by the board under Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(e) Notwithstanding subdivision (b), a medium employer may require an enrollee to contribute more than 20 percent of the cost of coverage if both of the following apply:

(1) The coverage provided by the employer includes coverage for dependents.

(2) The employer contributes an amount that exceeds 80 percent of the cost of the coverage for an individual employee.

(f) The contract includes prescription drug coverage with out-of-pocket costs for enrollees consistent with subdivision (d).

1357.23. On and after January 1, 2006, all health care service plans contracting with employers consistent with Section 1357.22 or with the State Health Purchasing Program shall make reasonable efforts to contract with county hospital systems and clinics, including providers or networks of providers that refer enrollees to such hospitals and clinics, as well as community clinics and other safety net providers. This section shall not prohibit a plan from applying appropriate credentialing requirements consistent with this chapter. This section shall not apply to a nonprofit health care service plan that provides hospital services to its enrollees primarily through a nonprofit hospital corporation with which the health care service plan shares an identical board of directors.

SEC. 4. Chapter 8.1 (commencing with Section 10760) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 8.1. INSURANCE MARKET REFORM

10760. If the provisions of Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code are held invalid, then the provisions of this chapter shall become inoperative.

10761. (a) Notwithstanding any other provision of law, on and after January 1, 2006, except as specified in subdivision (b), all requirements in Chapter 8 (commencing with Section 10700) applicable to offering, marketing, and selling health benefit plans to small employers as defined in that chapter, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans to all employers, guaranteed renewal of all health benefit plans, use of the risk

adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that chapter, shall be applicable to all health benefit plans offered to all small and medium employers providing coverage to employees pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, except as follows:

(1) For small and medium employers with two to 50 eligible employees, all requirements in that chapter shall apply. As used in this chapter, "small employer" shall have the meaning as defined in Section 2122.5 of the Labor Code and "medium employer" shall have the meaning as defined in Section 2122.4 of the Labor Code, unless the context otherwise requires.

(2) For medium employers with 51 or more eligible employees, all requirements in that chapter shall apply, except that the health insurers may develop health care coverage benefit plan designs to fairly and affirmatively market only to medium employer groups of 51 to 199 eligible employees, and apply a risk adjustment factor of no more than 115 percent and no less than 85 percent of the standard employee risk rate.

(b) Insurers shall be required to comply with this section only beginning with the date when coverage begins to be offered through the State Health Purchasing Program pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

10762. On and after January 1, 2006, a health insurer selling a policy to an employer, as defined in Section 2122.6 of the Labor Code, providing health coverage to insureds pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code shall meet all of the following requirements:

(a) The employer shall be responsible for the cost of health care coverage except as provided in this section.

(b) An employer may require a potential enrollee to pay up to 20 percent of the cost of the coverage, proof of which is provided by the employer in lieu of paying the fee required by Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, unless the wages of the potential enrollee are less than 200 percent of the federal poverty guidelines, as specified annually by the United States Department of Health and Human Services. For enrollees making a contribution for family coverage and whose wages are less than 200 percent of the federal poverty guidelines for a family of three, the applicable enrollee contribution shall not

exceed 5 percent of wages. For enrollees making a contribution for individual coverage and whose wages are less than 200 percent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed 5 percent of wages of the individual.

(c) If an employer, as defined in Section 2122.6 of the Labor Code, chooses to purchase more than one means of coverage for potential enrollees and, if applicable, dependents, the employer may require a higher level of contribution from potential enrollees as long as one means of coverage meets the standards of this section.

(d) An employer, as defined in Section 2122.6 of the Labor Code, may purchase health care coverage that includes additional out-of-pocket expenses, such as copayments, coinsurance, or deductibles. In reviewing enrollee share-of-premium, deductibles, copayments, and other out-of-pocket costs, the department shall consider those permitted by the board under Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(e) Notwithstanding subdivision (b), a medium employer may require an enrollee to contribute more than 20 percent of the cost of coverage if both of the following apply:

(1) The coverage provided by the employer includes coverage for dependents.

(2) The employer contributes an amount that exceeds 80 percent of the cost of the coverage for an individual employee.

(f) The contract includes prescription drug coverage with out-of-pocket costs for enrollees consistent with subdivision (d).

10763. On and after January 1, 2006, all insurers that sell insurance policies to employers consistent with Section 10762 or to the State Health Purchasing Program shall make reasonable efforts to include as preferred providers county hospital systems and clinics, including providers or networks of providers that refer enrollees to those hospitals and clinics, as well as community clinics and other safety net providers. This section shall not prohibit a plan from applying appropriate credentialing requirements consistent with this chapter. This section shall not apply to a nonprofit health care service plan that provides hospital services to its enrollees primarily through a nonprofit hospital corporation with which the plan shares an identical board of directors.

10764. (a) On and after January 1, 2006, except as provided in subdivision (b), health insurers shall not offer or sell the following insurance policies to employers providing coverage to employees pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code:

(1) A Medicare supplement, vision-only, dental-only, or Champus-supplement insurance policy.

(2) A hospital indemnity, accident-only, or specified disease insurance policy that pays benefits on a fixed benefit, cash-payment-only basis.

(b) However, an insurer may sell one or more of the types of policies listed in paragraph (1) or (2) of subdivision (a) if the employer has purchased or purchases concurrently health care coverage meeting the standards of Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(c) If an employer, as defined in Section 2022.6 of the Labor Code, chooses to purchase more than one means of coverage, the employer may require a higher level of contribution from potential enrollees so long as one means of coverage meets the standards of this section.

(d) An employer, as defined in Section 2122.6 of the Labor Code, may purchase health care coverage that includes additional out-of-pocket expenses, such as coinsurance or deductibles. In reviewing the share-of-premium, deductibles, copayments, and other out-of-pocket costs paid by insureds, the department shall consider those permitted by the board under Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code.

(e) Notwithstanding subdivision (b), a medium employer, as defined in Section 2122.4 of the Labor Code, may require an enrollee to contribute more than 20 percent of the cost of coverage if both of the following apply:

(1) The coverage provided by the employer includes coverage for dependents.

(2) The employer contributes an amount that exceeds 80 percent of the cost of the coverage for an individual employee

(f) The policy includes prescription drug coverage, which shall be subject to coinsurance, deductibles, and other out-of-pocket costs consistent with (d).

SEC. 5. Section 12693.55 is added to the Insurance Code, to read:

12693.55. (a) Prior to implementation of the Health Insurance Act of 2003, the board shall to the maximum extent permitted by federal law ensure that persons who are either covered or eligible for Healthy Families will retain the same amount, duration, and scope of benefits that they currently receive or are currently eligible to receive, including dental, vision and mental benefits. The board shall consult with a stakeholder group that shall include all of the following:

(1) Consumer advocate groups that represent persons eligible for Healthy Families.

(2) Organizations that represent persons with disabilities.

(3) Representatives of public hospitals, clinics, safety net providers, and other providers.

(4) Labor organizations that represent employees whose families include persons likely to be eligible for Healthy Families.

(5) Employer organizations.

(b) The board shall develop a Healthy Families premium assistance program for eligible individuals as permitted under federal law to reduce state costs and maximize federal financial participation by providing health care coverage to eligible individuals through a combination of available employer-based coverage and a wraparound benefit that covers any gap between the employer-based coverage and the benefits required by this part.

(c) The board shall do all of the following in implementing the premium assistance program:

(1) Require eligible individuals with access to employer-based coverage to enroll themselves or their family or both in the available employer-based coverage if the board finds that enrollment in that coverage is cost-effective.

(2) Promptly reimburse an eligible individual for his or her share of premium cost under the employer-based coverage, minus any contribution that an individual would be required to pay pursuant to Section 12693.43.

(d) If federal approval of a premium assistance program cannot be obtained, the board in consultation with the stakeholder group shall explore alternatives that provide that persons who are either covered or eligible for Healthy Families retain the same amount, duration and scope of benefits that they currently receive or are