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Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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1980 – AB 3068 (Bannai)

Pages 2-26

1982 – AB 1262 (Torres)

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1988 – AB 2647 (Campbell)

Pages 77-79

October 2007

ASSEMBLY BILL

No. 3068

Introduced by Assemblyman Bannai

March 7, 1980

REFERRED TO COMMITTEE ON FINANCE, INSURANCE, AND COMMERCE

An act to add Part 6.5 (commencing with Section 12700) to Division 2 of the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 3068, as introduced, Bannai (Fin., Ins., & Com.). Comprehensive health insurance.

The existing law has no provisions relating to qualified comprehensive health insurance.

This bill would enact provisions relating to comprehensive health insurance which would, among other things, do all of the following:

(1) Require, as a condition to transacting health insurance business in this state, a carrier offering group or individual policies of health insurance, to offer qualified comprehensive health insurance through group policies and through individual policies and by participating in the California Comprehensive Health Insurance Association, created by the bill.

(2) Require every employer with respect to any group health insurance policy delivered or issued for delivery in this state, or a self-insured employee welfare benefit plan established in this state, with specified exceptions, to offer to its employees a plan of coverage providing health benefits, as specified.

(3) Specify those individuals eligible to be covered under

a group comprehensive health insurance plan offered pursuant to the bill.

(4) Establish a nonprofit legal entity to be known as the California Comprehensive Health Insurance Association, for the purpose of assuring that qualified comprehensive health insurance is made available throughout the year to each California resident applying for such coverage.

(5) Require that each carriers, health maintenance organizations and self-insurers providing health insurance or health care services in this state be a member of such association.

(6) Provide for the establishment of a board of directors of the association to be selected by the members of the association subject to the approval of the insurance commissioner.

(7) Require such association to submit to the commissioner a plan of operation for the association.

(8) Provide that the association be subject to examination by the commissioner.

(9) Require the State Department of Social Services to secure qualified comprehensive health insurance coverage for all eligible recipients and to enter into contractual agreements with carriers of the association to perform physical intermediary functions.

(10) Make various technical and conforming changes.

Under existing law, Sections 2231 and 2234 of the Revenue and Taxation Code require the state to reimburse local agencies and school districts for certain costs mandated by the state. Other provisions require the Department of Finance to review statutes disclaiming these costs and provide, in certain cases, for making claims to the State Board of Control for reimbursement.

This bill provides that no appropriation is made by this act pursuant to Section 2231 or 2234, but recognizes that local agencies and school districts may pursue their other available remedies to seek reimbursement for these costs.

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

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

1 SECTION 1. Part 6.5 (commencing with Section
2 12700) is added to Division 2 of the Insurance Code, to
3 read:

4
5 PART 6.5. COMPREHENSIVE HEALTH
6 INSURANCE.
7

8 12700. As used in this part:

9 (a) "Association" means the California
10 Comprehensive Health Insurance Association
11 established under Section 12712.

12 (b) "Carrier" means an insurer providing medical,
13 hospital, or surgical expense incurred health insurance
14 policies.

15 (c) "Commissioner" means the Insurance
16 Commissioner.

17 (d) "Eligible expenses" means those charges for
18 health care services and articles provided for in Section
19 12703.

20 (e) "Employer" means any person, partnership,
21 association, trust, estate, corporation, whether foreign or
22 domestic, or legal representative, trustee in bankruptcy,
23 receiver or trustee, or the legal representative of a
24 deceased person, including the State of California and
25 each county, city, and city and county therein, which has
26 in its regular employ one or more employees during any
27 calendar year after the effective date of this part.

28 (f) "Health care facility" means any institution
29 providing health care services that is licensed in this state,
30 including institutions engaged principally in providing
31 services for health maintenance organizations or for the
32 diagnosis or treatment of human disease, pain, injury,
33 deformity, or physical condition, including a general
34 hospital, special hospital, mental hospital, public health
35 center, diagnostic center, treatment center,
36 rehabilitation center, extended care facility, skilled
37 nursing facility, nursing home, intermediate care facility,
38 tuberculosis hospital, chronic disease hospital, maternity

1 hospital, outpatient clinic, home health care agency,
2 bioanalytical laboratory, or central services facility
3 servicing one or more such institutions, but excluding
4 institutions that provide healing solely by prayer.

5 (g) "Health care institutions" means skilled nursing
6 facilities, home health agencies, and hospitals.

7 (h) "Health care provider" means any physician,
8 hospital, or other person who is licensed in this state to
9 furnish health care services.

10 (i) "Health care services" means any services or
11 products included in the furnishing to any individual of
12 medical or dental care, or hospitalization, or incident to
13 the furnishing of such care or hospitalization, as well as
14 the furnishing to any person of any other services or
15 products for the purpose of preventing, alleviating,
16 curing, or healing human illness or injury.

17 (j) "Health insurance" means hospital, surgical, and
18 medical expense incurred policies, nonprofit hospital
19 service plans, and self-insured employee welfare benefit
20 plans; however, the term "health insurance" does not
21 include short-term travel accident policies, accident only
22 policies, fixed indemnity policies, automobile medical
23 payment, or incidental coverage issued with or as a
24 supplement to liability insurance.

25 (k) "Health maintenance organization" means any
26 person or entity who undertakes to provide for, arrange
27 for, pay for, or reimburse any part of the cost of any
28 health care services, and at least a part of such
29 arrangement consists of arranging for or the provision of
30 health care services, as distinguished from
31 indemnification against the cost of such services, on a
32 prepaid basis.

33 (l) "Insured" means all individuals who are provided
34 qualified comprehensive health insurance coverage
35 under an individual or group policy, including all
36 dependents and other insured persons, if any.

37 (m) "Medical" means medical assistance funded by
38 state and federal agencies.

39 (n) "Medicare" means Title XVIII of the Social
40 Security Act (42 U.S.C. 1395 et seq.).

1 (o) "Policy" means a contract, policy, or plan of health
2 insurance.

3 (p) "Policy year" means a 12-month period during
4 which a policy provides coverage or obligates the carrier
5 to provide health care services.

6 (q) "Qualified comprehensive health insurance"
7 means the coverage specified in Section 12703 of this part.

8 (r) "Qualified psychologist" means a person who:

9 (1) Is licensed or certified as a psychologist;

10 (2) Has a doctoral degree in clinical psychology; and

11 (3) Has at least two years of supervised experience in
12 clinical psychology in a licensed hospital or mental health
13 center.

14 (s) "Self-insurer" means an employer who provides
15 services, payment for, or reimbursement of any part of
16 the cost of health care services other than payment of
17 insurance premiums or subscriber charges to a carrier.

18 (t) "Services of a skilled nursing facility" means that
19 such services must commence within 14 days following a
20 confinement of at least three consecutive days in a
21 hospital for the same condition.

22 (u) "Skilled nursing facility," "home health agency,"
23 "hospital," and "home health services" have the
24 meanings assigned to them pursuant to federal law (42
25 U.S.C. 1395).

26 12701. (a) As a condition to transacting health
27 insurance business in this state, a carrier shall, in
28 connection with the offering of every individual or group
29 health insurance policy to be issued for delivery in
30 California, offer qualified comprehensive health
31 insurance through group policies, through individual
32 policies, and by participating in the California
33 Comprehensive Health Insurance Association under
34 Section 12712; or by a combination of any of the methods
35 specified herein.

36 Such obligation to offer qualified comprehensive
37 health insurance required shall not arise due to the fact
38 that a carrier issues short term, travel accident policies,
39 accident policies, accident only policies, fixed indemnity
40 policies, automobile medical payment, or incidental

1 coverages issued with or as a supplement to liability
2 policies.

3 (b) Any health maintenance organization or
4 self-insurance plan shall include a conversion privilege
5 for its members, covered employees, and other covered
6 individuals under which qualified comprehensive health
7 insurance coverage is available immediately upon
8 termination of coverage under the health maintenance
9 organization or self-insurance plans. Conversion benefits
10 shall be made available through the association or
11 otherwise.

12 12702. (a) Every employer with respect to any group
13 health insurance policy delivered or issued for delivery in
14 this state, or a self-insured employee welfare benefit plan
15 established in this state, except as provided below, shall
16 offer to its employees a plan of coverage which provides
17 benefits equivalent to those enumerated in subdivision
18 (a) of Section 12703, subject to the exclusions permitted
19 by subdivision (c) of Section 12703. Employers shall
20 inform their employees of the availability of qualified
21 comprehensive health insurance. The employer's
22 obligation to make such coverage available shall arise
23 when the employer has either:

24 (1) Twenty-five or more employees and 50 percent or
25 more of them apply for coverage; or

26 (2) Less than 25 employees and 10 employees apply
27 for such coverage.

28 If more than 50 percent of the employees apply for
29 qualified comprehensive health insurance coverage, an
30 employer shall make available the qualified
31 comprehensive coverage to all of its covered employees.
32 However, an employer or carrier may discontinue a plan
33 providing qualified comprehensive health insurance or
34 equivalent benefits when enrollment drops below 50
35 percent of the employees or less than 10 if there are less
36 than 25 total employees. No other provision of this part
37 may be construed to limit the ability of employees to
38 select among different health insurance options offered
39 by employers at any time. The term "employee" shall not
40 include employees who work less than 20 hours per week

1 and 26 weeks per year.

2 (b) The plan shall be financed from funds solely
3 contributed by the employer or solely by the employees
4 or any combination thereof, subject to the condition that
5 the employer contribute at least the same absolute dollar
6 amount for purchase or provision of the coverage on
7 behalf of each employee as the employer pays or would
8 pay for any other health benefit plan continued or made
9 available to employees.

10 (c) The requirements of this section shall not apply to:

11 (1) Employers providing employees with health
12 benefits coverage under terms of a collectively bargained
13 agreement of the employer and the employees' union
14 representatives;

15 (2) Employers with fewer than 10 employees; or

16 (3) Employers that demonstrate compliance with the
17 purpose of this part by submitting to the commissioner a
18 plan of employee coverage that is determined by the
19 commissioner to be no less favorable to the insured or
20 covered member than the qualified comprehensive
21 coverage required to be made available hereunder.
22 Employers demonstrating such compliance shall not be
23 required to meet any other requirements of this section.
24 The commissioner may adopt appropriate equivalency
25 tables or guidelines to be used in determining whether
26 the employer's plan of coverage is no less favorable to the
27 insured or covered member than qualified
28 comprehensive coverage.

29 (d) An employer may offer qualified comprehensive
30 health insurance coverage even though the employer is
31 not be obligated to do so.

32 12703. (a) Qualified comprehensive health
33 insurance shall pay reasonable and customary charges for
34 necessary health care services rendered or furnished for
35 the diagnosis or treatment of illness or injury, which
36 exceed the deductible and copayment amounts
37 applicable under Section 12704, when such charges are
38 eligible expenses. "Eligible expenses" means the charges
39 for the following health care services and articles to the
40 extent furnished by a health care provider in an

1 emergency situation or furnished or prescribed by a
2 physician:

3 (1) Hospital services, including charges for the
4 institution's most common semi-private room, and for
5 private room only when medically necessary;

6 (2) Professional services for the diagnosis or treatment
7 of injuries, illnesses, or conditions, other than mental or
8 dental, which are rendered by a physician, or, at his or
9 her direction, by his or her staff of registered graduate
10 nurses and allied health professionals;

11 (3) The first 20 professional visits for the diagnosis or
12 treatment of one or more mental conditions rendered
13 during the year by one or more physicians, or, at the
14 direction by their staff of registered graduate nurses and
15 allied health professionals;

16 (4) Drugs and contraceptive devices requiring a
17 physician's prescription;

18 (5) Services of a skilled nursing facility for not more
19 than 180 days per year;

20 (6) Services of a home health agency up to 270 days of
21 service per year;

22 (7) Use of radium or other radioactive materials;

23 (8) Oxygen;

24 (9) Anesthetics;

25 (10) Prostheses, other than dental;

26 (11) Rental of durable medical equipment which has
27 no personal use in the absence of the condition for which
28 prescribed;

29 (12) Diagnostic x-rays and laboratory tests;

30 (13) Oral surgery for:

31 (A) Excision of partially or completely erupted
32 impacted teeth;

33 (B) Excision of a tooth root without the extraction of
34 the entire tooth; or

35 (C) The gums and tissues of the mouth when not
36 performed in connection with the extraction or repair of
37 teeth;

38 (14) Services of a physical therapist and services of a
39 speech therapist; and

40 (15) Professional ambulance services to the nearest

1 health care facility qualified to treat the illness or injury.

2 (b) For purposes of this section, if benefits are
3 provided in the form of services rather than cash
4 payments, their value shall be determined on the basis of
5 their monetary equivalency.

6 (c) The following do not constitute eligible expenses
7 in any qualified comprehensive health insurance plan
8 within the scope of this section:

9 (1) Services for which a charge is not made in the
10 absence of insurance or for which there is no legal
11 obligation on the part of the patient to pay;

12 (2) Services and charges made for benefits provided
13 under the laws of the United States including medicare,
14 military service-connected disabilities, medical services
15 provided for members of the armed forces and their
16 dependents or for employees of the armed forces of the
17 United States, medical services financed in the future on
18 behalf of all citizens by the United States, but not
19 including medicaid;

20 (3) Benefits which would duplicate the provision of
21 services or payment of charges for any care for injury or
22 disease either:

23 (A) Arising out of and in the course of an employment
24 subject to a worker's compensation or similar law; or

25 (B) For which benefits are payable without regard to
26 fault under a coverage statutorily required to be
27 contained in any motor vehicle or other liability
28 insurance policy or equivalent self-insurance.

29 However, such provision shall not authorize exclusion
30 of charges that exceed the benefits payable under the
31 applicable workers' compensation or no-fault coverage;

32 (4) Care which is primarily for custodial or domiciliary
33 purpose;

34 (5) Cosmetic surgery unless provided as result of an
35 injury or medically necessary surgical procedure; and

36 (6) Any charge for services or articles, the provision of
37 which is not within the scope of the license or certificate
38 of the institution or individual rendering such services.

39 12704. (a) Subject to the limitation provided in
40 subdivision (c), a qualified comprehensive health

1 insurance policy offered in accordance with this chapter
2 shall impose a two hundred dollar (\$200) deductible on
3 a per person, per policy year basis. The deductible shall
4 be applied to the first two hundred dollars (\$200) of
5 eligible expenses incurred by the covered person.

6 (b) Subject to the limitation provided in subdivision
7 (c), a mandatory copayment requirement shall be
8 imposed at the rate of 20 percent of eligible expenses in
9 excess of the mandatory deductible.

10 (c) The maximum aggregate out-of-pocket payments
11 for eligible expenses by the insured in the form of
12 deductibles and copayments shall not exceed two
13 hundred dollars (\$200) or 10 percent of the insured's
14 adjusted gross income, whichever is greater. Such
15 limitation shall be applied on a per insured, per policy
16 year basis. The maximum out-of-pocket expense limit
17 shall not apply to any insured that fails to provide the
18 carrier with adequate evidentiary information on
19 adjusted gross income.

20 The amount of the out-of-pocket expense limitation for
21 an insured shall be administratively determined annually
22 by the carrier according to information provided by the
23 insured. The maximum out-of-pocket expense limit shall
24 be based upon the insured's adjusted gross income in the
25 last full tax year immediately preceding the
26 comprehensive health insurance policy year. The insured
27 shall provide information reasonably satisfactory to the
28 carrier disclosing the required adjusted gross income
29 amounts. Submission of information on income through a
30 sworn affidavit or a notarized statement shall be accepted
31 by carriers as satisfactory disclosure of income. If a policy
32 or certificate of coverage covers more than one family
33 member or dependent, the applicable adjusted gross
34 income figure shall be the aggregate adjusted gross
35 income of all the covered individuals. The information
36 furnished by the insured under this section or the fact
37 that it is not provided shall remain confidential and shall
38 not be used by the carrier for any other purpose.

39 (d) Except for coverages in effect on December 31,
40 1980, carriers providing qualified comprehensive health

1 insurance shall be prohibited from including therein any
2 form of health insurance primarily designed to
3 supplement qualified comprehensive plan coverage by
4 providing coverage for the deductible, copayment, or
5 exclusion amounts under a qualified comprehensive plan
6 unless such coverage is provided through a separate
7 policy and purchased by the insured.

8 12705. (a) No person shall be eligible for qualified
9 comprehensive health insurance coverage who, at the
10 effective date of coverage, has or would have coverage
11 under a qualified comprehensive plan either
12 individually, through a group, or as a dependent.

13 (b) Coordination of benefit provisions may be
14 included in a group qualified comprehensive health
15 insurance plan, if such benefits are not less favorable to
16 the insured. Benefits provided by qualified
17 comprehensive health insurance shall be secondary to
18 any health insurance provided under any other state or
19 federal law, except Medi-Cal. Notwithstanding any
20 contrary requirement of state law, benefits of a qualified
21 comprehensive health insurance plan shall not be
22 coordinated with or reduced by reason of any separate
23 coverage of the deductible or copayment amounts
24 permitted by subdivision (d) of Section 12704.

25 (c) Qualified comprehensive health insurance,
26 whether issued by carriers or issued or reinsured by the
27 association under Section 12712 shall conform to all of the
28 requirements enumerated herein. No qualified
29 comprehensive health plan contract shall be delivered or
30 issued for delivery until approved by the commissioner.

31 (d) If a qualified comprehensive health insurance
32 policy provides that coverage of a dependent unmarried
33 child terminates when the child becomes 19 years of age
34 (or 25 years of age if he or she is enrolled full time in an
35 accredited educational institution), the policy shall also
36 provide in substance that attainment of the limiting age
37 shall not operate to terminate his or her coverage while
38 he or she is, and continues to be, both:

39 (1) Incapable of self-sustaining employment by the
40 reason of mental retardation or physical handicap; and

1 (2) Chiefly dependent upon the person in whose
2 name the contract is issued, or the insured member, in
3 the case of a group policy, for support and maintenance.

4 However, proof of such incapacity and dependency
5 shall be furnished to the carrier within 30 days of the
6 child's attainment of the limiting age, and subsequently
7 as may be required by the carrier, but not more
8 frequently than annually after the two-year period
9 following the child's attainment of the limiting age.

10 (e) Any qualified comprehensive health insurance
11 policy that provides coverage for a family member of the
12 person in whose name the contract is issued shall, as to
13 the family member's coverage, also provide that the
14 health insurance benefits applicable for children be
15 payable with respect to a newly born child of the person
16 in whose name the contract is issued from the moment of
17 birth. The coverage for newly born children shall consist
18 of coverage of injury or illness, including the necessary
19 care and treatment of medically diagnosed congenital
20 defects and birth abnormalities. If payment of a specific
21 premium is required to provide coverage for the child
22 the contract shall require that notification of the birth of
23 a child and payment of the required premium be
24 furnished to the carrier within 31 days after the date of
25 birth so that such coverage may be continued beyond the
26 31-day period.

27 (f) Qualified comprehensive health insurance plans
28 may contain provisions under which coverage is excluded
29 during a period of six months following the effective date
30 of coverage as to a given covered individual for
31 preexisting conditions, as long as:

32 (1) The condition manifested itself within a period of
33 six months before the effective date of coverage in such
34 a manner as would cause an ordinarily prudent person to
35 seek diagnosis, care, or treatment; or

36 (2) Medical advice or treatment was recommended or
37 received within a period of six months before the
38 effective date of coverage.

39 This subdivision may not be construed to prohibit
40 preexisting condition provisions in an insurance policy

1 which are more favorable to the insured.

2 (g) Any individual qualified comprehensive health
3 insurance plan issued as a result of conversion from group
4 health insurance, from a health maintenance
5 organization plan, or from a self-insured group shall
6 credit the time covered under a group or individual plan
7 to the durational requirements of this section.

8 (h) Any individual qualified health insurance plan
9 issued as a result of the withdrawal of a carrier from the
10 individual health insurance market under paragraph (2)
11 of subdivision (a) of Section 12707 shall credit the time
12 covered under the termination policy to the durational
13 requirements of this section.

14 12706. (a) A group comprehensive health insurance
15 plan offered pursuant to this part shall be one under
16 which the individuals eligible to be covered include:

17 (1) Each qualified employee or member of the group
18 policyholder;

19 (2) The spouse of each qualified employee or
20 member; and

21 (3) The dependent unmarried children of the
22 qualified employee or member who are:

23 (A) Under 19 years of age; or

24 (B) Under 25 years of age and are full-time students in
25 accredited educational institutions.

26 (b) The group comprehensive health insurance plan
27 shall also provide for the continuation of coverage in
28 accordance with each of the following circumstances:

29 (1) Upon layoff, leave of absence, or termination of
30 employment, other than as a result of death of the
31 employee, continuation of the coverage for such
32 employee and his covered dependents to the end of the
33 second calendar month following the calendar month in
34 which such layoff, leave of absence, or termination
35 commenced.

36 (2) Upon the death of the employee, continuation of
37 coverage for the covered dependents of such employee
38 to the end of the second calendar month following the
39 calendar month in which death occurred;

40 (3) During an employee's absence due to illness or

1 injury, continuation of coverage for such employee and
2 his or her covered dependents for at least 30 months from
3 the beginning of such absence; or

4 (4) Upon termination of the group plan, coverage for
5 covered individuals who were totally disabled on the date
6 of termination, shall be continued for a period of 12
7 calendar months following the calendar month in which
8 the plan was terminated, provided that a claim is
9 submitted therefor within two years of the termination of
10 the plan. Such continued coverage shall also include
11 pregnancy benefits, provided the covered individual was
12 pregnant on the date the plan was terminated.

13 (c) The coverage of any covered individual
14 terminates:

15 (1) As to a child, at the end of the premium period in
16 which the child marries, ceases to be a dependent of the
17 employee, or attains the age of 19, whichever occurs first,
18 except that if the child is a full-time student at an
19 accredited institution, such coverage shall be continued
20 while the child remains unmarried and a full-time
21 student, but not beyond the premium period in which
22 the child attains the age of 25;

23 (2) As to the employee's spouse, at the end of the
24 premium period in which a divorce, annulment, or legal
25 separation is obtained; and

26 (3) As to the employee or employee's spouse, the date
27 preceding such person's eligibility for medicare benefits
28 under Title XVIII of the Social Security Act (42 U.S.C.
29 1395 et seq.).

30 (d) Any employee or dependent entitled to a
31 continuation of coverage under this section at a time
32 when the employer changes plans, and who would
33 thereby lose his or her continuation of coverage, shall be
34 eligible under any successor plan for not less than the
35 continuation of the coverage that would have been
36 required had the prior plan remained unchanged.

37 (e) Any continuation of coverage required by this
38 section, other than that required in subsection (4) of
39 subdivision (b), shall be subject to the requirement on
40 the part of the individual whose coverage is to be

1 continued, that the individual contribute the part of the
2 premium he or she would have been required to
3 contribute had the employee remained an active covered
4 employee.

5 (f) The group comprehensive health insurance plan
6 shall permit an employee required to be made eligible for
7 coverage thereunder to elect instead, to apply for
8 coverage from any licensed health maintenance
9 organization and to have the employer pay toward the
10 cost of coverage by such organization an amount equal to
11 the amount the employer would pay toward the cost of
12 coverage of such employee under the employer's plan.

13 (g) The group comprehensive health insurance plan
14 shall make available to any eligible person covered under
15 the plan, a conversion privilege under which qualified
16 comprehensive health insurance shall be available
17 immediately upon termination of coverage under the
18 group plan; however, the conversion coverage shall not
19 duplicate any coverages continued under the terminated
20 group plan.

21 (h) No group qualified comprehensive health
22 insurance plan shall exclude any individual member who
23 would otherwise be eligible for coverage under a group
24 plan solely on the basis that the individual is either:

25 (1) Eligible for coverage under the state Medi-Cal
26 program; or

27 (2) Uninsurable under individually underwritten
28 health standards.

29 12707. (a) The individual qualified comprehensive
30 health insurance policy shall contain provisions under
31 which the carrier or association shall be obligated to
32 renew the contract until the earlier of:

33 (1) The day on which the individual in whose name
34 the contract is issued first becomes eligible for medicare
35 coverage, except that in a family policy covering both
36 husband and wife, the age of the younger spouse shall be
37 used as the basis for meeting the age or such durational
38 requirement; or

39 (2) The next anniversary date which has been
40 preceded by at least 120 days before notice from the

1 carrier that is refusing to renew on the next policy
2 anniversaries of all individual qualified comprehensive
3 health insurance plans in force in this state and that it
4 shall no longer issue individual health insurance in this
5 state, except conversion policies required under the
6 terms of group or individual policies. As a condition
7 precedent to a carrier's refusal to renew, it shall arrange
8 for the availability of qualified comprehensive health
9 insurance for all of the individual policyholders which
10 shall credit the time covered under the terminating
11 policy to any durational requirement for coverage of
12 preexisting conditions under the new policy.

13 (b) The carrier or association shall not change the
14 rates for individual qualified comprehensive health
15 insurance, except on a class basis with a clear disclosure
16 in the policy of the carrier's or association's right to do so.

17 (c) The individual qualified comprehensive health
18 insurance policy shall provide that upon the death of the
19 individual in whose name the contract is issued, every
20 other individual then covered under the contract may
21 elect, within a period specified in the contract, to
22 continue coverage under the same or a different contract
23 until such time as he would have ceased to be entitled to
24 coverage had the individual in whose name the contract
25 was issued lived.

26 12708. On and after September 1, 1981, every health
27 care provider shall make reasonable efforts before
28 providing services to determine whether the recipient of
29 the provider's health care services is covered under
30 qualified comprehensive health insurance, and shall
31 make a reasonable effort to advise the recipient, upon
32 request, of any health care expenses rendered by the
33 provider that are not eligible for reimbursement under
34 qualified comprehensive health insurance.

35 12709. Carriers, the association, and health care
36 providers may enter into negotiations and agreements
37 for the establishment of direct payment plans, automatic
38 assignments, or other mechanisms under which carrier
39 payments shall be accepted as complete fulfillment of
40 charges made by the provider for eligible expenses or

1 expenses covered under a health insurance plan. Any
2 reduction in charges of health care providers shall apply
3 to all purchasers and third party purchasers of health care
4 services, and no health care provider shall discriminate in
5 its charges as to any purchaser of health care services.

6 12710. Benefits payable under qualified
7 comprehensive health insurance policies shall be
8 necessary for care and treatment, and for reasonable and
9 customary charges. Charges payable under qualified
10 comprehensive health insurance shall be subject to
11 review by mechanisms to be determined by the carrier
12 or association in accordance with regulations adopted by
13 the commissioner. Any such charges determined shall be
14 furnished to the insured upon written request.

15 12711. A health care provider shall not refuse to
16 render health care services to any person covered under
17 qualified comprehensive health insurance because of the
18 scope of the insured's coverage. Any violation of Sections
19 12708, 12709, or 12710 shall be grounds for suspension or
20 revocation of the provider's license in accordance with
21 procedures established by the appropriate state licensing
22 agency.

23 12712. There is hereby established a nonprofit legal
24 entity to be known as the California Comprehensive
25 Health Insurance Association, which shall assure that
26 qualified comprehensive health insurance is made
27 available throughout the year to each California resident
28 applying for such coverage. All carriers, health
29 maintenance organizations, and self-insurers providing
30 health insurance or health care services in this state shall
31 be members of the association. Each carrier, in meeting
32 its obligation under this section, may elect to issue a
33 qualified comprehensive health insurance policy in its
34 own name, may reinsure the policy with the association,
35 or may refer the risk to the association which will provide
36 the qualified comprehensive health insurance in the
37 name of the association. The association shall operate
38 under a plan of operation established and approved
39 under Section 12714 and shall exercise its powers through
40 a board of directors established pursuant to section 12713.

1 12713. The board of directors of the association shall
2 be selected by the members of the association subject to
3 approval by the commissioner. To select the initial board
4 of directors and to initially organize the association, the
5 commissioner shall give notice to all members in this
6 state of the time and place of the organizational meeting.
7 In determining voting rights at the organizational
8 meeting, each member shall be entitled to one vote in
9 person or by proxy. If the board of directors is not
10 selected within 60 days after the organizational meeting,
11 the commissioner shall appoint the initial board. In
12 approving or selecting members of the board, the
13 commissioner shall consider whether all members are
14 fairly represented. Members of the board may be
15 reimbursed from the moneys of the association for
16 expenses incurred by them as members, but shall not be
17 otherwise compensated by the association for their
18 services.

19 12714. (a) The association shall submit to the
20 commissioner a plan of operation for the association and
21 any amendments thereto necessary or suitable to assure
22 the fair, reasonable, and equitable administration of the
23 association. The plan of operation shall become effective
24 upon approval, in writing, by the commissioner,
25 consistent with the date on which the coverage is to be
26 made available. The commissioner shall, after notice and
27 hearing, approve the plan of operation if the plan is
28 determined to be suitable to assure the fair, reasonable,
29 and equitable administration of the association and
30 provides for the sharing of association losses on an
31 equitable proportionate basis among the member
32 carriers, health maintenance organizations, and
33 self-insurers. If the association fails to submit a suitable
34 plan of operation within 180 days after the appointment
35 of the board of directors, or at any time thereafter the
36 association fails to submit suitable amendments to the
37 plan, the commissioner shall adopt appropriate rules
38 necessary or advisable to implement this section. Such
39 rules shall be effective until modified by the
40 commissioner or superseded by a plan submitted by the

1 association and approved by the commissioner.

2 (b) The plan of operation shall:

3 (1) Establish procedures for the handling and
4 accounting of assets and moneys of the association;

5 (2) Establish the amount and method of reimbursing
6 members of the board;

7 (3) Establish regular times and places for meetings of
8 the board of directors;

9 (4) Establish procedures for records to be kept of all
10 financial transactions and for the annual fiscal reporting
11 to the commissioner;

12 (5) Establish procedures whereby selections for the
13 board of directors are to be made and submitted to the
14 commissioner for his approval;

15 (6) Contain additional provisions necessary or proper
16 for the execution of the powers and duties of the
17 association; and

18 (7) Establish procedures for the periodic advertising
19 on behalf of all member carriers of the general
20 availability of the qualified comprehensive health
21 insurance coverages from individual carriers and the
22 association.

23 (c) The plan of operation may provide that any of the
24 powers and duties of the association be delegated to a
25 person who will perform functions similar to those of this
26 association, or its equivalent, in two or more states. A
27 delegation shall take effect only with the approval of both
28 the board of directors and the commissioner. The
29 commissioner shall not approve a delegation unless the
30 protections afforded to the insured are substantially
31 equivalent to or greater than those provided herein. If
32 the commissioner determines that participation of
33 association members doing business in this state in a
34 multistate organization is not in the best interest of the
35 citizens of this state, the commissioner may require those
36 members to establish and operate a state comprehensive
37 health insurance association solely in this state as
38 required herein.

39 12715. (a) The association shall have the general
40 powers and authority enumerated by this subdivision in

1 accordance with the plan of operation approved by the
2 commissioner under subdivision (a) of Section 12714. The
3 association shall have the general powers and authority
4 granted under the laws of this state to carriers licensed to
5 transact the kinds of health service or insurance included
6 under Section 12700.

7 The association shall have the specific authority and
8 duty to:

9 (1) Enter into contracts as are necessary or proper to
10 carry out the provisions of this part;

11 (2) Sue or be sued, including taking any legal actions
12 necessary or proper for recovery of any assessments for
13 or on behalf of, or against participating carriers;

14 (3) Take legal action necessary to avoid the payment
15 of improper claims against the association or the coverage
16 provided by or through the association;

17 (4) Establish appropriate rates, scales of rates, rate
18 classifications, and rating adjustments, such rates not to
19 be unreasonable in relation to the coverage provided and
20 the reasonable operational expenses of the association;

21 (5) Administer any type of reinsurance program for or
22 on behalf of members;

23 (6) Pool risks among members;

24 (7) Issue policies of insurance on an indemnity or
25 provision of service basis providing the coverage
26 required by this part in its own name or on behalf of
27 members, including the provision of conversion policies
28 for persons covered under group health insurance
29 policies, health maintenance organization plans, and
30 self-insurer plans;

31 (8) Issue policies to individuals whose coverage is
32 otherwise terminated under Section 12707;

33 (9) Administer separate pools, separate accounts, or
34 other plans or arrangements considered appropriate for
35 separate members or groups of members;

36 (10) Operate and administer any combination of
37 plans, pools, reinsurance arrangements, or other
38 mechanisms as deemed appropriate to best accomplish
39 the fair and equitable operation of the association; and

40 (11) Appoint from among members appropriate legal,

1 actuarial, and other committees as necessary to provide
2 technical assistance in the operation of the association,
3 policy, and other contract design, and any other function
4 within the authority of the association.

5 12716. (a) Every member shall participate in the
6 association. A member shall determine the particular
7 risks it elects to reinsure in the association or have
8 coverage issued by the association on its behalf. The
9 election of particular risks shall be made from the
10 following risk classes the member underwrites in
11 California:

12 (1) Individual, excluding group conversions;

13 (2) Group conversions; and

14 (3) Groups with fewer than 50 employees or
15 members.

16 (b) A member or group policyholder may not select
17 out individual eligible lives from a group and reinsure
18 them in the association. Members electing to administer
19 risks which are reinsured in the association shall comply
20 with the benefit determination guidelines and the
21 accounting procedures established by the association. A
22 risk reinsured by the association shall not be withdrawn
23 by the participating carrier except in accordance with
24 the rules established by the association.

25 (c) Rates for coverages issued by the association or
26 reinsured through the association shall not be
27 unreasonable in relation to the benefits provided, the risk
28 experience, and the reasonable expenses of providing the
29 coverage. Separate scales of premium rates shall apply for
30 individual risks and group risks, consisting of one rate for
31 each of a number of age brackets of insured individuals
32 and one rate for all eligible dependents. Rates shall be
33 adjusted for area variations in health care provider costs.
34 Premium rates shall take into consideration the extra
35 morbidity and administration expenses, if any, for risks
36 reinsured in the association, reasonable expense
37 allowances to members reinsuring risks, and the level of
38 rates charged by carriers for groups of 50 or fewer lives.
39 All rates adopted by the association shall be submitted to
40 the commissioner for approval. Rates for coverages issued

1 by the association shall be subject to the requirements of
2 Section 12723.

3 12717. Following the close of the association's fiscal
4 year, the association shall determine the net premiums
5 (reinsurance premiums less administrative expense
6 allowance), the expenses of administration pertaining to
7 the reinsurance operations of the association, and the
8 incurred losses for the year. Any net loss shall be assessed
9 by the association to all members in proportion to their
10 respective shares of total health insurance premiums
11 received in this state during the calendar year (or with
12 paid losses in the year) coinciding with or ending during
13 the fiscal year of the association or any other equitable
14 basis as may be provided in the plan of operation. For
15 self-insurer and health maintenance organization
16 members of the association, the proportionate share of
17 losses shall be determined through the application of an
18 equitable formula based upon claims paid or the value of
19 services provided. In sharing losses, the association may
20 abate or defer in any part the assessment of a member,
21 if, in the opinion of the board, payment of the assessment
22 would endanger the ability of the member to fulfill its
23 contractual obligations. Net gains, if any, shall be held at
24 interest to offset future losses or allocated to reduce
25 future premiums.

26 12718. Expense allowances referred to in Section
27 12717 shall also be applicable to risks for which particular
28 members do not elect to administer one or more classes
29 or risks reinsured in the association. Any net loss to the
30 association represented by the excess of its actual
31 expenses of administering policies issued by the
32 association over the applicable expense allowance shall
33 be separately assessed to the members. All assessments
34 shall be on an equitable formula established by the
35 association.

36 12719. The association shall conduct periodic audits to
37 assure the general accuracy of the financial data
38 submitted to the association and the association shall have
39 an annual audit of its operations by an independent
40 certified public accountant.

1 12720. The association shall be subject to examination
2 by the commissioner. The board of directors shall submit,
3 not later than March 30th of each year, a financial report
4 for the preceding calendar year in a form approved by
5 the commissioner.

6 12721. All policy forms issued by the association or
7 reinsured through the association shall conform in
8 substance to prototype forms developed by the
9 association, and shall in all other respects conform to the
10 requirements enumerated herein, including the
11 requirement that such forms shall be filed with and
12 approved by the commissioner before use.

13 12722. The association shall not issue or reinsure
14 qualified comprehensive health insurance plan coverage
15 to any individual or group, which on the effective date of
16 coverage applied for or reinsured, already has or would
17 have qualified comprehensive health insurance coverage
18 as an insured or covered dependent.

19 12723. (a) Rates established by carriers for qualified
20 comprehensive health insurance shall be reasonable in
21 relation to benefits provided.

22 (b) Every carrier shall file with the commissioner all
23 rates and supplementary rate information and all
24 changes and amendments thereof made by it for use in
25 this state applicable to qualified comprehensive health
26 insurance coverages on or before the date the rates
27 become effective.

28 (c) Each filing and any supporting information filed
29 under this section shall be open to public inspection.
30 Copies may be obtained by any person upon request and
31 upon payment of a reasonable charge.

32 (d) If the commissioner determines that a rate is not
33 reasonable in relation to benefits provided, he or she shall
34 order that its use be discontinued for any policy issued or
35 renewed after a date specified in the order.

36 (e) Within one year after the effective date of an order
37 under subdivision (d), no rate promulgated to replace a
38 disapproved rate shall be used until it has been filed with
39 the commissioner and not disapproved within 30 days
40 thereafter.

1 (f) Whenever a carrier has no legally effective rates as
2 a result of the commissioner's disapproval of rates or
3 other action, the commissioner shall, upon request,
4 specify interim rates for the carrier which are substantial
5 enough to protect the interests of all parties. Additionally,
6 the commissioner may order that a specified portion of
7 the premiums be placed in an approved escrow account.
8 Whenever new rates become legally effective, the
9 commissioner shall order the escrowed funds or any
10 change in the interim rates to be distributed
11 appropriately, except that de minimus refunds to
12 policyholders shall not be required.

13 (g) The premium charged for a plan of coverage not
14 issued by or reinsured through the association shall not
15 exceed the premium that would be applicable for the
16 same plan of coverage issued by or reinsured in the
17 association.

18 12724. The State Department of Social Services shall
19 secure qualified comprehensive health insurance
20 coverage for all eligible recipients; and the department
21 shall enter into contractual agreements with carriers of
22 the association to perform fiscal intermediary functions.
23 The State Department of Social Services may contract
24 with one or more insurers offering qualified
25 comprehensive health insurance coverage or the
26 association for the provision of such coverages, as
27 modified by this section, to persons eligible for medical
28 assistance. Notwithstanding any provision to the
29 contrary, the State Department of Social Services shall
30 modify any coverages contracted for under this section to
31 conform to federal and state medicare or Medi-Cal
32 requirements, including revisions of health care benefits
33 as necessary. Any insurer or the association entering into
34 an agreement with the State Department of Social
35 Services for the provisions of coverage under this section
36 may be authorized by that department to undertake such
37 activities as a fiscal agent or intermediary as necessary
38 and appropriate in the administration of the State
39 Department of Social Services program.

40 12725. The commissioner may adopt the appropriate

1 rules and regulations necessary to implement the
2 provisions of this part.

3 SEC. 2. Notwithstanding Section 2231 or 2234 of the
4 Revenue and Taxation Code, no appropriation is made by
5 this act pursuant to these sections. It is recognized,
6 however, that a local agency or school district may pursue
7 any remedies to obtain reimbursement available to it
8 under Chapter 3 (commencing with Section 2201) of Part
9 4 of Division 1 of that code.

O

AMENDED IN ASSEMBLY JANUARY 11, 1982

CALIFORNIA LEGISLATURE—1981-82 REGULAR SESSION

ASSEMBLY BILL

No. 1262

Introduced by Assemblyman Torres

March 19, 1981

An act to add Part 6.5 (commencing with Section 12700) to Division 2 of the Insurance Code, relating to health insurance, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1262, as amended, Torres. Comprehensive and catastrophic health insurance.

The existing law has no provisions relating to health insurance for comprehensive and catastrophic illness and injury.

This bill would enact the California Comprehensive Health Insurance Act to do, among other things, all of the following:

(1) Establish a joint underwriting association of health insurers under state auspices to market standard policies of insurance to small groups and individuals at actuarially sound rates without prohibiting the sale of such policies by individual underwriters.

(2) Establish an insurance policy grading system which classifies policies with respect to certain standards.

(3) Mandate that all employers in this state who make insurance available to employees offer at least one qualified plan, as defined.

(4) Require all health insurers to offer a qualified plan to eligible groups or individual applicants.

(5) Require all health insurers in this state to affirmatively offer major medical coverage in their policies of insurance which are not qualified plans.

(6) Require insurance and health and hospital service plan contracts to include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions.

(7) Establish a California Catastrophic Health Expense Protection Fund to pay the expense of individuals who incur medical costs over prescribed amounts.

The bill would also define covered expenses to include specified services and benefits. It would provide for certification of a qualified Medicare supplement plan for persons over the age of 65 years, with such plan to supplement Medicare, as specified. The bill would also specify the duties of the Insurance Commissioner.

The bill would establish a Comprehensive Health Insurance Association of all insurers, self/insurers, fraternal and health or hospital care service plans who are authorized to transact insurance in this state, and exempt such association from taxation under the laws of this state including all property owned by the association. The bill would specify powers and duties of the association.

The bill would also enact the California Catastrophic Health Expense Protection Act, under the direction of the Director of the Department of Health Services. The act would provide for state assistance to eligible persons, as determined by the director.

The bill would also create in the State Treasury the California Catastrophic Health Expense Protection Fund with an initial appropriation from the General Fund of \$10,000,000. The appropriation would be used without regard to fiscal year for the purpose of funding specified activities of the Department of Health Services.

Existing law contains no provision directly relating to comprehensive health insurance. However, existing law contains numerous provisions relating to various forms of health insurance, including individual and group insurance, employee welfare benefit plans, nonprofit hospital service plans, and health care service plans. Among other things, existing law regulates, in various ways, required provisions and coverage, rights of conversion upon termination of coverage, and coordination with other sources of health

benefits.

This bill would require every carrier offering individual health insurance to make a qualified individual comprehensive health care plan available to every resident of the state who is not eligible for Medicare.

It would require every self-insurer whose plan covers 3 or more employees to make an individual comprehensive health care plan available as a conversion privilege.

It would require every carrier offering group health insurance to make a group comprehensive plan available to every employer of 3 or more employees.

It would require every carrier offering a Medicare supplement plan to make a Medicare supplement plan available to every eligible person.

The bill would specify the required minimum standard of the various forms of comprehensive coverage.

Required coverage could be provided by the California Comprehensive Health Insurance Association, which would be created by the bill. Insurers transacting health insurance would be required to be members.

Coverage could also be provided by a residual market mechanism.

Rates for coverage could not exceed that established by the California Comprehensive Health Insurance Association.

The bill would provide for the establishment of regulations by the Insurance Commissioner of standards for policy provisions and for coverage for individual policies of health insurance.

The bill would specify required provisions for all group health policies or contracts.

The bill would contain various other provisions.

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

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

- 1 SECTION 1. Part 6.5 (commencing with Section
- 2 12700) is added to Division 2 of the Insurance Code, to
- 3 read:

1 PART 6.5. COMPREHENSIVE AND
2 CATASTROPHIC HEALTH INSURANCE
3 CHAPTER 1. FINDINGS
4

5 12700. The Legislature finds that the lack of
6 reasonably priced comprehensive and catastrophic
7 health insurance coverage places many Californians at
8 risk of pauperization in the event of serious illness. The
9 Legislature further finds a substantial number of
10 Californians are not able to acquire adequate health
11 insurance because of circumstances related to:

- 12 (a) The size of their employing firm;
13 (b) Preexisting conditions of illness;
14 (c) Low cash incomes above public assistance levels.

15 In addition, current trends in medical care costs
16 threaten the financial stability of more and more
17 Californians as copayments, deductibles, expenses of
18 uncovered services and premiums increase at a faster
19 rate than income.

20 It is the intent of the Legislature, therefore, in the
21 ~~passage of this act~~ *enactment of this part*, to accomplish
22 the following purposes:

23 (a) Establish a joint underwriting association of health
24 insurers under state auspices to market standard policies
25 of insurance to small groups and individuals at actuarially
26 sound rates without prohibiting the sale of such policies
27 by individual underwriters;

28 ~~(b) Establish an insurance policy grading system~~
29 ~~which shall classify policies with respect to certain~~
30 ~~standards. Such policies will be called "qualified plans";~~

31 ~~(c) Mandate that all employers in the state, who make~~
32 ~~insurance available to employees, offer at least one~~
33 ~~qualified plan;~~

34 ~~(d) Require all health insurers in the state to offer a~~
35 ~~qualified plan to eligible groups or individual applicants;~~

36 ~~(e) Require all health insurers in the state to~~
37 ~~affirmatively offer major medical coverage in their~~
38 ~~policies of insurance which are not qualified plans;~~

39 ~~(b) Require all carriers and self-insurers in the state~~
40 ~~who issue comprehensive and Medicare supplement~~

1 *plans to offer comprehensive and Medicare supplement*
2 *plans to eligible groups or individual applicants.*

3 ~~(f)~~

4 (c) Require insurance, and health and hospital service
5 plan contracts to to include the right to convert to an
6 individual coverage ~~qualified plan without the addition of~~
7 ~~plan. underwriting restrictions;~~

8 ~~(g) Establish a state catastrophic health expense~~
9 ~~protection fund to pay the expense of individuals who~~
10 ~~incur medical care costs over prescribed amounts.~~

11 ~~12700.1.~~

12 12701. This act shall be known and may be cited as the
13 California Comprehensive Health Insurance Act.

14

15 CHAPTER 2. DEFINITIONS

16

17 12702. For the purposes of this part, the terms and
18 phrases used herein shall have the following meanings:

19 (a) "Employer" means any person, partnership,
20 association, trust, estate or corporation, or political
21 subdivision, which employs ~~ten~~ *one* or more individuals
22 who are residents of this state.

23 (b) "Health or hospital care service plan" means an
24 entity licensed, or exempted, as provided in applicable
25 provisions of the Health and Safety Code with the
26 exception of specialized health *care* service plans and
27 nonprofit hospital service plans contained in Chapter 11
28 (commencing with Section 11491).

29 (c) ~~"Qualified~~ "Comprehensive Health Insurance
30 plan" means those health benefit plans which have been
31 certified by the commissioner as providing the minimum
32 benefits required under this part or the actuarial
33 equivalent of those benefits.

34 (d) ~~"Qualified Medicare Plan~~ "Medicare Supplement
35 Plan" means those health benefit plans which have been
36 certified by the commissioner as providing the minimum
37 benefits required under this part or the actuarial
38 equivalent of those benefits.

39 (e) "Commissioner" means the Insurance
40 Commissioner.

1 (f) "Dependent" means a spouse or unmarried child
2 under the age of 19 years, a dependent child who is a
3 student under the age of 25 and financially dependent
4 upon the parent, or a dependent child of any age who is
5 disabled.

6 (g) "Employee" means any California resident who
7 has entered into the employment of or works under
8 contract or service or apprenticeship with any employer.
9 "Employee" does not include a person who has been
10 employed for less than 30 days by his present employer,
11 nor one who is employed less than 30 hours per week by
12 his present employer, nor an independent contractor.

13 (h) "Plan of health coverage" means any plan or
14 combination of plans of coverage, including
15 combinations of self-insurance, individual accident and
16 health insurance policies, group accident and health
17 insurance policies, coverage under a nonprofit hospital or
18 medical service plan or coverage under a health or
19 hospital care service plan subscriber contract.

20 (i) "Insurer" means those companies operating in the
21 state offering or selling policies or contracts of accident
22 and health insurance. "Insurer" does not include health
23 or hospital care service plans.

24 (j) "Accident and health insurance policy" or "policy"
25 means insurance or nonprofit hospital or medical service
26 plan contracts providing benefits for hospital, surgical
27 and medical care. "Policy" does not include coverage
28 which is (1) limited to disability or income protection
29 coverage, (2) automobile medical payment coverage, (3)
30 supplemental or liability insurance, (4) designed solely to
31 provide payments on a per diem, fixed indemnity or
32 nonexpense incurred basis, (5) credit accident and health
33 insurance, (6) designed solely to provide dental or vision
34 care, (7) blanket accident and sickness insurance, (8)
35 accident only coverage issued by licensed insurance
36 agents or solicitors which provides reasonable benefits in
37 relation to the cost of services.

38 (k) "Health benefits" means benefits offered to
39 employees on an indemnity or prepaid basis which pay
40 the costs of or provide medical, surgical or hospital care.

1 (l) "Eligible person" means an individual who is a
2 resident of California and meets the enrollment
3 requirements specified in this part.

4 (m) "California Comprehensive Health Insurance
5 Association" or "association" means the association
6 created by this part *which shall include all insurers and*
7 *fraternals.*

8 (n) "Medicare" means Part A and Part B of the United
9 States Social Security Act, Title XVIII, as amended, 42
10 U.S.C.A. Sections 1394, et seq.

11 (o) "Medicare supplement plan" means any plan of
12 insurance protection which provides benefits for the
13 costs of medical, surgical, or hospital care and which is
14 marketed as providing benefits which complement or
15 supplement the benefits provided by Medicare.

16 (p) "State plan premium" means the premium
17 determined pursuant to this part.

18 (q) "Writing carrier" means the insurer or insurers
19 and health or hospital care service plan or plans selected
20 by the association and approved by the commissioner to
21 administer the comprehensive health insurance plan.

22 (r) "Fraternal beneficiary association" or "fraternal"
23 means a corporation, society, order, or voluntary
24 association without capital stock which sells health and
25 accident insurance in accordance with applicable
26 provisions of law governing such associations.

27 (s) "Comprehensive health insurance plan" or "state
28 plan" means policies of insurance and contracts of health
29 or hospital care service plan coverage offered by the
30 association through the writing carrier.

31 (t) "Self-insurer" means an employer or an employee
32 welfare benefit plan which directly or indirectly provides
33 a plan of health coverage to its employees and
34 administers the plan of health coverage or through an
35 insurer, trust, or agent except to the extent of accident
36 and health premium, subscriber contract charges or
37 health or hospital service plan contract charges.
38 "Self-insurer" does not include an employer engaged in
39 the business of providing health care services to the
40 public who provides health care services directly to his

1 employees at no charge to them.

2 (u) "Self-insurance" means a plan of health coverage
3 offered by a self-insurer.

4 (v) "Medi-Cal" means those benefits offered pursuant
5 to Chapter 7 (commencing with Section 14000) or
6 Chapter 8 (commencing with Section 14500) of Part 3 of
7 Division 9 of the Welfare and Institutions Code.

8 (w) "Carrier" means an insurer, a nonprofit hospital
9 service plan, a health care service plan regulated by the
10 Department of Corporations, or a fraternal beneficiary
11 association.

12 (x) "Residual market association" means an
13 association of nonprofit hospital and health care service
14 plans organized in the same manner as the
15 Comprehensive Health Insurance Association.

16
17 CHAPTER 3. COVERAGE
18

19 12703. (a) Every carrier offering individual health
20 insurance in this state shall, as a condition of transacting
21 health insurance, make a qualified individual
22 comprehensive health care plan described in Section
23 12704 available to every resident of this state who is not
24 eligible for Medicare. An individual shall have a choice of
25 a qualified plan of insurance with a low, middle, or high
26 deductible option as described in subdivision (b) of
27 Section 12704. Individual comprehensive health care
28 plans may be made available through participation in the
29 California Comprehensive Health Insurance Association
30 in accordance with Section 12709, or a residual market
31 association in accordance with Section 12710.

32 (b) The premium charged for a plan which is not
33 insured by or through the California Comprehensive
34 Health Insurance Association or any other residual
35 market association, may not exceed the premium which
36 would be applicable for participation in those
37 associations. The premium charged for a plan insured by
38 or through the California Comprehensive Health
39 Insurance Association shall be precisely the premium
40 established for that classification under the California

1 *Comprehensive Health Insurance Association.*

2 (c) *Every self-insurer whose plan covers three or*
3 *more employees shall make an individual comprehensive*
4 *health care plan, described in Section 12708, available*
5 *under a conversion privilege to every person covered by*
6 *the plan who is a resident of this state, who is not eligible*
7 *for Medicare and whose coverage under the self-insured*
8 *plan ceases as a result of layoff, death or termination of*
9 *employment. An individual shall have the choice of the*
10 *low option or middle option or high option deductible*
11 *described in Subdivision (b) of Section 12704. The*
12 *individual comprehensive health care plans may be*
13 *provided through a carrier or through participation in*
14 *the Health Insurance Association in accordance with*
15 *Section 12709. The premium charged for a plan which is*
16 *not insured by or through the California Comprehensive*
17 *Health Insurance Association may not exceed the*
18 *premium established for that particular classification*
19 *under the California Comprehensive Health Insurance*
20 *Association. The premium charged for a plan which is*
21 *insured by or through the California Comprehensive*
22 *Health Insurance Association shall be precisely the*
23 *premium established for that particular classification*
24 *under the California Comprehensive Health Insurance*
25 *Association.*

26 (d) *Every carrier offering group health insurance in*
27 *this state shall, as a condition of transacting that health*
28 *insurance, make a group comprehensive health care*
29 *plan, as described in Section 12705, available to every*
30 *employer of three or more eligible employees. An*
31 *employer shall have the choice of the low option or*
32 *middle option or high option deductible described in*
33 *subdivision (b) of Section 12704. Group comprehensive*
34 *health care plans may be made available to employers of*
35 *between 3 and 25 eligible employees through*
36 *participation in the Health Insurance Association, in*
37 *accordance with Section 12709 or the residual market*
38 *association, in accordance with Section 12710. The*
39 *premium charged for a plan on groups of between 3 and*
40 *25 eligible employees which is not insured by or through*

1 the California Comprehensive Health Insurance
2 Association or a residual market association may not
3 exceed the premium which would be applicable through
4 participation in these associations. The premium charged
5 for a plan which is insured by or through the California
6 Comprehensive Health Insurance Association shall be
7 precisely the premium established for that particular
8 classification under the California Comprehensive
9 Health Insurance Association.

10 (e) Every carrier offering Medicare supplement plans
11 in this state shall as a condition of transacting that health
12 insurance make a Medicare supplement plan described
13 in subdivision (f) of Section 12704 available to each
14 person who is eligible for Medicare coverage and who
15 applies for a Medicare supplement plan. Medicare
16 supplement plans may be made available through
17 participation in the California Comprehensive Health
18 Insurance Association in accordance with Section 12709
19 or a residual market association, in accordance with
20 Section 12710. The premium charged for a plan, which is
21 not insured by or through the California Comprehensive
22 Health Insurance Association or any other residual
23 market association, may not exceed the premium which
24 would be applicable through participation in those
25 associations. The premium charged for a plan which is
26 insured by or through the California Comprehensive
27 Health Insurance Association shall be precisely the
28 premium established for that particular classification
29 under the California Comprehensive Health Insurance
30 Association.

31 (f) Except as provided in Subdivision (c) of Section
32 12711 nothing in this chapter shall preclude the right of
33 carriers to transact other kinds of insurance for which
34 they are authorized, nor preclude the right of carriers to
35 transact any other lawful kind of health insurance.

36 (g) Nothing in this chapter shall require a carrier to
37 make available coverage under a group or individual
38 comprehensive health care plan or Medicare supplement
39 plan to any person or group who is already covered under
40 such a plan.

1 12704. All individual and all group comprehensive
2 health care plans shall include minimum standard
3 benefits as described in this section.

4 (a) Except as provided in subdivisions (b) and (c),
5 minimum standard benefits shall be benefits, including
6 coverage for catastrophic illness, with a life-time
7 maximum of one million dollars (\$1,000,000) per
8 individual, for reasonable charges or, the allowance
9 agreed upon between a provider and a carrier for the
10 following health care services, rendered to an individual
11 covered by the plan for the diagnosis or treatment of
12 nonoccupational disease or injury: (1) hospital services;
13 (2) professional services which are rendered by a
14 physician, or by a registered nurse in accordance with
15 standardized procedures, other than services for mental
16 or dental conditions; (3) the diagnosis or treatment of
17 mental conditions, as defined by the commissioner,
18 rendered during the year by one or more physicians on
19 other than an inpatient basis, or by their staffs of
20 registered nurses, in accordance with standardized
21 procedures, up to a yearly maximum benefit of one
22 thousand dollars (\$1,000); (4) legend drugs requiring a
23 physician's prescription; (5) services of a skilled nursing
24 facility for not more than 120 days in a calendar year,
25 provided such services commence within 14 days
26 following a confinement of at least three consecutive days
27 in a hospital for the same condition; (6) home health
28 agency services, as defined by the commissioner, up to a
29 maximum of 180 visits in a calendar year, provided those
30 services commence within seven days following
31 confinement in a hospital or skilled nursing facility of at
32 least three consecutive days for the same conditions,
33 provided further, in the case of an individual diagnosed
34 by a physician as terminally ill with a prognosis of six
35 months or less to live, such home health agency services
36 may commence irrespective of whether that covered
37 person was so confined, or, if the covered person was so
38 confined, irrespective of the seven-day period, and the
39 yearly benefit for medical social services, as hereinafter
40 defined, shall not exceed two hundred dollars (\$200); (7)

1 use of radium or other radioactive materials; (8)
2 outpatient chemotherapy for the removal of tumors and
3 treatment of leukemia, including outpatient
4 chemotherapy; (9) oxygen; (10) anesthetics; (11)
5 nondental prosthesis and maxillo-facial prosthesis used to
6 replace any anatomic structure lost during treatment for
7 head and neck tumors or additional appliances essential
8 for the support of the prosthesis; (12) rental of durable
9 medical equipment which has no personal use in the
10 absence of the condition for which prescribed; (13)
11 diagnostic X-rays and laboratory tests as defined by the
12 commissioner; (14) oral surgery for: (A) excision of
13 partially or completely unerupted impacted teeth, or (B)
14 excision of a tooth root without the extraction of the
15 entire tooth; (15) services of a licensed physical therapist,
16 rendered under the direction of a physician; (16)
17 transportation by a local professional ambulance to the
18 nearest health care institution qualified to treat the illness
19 or injury; (17) certain other services which are medically
20 necessary in the treatment or diagnosis of an illness or
21 injury as may be designated or approved by the insurance
22 commissioner; (18) confinement in a facility established
23 primarily for the treatment of alcoholism and licensed for
24 such care by the state, or in a part of a hospital used
25 primarily for such treatment, shall be a covered expense
26 for a period of at least 45 days within any calendar year.
27 "Medical social services" as used in paragraph (6) means
28 services rendered, under the direction of a physician by
29 a qualified social worker holding a master's degree from
30 an accredited school of social work, including but not
31 limited to (A) assessment of the social, psychological and
32 family problems related to or arising out of the covered
33 person's illness and treatment; (B) appropriate action
34 and utilization of community resources to assist in
35 resolving those problems; (C) participation in the
36 development of treatment for such covered persons.
37 (b) Minimum standard benefits may include one or
38 more of the following provisions: (1) Subject to the
39 provisions of paragraph (3) the plan may require
40 deductibles. The "low option deductible" shall be two

1 hundred dollars (\$200) per person, the "middle option
2 deductible" shall be five hundred dollars (\$500) per
3 person, the "high option deductible" shall be seven
4 hundred fifty dollars (\$750) per person. The amount of
5 the deductible may not be greater when a service is
6 rendered on an outpatient basis than when that service
7 is offered on an inpatient basis. Expenses incurred during
8 the last three months of a calendar year and actually
9 applied to an individual's deductible for that year shall be
10 applied to that individual's deductible in the following
11 calendar year. The two hundred dollar (\$200) maximum,
12 the five hundred dollar (\$500) maximum and the seven
13 hundred fifty dollar (\$750) maximum may be adjusted
14 yearly to correspond with the change in the medical care
15 component of the consumer price index, as adjusted by
16 the commissioner. The base year for that computation
17 shall be the first full year of operation of the plan. (2)
18 Subject to the provisions of paragraph (3), the plan shall
19 require a maximum copayment of 20 percent for charges
20 for all types of health care in excess of the deductible and
21 50 percent for services listed in paragraph (3) of
22 subdivision (a) in excess of the deductible. (3) The sum
23 of the deductible and copayments required in any
24 calendar year under any option may not exceed a
25 maximum limit of one thousand dollars (\$1,000) per
26 covered individual, or two thousand dollars (\$2,000) per
27 covered family; provided, covered expenses incurred
28 after the applicable maximum limit has been reached
29 shall be paid at the rate of 100 percent, except that
30 expenses incurred for treatment of mental and nervous
31 conditions may be paid at the rate of 50 percent as
32 specified in paragraph (3) of subdivision (a). The one
33 thousand dollar (\$1,000) and two thousand dollar
34 (\$2,000) maximums shall be adjusted yearly to
35 correspond with the change in the medical care
36 component of the consumer price index as adjusted by
37 the commissioner. (4) The plan may limit lifetime
38 benefits to a maximum of not less than one million dollars
39 (\$1,000,000) per covered individual. (5) No preexisting
40 condition exclusion shall exclude coverage of any

1 *preexisting conditions unless: (A) The condition first*
2 *manifested itself within the period of six months*
3 *immediately prior to the effective date of coverage in*
4 *such a manner as would cause a reasonably prudent*
5 *person to seek diagnosis, care or treatment; (B) medical*
6 *advice or treatment was recommended or received*
7 *within the period of six months immediately prior to the*
8 *effective date of coverage, or (C) the condition is*
9 *pregnancy existing on the effective date of coverage. No*
10 *policy shall exclude coverage for a loss due to preexisting*
11 *conditions for a period greater than six months following*
12 *the effective date of coverage. Any individual*
13 *comprehensive health care plan issued as a result of*
14 *conversion from group health insurance or from a*
15 *self-insured group shall credit the time covered under*
16 *the group health insurance toward any exclusion.*

17 *(c) Plans providing minimum standard benefits need*
18 *not provide benefits for the following: (1) Any charge for*
19 *any care, for any injury, or disease either (A) arising out*
20 *of and in the course of an employment subject to a*
21 *workers' compensation or similar law or (B) to the extent*
22 *benefits are payable without regard to fault under a*
23 *coverage statutorily required to be contained in any*
24 *motor vehicle or other liability insurance policy or*
25 *equivalent self-insurance; (2) any charge for treatment*
26 *for cosmetic purposes other than surgery for the prompt*
27 *repair of an accidental injury sustained while covered;*
28 *provided "cosmetic" shall not mean replacement of any*
29 *anatomic structure removed during treatment of tumors;*
30 *(3) any charge for travel, other than transportation by*
31 *local professional ambulance to the nearest health care*
32 *institution qualified to treat the illness or injury; (4) any*
33 *charge for private room accommodations to the extent it*
34 *is in excess of the institution's most common charge for*
35 *a semiprivate room; (5) any charge by health care*
36 *institutions to the extent that it is determined by the*
37 *carrier that the charge exceeds the reasonable charge in*
38 *the locality for the service, or an agreed upon allowance;*
39 *(6) any charge for services or articles to the extent that*
40 *it exceeds the reasonable charge in the locality for the*

1 service, or an agreed upon allowance; (7) any charge for
2 services or articles which are determined not to be
3 medically necessary, except that this shall not apply to
4 the fabrication or placement of the prosthesis as specified
5 in paragraph (11) of subdivision (a) and paragraph (2);
6 (8) any charge for services or articles the provision of
7 which is not within the scope of the license or certificate
8 of the institution or individual rendering such services or
9 articles; (9) any charge for services or articles furnished,
10 paid for or reimbursed directly by or under any law of a
11 government, except as otherwise provided herein; (10)
12 any charge for services or articles for custodial care or
13 designed primarily to assist an individual in meeting his
14 activities of daily living; (11) any charge for services
15 which would not have been made if no insurance existed
16 or for which the covered individual is not legally
17 obligated to pay; (12) any charge for eyeglasses, contact
18 lenses or hearing aids or the fitting thereof; (13) any
19 charge for dental care not specifically covered by this
20 part; and (14) any charge for services of a registered
21 nurse who ordinarily resides in the covered individual's
22 home, or who is a member of the covered individual's
23 family or the family of the covered individual's spouse.

24 (d) Whenever a covered individual who receives
25 benefits for an injury has a right of recovery against any
26 person or organization, a carrier that has paid those
27 benefits to or for the insured person shall be subrogated
28 to all such rights of recovery to the extent of its payments.

29 (e) The minimum standard benefits of any individual
30 or group comprehensive health care plan may be
31 satisfied by catastrophic coverage offered in conjunction
32 with basic hospital or medical-surgical plans on an
33 expense incurred or service basis as approved by the
34 commissioner as providing at least equivalent benefits.

35 (f) All Medicare supplement plans offered pursuant to
36 this part to persons over the age of 65 years shall provide
37 coverage of 50 percent of the deductible and copayment
38 required under Medicare and 80 percent of the charges
39 for covered services described in this section which
40 charges are not paid by Medicare. The coverage shall

1 *include a limitation of one thousand dollars (\$1,000) per*
2 *person in total annual out-of-pocket expenses for the*
3 *covered services. The coverage may be subject to a*
4 *maximum lifetime benefit of not less than one hundred*
5 *thousand dollars (\$100,000).*

6 *12705. A group comprehensive health care plan shall*
7 *contain the minimum standard benefits prescribed in*
8 *Section 12704, including the choice of the low option,*
9 *middle option or high option deductible, and shall also*
10 *conform in substance to the requirements of this section.*

11 *(a) The plan shall be one under which the individuals*
12 *eligible to be covered include: (1) each eligible*
13 *employee; (2) the spouse of each eligible employee; and*
14 *(3) dependent unmarried children, who are under the*
15 *age of 19 or are full-time students under the age of 23 at*
16 *an accredited institution of higher learning.*

17 *(b) The plan shall provide the option to continue*
18 *coverage under each of the following circumstances until*
19 *eligible for other group insurance: (1) Upon layoff or*
20 *leave of absence, or termination of employment, other*
21 *than as a result of death of the employee, continuation of*
22 *coverage for such employee and his covered dependents*
23 *to the end of the 39th week following the day on which*
24 *the employee lost eligibility to participate in the group;*
25 *(2) upon the death of the employee, continuation of*
26 *coverage for the covered dependents of such employee*
27 *to the end of the 39th week following the day on which*
28 *the employee lost eligibility to participate in the group;*
29 *(3) during an employee's absence due to illness or injury,*
30 *continuation of coverage for such employee and his*
31 *covered dependents during continuance of such illness or*
32 *injury or for up to 12 months from the beginning of such*
33 *absence; (4) upon termination of the group plan,*
34 *coverage for covered individuals who were totally*
35 *disabled on the date of termination, shall be continued*
36 *without premium payment during the continuance of*
37 *such disability for a period of 12 calendar months*
38 *following the calendar month in which the plan was*
39 *terminated, provided a claim is submitted therefor*
40 *within one year of the termination of the plan; (5) the*

1 coverage of any covered individual shall terminate: (A)
2 as to a child, at the end of the month following the month
3 in which the child marries, ceases to be dependent on the
4 employee or attains the age of 19, whichever occurs first,
5 except that if the child is a full-time student at an
6 accredited institution, the coverage may be continued
7 while the child remains unmarried and a full-time
8 student, but not beyond the month following the month
9 in which the child attains the age of 23. If on the date
10 specified for termination of coverage on a dependent
11 child, the child is unmarried and incapable of
12 self-sustaining employment by reason of mental or
13 physical handicap and chiefly dependent upon the
14 employee for support and maintenance, the coverage on
15 such child shall continue while the plan remains in force
16 and the child remains in such condition, provided proof
17 of such handicap is received by the carrier within 31 days
18 of the date on which the child's coverage would have
19 terminated in the absence of such incapacity. The carrier
20 may require subsequent proof of the child's continued
21 incapacity and dependency but not more often than once
22 a year thereafter; (B) as to the employee's spouse, at the
23 end of the month following the month in which a divorce,
24 annulment or legal separation is obtained; and (C) as to
25 the employee or dependent as of midnight of the day
26 preceding such person's eligibility for benefits under
27 Title XVIII of the Social Security Act; (6) any
28 continuation of coverage required by this section except
29 paragraph (4) of subdivision (b) may be subject to the
30 requirement, on the part of the individual whose
31 coverage is to be continued, that the individual
32 contribute that portion of the premium he would have
33 been required to contribute had the employee remained
34 an active covered employee, except that the individual
35 may be required to pay the entire premium at the group
36 rate if coverage is continued in accordance with
37 paragraph (1) of subdivision (b) above, provided the
38 employer shall not be legally obligated by this part to pay
39 that premium if not paid timely by the employee.
40 (c) The commissioner shall promulgate regulations

1 concerning coordination of benefits between the plan
2 and other health insurance plans.

3 (d) The plan shall make available to California
4 residents, in addition to any other conversion privilege
5 available, a conversion privilege under which coverage
6 shall be available immediately upon termination of
7 coverage under the group plan. The terms and benefits
8 offered under the conversion benefits shall be at least
9 equal to the terms and benefits of an individual
10 comprehensive health care plan.

11 12708. An individual comprehensive health care plan
12 shall contain the minimum standard benefits prescribed
13 in Section 12704, including the choice of the low option,
14 middle option or high option deductible, and shall also
15 conform in substance to the requirements of this section.
16 Each individual comprehensive health care plan shall
17 contain provisions:

18 (a) Which obligate the carrier to continue the
19 contract until the earlier of the following:

20 (1) The date on which the individual in whose name
21 the contract was issued first becomes eligible for
22 coverage under Title XVIII of the Social Security Act or
23 under a group comprehensive health care plan.

24 (2) The plan anniversary date at least 60 days prior to
25 which the carrier has mailed to the individual at his last
26 address shown on the carrier's records written notice of
27 its decision not to continue coverage on a class basis only.

28 The carrier may reserve the right to adjust premiums
29 by classes in accordance with its experience for policies
30 or contracts not written by or through the California
31 Comprehensive Health Insurance Association, provided
32 that premium may not exceed the premium established
33 for that particular class by the California Comprehensive
34 Health Insurance Association.

35 (b) Which, upon the death of the individual in whose
36 name the contract was issued, permits every other
37 individual then covered under the contract to elect,
38 within such period as shall be specified in the contract, to
39 continue the same coverage until such time as he would
40 have ceased to be entitled to coverage had the individual

1 *in whose name the contract was issued lived.*

2 *(c) Under which the benefits payable shall be excess*
3 *to all other sources of health insurance benefits, including*
4 *benefits provided pursuant to any state or federal law*
5 *other than Medicaid.*

6 *12709. There is hereby created a nonprofit legal*
7 *entity to be known as the California Comprehensive*
8 *Health Insurance Association. All insurers and*
9 *self-insurers doing business in the state, as a condition to*
10 *their authority to transact the applicable kinds of health*
11 *insurance defined in Section 12702, shall be members of*
12 *the association if not otherwise prohibited by federal law.*
13 *The association shall perform its functions under a plan*
14 *of operation established and approved under subdivision*
15 *(a), and shall exercise its powers through a board of*
16 *directors established under this section.*

17 *(a) (1) The board of directors of the association shall*
18 *be made up of seven individuals selected by participating*
19 *members, subject to approval by the commissioner. To*
20 *select the initial board of directors, and to initially*
21 *organize the association, the commissioner shall give*
22 *notice to all members of the time and place of the*
23 *organizational meeting. In determining voting rights at*
24 *the organizational meeting each member shall be*
25 *entitled to vote in person or by proxy. The vote shall be*
26 *a weighted vote based upon the net health insurance*
27 *policy premium derived from this state in the previous*
28 *calendar year. If the board of directors is not selected*
29 *within 60 days after notice of the organizational meeting,*
30 *the commissioner may appoint the initial board. In*
31 *approving or selecting members of the board, the*
32 *commissioner may consider, among other things,*
33 *whether all members are fairly represented. Members of*
34 *the board may be reimbursed from the moneys of the*
35 *association for expenses incurred by them as members,*
36 *but shall not otherwise be compensated by the*
37 *association for their services.*

38 *(2) The board shall submit to the commissioner, a plan*
39 *of operation for the association necessary or suitable to*
40 *assure the fair, reasonable and equitable administration*

1 of the association. The plan of operation shall become
2 effective upon approval in writing by the commissioner
3 consistent with the date on which the coverage under
4 this act must be made available. The commissioner shall,
5 after notice and hearing, approve the plan of operation
6 provided such plan is determined to be suitable to assure
7 the fair, reasonable and equitable administration of the
8 association, and provides for the sharing of association
9 gains or losses on an equitable proportionate basis. If the
10 board fails to submit a suitable plan of operation within
11 180 days after its appointment, or if at any time thereafter
12 the board fails to submit suitable amendments to the
13 plan, the commissioner shall, after notice and hearing,
14 adopt and promulgate those reasonable rules as are
15 necessary or advisable to effectuate the provisions of this
16 section. The rules shall continue in force until modified
17 by the commissioner or superseded by a plan submitted
18 by the board and approved by the commissioner. The
19 plan of operation shall, in addition to requirements
20 enumerated in Sections 12702 to 12713, inclusive, do all
21 the following:

22 (A) Establish procedures for the handling and
23 accounting of assets and moneys of the association.

24 (B) Establish regular times and places for meetings of
25 the board of directors.

26 (C) Establish procedures for records to be kept of all
27 financial transactions, and for the annual fiscal reporting
28 to the commissioner.

29 (D) Establish procedures whereby selections for the
30 board of directors shall be made and submitted to the
31 commissioner.

32 (E) Establish procedures to amend, subject to the
33 approval of the commissioner, the plan of operations.

34 (F) Establish procedures for the selection of an
35 administering carrier and set forth the powers and duties
36 of the administering carrier.

37 (G) Contain additional provisions necessary or proper
38 for the execution of the powers and duties of the
39 association.

40 (H) Establish procedures for the advertisement on

1 *behalf of all participating carriers of the general*
2 *availability of the comprehensive and Medicare*
3 *supplement coverage under Sections 12702 to 12713.*

4 *(b) The association shall have the general powers and*
5 *authority granted under the laws of this state to carriers*
6 *to transact the kinds of plans of health coverage defined*
7 *under Section 12702, and in addition thereto, the specific*
8 *authority to do all the following:*

9 *(1) Enter into contracts necessary or proper to carry*
10 *out the provisions and purposes of Sections 12702 to*
11 *12713.*

12 *(2) Sue or be sued, including taking any legal actions*
13 *necessary or proper for recovery of any assessments for,*
14 *on behalf of, or against participating members.*

15 *(3) Take such legal action necessary to avoid the*
16 *payment of improper claims against the association or the*
17 *coverage provided by or through the association.*

18 *(4) Establish, with respect to health insurance*
19 *provided by or on behalf of the association, appropriate*
20 *rates, scales of rates, rate classifications and rating*
21 *adjustments, such rates not to be unreasonable in relation*
22 *to the coverage provided and the operational expenses of*
23 *the association.*

24 *(5) Administer any type of reinsurance program, for*
25 *or on behalf of participating members.*

26 *(6) Pool risks among participating members.*

27 *(7) Issue policies of insurance on an indemnity or*
28 *provision of service basis providing the coverage*
29 *required by Sections 12702 to 12713 in its own name or on*
30 *behalf of participating members.*

31 *(8) Administer separate pools, separate accounts or*
32 *other plans as deemed appropriate for separate members*
33 *or groups of members.*

34 *(9) Operate and administer any combination of plans,*
35 *pools, reinsurance arrangements or other mechanisms as*
36 *deemed appropriate to best accomplish the fair and*
37 *equitable operation of the association.*

38 *(10) Set limits on the amounts of reinsurance which*
39 *may be ceded to the association by its members.*

40 *(11) Appoint from among participating members*

1 appropriate legal, actuarial and other committees as
2 necessary to provide technical assistance in the operation
3 of the association, policy and other contract design, and
4 any other function within the authority of the association.

5 (c) Every member shall participate in the association
6 in accordance with the provisions of this subdivision.

7 (1) A participating member shall determine the
8 particular risks it elects to have written by or through the
9 association. A member shall designate which of the
10 following classes of risks it shall underwrite in the state,
11 from which classes of risk it may elect to reinsure selected
12 risks:

13 (A) Individual, excluding group conversion.

14 (B) Individual, including group conversion.

15 (C) Groups of between 3 and 25 employees or
16 members.

17 (D) Medicare supplement plans.

18 (2) No member or employer shall be permitted to
19 select out individual lives from an employer group to be
20 insured by or through the association. Members electing
21 to administer risks which are insured by or through the
22 association shall comply with the benefit determination
23 guidelines and the accounting procedures established by
24 the association. A risk insured by or through the
25 association cannot be withdrawn by the participating
26 member except in accordance with the rules established
27 by the association.

28 (3) Rates for coverage issued by or through the
29 association shall not be excessive, inadequate or unfairly
30 discriminatory. Separate scales of premium rates based
31 on age shall apply for individual risks and group risks.
32 Group rates may be adjusted for area variations in
33 provider costs, but individual rates shall not be adjusted
34 for area variations in provider costs. Premium rates shall
35 take into consideration the substantial extra morbidity
36 and administrative expenses for association risks,
37 reimbursement or reasonable expenses incurred for the
38 writing of association risks and the level of rates charged
39 by insurers for groups of 10 lives. In no event shall the rate
40 for a given classification or group be less than 125 percent

1 nor more than 150 percent of the average group rate
2 charged for that classification or group with similar
3 characteristics under a policy covering 10 lives. All rates
4 shall be promulgated by the association through an
5 actuarial committee consisting of five persons who are
6 members of the American Academy of Actuaries, shall be
7 filed with the commissioner and may be disapproved
8 within 60 days from the filing thereof if excessive,
9 inadequate, or unfairly discriminatory.

10 (d) (1) Following the close of each fiscal year, the
11 administering carrier shall determine the net premiums,
12 reinsurance premiums less administrative expense
13 allowance, the expense of administration pertaining to
14 the reinsurance operations of the association and the
15 incurred losses for the year. Any net loss shall be assessed
16 to all participating members in proportion to their
17 respective shares of the total health insurance policy
18 premiums earned in this state during the calendar year,
19 or with paid losses in the year, coinciding with or ending
20 during the fiscal year of the association or on any other
21 equitable basis as may be provided in the plan of
22 operations. For self-insured members of the association,
23 health insurance premiums earned shall be established
24 by dividing the amount of paid health losses for the
25 applicable period by 85 percent. Net gains, if any, shall be
26 held at interest to offset future losses or allocated to
27 reduce future premiums.

28 (2) Any net loss to the association represented by the
29 excess of its actual expenses of administering policies
30 issued by the association over the applicable expense
31 allowance shall be separately assessed to those
32 participating members who do not elect to administer
33 their plans. All assessments shall be on an equitable
34 formula established by the board.

35 (3) The association shall conduct periodic audits to
36 assure the general accuracy of the financial data
37 submitted to the association, and the association shall
38 have an annual audit of its operations by an independent
39 certified public accountant. The annual audit shall be
40 filed with the commissioner for his review.

1 (e) All policy forms issued by or through the
2 association shall conform in substance to prototype
3 forms developed by the association, shall in all other
4 respects conform to the requirements of this act, and shall
5 be approved by the commissioner. The commissioner
6 may disapprove any such form if it contains a provision
7 or provisions which are unfair or deceptive or which
8 encourage misrepresentation of the policy.

9 (f) The association shall not issue nor reissue
10 comprehensive health care plan coverage with respect to
11 any person who is already covered under an individual or
12 group comprehensive health care plan, or who is eligible
13 for Medicare or who is not a resident of this state.

14 (g) Benefits payable under a comprehensive health
15 care plan insured by or reinsured through the association
16 shall be paid net of all other health insurance benefits
17 paid or payable through any other source, and net of all
18 health insurance coverages provided by or pursuant to
19 any other state or federal law including Title XVIII of the
20 Social Security Act, Medicare, but excluding Medi-Cal.

21 (h) There shall be no liability on the part of and no
22 cause of action of any nature shall arise against any carrier
23 or its agents or its employees, the California
24 Comprehensive Health Insurance Association or its
25 agents or its employees or the residual market
26 mechanism established under the provisions of Section
27 12710 or its agents or its employees, or the commissioner
28 or his representatives for any action taken by them in the
29 performance of their duties under Sections 12702 to
30 12713. This provision shall not apply to the obligations of
31 a carrier, a self-insurer, the California Comprehensive
32 Health Insurance Association or the residual market
33 mechanism for payment of benefits provided under a
34 comprehensive health care or Medicare supplement
35 plan.

36 12710. (a) Hospital and health care service plans may
37 elect to meet the obligations of Section 12703 by
38 participating in the California Comprehensive Health
39 Insurance Association established in Section 12709 as a
40 full member thereof, or by making comprehensive health

1 care or Medicare supplement plans available directly
2 through a subscriber contract or combination of contracts
3 or by forming a separate residual market mechanism
4 substantially similar to the association established in
5 Section 12709.

6 (b) In the event that hospital and health care service
7 plans choose to form a separate residual market
8 mechanism, the commissioner shall have the same
9 regulatory powers over that residual market mechanism
10 as he or she has over the California Comprehensive
11 Health Insurance Association, and that residual market
12 mechanism shall have the same powers and duties as the
13 association. Rating classifications under a residual market
14 mechanism established under this section need not be
15 the same as the classifications established under this
16 association, but any rates established by the residual
17 market mechanism shall be approved by the
18 commissioner. The commissioner shall promulgate
19 regulations to carry out the requirements of this section.

20 (c) If the hospital and health care service plans do not
21 elect to participate in the California Comprehensive
22 Health Insurance Association those hospital and health
23 care service plans shall be required to make available an
24 individual comprehensive health care plan to every
25 resident of the state whose coverage under a group or
26 individual contract issued by the hospital and health care
27 service plan has terminated. That coverage may be made
28 available through a separate residual market mechanism
29 established under this section.

0 12711. In order to provide reasonable simplification of
1 terms and coverages of individual accident and sickness
2 insurance policies and contracts, to facilitate public
3 understanding and comparison, to eliminate provisions
4 which may be misleading or unreasonably confusing in
5 connection with either the purchase of such coverage or
6 with the settlement of claims and to provide for full
7 disclosure in the sale of such coverages:

8 (a) The commissioner shall issue regulations to
9 establish specific standards for policy provisions used in
0 individual health insurance policies or contracts, but not

1 including group conversion policies or contracts, which
2 shall be in addition to other applicable laws of this state
3 which may cover the terms of renewability, initial and
4 subsequent conditions of eligibility, non-duplication of
5 coverage provisions, coverage of dependents,
6 termination of insurance, probationary periods,
7 limitations, exceptions, reductions, elimination periods,
8 requirements for replacements, recurrent conditions,
9 pre-existing conditions, and the definition of the terms
10 hospital, accident, sickness, injury, physician, accidental
11 means, total disability, permanent disability, partial
12 disability, nervous disorders, guaranteed renewable, and
13 noncancelable.

14 (b) The commissioner shall adopt regulations that
15 specify prohibit policy provisions not otherwise
16 specifically authorized by statute which in the opinion of
17 the commissioner are unjust, unfair or unfairly
18 discriminatory to the policyholder, any person insured
19 under the policy, or any beneficiary.

20 (c) The commissioner shall adopt regulations, to
21 establish minimum standards for benefits under each of
22 the following categories of coverage in individual
23 policies, other than conversion policies issued pursuant to
24 a contractual conversion privilege under a group policy:
25 basic hospital expense coverage, basic medical-surgical
26 expense coverage, hospital confinement indemnity
27 coverage, major medical expense coverage, disability
28 income protection coverage, accident only coverage and
29 specified accident coverage. Specified disease policies,
30 riders and benefits shall be prohibited whether issued on
31 a group or individual basis.

32 (d) Nothing in this section shall preclude the issuance
33 of any policy which combines two or more of the
34 categories of coverage enumerated in subdivision (c),
35 except that specified accident coverage shall not be
36 combined with any other category of coverage. The
37 commissioner shall prescribe the method of
38 identification of policies based upon coverage provided.

39 (e) No policy shall be delivered or issued for delivery
40 in this state which does not meet the prescribed

1 *minimum standards for the categories of coverage listed*
2 *in subdivision (c), provided nothing in this section shall*
3 *preclude the issuance or delivery of any policy which*
4 *does not meet such prescribed minimum standards of*
5 *coverage so long as such policy is clearly identified as not*
6 *meeting such prescribed standards.*

7 *(f) No such policy or contract shall be delivered in this*
8 *state unless:*

9 *(1) An outline of coverage described herein*
10 *accompanies the policy or (2) the outline of coverage*
11 *described in this section is delivered to the applicant at*
12 *the time application is made and acknowledgement of*
13 *receipt of certificate of delivery of such outline is*
14 *provided the carrier with the application. In the event*
15 *the policy or contract is issued on a basis other than that*
16 *applied for, the outline of coverage properly describing*
17 *the policy shall accompany the policy when it is*
18 *delivered. The outline of coverage shall include: (A) a*
19 *statement identifying the applicable category or*
20 *categories of coverage provided by the policy in*
21 *accordance with this section; (B) a description of the*
22 *principal benefits and coverage provided in the policy;*
23 *(C) a statement of the exceptions, reductions and*
24 *limitations contained in the policy or contract; (D) a*
25 *statement of the renewal provisions including any*
26 *reservation by the carrier of a right to change premiums;*
27 *and (E) a statement that the outline is a summary of the*
28 *policy issued or applied for and that the policy should be*
29 *consulted to determine governing contractual provisions.*

30 *(g) If a carrier elects to use a simplified application*
31 *form, with or without any questions as to the applicant's*
32 *health at the time of application, but without any*
33 *questions concerning the insured's health history or*
34 *medical treatment history, the policy shall cover loss*
35 *developing after six months from any pre-existing*
36 *condition not specifically excluded from coverage by the*
37 *terms of the policy and, except as so provided, the policy*
38 *shall not include wording that would permit a defense*
39 *based upon pre-existing conditions.*

40 *(h) Regulations promulgated pursuant to this section*

1 shall specify an effective date applicable to policy and
2 benefit riders delivered or issued for delivery in this state
3 on and after such effective date which shall not be less
4 than 180 days after the date of adoption or promulgation.

5 12712. (a) In order to assure reasonable continuation
6 of coverage and extension of benefits to the citizens of
7 this state, all group health policies or contracts delivered
8 or issued for delivery or renewal in this state on or after
9 April 1, 1983, shall, subject to the provisions of subdivision
10 (c), contain those provisions described in subdivisions
11 (b) and (d) of Section 12705.

12 (b) The commissioner shall, within 180 days after April
13 1, 1983, adopt regulations covering group coverage
14 discontinuance and replacement.

15 (c) Nothing in this section shall alter or impair existing
16 group policies or contracts which have been established
17 pursuant to an agreement which resulted from collective
18 bargaining, and the provisions required by this section
19 shall become effective upon the next regular renewal and
20 completion of the collective bargaining agreement.

21

22

CHAPTER 3. COVERAGE

23

24 12700.2. Every employer who provides or makes
25 available to his employees a plan of health insurance
26 coverage shall make available to such employees
27 employed in this state a plan or combination of plans
28 which have been certified by the commissioner as a Class
29 B qualified plan. If such plan does not meet the
30 requirements of this part for a Class B qualified plan, the
31 employer shall make available a supplemental plan of
32 health benefits which, when combined with the existing
33 plan of health benefits, constitutes a Class B coverage
34 plan. The plan or combinations of plans may be financed
35 from funds contributed solely by the employer or solely
36 by the employees or any combination thereof. The plans
37 may consist of self-insurance, health or hospital care
38 service plan contracts, group policies or individual
39 policies or any combination thereof.

40 12700.3. In the event that an employer fails to comply

with the provisions of Section 12700.2; none of the employer's costs for health benefits shall qualify as an income tax deduction for purposes of state taxation. In the case of an employer who qualifies as a nonprofit tax exempt organization for purposes of taxation; if the employer fails to make available at least a Class B qualified plan to his employees; the employer shall lose his status as an exempt organization.

12700.4. For each type of qualified plan described in this part; an insurer or fraternal issuing individual policies of accident and health insurance in this state; other than group conversion policies; shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

12700.5. An insurer or fraternal issuing Medicare supplement plans in this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

12700.6. For each type of qualified plan described in Section 12700.12; an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

12700.7. Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every

1 applicant for a new unqualified policy at the time of
2 application and annually to every holder of an
3 unqualified policy of accident and health insurance. The
4 coverage shall provide that when a covered individual
5 incurs out-of-pocket expenses of five thousand dollars
6 (\$5,000) or more within a calendar year for services
7 covered in Section 12700.12, benefits shall be payable,
8 subject to any copayment authorized by the
9 commissioner, up to a maximum lifetime limit of two
10 hundred fifty thousand dollars (\$250,000).

11 12700.8. No policy of accident and health insurance
12 may be issued or renewed in this state 180 days after the
13 effective date of this chapter by an insurer or a fraternal
14 which has not complied with the requirements of this
15 chapter.

16 12700.9. An insurer or fraternal may fulfill its
17 obligations under this chapter by issuing the required
18 coverages in their own name and reinsuring the risk and
19 administration of the coverages with the association in
20 accordance with this part.

21 12700.10. Nothing in this part shall require an insurer
22 or fraternal to offer or issue a policy to any person who
23 does not meet the underwriting or membership
24 requirements of the insurer or fraternal.

25 12700.11. Upon application by an insurer, fraternal, or
26 employers for certification of a plan of health coverage as
27 a qualified plan or a qualified Medicare supplement plan
28 for the purposes of this part, the commissioner shall make
29 a determination within 90 days as to whether the plan is
30 qualified. All plans of health coverage shall be labeled as
31 "qualified" or "nonqualified" on the front of the policy or
32 evidence of insurance. All qualified plans shall indicate
33 whether they are Class A, B, or C coverage plans.

34 12700.12. A plan of health coverage shall be certified
35 as a Class A qualified plan if it otherwise meets the
36 applicable requirements of law in this state, whether or
37 not the policy is issued in California, and meets or exceeds
38 the following minimum standards:

39 (a) The minimum benefits for a covered individual
40 shall, subject to the other provisions of this subdivision, be

1 equal to at least 80 percent of the cost of covered services
2 in excess of an annual deductible which does not exceed
3 one hundred fifty dollars (~~\$150~~) per person. The
4 coverage shall include a limitation of three thousand
5 dollars (~~\$3,000~~) per person on total annual out/of/pocket
6 expenses for services covered under this subdivision. The
7 coverage shall be subject to a maximum lifetime benefit
8 of not less than two hundred fifty thousand dollars
9 (~~\$250,000~~).

10 Such limitation on total annual out/of/pocket expenses
11 and the maximum lifetime benefit shall not be subject to
12 change or substitution by use of an actuarially equivalent
13 benefit.

14 (b) Covered expenses shall be the usual and
15 customary and reasonable charges for the following
16 services and articles when prescribed by a physician:

- 17 (1) Hospital services;
- 18 (2) Professional services for the diagnosis or treatment
19 of injuries, illnesses, or conditions, other than outpatient
20 mental or dental, which are rendered by a physician or
21 at his direction;
- 22 (3) Drugs requiring a physician's prescription;
- 23 (4) Services of a nursing home for not more than 120
24 days in a year if the services would qualify as
25 reimbursable services under Medi-Cal;
- 26 (5) Services of a home health agency if the services
27 would qualify as reimbursable services under Medi-Cal;
- 28 (6) Use of radium or other radioactive materials;
- 29 (7) Oxygen;
- 30 (8) Anesthetics;
- 31 (9) Prostheses, other than dental;
- 32 (10) Rental or purchase, as appropriate, of durable
33 medical equipment, other than eyeglasses and hearing
34 aids;
- 35 (11) Diagnostic X-rays and laboratory tests;
- 36 (12) Oral surgery for partially or completely
37 unerupted impacted teeth; a tooth root without the
38 extraction of the entire tooth; or the gums and tissues of
39 the mouth when not performed in connection with the
40 extraction or repair of teeth;

1 (13) Rehabilitative services if the services would
2 qualify as reimbursable under Medi-Cal;

3 (14) Transportation provided by licensed ambulance
4 service to the nearest facility qualified to treat the
5 condition.

6 (e) Covered expenses for the services and articles
7 specified in this subdivision do not include the following:

8 (1) Any charge for care for injury or disease either (i)
9 arising out of an injury in the course of employment and
10 subject to a workers' compensation or similar law; (ii) for
11 which benefits are payable without regard to fault under
12 coverage statutorily required to be contained in any
13 motor vehicle, or other liability insurance policy or
14 equivalent self-insurance or (iii) for which benefits are
15 payable under another policy of accident and health
16 insurance, Medicare or any other governmental program
17 except as otherwise provided by law.

18 (2) Any charge for treatment for cosmetic purposes
19 other than surgery for the repair of an injury or birth
20 defect;

21 (3) Care which is primarily for custodial or domiciliary
22 purposes which would not qualify as eligible services
23 under Medi-Cal.

24 (4) Any charge for confinement in a private room to
25 the extent it is in excess of the institution's charge for its
26 most common semi-private room; unless a private room
27 is prescribed as medically necessary by a physician. If the
28 institution does not have semi-private rooms its most
29 common semi-private room charge shall be considered to
30 be 90 percent of its current private room charge.

31 (5) That part of any charge for services or articles
32 rendered or prescribed by a physician, dentist, or other
33 health care personnel which exceeds the prevailing
34 charge in the locality where the service is provided;

35 (6) Any charge for services or articles the provision of
36 which is not within the scope of authorized practice of
37 the institution or individual rendering the services or
38 articles; and

39 (7) Any charge for services or articles deemed not to
40 be medically necessary.

1 12700.13. A plan of health coverage shall be certified
2 as a Class B qualified plan if it meets the requirements
3 established by Section 12700.12; except that the
4 deductible shall not exceed five hundred dollars (~~\$500~~)
5 per person.

6 12700.14. A plan of health coverage shall be certified
7 as a Class C qualified plan if it meets the requirements
8 established by Section 12712; except that the deductible
9 shall not exceed one thousand dollars (~~\$1,000~~) per person.

10 12700.15. A health or hospital/care service plan which
11 provides the comprehensive services required by the
12 Knox/Keene Act and is a qualified health maintenance
13 organization pursuant to federal law shall be deemed to
14 be providing a Class A qualified plan.

15 12700.16. Any plan which provides benefits to persons
16 over the age of 65 years may be certified as a qualified
17 Medicare supplement plan if the plan is designed to
18 supplement Medicare and provides coverage of 50
19 percent of the deductible and copayment required under
20 Medicare and 80 percent of the charges for covered
21 services described in Section 12700.12 which charges are
22 not paid by Medicare. The coverage shall include a
23 limitation of one thousand dollars (~~\$1,000~~) per person on
24 total annual out/of/pocket expenses for the covered
25 services. The coverage may be subject to a maximum
26 lifetime benefit of not less than one hundred thousand
27 dollars (~~\$100,000~~).

28 12700.17. For the first 18 months of operation of the
29 comprehensive health insurance plan, the association
30 shall establish the following premiums to be charged for
31 membership in the comprehensive health insurance
32 plan:

33 (a) The premium for the Class C qualified plan shall
34 be the average of rates charged by the five insurers with
35 the largest number of individuals in a Class C individual
36 qualified plan of insurance in force in California;

37 (b) The premium for the Class B qualified plan shall
38 be the average rates charged by the five insurers with the
39 largest number of individuals in a Class B individual
40 qualified plan of insurance in force in California;

1 (c) The premium for a qualified Medicare supplement
2 plan shall be the average of rates charged by the five
3 insurers with the largest number of individuals enrolled
4 in a qualified Medicare supplement plan; and,

5 (d) The charge for health or hospital care service plan
6 coverage shall be based on generally accepted actuarial
7 principles appropriate to organized prepayment systems.

8 12700.18. For subsequent enrollees or renewals of
9 membership, the schedule of premiums for membership
10 in the health insurance plan shall be designed to be
11 self/supporting and based on generally accepted actuarial
12 principles.

13
14 CHAPTER 4. DUTIES OF THE COMMISSIONER

15
16 12700.19. The commissioner may do all of the
17 following:

18 (a) Formulate general policies to advance the
19 purposes of this part;

20 (b) Supervise the creation of the California
21 Comprehensive Health Association within the limits
22 described in Section 12700.20;

23 (c) Approve the selection of the writing carrier by the
24 association and approve the association's contract with
25 the writing carrier including the state plan coverage and
26 premiums to be charged;

27 (d) Appoint advisory committees;

28 (e) Conduct periodic audits to assure the general
29 accuracy of the financial data submitted by the writing
30 carrier and the association;

31 (f) Contract with the federal government or any other
32 unit of government to ensure coordination of the state
33 plan with other governmental assistance programs;

34 (g) Undertake directly or through contracts with
35 other persons studies or demonstration programs to
36 develop awareness of the benefits specified in this part,
37 so that the residents of this state may best avail
38 themselves of the health care benefits provided herein;
39 and,

40 (h) Contract with insurers and others for

1 administrative services and adopt, amend, suspend, and
2 repeal rules as reasonably necessary to carry out and
3 make effective the provisions and purposes of this part.

4
5 CHAPTER 5. COMPREHENSIVE HEALTH INSURANCE
6 ASSOCIATION

7
8 12700.20. There is hereby established a
9 Comprehensive Health Insurance Association to
10 promote the public health and welfare of the people of
11 the State of California, with membership consisting of all
12 insurers, self/insurers, fraternal and health or hospital
13 care service plans authorized to transact business in this
14 state. The Comprehensive Health Insurance Association
15 shall be exempt from taxation under the laws of this state
16 and all property owned by the association shall be exempt
17 from taxation.

18 12700.21. (a) The board of directors of the association
19 shall be made up of seven individuals selected by
20 participating members, subject to approval by the
21 commissioner. To select the initial board of directors, and
22 to initially organize the association, the commissioner
23 shall give notice to all members of the time and place of
24 the organizational meeting. In determining voting rights
25 at the organizational meeting, each member shall be
26 entitled to vote in person or proxy. The vote shall be a
27 weighted vote based upon the member's cost of
28 self/insurance, accident and health insurance premium,
29 subscriber contract charges, or health or hospital care
30 service plan contract payment derived from or on behalf
31 of California residents in the previous calendar year, as
32 determined by the commissioner. If the board of
33 directors is not selected within 60 days after notice of the
34 organizational meeting, the commissioner may appoint
35 the initial board. In approving or selecting members of
36 the board, the commissioner shall consider, among other
37 things, whether all types of members are fairly
38 represented. Members of the board may be reimbursed
39 from the moneys of the association for expenses incurred
40 by them as members, but shall not otherwise be

1 compensated by the association for their services. The
2 costs of conducting meetings of the association and its
3 board of directors shall be borne by members of the
4 association.

5 (b) All members shall maintain their membership in
6 the association as a condition of transacting accident and
7 health insurance, self-insurance, or health or hospital care
8 service plan business in this state. The association shall
9 submit bylaws and operating rules to the commissioner
10 for approval.

11 12700.22. All meetings of the association, its board,
12 and any committees of the association, shall be open to
13 the public.

14 12700.23. All members shall enter into a contract with
15 the association according to terms specified in Section
16 12700.26. The contract of reinsurance shall be executed
17 on or before July 1, 1982, for a period of one year and shall
18 be renewed annually thereafter. A company which
19 ceases to do business within the state shall remain liable
20 under the contract for the reinsurance contracted for
21 during that calendar year.

22 12700.24. In the performance of their duties as
23 members of the association, the members shall be exempt
24 from the provisions of any law prohibiting combinations
25 in restraint of trade.

26 12700.25. The association may:

27 (a) Exercise the power granted to insurers under the
28 laws of this state;

29 (b) Sue or be sued;

30 (c) Enter into contracts with insurers, similar
31 associations in other states or with other persons for the
32 performance of administrative functions including the
33 functions provided for in subdivisions (e) and (f);

34 (d) Establish administrative and accounting
35 procedures for the operation of the association;

36 (e) Provide for the reinsuring of risks incurred as a
37 result of issuing the coverages required by this part by
38 members of the association. Each member which elects
39 to reinsure its required risks shall determine the
40 categories of coverage it elects to reinsure in the

1 association. The categories of coverage are:

- 2 (1) Individual qualified plans, excluding group
- 3 conversions;
- 4 (2) Group conversions;
- 5 (3) Group qualified plans with fewer than 50
- 6 employees or members; and
- 7 (4) Major medical coverage.

8 A separate election may be made for each category of
9 coverage. If a member elects to reinsure the risks of a
10 category of coverage, it must reinsure the risk of the
11 coverage of every individual covered under every policy
12 issued in that category. A member electing to reinsure
13 risks of a category of coverage shall enter into a contract
14 with the association establishing a reinsurance plan for
15 the risks. This contract may include provision for the
16 pooling of member's risks reinsured through the
17 association and it may provide for assessment of each
18 member reinsuring risks for losses and operating and
19 administrative expenses incurred or estimated to be
20 incurred in the operation of the reinsurance plan. The
21 reinsurance plan shall be approved by the commissioner
22 before it is effective. Members electing to administer the
23 risks which are reinsured in the association shall comply
24 with the benefit determination guidelines and
25 accounting procedures established by the association.
26 The fee charged by the association for the reinsurance of
27 risks shall not be less than 110 percent of the total
28 anticipated expenses incurred by the association for the
29 reinsurance;

30 (f) Provide for the administration by the association of
31 policies which are reinsured pursuant to subdivision (e).
32 Each member electing to reinsure one or more
33 categories of coverage in the association may elect to
34 have the association administer the categories of
35 coverage on the member's behalf. If a member elects to
36 have the association administer the categories of
37 coverage, it must do so for every individual covered
38 under every policy issued in that category. The fee for the
39 administration shall not be less than 110 percent of the
40 total anticipated expenses incurred by the association for

1 the administration.

2 12700.26: Upon certification as an eligible person in
3 the manner provided by this chapter, an eligible person
4 may enroll in the comprehensive health insurance plan
5 by payment of the state plan premium to the writing
6 carrier.

7 12700.27: Any employer which has in its employ one
8 or more eligible persons enrolled in the comprehensive
9 health insurance plan may make all or any portion of the
10 state plan premium payment to the state plan directly to
11 the writing carrier.

12 12700.28: Not less than 87½ percent of the state plan
13 premium paid to the writing carrier shall be used to pay
14 claims; and not more than 12½ percent shall be used for
15 the payment of agent referral fees as authorized in
16 Section 12700.46 and for payment of the writing carrier's
17 direct and indirect expenses; as specified in Section
18 12700.38.

19 12700.29: Any income in excess of the costs incurred
20 by the association in providing reinsurance or
21 administrative services pursuant to this part shall be held
22 at interest and used by the association to offset losses due
23 to claims expenses of the state plan or allocated to reduce
24 state plan premiums.

25 12700.30: Each member of the association shall share
26 the losses due to claims expenses of the comprehensive
27 health insurance plan for plans issued or approved for
28 issuance by the association; and shall share in the
29 operating and administrative expenses incurred or
30 estimated to be incurred by the association incident to
31 the conduct of its affairs; pursuant to the terms of the
32 individual reinsurance contracts executed by the
33 association with each member. Deviations in the claims
34 experience of the state plan from the premium payments
35 allocated to the payment of benefits shall be the liability
36 of the association members. Association members shall
37 share in the claims expense of the state plan and
38 operating and administrative expenses of the association
39 in an amount equal to the ratio of the member's total cost
40 of self/insurance; accident and health insurance

1 premium; subscriber contract charges; or health or
2 hospital care service plan contract charges received from
3 or on behalf of California residents as divided into the
4 total cost of self-insurance; accident and health or hospital
5 insurance premium; subscriber contract charges; and
6 health care service plan contract charges received by all
7 association members from or on behalf of California
8 residents; as determined by the commissioner. The
9 reinsurance contract shall provide for an annual
10 determination and assessment of each member's liability;
11 if any. Payment of the assessment shall be due within 30
12 days after the end of the association's fiscal year. Subject
13 to the approval of the commissioner, the reinsurance
14 contract may provide for interim assessments as may be
15 necessary to assure the financial capability of the
16 association in meeting the incurred or estimated claim
17 expenses of the state plan and operating and
18 administrative expenses of the association; until the
19 association's next annual fiscal year end assessment.
20 Failure by a member to tender to the association; the
21 assessed reinsurance payment within 30 days of
22 notification by the association shall be grounds for
23 termination of the member's membership.

24 Net gains, if any, from the operation of the state plan
25 shall be held at interest and used by the association to
26 offset future losses due to claims expenses of the state
27 plan or allocated to reduce state plan premiums.

28 **12700.31.** The association through its comprehensive
29 health insurance plan shall offer policies which provide
30 the benefits of a Class C qualified plan; a Class B qualified
31 plan; a Class A qualified plan; and a qualified Medicare
32 supplement plan. They shall offer health or hospital care
33 service plan contracts in those areas of the state where a
34 health or hospital care service plan has agreed to make
35 the coverage available and has been selected as a writing
36 carrier.

37 **12700.32.** Any member of the association may submit
38 to the commissioner the policies of accident and health
39 insurance or the health or hospital care service plan
40 contracts which are being proposed to serve in the

1 comprehensive health insurance plan. The time and
2 manner of the submission shall be prescribed by rule of
3 the commissioner.

4 12700.33. Upon the commissioner's approval of the
5 policy forms and contracts submitted, the association
6 shall select policies and contracts submitted by a member
7 or members of the association to be the comprehensive
8 health insurance plan. This selection shall be based upon
9 criteria including the member's proven ability to handle
10 large group accident and health insurance cases; efficient
11 claim paying capacity; and the estimate of total charges
12 for administering the plan. The association may select
13 separate writing carriers for the three types of qualified
14 plans; the qualified Medicare supplement plan; and the
15 health or hospital service plan contract.

16 12700.34. The writing carrier shall perform all
17 administrative and claims payment functions. The
18 writing carrier shall provide these services for a period of
19 three years; unless a request to terminate is approved by
20 the commissioner. The commissioner shall approve or
21 deny a request to terminate within 90 days of its receipt.
22 A failure to make a final decision on a request to
23 terminate within the specified period shall be deemed to
24 be an approval. Six months prior to the expiration of each
25 three/year period, the association shall invite submissions
26 of policy forms from members of the association;
27 including the writing carrier. The association shall follow
28 the provisions of Section 12700.33 in selecting a writing
29 carrier for the subsequent three/year period.

30 12700.35. The writing carrier shall provide to all
31 eligible persons enrolled in the plan an individual policy
32 or certificate, setting forth a statement as to the insurance
33 protection to which the person is entitled, with whom
34 claims are to be filed and to whom benefits are payable.
35 The policy or certificate shall indicate that coverage was
36 obtained through the association.

37 12700.36. The writing carrier shall submit to the
38 association and the commissioner on a monthly basis a
39 report on the operation of the state plan. Specific
40 information to be contained in this report shall be

1 determined by the association prior to the effective date
2 of the state plan.

3 12700.37. All claims shall be paid by the writing
4 carrier. Such claims shall indicate that the claim was paid
5 by the state plan. Each claim payment shall include
6 information specifying the procedure to be followed in
7 the event of a dispute over the amount of payment.

8 12700.38. The writing carrier shall be reimbursed
9 from the state plan premiums received for its direct and
10 indirect expenses. Direct and indirect expenses shall
11 include, but need not be limited to, a pro rata
12 reimbursement for that portion of the writing carrier's
13 administrative, printing, claims administration,
14 management and building overhead expenses which are
15 assignable to the maintenance and administration of the
16 state plan. The association shall approve cost accounting
17 methods to substantiate the writing carrier's cost reports
18 consistent with generally accepted accounting principles.
19 Direct and indirect expenses shall not include costs
20 directly related to the original submission of policy forms
21 prior to selection as the writing carrier.

22 12700.39. The writing carrier shall at all times when
23 carrying out its duties under this part be considered an
24 agent of the association and the commissioner with civil
25 liability subject to applicable provisions of law regulating
26 contract claims against the state by a party to a state
27 contract.

28 12700.40. Premiums received by the writing carrier
29 for the comprehensive health insurance plan are
30 specifically exempted from paying any state-imposed
31 gross premiums tax.

32 12700.41. The comprehensive health insurance plan
33 shall be open for enrollment by eligible persons. An
34 eligible person may enroll by submission of a certificate
35 of eligibility to the writing carrier. The certificate may
36 provide the following:

37 (a) Name, address, age, and length of time at
38 residence of the applicant;

39 (b) Name, address and age of spouse and children, if
40 any, if they are to be insured;

1 (c) Evidence of rejection, or a requirement of
2 restrictive riders, or a preexisting/conditions limitation
3 on a qualified plan, the effect of which is to substantially
4 reduce coverage from that received by a person
5 considered a standard risk, by at least two association
6 members within six months of the date of the certificate;
7 and

8 (d) A designation of the coverage desired.

9 An eligible person may not purchase more than one
10 policy from the state plan.

11 ~~12700.42.~~ Within 30 days of receipt of the certificate
12 described in Section ~~12700.41~~, the writing carrier shall
13 either reject the application for failing to comply with the
14 requirements in Section ~~12700.41~~ or forward the eligible
15 person a notice of acceptance and billing information.
16 Insurance shall be effective immediately upon receipt of
17 the first month's state plan premium, and shall be
18 retroactive to the date of the application, if the applicant
19 otherwise complies with the requirements of this part.

20 ~~12700.43.~~ No person who obtains coverage pursuant
21 to this part shall be covered for any preexisting condition
22 during the first six months of coverage under the state
23 plan if the person was diagnosed or treated for that
24 condition during the 90 days immediately preceding the
25 filing of an application.

26 ~~12700.44.~~ The association pursuant to a plan approved
27 by the commissioner shall disseminate appropriate
28 information to the residents of this state regarding the
29 existence of the comprehensive health insurance plan
30 and the means of enrollment. Means of communication
31 may include use of the press, radio and television, as well
32 as publication in appropriate state offices and
33 publications.

34 ~~12700.45.~~ The association shall devise and implement
35 means of maintaining public awareness of the provisions
36 of this chapter and shall administer such provisions in a
37 manner that facilitates public participation in the state
38 plan.

39 ~~12700.46.~~ The writing carrier shall pay an agent's
40 referral fee of twenty-five dollars (~~\$25~~) to each insurancee

1 agent who refers an applicant to the state plan; if the
2 application is accepted. Selling or marketing of qualified
3 state plans shall not be limited to the writing carrier or
4 its agents. The referral fees shall be paid by the writing
5 carrier from money received as premiums for the state
6 plan.

7 12700.47. Every insurer which rejects or applies
8 underwriting restrictions to an applicant for accident and
9 health insurance shall notify the applicant of the
10 existence of the state plan; the requirements for being
11 accepted in it; and the procedure for applying to it.

12 12700.48. Every program of self-insurance; policy of
13 group accident and health insurance or contract of
14 coverage by a health or hospital care service plan written
15 or renewed in this state; shall include, in addition to
16 existing provisions of law relating to continuation of
17 coverage after termination of employment; the right to
18 convert to an individual coverage qualified plan without
19 the addition of underwriting restrictions regardless of the
20 reason for leaving the group. The person leaving the
21 group may exercise his right to conversion within 30 days
22 of leaving the group. Plans of health coverage shall also
23 include a provision which; upon the death of the
24 individual in whose name the contract was issued;
25 permits every other individual then covered under the
26 contract to elect, within the period specified in the
27 contract; to continue coverage under the same or a
28 different contract without the addition of underwriting
29 restrictions until the person would have ceased to have
30 been entitled to coverage; had the individual in whose
31 name the contract was issued lived. An individual
32 conversion contract issued by a health or hospital care
33 service plan shall not be deemed to be an individual
34 enrollment contract for the purposes of individual
35 enrollment provisions of the Knox/Keene Act.

36 12700.49. An employer who employs in this state; on
37 the average during a calendar quarter, 100 employees or
38 more; other than employees engaged in seasonal
39 employment and who offers a health benefits plan to
40 employees; whether (a) purchased from an insurer or a

1 health or hospital care service plan; or (b) provided on
 2 a self insured basis; shall, upon the next renewal of the
 3 health benefits plan contract offer his employees a dual
 4 option to obtain health benefits through either an
 5 accident and health insurance policy or a health or
 6 hospital care service plan contract if one is available. An
 7 option need not be provided if less than 25 employees
 8 select such option.

9 12700.50. An employer may make the dual offers
 10 specified in Section 12700.49 through an insurer, a health
 11 or hospital care service plan or on a self/insured basis. If
 12 an offer is made on a self/insured basis, the accident and
 13 health insurance type of coverage or health or hospital
 14 care service plan type of coverage shall meet the
 15 requirements of the laws of this state as to the services
 16 covered or benefits provided.

17 12700.51. No insurer shall make acceptance of its offer
 18 to provide insurance coverage contingent on acceptance
 19 by the employer of health or hospital care service plan
 20 coverage by a particular health or hospital care service
 21 plan. No health maintenance organization shall make
 22 acceptance of its offer to provide health maintenance
 23 organization coverage contingent on acceptance by the
 24 employer of insurance coverage by a particular insurer.
 25 No offer to provide the accident and health insurance
 26 policy and the health maintenance organization contract
 27 shall combine the two in a single/price package.

28
 29 CHAPTER 6. CALIFORNIA CATASTROPHIC HEALTH
 30 EXPENSE PROTECTION ACT

31
 32 12701. This chapter may be cited as the California
 33 Catastrophic Health Expense Protection Act.

34 12702. For the purposes of this chapter:

35 (a) "Eligible person" means any person who is a
 36 resident of California and who, while a resident of
 37 California, has been found by the director to have
 38 incurred an obligation to pay qualified expenses for
 39 himself or herself and any dependents in any 12
 40 consecutive months exceeding:

1 (1) 40 percent of his or her household income up to
2 fifteen thousand dollars (\$15,000) plus 50 percent of his or
3 her household income between fifteen thousand dollars
4 (\$15,000) and twenty-five thousand dollars (\$25,000);
5 plus 60 percent of his or her household income in excess
6 of twenty-five thousand dollars (\$25,000); or;

7 (2) Two thousand five hundred dollars (\$2,500);
8 whichever is greater except that the level of required
9 obligation shall be reduced by an amount equal to three
10 times the out-of-pocket expense for health insurance
11 premiums incurred by an eligible person.

12 (b) "Qualified expense" means any charge incurred
13 subsequent to July 1, 1982, for a health service which is
14 included in the list of covered services described in
15 Section 25700.12 of this part, and for which no third party
16 is liable.

17 (c) "Dependent" means a spouse or unmarried child
18 under the age of 19 years; a child who is a student under
19 the age of 25 and financially dependent upon the parent;
20 or a child of any age who is disabled and dependent upon
21 the parent.

22 (d) "Gross income" means federally adjusted gross
23 income and the sums of the following to the extent not
24 included in this subdivision:

25 (1) Additions to federally adjusted gross income as
26 provided by state revenue and taxation provision relating
27 to:

28 (A) Federally, but not state, exempt interest;

29 (B) Federally deductible state income tax;

30 (C) Disallowed depreciation;

31 (D) Federally exempt interest and dividends; and the

32 (E) Amount of excluded gain realized by a trust or sale
33 or exchange of property.

34 (2) All nontaxable income;

35 (3) Recognized long-term capital gains;

36 (4) Dividends excluded from federal adjusted gross
37 income pursuant to Section 116 of the Internal Revenue
38 Code of 1954;

39 (5) Public assistance and relief;

40 (6) Any pension or annuity, including railroad

1 retirement benefits; all payments received under the
2 federal Social Security Act (~~42 U.S.C.A. Section 1394 et~~
3 ~~seq.~~) supplemental security income and veteran's
4 disability pensions; which was not exclusively funded by
5 the applicant or spouse; or which was funded exclusively
6 by applicant or spouse and which funding payments were
7 excluded from federal adjusted gross income in the years
8 when the payments were made;

9 ~~(7) Nonstate taxable interest received from the state~~
10 ~~or federal government or any instrumentality or political~~
11 ~~subdivision thereof;~~

12 ~~(8) Workers' compensation;~~

13 ~~(9) Unemployment benefits;~~

14 ~~(10) Nontaxable strike benefits; and~~

15 ~~(11) The gross amounts of payments received in the~~
16 ~~nature of disability income or sick pay as a result of~~
17 ~~accident, sickness or other disability, whether funded~~
18 ~~through insurance or otherwise. In the case of an~~
19 ~~individual who files an income tax return on a fiscal year~~
20 ~~basis, the term "federal adjusted gross income" shall~~
21 ~~mean federal adjusted gross income reflected in the fiscal~~
22 ~~year ending in the calendar year. "Income" does not~~
23 ~~include:~~

24 ~~(i) Amounts excluded pursuant to Section 101 of the~~
25 ~~Internal Revenue Code, subdivision (a) of Section 102;~~
26 ~~and Sections 117 and 121 (~~26 U.S.C., Sections 102, 117;~~~~
27 ~~121);~~

28 ~~(ii) Amounts of any pension or annuity which was~~
29 ~~exclusively funded by the applicant or spouse and which~~
30 ~~funding payments were not excluded from federal~~
31 ~~adjusted gross income in the years when the payments~~
32 ~~were made;~~

33 ~~(iii) Gifts from nongovernmental sources;~~

34 ~~(iv) Surplus food or other relief in kind supplied by a~~
35 ~~governmental agency or relief granted pursuant to any~~
36 ~~federal or state or local tax credits.~~

37 ~~(e) "Household income" means the gross income of an~~
38 ~~eligible person and all of his or her dependents for the~~
39 ~~calendar year preceding the year in which an application~~
40 ~~is filed pursuant to Section 12703.~~

1 (f) "Director" means the Director of the Department
2 of Health Services.

3 (g) "Third party" means any person other than the
4 eligible person or his or her dependents.

5 12703. Any person who believes that they are or will
6 become an eligible person may submit an application for
7 state assistance to the director. The application shall
8 include a listing of expenses incurred prior to the date of
9 the application and shall designate the date on which the
10 12/month period for computing expenses began.

11 12704. If the director determines that an applicant is
12 an eligible person, the director shall pay 95 percent of all
13 qualified expenses of the eligible person and his or her
14 dependents in excess of:

15 (a) Forty percent of his or her household income
16 under fifteen thousand dollars (~~\$15,000~~) plus 50 percent
17 of his or her household income between fifteen thousand
18 dollars (~~\$15,000~~) and twenty-five thousand dollars
19 (~~\$25,000~~) plus 60 percent of his or her household income
20 in excess of twenty-five thousand dollars (~~\$25,000~~); or,

21 (b) Two thousand five hundred dollars (~~\$2,500~~);
22 whichever is greater for the 12/month period in which
23 the applicant becomes an eligible person. The director
24 shall by regulation establish procedures for determining
25 whether, and to what extent, qualified expenses are
26 reasonable charges; unless otherwise provided for by
27 regulation, charge shall be reviewed for reasonableness
28 by the same procedures used to review and limit
29 reimbursement under Medi-Cal. If the director
30 determines that the charge for a health service is
31 excessive, the director may limit payment to the
32 reasonable charge for that service. If the director
33 determines that a health service provided to an eligible
34 person was not medically necessary, the director may
35 refuse to pay for the service. The director may contract
36 with a review organization (as defined in 42 U.S.C.,
37 Section 1320, et seq.), in making any determination as to
38 whether or not a service was medically necessary. If the
39 director in accordance with this section refuses to pay all
40 or a part of the charge for a health service, the unpaid

1 portion of the charge shall be deemed to be an
2 unconseionable fee; against the public policy of this state,
3 and unenforceable in any action brought for the recovery
4 of moneys owed.

5 12705. Whenever the director pays for or becomes
6 liable for payments for health services under the
7 provisions of this chapter, the director shall have a lien for
8 payments and liabilities for the services upon any and all
9 causes of action which acerue to the person to whom the
10 services were furnished, or his legal representatives, as a
11 result of injuries which directly or indirectly led to the
12 incurring of qualified expenses.

13 12706. The director may perfect and enforce his or
14 her lien by following applicable procedures of law except
15 that the director shall have one year from the date when
16 the last item of health service was furnished in which to
17 file his or her verified lien statement. The statement shall
18 be filed with the appropriate clerk of court in the county
19 in which the recipient of the services resides or in the
20 county in which the action was filed.

21 12707. Where a third party may be liable in whole or
22 in part for payment for health services, the director may
23 consider the charges for the health services to be
24 qualified expenses if the eligible person assigns any rights
25 aceruing by virtue of any third party liability to the
26 director to the extent necessary to reimburse the state for
27 any payments made under the provisions of this section.

28 12708. Upon furnishing assistance under the
29 provisions of this chapter, the Department of Health
30 Services shall be subrogated, to the extent of its payments
31 for health services, to any rights the eligible person or his
32 or her dependent may have under the terms of any plan
33 of health coverage. The right of subrogation shall not
34 attach prior to written notice of the exercise of
35 subrogation rights to the issuer of the plan of health
36 coverage.

37 The Attorney General, or the appropriate city
38 attorney, acting upon direction from the Attorney
39 General, may institute or join a civil action against the
40 issuer of the plan of health coverage to recover under this

1 part.

2 12700. The director shall:

3 (a) Promulgate reasonable rules to implement this
4 chapter;

5 (b) Establish application forms and procedures for the
6 use of persons seeking to be declared an eligible person;
7 and;

8 (c) Investigate applications to determine whether or
9 not the applicant is a qualified person and investigate
10 claims from providers of health services to determine
11 whether or not to pay them.

12 12710. The director may:

13 (a) Enter into contracts with the United States or any
14 state agency, instrumentality or political subdivision
15 thereof for the purpose of coordinating the program
16 established by this chapter with other programs which
17 provide or pay for the delivery of health services;

18 (b) Enter into contracts with third parties to perform
19 some or all of the duties imposed on the director by this
20 chapter.

21 12711. The final decision of the director denying an
22 application for status as an eligible person or denying all
23 or part of the charges for a health service may be
24 appealed by any interested party pursuant to the
25 Administrative Procedure Act (Chapter 4 (commencing
26 with Section 11370); Chapter 4.5 (commencing with
27 Section 11371); Chapter 5 (commencing with Section
28 11500); of Division 3 of Title 2 of the Government Code);
29 as amended.

30 12712. There is hereby created in the State Treasury;
31 the California Catastrophic Health Expense Protection
32 Fund. There is initially appropriated from the General
33 Fund for deposit in the California Catastrophic Health
34 Expense Protection Fund, the sum of ten million dollars
35 (\$10,000,000). The appropriation is to be used without
36 regard to fiscal year for the purpose of funding the
37 activities of the Department of Health Services as are
38 authorized by the provisions of this part and the
39 administration thereof.

40 SEC. 2. Sections 12700.2, 12700.26, 12700.31, 12700.41,

1. ~~12700.48~~, and ~~12700.49~~ of this act shall become operative
- 2 July 1, 1982.

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AMENDED IN ASSEMBLY SEPTEMBER 10, 1987

AMENDED IN ASSEMBLY APRIL 20, 1987

CALIFORNIA LEGISLATURE—1987-88 REGULAR SESSION

ASSEMBLY BILL

No. 2647

Introduced by Assembly Member Campbell

March 10, 1987

An act relating to national health program.

LEGISLATIVE COUNSEL'S DIGEST

AB 2647, as amended, Campbell. National health program.

Under existing law there is no national health program.

This act would submit to the voters at the next statewide election a measure requiring the Governor to request the President and the Congress to enact a national health program.

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

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

1 SECTION 1. At the next statewide election in
2 accordance with the provisions of the Government Code
3 and the Elections Code governing the submission of
4 statewide measures to the voters the following measure
5 shall be submitted to the voters:

6

7

National Health Program

8

9 We, the people of the State of California, do hereby
10 find and declare as follows:

11 The United States through public and private sources

1 will expend in 1987 10 times the amount spent on health
2 care 20 years ago.

3 The dramatic rise in health care expenditures has both
4 played a major role in fueling inflation and still left
5 millions of Americans without needed health services
6 and without protection against the catastrophic costs of
7 acute and long-term care.

8 The State of California and other states have limited
9 ability to control and shape policy for health care
10 programs that transcend state boundaries and are, most
11 often, national in scope.

12 The trend in health care costs predicts both a greater
13 share of the nation's limited resources going into health
14 care and less health care coverage and protection being
15 afforded the people of the United States.

16 The Governor shall prepare and transmit on or before
17 December 31, 1988, a request to the President and all
18 members of the Congress of the United States to enact by
19 January 1, 1990, legislation establishing a national health
20 program, providing accessibility for all ~~Americans;~~
21 ~~freedom of choice;~~ a comprehensive range of services;
22 ~~fiscally sound financing through the private and public~~
23 ~~sectors;~~ allowance for innovation in delivery systems;
24 provision for pilot projects; incorporation of professional
25 standards; and decisionmaking with reliance on
26 professional *judgement and sensitivity to consumer*
27 *input.*

28 SEC. 2. Notwithstanding any other provision of law,
29 all ballots of the election shall have printed thereon and
30 in a square thereof, the words: "National Health
31 Program," and in the same square under those words, the
32 following in eight-point type: "This act requires the
33 Governor to request the President and the Congress to
34 enact a national health program." Opposite the square,
35 there shall be left spaces in which the voters may place
36 a cross in the manner required by law to indicate whether
37 they vote for or against the act.

38 Where the voting in the election is done by means of
39 voting machines used pursuant to law in the manner that
40 carries out the intent of this section, the use of the voting

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

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