31 specified in Section 15555..... \$_____
- 32

O