## Ninety Years of Health Insurance Reform Efforts in California

**Bill and Proposition Files**

Compiled by

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Proposition 186: Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure expressly amends the Constitution by adding sections thereto, and repeals and adds sections to various codes; therefore, existing provisions proposed to be deleted are printed in striking type and new provisions proposed to be added are printed in italic type to indicate that they are new.

PROPOSED LAW

CALIFORNIA HEALTH SECURITY ACT

SECTION 1. This initiative establishes a California health security system that will protect California consumers, taxpayers, and employers from the skyrocketing cost of health care. Savings will be achieved by limiting health care costs, eliminating waste, and emphasizing disease prevention. Under the time-tested single-payer system established by the best way to ensure that a health service system that will be administered by an elected Health Commissioner, the practice of medicine will remain private. Under the health security system, all Californians will have free choice of health care provider, regardless of employment, and access to comprehensive health care, including long-term care. The health security system will provide these services for the same or less money in real dollars than is spent on health care in California today.

SECTION 2. Division 13 (commencing with Section 25000) is added to the Welfare and Institutions Code, to read:

DIVISION 13. CALIFORNIA HEALTH SECURITY ACT

CHAPTER 1. Findings and Purpose

25001. Findings and declarations. The people of the State of California find and declare as follows:

(a) Californians have a right not to be financially burdened when they or their loved ones become sick or ill.

(b) Californians have a right not to be driven into insolvency by the spiraling cost of employee medical benefits.

(c) Californians have a right to high-quality health care.

(d) Californians should be guaranteed the freedom to choose their own doctor or other health care provider.

(e) Californians should not be at risk of losing their health benefits if they change or lose their jobs.

(f) California taxpayers are bearing enormous financial costs because many Californians do not have a regular health care provider. This lack of primary care leads to expensive crises of emergency facilities resulting in exorbitant financial costs that are ultimately born by the taxpayers.

(g) Because health care costs are rising faster than wages and prices, the number of uninsured and under-insured Californians is growing at an alarming rate. Over five million Californians presently have no health insurance. Children, low-income working and unemployed individuals, and individuals with disabilities and chronic conditions, in particular, are having a harder and harder time getting all types of medical care.

(h) In spite of the fact that employers and individuals spend huge amounts of money purchasing health insurance from insurance companies, the insurance they purchase often does not provide adequate medical care or real protection from financial ruin, especially if a loved one develops a catastrophic illness or needs long-term care.

(i) Excessive savings will be achieved in California upon institution of a single-payer for health care. Savings will be achieved by decreasing wasteful administrative overhead, bargaining for the best possible prescription drug prices, providing more cost-effective primary care, and by providing long-term care at home. The current health care system is wasteful because the system is so complex that the government must be able to fund universal coverage for all medical care services and extend benefits to include long-term care, mental health care, and some dental services, and increase the resources available to prevent disease, all for the same amount of money currently spent on health care in California.

(j) The quality of health care can be improved in California upon institution of a single-payer for health care. Quality can be improved by changing those features of the health care system that undervalue consumers and which subject some to the risks of unnecessary medical treatments.

(k) Because people always need health care services, prices for these services often do not respond to normal supply-and-demand market forces. As a result, health care costs much more than it should to provide for the health care needs of all Californians. An effective health care system will be unlikely to keep costs in check or provide universal health services to the population. Price control is therefore necessary to achieve cost containment and to make quality health care accessible to all.

(l) Health care consumers need to participate in developing and reviewing public policies affecting the quality, accessibility, and accountability of health care service providers. Health care consumers therefore have the right voluntarily to join and support a democratically-controlled Health Care Consumer Council that will represent their interests before administrative, judicial, and legislative bodies, and that will have an efficient and honest system for funding.

(m) Health care consumers need to participate in developing and reviewing public policies affecting the quality, accessibility, and accountability of health care service providers. Health care consumers therefore have the right voluntarily to join and support a democratically-controlled Health Care Consumer Council that will represent their interests before administrative, judicial, and legislative bodies, and that will have an efficient and honest system for funding.

(k) To control health care costs without compromising quality, primarily by eliminating wasted overhead and excessive expenditures that do not contribute to the quality of health care.

(l) To finance the health security system in a manner that is fair, and spend no more money per individual in real dollars than is now being spent on health care in California.

(a) To provide incentives by which competition can improve quality and service in the health care system. When consumers have freedom of choice of health care providers, instead of a restricted choice of health plans based on what they can afford, providers have an incentive to provide the best quality care and service, in order to attract patients. When providers have freedom of mode of reimbursement, such as a choice of fee-for-service, capitation or salary, under an overall budget, they can focus on taking the best possible care of their patients, without bureaucratic intrusion into the relationship between individual providers and their patients.

(b) To allocate health security system funds effectively in order to make the highest standards of care available for all Californians.

(c) To address the current and future health care needs of all Californians through emphasis on public health measures, changes in training and distribution of health care workers, and increased research into the causes of disease and the most effective means of preventing illness.

(d) To convert the current health care delivery system from one focused on emergency care to one focused on primary health care services and the promotion, restoration, and maintenance of health. These reforms will integrate all health care services and emphasize preventive services, early intervention, vigorous
rehabilitation, and restorative care in order to make health care a more vital part of individual and community life.

(h) To establish a governance structure for the health security system that is democratic and accountable while ensuring the quality, reliability, efficiency, and effectiveness of the system.

(i) To ensure effective representation of the interests of the state's health care consumers, including administrative, judicial, and legislative bodies by establishing a Health Care Consumer Council fund to be established by voluntary contributions and grants and controlled by a democratically-elected board of directors.

(ii) To provide initial benefits under the health security system as of January 1, of the second year following passage of this act, with full benefits provided no more than four years later.

(iii) To have a neutral effect on the spending limit in Article XIII B of the California Constitution so that spending under this act neither increases nor decreases the amount of appropriations available for non-health-related spending by state and local entities.

(iv) To give the elected Health Commissioner the maximum authority permitted by law to determine budgeting needs and appropriations for the health security system.

(v) To achieve compliance with federal health care reform legislation and to obtain the maximum amount of federal revenues possible to fund the health security system.

25006. Construction. This act shall be liberally construed to accomplish its purposes.

Chapter 3. Definitions

25004. The definitions contained in this section shall govern the construction of this division, unless the context requires otherwise.

(a) "A academic medical center" means a health facility associated with a degree-granting health professional training program and with major resource commitments to research.

(b) "Advisory board" means the Health Care Policy Advisory Board appointed by the commissioner to make expert recommendations on all aspects of health care policy.

(c) "Base year" means the 12 months prior to the passage of this act.

(d) "Base fiscal year" means the fiscal year of passage of the act.

(e) "Capitation" means allocation of health security system funds to a professional provider or integrated professional provider network based on the number of individuals whose health care must be covered, with respect to all benefits available under the health security system, for the calendar year, or part thereof, by that professional provider or professional provider network.

(f) "Clinic" means a facility licensed pursuant to Chapter 1 (commencing with Section 12500) and Division 2 of the Health and Safety Code, subject to standards and criteria.

(g) "Clinical case manager" means a licensed professional provider who provides care management of an individual's health care. A case manager shall be a primary care professional provider, except in the case of individuals with particular chronic medical conditions requiring a specialist to be the case manager. An individual may select a specialist as a case manager if his or her primary health care needs are served within that specialty and the specialist is able and willing to provide individual case management.

(h) "Clinical case management" means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health care needs through communications and available resources to promote quality, cost-effective outcomes.

(i) "Commissioner" means the California State Health Commissioner, whose office is established by this act.

(j) "Complementary medicine" means those medical and health practices based upon empirical healing beliefs and cultural traditions that do not rely on prescribing pills, chemicals, and vaccines, and that are not considered a part of traditional medicine.

(k) "Consumer council" means the Health Care Consumer Council established by this act.

(l) "Effective date" means the day after passage of this act.

(m) "Essential care" means health care services that are not emergency care or urgent care, as determined by the commissioner based on recommendation of the advisory board.

(n) "Employee" means a resident of California who works for an employer, is listed on the employer's payroll records, and is under the employer's control.

(o) "Employer" means any person, partnership, corporation, association, joint venture, or public or private entity employing for wages, salary, or other compensation, one or more employees at any one time to work in this state. "Employer" does not include self-employed persons with respect to earnings from self-employment.

(p) "Emergency care" means health care services required for alleviation of severe pain or distress or for immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to disability or death, as defined in Section 19535 of the Welfare and Institutions Code.

(q) "Health facility" means a facility licensed pursuant to Chapter 2 (commencing with Section 12500) and Division 2 of the Health and Safety Code, subject to standards and criteria.

(r) "Health security system" means the program of comprehensive health services administered by the commissioner as set out in this act, and all policies and directives of the commissioner.

(s) "Medical care" means all health care items and services, except for items and services not reasonably necessary for the diagnosis, treatment, or prevention of illness or injury or to improve the functioning of a malformed or injured body member, according to guidelines established by the commissioner based on recommendations of the advisory board.

(t) "Medical indication" means the fact of medical conditions for which there is evidence that a particular service improves the overall health outcome of patients receiving that service.

(u) "Medically appropriate" means all health care services and procedures considered for the care of a patient's health care items and services subject to the guidelines established by the commissioner based on recommendation of the advisory board.

(v) "Mental health care" means health care services provided for the prevention, diagnosis, or treatment, of mental disorders, including substance dependence and abuse and diseases of the brain.

(w) "Mode of reimbursement" means the way in which a professional provider is paid, including, but not necessarily limited to, any of the following: (1) A fee for each service provided.

(x) "Capitation.

(y) Salary.

(z) "Primary care" means comprehensive, longitudinal, individual clinical prevention and treatment services, provided by a professional provider acting within the scope of his or her practice, subject to standards and criteria.

(aa) "Primary care provider" means a professional provider delivering primary care.

(bb) "Professional provider" means an individual licensed to provide health care services pursuant to Division 2 (commencing with Section 5000 of the Business and Professions Code, subject to standards and criteria.

(cc) "Provider" means a professional provider, health facility, or clinic, subject to standards and criteria.

(dd) "Regional administrator" means the individual appointed by the commissioner to coordinate health security system activities in a system region.

(ee) "Regional consumer advocate" means the individual appointed for each system region by the commissioner to serve as the ombudsman and liaison between the health care consumer and the health security system.

(ff) "Resident" means a resident of California as determined pursuant to Section 244 of the Government Code, or as otherwise defined by the Legislature.

(gg) "Residential care" means both of the following: (1) Outpatient health care services other than those that constitute primary care.

(hh) "Inpatient health care services other than those that constitute tertiary care.

(ii) "Specialist" means those professional providers who are specialist licensed or eligible for certification, who currently provide specialized health care services in the State of California, or who provide specialized health care services to patients referred from primary care providers, case managers, and other specialists, subject to standards and criteria.

(jj) "State gross domestic product" means the sum total of the value of all goods sold, and services provided, in the State of California for any given year as determined by the U.S. Department of Commerce.

(kk) "Standards and criteria" means standards and criteria as promulgated by the commissioner.

(ll) "System" means the health security system established by this act.

(mm) "System budget" means the amount of money projected to be spent in the state on health care in any given year under the health security system pursuant to Chapter 1 (commencing with Section 25010) of this part.

(nn) "System formulary" means the list of drugs that are covered for payment by the health security system when prescribed by a professional provider acting within the scope of his or her practice.

(oo) "System region" means a region of the state composed of one or more geographically contiguous counties grouped on the basis of common economic or demographic characteristics, for administrative and other purposes of the health security system.

(pp) "Tertiary care" means the specialized diagnostic and treatment services for which regional referral centers have been designated by the commissioner.

Chapter 3. Eligibility

25006. (a) All Californians who meet residency requirements defined by the Legislature and certified by the commissioner are eligible for covered benefits specified in Chapter 4 (commencing with Section 25010), other than long-term care benefits as provided in Article 4 (commencing with Section 25025) of Chapter 4.

(b) A California resident eligible for benefits under subdivision (a) is further eligible for long-term care benefits as provided in Article 4 (commencing with Section 25025) of Chapter 4 upon showing any of the following:

(i) That he or she has been employed full time for not less than 24 months, or a correspondingly greater number of months of part-time employment, by an employer who, for the entire time, met either of the following requirements:

(A) Made payments into the Health Security Fund pursuant to Section 25115, less any credit allowed under Section 23303 of the Revenue and Taxation Code.

(B) Was exempt from making payments pursuant to Section 25156.

(ii) That he or she has, for a period of two years, made individual payments by way of taxes or otherwise into the Health Security Fund pursuant to Section 25120, less any credit allowed under an appropriate (b) of Section 23303 of the Revenue and Taxation Code.

(iii) That he or she was, for the period specified, a dependent member of the household of a person qualifying under paragraph 11 or 12.

(iv) That he or she is entitled under federal law to those benefits.

(c) Until such time as the Legislature establishes residency requirements for purposes of this act, residency shall be determined according to Section 244 of the Government Code.

(d) Any individual who is not eligible for long-term care under subdivision (b) shall be eligible for care in the same extent and under the same conditions as he or
she would have been eligible under programs existing prior to the effective date of this act, including, but not limited to, the Medical Assistance Program (Medi-Cal) and the California Children's Services program.

25007. Eligibility cards.
(a) The regional administrator for each system region shall certify the eligibility of each individual within the region, pursuant to Section 25008, and shall provide each eligible individual with a card identifying number listing any limitations of the services for which the individual is eligible. The card shall be in the form and manner as determined by the commissioner, or as required by federal law.
(b) (1) In the case of minors under the age of 18, the regional administrator shall issue the card to a person having legal custody of the minor. More than one minor may be listed on a single card.
(2) Any eligible minor, personally capable of giving consent to health care may apply to the regional administrator for a separate card. The card shall be limited to the types of care for which the minor may lawfully consent.
(c) (1) Within 30 days of receipt of a completed application, the regional administrator shall issue an eligibility card, or provide a written explanation for its denial or any restrictions placed thereon.
(2) If good cause exists to believe that the applicant may not meet the eligibility requirements of Section 25008, the regional administrator may extend the period under paragraph (1) up to an additional 30 days to permit further investigation.
(3) Where necessary to avoid an interruption in care, the regional administrator may issue a temporary eligibility card.

25009. Presumptive eligibility.
(a) If a patient arrives at a health facility or clinic who is unconscious, comatose, or otherwise unable because of his or her physical or mental condition to document eligibility or to act in his or her own behalf, or if the patient is a minor, the patient shall be presumed to be eligible and the health facility or clinic shall provide care as if the patient were eligible.
(b) Any individual committed to an acute psychiatric facility or to a hospital with psychiatric beds pursuant to any provision of Section 5150 of the Welfare and Institutions Code providing for involuntary commitment, shall be presumed eligible.

25009. Nothing in the California Health Security Act shall relieve the counties of their obligation under Part 5 (commencing with Section 17000) of Division 9.

Chapter 4. Benefits

Article 1. General

25010. (a) Any eligible individual may choose to receive services under this division from any willing professional provider participating in the health security system.
(b) No eligible individual shall be required to meet a deductible or copayment as a condition for receiving health care services by any health facility or clinic or professional provider reimbursed by the health security system except as follows:
(1) As authorized by the commissioner under provisions for implementing phase-ins of the health security system, as provided in Chapter 10 (commencing with Section 25020).
(2) For outpatient prescription drugs as specified in Article 3 (commencing with Section 25020).
(3) For room and board charges as specified in Article 4 (commencing with Section 25015) and Article 5 (commencing with Section 25025) of this chapter.
(4) For cost control purposes as specified in Article 8 (commencing with Section 25225) of Chapter 7.

Article 2. Medical Benefits

25015. Covered benefits in this chapter shall include all medical care determined to be medically appropriate by the patient's health care provider, except as excluded under Section 25445, including, but not limited to, all of the following:
(a) Inpatient and outpatient health facility or clinic services other than long-term care as defined in subdivision (a) of Section 25025.
(b) Inpatient and outpatient professional provider services, including eye care and home health care.
(c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.
(d) Maternity, perinatal, and maternal care.
(e) Dental medical equipment and appliances including prosthetics, eyeglasses, and hearing aids, as determined by the commissioner.
(f) Pediatric.
(g) Chiropractic.
(h) Dialysis.
(i) Emergency transportation and necessary transportation for health care services for the disabled, as determined by the commissioner.
(j) Rehabilitation care.
(k) Long-term care for health care services, including sign language, for those unable to speak, hear, or understand English, and for the hearing impaired.
(l) Vision.

25016. Covered benefits in this chapter shall include:
(a) Children's preventive care, well-child care, immunizations, screening, outreach, and education.
(b) Adult preventive care including mammograms, Pap smears and other screening, outreach, and educational services.

Article 3. Prescription Drugs

25020. Covered benefits in this chapter shall include pharmacological products of proven pharmaceutical effectiveness pursuant to a system formulated composed of the best-priced prescription drugs of proven efficacy for particular conditions as set out in Section 25215. In establishing the formulary, and achieving the lowest possible price for formulary drugs, the commissioner shall not be considered to be the dispenser or distributor of formulary drugs.
(b) Only those prescription drugs on the system formulary shall be reimbursed under the health security system, except where special standards and criteria are met.
(c) The health security system shall cover the full cost of all drugs provided during hospitalizations and during emergency care.
(d) Except as otherwise provided in this subdivision, a copayment of not more than three dollars ($3) per prescription shall be charged for outpatient prescription drugs.
(1) Standards and criteria for application of, and a ceiling on, outpatient prescription drug copayments shall be established.
(2) List of drugs available without copayments, including, but not limited to, anesthetics, antibiotics, drugs to combat infectious diseases including tuberculosis, blood derivatives and immune serum globulins, vaccines, and sera, shall be established and may be modified at the discretion of the commissioner.
(3) A mechanism for waiving the prescription drug copayment requirement in the case of individuals whose financial resources are insufficient to meet any copayment shall be established by the commissioner.
(4) A mechanism for daily drug dispensing for those individuals who are eligible for drugs without copayment pursuant to paragraphs (2) and (3) of subdivision (a), but who are deemed unable to manage their own drugs on the basis of reduced loss of prescribed drugs provided without copayment, shall be established according to standards and criteria.

Article 4. Long-Term Services

25025. (a) Long-term services necessary for the physical health, mental health, social, and personal needs of individuals with limited self-care capabilities are covered benefits under this division as provided in this section.
(b) Long-term care services shall include all of the following:
(1) Institutional and residential care including Alzheimer's disease units.
(2) Home health care.
(3) Hospice care.
(4) Home- and community-based services, including personal assistance and attendant care.
(5) Appropriate access to specially consultation within long-term care settings.
(6) Reassessment of an individual's need for long-term services, conducted at appropriate intervals, but not less than once a year.
(7) Individual needs for long-term care shall be determined through a standardized assessment of the individual's abilities for self-care and need for a particular level of care. This assessment shall occur at the time of discharge planning, if applicable, and otherwise shall occur before provision of long-term care services under this section, and shall include all of the following, unless otherwise specified by the commissioner:
(1) Medical examinations necessary to determine what level of medical care is required.
(2) Environmental and psychosocial evaluations to determine what the individual can and cannot do for himself or herself physically, as well as mentally.
(3) Services, service coordination, or case management, to ensure that necessary services are provided to enable the individual to remain at home.
(4) Early intervention services and individual family services for the developmentally disabled pursuant to Part 11 of the Individuals with Disabilities Education Act (20 U.S.C. 1411, et seq.) and Title 14 (commencing with Section 96000) of the Government Code.
(5) Other activities may be provided in the individual's home, or through community-based, residential, or institutional programs, pursuant to standards and criteria.
(6) Providing long-term services under this section, the commissioner shall encourage and reimburse noninstitutional long-term services where appropriate, as determined pursuant to the assessment and reassessment process. At the discretion of the commissioner, up to 10 percent of the cost to the health security system of institutional care may be expanded in order to allow persons needing long-term services to remain safely in their homes to the maximum extent possible.
(7) The health security system shall not cover that portion of long-term care expenses incurred for room and board, unless an individual has no resources for payment as determined by the commissioner. Persons with low income and assets shall be charged for basic room and board at a reduced rate corresponding to a percentage of Social Security or other income, as determined by the commissioner.
(8) Additional amenities for room and board may be purchased at individual expense.

Article 5. Mental Health Care Benefits

25030. (a) Mental health care services that are medically appropriate, including, but not limited to, treatment for substance abuse and treatment for diseases of the brain, are covered benefits under this division.
(b) Covered mental health care benefits in this chapter shall include, but not be limited to, the following, when determined to be medically appropriate by the commissioner:
(1) Crisis intervention, including assessment, diagnosis, brief emergency treatment, and referral.
(2) Outpatient services, including, but not limited to, adult day care, detoxification services, home health care, psychosocial rehabilitation, and professionally sponsored and professionally supervised self-help and peer-support programs which are approved by the commissioner.
(3) Intermediate-level care, including, but not limited to, intensive day and evening programs and institutional and residential services. The health security system

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system shall not cover that portion of intermediate-level care expenses incurred for room and board in excess of one meal per day, unless an individual has no resources for payment. Persons with low income and assets shall be charged for basic room and board at a reduced rate, as determined by the commissioner. The reduced rate charged to individuals with low income for room and board shall be a percentage of Social Security or other income, to be determined by the commissioner. Additional amenities for room and board may be purchased at individual expense.

(4) Inpatient health facility services as approved by the commissioner based on the recommendations of the advisory board.

(5) Professional provider services at outpatient, intermediate, and inpatient levels of care, including, but not limited to, individual, family, and group psychotherapy, medical management, psychological testing, and mental health case management and coordination of care.

(6) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services, as provided in Article 2 (commencing with Section 25015).

(c) Prescription drugs, as provided in Article 4 (commencing with Section 25020).

(d) Services under paragraph (3) of subdivision (b) may be integrated with long-term care services described under Article 4 (commencing with Section 25025) at the discretion of the commissioner.

(e) During the first year that benefits are available under the health security system, a patient copayment may apply to certain outpatient mental health care services, as provided in Article 5 (commencing with Section 25065) of Chapter 19.

Article 6. Dental Benefits

25035. Dental services are covered under this chapter as specified by the commissioner. To the extent funding permits, dental benefits shall include the following, in the priority listed:

(1) Emergency dental services.

(2) Dental care for all children, to the same extent and under the same conditions as they would have been eligible for under programs existing prior to the effective date of this act, including, but not limited to, Medi-Cal.

(2) Preventive dental services for children and nonmexican orthodontia for individuals under the age of 18.

(3) Preventive dental services for individuals over the age of 18 and restorative care.

Article 7. Expansion of Covered Benefits

25040. (a) The commissioner may expand benefits beyond the minimum benefits described in this chapter when expansion meets the intent of this division and there are sufficient funds to cover the expansion.

(b) The commissioner may expand benefits previously offered by the health security system or institute new programs of benefits, provided that the commissioner determines it is of equivalent therapeutic value or is a less costly treatment alternative to a listed service, and if the service or benefit is provided by a professional provider acting within the scope of his or her practice, according to standards and criteria.

Article 8. Excluded Benefits

25045. (a) Services determined to have no medical indication by the advisory board shall be excluded from coverage under the health security system.

(b) Services shall be excluded from coverage under the cost containment provisions of Section 25040.

Article 9. Coverage for Californians While Out-Of-State

25055. (a) The health security system shall cover all eligible Californians residing out-of-state for up to 90 days in each 12-month period.

(b) Coverage for non-emergency care shall be at prevailing local rates.

(c) Coverage for non-emergency care shall be according to rates and conditions established by the commissioner. The commissioner may require transport back to California for further treatment when the patient is medically stable.

(d) The commissioner may make arrangements for reciprocal coverage with other states or countries, provided that the programs provided by the other states or countries are comparable to those available in California in coverage, cost, and quality.

Article 10. Emergency Benefits

25059. (a) Emergency care and health care services necessary to safeguard the health of the population shall be readily available through the health security system to all individuals.

(b) The commissioner shall provide funding to public fire agencies for delivery of emergency medical services and emergency transportation.

Chapter 5. Governance and Administration

Article 1. California State Health Commissioner

25060. (a) There is a California State Health Commissioner. The Office of the State Health Commissioner is an agency of the State of California.

(b) The commissioner shall administer the California Health Security System.

(c) The first commissioner shall be appointed by the Governor not less than 75 nor more than 100 days following passage of this act, and shall be confirmed by the Legislature upon 30 days of nomination.

(d) The commissioner shall stand for election at the same time and in the same manner as the Governor.

(e) At any time that the commissioner is unable to perform the duties of the office, the deputy health commissioner may perform those duties for a period of up to 90 days.

(f) The commissioner may be impeached for misfeasance of office.

(g) In the event of vacancy, or inability of the commissioner to perform the duties of office for a period of more than 90 days, an acting commissioner shall be appointed by the Governor and confirmed by the Legislature, for the balance of the commissioner's term.

(h) Compensation and benefits of the commissioner shall be determined pursuant to Section 2 of Article III of the California Constitution.

(i) The commissioner shall appoint a deputy health commissioner.

(j) Whether the commissioner or the deputy health commissioner, nor either's spouse or children, shall be an employee, director, or stockholder of any company researching, developing, or marketing products or services that would have a financial interest in the outcome of deliberations in which that member would participate as a result of the commissioner's appointment, during the time of appointment and for a period of three years after completion of the appointment.

Article 2. Health Commissioner Powers and Duties

25063. The commissioner's powers include all and any powers necessary and proper to implement this act, and to promote its underlying aims and purposes. These broad powers include, but are not limited to, the power to set rates and promulgate generally binding regulations on any and all matters relating to the implementation of this act and its purposes.

25065. The commissioner shall do all of the following:

(a) Establish and maintain a health security system for all Californians, as required by this division, including:

(1) Implement statutory eligibility standards.

(2) Establish and maintain a benefits package for consumers which meets or exceeds the minimums required by law.

(3) Act directly, or through one or more contractors, as the single payer for all claims for services provided under this chapter.

(b) Develop and implement separate formulas for determining budgets pursuant to Section 3 (commencing with Section 25165) of Chapter 7.

(c) Review the formula described in paragraph (4) annually for appropriateness and sufficiency, and to ensure that administrative costs of the health security system shall not exceed the limits set in Section 3 (commencing with Section 25165) of Chapter 7.

(d) Implement, to the extent permitted by federal law, standardized claims and reporting methods.

(e) Establish an enrollment system that will ensure that all eligible Californians, including those who travel frequently, those who cannot read, and those who do not speak English, are aware of their right to health care, and are formally enrolled.

(f) Determine the number and precise county-by-county composition of the state's insurance, based on criteria of common economic and demographic features and geographic contiguity.

(g) Bid for prescription drug contracts in order to achieve the lowest possible cost for drugs available under the system formulary.

(h) Negotiate for, or act, rates, fees, and prices involving any aspect of the health security system, and establish procedures relating thereto.

(i) Administer the revenues of the health security system in accordance with Chapter 6 (commencing with Section 25100).

(j) Procure funds including loans, lease or purchase property, obtain appropriate liability and other forms of insurance for the health security system, its agents, and agents.

(k) Establish, appoint, and fund, as part of the administration of the health security system, the following:

(1) A Health Care Policy Advisory Board pursuant to Section 25068.

(l) A regional administrator with appropriate staff for each region established by the commissioner.

(m) A regional consumer advocate with appropriate staff for each region established by the commissioner.

(n) Administer all aspects of the health security system that include, but are not limited to, all of the following:

(1) Establish eligibility and criteria for allocation of operating funds and funds from named accounts as described in Section 25290 to system regions.

(2) Meet regularly with the regional administrators and regional consumer advocates to review the impact of the health security system and its policies on the system regions.

(3) Budget the Public Health and Prevention Account, Innovations Account, Capital Improvements Account, Health Worker Training Account, and Reserve Account for each system region in a manner determined by the commissioner to most equitably meet the health care needs of the population of the state as a whole and the population within each region pursuant to the specific purposes for those accounts that have been established as described in Article 8 (commencing with Section 25205) of Chapter 7.

(q) Achieve the best pharmaceutical drug prices for the health security system pursuant to Section 25215.

(q) Gather and analyze data necessary for the efficient and equitable functioning of the health security system pursuant to Section 25065.

(f) In addition to all other powers conferred under this division, the commissioner may:

(1) Employ appropriate staff as necessary to implement this division.

(2) Delegate to appointed staff any aspect of the health security system that is the responsibility of the commissioner. Individuals employed by the commissioner or any department or state agency that is made a part of the health security system shall perform their duties as the commissioner assigns them.

(3) Employ and direct attorneys on staff or as outside counsel in the defense or implementation of any provision of this act.

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(4) Sue and be sued to enforce any provision of this act.
(5) Seek, at his or her discretion, legal advice or counsel from the Attorney General.
(6) Incur traveling expenses as are necessary for the performance of his or her duties.

(7) Issue subpoenas, administer oaths, and examine under oath any person as to any matter material to the administration of the health security system.
(8) Promulgate procedures and standards for competitions of bidding which shall govern the contracts authorized by this section. Notwithstanding any other provision of law, the contracts shall be subject to the competitive bidding requirement as promulgated, and no others.
(9) Assure all existing statutes regarding confidentiality of medical records shall continue to apply to the health security system. No policy, directive, or study by the commissioner may be taken that compromises confidentiality of medical records as required by law.

25065. Nothing contained in this act shall prevent the Legislature from transferring to the health security systems programs for health care, including mental health care for patients in state hospitals and other health care facilities owned by the state, and facilities located in state prisons.

25067. (a) The commissioner shall not set any rate, fee, or price, that is confiscatory.
(b) Any provider, vendor, or other person aggrieved by a rate, fee, or price set by the commissioner, upon the production of credible evidence that the rate, fee, or price is confiscatory, shall be entitled to a timely hearing.
(c) This section shall not apply to any rate, fee, or price that is negotiated with the commissioner.

Article 3. Health Care Policy Advisory Board

25068. (a) The commissioner shall establish and appoint a Health Care Policy Advisory Board consisting of health care and public health professionals and other experts, including one member of the Health Security Board.
(b) Members of the advisory board, other than the Director of Health Services, and any committee or task force established by the commissioner, shall be subject to all of the following:
   (1) Serve for a period determined by the commissioner and shall be exempt from civil service pursuant to subdivision (d) of Section 4 of Article VII of the California Constitution.
   (2) Shall receive a salary and other compensation as determined by the commissioner.
   (3) Shall not be an employee, director, or stockholder of any for-profit company researching, developing, marketing, or providing health care products or services during the time of appointment and for a period of three years after completion of service on the advisory board, task force, or committee. No individual shall be appointed to the advisory board, task force, or committee whose spouse or child is an employee, director, or stockholder of any for-profit company researching, developing, marketing, or providing health care products or services.
   (c) The Director of Health Services shall be a member of the advisory board and shall serve without additional compensation.

25070. The advisory board shall do all of the following:
(a) Make policy recommendations on medical issues, population-based public health issues, research priorities, scope of services, expanding access to care, and health care system evaluation.
(b) Review proposals for innovative approaches to health promotion, disease and injury prevention, education, research, and health care delivery.
(c) Be consulted by the commissioner regarding any matter involving practice or quality under the health security system.
(d) Recommend expert task forces, including an expert formulary committee, to assist the commissioner in developing the commissioner's recommendations to study and make recommendations on specialized areas of medical policy and effectiveness.
(e) Identify medical services for which there is no credible evidence of significant benefit.
(f) Establish standards and criteria by which requests by health facilities for capital improvements shall be evaluated.

25071. The responsibilities of the formulary committee shall include, but need not be limited to, all of the following:
(a) Prepare, and update as required, a formulary that shall contain drugs covered under the health security system.
(b) Make recommendations to the commissioner as to which drugs are of proven efficacy for particular conditions.
(c) Identify those prescription drugs that are of comparable efficacy or that lack distinguishing features that would justify their independent inclusion in a health security system.

25073. The commissioner shall establish a mechanism to allow the consumer council and any organization or advocacy groups with special health-care-related interests, including those representing health-care providers, to provide input to the advisory board on a regular basis.

Article 4. Regional Administration

25074. (a) There shall be a regional administrator in each system region whose duties shall include, but are not limited to, negotiating service contracts, preparing budgets, overseeing and funding of capital expense projects of health facilities and clinics in the region, reviewing guidelines and formularies formulated by the commissioner.
(b) Each regional administrator shall be exempt from civil service pursuant to subdivision (d) of Section 4 of Article VII of the California Constitution.
(c) The regional administrator shall not be an employee, director, or stockholder of any for-profit company researching, developing, marketing, or providing health care products or services during the time of appointment and for a period of three years after completion of service. No individual shall be appointed as a regional administrator whose spouse or child is an employee, director, or stockholder of any for-profit company researching, developing, marketing, or providing health care products or services.

25075. Regional Consumer Advocates.
(a) There shall be a regional consumer advocate in each system region, appointed by the commissioner.
(b) The regional consumer advocate shall monitor the effectiveness of the health security system within a system region including, but not limited to, examining all of the following:
   (1) Complainants and suggestions from the public.
   (2) Proposals to be considered by the commissioner in the future.
   (3) The commissioner's plans for changes in resource allocation.
   (4) The extent to which individual health facilities and clinics in a system region have the needs of the community in which they are located.
   (5) Any other factor bearing on the effectiveness of the health security system.
   (c) The regional consumer advocate shall receive, investigate, and respond to complaints from the public or any aspect of the health security system, referring the results of investigations to the appropriate professional provider or facility licensing board or law enforcement agencies, as appropriate.

The regional consumer advocate shall publish an annual report to the public containing an evaluation of the health security system in that system region, including, but not limited to, the items described in subdivision (b).
(e) The regional consumer advocate shall hold public hearings no less than yearly, but not limited to, the items listed in subdivision (b).
(f) In the pursuit of his or her duties, the regional consumer advocate shall have unlimited access to all non-confidential and non-privileged documents in the commissioner's possession, or control of the commissioner, regional administrator, and health security system staff.
(g) The regional consumer advocate shall not be an employee, director, or stockholder of any for-profit company researching, developing, marketing, or providing health care products or services during the time of appointment and for a period of three years after completion of service. No individual shall be appointed as a regional consumer advocate whose spouse or child is an employee, director, or stockholder of any for-profit company researching, developing, marketing, or providing health care products or services.

Article 5. Health Care Consumer Council

25080. (a) There is established a Health Care Consumer Council as an agency to do all of the following:
(b) Advise the commissioner on behalf of health care consumers of the state regarding policies and practices in the provision and delivery of health care services and supplemental health insurance.
(c) Educate health care consumers about preparation and submission of claims or disputes to the any aspect of the health security system.
(d) Maintain, maintain, intervene, or participate in any proceeding related to health care services or supplemental health insurance which affects the interests of health care consumers, except that the consumer council shall not represent any person in any action for compensation for injury or damages arising from any provision of health care services or supplemental health insurance.
(e) Approve before local, state, and federal legislative or policymaking bodies to advocate and lobby on behalf of the interests of health care consumers.
(f) Conduct and support research, surveys, conferences, and public information activities concerning health care and supplemental health insurance matters.
(g) Advise the commissioner on behalf of health care consumers.
(h) Perform all acts necessary or expedient for the administration of its affairs and the attainment of its purposes.

The membership of the consumer council shall consist of all individual health care consumers 18 years of age or older residing in the state who have contributed to the consumer council the appropriate annual membership fee. The Board of Directors of the Health Care Consumer Council shall establish an annual membership fee of not less than ten dollars ($10), to be adjusted every three years for inflation, and provide for reduced fee membership for low-income individuals.
(i) Within 90 days of the effective date of this act, the Governor shall appoint five individuals to the interim board of directors, and the Rules Committee of the Senate and the Speaker of the Assembly shall each appoint 10 individuals to the interim board of directors.
(j) The interim board of directors shall, prior to the date benefits are first provided under this act, regulate the consumer council, elect its consumer council officers, and authorize consumers of and solicit their membership in the consumer council; elect officers; employ such staff as are necessary; solicit funds; determine the consumer council administration, each of which, shall consist of two state senators districts; establish procedures for democratic election of 20 members of the board of directors; oversee the election campaign, tally the votes, and install the elected and appointed directors; and carry out all other duties and exercise all other powers necessary to establish the first elected board of directors in which the following provisions apply:
(k) The first election of the board of directors regarding conflicts of interest, contribution limitations, nomination procedures, requirements of candidates to administer statements of financial interest, background, and regarding the reimbursement of actual, reasonable expenses of interim directors. The agency shall not participate in any representation of health care consumers before any administrative, judicial, or legislative body before the first elected board of directors is installed.
(l) The Board of Directors of the Health Care Consumer Council shall consist of 25 members, of which, one shall be appointed by the Governor, two shall be
appointed by the Rules Committee of the Senate and two shall be appointed by the Speaker of the Assembly, subject to the approval of the members of subdivisions (9) of this article regarding qualifications for directors. The remaining 20 shall be elected by the membership. The term for all appointed directors shall be two years. Each elected director shall represent a consumer council electoral district. One such director shall serve for a one-year term and one-third of such directors shall serve for a two-year term. The directors shall draw lots upon their installation to determine their respective terms, with the board maintaining the regularity and uniformity of its meetings. All directors shall serve without compensation, but may be reimbursed for actual, reasonable expenses incurred by them in the performance of their duties.

(1) No person employed, director, consultant, attorney, or accountant of any private health insurance provider shall be a candidate for any health care provider, or spouse or child of any such individual, shall be eligible to be appointed or elected to either the interim or subsequent boards of directors, and no candidate for the office of director shall represent the same health care provider or another employer, or any other employer in any capacity, until at least one year has passed since such employment or representation. No elected member of the board of directors shall serve more than two consecutive terms and no appointed member shall serve more than one term. No board of directors member or candidate may hold any other elective public office or be a candidate for elective public office or be appointed to hold state or local office. No elected director or member may hold any other elective public office or be appointed to hold state or local office.

(c) Not more than 60 days after the membership of the consumer council reaches 25% of the members of consumer council districts, the interim board of directors shall set a date for the first general election of directors and shall notify every member. The date for elections shall be not less than four months nor more than six months after such notification. The election of board members shall be fixed by the board of directors at least four months in advance of the date chosen for the election.

(d) The board of directors shall have the following duties:

(1) To determine the conduct and timing of elections and campaign fun and the board of directors inconsistent with this act.

(2) To establish policies and procedures regarding conflicts of interest; campaign contributions; nominations of candidates for election; and the requirements of candidates to submit statements of financial interest, background, and position; and regarding reimbursement of actual, reasonable expenses of directors.

(e) To establish the policies of the consumer council regarding appearances before the commissioner, administrative, judicial, and legislative bodies, and regarding other activities which the consumer council has the authority to perform under state law.

(f) To maintain up-to-date membership roll.

(g) To keep minutes, books, and records which shall reflect all the acts and transactions of the board of directors which shall be open to examination by any member during regular business hours.

(h) To maintain and make all reports and studies compiled by the consumer council pursuant to this article available for public inspection during regular business hours.

(i) To maintain for inspection by the membership quarterly statements of the financial and substantive operations of the consumer council.

(j) To cause the consumer council's books to be audited by an independent certified public accountant at least once each fiscal year, and to make the audit available to the general public.

(k) To prepare, as soon as practicable after the close of the consumer council's fiscal year, an annual report of the consumer council's financial and substantive operations to be made available for public inspection.

(l) To conduct an annual membership meeting and therein report to the members of the candidate directors and policies of the consumer council. In addition, the consumer council shall sponsor on behalf of each director at least one meeting per year in each consumer council electoral district.

(m) To employ a director and non-director staff.

(n) To hold regular meetings, including meetings by telephone conference, at least once every four months on dates and at places as it may determine. Special meetings may be called by the president of the board or by at least one-quarter of the directors upon at least five days notice. One-half of the directors plus one shall constitute a quorum. All meetings of the board of directors shall be open to the public. Complete minutes of the meetings shall be kept.

(o) To carry out all other duties and responsibilities imposed upon the consumer council and its board of directors and to exercise all powers necessary to accomplish the purposes of this article.

(p) To hire and discharge the board of directors shall be subject to the conflict of interest provisions in subdivision (9) of this section. The executive director may not be a candidate for the board of directors while serving as executive director. All candidates for executive director shall submit a statement of financial interest and record of benefits received by the board of directors shall be required to file the statement annually. The executive director shall be exempt from civil service and shall serve at the pleasure of the board of directors.

(q) The consumer council shall be funded in part by contributions of its members and through other grants or donations, including interagency compensation funds for which it might be eligible, except that no gift, loan, or other aid received by the consumer council, health care industry company, or member, director, employee or agent thereof.

(r) A "Health Consumer Representation Fund, ("fund") shall hereby be created and shall be maintained as a trust fund by the Treasurer under section 16299 of the Government Code. Member fees and all other moneys received by the consumer council shall be deposited in the fund. Moneys in the fund shall be solely and continuously appropriated for expenditure by the board of directors to cover all actual and necessary expenses incurred in carrying out the purposes of this section. The Legislature shall have no right of appropriation of moneys in the fund.

39.5 The consumer council shall prepare and furnish any state agency an excel listing voluntary membership contributions which shall be included, upon the request of the consumer council, in any meeting by that agency to at least 1,000 individuals.

39.6 The consumer council shall do both of the following:

(a) Upon furnishing any state agency the enclosure permitted that agency to retain at least 5% of the state agency for all reasonable incremental internal expenses as a result of compliance with this subdivision above the total postage and handling costs that otherwise would have been incurred without the enclosure, provided that an itemized accounting of the additional costs shall be included first.

(b) The consumer council shall not sponsor, endorse, or otherwise support or oppose any political party or the candidacy of any individual for elective office.

(c) The consumer council may employ and direct attorneys on staff or as outside counsel in the defense or implementation of any of its powers. The consumer council may use and be used.

(d) Nothing in this article shall be construed to limit the right of any individual or group of individuals to initiate, intervene in, or otherwise participate in any proceeding before any administrative, judicial, or legislative bodies, nor to require any petition or notification to the commissioner as a condition precedent to such right; nor to relieve any agency, court, or other public body of any obligation, or affect its discretion to permit intervention or participation by a consumer or group of consumers in any proceeding or activity; nor to limit the right of any individual or individuals to obtain administrative or judicial review.

Article 5. Public Hearing

25610. The commissioner, regulatory consumer advocates, and consumer council shall jointly sponsor public hearing, no less than yearly in each system area, at which testimony shall be taken regarding all of the following:

(a) The commissioner's proposals for resource allocation, revenue generation, and other substantive policy changes.

(b) The responsiveness of health facilities and clinics in a region to the health care needs of the local communities and populations they serve.

Article 7. Monitoring and Data Gathering

25655. (a) The commissioner shall guarantee that the data gathering and analyses necessary for the functioning of the system, including, but not limited to, review of access to care, quality, efficiency, and appropriateness of care and services, professional provider participation, population-based health outcomes, health care financing, and geographic distribution of health care providers.

(b) The commissioner, in consultation with the advisory board, shall establish a standard set of indicators and methods to be used to assess the effectiveness of the health security system in implementing and fulfilling the intents and purposes of this act. This should include, but is not limited to, the current central for Disease Control and Prevention's consensus list of population health outcome indicators, indicators of child health, maternal health, and child health, safety and cost of births, prematurity and appropriate treatment of care for cancer and other diseases, financial survival and success rates for common procedures, functional status in the elderly, communicable disease rates, monitoring of out-of-pocket expenditures, available services including managed care, and the number and types of staff employed by professional providers, and the number of each category of professional provider giving hands-on care.

(c) As a condition of reimbursement, professional providers and health facilities and shall be required to comply with the commissioner to a certain amount of clinical data to be used to assist in the health security system's health outcome monitoring effort for the purposes of improving the effectiveness of practice by professional providers and health facilities.

(d) Clinical data provided by individual professional providers shall be confidential and used only for statistical and system-wide purposes, and for improving the quality of care.

(e) The commissioner shall make the nonconfidential data and analysis generated pursuant to this section available to the consumer council, state and local health departments, and the public in a timely manner.

(f) The commissioner shall establish uniform fiscal and medical reporting requirements for all health care professional providers. Health facilities and clinics and professional providers, including those in integrated delivery systems, shall provide information to the commissioner about financial relationships with other health facilities, clinics, and professional providers. The information shall be available for public disclosure in order to assure that health facilities, clinics, and professional providers do not collude to increase prices or reduce cost controls.

(g) The commissioner shall make available to the commissioner all available information regarding administration and any other aspects of the health security system that they might request for the purpose of compiling reports and data analyses.

(h) None of the data disclosure activities of the health security system shall infringe on the confidentiality of health security system information on individuals and their medical records.

Course 6. Functional Analysis

Article 1. Funding of the Health Security System

25100. There is established a special fund in the State Treasury, to be called the Health Security Fund, for the purpose of implementing this act.

25110. (a) All moneys collected, received, and transferred pursuant to this article shall be deposited in the State Treasury to be used for the purpose of the Health Security Fund for the purpose of financing the health security system.
(b) The money in the Health Security Fund shall not be considered state revenues or state money or proceeds of taxes for purposes of Sections 3 and 8 of Article XVI of the California Constitution.

25102. (a) If, for each of two consecutive years, the balance remaining in the Health Security Fund at the end of the fiscal year is greater than 1% of the system budget, and the Executive Officer has been fully reimbursed, the commissioner shall request the Legislature to reduce the tax rates under this chapter.

(b) Subdivision (a) shall apply only after full phase-in of benefits as set forth in Section 25006.

Article 2. Sources of Funding

25105. Federal contributions to the Health Security Fund.

The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation so that all current federal payments for health care shall be paid directly to the health security system, which shall then assume responsibility for all benefits and services previously paid for by the federal government with these funds. In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution to health care services in California equal to the amount of the federal contribution to the state as a result of the waivers, exemptions, agreements, or legislation.

25108. State contributions to the Health Security Fund.

(a) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation so that all current state payments for health care shall be paid directly to the health security system, which shall then assume responsibility for all benefits and services previously paid for by state government with these funds. In obtaining the waivers, the commissioner shall extend the extent that the commissioner obtains authorization to maintain eligibility records for programs transferred to the health security system, the commissioner shall seek from the state government a contribution to health care services in California equal to the amount of the state contribution to the state as a result of the waivers, exemptions, agreements, or legislation.

(b) It is the intent of the people that the Legislature cooperate with the commissioner in transferring funding for state programs for health services to the health security system.

25110. County and local contributions to the Health Security Fund.

The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation so that all current county or local government payments for health care, including employee health benefits and health benefits for retired employees, shall be paid directly to the health security system, which shall then assume responsibility for all benefits and services previously paid for by counties or other local agencies with the same or similar programs. In obtaining the waivers, the commissioner shall seek from the state government a contribution to health care services in California equal to the amount of the contribution to the state as a result of the waivers, exemptions, agreements, or legislation, the commissioner shall seek contributions for health care services that shall not decrease in relation to expenditures for health care services in the year of passage of the act, corrected for change in state gross domestic product and population.

25112. The health security system's responsibility for providing care shall be secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for these programs is not transferred to the Health Security Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the health security system.

25113. The commissioner has the authority to maintain eligibility records for programs transferred to the health security system, the commissioner shall seek to maintain eligibility records for programs transferred to the health security system, the commissioner shall seek from the state government a contribution to health care services in California equal to the amount of the contribution to the state as a result of the waivers, exemptions, agreements, or legislation.

25115. Employer contributions to funding the health security system.

All employers shall contribute to health security system January 1 of the second year following passage of this act, as provided in Section 30001 of the Revenue and Taxation Code.

25119. Individual contributions to funding the health security system.

All individuals shall pay a Health Security Fund income tax commencing January 1 of the second year following passage of this act, as provided in Sections 30004 through 30007, inclusive, of the Revenue and Taxation Code.

25126. Medi-Cal Fund.

25126. (a) (1) If and to the extent the Legislature transfers Medi-Cal funding, the commissioner shall pay all premiums, deductibles, and coinsurance for qualified Medicare beneficiaries who are receiving SSI benefits.

(b) In the event that the commissioner obtains authorization to fund Medi-Cal in California, this subdivision shall lapse and be replaced by subdivision (b).

(c) Medicare Part B payments which previously were made by individuals or the commissioner shall, commencing in the second year following passage of this act, be paid by the health security system for all individuals eligible for both the health security system and the Medicare program, provided arrangements have been made to pay Medicare revenues into the Medi-Cal Security Fund pursuant to Section 25105.

(d) Until appropriate waivers have been obtained, the commissioner shall make all arrangements for which all payments which would have been eligible to have Medi-Cal pay their Medicare Part B premium prior to the effective date of this act.

25130. Cigarette and Tobacco Products Surcharge.

All distributors of cigarettes and tobacco products shall pay a Health Security Fund tobacco tax commencing January 1 of the second year following passage of this act, as provided in Section 30238.5 of the Revenue and Taxation Code.

25134. The Legislature may provide for the collection and administration of the taxes imposed by this act consistent with the collection of other similar taxes.

25135. Nothing in this act shall be construed to effect or diminish the benefits that an individual may have under a collective bargaining agreement.

Article 3. Federal Preemption

25136. Exempt employers.

(a) An employer is exempt from the payroll tax requirements of Section 31515 of this code and Sections 33001 to 33009, inclusive, of the Revenue and Taxation Code if it has established an employee benefit plan subject to federal law which meets the funding provisions of this chapter.

(b) Notwithstanding paragraph (1), an exempt employer shall comply with the reporting requirements of subdivision (b) of Section 33001 of the Revenue and Taxation Code, to the extent permitted by federal law.

(c) An employer is exempt from any other provisions of this act to the extent compliance with the provision would be preempted by federal law. It is the intent of the people that the provisions of this act be construed to be consistent with federal law.

25137. Waiver.

(a) The commissioner shall pursue all reasonable means to secure repeal or waiver of any provision of federal law that preempts any provision of this act.

(b) In the event repeal or waiver cannot be secured, the commissioner shall exercise his or her powers to promulgate rules and regulations, or seek confirming state legislation, that are consistent with federal law in an effort to best fulfill the purposes of this act.

25138. Employees covered by health plan subject to preemption.

(a) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan which, under federal law, preempts provisions of this act, shall first seek benefits under that contract or plan before receiving benefits under this act.

(b) No benefits shall be denied under this act unless the employee has failed to take reasonable steps to secure like benefits from the contract or plan, if those benefits are available.

(c) Nothing in this section shall preclude an employee from receiving benefits under this act that are superior to benefits available to the employee under the contract or plan.

(d) Nothing in this act is intended, nor shall this act be construed, to discourage recognition of contracts or plans that are prohibited by federal law.

(e) Any physician or health care provider, including a hospital, may render services pursuant to a contract or plan subject to federal preemption without regard to the limitations on professional provider fees contained in Section 25180.

(f) To the extent permitted by federal law, the provider shall first seek payment from the contract or plan, before submitting bills to the health security system.

(g) Any fee charged by the provider in excess of the rate set or negotiated by the commissioner shall not serve to increase the amount of funds being made available to the provider from the health security system in the current or subsequent years.

Article 4. Subrogation

25139. (a) It is the intent of the people to establish a single public-payer for all health care in the State of California. However, until such time as the role of all other payers for health care have been terminated, it is the intent of the people to recover health care costs from collateral sources whenever medical services are provided to an individual that are or may be covered services under a policy of insurance, health benefits plan, or other collateral source available to that individual.

(b) As used in this article, the term collateral sources includes all of the following:

(1) Insurance companies and carriers, as defined in Section 14124.70, including the medical components of automobile, homeowners, and other forms of insurance.

(2) Health care and pension plans.

(3) Employers.

(4) Employee benefit contracts.

(5) Government benefits programs including, but not limited to, workers' compensation.

(6) A judgment for damages for personal injury.

(7) Any third party who is or may be liable to the individual for health care services or costs.

(8) The term collateral source does not include either of the following:

(1) A contract or plan subject to federal preemption as described in Article 3 (commencing with Section 25136) of this chapter.

(2) Any governmental unit, agency or service, to the extent that subrogation is prohibited by law. An entity described in subdivision (b) is not excluded from the obligations imposed by this article by virtue of a contract or relationship with a governmental unit, agency or service.

(3) It is the further intent of the people that the commissioner and the Legislature make every attempt to negotiate waivers, seek federal legislation or make such arrangements to incorporate collateral sources to California into the health security system.

25140. Whenever an individual receives health care services under the health security system, for which another entity is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and the commissioner and provide information identifying the collateral source, the nature and extent of the collateral entitlement, and other relevant information as requested by the commissioner.

25141. Use of an eligibility card for, or receipt of, health care services under this act for which an individual is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, shall be deemed an assignment by the individual to the health security system of his or her rights from or against the
c) The health security system shall seek reimbursement from the collateral source for services provided to the individual, and may institute appropriate action, including suit, to recover same. Upon demand, the collateral source shall pay all or any part of the expenses of the health security system, as it would have paid or expended on behalf of the individual for health care services provided by the health security system.

(b) In addition to any other right to recovery provided in this article, the commissioner shall have the same right to recover the reasonable value of benefits from a collateral source as provided to the Director of Health Services by Article 35 (commencing with Section 14124.70) of Chapter 7 of Part 5 of Division 6, in the manner so provided.

25143. If a collateral source is exempt from subrogation or the obligation to reimburse the health security system as provided in Sections 25136 and 25139, the commissioner may require that an individual who is entitled to medical services from the source first seek those services from that source.

25144. To the extent permitted by federal law, contractual retiree health benefits shall be subject to the same subrogation as other contracts, allowing the health security system to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenues of the benefits directly to the health security system.

25145. Upon integration of workers' compensation health benefits into the health security system, the cost of workplace-related medical claims that are found to result from unsafe workplace conditions or negligence on the part of the employer shall be borne by the employer rather than the health security system.

Article 5. Other Considerations

25147. (a) Revenue to operate the health security system shall be generated in a manner intended to coincide in the aggregate with financial responsibility for health care expenditures in the base year, and not exceed the limits described in Article 1 (commencing with Section 25150) of Chapter 7.

(b) In the event of unanticipated expenditures in excess of the Reserve Account, or if cost control mechanisms indicated under Article 8 (commencing with Section 25290), of Chapter 7, are unable to lower expenditures without endangering the health of Californians, the commissioner may request the Legislature to increase health security system funding either by increasing tax rates on the sources described in Section 25237, or from other revenue sources. In either case, the employer shall be borne by the employer rather than the health security system.

(c) In the event that federal health care reform legislation is passed prior to or subsequent to passage of this act, the commissioner shall take all steps necessary to ensure that all funds available to California for benefits and services covered under the federal health care system are paid to the Health Security Fund.

(d) In the event of federal health care reform legislation including payroll, individual income or cigarette and tobacco products taxation, and to the extent that agreements are reached to transfer those revenues into the Health Security Fund, the Legislature may enact a proportional decrease in the payroll, individual, and cigarette and tobacco taxes established by this act pursuant to Sections 30133.5 and 30201 to 30207. Inclusion of the Revenue and Taxation Code in order that revenues to the Health Security Fund be maintained within the limits established by subdivision (a) of Section 25102 and subdivision (a) of Section 25196.

25148. (a) Default, underpayment, or late payment of any tax or other obligation imposed by this act shall result in the remedies and penalties provided by law except as provided in this section.

(b) Eligibility for benefits under Chapter 4 (commencing with Section 25910), except for those benefits provided by Article 4 (commencing with Section 25905) of Chapter 4, relating to long-term care, shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by this chapter.

(c) (1) Eligibility for benefits provided by Article 4 (commencing with Section 25925) of Chapter 4, relating to long-term care, shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by employers by Section 25115.

(2) Eligibility for benefits provided by Article 4 (commencing with Section 25925) of Chapter 4, relating to long-term care, shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by employers by Section 25115.

(b) Allocation of budgetary and expenditure.

Article 1. Expenditure Limit

25150. (a) It is the intent of the people of this state that expenditures under this act not exceed in any year expenditures for the prior year adjusted for changes in the state's gross domestic product and population.

(b) If the Reserve Account is not fully funded, mandatory cost control measures as described in Section 25240 shall be triggered when the cumulative expenditures of the health security system, on an annualized basis, exceed 95% of the health security system budget exclusive of the Reserve Account, except during the last month of the fiscal year.

(c) If the Reserve Account is fully funded, and during the last month of the fiscal year, mandatory cost control measures as described in Section 25240 shall be triggered when the cumulative expenditures of the health security system on an annualized basis exceed 100% of the health security system budget exclusive of the Reserve Account.

Article 2. Appropriations

25151. (a) It is the intent of the people that all moneys in the Health Security Fund be appropriated to the health security system to support the implementation of this act.

(b) On July 1 of any year, all moneys in the Reserve Account are appropriated to the commissioner for the purpose of implementing the health security system if a Budget Act for the fiscal year beginning on that July 1 has not been enacted by that date. The authority to spend funds from the Reserve Account for that fiscal year, pursuant to this subdivision, shall be terminated upon enactment of the Budget Act by which the Budget Act continues that authority.

(c) The Legislature may appropriate additional money from the General Fund or from other sources to support the implementation of this act.

Article 3. Health Security System Budgets

25155. Preparation of Budgets.

(a) The commissioner shall prepare an annual budget in the manner prescribed by law. The budget shall include all of the following:

(i) A system budget which includes all expenditures for the health security system.

(ii) Regional budgets, which include all expenditures for the health security system within each system region.

(iii) Global budgets for each of the two principal mechanisms of professional program reimbursement (fee-for-service and integrated health delivery system) if and for individual health facilities and their associated clinics. The global budgets shall be part of the regional budget for each system region.

(iv) A capital expenditure budget, as described in Section 25215.

(b) The commissioner shall prepare the system budget for the health security system to be submitted to the Legislature as part of the Governor's Budget.

25156. System Budget.

(a) The cost of the health security system, including the cost of all services and benefits provided, administration, data gathering and other activities, and revenues deposited within the named accounts pursuant to Section 25256, shall comprise the system budget.

(b) Moneys in the Reserve Account shall not be considered as available revenues for purposes of preparing the system budget.

25157. Regional Budgets.

(a) The commissioner, in consultation with the regional administrator, shall prepare a regional budget for each system region. The budget shall include allocations for each of the following:

(i) Fee-for-service providers.

(ii) Capitated providers.

(iii) Health facilities and associated clinics that are not part of a capitated provider network.

(b) The allocations in subdivision (a) shall consider the relative usage of fee-for-service providers, capitated providers, and health facilities and associated clinics that are not part of a capitated provider network within the system region. The global budgets shall be adjusted from year to year to reflect changes in the utilization of services, changes in payment for capitated services, and the addition or exclusion of covered services made by the commissioner upon recommendation of the advisory board.

(c) The global budget for fee-for-service providers in each system region shall be further divided among categories of licensed professional providers, thus establishing a total annual budget for each category within each region. Each of these category budgets shall be sufficient to cover all insured services anticipated to be necessary for the delivery of health care services within the region, at the rates negotiated or set by the commissioner, except as necessary for cost containment purposes described in Article 8 (commencing with Section 25225) of Chapter 7.

(d) The global budget for capitated providers shall be sufficient to cover all eligible individuals choosing an integrated health delivery system within the system region, at the capitation rates negotiated or set by the commissioner, except as necessary for cost containment purposes under Article 8 (commencing with Section 25225) of Chapter 7.

(e) Each health facility and clinic in a system region, apart from those that are
part of capitated integrated delivery systems, shall have a facility budget that encompasses all operating expenses for the primary care provider. In establishing a facility budget, the commissioner shall develop and utilize separate formulas that reflect the differences in cost of primary, secondary, and tertiary care services and health care services provided by academic medical centers. (b) Budgets under this article, the commissioner shall consider anticipated increased expenditures and savings including, but not limited to, all of the following: (a) Projected increases in expenditures due to improved access for underserved populations and increased reimbursement for primary care services. (b) Projected administrative savings under the single-payer mechanism. (c) Projected savings in prescription drug expenditures under competitive bidding rules for prescription drugs. (d) Projected savings in health facility and clinic costs due to decreased acuity of hospitalization in some cases, and appropriate availability of long-term care facilities in other cases. (e) Projected savings due to provision of primary care rather than emergency room treatment. (f) Projected savings from termination of reimbursement of procedures of no documented benefit or for which appropriate indications are not present. (g) Projected savings from diminished reimbursement for procedures and services of marginal benefit, as determined by the advisory board. (h) Projected savings from decreased reimbursement of specialty care relative to primary care. (i) Projected savings due to realization of high-technology and experimental services. (2) In preparing the system budget the commissioner shall also consider, in addition to changes in the state gross domestic product and population from year to year, anticipated additional expenditures due to medically appropriate increases in utilization of services, and differences in per capita health care spending, in the population, and technological advances allowing better diagnosis and treatment of disease. (2.1) Commencing with the second budget year, the administrative costs of the health security system incurred by the commissioner shall be 4 percent or less of the total funds appropriated for the health security system. If administrative costs exceed 4 percent, the commissioner shall report to the Legislature the reasons for excess administrative costs. (b) That amount of the system budget remaining after funds are allocated for administration, data gathering, and the named accounts pursuant to Section 25120, shall be budgeted for the system regions, in the manner described commencing with Section 25157, to provide benefits pursuant to Chapter 4 (commencing with Section 25910). Article 4. Provider Reimbursement (25800) (a) Professional providers registered for reimbursement with the system shall, with respect to all covered services provided to an eligible individual under Chapter 4 (commencing with Section 25910), do all of the following: (1) Submit all bills to the regional administrator pursuant to procedures established by the commissioner. (2) Not charge the system an amount in excess of rates negotiated or set by the commissioner. (3) Not charge the patient any additional amount or copayment except as specified under Sections 25830, 25830.1, and 25835. (b) Professional providers registered for reimbursement under the system who have submitted bills for covered services in accordance with the guidelines established by the commissioner shall be paid promptly. Interest shall accrue on all bills 45 days past due at the rate of 19 percent. (25810) (a) Health facilities and clinics registered with the health security system may choose to be reimbursed on the basis of either a facility budget or an integrated capitated budget under the health security program. The provider must meet the criteria pursuant to Section 25158, or as a capitated integrated professional provider network pursuant to subdivision (c) of Section 25180. (b) The budget specified in paragraph (a) shall be negotiated with each participating health facility or clinic on an annual basis, with adjustments during the year made for epidemics and other unforeseen catastrophic changes in the general health status of a patient population, at the discretion of the commissioner. (c) Surplus generated from the operating section of a health facility or clinic facility budget shall not be used for the payment or reimbursement of any capital cost, except in accordance with the provisions of Sections 25213 and 25215. (d) Any surplus a health facility and clinic may be able to generate through increased efficiency of operation may be used to develop new and innovative programs, as approved by the commissioner, or shall be returned to the health security system. (e) Health facilities and clinics shall inform the commissioner as soon as evidence suggests that operating expenses will exceed the facility budget. (f) If the operating deficit exceeds the facility budget, the commissioner shall investigate the cause. If it is determined that the operating deficits do not exceed the facility budget, the commissioner, by adjusting the facility budget for the health facility or clinic shall be adjusted and appropriately modified in the current or subsequent year, or both, to cover the anticipated shortfall. (2) To the extent that it is determined that the operating deficit was not justifiable under the terms of the health security system, adjustments in the facility budget shall be made. Instead, recommendations for improved efficiency or other changes necessary to bring costs within the health facility or clinic's facility budget, or other changes, may be made by the regional administrator. Implementation of these recommendations may be a precondition for funding in the next health security system year. (g) (1) Every health facility or clinic facility budget shall allow for the care of individuals who are not enrolled in the health security system or are not eligible for services, at the same rates as for enrolled individuals. Notwithstanding the provisions of the health security system, the health facility or clinic may be barred from receiving health security system funds in the subsequent year unless, at the discretion of the commissioner, subject to the review procedures in Section 25300, the health facility or clinic shall: (a) Fairly compensate a professional provider or a group of professional providers. (b) Experience a substantial increase in enrollees. Notwithstanding this section, the commissioner may impose the following conditions for reimbursement: (1) Provide discrimination in eligibility for reimbursement against a class of professional providers who are providing services within the scope of practice permitted by law. (2) Annually in the manner described with the commissioner. (3) Apply those conditions to any professional provider or a group of professional providers. (4) Under these conditions, the commissioner may approve the following: (a) Nonprofit health facilities and clinics, not for profit, operating under the supervision of a primary care provider, and that all individuals do receive services from a primary care provider. The primary care provider may be an individual professional provider or a group of professional providers. Under these conditions, the primary care provider shall be reimbursed at the primary care rate rather than the specialty care rate. (b) Projected savings due to regionalization of high-technology and experimental services. (c) Projected savings from diminished reimbursement for procedures and services of marginal benefit, as determined by the advisory board.
some restrictions on capital expansion that apply to all other health facilities, clinics and professional providers.

(3) Health facilities, clinics, and providers organizing as an integrated delivery system that are for-profit shall be capitlated or facility budgeted by the same criteria and at the same rates as non-profit entities.

(4) If any professional provider involved in an integrated health system has an existing collective bargaining agreement or agreement, those collective bargaining agreements may be extended to the employees of all of the professional providers in the integrated system, unless otherwise prohibited by law.

(5) If a provider shall prevent the commissioner from after public hearings, from termination of the participation of a health facility or clinic in the health security system, should evidence should lead the commissioner to conclude either of the following:

(1) That the health facility or clinic is unable to meet minimum requirements relating to the number and type of professional providers on the staff, the type of equipment available to the facility or the range of specialty services provided by the facility or other standards and criteria.

(2) That the health facility or clinic provides care significantly below the standards for facilities in the region.

(6) Different standards and criteria pursuant to subdivision (d), the commissioner may authorize conversion of the facilities to meet health care needs in such areas as long-term care.

(8) The commissioner may authorize conversion of the facilities to meet health care needs in such areas as long-term care.

(10) During the open enrollment period, an individual may enroll in another capitated health care system with a primary care provider in the fee-for-service sector may choose to enrollment in a capitated practice at any time.

(11) Any professional provider accepting payment from the health security system on a prepaid basis shall allow any eligible individual to enroll in the order of application, up to a reasonable limit determined by the capacity of the capitated practice to provide services.

(12) If an enrollee accepts payment from the health security system on a prepaid basis, as a condition of approval to participate in the provision of benefits under this division, shall demonstrate they will provide, or arrange and pay for, all of the benefits required for the capitated payment negotiated or set by the commissioner.

(13) Nothing in this division shall prohibit an integrated delivery system or other capitated practice from offering additional benefits beyond those set forth in Chapter 4 (commencing with Section 35610). The additional benefits shall be clearly set forth in a disclosure and practice description materials provided to individuals eligible for services under this division.

(b) The commissioner shall incorporate the reimbursement policies and professional incentives for non-capital providers and community outreach and preventive services. As a condition of receiving the incentives, professional providers shall coordinate their efforts with those of the State Department of Social Services, local health departments, and other agencies funded from the Public Health and Prevention Account, in a manner specified by the commissioner.

(b) The commissioner shall reimburse collaborative practice costs to meet the ambulatory care needs of underserved areas and populations.

(c) The commissioner shall consider the special needs and requirements of rural hospitals in California that are financially distressed and in danger of closure. The commissioner may provide technical assistance with respect to the reimbursement and other requirements and procedures of the health security system for rural hospitals, when appropriate, in order to preserve the availability of health care services.

Article 5. Capital Expenditures

25213. (a) The purpose of this article is to assure that health care facilities that are reimbursed by the health security system do not engage in unnecessary capital expenditures and thereby contribute to health care cost inflation.

(b) On the operating date of this article, no licensed health care facility or any individual acting on behalf of a licensed health care facility shall incur any capital expenditure or any capital expenditure or any facility other than as permitted by law.

(c) The commissioner shall require any reimbursement under this division amounts for capital expenditures, operating expenses for capital improvements, and the cost of services provided by those capital improvements, made or incurred by a facility, or a clinic, or provider after the date of entry into this article, unless that capital expenditure was approved by the commissioner.

(d) As used herein the term "capital expenditure" is an expenditure that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance of an eligible source funding:

(A) Exceeds five hundred thousand dollars ($500,000).

(B) Changes the bed capacity of the facility with respect to which the expenditure is made.

(C) Adds new service or license category.

(D) For purposes of this section, the cost of studies, surveys, design plans and drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which an expenditure exists shall be included in determining whether the expenditure exceeds the dollar amount specified in this section.

(E) When a health care facility or individual acting on behalf of a health care facility obtains by lease or comparable arrangement any facility or part thereof or any equipment for a facility, the market value of which would have been a capital expenditure, the lease or arrangement shall be considered a capital expenditure for purposes of this section.

(F) The commissioner shall only approve a capital expenditure if it is in conformity with standards, criteria, and plans developed by the commissioner to accomplish one or more of the following:

(1) To meet needs.

(2) To eliminate, inappropriate, or unnecessary services by regionalizing tertiary care services in appropriate facilities.

(3) To encourage the expansion of those facilities with superior records of consumer satisfaction and operating efficiency.

(4) To convert to non acute care use general acute care hospitals of less than 150 licensed beds within Standard Metropolitan Statistical Areas.

(5) To assure that health care facilities adequately serve the needs of the community including the disabled and populations with special medical needs.

(6) To promote joint, cooperative, or shared health care resources.

(7) To assure the development of new technologies in appropriate facilities.

(8) To meet the special needs of rural hospitals.

(b) The commissioner shall establish procedures for the review of capital expenditures.

(c) The commissioner may approve capital expenditures for either of the following reasons:

(1) To meet parking, seismic safety, fire safety, physical accessibility for the disabled, energy or water conservation, or other public health and safety requirements of federal, state, or local governments.

(2) To meet the temporary or permanent conversion of general acute care beds to skilled nursing beds or the addition of skilled nursing beds to any general acute care hospital.

Article 6. Capital Allocation

25215. (a) Funds appropriated for capital expenditures pursuant to the capital expenditures budget shall be placed in the Capital Improvements Account, pursuant to this section and Section 25155.

(b) When a capital improvements budget has been approved by the commissioner, it may be funded either from the Capital Improvements Account or from other sources. All capital improvements made from the Capital Improvements Account shall remain the property of the State of California under the health security system.

(c) No later than January 1 of the second year following passage of this act, the commissioner shall report on the capital needs of health facilities and clinics in each service area. In addition to other matter deemed relevant by the commissioner, the report shall identify the capital needs of all of the following:

(1) County health facilities and clinics.

(2) Urban centers with per capita investment in health facilities and clinics substantially different from the state average.

(3) Geographic areas where the distance to health facilities and clinics imposes a barrier to care.

Article 7. Formulary

25216. (a) In order to achieve the lowest possible cost for prescription drugs the commissioner shall do all of the following:

(1) Establish a health security system formulary composed of the best-priced prescription drugs of proven efficacy for a particular condition. The formulary may include in whole or in part the List of Contract Drugs established pursuant to Sections 14105.3 through 14105.35, inclusive, and Section 14105.405 of the Welfare and Institutions Code. The commissioner shall have the authority to enter into purchase contracts for prescription drugs pursuant to these sections.

(2) Use his or her bidding power to negotiate directly from the manufacturer the lowest possible prices for drugs provided under the health security system.

(3) Establish standards and criteria as needed to ensure that only those prescription drugs on the formulary shall be reimbursed under the health security system.

(4) Establish standards and criteria as needed to ensure that formulary drugs are substituted for prescription drugs as written non-formulary drugs, with the approval of the prescribing provider.

(5) Establish standards and criteria by which certain non-prescription, over-the-counter, investigational, and other exceptional drugs, and nutritional supplements, that are of particular benefit for the treatment of specific medical
conditions, or that are cost-effective compared to prescription drugs, may be reimbursed when prescribed by a licensed provider acting within the scope of his or her practice.

(b) Use his or her express or implied powers to reduce the direct cost of prescription drugs.

(c) Encourage the rational use of prescription drugs through educational, outreach, and other programs.

(d) In establishing the formulary and standards and criteria for purposes of this section, the commissioner shall seek the advice of the advisory board.

(e) Formulary drugs, reimbursable under the health security system, shall be substituted for prescription drugs for comparable non-formulary drugs, with the approval of the prescribing provider, pursuant to standards and criteria.

Article 9. Cost Control Measures

25225. The commissioner shall not carry out any cost control measure that limits access to care that is needed on an emergent or urgent basis, or that is medically appropriate for the patient's medical condition.

25226. (a) In order to control costs the commissioner shall strive at all times to do all of the following:

(1) Eliminate administrative and other costs that do not contribute to health care.

(2) Identify and eliminate wasteful and unnecessary care that is of no benefit to patients receiving that care.

(3) Identify and foster those measures that prevent disease and maintain health.

(b) In the event that the measures taken pursuant to subdivision (a) are insufficient to meet the stated goals of the health security system, the commissioner shall study the use of inappropriate services to escalate costs. The commissioner shall adjust the next year's budget, pursuant to Section 25228, to be corrected for the degree of overutilization identified for particular services or particular categories of licensed providers, under particular modes of reimbursement.

(c) Restrictions in budgets under paragraph (j) that are not based on the need for services, new technology, or changing patterns of costs are reviewed at the next quarterly meeting of the advisory board.

25240. (a) In the event that cost control is required by subdivision (b) of Section 25150, the commissioner may request that the Legislature increase appropriations for the health security system. Any request shall be accompanied by a report on the causes of the increases in expenditures beyond the increase in gross domestic product, adjusted for population, and measures taken to control costs pursuant to Section 25226.

(b) In the event that this action is taken pursuant to subdivision (a) and Section 25226 are insufficient to contain costs or increase revenues, the commissioner may, as necessary, defer funding of the Reserve Account and reduce funding of the named accounts for a period not to exceed one year, and establish restrictions or copayments on elective services.

(c) Restrictions on, and copayments for, elective services, as necessary to balance the system budget, shall be applied by the commissioner in order of increasing efficacy, as determined by the advisory board. To compete with the elective services that are clearly beneficial for treatment of a patient's condition, the last services to be restricted or to have a copayment applied.

(d) Definitions: A term in Section 25226 shall not be used to restrict coverage of a specific diagnosis, unless the commissioner finds both of the following:

(1) That the diagnosis or the available treatments are often inappropriate.

(2) That a means of distinguishing appropriate from inappropriate utilization of services for the diagnosis is established based on recommendations of the advisory board.

Article 9. Named Accounts in the Health Security Fund

25250. There is in the Health Security Fund a number of named accounts. The commissioner shall propose budgets that fully fund these accounts as provided for in this act except under the circumstances described in Section 25240:

(a) The Public Health and Prevention Account.

(b) The Uninsured Account.

(c) The Capital Improvements Account.

(d) The Reserve Account.

(e) The Health Worker Training Account.

25251. (a) There is in the Health Security Fund the Public Health and Prevention Account. Funds in the Public Health and Prevention Account shall be budgeted for programs designed to prevent disease, including, but not limited to, community-based activities, nutrition and health promotion programs, training programs, and research as described in Chapter 8 commencing with Section 25260.

(b) The programs funded by the Public Health and Prevention Account shall give priority to meeting the population-based health care needs of population groups with the greatest unmet needs, to provide public health outreach to underserved populations, and research designed to better understand, reduce, or eliminate the causes of illnesses in the population as a whole and enhance quality of life.

(c) All existing population-based public health programs of the State Department of Health Services and the county departments of health shall be funded from the Public Health and Prevention Account. Nothing in this act shall be construed to require any decrease in funding for population-based programs of the State Department of Health Services and the county departments of health.

(d) The Public Health and Prevention Account shall be used to provide additional funding for existing programs of the State Department of Health Services and funding for new programs designed to improve health outcomes of the population, addressing the educational, social, economic, basic biological, and other causes of ill health.

(1) To develop new programs for funding by the Public Health and Prevention Account, the commissioner may consult with the Director of Health Services, local boards, the directors of county health departments, the State Department of Health Services and the county health officials to determine the areas of investment likely to have the greatest impact on future improvement of health outcomes for the population in each system region.

(2) New programs shall be coordinated with existing public health and human services programs and may be funded by grants or by contributions from nonprofit human services agencies, or may be established by the commissioner directly.

(3) The Public Health and Prevention Account may be used to provide funding for school-based services to provide such services as immunizations and health education, as deemed appropriate by the commissioner.

(4) (a) In the first four budget years under this act, the commissioner's proposed budget shall include funding for the Public Health and Prevention Account at a level not less than the sum of all population-based public health expenditures of the state and local health departments in the base year, supplemented by an additional 0.00 percent. In the fifth year and subsequent budget years under this act, the commissioner's proposed budget shall include the amount of the Public Health and Prevention Account at a level not less than five percent (5%) of total annual health security system revenues.

(b) There is in the Health Security Fund the Innovations Account. Funds in this account shall be expended for research and development of new strategies for disease treatment and care. These funds shall be used to give priority to treatments and care that are developed in response to identified needs of patients and caregivers; patients' role in the treatment decision process; and outcomes of the patients and caregivers. The commissioner's proposed budget shall include funding for the Fund at a level not less than one percent (1%) of total annual health security system revenues.

(5) The commissioner's proposed budget shall include funding of the Innovations Account at a level not less than one percent (1%) of total annual health security system revenues.

(b) There is in the Health Security Fund the Capital Improvements Account. The commissioner, in consultation with the advisory board, shall establish an annual budget for the Capital Improvements Account. In the event that the commissioner's proposed budget shall include the amount to be included in each regional budget for capital improvements to be funded out of the Capital Improvements Account.

(c) The commissioner's proposed budget shall include the amount to be included in each regional budget for capital improvements to be funded out of the Capital Improvements Account.

(d) The commissioner's proposed budget shall include the amount to be included in each regional budget for capital improvements to be funded out of the Capital Improvements Account.

(e) The commissioner shall submit the Reserve Account and the Capital Improvements Account for approval by the advisory board. This shall be done in a manner that ensures the necessary funds for the Reserve Account and the Capital Improvements Account are available.

(f) The budget of the Reserve Account and the Capital Improvements Account shall be reviewed and approved by the advisory board.

(g) The commissioner shall retain the Reserve Account for budgetary shortfalls, epidemics, or other extraordinary circumstances as defined by the commissioner and as set forth in Section 25151. The commissioner's proposed budget shall contain funding for the Reserve Account equal to one percent (1%) of the system budget, unless the commissioner determines that a different amount is needed for prudent operation of the health security system.

(h) Funds in the Health Worker Training Account may be used to allow health workers displaced by transition to the health security system to be retrained and placed in jobs that meet the new needs of the system.

(i) The commissioner, in consultation with the employer, establish job retraining or apprenticeship training programs in each system region, pursuant to this section, to be funded from the Health Worker Training Account.

(j) After three years, the commissioner may discontinue the following:

(1) Propose termination of the Health Worker Training Account.

(2) Continue the Health Worker Training Account, and its inclusion in the commissioner's proposed budgets, for the purpose of providing career education and training assistance that will enhance the delivery of health care to California communities that are underserved either in the quality of health care or in accessibility to health care providers.

Article 10. Transfer of Other State Programs

25257. (a) Programs for individual clinical prevention and treatment,
previously administered by the State Department of Health Services, the State Department of Mental Health, the Department of Rehabilitation, the Department of Aging, the State Department of Developmental Services and the State Department of Social Services, and any other state or county entity that provides individual clinical prevention and treatment services, shall be administered by the commissioner to the extent that these programs are transferred to the health security system.

(b) Local health departments shall continue to provide clinical services when needed to reach special or underserved populations and to fulfill the counties' responsibilities to provide a public health care system as specified in Section 25261. However, to the greatest extent possible, these programs shall be funded for these services from the Health Security Fund under the same overall operating expense budgets according to formulae applied to all health facilities and county departments.

(c) Those programs concerned with population-based public health activities and core public health functions shall remain the responsibility of the State Department of Health Services and shall be funded from the Public Health and Prevention Account pursuant to Section 25351.

(d) It is the intent of the people that the Legislature take steps to consolidate the administration of residual programs in those state departments whose functions have been significantly appropriated to the health security system in order to maintain administrative efficiency and to effectively carry out the goals for which any residual programs were established.

CHAPTER 8. PRIMARY CARE, TERTIARY CARE, PUBLIC HEALTH, RESEARCH, AND HEALTH CARE WORKERS GRANTS PROGRAM DISTRIBUTION

Article 1. Primary Care

25260. The people find that quality and efficiency in the delivery of health care services can best be achieved when the ratio of primary care to specialist physicians is one-to-one. Accordingly, the commissioner shall develop and implement appropriate policies which are intended to achieve this ratio.

Article 2. Tertiary Care

25265. (a) The commissioner shall designate one or more tertiary care referral centers for each system region, where specialized, experimental, high-technology, and high-expense procedures and services shall be performed based on the expertise available, and outcomes demonstrated at those centers.

(1) The commissioner shall guarantee that specialized, high-technology, and high-expense procedures and services are performed at the highest level of competence and care fully accessible to all Californians with conditions whose effective treatment requires such care.

(2) The commissioner shall guarantee that the specialized services available in tertiary care referral centers are not in oversupply or otherwise available in ways that are likely to foster their inappropriate use.

(3) Tertiary care referral centers shall include, but need not be limited to, academic medical centers and county hospitals in the region, unless the commissioner finds compelling reasons to designate otherwise.

(b) The services whose reimbursement is restricted to the designated tertiary care referral centers shall be determined and specified no less than yearly by the commissioner on recommendation of the advisory board.

(c) The commissioner shall take such measures as may be necessary to ensure that regionalization of specialized services does not result in barriers to appropriate and reasonable access to those services.

Article 3. Public Health

25270. (a) The advisory board shall make recommendations to the commissioner on technology assessment, cost-effectiveness, practice guidelines and standards, and promotion of population-based health strategies with an emphasis on prevention. Funding to carry out these recommendations, and to carry out public health programs and disease prevention strategies shall be budgeted from the Public Health and Prevention Account in the form of grants for specific programs of the State Department of Health Services, county health departments, State Department of Education, or other state or local government or private non-profit human services agencies, or to programs established directly by the commissioner.

(b) It is the intent of the people that the Legislature not use funding by the commissioner of new programs under the auspices of the State Department of Health Services, county health departments, State Department of Education, or other state or local government or private non-profit human services agencies as a basis for diminishing existing funding of these departments and agencies.

Article 4. Academic Medical Centers

25275. (a) The commissioner shall acknowledge the special role of academic medical centers in providing individual health care services delivery, public health and basic research affecting health care outcomes and costs, and health worker education and training in establishing special formulas by which facility budgets for academic medical centers are established.

(b) The commissioner shall meet with representatives of academic medical centers no less than yearly to promote the needs of the health security system and better coordinate the supply, distribution and demand to fulfill the objectives of this act. These objectives include:

(1) Achieving the targeted ratio of primary care to specialist physicians specified above.

(2) Achieving the number, geographic, discipline and specialty distribution of professional providers to that needed by the state as a whole.

(3) The period of years to be followed by the commissioner, the number and geographic and specialty distribution of professional providers as needed to staff underserved areas and communities.

(c) Actions of the commissioner with respect to academic medical centers shall be limited to those resulting from the replacement of multiple third party providers by a single-payer for health care services.

Article 5. Research

25280. (a) The commissioner may provide competitive grants to academic medical centers and other health professional schools in the state and to local health care experts in the regions to improve the effectiveness of the health security system or at a level of funding not exceeded by the advisory board. The funding shall be for the following purposes:

(1) (A) To determine, and periodically review, the medical conditions that are effectively treated by particular new and currently practiced procedures and services.

(B) The outcome of these studies shall be provided to the advisory board for use in establishing recommendations regarding medical indications for new and currently practiced services and procedures, and to the commissioner and professional provider representatives for the purposes of negotiating rates and fee schedules for professional provider reimbursement and health facility or clinic facility budgets, and in decisions regarding capital expansion.

(2) To carry out basic biomedical and clinical research whose eventual outcome may prevent disease or allow it to be treated with greater efficacy and cost-effectiveness than is the case now.

(3) To carry out research into all aspects of health care services, organization, delivery, and population-based public health.

(b) Specific funding for these and other activities which explore new and innovative approaches to the current and future health care needs of California shall be the appropriation of the last mills from the Public Health and Prevention funds, from the Public Health and Prevention Account and the Innovations Account and shall be calculated separately from the facility budget for provision of services and health worker training of academic medical centers or the budget for local health departments.

Article 6. Miscellaneous

25281. The commissioner may establish standards and criteria regarding any aspect of primary care, tertiary care, public health, health worker training, and research not specified in this chapter.

CHAPTER 9. ENFORCEMENT

25282. (a) No provider that receives funds or provides care pursuant to this division shall discriminate against a person seeking care on the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, medical condition, marital status, sex, sexual orientation, age, wealth, or any other basis proscribed by the civil rights laws of this state, provided that nothing in this act shall require a professional provider or health facility or clinic to perform a particular service where either of the following applies:

(1) The particular service is outside its scope of practice which is bona fide limited to certain medical specialties, services, or age groups.

(2) The professional provider or health facility or clinic asserts a religious or conscientious objection to providing the particular service.

(b) Any person who is eligible for health care services under this division has the right to equitable access to medically appropriate health care, and shall have standing to enforce this section.

(c) Standards and criteria shall be established to assure that health care providers shall not have a financial interest in laboratory and diagnostic facilities to which they refer patients for tests, procedures, or services.

(d) Standards and criteria shall be established to ensure that patient data disclosed by any health facility, clinic, or professional provider reimbursed under the health security system, in order to safeguard patient care and the integrity of the system.

25284. The commissioner shall exclude from participation in any program under this division:

(e) Any provider that has been convicted, under either state or federal law, of a criminal offense relating to any of the following:

(1) The delivery of an item or service under the act or any other federal or state health care program.

(2) The neglect or abuse of a patient in connection with the delivery of health care.

(3) Fraud, theft, embezzlement, breach of financial responsibility, or other financial misconduct in connection with the delivery of health care or with respect to any act or omission in a program operated by or financed in whole or in part by an entity, state, or local government agency, or any person who is regulated by such an entity.

(4) The interference with or obstruction of any act of the commissioner.

(5) The unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(f) Any provider whose license to provide health care has been revoked or suspended by any state licensing agency or who otherwise lost a license or the right to apply for or renew a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

(g) Any provider that has been suspended or excluded from participation in any federal or state program involving the provision of health care, including, but not limited to, Medicare, Medicaid, Medi-Cal, and programs of the Department of Defense and the Veterans Administration.

(h) Any provider that the commissioner determines any of the following:

(1) Has failed to submit or cause to be submitted to the commissioner bills or requests for payment for items or services furnished, where the bills or requests are based on charges or costs in excess of permitted charges or costs, unless the commissioner finds there is good cause for the bills or requests.

(2) Has furnished or caused to be furnished services to patients substantially in excess of the needs of the patients or of a quality that fails to meet...
professional recognized standards of health care.

(3) In a health maintenance organization or other capitated program and has failed substantially to provide medically necessary items and services that are required under this act to be provided to eligible individuals if the failure has adversely affected or has had a substantial likelihood of adversely affecting those individuals.

(d) Any provider that did not fully or accurately make any disclosure required to be made by a health care facility or other provider under this act.

(i) Any provider that fails to grant the commissioner access upon reasonable request of the commissioner, pursuant to regulations promulgated by the commissioner, to enable the commissioner to do any of the following:

(1) To review data and records relating to compliance with conditions for participation and payment.

(2) To perform the audits and surveys required by this act.

(3) To review records, documents, and other data necessary to the performance of the statutory functions of the commissioner.

25285. The commissioner may exclude the following providers from participation under this act:

(a) Any provider found to violate Sections 25283 or 25283.

(b) Any person, including an organization, agency, or other entity, but excluding a covered individual, that presents or causes to be presented to an officer, employee or agent of the commissioner a claim or request for payment that the commissioner determines meets any of the following definitions:

(1) It is for a service or item that the person knows or should know was not provided as claimed.

(2) It is for a service or item and the person knows or should know the claim is false or fraudulent.

(3) It is presented for a physician's service in an item or service incident to a physician's service by a person who knows or should know that the individual who furnished or supervised the furnishing of the service was not licensed as a physician or who was not a medical specialty by medical specialty board when the individual was represented as certified or the individual had been previously excluded from participation.

(4) It is in violation of this act or any regulation issued thereunder.

(e) Any person, including an organization, agency, or other entity, but excluding a covered individual that does any of the following:

(1) Makes a payment or provides an item or service, directly or indirectly, to any other person or entity in an amount to reduce or limit the service provided to a covered individual under this act.

(2) Offers to pay or solicits or receives any remuneration (including, but not limited to, royals, bribes, rebates, directly or indirectly, overtly or covertly, in cash or in kind, in return for either of the following):

(A) Requiring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment is made under this act.

(B) Purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or time for which payment may be made in whole or in part under this act.

(c) Substitution (e) shall not apply to any of the following:

(1) Any discount or other reduction in price obtained by a provider of service or other entity if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this act.

(2) Any amount paid by an employee to an employer (who has a bona fide employment relationship with that employer) for employment in the provision of covered items and services.

(3) Any other agreement or payment practices that the commissioner determines, pursuant to regulations promulgated by the commissioner, are not intended to reduce or influence the quantity or quality of services provided under this act.

(d) Any provider found to provide substandard care or engage in unprofessional conduct.

(e) Standards and criteria shall be established to review the care provided by providers to detect potential and actual quality of care problems and to prevent over-utilization or under-utilization of services paid for by the health security system.

25286. In addition to any other penalties prescribed by law, the commissioner may impose a civil money penalty of not more than $5,000 for each violation of this chapter. In addition, such a person shall be subject to an assessment of not more than twice the amount of unlawful payment or damages sustained by the State of California resulting from the violation. In addition, the commissioner may make a determination in the same proceeding to exclude the person from participation in the health security system.

25289. The commissioner shall establish regulations and procedures for the review of any action which may result in exclusion or penalties under this chapter.

(i) In the case of limited exclusion or subdivision of a facility by Sections 869 through 899.9, inclusive, of the Business and Professions Code. The commissioner and all other individuals participating in the review procedures shall have all the immunity or protection provided by Sections 33775.5 of the Code of Civil Procedure and Section 928 of the Business and Professions Code. The review procedures shall be protected from discovery by Sections 1118, 1168.1, 1157, and 1557.5 of the Evidence Code.

(b) In the case of exclusion, limitation, or penalty for any other reason permitted by this chapter, the review procedures shall be consistent with Section 25405.

25290. (a) An exclusion shall be effective at such time and upon such conditions as the commissioner determines.

(b) An exclusion may be terminated at such time and upon such conditions as the commissioner determines.

25291. (a) The commissioner shall provide notice to the public of all exclusions in accordance with regulations promulgated by the commissioner.

(b) The commissioner shall file a report pursuant to Section 850 of the Business and Professions Code with respect to any professional provider whose participation in the health security system has been limited in any way or who has been excluded from participation.

CHAPTER 10. IMPLEMENTATION

Article 1. Initial Health Security System Budget

25300. (a) The commissioner shall seek from the Legislature sufficient appropriation for start-up expenditures and transition costs.

(b) Any money appropriated under subsection (a) shall be repaid with interest to the General Fund from the Health Security Fund within two years, unless a longer period is authorized by the Legislature.

Article 3. Phase-In of Benefits

25305. (a) Benefits under Article 2 (commencing with Section 25315), Article 3 (commencing with Section 25320), and Article 4 (commencing with Section 25330) of Chapter 4 shall be available to eligible individuals commencing January 1 of the second year following passage of this act.

(b) During the first year of benefits under this act, the commissioner may establish copayments as follows:

(1) For any elective service or prescription drug not to exceed $5 for each procedure or prescription.

(2) For outpatient mental health care services, after the 25th visit rendered in the year not to exceed:

(A) For the case of a services rendered by a fee-for-service provider, 50% of the fee charged for each visit or rendered service.

(B) In the case of services rendered by capitated providers, $25 per visit or rendered service.

(c) Individuals who receive benefits under the federal Medicare program, the CHAMPUS Program, or the Federal Employees Health Benefit Plan, or who are exempt from copayments under federal law, shall not be required to pay the copayments specified in this section.

(d) During the first year of benefits under this act, no copayment shall be required for any covered benefit, other than as established by the commissioner pursuant to Sections 25203 and 25240, provided that the commissioner may extend the period of copayment under subdivision (b) for up to one additional year upon making a finding that the health security system is not yet capable of absorbing the full cost of the benefits.

(e) Benefits under Article 6 (commencing with Section 25335) of Chapter 4 shall be available to eligible individuals commencing January 1 of the third year following passage of this act.

(f) Benefits under Article 4 (commencing with Section 25330) of Chapter 4 shall be available to eligible individuals commencing January 1 of the fourth year following passage of this act.

Article 4. Health Worker Staffing Ratios Changes

25310. (a) Commencing on the effective date of this act, no health facility, clinic, or professional provider shall increase the ratio of patients to licensed or registered nurses without the approval of the commissioner. Petitions for waivers shall be made public and may not be approved without 30 days public notice.

(b) Prior to the date benefits are first available under this act, the commissioner shall establish minimum safe staffing standards for all settings in which health care is provided including minimum public health staffing standards.

Article 5. Transition of Capitated Integrated Health Delivery Systems

25320. (a) Individuals enrolled in a capitated integrated health delivery system on December 31 of the year following passage of this act, shall be considered enrolled in that integrated health delivery system for the purposes of initial benefits effective January 1 of the second year following passage of this act, unless the particular integrated delivery system in which they are enrolled has not been registered by the health security system or has selected a non-capitated mode of reimbursement under the health security system.

(b) The commissioner shall meet with representatives of registered integrated health care delivery systems in each system region to establish initial benefits under this act, for the purposes of coordinating their transition to the health security system.

(c) The commissioner shall consider the special needs and requirements of capitated integrated health delivery systems in California. The commissioner may provide technical assistance or promulgate regulations with respect to the reimbursement and other requirements and procedures of the health security system in order to transition the capitated integrated health delivery systems in California. The commissioner shall continue the policy and practices established in this chapter to ensure the availability of the health care services in California.

CHAPTER 11. MISCELLANEOUS

Article 1. Hearings and Judicial Review

25400. (a) Any person aggrieved by a decision, order, rule, regulation, action or failure to act, in any manner, by the commissioner, or by any regional administrator, may seek judicial review.

(b) In any suit brought by one or more individuals contesting an action of the commissioner restricting compensation offered under this program, a prevailing plaintiff shall be awarded costs of suit and reasonable attorney's fees.

(c) In any action or proceeding challenging a legislative amendment to this act:

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(1) The party or parties asserting the validity of the amendment shall have the burden of proof by clear and convincing evidence that the amendment is consistent with the purposes for which it was made. The purposes of this act include not only the intent, findings, and determination set forth in Section 25001 and 25002, but also the means the act employs to achieve its stated aims.

(2) A legislative amendment inconsistent with the purposes of this act shall be declared invalid, and the prevailing plaintiff, other than the commissioner, an officer or member of a department, board, or agency established by this act, shall be awarded costs of suit and reasonable attorney's fees.

25005. (a) Any quasi-judicial hearing required by law shall be conducted in accordance with the Code of Civil Procedure (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except as provided in this act or in regulations promulgated by the commissioner.

(b) The hearing shall be conducted by a hearing officer appointed by the commissioner to hear evidence and to administer the exclusion of evidence and may exercise all other powers relating to the conduct of the hearing.

Article 2. Insurance and Practice Outside the Health Security System

24415. (a) Any person providing or offering health care or insurance to any individual for a fee or other consideration that covers benefits available under the health security system shall inform such individuals, in writing, of the benefits for which they may be eligible under the health security system.

(b) The commissioner may establish a uniform notice, specifying both content and print size, to be included in any place of business, advertisement, policy of insurance, or offer to insure, as described in subdivision (a). The notice shall be limited to an advertisement of rights under this act and the name and phone number of a local office that can provide further information.

(c) Failure to provide the notice required by this section shall constitute an unfair business practice, entitling the individual to rescission, restitution, damages, and attorney's fees as provided by law and result in other action by the commissioner as authorized by law.

25420. Any health facility, clinic, or professional provider may elect to participate in the health security system, as defined under this act.

25421. (a) Except as provided in Section 25219, a participating health facility, clinic, or professional provider may provide care to any recipient whose premium is paid by the commissioner, if the commissioner shall make a positive determination that the patient's health needs cannot be met by care available through other means.

(b) Except as provided in Article 4 (commencing with Section 25180) of Chapter 7, a participating health facility, clinic, or professional provider may provide care to any recipient whose premium is paid by the commissioner, if the commissioner shall make a positive determination that the patient's health needs cannot be met by care available through other means.

25510. Exemption from state and federal antitrust laws.

(a) Actions taken by or on behalf of the commissioner or by any person as authorized by this act, shall not be considered a violation of California antitrust laws, including, but not limited to, Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code.

(b) It is the intent of the people of the State of California that all Californians receive high-quality health care coverage in the most efficient and cost-effective manner possible.

(c) In furtherance of this intent, the people find and declare that it is in the public interest to enable the ability of professional providers, health facilities, and clinics to form bargaining units for the purpose of contracting for the delivery of health care services, and that it is in the public interest for the health security system to contract with vendors, professional providers, health facilities and clinics to further the purposes of this act.

(d) The people further find and declare that the existing marketplace for health care services, relying on contracts between individual providers, both institutional and professional, and individual insurers and purchasers, has not proven effective, and has been unable to provide quality and efficient health care to all Californians.

(e) The people further find and declare that the efficient operation of the health security system, including its stated purpose of providing universal, comprehensive, accessible, portable, and publicly administered health care, providing the greatest freedom of choice to health consumers, requires the displacement of competition among providers, insurers, and purchasers of health care services.

(f) Therefore, for California Legislature has previously demonstrated a similar intent and public purpose in Section 16770 of the Business and Professions Code, Sections 1942.6 and 1979.9 of the Health and Safety Code, Section 10133.5 of the Insurance Code, and Sections 1050, 1007, 1077, and 1078.5 of the Business and Professions Code.

(g) It is the intent of the people, therefore, that the formation of groups and combinations of providers and health facilities and the concentration of purchasing power and regulatory authority in the health security system, be exempt from federal antitrust constraints.

(h) The people find and declare all of the following:

(1) There is a compelling state public interest in each action undertaken by or on behalf of the commissioner, and every other state and local agency, board, council, and officer acting under and in furtherance of this act, including, but not limited to, those actions otherwise considered in restraint of trade.

(2) This act prescribes and exercises the degree of state direction and supervision of other health care programs that shall not provide for state financing under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this act.

(3) This section does not create a new public policy, but rather it relates to any agreement or arrangement to exclude from any of the above-described groups or combinations, any person who is lawfully qualified to perform the services to be performed by the members of the group or combination, where the ground for the exclusion is failure to possess in all cases license or certification as is possessed by the members of the group or combination.

25525. Compliance with federal health care reform legislation.

(a) The commissioner shall use all means at his disposal in this act, and which actions taken pursuant to this act, must be modified to achieve compliance with requirements for state health plans as specified by federal laws or regulations including those enacted after submission of this ballot initiative, or other federal laws and regulations.

(b) If any statutory provision of this act must be modified to achieve compliance with federal health care reform legislation, the commissioner shall seek to achieve compliance with federal health care reform legislation by conforming the provisions of this act, as required by federal law, the commissioner shall seek to achieve compliance with such federal requirements.

1. Federal waiver

(a) The commissioner shall seek all appropriate federal waivers, exemptions, agreements or legislation that shall allow all federal payments for medical, mental health, and long-term care provided by this act.

2. Federal waiver

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

25532. Construction.

This act shall be construed as necessary to comply with federal health care legislation, consistent with the intent of the act to establish a single payer for health care with freedom of choice of professional provider and a single standard of care for all Californians eligible for particular services under the health security system.

SECTION 3. Section 13 is hereby added to Article XIII B of the California Constitution to read as follows:

S.C.C. 13. (a) "Appropriations subject to limitation" for each entity of government, do not include appropriations for purposes of the California Health Security Act.

(b) Appropriations subject to limitation" for each entity of government shall be lowered in any year by the amount excluded from limitation under subdivision (a), in the case of this amount was not included in the previous year.

SECTION 4. Section 20 is hereby added to Article XVI of the California Constitution to read as follows:

(a) There is established a special fund in the State Treasury, to be called the Health Security Fund, for the purpose of implementing the California Health Security Act.

(b) All moneys collected, received, and transferred pursuant to the California Health Security Act shall be deposited to the credit of the Health Security Fund for the purpose of financing the health security system.

The money in the Health Security Fund shall not be considered state revenues or state money or proceeds of taxes for purposes of Sections 3 and 8 of this article.

SECTION 5. Unless expressly provided for in this act, the provisions of Part 2 (commencing with Section 10150) of Division 2 of the Insurance Code, shall not be applicable to this act.

SECTION 6. Welfare and Institutions Code Sections 5755, 10720, 10721, 10723, and 10724 are hereby deleted as unnecessary.

5750. Administrative rules; standards; rules and regulations.

(a) The California State Health Commissioner shall administer this part.

(b) Notwithstanding any other provision of this act, standards and regulations for mental health services shall be adopted in the manner set out in Chapter 4 (commencing with Section 25100) of Division 13 (California Health Security Act) for the adoption of standards and regulations for other benefits provided under this act consistent with Sections 10720 and 10721.

(d) Notwithstanding any other provision of this act, the duties, powers, responsibilities, functions and jurisdiction of the Citizen Advisory Council and the California Commission of Mental Health Services under this part are transferred to the Health Care Policy Advisory Board as defined in subdivision (b) of Section 25409, unless the California State Health Commissioner determines otherwise by regulation.
(c) The transfer of the purposes, responsibilities, functions, property, assets, and employees of the Department of Mental Health to the California State Health Commissioner shall occur as provided in Sections 10720, 10721, and 10722, as added by this act.

(d) All regulations heretofore adopted by the Director of Mental Health which relate to the Director of Mental Health’s duties, purposes, responsibilities, functions, and jurisdiction as well as payment, accounting, auditing, and collection of funds under this part, and that are in effect on the date of passage of this act, shall remain in effect and shall be fully enforceable by the State, and until readopted, amended, or repealed, by the California State Health Commissioner.

10720. Duties of the California State Health Commissioner. The California State Health Commissioner shall administer the chapters and parts referred to in Section 10721, as well as any other law in this division pertaining to the administration of health care services and medical assistance. As used in the chapters and parts referred to in Section 10721, the term “director” and “department” mean the California State Health Commissioner.

10721. Transfer of functions; effective date; impairment of contracts.

(a) The California State Health Commissioner succeeds to and is vested with the duties of the State Department of Health Services pursuant to Chapter 6 (commencing with Section 13800), Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 9 (commencing with Section 14400), Chapter 10 (commencing with Section 14600), Chapter 11 (commencing with Section 14800), and Chapter 12 (commencing with Section 15000) of Division 4 of Part 4 of Article 4 of Chapter 2 of Title 14 of the Government Code.

(b) (1) No case shall the substitution of the California State Health Commissioner for the State Department of Health Services be considered a breach of contract or failure of performance, nor shall it disturb the legal relationship of the two parties.

(2) The California State Health Commissioner shall have possession and control of all records, papers, offices, equipment, supplies, money, funds, appropriations, land and other property, real or personal held for the use or on behalf of the Director of Health Services in the performance of his or her duties, powers, purposes, responsibilities, and jurisdiction that are vested in the State Department of Health Services for the purposes of carrying out the chapters and parts referred to in Section 10721.

10723. Transfer of officers and employees. All officers and employees of the State Department of Health Services who are on the effective date of this act are serving in the state civil service, other than temporary employees, and engaged in the performance of the duties in the Health Services Code, as provided in Section 9 of Chapter 1 of Part 6 of Division 4 of Title 5 of the Government Code, by Section 10721 shall be transferred to the California State Health Commissioner. The status, positions, and rights of those individuals shall not be affected by the transfer and they shall be entitled to the same retirement benefits as the officers and employees of the State Department of Health Services, the State Department of Health Services Commission, pursuant to the State Civil Service Act except as to positions exempt from civil service.

10724. Retention of officers, employees, and effectiveness; readoption, amendment, or repeal. All regulations hereafter adopted by the Director of Health Services that relate to the payment, accounting, auditing, and collections functions vested in the State Department of Health Services, or by any predecessor department that relate to health care services or medical assistance functions vested in the State Department of Health Services, and that are in effect immediately preceding the effective date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended or repealed by the California State Health Commissioner.

SECTION 7. Health and Safety Code Sections 443.20, 446, and 446.55 are added, to read as follows:

443.20. The California Health Policy and Data Advisory Commission is abolished. The California State Health Commissioner succeeds to and is vested with all the duties, powers, purposes, responsibilities, and jurisdiction of the California Health Policy and Data Advisory Commission, including, but not limited to, the functions and responsibilities pertaining to this section.

446. The Office of Statewide Health Planning and Development is abolished. The California State Health Commissioner succeeds to and is vested with all the duties, powers, purposes, responsibilities, and jurisdiction of the Office of Statewide Health Planning and Development, including, but not limited to, those functions and responsibilities performed pursuant to this division.

446.55. All regulations hereafter adopted by the Office of Statewide Health Planning and Development that are in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended or repealed by the California State Health Commissioner.

SECTION 8. Section 30123.5 and Part 14.5 of Division 2, commencing with Section 30000, are hereby added to the Revenue and Taxation Code to read as follows:

30123.5. Health Security System Cigarette and Tobacco Products Surtax.

(a) In addition to the tax imposed upon the distribution of cigarettes by this chapter, there shall be imposed on every distributor a tax upon the distribution of cigarettes at the rate of 50 mills ($0.05) for each cigarette distributed.

(b) There shall be imposed on every distributor of tobacco products based on the wholesale cost of these products, at a tax rate, as determined annually by the State Board of Equalization, which is equivalent to the combined rate of tax imposed on cigarettes by this subdivision (a).

(c) The rate specified in subdivisions (a) and (b) shall be reduced by an amount equal to any tax imposed on like cigarettes and tobacco products pursuant to federal health and safety legislation, to the extent that the federal tax revenues are contributed to the Health Security Fund.

(d) The revenues generated pursuant to this section shall be deposited in the Health Security Fund.

PART 14.5. HEALTH SECURITY FUND

30000. Definitions. The definitions contained in this section shall govern the construction of this part, unless the context requires otherwise.

(a) “Act” means the California Health Security Act (Division 19 (commencing with Section 25900) of the Welfare and Institutions Code).

(b) “Base year” means the twelve months prior to the passage of the California Health Security Act.

(c) “Employer” means one of the following: (i) A trade, concern, corporation, association, joint venture, or public or private entity employing for wages, salaries, or other compensation, one or more employees at any one time to work in this state. (ii) “Employer” does not include self-employed persons with respect to self-employed earnings.

(d) “Employee” means a resident of California who works for an employer, is listed on the employer’s payroll records, and is under the employer’s control.

(e) “Employer payroll records” means a record or records that list the employer’s payroll, including name, address, occupation, and amount paid to an employee.

(f) “Employer payroll records” does not include self-employed persons with respect to self-employed earnings.

30001. Employer Health Security System Payroll Tax. (a) All employers shall pay a health security payroll tax commencing January 1 of the calendar year following the passage of the California Health Security Act. The tax shall be paid quarterly.

(b) (1) Not later than March 15 of the year following the passage of the act, each employer shall report to the Health Security Commissioner, by means and forms determined by the commissioner, the number of employees, the amount paid as employer health insurance and benefits, and both in absolute dollars and as a percentage of overall payroll, for the base year.

(2) An employer without a base year payroll shall estimate the items in paragraph (1) for its first full year of operation after the base year and report them to the commissioner: Within 90 days of completing the first full year of doing business in the state, the employer shall file a corrected report with the commissioner. The first full year of doing business in the state shall serve as the employer’s base year for the purposes of this section.

(c) No employer shall pay more than one percent of payroll tax for each year following the year in which it first became a healthcare enrollee.

(d) The health security payroll tax rate shall be determined in a manner that will result in the total tax collections equaling the total amount paid by employers to cover the cost of health and welfare benefits.

30002. Employer Health Security System Payroll Tax. (a) Each employer shall pay a health security payroll tax commencing January 1 of the calendar year following the passage of the California Health Security Act. The tax shall be paid quarterly.

(b) (1) Not later than March 15 of the year following the passage of the act, each employer shall report to the Health Security Commissioner, by means and forms determined by the commissioner, the number of employees, the amount paid as employer health insurance and benefits, and both in absolute dollars and as a percentage of overall payroll, for the base year.

(2) An employer without a base year payroll shall estimate the items in paragraph (1) for its first full year of operation after the base year and report them to the commissioner: Within 90 days of completing the first full year of doing business in the state, the employer shall file a corrected report with the commissioner. The first full year of doing business in the state shall serve as the employer’s base year for the purposes of this section.

(c) No employer shall pay more than one percent of payroll tax for each year following the year in which it first became a healthcare enrollee.

(d) The health security payroll tax rate shall be determined in a manner that will result in the total tax collections equaling the total amount paid by employers to cover the cost of health and welfare benefits.

30003. Credit Against Employer Health Security Payroll Tax. (a) With respect to each employee affected, an employer who, on the date of
passage of this act, was under a contractual or legal obligation to provide the employee with health care benefits, that are covered benefits under this act, or to pay for such benefits through a policy of insurance or otherwise, shall receive a credit against its payroll tax obligation in a tax period equal to the amount it pays during said tax period for the benefits or insurance pursuant to the contract or legal obligation.

(1) Entitlement to the credit shall lapse upon the expiration of the contractual or legal obligation. No credit may be claimed for any obligation arising on or after the effective date of this act.

(2) This subdivision shall not apply to obligations subject to federal preemption as described in Article 3 (commencing with Section 25130) of Chapter 6 of Division 19 of the Welfare and Institutions Code.

(3) (a) In the event that the amount of a credit provided by this section exceeds the employer's payroll tax obligation for any affected employee, the excess shall be credited against the employer's tax obligation imposed by Section 33004.

(b) In the case of an employer exempt from the payroll tax obligation pursuant to Section 25138 of the Welfare and Institutions Code, the amount of credit to be credited to the employer's tax obligation shall be determined in the same manner as in the case of a non-exempt employer.

(4) No credit may be carried over from year to year or transferred among employers.


(a) All heads of households and persons subject to California income tax shall pay a health security income tax commencing January 1 of the second year following passage of the California Health Security Act.

(b) The tax rate shall be 2.5 percent of taxable income as defined in Section 17073, but not less than fifty dollars ($50) per household per year.

(c) In the case of households in which all members of the household receive their income from a single source, the employer shall establish mechanisms or coordinate with other state agencies to establish mechanisms, for the collection of the minimum tax, including, but not limited to, deduction of the tax from transfer payments or entitlements.

33005. Credit Against Individual Health Security Income Tax.

(a) Individuals shall receive a credit against their individual health security income tax obligation, as calculated under this section, of both of the following:

(1) Any credit arising under subdivision (b) of Section 33003.

(2) Any premium or tax paid by the individual required by federal health care reform legislation, to the extent that the payments are mandatory and no election is allowed for a separate payer system.

(b) In no case shall the amount of a credit provided under this section exceed the individual's health security income tax obligation in any year. No credit may be carried from year to year.

33006. (a) Nothing in the California Health Security Act shall be construed to interfere with an employer choosing to pay, in part or in full, the individual health security income tax for an employee.

(b) If an employer chooses to pay the health security income tax on behalf of an employee, the payments shall not constitute for any obligation of the employer pursuant to Section 33005.


(a) Persons filing a California income tax return shall pay a health security income surtax of 2.5 percent on net taxable income in excess of two thousand fifty dollars ($2,550).

(b) Notwithstanding subdivision (a), married couples filing a California joint income tax return shall pay a health security income surtax of 2.5 percent on net taxable income in excess of five thousand dollars ($5,000).

(c) The surtax imposed in this subdivision on the individual health security income tax imposed by Section 33004.

SECTION 9. Legislative Amendment.

(a) This act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by rollcall vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(b) The two-thirds vote requirement of subdivision (a) shall not apply to any provision of this act that meets any of the following requirements:

(1) Specifically mentions and authorizes action by the Legislature, in which case a majority of the membership in each house shall be sufficient for amendment.

(2) Specifically states a different method for amendment, in which case that method shall be used.

(3) Must be amended to achieve compliance with federal health care reform legislation, pursuant to Sections 25526 and 25530 of the Welfare and Institutions Code, in which case a simple majority of the membership in each house shall be sufficient for amendment.

SECTION 10. Severability.

If any provisions of this act or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other provisions or application of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are severable. Towards this end, it is hereby declared that any individual, subdivision, paragraph, sentence, or clause shall be severed from the remainder of the act to preserve its remaining provisions.

SECTION 11. Repeal of Welfare and Institutions Code Sections 7570, 10720, 10721, 10724, 10725, 10729, 10729, and 10726, and Health and Safety Code Sections 443.20, 443.21, 446, 446.1, 446.2, 446.3, and 446.35.

Welfare and Institutions Code Section 7570 is hereby repealed.

The Department of Mental Health shall administer this part and shall adopt standards for approval of mental health services; and rules and regulations necessary therefor. However, these standards, rules, and regulations shall be adopted only after consultation with the California Council on Mental Health and the California Conference of Local Mental Health Directors, except that none of these standards, rules, and regulations shall require approval by the California Conference of Local Mental Health Directors by majority vote of those present at any meeting of the conference, and any conference may adopt such standards, rules, and regulations by majority vote of those present at the meetings of the conference.

For regulations pertaining to psychiatric health facilities, the vote by the conference, following consultation, shall be only advisory to the State Department of Mental Health.

(a) If the conference refuses or fails to approve standards, rules, or regulations submitted to it by the State Department of Mental Health for its approval, the State Department of Mental Health may submit these standards, rules, or regulations to the conference, which conference may adopt or reject the conference's action.

(b) If the conference refuses or fails to approve standards, rules, or regulations submitted to it by the State Department of Mental Health for its approval, the State Department of Mental Health may submit these standards, rules, or regulations to the conference, in which case the conference may adopt or reject the conference's action.

(c) By July 1, 1994, or June 30, 1995, inclusive, the conference shall adopt standards and regulations for the administration of the program of services to treat the mentally ill, and a member designated by the State Advisory Health Council.

(d) If the conference refuses or fails to approve standards, rules, or regulations submitted to it by the State Department of Mental Health for its approval, the State Department of Mental Health may submit these standards, rules, or regulations to the conference, in which case the conference may adopt or reject the conference's action.

(e) By July 1, 1994, or June 30, 1995, inclusive, the conference shall adopt standards and regulations for the administration of the program of services to treat the mentally ill, and a member designated by the State Advisory Health Council.

(f) The conference shall submit these standards and regulations to the State Department of Mental Health, and the Department of Mental Health shall adopt or reject these standards and regulations, as the case may be.

(g) The conference shall submit these standards and regulations to the State Department of Mental Health, and the Department of Mental Health shall adopt or reject these standards and regulations, as the case may be.

(h) The conference shall submit these standards and regulations to the State Department of Mental Health, and the Department of Mental Health shall adopt or reject these standards and regulations, as the case may be.
investigation of the department is required to use, submit or maintain such forms, reports or records.

Welfare and Institutions Code Section 10726 is hereby repealed.

19926. All regulations hereinafter adopted by the Director of the State Department of Health of the functions vested in the State Department of Health Services, or by the State Department of Health or any predecessor department which relate to health care services or medical assistance functions vested in the State Department of Health Services, and which are in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until rescinded, amended or repealed by the State Director of Health Services.

Health and Safety Code Section 445.20 is hereby repealed.

445.20. There is hereby created the California Health Policy and Data Advisory Commission to be composed of 11 members.

The Governor shall appoint seven members, one of whom shall be a hospital chief executive officer, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group health plan health care service plan, one of whom shall be a representative of a business association concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor association concerned with health, and one of whom shall be a general member.

The chairperson shall be designated by the Governor. The Governor shall designate four original appointments which will be for four-year terms. The Governor shall designate three original appointments which will be for two-year terms. The Speaker of the Assembly shall designate one original appointment which will be for two years and one original appointment which will be for four years. The Senate Rules Committee shall designate one original appointment which will be for two years and one original appointment which will be for four years. Thereafter, all appointments shall be for four-year terms.

In addition to the 11 original appointees to the commission, the chairperson of the Advisory Health Council on December 31, 1985, and the chairperson of the California Health Facility Association shall be ex-officio members, shall serve for four-year terms. During their terms when the commission shall have 15 members, they shall be full voting representatives.

Health and Safety Code Section 445.21 is hereby repealed.

445.21. There is hereby created the Commission:

(a) "Commission" means the California Health Policy and Data Advisory Commission.

(b) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1259) of Division 2.

(c) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

(d) "Office" means the Office of Statewide Health Planning and Development.

(e) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures which have been adjusted for demographic and clinical factors.

Health and Safety Code Section 445.3 is hereby repealed.

445.3. There is in the state government, in the Health and Welfare Agency, an Office of Statewide Health Planning and Development.

Health and Safety Code Section 446.1 is hereby repealed.

446.1. The Office of Statewide Health Planning and Development is under the control of an executive officer known as the Director of Statewide Health Planning and Development, who shall be appointed by the Governor, subject to confirmation by the Senate, and held office at the pleasure of the Governor. He shall receive the annual salary provided by Article 1 (commencing with Section 11509) of Chapter 6 of Part 1 of Division 3 of Title 2 of the Government Code.

Health and Safety Code Section 446.2 is hereby repealed.

446.2. The Director of Statewide Health Planning and Development shall have the powers of a head of the department pursuant to Chapter 2 (commencing with Section 11509) of Part 1 of Division 3 of Title 2 of the Government Code.

Health and Safety Code Section 446.3 is hereby repealed.

446.3. The Office of Statewide Health Planning and Development succeeds to and is vested with all the duties, powers, purposes, responsibilities, and jurisdiction of the State Department of Health relating to health planning and research development. The office shall assume the functions and responsibilities of the Facilities Construction Unit of the former State Department of Health, including, but not limited to, those functions and responsibilities performed pursuant to the following provisions of law:

Article 5.5 (commencing with Section 1259) of Chapter 2 of Part 1 of Division 2; Article 10 (commencing with Section 12370) and Article 10 (commencing with Section 12670) of Chapter 5 of Part 1 of Division 2; Chapter 2 (commencing with Section 12570) and Chapter 4 (commencing with Section 12580) of Part 1 of Division 1; Part 2.5 (commencing with Section 12590) of Division 1, Section 12594; Chapter 10 (commencing with Section 12701) of Division 2; Section 10110; and Division 10.5 (commencing with Section 12599).

Health and Safety Code Section 446.5 is hereby repealed.

446.5. All regulations hereinafter adopted by the State Department of Health which relate to functions vested in the Office of Statewide Health Planning and Development which are in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until rescinded, amended, or repealed by the Office of Statewide Health Planning and Development:
An act to add Division 25 (commencing with Section 25000) to the Welfare and Institutions Code, relating to health care coverage. An act relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

SB 2123, as amended, Lee. Health care coverage.

Existing law provides for the licensure and regulation of health care service plans, disability insurers covering hospital, medical, or surgical benefits, health facilities, clinics, and health care professionals.

This bill would enact the CalCare Health Insurance Act (CalCare), a state health insurance system.

The bill would require the Legislative Analyst to undertake a study of methods to organize and finance CalCare and to make projections of the amount needed to fund the program fully a system of universal health care. The bill would require the results of the study to be reported to the Legislature by April 1, 1999. The bill would prohibit CalCare from being implemented unless the Legislative Analyst notifies the Secretary of State that legislation has been enacted to fund CalCare.
The bill would set forth the benefits to be covered by Cal-Care, including long-term care for certain persons and dental benefits to the extent funding permits.

The bill would establish the Cal-Care Health Trust as a state agency to be governed by the Cal-Care Commission, with prescribed membership and duties, to implement Cal-Care. The bill would establish the Office of Quality Assurance and Development under the supervision of a director to be appointed by, and to report to, the commission. The bill would establish a Medical Advisory Board and Advisory Board for Complementary and Alternative Medicine, under the direction of the commission.

The bill would require Cal-Care to be administered on a regional basis by a regional administrator in each service region, appointed by the commission, with appropriate staff and funding.

The bill would require the appointment of a consumer advocate in each county to monitor the effectiveness of Cal-Care.

The bill would require the commission to establish procedures for enforcing standards of care and staffing and to establish procedures for patient complaints and grievances.

The bill would require all persons to be eligible for covered services if the persons are residents of the state for six months or longer or are otherwise eligible for services under federal or state law.

The bill would establish the Cal-Care Fund in the State Treasury and would require all moneys collected, received, and transferred pursuant to the act to be deposited in the fund for the purpose of financing Cal-Care. The bill would continuously appropriate the funds to the commission.

The bill would require the commission to seek all necessary federal waivers, exemptions, agreements, or legislation in order that all federal payments for health care be paid directly to Cal-Care.

The bill would state the intent of the Legislature to ensure that state payments for health care be paid directly to Cal-Care.
The bill would state the intent of the Legislature to recover health care costs from insurers, plans, and other collateral sources.

The bill would require the commission to prepare annual budgets.

The bill would prohibit a health facility or clinic from incurring a capital expenditure or receiving a health facility construction loan without obtaining the prior approval of the commission.

The bill would further set forth a process for triggering mandatory cost control measures.

The bill would establish various accounts in the Cal-Care Fund.

The bill would authorize any health care provider, including a health care professional, health facility, or clinic, to participate in Cal-Care. The bill would prohibit a health care provider from charging any individual, including an individual not eligible for benefits under Cal-Care, for a service or procedure that is a covered benefit under Cal-Care.

The bill would set forth a system for compensating health care providers, including on a fee for service basis or capitation basis.

The bill would set forth a procedure whereby individuals may enroll under capitated or fee for service payment arrangements.

The bill would set forth a process for initial implementation of Cal-Care.

The bill would prohibit actions taken by or on behalf of the commission from being considered a violation of state antitrust laws. The bill would state the intent of the Legislature regarding exemption from federal antitrust laws.

The bill would require any person providing or offering health care or insurance that covers benefits available under Cal-Care to an individual, to inform the individual in writing of the benefits for which the individual may be eligible under Cal-Care.

The bill would provide that Cal-Care would become operative only if ACA _____ receives voter approval at an unspecified election.
The people of the State of California do enact as follows:

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

(a) The current patchwork of privately and publicly insured health care programs leave large populations uninsured, is administratively inefficient, and confusing to consumers and providers.

(b) Twenty percent of Californians have no health insurance and 80 percent of the uninsured are working people or their families.

(c) The lack of access to health care by people who are uninsured or underinsured is a threat to public health, results in inadequate care, and increases health care costs by delaying needed preventive and primary care.

(d) Under managed care systems, financial decisions have taken precedence over medical decisions, undermining the quality of patient care.

(e) Current managed care cost-cutting policies are affecting the quality of care and hurt both patients and health care providers by causing cutbacks in staffing levels, lengths of stays in the hospital, the types of medical care provided to patients, and the types of personnel available to provide care.

(f) Incremental legislative reform of managed care abuses cannot address the fundamental problems of lack of access, cost, quality, and accountability.

(g) The replacement of the current system with a unified and universal system of publicly financed health care would provide comprehensive, quality health care for all Californians, control the escalating costs of health care through global budgeting, eliminate waste and inefficiency, and achieve public accountability for meeting standards of high quality care, without

(f) The state needs to determine a health care financing method that will ensure comprehensive and
quality health care for all Californians, control costs, minimize waste and inefficiency, and achieve public accountability, without increasing current total per capita health care expenditures within the state.

SEC. 2. It is the intent of the Legislature to establish a humane, ethical, well-organized health care system that will provide individuals with high-quality health care, bring to an end the possibility of bankruptcy and impoverishment because of illness, exist within its financial means, and allow a decent living to those who work within it.

SEC. 3. It is the intent of the Legislature to establish expenditures.

SEC. 2. It is the intent of the Legislature to end the possibility that a prolonged illness may cause bankruptcy and impoverishment for residents of the state. The Legislature must ensure a health care system based on all of the following principles:

(a) Promotion of people’s health is a responsibility of good government.

(b) The health care system shall strive to permit each individual to attain an optimum state of health.

(c) Individuals will be supported and encouraged to be responsible and conscientious in achieving their best state of health.

(d) Emphasis shall be placed on primary and preventive services and the promotion, restoration, and maintenance of health.

(e) There shall be a single funding, purchasing, and governance mechanism, which shall be administered locally.

(f) The governance structure shall be democratic, accountable, and accessible.

(g) Consumers and providers of health care shall be involved in policy development and system oversight.

(h) The system will exist within its financial means.
(h) In recognition of the fact that one out of every three Americans sees alternative and complementary health practitioners, the system will investigate these modalities and include them in the benefit package, as they are proven safe and effective.

(i) The system shall prohibit discrimination based on a current or preexisting condition, a genetic condition or defect, a physical or mental disability, race, religion, sex, immigration status, national origin or ancestry, sexual orientation, or marital status. Compliance with state and federal civil rights and disabilities laws will be a condition of licensure and accreditation for providers and facilities.

(j) No one shall be denied care because of inability to pay.

SEC. 4. (a) The Legislative Analyst, or a party with whom it contracts, shall undertake a study of methods to finance the CalCare Health Insurance Act (Division 25 (commencing with Section 25000) of the Welfare and Institutions Code) and shall make projections of the amount needed to fund the program fully. The results of the study shall be reported to the Legislature no later than April 1, 1999. It is the intent of the Legislature to use the results of the study in formulating legislation to fund the CalCare Health Insurance Act.

(b) The study shall report on, but not be limited to, all of the following:

(1) Projected cost of providing universal health care benefits to all California residents, incorporating the projected savings that will accrue to a single payer system.

(2) Because the CalCare Health Insurance Act will redirect most funds currently spent on health care in California into a single system of universal benefits for all California residents, the study shall analyze the utilization of the findings of the study to formulate legislation that will
create a universal health care system for the state. The legislation shall incorporate the system of finance and administration proven superior by the study.

(b) The study shall report on the projected costs and savings of all the following methods of achieving universal care:

1. Single payer financing and administration.
2. Managed care financing and administration.
3. Medical savings accounts.
4. Tax credits.
5. Other methods.

(c) The study shall analyze the magnitude of current health care expenditures in California. Current public sector funding streams include Medicare, Medi-Cal, Healthy Families, CHAMPUS, state and county health programs, and other programs. Private sector funds include employer contributions for health benefits, premiums paid by individuals for insurance, co-payments, deductibles, out-of-pocket payments for noncovered services, and other funds.

(d) The study shall consider financing options, including a mix of financing options, in exploring a tax-based finance system. Options shall include financing based on cost-sharing similar to that currently practiced in California, with government expenditures providing approximately 44 percent, employer contributions 23 percent, and individual contributions 31 percent. Options should also explore shifting the relative cost burdens among these groups. The study shall consider all of the following financing options:

1. Raising revenues through the personal income tax, including reinstating the top brackets of the personal income tax, or through individual payroll deductions, or both.
2. A mandatory payroll tax on all employers, including an equivalent tax on the payroll of independent contractors.
3. Increasing the sales tax rate or broadening the sales tax base.
(4) Potential increased drawdown of federal funds that may currently be underutilized.

(5) The use of a tobacco products tax, or use of proposed tobacco settlement revenues.

(d) The study shall analyze the distributive burden of each finance option, including the impact on employers who currently provide health benefits and on those who do not and the potential tax burden on all taxpayers.

(e) The study shall project the potential savings that accrue to a single-payer system in the following ways:

(1) Savings from instituting the Cal-Care Health Insurance Act single administrative systems and a single administrative system and eliminating the costs of multiple insurance payers administrative systems, including their costs for advertising, making and updating risk assessments, and incorporating profit margins into the cost of health insurance.

(2) Savings from the administrative coordination of all health care services.

(3) Savings from eliminating the need for hospital and provider billing departments.

(4) Savings from aggressive use of bulk purchasing power for drugs and medicinals, medical hardware, software, and construction supplies.

(5) Savings by providing primary and preventive care to individuals who currently use emergency rooms and who often present themselves for care when they are very ill.

(6) Savings from regionalization of high technology and experimental services.

(7) Savings from Cal-Care Commission review and approval requirements for capital expenditures over one million dollars ($1,000,000) and rationalization of capital expenditures.

(8) Savings from decreased reimbursement of specialty services relative to primary care.
(9) Estimated savings to employers due to a more healthy work force.
(10) Estimated savings from increased ability to minimize fraudulent billing.
(11) Estimated savings by recovery, on a one-time basis, of that portion of premiums collected by a health care service plan or disability insurer, or indemnity insurance company that is held in reserve for payment of future liabilities, if a company ceases to provide insurance or direct health services in California.

SEC. 5. Division 25 (commencing with Section 25000) is added to the Welfare and Institutions Code, to read:

DIVISION 25. CAL-CARE HEALTH INSURANCE ACT

CHAPTER 1. GENERAL

25000. This division shall be known and may be cited as the Cal-Care Health Insurance Act.
25001. This division establishes Cal-Care, a California health insurance system with the purpose of providing all Californians with quality, affordable health care, including long-term care and free choice of health care provider, and controlling the cost of health care.
25002. This division shall be liberally construed to accomplish its purposes.
25003. For purposes of this division, the following definitions shall apply:

All matter omitted in this version of the bill appears in the bill as amended in the Senate, April 13, 1998 (JR 11)
SENATE BILL No. 480

Introduced by Senator Solis
(Coauthor: Senator Hayden)
(Coauthors: Assembly Members Bock, Keeley, Knox, Romero, and Steinberg)

February 18, 1999

An act to add Division 25 (commencing with Section 25000) to the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

SB 480, as amended, Solis. Health care coverage.
Existing law provides for the regulation of health care providers by various state agencies.
This bill would require the Secretary of the California Health and Human Services Agency to submit various reports to the Legislature, on or before December 1, 2001, concerning the results of the process established to examine the options for achieving providing universal health care coverage, including a specified annual report, beginning December 1, 2000.
The people of the State of California do enact as follows:

SECTION 1. Division 25 (commencing with Section 25000) is added to the Welfare and Institutions Code, to read:

DIVISION 25. HEALTH CARE COVERAGE

25000. It is the intent of the Legislature to create a process by which the options for achieving universal health care coverage can be thoroughly examined.

25001. The Secretary of the California Health and Human Services Agency shall report back to the Legislature on the options for achieving universal health care coverage, including:

(a) The options for financing universal health coverage.
(b) The institutional mechanism or mechanisms by which universal health coverage may be delivered.
(c) The extent and scope of the health coverage which all California residents may have.

25002. To develop the options for achieving universal health care coverage described in Section 25001, the secretary shall establish a process by which these options are developed. The process shall at a minimum include the following:

(a) The examination and utilization of research results from the study performed by the University of California with regard to methods of financing, delivering and defining universal health coverage, done pursuant to the criteria in Senate Concurrent Resolution 100 of the 1997–1998 Regular Session of the Legislature.
(b) The examination and utilization of other data and information, as requested by the secretary or provided to the secretary, with regard to methods of financing, delivering, or defining universal health coverage.
(c) Developing a process by which representatives of health care consumers, providers, insurers, health care workers, advocates, counties, and all other interested parties are engaged in discussion, debate, and eventual resolution and debate of the issues faced by the state in providing universal health coverage. The secretary shall develop the methods by which this discussion occurs, provided that it is broadly inclusive of all groups with an interest in universal health coverage.

(d) Interagency participation including, but not limited to, the State Department of Health Services, the State Department of Mental Health, the Department of Finance, the Managed Risk Medical Insurance Board, the Department of Consumer Affairs, the Public Employees’ Retirement System, the State Department of Social Services, the Department of Corporations, the Department of Insurance, and any other appropriate agencies which the secretary determines can contribute to the effort to provide universal health coverage.

(e) Working with Obtaining information from the United States Health Care Financing Administration to develop a plan for appropriate regarding whether federal waivers or other forms of federal participation if necessary.

25003. The secretary shall report back to the Legislature on or before December 1, 2001, on the results of the process established to examine the options for providing universal health coverage.

25004. Each year, beginning December 1, 2000, the secretary shall report to the Legislature on the extent to which progress has been made in increasing and improving coverage of the previously uninsured, and on the extent to which residents of California continue to lack health coverage.
Introduced by Senator Speier
(Principal coauthor: Assembly Member Goldberg)

February 14, 2002

An act to add Division 100 (commencing with Section 100000) to the Health and Safety Code, and to amend Section 14005.30 of, and to add Section 14005.41 to the Health and Safety Code, to add Section 12693.705 to the Insurance Code, and to amend Sections 14005.30 and 14011 of, and to add Sections 14005.41 and 14005.42 to, the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1414, as amended, Speier. Health care coverage.

Existing law provides health care coverage to various segments of the population under the Healthy Families Program and the Access for Infants and Mothers Program, including low-income families and individuals unable to obtain coverage through his or her employer or under the Medi-Cal program.

This bill would integrate the Medi-Cal children and families program, the Healthy Families Program, and the Access for Infants and Mothers Program to establish the Healthy California Program for the purpose of providing health care and health coverage to all citizens and legal immigrants without access to affordable, employer-based coverage. The bill would require the Managed Risk Medical Insurance Board to administer the program. The bill would authorize the board to
contract with health care service plans, disability insurers, and managed care organizations to provide health coverage for the program. The bill would require the board and the department to apply for appropriate federal waivers to enable the state to obtain matching federal funds for the program. The bill would provide that the program would not be implemented unless federal funding is obtained.

Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision services to eligible children pursuant to a federal program, entitled the State Children’s Health Insurance Program. Under existing law, in order to be eligible, an applicant must be applying on behalf of a child who meets certain requirements, including being in a family having a gross annual household income equal to or less than 200% of the federal poverty level, and meeting citizenship and immigration status requirements established by federal law.

This bill would require the board to require applicants for, and recipients of, benefits under the Healthy Families Program, to provide independent documentation that they meet the qualifications for eligibility only to the extent required by federal law, except as specified. The bill would require these applicants and recipients to file an affirmation, signed under penalty of perjury, providing specified income information in connection with the board’s eligibility determination. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program administered by the State Department of Health Services under which qualified low-income persons are provided with health care services. Existing law requires the department, to the extent that federal financial participation is available, to adopt an income disregard for applicants equal to the difference between the income standard and the amount equal to 100% of the federal poverty level applicable to the size of the family. Existing law provides that a recipient shall be entitled to the same income disregard to the extent that it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

This bill would, to the extent that federal financial participation and funding in the budget are available, require the department, upon receipt of the federal waiver, to disregard all income and assets for specified applicants and recipients.
This bill would require employers to pay a Healthy California premium payroll tax as a percentage of each employee’s wages, as determined by the board, or authorize them to instead provide health benefits if certain requirements are met. The bill would provide that the tax would be progressive with tax rates.

By imposing a new tax, the bill would result in a change in state taxes for the purpose of increasing revenues within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of 2/3 of the membership of each house of the Legislature.

Existing law requires applicants for benefits under the Medi-Cal program who are not recipients of aid under other specified public assistance programs to file an affirmation providing certain income information in connection with the department’s eligibility determination.

This bill would require the above affirmation to be signed under penalty of perjury. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program. The bill would also require applicants and recipients to provide independent documentation that they meet the qualifications for eligibility only to the extent required by federal law, except as specified.

Under existing law, counties are responsible for the implementation of eligibility determinations under the Medi-Cal program.

By extending the eligibility for benefits under the Medi-Cal program and modifying the eligibility determination process, this bill would increase the responsibilities of the counties in the administration of the Medi-Cal program and would result in a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

SECTION 1. The Legislature finds and declares the following:

(a) Governor Gray Davis signed Senate Bill 480, Solis (Chapter 990, Statutes of 1999), which required the Secretary of the California Health and Human Services Agency to report back to the Legislature on the options for achieving universal health care coverage and on the state of health coverage in California.

(b) The Secretary of the California Health and Human Services Agency established the Health Care Options Project which solicited proposals for expanding health care coverage in California and selected nine authors to develop their ideas for health care reform.

(c) The Secretary of the California Health and Human Services Agency contracted with an independent agency to do a fiscal analysis of the nine proposals.

(d) One of the nine proposals was the Healthy California Program which proposes to cover all citizens and legal immigrants residing in California.

(e) The Healthy California Program proposes to first maximize existing federal matching funds in stage 1 to all noncustodial adults up to 150 percent of the federal poverty level.

(f) The Healthy California Program proposes in stage 2 to capture additional federal funds and institute a pay-or-play approach that avoids the barrier that the Employee Retirement Income Security Act poses to state reforms that try to require employers to help pay for coverage.

(g) The pay-or-play approach will require employers to choose whether to play by providing private coverage or pay a premium as a percentage of payroll to the state program.

(h) This act will guarantee that all eligible persons will have the choice between participating in their employer’s plan if one is offered, or enrolling in Healthy California Program coverage through the program.

(i) The Healthy California Program will not cover all residents of California and it is not the intent of the Legislature to eliminate the funding for safety net programs.

SEC. 2. Division 100 (commencing with Section 100000) is added to the Health and Safety Code, to read:
DIVISION 100. THE HEALTHY CALIFORNIA PROGRAM

CHAPTER 1. GENERAL PROVISIONS

100000. The Healthy California Program is hereby created.
100001. For purposes of this division, the definitions contained in this section have the following meanings:
(a) “Program” means the Healthy California Program that provides health coverage to all citizens and legal immigrants residing in this state without access to affordable employer-based coverage.
(b) “Applicant” means a person who applies for coverage under the program.
(c) “Board” means the Managed Risk Medical Insurance Board.
(d) “Department” means the State Department of Health Services.
(e) “Enrollee” means an applicant who qualified and was accepted into the program.
(f) “Fund” means the Healthy California Fund.

CHAPTER 2. DUTIES AND RESPONSIBILITIES

100002. The program shall be administered by the board. The board shall conduct outreach programs to locate potentially eligible persons, determine eligibility of applicants, and monitor and ensure the quality of the program, including assuring that culturally competent services are available to applicants and enrollees.
100003. The board may contract directly with health care providers, including health care service plans, disability insurers, and managed care organizations to provide health coverage for the program.
100004. (a) The board shall adopt regulations to establish a standard benefits package for all enrollees that will be similar to those benefits offered by the Healthy Families Program.
(b) All citizens and legal immigrants shall be eligible to receive
(b) Upon the implementation of stage 2, all citizens and legal immigrants not covered by Medicare or CHAMPUS shall be eligible to receive these benefits. For purposes of this section,
“legal immigrants” shall be defined consistent with the eligibility requirements and definitions employed by the Medi-Cal program under Section 14007.5 of the Welfare and Institutions Code.

(c) (1) An enrollee who would qualify for Medi-Cal pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 6 of the Welfare and Institutions Code shall receive expanded benefits and shall not be charged copays or deductibles that exceed those charged by the Medi-Cal no-share-of-cost program.

(2) The board shall adopt regulations necessary to define and implement these expanded benefits.

10005. The board and the department shall apply for appropriate federal waivers, as determined by the board, that will enable the state to obtain matching federal funds to help pay for the coverage of all persons who would otherwise qualify for the Medi-Cal and Healthy Families Programs.

10006. (a) The program shall be implemented in two stages and in the first stage of the program, the board and the department shall do the following:

(1) Maximize federal matching funds for the Medi-Cal program to provide coverage to noncustodial adults up to 150 percent of the federal poverty level.

(2) Integrate the Medi-Cal children and families programs, the Healthy Families Program, and the Access for Infants and Mothers Program into a new program called the Healthy California Program. The Healthy California Program shall use one simplified application and shall continue the same eligibility levels used currently in the Medi-Cal children and families programs, the Healthy Families Program, and the Access for Infants and Mothers Program, with the board and the department maximizing the federal funds available in the federal medicaid and State Children’s Health Insurance Programs.

(b) In the second stage of the program, the board shall do the following:

(1) Work with the department to make all families eligible for federal matching funds regardless of income or assets.

(2) Receive payroll premium tax payments from employers and employees for all employees not covered through employers.

(3) Reduce administrative costs.
100007. (a) There is hereby created in the State Treasury the Healthy California Fund which is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in this division.

(b) The board shall authorize the expenditure from the fund of any state funds or federal funds deposited into the fund. The board may authorize the State Department of Health Services to transfer funds appropriated to the department for the program to the Healthy California Fund and to also deposit those funds in, and to disburse those funds from, the Healthy California Fund.

(c) Notwithstanding any other provision of law, this division shall be implemented only if, and to the extent that, as provided under Title XXI of the Social Security Act, federal financial participation is available and state plan approval is obtained.

100008. (a) Notwithstanding any other provision of law, employers in the State of California shall pay a Healthy California premium payroll tax as a percentage of each employee’s wages, as determined by the board. Employers may choose instead to provide health benefits and shall receive a credit for the full amount of the tax if the actuarial value of the health benefits provided is equivalent to the value of the standard benefits package and if the employee accepts the benefits offered.

(b) The Healthy California premium payroll tax shall be progressive with tax rates and shall increase with increasing levels of income. The rates shall be reduced for small employers with low-wage workers.

(c) This section shall become operative upon completion of stage 1.

SEC. 3. Section 12693.705 is added to the Insurance Code, to read:

12693.705. (a) Subject to subdivisions (b) and (c), the board shall require applicants and recipients to provide independent documentation that they meet the qualifications for eligibility only to the extent required by federal law.

(b) The board shall require every applicant for, and recipient of, benefits under this part to file an affirmation, signed under penalty of perjury, setting forth any facts about his or her annual income, applicable income deductions, and other qualifications for eligibility as may be required by the board. The statements shall be on forms prescribed by the board.
(c) Nothing in this section shall affect the board’s authority to verify eligibility through the Income Eligibility Verification System match under Section 1137 of the federal Social Security Act (42 U.S.C. Section 1320b-7), or to conduct paperless posteligibility random sampling.

SEC. 4. Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).

(3) To the extent federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code authorizing the state to disregard all changes in income or assets of a beneficiary until the next annual redetermination under Section 14012. The department shall implement this paragraph only if, and to the extent that, the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to expand simplify eligibility for Medi-Cal under subdivision (a) by establishing the amount of countable resources individuals or families are allowed to retain at the same amount medically needy individuals and families are allowed to retain, except that a family of one shall be allowed to retain countable resources in the amount of three thousand dollars ($3,000), by exempting all resources.
(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent that it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

(d) To the extent federal financial participation is available and funding is available in the budget, the department shall, upon receipt of the federal waiver under Section 1115 of the Social Security Act, as specified in Section 14005.41 of the Welfare and Institutions Code, disregard all income and assets for applicants and recipients under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).

(e) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 and following) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

(f) Subdivision (b) shall be applied retroactively to January 1, 1998.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, the department shall provide a status
report to the Legislature on a semiannual basis until regulations
have been adopted.

SEC. 4. SEC. 5. Section 14005.41 is added to the Welfare and
Institutions Code, to read:

14005.41. (a) Notwithstanding any other provision of law,
any California resident who is an independent adult and whose
income is at or below 150 percent of the federal poverty level shall
receive health care benefits and services specified in this chapter,
to the same extent that they are available to a recipient eligible
pursuant to Section 1931(b) of the Social Security Act (42 U.S.C.
Sec. 1396u-1).

(b) For purposes of this section, an “independent adult” is a
person who is over 18 years of age, under 65 years of age, not
pregnant, neither a parent or a caretaker relative, and neither blind
nor disabled as defined for purposes of the Supplemental Security
Income/State Supplementary Program for the Aged, Blind and
Disabled (SSI/SSP) program.

(c) For purposes of this section, countable income shall be
determined by applying the same income and resource disregards
and exemptions that are provided to applicants for health care
benefits and services specified in this chapter pursuant to Section
1931(b) of the Social Security Act (42 U.S.C. Sec. 1396u-1).

(d) The department shall maximize the federal reimbursement
received for services provided under this chapter to independent
adults, including, without limitation, through seeking appropriate
waivers under Section 1115 of the Social Security Act (42 U.S.C.
Sec. 1315).

(e) Implementation of the section shall be conditional on funds
being available in the budget.

SEC. 6. Section 14005.42 is added to the Welfare and
Institutions Code, to read:

14005.42. (a) The department shall exercise all options
available under federal law to simplify eligibility for Medi-Cal
benefits by exempting all resources of the following individuals in
the determination of eligibility for benefits under the Medi-Cal
program:

(1) Persons receiving benefits under the Medi-Cal program
pursuant to Section 14005.30.
(2) Medically needy family persons receiving benefits under the Medi-Cal program pursuant to Section 14005.7, if their countable income does not exceed 200 percent of the federal poverty level applicable to the size of the family.

(b) The department shall seek a federal waiver for any group described in subdivision (a) for which an option is not available to apply the procedures required by subdivision (a).

SEC. 7. Section 14011 of the Welfare and Institutions Code is amended to read:

14011. (a) Each applicant who is not a recipient of aid under the provisions of Chapter 2 (commencing with Section 11200) or Chapter 3 (commencing with Section 12000) shall be required to file an affirmation, signed under penalty of perjury, setting forth any facts about his or her annual income and other resources and qualifications for eligibility as may be required by the department. Such statements shall be on forms prescribed by the department.

(b) To the extent permitted by federal law, eligibility for medical assistance for such applicants shall not be granted until the applicant or designated representative provides independent documentation verifying statements of gross income by type and source; income amounts withheld for taxes; health care benefits available through employment, retirement, military service, work-related injuries or settlements from prior injuries; employee retirement contributions, and other employee benefit contributions; deductible expenses for maintenance or improvement of income-producing property; and status and value of property owned, other than property exempt under Section 14006. The director may prescribe those items of exempt property which the director deems should be verified as to status and value in order to reasonably assure a correct designation of those items as exempt. Subject to subdivisions (g), (h), and (i), the department shall require applicants and recipients to provide independent documentation that they meet the qualifications for eligibility only to the extent required by federal law.

(c) The verification requirements of subdivision (b) apply to income, income deductions, and property both of applicants for medical assistance (other than applicants for public assistance) and to persons whose income, income deductions, expenses or
property holdings must be considered in determining the applicant’s eligibility and share of cost.

(d) A determination of eligibility and share of cost may be extended beyond otherwise prescribed time frames if, in the county department’s judgment, and subject to standards of the director, the applicant or designated representative has good cause for failure to provide the required verification and continues to make a good faith effort to provide such verification.

(e) To the extent permitted by federal law, in addition to the other verification requirements of this section, a county department may require verification of any other applicant statements, or conduct a full and complete investigation of the statements, whenever a verification or investigation is warranted in the judgment of the county department.

(f) If documentation is unavailable, as defined in regulations promulgated by the department, the applicant’s signed statement as to the value or amount shall be deemed to constitute verification.

(g) Nothing in this section shall affect the department’s authority to verify eligibility through the Income Eligibility Verification System match mandated by Section 1137 of the federal Social Security Act (42 U.S.C. Sec. 1320b-7), to conduct a paperless posteligibility random sampling, or to develop a Medicaid eligibility quality control pilot program to conduct focused paperless reviews to evaluate the impact of eliminating or reducing documentation and verification requirements on proper eligibility determinations.

(h) The department shall target the use of the data produced by the Income Eligibility Verification System in ways that are most cost-effective and beneficial, as provided in Section 435.953 of Title 42 of the Code of Federal Regulations.

(i) By March 31, 2003, the department shall develop and submit for approval by the Secretary of the United States Department of Health and Human Services a plan listing categories of information items to be excluded from followup per Section 15804.4 of the State Medicaid Manual. This plan shall be developed in consultation with school districts, consumer advocates, representatives from county welfare departments, and other stakeholders.

SEC. 8. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this
act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.
Introduced by Assembly Member Frommer
(Coauthors: Assembly Members Chan, Koretz, and Salinas)

February 21, 2003

An act relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST
AB 1527, as amended, Frommer. Health care coverage.
Under existing law, a small employer, as defined, may participate on a voluntary basis in a program to provide health care coverage to its employees. Existing law, the Medi-Cal program, provides health care benefits to eligible beneficiaries, and the Healthy Families Program, which is administered by the Managed Risk Medical Insurance Board, arranges for the provision of health care services to eligible children and their uninsured parents.
This bill would declare the Legislature’s intent to increase the number of Californians who have affordable, high quality health care coverage by implementing specified programs.
The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to increase the number of people in California who have affordable, high quality health care coverage by doing all of the following:

(a) Establishing a “pay or play” system under which an employer with 51 or more employees is required either to provide quality health care coverage that includes prescription drug benefits for his or her employees and their dependents or to pay a fee so that his or her employees and their dependents may obtain coverage from a statewide pool.

(b) Establishing a purchasing pool to be operated by the Managed Risk Medical Insurance Board to provide health care coverage for employees and their dependents of employers who do not provide coverage directly.

(c) Maximizing federal financial participation in health care coverage for individuals eligible for the Healthy Families Program and the Medi-Cal program through a premium assistance program that allows eligible employees to enroll in employment-based health coverage with reimbursement from the state for the employee’s share of the premium and for the cost of any benefits or services required by those programs that are not covered under the employer’s plan.

(d) Providing assistance to small employers for the cost of providing coverage to their employees and to employees who cannot afford their share of the premium costs. For those employers who are not subject to the “pay or play” requirements, assistance would be intended to serve as an incentive to purchase coverage.
An act relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST
Existing law provides health care coverage programs to segments of the population meeting specified criteria who are otherwise unable to obtain health care coverage.
This bill would state the intent of the Legislature to enact the Healthy California Act of 2003 to ensure access to health care coverage for all Californians.
The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to enact the Healthy California Act of 2003 in order to ensure access to health care coverage for all Californians by all of the following:

(a) Enacting a standard uniform benefit package that is universally available without barriers through health care service plans and health insurers.

(b) Requiring individual responsibility and accountability to secure and maintain health care coverage.

(c) Ensuring that all persons eligible for Medi-Cal, the Healthy Families Program, or other governmental health care coverage or assistance are enrolled in the specific program and receive the services to which they are entitled.

(d) Requiring universal employer participation.

(e) Providing public support, in varying degrees, for all persons, through tax policies, subsidies, and sponsorships.

SEC. 2. It is the goal of this act to achieve the maximum feasible enrollment of Californians in health plans that offer, at a minimum, a standard uniform benefit package to all individuals.
An act to add Part 8.5 (commencing with Section 2020) to Division 2 of the Labor Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 2, as amended, Burton. Health care coverage.

Existing law does not provide a system of health care coverage for all California residents and does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program administered by the State Department of Health Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would declare the intent of the Legislature to ensure health care coverage for working Californians and their families.

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

SECTION 1. The Legislature finds and declares all of the following:
(a) The Legislature finds and declares that working Californians and their families should have health insurance coverage.
(b) The Legislature further finds and declares that most working Californians obtain their health insurance coverage through their employment.
(c) The Legislature finds and declares that in 2001, more than 6,000,000 Californians lacked health insurance coverage at some time and 3,600,000 Californians had no health insurance coverage at any time.
(d) The Legislature finds and declares that more than 80 percent of Californians without health insurance coverage are working people or their families. Most of these working Californians without health insurance coverage work for employers who do not offer health benefits.
(e) The Legislature finds and declares that people who are covered by health insurance have better health outcomes than those who lack coverage. Persons without health insurance are more likely to be in poor health, more likely to have missed needed medications and treatment, and more likely to have chronic health conditions that are not properly managed.
(f) The Legislature finds and declares that employers who do not provide health benefits to their workers have an unfair competitive advantage over those employers who provide health benefits. Employers who provide health benefits often pay directly for the failure of other employers to provide health benefits by providing health benefits to spouses and other dependents who should be covered by the spouse’s or dependent’s employer. Employers who provide health benefits also pay directly when a previously uninsured person becomes an employee and the accumulated health costs due to lack of insurance burden the employer providing health benefits.
(g) The Legislature further finds and declares that health benefit costs in California generally are lower than costs in other states but employers generally are less likely to offer coverage.
(h) The Legislature further finds and declares that controlling health care costs can be more readily achieved if all working people and their families have health benefits so that cost shifting is minimized.

(i) It is therefore the intent of the Legislature to assure that working Californians and their families have health benefits and that their employers shall either provide those benefits or pay a user fee to the State of California so that the state may serve as a purchasing agent to pool those fees to purchase coverage that would otherwise have been purchased directly by employers.

(j) The Legislature further finds and declares that, while covering all working people and their families will substantially reduce the number of Californians without health insurance coverage, several million Californians will still lack health coverage.

(k) It is therefore not the intent of the Legislature to reduce or eliminate funding for safety net programs that provide access to care for those who remain uninsured.

SEC. 2. Part 8.5 (commencing with Section 2020) is added to Division 2 of the Labor Code, to read:

PART 8.5. EMPLOYEE HEALTH INSURANCE

CHAPTER 1. GENERAL PROVISIONS

Article 1. Title and Purpose

2020. This part shall be known and may be cited as the Health Insurance Act of 2003.

2020.5. It is the purpose of this part to ensure that all working Californians and their families are provided health care coverage.

2021. This part shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that are more favorable to the employees than the health care coverage required by this part.
Proposition 71 (cont.)

(b) “State service,” solely for purposes of qualification for benefits and retirement allowances under this system, shall also include service rendered as an officer or employee of a county if the salary for the service constitutes compensation earnable by a member of this system under Section 20638.

SEC. 7. Severability
If any provision of this act, or part thereof, is for any reason held to be invalid or unconstitutional, the remaining provisions shall not be affected, but shall remain in full force and effect, and to this end the provisions of this act are severable.

Proposition 72

This law proposed by Senate Bill 2 of the 2003–2004 Regular Session (Chapter 673, Statutes of 2003) is submitted to the people as a referendum in accordance with the provisions of Section 9 of Article II of the California Constitution.

This proposed law amends and adds sections to various codes; therefore, new provisions proposed to be added are printed in italic type to indicate that they are new.

PROPOSED LAW

SECTION 1. The Legislature finds and declares all of the following:
(a) The Legislature finds and declares that working Californians and their families should have health insurance coverage.
(b) The Legislature further finds and declares that most working Californians obtain their health insurance coverage through their employment.
(c) The Legislature finds and declares that in 2001, more than 6,000,000 Californians lacked health insurance coverage at some time and 3,600,000 Californians had no health insurance coverage at any time.
(d) The Legislature finds and declares that more than 80 percent of Californians without health insurance coverage are working people or their families. Most of these working Californians without health insurance coverage work for employers who do not offer health benefits.
(e) The Legislature finds and declares that employment-based health insurance coverage provides access for millions of Californians to the latest advances in medical science, including diagnostic procedures, surgical interventions, and pharmaceutical therapies.
(f) The Legislature finds and declares that people who are covered by health insurance have better health outcomes than those who lack coverage. Persons without health insurance are more likely to be in poor health, more likely to have missed needed medications and treatment, and more likely to have chronic conditions that are not properly managed.
(g) The Legislature finds and declares that persons without health insurance are at risk of financial ruin and that medical debt is the second most common cause of personal bankruptcy in the United States.
(h) The Legislature further finds and declares that the State of California provides health insurance to low- and moderate-income working parents and their children through the Medi-Cal and Healthy Families programs and pays the cost of coverage for those working people who are not provided health coverage through employment. The Legislature further finds and declares that the State of California and local governments fund county hospitals and clinics, community clinics, and other safety net providers that provide care to those working people whose employers fail to provide affordable health coverage to workers and their families as well as to other uninsured persons.
(i) The Legislature further finds and declares that controlling health care costs can be more readily achieved if a greater share of working people and their families have health benefits so that cost shifting is minimized.
(j) The Legislature finds and declares that the social and economic burden created by the lack of health coverage for some workers and their dependents creates a burden on other employers, the State of California, affected workers, and the families of affected workers who suffer ill health and risk financial ruin.

SEC. 8. Amendments

The statutory provisions of this measure, except the bond provisions, may be amended to enhance the ability of the institute to further the purposes of the grant and loan programs created by the measure, by a bill introduced and passed no earlier than the third full calendar year following adoption, by 70 percent of the membership of both houses of the Legislature and signed by the Governor, provided that at least 14 days prior to passage in each house, copies of the bill in final form shall be made available by the clerk of each house to the public and news media.

(k) It is therefore the intent of the Legislature to assure that working Californians and their families have health benefits and that employers pay a user fee to the State of California so that the state may serve as a purchasing agent to pool those fees to purchase coverage for all working Californians and their families that is not tied to employment with an individual employer. However, consistent with this act, if the employer voluntarily provides proof of health care coverage, that employer is to be exempted from payment of the fee.

(f) It is further the intent of the Legislature that workers who work on a seasonal basis, for multiple employers, or who work multiple jobs for the same employer should be afforded the opportunity to have health coverage in the same manner as those who work full-time for a single employer.

(m) The Legislature recognizes the vital role played by the health care safety net and the potential impact this act may have on the resources available to county hospital systems and clinics, including physicians or networks of physicians that refer patients to such hospitals and clinics, as well as emergency rooms, first aid clinics and other safety net providers. It is the intent of the Legislature to preserve the viability of this important health care resource.

(n) Nothing in this act shall be construed to diminish or otherwise change existing protections in law for persons eligible for public programs including, but not limited to, Medi-Cal, Healthy Families, California Children’s Services, Genetically Handicapped Persons Program, county mental health programs, programs administered by the Department of Alcohol and Drug Programs, or programs administered by local education agencies. It is further the intent of the Legislature to preserve benefits available to the recipients of these programs, including dental, vision, and mental health benefits.

SEC. 2. Part 8.7 (commencing with Section 2120) is added to Division 2 of the Labor Code, to read:

PART 8.7. EMPLOYEE HEALTH INSURANCE

CHAPTER 1. TITLE AND PURPOSE

2120. This part shall be known and may be cited as the Health Insurance Act of 2003.

2120.1. (a) Large employers, as defined in Section 2122.3, shall comply with the provisions of this part applicable to large employers commencing on January 1, 2007, except that those employers with at least 20 employees but no more than 49 employees are not required to comply with the provisions of this part unless a tax credit is enacted that is available to those employers with at least 20 employees but no more than 49 employees. The tax credit shall be 20 percent of net cost to the employer of the fee owed under Chapter 4 (commencing with Section 2140). “Net cost” means the dollar amount of the employer fee or the credit consistent with Section 2160.1 reduced by the employee share of that fee or credit and further reduced by the value of state and federal tax deductions.

2120.2. It is the purpose of this part to ensure that working Californians and their families are provided health care coverage.

2120.3. This part shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or other-sponsored plans that are more favorable to the employees than the health care coverage required by this part.
2122. Unless the context requires otherwise, the definitions set forth in this chapter shall govern the construction and meaning of the terms and phrases used in this part.

2122.1. “Dependent” means the spouse, domestic partner, minor child of a covered enrollee, or child 18 years of age and over who is dependent on the enrollee, as specified by the board. “Dependent” does not include a dependent who is provided coverage by another employer or who is an eligible enrollee as a consequence of that dependent’s employment status.

2122.2. “Enrollee” means a person who works at least 100 hours per month for any individual employer and has worked for that employer for three months. The term includes sole proprietors or partners of a partnership, if they are actively engaged at least 100 hours per month in that business.

2122.3. “Large employer” means a person, as defined in Section 7701(a) of the Internal Revenue Code, or public or private entities employing for wages or salary 200 or more persons to work in this state.

2122.4. “Medium employer” means a person, as defined in Section 7701(a) of the Internal Revenue Code, or public or private entities employing for wages or salary at least 2 but no more than 199 persons to work in this state.

2122.5. “Small employer” means a person, as defined in Section 7701(a) of the Internal Revenue Code, or public or private entity employing for wages or salary at least 2 but no more than 19 persons to work in this state.

2122.6. “Employer” means an employing unit as defined in Section 135 of the Unemployment Insurance Code, that is either a large employer or medium employer, as defined in Sections 2122.3 and 2122.4. For purposes of this part, an employer shall include all of the members of a controlled group of corporations. A “controlled group of corporations” means controlled group of corporations as defined in Section 1563(a)(1) of the Internal Revenue Code, except that “more than 50 percent” shall be substituted for “at least 80 percent” each place it appears in Section 1563(a)(1) of the Internal Revenue Code and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

2122.7. “Principal employer” means the employer for whom an enrollee works the greatest number of hours in any month.

2122.8. “Wages” means wages as defined in subdivision (a) of Section 200, paid directly to an individual by his or her employer.

2122.9. “Fund” means the State Health Purchasing Fund created pursuant to Section 2210.

2122.10. “Program” means the State Health Purchasing Program, which includes a purchasing pool providing health care coverage for enrollees, and, if applicable, their dependents, which will be financed by fees paid by employers and contributions by enrollees.

2122.11. “Board” means the Managed Risk Medical Insurance Board.

2122.12. “Fee” means the fee as determined in Chapter 4 (commencing with Section 2140).

2130. The State Health Purchasing Program is hereby created. The program shall be managed by the Managed Risk Medical Insurance Board, which shall have those powers granted to the board with respect to the Healthy Families Program under Section 12693.21 of the Insurance Code, except that the emergency regulation authority referred to in subdivision (b) of that section shall only be in effect for this program from the effective date of this part until three years after the requirements of this program are in effect for large and medium employers as provided in Section 2120.1.

2130.1. Notwithstanding any other provisions of law to the contrary, the board shall have authority and fiduciary responsibility for the administration of the program, including sole and exclusive fiduciary responsibility over the assets of the fund. The board shall also have sole and exclusive responsibility to administer the program in a manner that will assure prompt delivery of benefits and related services to the enrollees, and, if applicable, dependents, including sole and exclusive responsibility over contract, budget, and personnel matters. Nothing in this section shall preclude legislative or state auditor oversight over the program.
2140.9. All amounts due and unpaid under this part, including unpaid penalties, shall bear interest in accordance with Section 1129 of the Unemployment Insurance Code.

2140.10. Nothing in this part shall preclude an employer from purchasing additional benefits or coverage, in addition to paying the fee.

Chapter 5. Enrollee Contribution

2150. The applicable enrollee contribution, not to exceed 20 percent of the fee assessed to the employer, shall be collected by the employer concurrently with the employer fee. The employer may agree to pay more than 80 percent of the fee, resulting in an enrollee and, if applicable, dependent contribution of less than 20 percent. 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, as specified annually by the United States Department of Health and Human Services, 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.

2150.1. (a) The board shall establish the required enrollee and dependent deductibles, coinsurance, or copayment levels for specific benefits, including total annual out-of-pocket cost.

(b) No out-of-pocket costs other than copayments, coinsurance, and deductibles in accordance with this section shall be charged to enrollees and dependents for health benefits.

(c) In determining the required enrollee and dependent deductibles, coinsurance, and copayments, the board shall consider whether the proposed copayment, coinsurance, and deductibles deter enrollees and dependents from receiving appropriate and timely care, including those enrollees with low or moderate family incomes. The board shall also consider the impact of out-of-pocket costs on the ability of employers to pay the fee. This section shall apply to enrollment information not otherwise received by the board or the Department of Managed Health Care.

2150.2. In the event that the employer fails to collect or transmit the enrollee contribution provided for under this part in a timely manner, the employer shall become liable for a penalty of 200 percent of the amount that the employer has failed to collect or transmit, and the employee shall be relieved of all liability for that failure. In no event shall the employer's failure to collect or transmit the required enrollee contribution or to provide enrollment information adversely affect the employee's eligibility for benefits as provided in regulation.

Chapter 6. Employer Credit Against the Fee

2160. An employer required to pay a fee to the fund may apply to the Employment Development Department for a credit against the fee by providing proof of coverage for eligible enrollees and their dependents, if applicable, consistent with Section 2140.3.

2160.1. Proof of coverage shall be demonstrated by any of the following:

(a) Any health care coverage that meets the minimum requirements set forth in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(b) A group health insurance policy, as defined in subdivision (b) of Section 106 of the Insurance Code, that covers hospital, surgical, and medical care expenses, provided the maximum out-of-pocket costs for insureds do not exceed the maximum out-of-pocket costs for enrollees of health care service plans providing benefits under a preferred provider organization policy.

For the purposes of this section, a group health insurance policy shall not include Medicare supplement, vision-only, dental-only, and Champus-supplement insurance. For purposes of this section, a group health insurance policy shall not include hospital indemnity, accident-only, and specified disease insurance that pays benefits on a fixed benefit, cash-payment-only basis.

(c) Any Taft-Hartley health and welfare fund or any other lawful collective bargaining agreement which provides for health and welfare coverage for collective bargaining unit or other employees thereby covered.

(d) Any employer sponsored group health plan meeting the requirements of the federal Employee Retirement Income Security Act of 1974, provided it meets the benefits required under subdivision (a) or (b) of this section.

(e) A multiple employer welfare arrangement established pursuant to Section 742.20 of the Insurance Code, provided that its benefits have not changed after January 1, 2004, or that it meets the benefits required under subdivision (a) or (b) of this section or is otherwise collectively bargained.

(f) Coverage provided under the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22850) of Division 5 of Title 2 of the Government Code, provided it meets the benefits required under subdivision (a) or (b) of this section or is otherwise collectively bargained.

(g) Health coverage provided by the University of California to students of the University of California who are also employed by the University of California.

2160.2. Nothing in this part shall preclude an employer from providing additional benefits or coverage.

Chapter 7. Participating Health Plans

2170. Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

2171. The board shall contract only with insurers that can demonstrate compliance with Section 10761.2 of the Insurance Code and only with health care service plans that can demonstrate compliance with the requirements of Section 1357.23 of the Health and Safety Code.

2173. (a) The board shall develop and utilize appropriate cost containment measures to maximize the cost-effectiveness of health care.
coverage offered under the program. The board shall consider the find-ings of the California Health Care Quality Improvement and Cost Containment Commission.

(b) Health care service plans, health insurers, and providers are encouraged to develop innovative approaches, services, and programs that may have the potential to deliver health care that is both cost-ef-fective and responsive to the needs of enrollees.

CHAPTER 8. ENROLLMENT AND COORDINATION WITH PUBLIC PROGRAMS

2190. (a) Employers shall provide information to the board regarding potential enrollees, and, if applicable, dependents as pre-scribed by the board to assist the board in obtaining information nec-essary for enrollment. In no case shall the board require the employer to obtain from the potential enrollee information about the family income or other eligibility requirements for Medi-Cal, Healthy Families, or other public programs other than that information about the enrollee’s employment status otherwise known to the employer con-sistent with existing state and federal law and regulation.

(b) The board shall obtain enrollment information from potential enrollees and, if applicable, dependents to be covered by the program. The enrollee may voluntarily provide information sufficient to deter-mine eligibility for Medi-Cal, Healthy Families, or other public programs if the enrollee chooses to seek enrollment in those programs. The board shall use a uniform enrollment form for obtaining that information. The board shall provide information to enrollees covered by the program regarding the coverage available under the program and other pro-grams, including Medi-Cal and Healthy Families, for which enrollees or dependents may be eligible.

2190.1. (a) An enrollee or dependent who would qualify for Medi-Cal pursuant to Part 7 (commencing with Section 14000) of Part 3 of Division 6 of the Welfare and Institutions Code and who chooses to provide information about eligibility for the Medi-Cal program shall be enrolled in the Medi-Cal program if determined eligible by the State Department of Health Services to be eligible for that program and shall be charged share-of-cost, copays, coinsurance, or deductibles in accor-dance with the requirements of that program.

(b) An enrollee or dependent who would qualify for the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of the Insurance Code and who chooses to provide information about eligibility for the Healthy Families Program shall be enrolled in the Healthy Families Program if determined eligible for that program and shall be charged share-of-premium, copays, coinsurance, or deductibles in accordance with the requirements of that program.

2190.2. (a) The board shall provide to the State Department of Health Services information concerning the potential or continuing eligi-bility of enrollees and dependents in the program for Medi-Cal.

(b) (1) For those enrollees and dependents of the program who are determined to be eligible for Medi-Cal, the board shall provide the state share of financial participation for the cost of Medi-Cal coverage pro-vided through the program.

(2) For those enrollees and dependents of the program who are determined to be eligible for Healthy Families, the board shall provide the state share of financial participation for the cost of Healthy Families coverage provided through the program.

(c) Nothing in this part shall affect the authority of the State Department of Health Services or the board to verify eligibility as required by federal law.

(d) The board shall have authority to make any necessary repay-ments of enrollee contributions to persons whose coverage is provided under this section only beginning with the date when coverage begins to be offered through the State Health Purchasing Program pursuant to Part 8.7 of the Labor Code and “medium employer” shall have the meaning as defined in Section 2122.5 of the Labor Code.

2190.3. Nothing in this part shall be construed to diminish or oth-erwise change existing protections in law for persons eligible for public programs, including, but not limited to, California Children’s Services, Genetically Handicapped Persons Program, county mental health pro-grams, programs administered by the Department of Alcohol and Drug Programs, or programs administered by local education agencies.

2190.4. In implementing this part, the board shall consult with organizations representing the interests of enrollees, particularly those who may be covered by public programs as well as family members, providers, advocacy organizations, and plans providing coverage under public programs.

CHAPTER 9. ADMINISTRATION

2200. A contract entered into by the board pursuant to this part shall be exempt from any provision of law relating to competitive bid-ding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual enrollee enroll-ments to a total amount not to exceed the amount appropriate for the program including applicable contributions.

2210. (a) The State Health Purchasing Fund is hereby created in the State Treasury and, notwithstanding Section 13340 of the Government Code, is continuously appropriated to the board for the purposes specified in this part.

(b) The board shall authorize the expenditure from the fund of applicable employer fees and enrollee contributions that are deposited into the fund. This shall include the authority for the board to transfer funds to two separate special deposit funds to be established by the board pursuant to this part, and administered respectively by the State Department of Health Services and the board, to be used as the state’s share of financial participation for the respective costs of Medi-Cal or Healthy Families coverage provided to enrollees, and, if applicable, dependents, who enroll in Medi-Cal or Healthy Families.

(c) Notwithstanding Section 2130.4, the board is authorized to obtain a loan from the General Fund for all necessary and reasonable expenses related to the establishment and administration of this part prior to the collection of the employer fee. The proceeds of the loan are subject to appropriation in the annual Budget Act. The board shall repay principal and interest, using the rate of interest paid under the Pooled Money Investment Account, to the General Fund no later than five years after the first year of implementation of the employer fee.

SEC. 3. Article 3.11 (commencing with Section 1357.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.11. Insurance Market Reform

1357.20. If the provisions of Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code are held invalid, then the provi-sions of this article shall become inoperative.

1357.21. (a) Notwithstanding any other provision of law, and on or after January 1, 2006, except as specified in subdivision (b), all require-ments in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan’s contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restrict-ions on risk categories to age, geographic region, and family composi-tion as described in that article, shall be applicable to all health care service plan contracts offered to all small and medium employers pro-viding coverage to employers 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 employ-ees, all requirements in that article shall apply. As used in this article, “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 other-wise requires.

(2) For medium employers with 51 or more eligible employees, all requirements in that article shall apply, except that the health care serv-ice plan may develop health care coverage benefit plan designs to fair-ly 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) Health care service plans 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).

1357.22. On and after January 1, 2006, a health care service plan con-tract with an employer as defined in Section 2122.6 of the Labor Code providing health coverage to enrollees or subscribers shall meet all of the following requirements:

TEXT OF PROPOSED LAWS

Proposition 72 (cont.)
(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 a subscriber or 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.

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

135723. On and after January 1, 2006, all health care service plans contracting with employers consistent with Section 135722 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 10760) 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 employers 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 care 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 a subscriber or 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.

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

(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 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 make determinations 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 currently eligible to receive, including vision, dental and mental health benefits.

SEC. 6. Section 131 of the Unemployment Insurance Code is amended to read:

131. “Contributions” means the money payments to the Unemployment Fund, Employment Training Fund, State Health Purchasing Fund, or Unemployment Compensation Disability Fund which are required by this division.

SEC. 7. Section 976.7 is added to the Unemployment Insurance Code, to read:

976.7. (a) In addition to other contributions required by this division and consistent with the requirements of Chapter 6 (commencing with Section 21160) of Part 8.7 of Division 2 of the Labor Code, an employer shall pay to the department for deposit into the State Health Purchasing Fund a fee in the amount set by the Managed Risk Medical Insurance Board for the State Health Purchasing Program in accordance with Chapter 4 (commencing with Section 2140) of Part 8.7 of Division 2 of the Labor Code. The fees shall be collected in the same manner and at the same time as any contributions required under Sections 976 and 1088.

(b) In notifying employers of the contributions required under this section, the department shall also provide notice of required employee contribution amounts consistent with Section 2150 of the Labor Code.

(c) An employer shall provide information to all newly hired and existing employees regarding the availability of Medi-Cal coverage for low- and moderate-income employees, including the availability of Medi-Cal premium assistance and well as Medi-Cal coverage for persons receiving coverage through the State Health Purchasing Fund. The Employment Development Department, in consultation with the State Department of Health Services and the Managed Risk Medical Insurance Board shall develop a simple, uniform notice containing that information.

SEC. 8. Section 14105.981 is added to the Welfare and Institutions Code, to read:

14105.981. (a) Prior to the implementation of the Health Insurance Act of 2003, annually for five years after its implementation, and every five years thereafter, the department shall report to the Legislature and the Managed Risk Medical Insurance Board regarding utilization patterns for Medi-Cal pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 6 of the Labor Code and every five years thereafter, the department shall report to the Legislature and the Managed Risk Medical Insurance Board regarding utilization patterns for Medi-Cal pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 6 of the Labor Code. The department shall also provide notice of required employer contribution amounts consistent with Section 2150 of the Labor Code.

(b) In notifying employers of the contributions required under this section, the department shall also provide notice of required employee contribution amounts consistent with Section 2150 of the Labor Code.

(c) An employer shall provide information to all newly hired and existing employees regarding the availability of Medi-Cal coverage for low- and moderate-income employees, including the availability of Medi-Cal premium assistance and well as Medi-Cal coverage for persons receiving coverage through the State Health Purchasing Fund. The Employment Development Department, in consultation with the State Department of Health Services and the Managed Risk Medical Insurance Board shall develop a simple, uniform notice containing that information.

SEC. 9. Section 14124.91 of the Welfare and Institutions Code is amended to read:

14124.91. (a) The State Department of Health Services shall, whenever it is cost-effective, pay the premium for third-party health coverage for beneficiaries under this chapter. The State Department of Health Services shall, when a beneficiary's third-party health coverage would lapse due to loss of employment or change in health status, lack of sufficient income for Medi-Cal coverage, or any other reason, continue the health coverage by paying the costs of continuation of group coverage pursuant to federal law or converting from a group to an individual plan, whenever it is cost-effective. Notwithstanding any other provision of a contract or of law, the time period for the department to exercise either of these options shall be 60 days from the date of lapse of the policy.

(b) In addition, contingent on federal financial participation, the department shall implement a Medi-Cal premium assistance program to cover state costs and maximize allowable federal financial participation by paying the premium for employer-based health care coverage available to persons who are eligible for Medi-Cal, and in combination with employer-based health care coverage providing a wraparound benefit that covers any gap between the employer-based health care coverage and the benefits permitted by the Medi-Cal program.
(c) The department in implementing the premium assistance program shall promptly reimburse an applicant for Medi-Cal for his or her share of premium, minus any share of cost required pursuant to this section. Once enrolled in both the premium assistance program and employer-based health care coverage, where the applicant or beneficiary avails himself or herself of the wraparound benefit, Medi-Cal shall pay for any copayments, deductibles, and other allowable out-of-pocket medical costs under the employer-based coverage.

(d) The department shall seek all state plan amendments and federal approvals as necessary to maximize the amount of any federal financial participation available.

SEC. 10. Section 14124.915 is added to the Welfare and Institutions Code, to read:

14124.915. (a) Six months prior to implementation of Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, the department shall notify Medi-Cal enrollees of the implementation of the Health Insurance Act of 2003, the categories of enrollees covered, the requirements of the program, the availability of Medi-Cal coverage for those persons, including the availability of a premium assistance program for those persons eligible for Medi-Cal who are also covered by employer-based coverage.

(b) Three months prior to the implementation of each phase of the program created by the Health Insurance Act of 2003, those persons enrolled in Medi-Cal shall be offered the opportunity to enroll in a Medi-Cal premium assistance program.

SEC. 11. Section 14124.916 is added to the Welfare and Institutions Code, to read:

14124.916. (a) Prior to the implementation of the Health Insurance Act of 2003, the department shall convene a stakeholder group that includes, but is not limited to, the following members:

(1) The Managed Risk Medical Insurance Board.

(2) Representatives of county welfare departments.

(3) Consumer advocacy groups that represent persons enrolled in or eligible to be enrolled in the Medi-Cal program.

(4) Organizations that represent persons with disabilities.

(5) Labor organizations that represent employees and their dependents who are likely to be eligible for enrollment in Medi-Cal.

(6) Representatives of public hospitals, clinics, provider groups, and safety net providers.

(b) The department in consultation with the stakeholder group shall develop a plan to accomplish the following objectives:

(1) Provide that enrollees and, if applicable, dependents who receive coverage consistent with the Health Insurance Act of 2003 and who are enrolled in Medi-Cal retain the same amount, duration, and scope of benefits to which those beneficiaries currently are entitled.

(2) Provide that enrollees and, if applicable, dependents who receive coverage consistent with the Health Insurance Act of 2003 and who are enrolled in Medi-Cal do not incur greater cost-sharing, including premiums, deductibles, and copays, than currently allowed under federal Medicaid law.

(3) Maximize continuity of care for enrollees and, if applicable, dependents who receive coverage consistent with the Health Insurance Act of 2003 and who are enrolled in Medi-Cal.

(4) Streamline and simplify eligibility and enrollment requirements for Medi-Cal beneficiaries who also have other coverage.

(c) The department shall report to the Legislature every six months and shall submit its final plan to the Legislature three months prior to initial implementation of the Health Insurance Act of 2003.

(d) The department shall seek all state plan amendments and federal approvals as necessary to maximize the amount of any federal financial participation available.

SEC. 12. Section 6254 of the Government Code is amended to read:

6254. Except as provided in Sections 6254.7 and 6254.13, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary course of business, provided that the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to any of the following:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(5) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(6) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes, except that state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (c) of Section 13960, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this subdivision shall require the disclosure of that portion of those investigative files that reflect the analysis or conclusions of the investigating officer.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual’s physical description including date of birth, color of eyes and hair, sex, height and weight, and any distinguishing marks, the name and date of arrest, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the concern thereunto, the identity of, and information related to, the individual involved who is accused of, or who is the subject of, any crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances accompanying the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288a, 288b, 289, 422.6, 422.7, 422.75, or 464.9 of the Penal Code may be withheld at the victim’s request, or at the request of the victim’s attorney.

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victim’s parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 220, 261, 261.3, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the request of the victim, or the victim’s parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code, except that the address of an individual arrested by Section 220, 261, 261.3, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph shall not be used directly or indirectly to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition, except records of fines imposed on the borrowers.

(k) Records, the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(l) Correspondence of and to the Governor or employees of the Governor in the custody of or maintained by the Governor’s legal affairs secretary, provided that public records shall not be transferred to the custody of the Governor’s Legal Affairs Secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public database maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this paragraph, except that the agency may consider making available those portions of an application that are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, that reveal the state agency’s deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator’s deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meetings, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. The exemption in this subdivision shall not apply to records in the public database maintained by the Native American Heritage Commission.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(u) (1) Information contained in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant’s medical or psychological history or that of members of his or her family.

(2) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(3) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(v) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695) and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meetings, minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.
Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of the Department of Consumer Affairs pursuant to Chapter 20 (commencing with Section 2120) of Division 2 of the Labor Code is held invalid, and this action is affirmed on final appeal, an employer may qualify for a full credit for those amounts spent for providing or reimbursing health care benefits, allowable by state law as a deductible business expense if the amount spent equals or exceeds the lower of the cost for Healthy Families or 150 percent of the cost for Medi-Cal 1931(b) coverage. In no instance shall the amount of the credit exceed the amount of the fee that would otherwise have been paid. The Employment Development Department shall specify the manner and means of submitting proof to obtain the credit.

(b) In the event that a contract entered into pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code is amended, the amendment shall be open to inspection one year after they have been fully executed.

(3) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of the Department of Consumer Affairs pursuant to Chapter 20 (commencing with Section 2120) of Division 2 of the Labor Code is held invalid, and this action is affirmed on final appeal, an employer may qualify for a full credit for those amounts spent for providing or reimbursing health care benefits, allowable by state law as a deductible business expense if the amount spent equals or exceeds the lower of the cost for Healthy Families or 150 percent of the cost for Medi-Cal 1931(b) coverage. In no instance shall the amount of the credit exceed the amount of the fee that would otherwise have been paid. The Employment Development Department shall specify the manner and means of submitting proof to obtain the credit.

(b) In the event that the provisions of Section 2160.1 of the Labor Code are held invalid and this action is affirmed on final appeal, an employer may qualify for a full credit for those amounts spent for providing or reimbursing health care benefits, allowable by state law as a deductible business expense if the amount spent equals or exceeds the lower of the cost for Healthy Families or 150 percent of the cost for Medi-Cal 1931(b) coverage. In no instance shall the amount of the credit exceed the amount of the fee that would otherwise have been paid. The Employment Development Department shall specify the manner and means of submitting proof to obtain the credit.

(c) In the event that Chapter 8.7 (commencing with Section 2120) of Division 2 of the Labor Code is held invalid, Article 3.11 (commencing with Section 1357.20) of Chapter 2.2 of Division 2 of the Health and Safety Code and Chapter 8.1 (commencing with Section 1357.70) of Part 2 of Division 2 of the Insurance Code shall become inoperative.

SEC. 14. This act shall become operative unless AB 1528 of the 103rd-104th Regular Session is also enacted and becomes effective.

SEC. 15. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
An act to add Division 112 (commencing with Section 130500) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST
AB 1670, as amended, Nation. Health care coverage.
Existing law establishes various programs, including the Medi-Cal program and the Healthy Families Program, to provide health care benefits to eligible persons. Under existing law, the Healthy Families Program is administered by the Managed Risk Medical Insurance Board.
This bill would establish a 3 part health care coverage program. The bill would require each resident of the state to obtain minimum health care coverage, as defined, and submit documentation, except as specified, of this coverage with his or her annual income tax return filed with the Franchise Tax Board. The bill would also require the Secretary of the Health and Human Services Agency to work in conjunction with counties to establish a purchasing pool through which an essential benefits plan, developed by the board and the Department of Managed Health Care, would be made available. The bill would also require the board and the department to establish a subsidy program for qualified employers, as defined, who offer essential benefits coverage for employees earning less that 200% of the federal poverty level.

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

SECTION 1. This act shall be known as the Universal Health Care Act of 2005.

SEC. 2. Division 112 (commencing with Section 130500) is added to the Health and Safety Code, to read:

DIVISION 112. UNIVERSAL HEALTH CARE

Chapter 1. Individual Mandate

130500. Residents of this state shall obtain and maintain minimum health care coverage for themselves and their dependents. “Minimum health care coverage” means coverage through a health care service plan regulated by the Department of Managed Health Care or a health insurance policy regulated by the Department of Insurance that has a maximum annual deductible of five thousand dollars ($5,000) per person under the plan or policy and provides first dollar coverage for all medically indicated preventative care.

130501. (a) Each resident shall submit proof of the health care coverage required by Section 130500 with his or her annual income tax return filed with the Franchise Tax Board, unless that coverage is provided through his or her employment as reflected by the employer’s payroll report submitted to the Employment Development Department.

(b) If a resident does not comply with subdivision (a), the Franchise Tax Board shall retain from any tax overpaid by the resident, the amount required to obtain the health care coverage described in Section 130500 from the purchasing pool in the resident’s county. The Franchise Tax Board shall transmit this sum to the purchasing pool.
Chapter 2. Purchasing Pool

130510. The Secretary of the Health and Human Services Agency shall, in conjunction with each county, establish a regional quasi-public purchasing pool to provide health care coverage for all individuals without that coverage. A county may join with other counties to operate a purchasing pool. Each regional quasi-public purchasing pool shall be administered by a board of not more than 11 and not less than five members.

130511. The purchasing pool shall negotiate with insurance companies and health care service plans to provide a range of products, including catastrophic coverage with medically indicated preventative care, an essential benefits plan, and any other product that can be offered in a cost-efficient manner.

130512. Insurance companies and health care service plans that participate in the purchasing pool shall guarantee the issuance of coverage to all applicants and shall charge rates on a modified community rating basis. A health care service plan participating in a purchasing pool shall offer, at a minimum, an essential benefits plan and a high deductible catastrophic plan, which shall include coverage for medically indicated preventative care. The Managed Risk Medical Insurance Board and the Department of Managed Health Care shall identify the benefits required for an essential benefits plan offered through the purchasing pool that is less expensive than an equivalent product and that provides basic coverage under a delegated risk model.

130513. Individuals and employers may purchase health care coverage through the purchasing pool to take advantage of the flexible benefit options and pricing it provides.

Chapter 3. Employer Participation

130520. (a) The Managed Risk Medical Insurance Board and the Department of Managed Health Care shall establish a voluntary, nonentitlement program to allocate available state and federal funds to subsidize qualified employers who offer essential benefits health care coverage for their employees who earn less than 200 percent of the federal poverty level as published quarterly in the Federal Register by the Department of
Health and Human Services. A qualified employer is one that has
less that 50 employees, 60 percent of whom earn less than 200
percent of the minimum wage.

(b) Notwithstanding subdivision (a), no subsidy shall be
provided to a qualified employer pursuant to this section if the
employer during the immediately preceding 12-month period,
offered health care coverage benefits to its employees. The
Managed Risk Medical Insurance Board and the Department of
Managed Health Care shall promulgate regulations specifying
other criteria applicable to this disqualification.
An act to add Section 1375 and Division 100 (commencing with Section 100000) to the Health and Safety Code, and to add Section 10112.55 to the Insurance Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1952, as amended, Nation. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, hereafter the Knox-Keene Act, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, the Managed Risk Medical Insurance Board administers various programs, including the Healthy Families Program, the Access for Infants and Mothers Program, and the California Major Risk Medical Insurance Program, to provide health care coverage to eligible persons.

This bill would establish the California Essential Health Benefits Program that would be managed by the board. The bill would require the board to offer an essential benefit plan, as defined, to employees without that coverage through their employment and to self-employed
and unemployed individuals. The bill would specify requirements for health care service plans and health insurers participating in the program and would exempt those plans and insurers from any inconsistent requirements in the Knox-Keene Act and from such provisions regulating health insurers. The bill would make those requirements applicable to all health care service plans and health insurers providing benefits to state residents. The bill would assess employers who do not provide health care coverage equivalent to an essential benefit plan a fee and would make the Employment Development Department responsible for administering those provisions. The bill would also require the program to make contributions toward the premium amount for coverage provided under the program, as specified, and for the premium cost for individuals outside of the program whose annual wages are less than 300 percent of the federal poverty level. The bill would create the Essential Health Benefits Fund where these payments and the employer assessment would be deposited. Because the bill would continuously appropriate the moneys in the fund, it would make an appropriation.

The bill would, on and after January 1, 2008, require each person, as specified, to demonstrate on an annual basis that he or she has health care coverage equivalent to the essential benefit plan and would assess a civil penalty for failure to comply with this requirement, which would be deposited into the General Fund. The bill would specify that this provision would apply only if the board certifies that health care coverage is affordable and available to state residents and would allow individuals to apply to the board for a hardship exemption from its requirements.

The bill would express the Legislature’s intent to limit the amount of an employer’s income tax deduction for health care coverage expenses and to establish rating and coverage requirements for all health care service plans and health insurers.

The bill would make legislative findings and state legislative intent regarding implementation of electronic recordkeeping systems for medical records and the establishment of a Center for Quality Medicine.

The bill would specify that its provisions are severable.

Because the bill would specify additional requirements under the Knox-Keene Act, the willful violation of which would be punishable as a crime, it would impose a state-mandated local program.
The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.


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

SECTION 1. This act shall be known and may be cited as the Healthy California Act.

SEC. 2. Section 1375 is added to the Health and Safety Code, to read:

1375. (a) Notwithstanding any other provision of law, it is the policy of this state that a health care service plan operate in a manner consistent with its participation in the California Essential Health Benefits Program established under Division 100 (commencing with Section 100000), referred to in this section as the program. Any provision of this chapter that is inconsistent with participation by a health care service plan in the program, including, but not limited to, benefit mandates, rating requirements, and definitions of employer group size, shall be waived by the department to the extent necessary to comply with the program. All provisions of this chapter that are consistent with participation by a health care service plan in the program shall remain in full force and effect, section as the program.

(b) Notwithstanding any other provision of this chapter, a health care service plan shall comply with all of the following requirements for all products offered or sold for compliance with the program:

(1) It shall offer the essential benefit plan described in Section 100021, and it may offer coverage for benefits in addition to those described in that section if it has a cost-sharing amount less than that described in that section.

(2) It shall not offer health care benefits coverage that has fewer benefits or a greater cost-sharing amount than the essential benefit plan described in Section 100021.
It shall rate health care benefits coverage pursuant to Section 100023.

(4) It shall include provisions for employer contribution and participation requirements and shall offer coverage to individuals and employer groups in a manner consistent with the program and any regulations and policies adopted by the Managed Risk Medical Insurance Board to implement the program.

SEC. 3 Division 100 (commencing with Section 100000) is added to the Health and Safety Code, to read:

DIVISION 100. THE CALIFORNIA ESSENTIAL HEALTH BENEFITS PROGRAM

Chapter 1. General

100000. (a) The Legislature hereby finds and declares the following:
(1) More than six million California residents lack health care benefits coverage for basic health care services. Most of these individuals are unable to purchase coverage at a reasonable price, or the coverage is not available to them through public or private programs.
(2) The lack of access to health care coverage negatively affects the health status of individuals without that coverage because of the delay in obtaining medical treatment or the failure to obtain it, thereby increasing the incidence of disease and illness in the state.
(3) The cost of providing hospital care to individuals without health care coverage is a burden on the taxpayers and most businesses in the state.
(4) While approximately ___ percent of employers in the state assist their employees in the purchase of health care coverage, many small employers are precluded from providing this assistance because of economic and cost concerns.
(5) The inability of certain employers to offer health care coverage to their employees hinders their ability to compete for capable employees in the labor market and, therefore, has a negative economic impact on the state.
(6) The best interests of the people of the state are served by promoting universal accessibility to health care coverage for all...
residents of the state, which is a matter of traditional state concern.

(b) It is the intent of the Legislature to enact the California Essential Health Benefits Program in order to ensure access to health care coverage for all Californians through all of the following actions:

1. Requiring employers to contribute to a program to pay for health benefits coverage for the individuals in this state without health care coverage.
2. Requiring individuals who do not have health care coverage through an employer or a public program to secure and maintain health care coverage.
3. Ensuring that all persons eligible for the Medi-Cal program, the Healthy Families Program, or other governmental health benefits coverage or assistance are enrolled in the specific program and receive the services for which they are eligible, if they choose to do so.
4. Establishing an essential benefit package that is available to all individuals in the state regardless of their health status.
5. Providing public support, in varying degrees, for all individuals in the state who are unable to afford health care coverage through tax policies and subsidies.
6. Reforming the current health insurance market.

(c) It is the goal of this division to achieve the maximum feasible enrollment of individuals in this state in health plans that offer, at a minimum, an essential benefit plan.

100001. The California Essential Health Benefits Program is hereby created in the California Health and Human Services Agency.

100002. Unless the context requires otherwise, the following definitions apply for purposes of this division:

(a) “Board” means the Managed Risk Medical Insurance Board established by Section 12710 of the Insurance Code.
(b) “Dependent” means the spouse, minor child, permanently disabled child, or legally dependent parent of a covered employee.
(c) “Essential benefit plan” means a health plan including only the essential health benefits contained in Section 100021 with an out-of-pocket cost amount established under that section.
(d) “Essential health benefits” means the minimum mandatory
covered services and cost-sharing limits contained in Section
100021.
(e) “Full-time employee” means ____.
(f) “Fund” means the Essential Health Benefits Fund created
in Section 100011, including the money deposited therein.
(g) “Health plan” means a health insurer regulated by the
Department of Insurance pursuant to Chapter 1 (commencing
with Section 10110) of Part 2 of Division 2 of the Insurance
Code, a health care service plan regulated by the Department of
Managed Health Care pursuant to Chapter 2.2 (commencing with
Section 1340) of Division 2, a self-funded employer sponsored
plan, a multiple employer trust, any other association that sells or
provides health care coverage to employees of employers, or a
Taft-Hartley Trust as defined by federal law, authorized to pay
for health care services in this state.
(h) “High option benefit plan” means a health plan with
coverage of benefits in excess of the essential health benefits
specified in Section 100021.
(i) (1) “Medically necessary” means an intervention that, as
recommended by the treating physician and surgeon and as
determined by a health plan’s medical director or physician and
surgeon designee, meets the following criteria:
   (A) It is a health intervention for the purpose of treating a
   medical condition.
   (B) It is the most appropriate supply or level of service,
   considering potential benefits and dangers to the patient.
   (C) It is known to be effective in improving health outcomes.
   For a new intervention, effectiveness is determined by scientific
evidence. For an existing intervention, effectiveness is
determined first by scientific evidence, then by professional
standards, then by expert opinion. is based on any one of the
following:
   (A) Peer-reviewed scientific and medical evidence regarding
   the effectiveness of the disputed service.
   (B) Nationally recognized professional standards.
   (C) Expert opinion.
   (D) Generally accepted standards of medical practice.
(E) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(2) If more than one health intervention meets the criteria of subparagraphs (A) to (E), inclusive, of paragraph (1), priority should be given to the health intervention that can be furnished in the most cost-effective manner safely and effectively to the patient. Cost-effective does not necessarily mean lowest price.

The determination of cost effectiveness shall include a review of the factors listed in subdivision (a) of Section 127660.

(j) “Part-time employee” means ____.

(k) “Principal employer” means the employer for whom an employee works the largest number of hours in any month.

(l) “Program” means the California Essential Health Benefits Program created in Section 100001.

(m) “Program contribution” means the contribution the program makes towards the premium of an employee and the employee’s dependents when the employee’s employer does not provide health care coverage that is at least equivalent to the essential benefit plan.

(n) “Wages” means all remuneration for services from whatever source, including salaries, commissions, bonuses, and tips and gratuities, paid directly to an individual by a customer or his or her employer.

Chapter 2. Administration

100010. The program shall be administered by the board. The board has the authority to do all of the following in administering the program:

(a) Determine the eligibility of applicants.

(b) Develop and propose a budget for the program.

(c) Administer the essential benefit plan as provided by this division.

(d) Contract with any public or private entity to administer or implement a process to provide the essential benefit plan under this division.

(e) Adopt rules and regulations to carry out the purposes of this division.
(f) Authorize expenditures from the fund or from other moneys appropriated to the board in the annual Budget Act or any other act to carry out the purposes of this division.

(g) Exercise all powers reasonably necessary to carry out the powers and responsibilities granted or imposed under this division.

(h) Collect all fees, charges, and premiums authorized by this division for deposit into the fund.

100011. (a) The Essential Health Benefits Fund is hereby created in the State Treasury. All funds collected for any of the following purposes shall be deposited into the fund:

(1) Assessments paid to the board by employers pursuant to Section 100024.

(2) Premium payments made pursuant to Section 100026.

(3) Any funds appropriated to the fund by the Legislature.

(b) Notwithstanding Section 13340 of the Government Code, all moneys in the fund are continuously appropriated, without regard to fiscal years, to the board to carry out the purposes of this division. Not more than ____ percent of the amounts deposited in the fund during a fiscal year shall be available for expenditure on expenses relating to administration of the program, other than the cost of providing coverage and premium subsidies, during the following fiscal year, unless appropriated by the Legislature for that purpose.

Chapter 3. Program Operation

100020. (a) The program shall offer an essential benefit plan to the full-time and part-time employees, and their dependents, of an employer who does not provide that coverage, as determined by the board. The program shall also offer an essential benefit plan to a self-employed individual and an unemployed individual and their dependents.

(b) The program shall also offer one or more high option benefit plans to individuals described in subdivision (a).

100021. (a) An essential benefit plan shall provide coverage for medically necessary, evidence-based services, as periodically updated by the board, within the following benefit categories:

(1) Preventive services.

(2) Physician services.
(3) Outpatient hospital services.
(4) In-patient hospital services.
(5) Pharmaceuticals.
(6) Diagnostic laboratory and diagnostic and therapeutic radiologic services.
(7) Emergency health care services.
(8) Home health services.
(9) Hospice services.
(b) (1) The board shall create an advisory group to recommend additions and deletions to the essential health benefits. In making its recommendation, the advisory group shall consider the factors listed in subdivision (a) of Section 127660. The advisory group shall include experts in each of the following areas:
(A) Clinical practice.
(B) Evidence-based outcomes research, including technology assessment.
(C) Clinical cost-benefit and cost-effectiveness analysis, including pharmaeconomics.
(2) The advisory group shall not review the interpretation or application of essential health benefits in individual patient cases and shall not replace independent medical review.
(c) The board shall establish the maximum annual out-of-pocket costs for an individual and for a family that shall not exceed ____ dollars ($____). The board may review these amounts annually and adjust them to reflect changes in health care costs. It is the intent of the Legislature that the amount of the out-of-pocket costs be such as to encourage the appropriate use of health services but not create a significant barrier to obtaining health care and that the board take into account the needs of low and moderate income persons in establishing the maximum out-of-pocket costs.
100022. (a) The board shall contract with any health insurer regulated by the Department of Insurance or any health care service plan licensed by the Department of Managed Health Care to provide an essential benefit plan in geographic areas where the insurer or plan operates. The board may directly contract with providers on a negotiated fee basis if coverage by a health care service plan or insurer is not available in a geographic area.
(b) The board shall also contract with a health care service
plan licensed by the Department of Managed Health Care or with
a health insurer regulated by the Department of Insurance to offer
one or more high option benefit plans under the program.
(c) In arranging coverage, by any means, the board is exempt
from the requirements of the Knox-Keene Health Care Service
Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
of Division 2) and the requirements of the Insurance Code
regulating health insurers. The activities of the board are exempt
from licensure or regulation by the Department of Insurance, the
Department of Managed Health Care, and any other agency of
state government.

100023. (a) The board shall establish rules on guaranteed
issue and risk adjustment for health plans participating in the
program. The rules shall ensure that program participants are not
denied coverage for preexisting conditions.
(b) A health plan participating in the program shall establish a
premium for the essential benefit plan that does not vary by
actual or expected claim experience or by any factor other than
geography and age.
(c) The board shall establish uniform geographic areas and age
groups as identified in paragraph (1) of subdivision (k) of Section
1357 to be used by the health plan to establish rates under this
section.
(d) Benefits offered in excess of the essential benefit plan shall
be rated on an actuarially appropriate basis, as established by the
health plan. The portion of a high option benefit plan that
includes the essential health benefits shall be rated pursuant to
the provisions of this section.
(e) It is the intent of the Legislature to establish the rating
factors that all health care service plans and health insurers are
required to utilize in order to achieve an equitable sharing of risk
among all plans and insurers and to establish coverage
requirements for all health care service plans and insurers,
including the requirement that coverage be available within the
program and outside of the program without regard to an
individual’s health status or health condition.
(f) The provisions of this section shall apply to all health care
service plan contracts and health insurance policies or
certificates that provide benefits to residents of this state.
100024. (a) An employer shall pay an annual assessment of not more than 7 percent of its total payroll cost for all full-time and part-time employees into the fund if the employer does not provide health care coverage that is, at minimum, equivalent to the essential benefit plan, as determined by the board, for its full-time and part-time employees and their dependents.

(b) Notwithstanding subdivision (a), if an employer provides health care coverage that is equivalent to the essential benefit plan to only its full-time employees and their dependents, or to only its full-time employees, the board may reduce the amount of the employer’s assessment by _____.

(c) An employer may apply to the board to obtain a refund of its assessment, in part or in whole, if it establishes to the board’s satisfaction, that it provided its employees the health care coverage described in subdivision (a) during an entire year or a part of the year.

(d) The board shall contract with the Employment Development Department to collect the assessment established by this section.

100025. Notwithstanding Section 100024, an employer who does not provide health care coverage that is, at minimum, equivalent to the essential benefit plan, as determined by the board, is exempt from paying the assessment for an employee if any of the following circumstances exists:

(a) The employer is not the principal employer of the employee.

(b) The employee has other health benefits coverage under any law of the United States or this state.

(c) The employee is covered as a dependent under a health care service plan, health insurance policy, or self-funded employer-sponsored plan that has health benefits coverage that is, at minimum, equivalent to the essential benefit plan, as determined by the board.

100026. (a) The program shall make a premium contribution for coverage obtained through the program for an employee, and his or her dependents, of an employer who does not provide health care coverage that is, at minimum, equivalent to the essential benefit plan, as determined by the board.

(b) The amount of the program contribution for the employee shall be 75 percent of the average premium of the three
essential benefit plans having the lowest premium cost that are available to that employee. The amount of the premium contribution for the dependent of an employee, who does not have health care coverage through the employer, shall be 50 percent of the average premium of the three essential benefit plans having the lowest premium cost that are available to the employee. The amount of the program contribution shall be subject to proration for part-time employees and their dependents, as set forth in regulations adopted by the board.

(c) The employee shall pay the balance of the premium amount remaining after the program contribution is made. The employee shall pay the deductible and all other out-of-pocket costs for the coverage.

(d) The program shall not make a premium contribution for coverage obtained through the program for a self-employed individual, an unemployed individual, individuals or their dependents. These individuals shall pay the total amount of the premium and all deductibles and out-of-pocket costs for the coverage. *The board shall establish policies for premium contributions for individuals who are unemployed through no fault of their own.*

(e) The board shall pay a portion of the premium cost for a person described in subdivision (e) or (d) *within the program or outside of the program* whose annual wages are less than 300 percent of the federal poverty level as published quarterly in the Federal Register by the Department of Health and Human Services. The amount of the premium cost paid by the board shall be determined by regulations it adopts.

100027. It is the intent of the Legislature that the amount of the assessment collected pursuant to Section 100024, combined with employee and program contributions made pursuant to Section 100026, shall be sufficient to arrange for an essential benefit plan for all eligible persons under the program.

100028. An employer shall not request or otherwise seek to obtain information concerning income or other eligibility requirements for public health benefit programs regarding an employee, or a dependent of an employee, other than information about the employee’s employment status otherwise known to the employer. For these purposes, public health benefit programs include, but are not limited to, the Medi-Cal program, the
Healthy Families Program, the Managed Risk Medical Insurance Program, and the Access for Infants and Mothers Program.

100029. The Employment Development Department shall adopt regulations to ensure that employers comply with the provisions of this division.

100030. It is the intent of the Legislature to establish a maximum for the deduction amount allowed for income—tax purposes for health care coverage expenses paid by an employer. It is the further intent of the Legislature to use any revenue resulting from this deduction cap to fund the program.

Chapter 4. Health Care Coverage Mandate

100040. Every (a) Except as provided in subdivision (b), on and after January 1, 2008, every individual who is 18 years of age or older or who is an emancipated minor and who resides in California and is not enrolled in a public health benefit program described in Section 100028, shall have and demonstrate to the board evidence of health care coverage for himself or herself and his or her dependents that is, at minimum, equivalent to the essential benefit plan.

(b) The requirements of subdivision (a) shall apply only if the board certifies that health care coverage is affordable and available to all residents of this state. The board shall make an annual determination as to the affordability and availability of health care coverage for the state’s residents. In determining whether coverage is affordable, the board shall take into account the ability of low and moderate income residents to pay for the coverage. If the board certifies that affordable health care coverage is available, an individual may appeal to the board for a personal or family hardship exemption from the requirements of subdivision (a).

100041. The Franchise Tax Board shall distribute to every person to whom it distributes information regarding personal income tax liability, including, without limitation, every person who filed a personal income tax return in the most recent calendar year, a form prepared by the board that informs the recipient of the requirement to establish and maintain health care coverage as described in Section 100040. The form shall include
information that explains the process by which the individual may obtain coverage through the program.

100042. Failure to demonstrate and to maintain health care coverage described in Section 100040 is punishable by a civil fine not exceeding an amount equal to twice the cost of the average premium for the three essential benefit plans offered through the program with the lowest premium. All fines collected under this section shall be deposited into the General Fund.

SEC. 4. Section 10112.55 is added to the Insurance Code, to read:

10112.55. (a) Notwithstanding any other provision of law, it is the policy of this state that a health insurer operate in a manner consistent with its participation in the California Essential Health Benefits Program established under Division 100 (commencing with Section 100000) of the Health and Safety Code, referred to as the program in the section. Any provision of this part that is inconsistent with participation by a health insurer in the program shall be waived by the department to the extent necessary to comply with the program. All provisions of this part that are consistent with participation by a health insurer in the program shall remain in full force and effect. as the program in the section.

(b) Notwithstanding any other provision of this part, a health insurer shall comply with the following requirements for all products offered or sold for compliance with the program:

(1) It shall offer the essential benefit plan described in Section 100021 of the Health and Safety Code, and it may offer coverage for benefits in addition to those described in that section if it has a cost-sharing amount less than that described in that section.

(2) It shall not offer health care benefits coverage that has fewer benefits or a greater cost sharing amount than the essential benefit plan described in Section 100021 of the Health and Safety Code.

(3) It shall rate health care benefits coverage pursuant to Section 100023 of the Health and Safety Code.

(4) It shall include provisions for employer contribution and participation requirements and shall offer coverage to individuals and employer groups in a manner consistent with the program and any regulations and policies adopted by the Managed Risk Medical Insurance Board to implement the program.
SEC. 5. The Legislature finds and declares all of the following:
(a) Implementation of electronic recordkeeping systems for medical records by hospitals, health insurers, health care service plans, and health care providers will improve treatment outcomes by creating a foundation for the development of evidence-based medicine and will save lives by ensuring health care providers timely access to important medical information about their patients.
(b) By transitioning to an electronic recordkeeping system for medical records, California’s health care system will realize billions of dollars in savings and will save tens of billions of dollars over the long term.
(c) It is the intent of the Legislature to ensure the timely expansion of an interoperable system of electronic recordkeeping systems for medical records among hospitals, health insurers, health care service plans, and health care providers. It is further the intent of the Legislature that the electronic recordkeeping systems for medical records comply with all applicable federal and state privacy requirements.

SEC. 6. It is the intent of the Legislature that all of the following occur:
(a) That the Managed Risk Medical Insurance Board contract with an academic institution or public policy research institution for the establishment of a Center for Quality Medicine.
(b) That the Center for Quality Medicine have a board of directors to oversee the center and advance the mission of the center.
(c) That the Center for Quality Medicine conduct research regarding medical treatment data and develop evidence-based guidelines and best practices using medical and scientific evidence. The research shall include, but need not be limited to, recommendations for benefit design, evaluation of cost effectiveness for new technologies and pharmaceuticals, quality measurements by providers and health plans, and the standardization of quality reporting. The center shall widely disseminate its findings, including a database of quality measurements.

SEC. 7. The provisions of this act are severable. If any provision of this act or its application is held invalid, that
invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
ASSEMBLY BILL No. 2450

Introduced by Assembly Member Richman

February 23, 2006

An act to add Part 1.5 (commencing with Section 437) to Division 1 of, and to add Division 113 (commencing with Section 130700) to, the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 2450, as introduced, Richman. Health care coverage: Cal-Health program.

Existing law establishes various programs, including the Medi-Cal program and the Healthy Families Program, to provide health care benefits to eligible persons. Under existing law, the Healthy Families Program is administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program is administered by the State Department of Health Services. Existing law also provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and requires plans to pay the department licensure fees and other fees, as specified, as reimbursement for administering the provisions regulating plans.

This bill would enact the Cal-Health Act that would require the State Department of Health Services to establish an enrollment and retention program to serve as a single point of entry, but not the exclusive method of enrollment and retention, for all health care programs offered by the state and local government agencies.

This bill would establish a 3-part health care coverage program. The bill, as the first part, would require each resident of the state to obtain minimum health care coverage, as defined. The bill, as the 2nd part, would require the Secretary of California Health and Human Services
to work in conjunction with counties to establish a purchasing exchange through which an essential benefits plan, developed by the Managed Risk Medical Insurance Board and the Department of Managed Health Care, would be made available. The bill, as the 3rd part, would require the board and the department to establish a subsidy program for eligible qualified employers, as defined, who offer essential benefits health coverage for eligible employees.

The bill would authorize the Franchise Tax Board to withhold any overpayment of income tax by a resident who failed to obtain minimum health care coverage that would be used to obtain coverage through the resident’s purchasing exchange. The bill would impose a tax on the gross premiums, as specified, of health care service plans that would be deposited into the Universal Health Care Fund, which would be created by the bill. The bill would, upon appropriation by the Legislature in the annual Budget Act, allocate the revenue in the fund to the Managed Risk Medical Insurance Board for specified health care coverage purposes.

Because the bill would require a county to form a purchasing exchange to obtain health care coverage, it would impose a state-mandated local program.

This bill would result in a change in state taxes for the purpose of increasing state revenues, within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of 2/3 of the membership of each house of the Legislature.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

State-mandated local program: yes.

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

1. SECTION 1. (a) The Legislature finds and declares the following:
(1) The uninsured population is a complex problem, influenced by a variety of economic and demographic factors, including employment, family income, racial diversity, age, and premium costs.

(2) The latest estimates indicate that approximately 6.4 million residents in California are without health care coverage, making California home to the largest number of uninsured residents.

(3) The largest segment of the uninsured consists of individuals in early adulthood, between 18 and 34 years of age, making up nearly 43 percent of the uninsured population.

(4) More than one half of California’s nearly one million uninsured children and nearly 10 percent of its uninsured adults are likely eligible for public health care coverage but, due to complex eligibility rules and application procedures and other program inefficiencies, are discouraged from applying and enrolling in those programs.

(b) To help improve California’s health care system, it is the intent of the Legislature to accomplish the following:

(1) Improve access, control costs, and enhance the quality of health care and the health care delivery system in California.

(2) Address the problem of uninsured Californians who are eligible for existing programs but, due to program inefficiencies are discouraged from applying and enrolling in those programs, provide easy, one-step, streamlined access for the currently eligible, but not enrolled, population by coordinating the administrative functions of those programs and providing electronic and accelerated enrollment for those programs.

(3) Ensure all Californians have access to quality health care, require every individual to maintain at least basic health care coverage that includes medically indicated preventive care. Basic health care coverage, including coverage for catastrophic illness and trauma, will reduce the incidence of “medical bankruptcy,” provide individuals with preventive care, and qualify them for network pricing, reducing the cost of medical visits.

(4) Develop a program to help lower-income individuals afford an essential benefit plan, which would be a comprehensive plan that includes in-patient, out-patient, and pharmaceutical coverage.

(5) Authorize the establishment of purchasing exchanges. These exchanges will increase the buying power of individuals
and small businesses, and allow negotiations directly with
insurance companies and health care service plans for a variety
of benefit packages that can be offered in a cost efficient manner.
Regardless of preexisting medical conditions or risk, individuals
will be guaranteed coverage through the purchasing exchanges at
affordable prices with a modified community rating. Current
administrative, marketing, and sales costs will be dramatically
reduced, and exchanges will allow individuals and small
businesses to enjoy the cost savings large groups and government
agencies enjoy. Furthermore, purchasing exchanges will
eliminate “job-lock” and enhance the portability of health care
coverage for individuals as they move from one job to another.
(6) Establish a voluntary employer program that will leverage
federal dollars and make it easier for small businesses and
individuals to purchase affordable health care coverage. The
program will assist small businesses with 50 or fewer employees,
voluntarily participating in the plan, in offering essential benefits
health care coverage for qualified low-income employees. The
program would provide federal and state subsidies, through the
Medi-Cal program and the Healthy Families Program, to the
extent available, to encourage employers and employees to
collaboratively gain access to high quality health care.

SEC. 2. Part 1.5 (commencing with Section 437) is added to
Division 1 of the Health and Safety Code, to read:

PART 1.5. CAL-HEALTH ACT

437. (a) The State Department of Health Services shall
establish an enrollment and retention program known as
Cal-Health. This program shall be a single point of entry, but not
the exclusive method of enrollment and retention, for all health
care programs offered by state and local government agencies.
(b) The department shall use, to the maximum extent possible,
an electronic enrollment process such as the department’s
“Health e-App” and may contract for private technology,
enrollment, and retention services.
(c) The department shall certify the enrollment of persons in
Cal-Health on an annual basis.

SEC. 3. Division 113 (commencing with Section 130700) is
added to the Health and Safety Code, to read:
DIVISION 113. HEALTH CARE MANDATE

CHAPTER 1. INDIVIDUAL REQUIREMENTS

130700. (a) Residents of this state shall obtain and maintain minimum health care coverage for themselves and their dependents.
(b) It is the resident’s responsibility to maintain health care coverage, which may be purchased by the resident directly, obtained through employment or a government-approved program, or obtained through any combination of these sources.
(c) “Minimum health care coverage” means coverage through a health care service plan regulated by the Department of Managed Health Care or a health insurance policy regulated by the Department of Insurance that has a maximum annual deductible of five thousand dollars ($5,000) per person under the plan or policy and that provides first-dollar coverage for all medically indicated preventive care.

130701. A low-income resident who earns less than 200 percent of the federal poverty level or who is eligible for health care coverage through a government-approved program, may participate in the program described in Chapter 3 (commencing with Section 130720) and receive essential benefits health care coverage as defined by the Managed Risk Medical Insurance Board and the Department of Managed Health Care pursuant to Section 130713.

130702. (a) If a resident does not comply with Section 130700, the Franchise Tax Board shall retain from any income tax overpaid by the resident, the amount required to obtain minimum health care coverage from the purchasing exchange where the resident resides. The Franchise Tax Board shall transmit this sum to the purchasing exchange to obtain minimum health care coverage for the resident.
(b) The Department of Insurance, the State Department of Health Services, and the Franchise Tax Board shall develop a program to verify a resident’s compliance with Section 130700.
Chapter 2. Purchasing Exchange

130710. The Secretary of California Health and Human Services shall, in conjunction with each county, establish a regional quasi-public purchasing exchange to provide health care coverage for all individuals within that region. A county may join with other counties to operate a purchasing exchange.

130711. Each regional quasi-public purchasing exchange shall be administered by a board of not more than 11 and not less than five members. The board may include ex officio members, including, but not limited to, a representative appointed by the Insurance Commissioner, by the Secretary of California Health and Human Services, and by the director. No member of the board shall have a contractual affiliation with a health care service plan or a health insurer operating in this state or be an employee of a plan or insurer.

130712. The purchasing exchange shall negotiate with insurance companies, health care service plans, and other medical providers to offer a range of products, including catastrophic coverage with medically indicated preventive care, an essential benefits plan, and any other product that can be offered in a cost-efficient manner.

130713. Health insurers and health care service plans that participate in the purchasing exchange shall guarantee the issuance of coverage to all applicants and shall charge rates on a modified community rating basis. A health care service plan participating in a purchasing exchange shall offer, at a minimum, an essential benefits plan and a high deductible plan both of which shall include coverage for preventive care. The Managed Risk Medical Insurance Board and the Department of Managed Health Care shall identify the benefits required for an essential benefits plan offered through the purchasing exchange that is equivalent to basic coverage under a delegated risk model.

130714. Health insurers and health care service plans that offer products in a region, shall offer those same products through the purchasing exchange for that region at the same or lower premium cost.

130715. A purchasing exchange shall implement an internal process and a process within the region that addresses issues of adverse selection in its region.
130716. Individuals and employers may purchase health care
coverage through the purchasing exchange to take advantage of
the flexible benefit options and pricing it provides.

Chapter 3. Voluntary Employer Participation
Healthy Employee Program

130720. (a) The Managed Risk Medical Insurance Board and
the Department of Managed Health Care shall establish a
voluntary, nonentitlement program to allocate available state and
federal funds to subsidize qualified employers who offer
essential benefits health care coverage for their employees who
earn less than 200 percent of the federal poverty level as
published quarterly in the Federal Register by the Department of
Health and Human Services or who are eligible for health care
coverage through a government-approved program. A qualified
employer is one that has less than 50 employees, 60 percent of
whom earn less than 200 percent of the minimum wage.

(b) Notwithstanding subdivision (a), no subsidy shall be
provided to a qualified employer pursuant to this section if the
employer during the immediately preceding 12-month period,
offered health care coverage benefits to its employees. The
Managed Risk Medical Insurance Board and the Department of
Managed Health Care shall promulgate regulations specifying
other criteria applicable to this disqualification.

(c) The Managed Risk Medical Insurance Board and the
Department of Managed Health Care may use existing programs
to administer the program described in this section, to the extent
the board and department determine doing so would be
appropriate and cost-effective. The board and the department
shall administer the program to maximize its receipt of federal
matching funds.

Chapter 4. Funding

130730. Notwithstanding any other provision of law, an
annual tax shall be imposed on a health care service plan doing
business in this state on the same base, at the same rates, and
subject to the same deductions as the tax imposed on insurers
pursuant to Section 28 of Article XIII of the California
Constitution. Each health care service plan shall pay the tax imposed by this section to the Managed Risk Medical Insurance Board. The tax shall be in lieu of all other taxes, state, county, and municipal, upon those plans and their property, except for those specified in subdivision (f) of Section 28 of Article XIII of the Constitution.

130731. (a) The Universal Health Care Fund is hereby created in the State Treasury. This fund shall be administered by the Managed Risk Medical Insurance Board.

(b) All revenue received pursuant to Section 130730 shall be deposited into the fund.

(c) The revenue in the fund, upon appropriation by the Legislature in the annual Budget Act, shall be allocated monthly by the board to provide funds in the following order of priority:

(1) To fund health care coverage for minors receiving that coverage pursuant to this division.

(2) To fund health care coverage for uninsured parents and responsible adults of children enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code) as provided in Section 12693.755 of the Insurance Code.

(3) To fund the subsidy program established pursuant to Section 130720.

SEC. 4. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.
An act to amend Section 11126 of, and to add Sections 6254.28, 12803.1, and 12803.2 to, the Government Code, to amend Sections 1357, 1357.12, 1363, and 1378 of, to add Section 1347 to, to add Article 3.11 (commencing with Section 1357.20) and Article 4.1 (commencing with Section 1366.10) to Chapter 2.2 of Division 2 of, and to add Chapter 4 (commencing with Section 128850) to Part 5 of Division 107 of, the Health and Safety Code, to amend Sections 10607, 10700, 10714, 12693.43, 12693.70, 12693.73, 12693.755, and 12693.76 of, to add
Sections 10293.5, 12693.57, 12693.58, 12693.59, 12693.621, and 12711.1 to, to add Chapter 1.6 (commencing with Section 10199.10) and Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to amend Section 144 of, to add Sections 131.1, 683.5, and 1095.1 to, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 14005.23, 14005.30, 14005.31, 14005.32, and 14008.85 of, to amend and repeal Section 14011.16 of, to add Sections 14005.301, 14005.331, 14005.82, and 14131.01 to, and to add Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 8, as amended, Nunez. Health care.

(1) Existing law creates the California Health and Human Services Agency.

This bill would require the agency to encourage fitness, wellness, and health promotion programs and to establish a program to track and assess the health care reforms implemented by the bill’s provisions. The bill would create an advisory body, chaired by the secretary of the agency, to guide the assessment and would require annual reports to the Legislature relating to the assessment. The bill would also require the agency, in consultation with the Board of Administration of the Public Employees’ Retirement System (PERS) to assume lead agency responsibility for professional review and development of best practice standards for high-cost chronic diseases that state health care programs would be required to implement upon their adoption. The bill would additionally require the agency, in consultation with PERS and health provider groups, to develop health care provider performance measurement benchmarks, as specified.

(2) Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers’ compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage to persons who
have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services and county welfare departments. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would, as of January 1, 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a statewide purchasing pool for health care coverage by employers and be administered by the Managed Risk Medical Insurance Board. The bill would generally require employers to elect prior to July 1, 2009, to make health expenditures, as specified, in an amount that is equivalent, at a minimum, to 7.5%, subject to adjustment by the board, of the employer’s total social security wages for its full-time or part-time employees, or both, or, alternatively, to pay an employer fee of that minimum amount for the applicable group of employees, who would be required to enroll in Cal-CHIPP. The bill would require an employer to commence paying the employer fee or making the health expenditures on October 1, 2009. The bill would make it unlawful for an employer to take certain actions for the purpose of avoiding this requirement. The bill would require employers to provide the Employment Development Department with specified wage and health expenditures information and comply with other specified requirements. The bill would authorize the department to assess a penalty against an employer who failed to comply with those requirements or failed to remit the employer fees and employee premium payments. The bill would require employers to set up a pretax Section 125 account under federal law for each employee to pay health insurance premiums. Revenues from the employer fees and penalties and employee premiums would be collected by the Employment Development Department for deposit in the California Health Trust Fund created by the bill, and moneys in the fund, other than penalty revenues, would be continuously appropriated to the board for the purposes of the bill. The bill would require the board to offer Cal-CHIPP enrollees a choice of various health plans and would require certain health care service plans to submit a good faith bid to be a participating plan through Cal-CHIPP. The bill would allow employees to decline employer-provided health expenditures or health care coverage under Cal-CHIPP if the employee premium cost exceeds specified amounts. The bill would exempt certain
writings of the board from disclosure under the Public Records Act and would specify that the board may meet in closed session to develop rates and contracting strategy pursuant to Cal-CHIPP.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program. The bill would also expand the number of persons eligible for the Medi-Cal program. The bill would delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child must meet citizen and immigration status requirements applicable to the program under federal law, thereby creating a state-only element of the programs. The bill would additionally, on and after July 1, 2008, disregard all income over 250% but less than or equal to 300% of the federal poverty level and would apply Medi-Cal program income deductions to a family income greater than 300% of the federal poverty level in determining eligibility for the Healthy Families Program. The bill would require the State Department of Health Care Services to seek any necessary federal approval to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill would enact other related provisions. Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program. The bill would provide that the board may implement the provisions of the bill expanding the Healthy Families Program only to the extent that funds are appropriated for these purposes in the annual Budget Act or in another statute.

(3) The bill would enact various health insurance market reforms, to be operative on specified dates, including requirements for guarantee issue of individual health care service plan contracts and health insurance policies, simplified benefit designs, modified small employer coverage, modified disclosures, and other related changes. The bill would prohibit the application, on and after January 1, 2010, of a risk adjustment factor to plans and contracts issued to employers with not more than 100 employees. The bill would require health care service plans and health insurers offering group plans on and after January 1, 2010, to offer a Cal-CHIPP Medi-Cal plan and Cal-CHIPP Healthy Families plan, as specified, at a rate negotiated with and approved by the Managed Risk Medical Insurance Board that is available to group members and dependents, if applicable, eligible for coverage through the Medi-Cal
program or the Healthy Families Program with respect to employees electing to obtain employer-provided coverage through a Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy Families plan, as specified, to collect premiums from employers and transmit them to the Managed Risk Medical Insurance Board. The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to adopt regulations by July 1, 2008, to require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care services and not on administrative costs. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all health care service plans and health insurers and providers shall adopt standard electronic medical records by January 1, 2012.

(4) Existing law, the California Major Risk Medical Insurance Program, administered by the Managed Risk Medical Insurance Board, provides major risk medical coverage for state residents meeting specified eligibility requirements.

This bill would require the board to establish a list of conditions or diagnoses making an applicant automatically eligible for the program and to develop a standardized questionnaire for carriers in the individual market to identify persons eligible for the program. The bill would prohibit a health insurer and a health care service plan from denying coverage to an individual, except for those who are automatically eligible for the program.

(5) The bill, effective July 1, 2008, would also create the California Health Care Cost and Quality Transparency Commission in the Health and Human Services Agency, with various powers and duties, including the development of a health care cost and quality transparency plan. The bill would authorize the commission to impose fees on data sources and data users, as specified, and to impose penalties on data sources that fail to file any report required by the commission. The bill would transfer certain data collection responsibilities from the Office of Statewide Health Planning and Development to the commission on July 1, 2009.

(6) The bill would create the California Health Benefits Service within the Health and Human Services Agency, with various powers and duties relative to creation of joint ventures between certain
county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans.

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.


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

SECTION 1. This act shall be known and may be cited as the California Health Care Reform and Cost Control Act.

SEC. 2. It is the intent of the Legislature to accomplish the goal of universal health care coverage for all California residents within five years. To accomplish this goal, the Legislature proposes to take all of the following steps:

(a) Ensure that all Californians have access to affordable, comprehensive health care coverage, including all California children regardless of immigration status, with subsidies for Californians with low incomes.

(b) Leverage available federal funds to the greatest extent possible through existing federal programs such as Medicaid and the State Children’s Health Insurance Program in support of health care coverage for low-income and disabled populations.

(c) Maintain and strengthen the health insurance system and improve availability and affordability of private health care coverage for all purchasers through (1) insurance market reforms; (2) enhanced access to effective primary and preventive services, including management of chronic illnesses; (3) promotion of cost-effective health technologies; and (4) implementation of meaningful, systemwide cost containment strategies.

(d) Engage in early and systematic evaluation at each step of the implementation process to identify the impacts on state costs, the costs of coverage, employment and insurance markets, health
delivery systems, quality of care, and overall progress in moving
toward universal coverage.

SEC. 2.5. Section 12803.1 is added to the Government Code,
to read:

12803.1. (a) The California Health Benefits Service is hereby
created within the California Health and Human Services Agency.
(1) The California Health Benefits Service (CHBS) shall be
governed by a nine member board appointed by the Governor, the
Senate Committee on Rules, and the Speaker of the Assembly.
The Governor shall appoint a representative of local initiatives
authorized under the Welfare and Institutions Code, a representative
of county organized health systems, and a representative of health
care purchasers. The Senate Committee on Rules shall appoint a
representative of local initiatives authorized under the Welfare and
Institutions Code, a representative of county organized health
systems, and a representative of health care consumers. The
Speaker of the Assembly shall appoint a representative of local
initiatives authorized under the Welfare and Institutions Code, a
representative of health care providers, and a representative of
organized labor. Terms of appointment shall be four years. The
members of the board shall elect a board chair from among the
nine appointed members.
(2) The board shall appoint an executive director for the board,
who shall serve at the pleasure of the board. The executive director
shall receive the salary established by the Department of Personnel
Administration for exempt officials. The executive director shall
administer the affairs of the board as directed by the board and
shall direct the staff of the board. The executive director may
appoint, with the approval of the board, staff necessary to carry
out the provisions of this section.
(b) The Health and Human Services Agency shall convene a
working group with the collaboration of the Department of
Managed Health Care, the State Department of Health Care
Services, and the Managed Risk Medical Insurance Board. This
working group shall assist CHBS in identifying statutory,
regulatory, or financial barriers or incentives that must be addressed
before CHBS can facilitate the establishment and maintenance of
one or more joint ventures between health plans that contract with,
or are governed, owned, or operated by, a county board of
supervisors, a county special commission, or county health
authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions Code. The working group shall also assist CHBS in identifying statutory, regulatory, or financial barriers or incentives that must be addressed before CHBS can enter into contracts with providers to provide health care services in counties in which there is not a prepaid health plan that contracts with, or is governed, owned, or operated by, a county board of supervisors, a county special commission, or a county health authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions Code. The working group shall, no later than April 1, 2008, report its findings to the executive director, the CHBS governing board, and the committees of jurisdiction in the Senate and Assembly.

(c) To the extent permitted under existing law, CHBS is authorized to solicit and assist prepaid health plans that contract with, or are governed, owned, or operated by, a county board of supervisors, a county special commission or county health authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions Code in forming joint ventures to create integrated networks of public health plans that pool risk and share networks. CHBS may, upon agreement of participating health plans, administer those joint ventures. Consistent with the recommendations pursuant to subdivision (b), and existing law, CHBS is authorized to develop networks to provide health care services in counties in which there is not a prepaid health plan that contracts with, or is governed, owned, or operated by, a county board of supervisors, a county special commission, or a county health authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions Code.

(1) In forming joint ventures, CHBS and participating health plans shall seek to contract with the 22 designated public hospitals, county health clinics, and community clinics.

(2) All joint ventures established pursuant to this section shall seek licensure as a health care service plan consistent with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of the Health and Safety Code). Prior to commencement of enrollment, the joint venture shall be licensed pursuant to that chapter.
(d) By March 1, 2009, and annually thereafter, CHBS shall submit a report to the committees of jurisdiction in the Senate and Assembly on implementation of this section and make recommendations on resources, regulatory, and legislative changes necessary to implement this section. The report shall also include recommendations on resources, policy, and legislative changes necessary to build and implement a system of health coverage throughout California.

SEC. 3. Section 12803.2 is added to the Government Code, to read:

12803.2. (a) The California Health and Human Services Agency shall encourage fitness, wellness, and health promotion programs that promote safe workplaces, healthy employer practices, and individual efforts to improve health.

(b) (1) The Secretary of California Health and Human Services shall establish and administer a program to track and assess the effects of health care reform as set forth in the California Health Care Reform and Cost Control Act. The secretary shall either complete the assessment or contract for its preparation. If the secretary determines to contract for the preparation of the assessment, he or she shall seek a partnership and contract with independent, nonprofit groups or foundations, academic institutions, or governmental entities providing grants for health-related activities. The secretary may seek other sources of funding, including grants, to fund the assessment. The assessment shall include, at minimum, the following components:

(A) An assessment of the sustainability and solvency of the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) (Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code). This assessment shall include the number of persons purchasing health care coverage through Cal-CHIPP by income bracket and by the size and type of their employer.

(B) An assessment of the cost and affordability of health care in California. This assessment shall include the cost of health care coverage products for individuals and families obtained through employers, city and county governments, the Medi-Cal program, the Public Employees’ Medical and Hospital Care Act, Medicare Advantage plans, and the individual market.
(C) An assessment of the health care coverage market in California, including a review of the various insurers and health care service plans, their offering and underwriting practices, their efficiency in providing health care services, and their financial conditions, including their medical loss ratios. This assessment shall also include an assessment of risk selection by the plans and insurers.

(D) An assessment of the effect on employers and employment, including employer administrative costs, employee turnover rate, and wages categorized by the type of employer and the size of the business.

(E) An assessment of employer-based health care coverage, including the number of employers providing coverage and the number paying into Cal-CHIPP categorized by employer characteristic.

(F) An assessment of the change in access and availability of health care throughout the state, including tracking the availability of health care coverage products in rural and other underserved areas of the state and assessing the adequacy of the health care delivery infrastructure to meet the need for health care services. This assessment shall include a more in-depth review of areas of the state that were determined to be medically underserved in 2007.

(G) An assessment of the impact on the county health care safety net system, including a review of the amount of uncompensated care and emergency room use.

(H) An assessment of health care coverage as compiled in the California Health Interview Survey or other applicable surveys.

(I) An assessment of the wellness and health status of Californians as compiled in the California Health Interview Survey or other applicable surveys.

(J) An assessment of the capacity of the various health care professions to provide care to the population included in health care reform, identifying the number of each profession and their location in the state.

(K) An assessment of the quality of the health care services, as determined by recognized measures, provided in California.

(L) An assessment of the availability and potential for increasing federal funding for health care services and coverage in California.

(M) Any other assessments as determined necessary by the advisory board established pursuant to paragraph (2).
(2) An advisory body of individuals with knowledge and expertise in health care policy reflecting the broad range of interests in health policy that is chaired by the Secretary of California Health and Human Services shall guide the assessment of health care reform. The Governor shall appoint five members to the advisory body, the Senate Committee on Rules shall appoint two members, and the Speaker of the Assembly shall appoint two members.

(3) To the extent possible, the assessment shall maximize the use of current surveys and databases, and the secretary shall seek partnerships with independent, nonprofit groups or foundations or academic institutions that administer or provide grants for health-related surveys and data collection activities to build on these current surveys and databases.

(4) To the extent feasible, in order to track the effect of health care reform on ongoing trends in the health care field, the assessments shall include data from years prior to the enactment of the California Health Care Reform and Cost Control Act.

(5) The Secretary of California Health and Human Services and the advisory body shall establish a timeline for reporting information to the appropriate policy and fiscal committees of the Legislature. At a minimum, the reporting timeline shall include the release of annual data to serve as a benchmark for the assessment of the health care reform. These annual benchmarks shall include the employer compliance rate and the cost of health care coverage in the state. In addition, the timeline shall include more in-depth reports addressing the items listed under paragraph (1).

(c) The California Health and Human Services Agency, in consultation with the Board of Administration of the Public Employees’ Retirement System, and after consultation with affected health care provider groups, shall develop health care provider performance measurement benchmarks and incorporate these benchmarks into a common pay for performance model to be offered in every state-administered health care program, including, but not limited to, the Public Employees’ Medical and Hospital Care Act, the Healthy Families Program, the Major Risk Medical Insurance Program, the Medi-Cal program, and Cal-CHIPP. These benchmarks shall be developed to advance a common statewide framework for health care quality measurement and reporting, including, but not limited to, measures that have
been approved by the National Quality Forum (NQF) such as the Health Plan Employer Data and Information Set (HEDIS) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and that have been adopted by the Hospitals Quality Alliance and other national and statewide groups concerned with quality.

(d) The California Health and Human Services Agency, in consultation with the Board of Administration of the Public Employees’ Retirement System, shall assume lead agency responsibility for professional review and development of best practice standards in the care and treatment of patients with high-cost chronic diseases, such as asthma, diabetes, and heart disease. In developing the best practice standards, the agency shall consider the use of an annual health assessment for patients. Upon adoption of the standards, each state health care program, including, but not limited to, programs offered under the Public Employees’ Medical and Hospital Care Act, the Medi-Cal program, the Healthy Families Program, the Major Risk Medical Insurance Program, and the California Cooperative Health Insurance Purchasing Program, shall implement those standards.

SEC. 3.5. Section 1347 is added to the Health and Safety Code, to read:

1347. The director shall provide regulatory and program flexibilities as may be necessary to facilitate new, modified, or combined licenses of local initiatives, county organized health systems, or the California Health Benefits Service, created pursuant to Section 12803.1 of the Government Code, seeking licensure for regional or statewide networks for the purposes of contracting with the Managed Risk Medical Insurance Board as a participating plan in the California Cooperative Health Insurance Purchasing Program by January 1, 2010, or for the purposes of providing coverage in the individual and group coverage markets. In providing those flexibilities, the director shall ensure that the health plans established pursuant to this section meet essential financial, capacity, and consumer protection requirements of this chapter.

SEC. 4. Section 1357 of the Health and Safety Code is amended to read:

1357. As used in this article:

(a) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health care plan
contract covering the employee, and includes dependents of
guaranteed association members if the association elects to include
dependents under its health coverage at the same time it determines
its membership composition pursuant to subdivision (o).

(b) “Eligible employee” means either of the following:

(1) Any permanent employee who is actively engaged on a
full-time basis in the conduct of the business of the small employer
with a normal workweek of at least 30 hours, at the small
employer’s regular places of business, who has met any statutorily
authorized applicable waiting period requirements. The term
includes sole proprietors or partners of a partnership, if they are
actively engaged on a full-time basis in the small employer’s
business and included as employees under a health care plan
contract of a small employer, but does not include employees who
work on a part-time, temporary, or substitute basis. It includes any
eligible employee, as defined in this paragraph, who obtains
coverage through a guaranteed association. Employees of
employers purchasing through a guaranteed association shall be
deemed to be eligible employees if they would otherwise meet the
definition except for the number of persons employed by the
employer. Permanent employees who work at least 20 hours but
not more than 29 hours are deemed to be eligible employees if all
four of the following apply:

(A) They otherwise meet the definition of an eligible employee
except for the number of hours worked.

(B) The employer offers the employees health coverage under
a health benefit plan.

(C) All similarly situated individuals are offered coverage under
the health benefit plan.

(D) The employee must have worked at least 20 hours per
normal workweek for at least 50 percent of the weeks in the
previous calendar quarter. The health care service plan may request
any necessary information to document the hours and time period
in question, including, but not limited to, payroll records and
employee wage and tax filings.

(2) Any member of a guaranteed association as defined in
subdivision (o).

(c) “In force business” means an existing health benefit plan
contract issued by the plan to a small employer.
(d) “Late enrollee” means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association’s plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s coverage, cessation of an employer’s contribution toward an employee or dependent’s coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program as
a result of exceeding the program’s income or age limits, or loss
of no share-of-cost Medi-Cal coverage.
(D) He or she requests enrollment within 30 days after
termination of coverage or employer contribution toward coverage
provided under another employer health benefit plan.
(2) The employer offers multiple health benefit plans and the
employee elects a different plan during an open enrollment period.
(3) A court has ordered that coverage be provided for a spouse
or minor child under a covered employee’s health benefit plan.
(4) (A) In the case of an eligible employee, as defined in
paragraph (1) of subdivision (b), the plan cannot produce a written
statement from the employer stating that the individual or the
person through whom the individual was eligible to be covered as
a dependent, prior to declining coverage, was provided with, and
signed, acknowledgment of an explicit written notice in boldface
type specifying that failure to elect coverage during the initial
enrollment period permits the plan to impose, at the time of the
individual’s later decision to elect coverage, an exclusion from
coverage for a period of 12 months as well as a six-month
preexisting condition exclusion, unless the individual meets the
criteria specified in paragraph (1), (2), or (3).
(B) In the case of an association member who did not purchase
coverage through a guaranteed association, the plan cannot produce
a written statement from the association stating that the association
sent a written notice in boldface type to all potentially eligible
association members at their last known address prior to the initial
enrollment period informing members that failure to elect coverage
during the initial enrollment period permits the plan to impose, at
the time of the member’s later decision to elect coverage, an
exclusion from coverage for a period of 12 months as well as a
six-month preexisting condition exclusion unless the member can
demonstrate that he or she meets the requirements of subparagraphs
(A), (C), and (D) of paragraph (1) or meets the requirements of
paragraph (2) or (3).
(C) In the case of an employer or person who is not a member
of an association, was eligible to purchase coverage through a
guaranteed association, and did not do so, and would not be eligible
to purchase guaranteed coverage unless purchased through a
guaranteed association, the employer or person can demonstrate
that he or she meets the requirements of subparagraphs (A), (C),
and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of “COBRA” set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program as a result of exceeding the program’s income or age limits or no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the
employee not more than 30 days after the date that the other health
coverage is exhausted or terminated. Upon enrollment, coverage
shall be effective not later than the first day of the first calendar
month beginning after the date the request for enrollment is
received. Notice of the special enrollment rights contained in this
paragraph shall be provided by the employer to an employee at or
before the time the employee is offered an opportunity to enroll
in plan coverage.
(e) “New business” means a health care service plan contract
issued to a small employer that is not the plan’s in force business.
(f) “Preexisting condition provision” means a contract provision
that excludes coverage for charges or expenses incurred during a
specified period following the employee’s effective date of
coverage, as to a condition for which medical advice, diagnosis,
care, or treatment was recommended or received during a specified
period immediately preceding the effective date of coverage.
(g) “Creditable coverage” means:
(1) Any individual or group policy, contract, or program that is
written or administered by a disability insurer, health care service
plan, fraternal benefits society, self-insured employer plan, or any
other entity, in this state or elsewhere, and that arranges or provides
medical, hospital, and surgical coverage not designed to supplement
other private or governmental plans. The term includes continuation
or conversion coverage but does not include accident only, credit,
coverage for onsite medical clinics, disability income, Medicare
supplement, long-term care, dental, vision, coverage issued as a
supplement to liability insurance, insurance arising out of a
workers’ compensation or similar law, automobile medical payment
insurance, or insurance under which benefits are payable with or
without regard to fault and that is statutorily required to be
contained in any liability insurance policy or equivalent
self-insurance.
(2) The federal Medicare program pursuant to Title XVIII of
the Social Security Act.
(3) The Medicaid program pursuant to Title XIX of the Social
Security Act.
(4) Any other publicly sponsored program, provided in this state
or elsewhere, of medical, hospital, and surgical care.
(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
(6) A medical care program of the Indian Health Service or of a tribal organization.
(7) A state health benefits risk pool.
(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).
(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).
(h) “Rating period” means the period for which premium rates established by a plan are in effect and shall be no less than six months.
(i) “Risk adjusted employee risk rate” means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.
(j) “Risk adjustment factor” means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. On and after January 1, 2010, no risk adjustment factor shall be applied.
(k) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.
(1) No more than the following age categories may be used in determining premium rates:
   Under 30
   30–39
However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.
(B) Married couple.
(C) One adult and child or children.
(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state’s population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) (i) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan’s service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas
encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into more than one region.

Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan’s existing service area.

(l) “Small employer” means either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer
purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(m) “Standard employee risk rate” means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(n) “Guaranteed association” means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (l), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association or a trust formed for, or sponsored by, an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed
to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(o) “Members of a guaranteed association” means any individual or employer meeting the association’s membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association’s discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

(p) “Affiliation period” means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

SEC. 5. Section 1357.12 of the Health and Safety Code is amended to read:

(a) (1) The premium for new business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan’s standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan’s applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. On and after January 1, 2010, no risk adjustment factor shall be applied.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The standard employee risk rates applied to a small employer for new business shall be in effect for no less than six months.

(b) (1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan’s standard employee risk rates.
The risk adjusted employee risk rates may not be more than 120 percent or less than 80 percent of the plan’s applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months. On and after January 1, 2010, no risk adjustment factor shall be applied.

(2) The premium charged a small employer for in force business shall be equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for no less than six months.

(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard employee risk rates for the first rating period of the new contract that the small employer elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan’s applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months. On and after January 1, 2010, no risk adjustment factor shall be applied.

(c) (1) For any small employer, a plan may, with the consent of the small employer, establish composite employee and dependent rates for either new business or renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivisions (a) and (b). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.
(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of no less than six months nor more than 12 months, except that a plan may reserve the right to redetermine the composite rates if the enrollment under the contract changes by more than a specified percentage during the rating period. Any redetermination of the composite rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period. If a plan reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the plan shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A plan reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

(d) Nothing in this section shall be construed to prevent a plan from changing the standard employee risk rates applied to a small employer in order to ensure that the plan’s rates for a standard benefit plan design sold pursuant to Section 1357.21 are not less than the plan’s rates for the same benefit plan design sold through the California Cooperative Health Insurance Purchasing Program (Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code).

SEC. 6. Article 3.11 (commencing with Section 1357.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.11. Insurance Market Reform

1357.20. Effective July 1, 2008, every full-service health care service plan that offers, markets, and sells health plan contracts to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board in consultation with the Department of Insurance and the Department of Managed Health Care. A health care service plan subject to this section may not exclude a potential enrollee from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical
condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1 of the Insurance Code.

1357.21. The department, in consultation with the Department of Insurance, shall require each health care service plan with one million or more enrollees in California, based on the plan’s enrollment in the prior year, to submit a good faith bid to the Managed Risk Medical Insurance Board in order to be a participating plan through the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

1357.22. It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient’s personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health care service plans and providers shall adopt standard electronic medical records by January 1, 2012.

1357.23. Effective July 1, 2008, all requirements in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan’s contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health care service plan contracts offered to all employers with 100 or fewer eligible employees, except as follows:

(a) For small employers with 2 to 50, inclusive, eligible employees, all requirements in that article shall apply.

(b) For employers with 51 to 100, inclusive, eligible employees, all requirements in that article shall apply, except that the health care service plan may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 100, inclusive, eligible employees.
(c) On and after January 1, 2010, no risk adjustment factor shall be applied to a plan contract offered to an employer with 51 to 100, inclusive, eligible employees.

1357.24. (a) Every group health care service plan shall obtain from each employer or group subscriber contracting with the health care service plan the premium contribution amounts the employer or group makes for each enrolled group member and dependent using the family-size categories premium payments made to the group plan.

(b) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a Cal-CHIPP Healthy Families plan established by the board so that group members and their dependents with family incomes at or below 300 percent of the federal poverty level that are determined eligible for coverage through the Healthy Families Program or who are eligible for Medi-Cal pursuant to Section 14005.301 of the Welfare and Institutions Code can enroll in the Cal-CHIPP Healthy Families plan. The Cal-CHIPP Healthy Families plan of a group health care service plan shall be provided at a rate negotiated with and approved by the board. The health care service plan shall collect the employer’s applicable dollar premium contribution for employees and, if applicable, dependents in the Cal-CHIPP Healthy Families plan and credit that amount toward the cost of the Cal-CHIPP Healthy Families plan.

(2) In lieu of meeting the requirements of paragraph (1), for employees and, if applicable, dependents eligible for coverage through the Healthy Families Program who have elected to enroll in a Cal-CHIPP Healthy Families plan, the health care service plan shall instead collect an amount determined by the board but not to exceed the employer’s applicable dollar premium contribution as identified in subdivision (a) and transmit that amount to the board towards the premium cost of a Cal-CHIPP Healthy Families plan.

(e) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a Cal-CHIPP Medi-Cal plan established by the board so that group members and their dependents that are determined eligible for coverage through the Medi-Cal program, except for coverage pursuant to Section 14005.301 of the Welfare and Institutions Code, can enroll in the Cal-CHIPP Medi-Cal plan. The
Cal-CHIPP Medi-Cal plan of a group health care service plan shall be provided at a rate negotiated with and approved by the board. The health care service plan shall collect the employer’s applicable dollar premium contribution for employees and, if applicable, dependents, in the Cal-CHIPP Medi-Cal plan and credit that amount toward the cost of the Cal-CHIPP Medi-Cal plan.

(2) In lieu of meeting the requirements of paragraph (1), for employees and, if applicable, dependents eligible for coverage through the Medi-Cal program who have elected to enroll in a Cal-CHIPP Medi-Cal plan, the health care service plan shall instead collect an amount determined by the board but not to exceed the employer’s applicable dollar premium contribution as identified in subdivision (a) and transmit that amount to the board towards the premium cost of a Cal-CHIPP Medi-Cal plan.

(d) Every health care service plan shall include in the plan’s evidence of coverage notice of the ability of employees and dependents with family incomes at or below 300 percent of the federal poverty level to enroll in Medi-Cal or Healthy Families coverage through a Cal-CHIPP Healthy Families plan or a Cal-CHIPP Medi-Cal plan, with instructions on how to apply for coverage.

1357.24. (a) For employees and, if applicable, dependents who are currently enrolled in or determined eligible for coverage through the Healthy Families Program or the Medi-Cal program and who are offered group coverage, the group health care service plan shall collect the employer’s applicable dollar premium contribution for those employees and, if applicable, dependents and transmit that amount to the board towards the cost of the applicable Cal-CHIPP plan.

(e) The department, in consultation with the board, may issue regulations, as necessary pursuant to the Administrative Procedure Act, to implement the requirements of this section. Until January 1, 2012, the adoption and readoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare.

(f) Employees and dependents receiving coverage through the Medi-Cal program or Healthy Families Program pursuant to this section shall make premium payments, if any, as determined by
the board and shall pay other cost sharing amounts. The amount
of the premium payments and cost sharing shall not exceed
premium payments or cost sharing levels for enrollment in those
programs required under the applicable state laws governing those
programs. The board shall consider using the process in effect on
January 1, 2008, for determining eligibility for the Medi-Cal
program, including the eligibility determination made by the
counties.

(c) As used in this section, the following terms have the
following meanings:
(1) “Board” means the Managed Risk Medical Insurance Board.
(2) “California Cooperative Health Insurance Purchasing
Program” or “Cal-CHIPP” shall have the same meaning as in
subdivision (c) of Section 12699.201 of the Insurance Code.
(3) “Cal-CHIPP Healthy Families plan” shall have the same
meaning as in Section 12699.201 of the Insurance Code.
(4) “Cal-CHIPP Medi-Cal plan” shall mean a plan providing
the same amount, duration, scope, and level of coverage provided
through the Medi-Cal program (Chapter 7 (commencing with
Section 14000) of Part 3 of Division 9 of the Welfare and
Institutions Code).

(d) This section shall apply to health care service plan contracts
issued, amended, or renewed on or after January 1, 2010.

1357.25. The requirements of this article shall not apply to a
specialized health care service plan or a Medicare supplement
contract.

1357.26. This article shall become operative on July 1, 2008.

SEC. 7. Section 1363 of the Health and Safety Code is amended
to read:
1363. (a) The director shall require the use by each plan of
disclosure forms or materials containing information regarding
the benefits, services, and terms of the plan contract as the director
may require, so as to afford the public, subscribers, and enrollees
with a full and fair disclosure of the provisions of the plan in
readily understood language and in a clearly organized manner.
The director may require that the materials be presented in a
reasonably uniform manner so as to facilitate comparisons between
plan contracts of the same or other types of plans. Nothing
contained in this chapter shall preclude the director from permitting
the disclosure form to be included with the evidence of coverage
or plan contract.

The disclosure form shall provide for at least the following
information, in concise and specific terms, relative to the plan,
plus additional information as may be required by the
director, in connection with the plan or plan contract:

1. The principal benefits and coverage of the plan, including
   coverage for acute care and subacute care.

2. The exceptions, reductions, and limitations that apply to the
   plan.

3. The full premium cost of the plan.

4. Any copayment, coinsurance, or deductible requirements
   that may be incurred by the member or the member’s family in
   obtaining coverage under the plan.

5. The terms under which the plan may be renewed by the plan
   member, including any reservation by the plan of any right to
   change premiums.

6. A statement that the disclosure form is a summary only, and
   that the plan contract itself should be consulted to determine
   governing contractual provisions. The first page of the disclosure
   form shall contain a notice that conforms with all of the following
   conditions:

   (A) (i) States that the evidence of coverage discloses the terms
       and conditions of coverage.

   (ii) States, with respect to individual plan contracts, small group
       plan contracts, and any other group plan contracts for which health
       care services are not negotiated, that the applicant has a right to
       view the evidence of coverage prior to enrollment, and, if the
       evidence of coverage is not combined with the disclosure form,
       the notice shall specify where the evidence of coverage can be
       obtained prior to enrollment.

   (B) Includes a statement that the disclosure and the evidence of
       coverage should be read completely and carefully and that
       individuals with special health care needs should read carefully
       those sections that apply to them.

   (C) Includes the plan’s telephone number or numbers that may
       be used by an applicant to receive additional information about
       the benefits of the plan or a statement where the telephone number
       or numbers are located in the disclosure form.
(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient’s choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient’s choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.
(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan’s major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.
(B) Lifetime maximums.
(C) Professional services.
(D) Outpatient services.
(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.
(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan’s preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

SEC. 8. Article 4.1 (commencing with Section 1366.10) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.1. California Individual Coverage Guarantee Issue

1366.10. It is the intent of the Legislature to do both of the following:

(a) Guarantee the availability and renewability of health coverage through the private health insurance market to individuals.
(b) Require that health care service plans and health insurers issuing coverage in the individual market compete on the basis of price, quality, and service, and not on risk selection.

1366.104. (a) On or before September 1, 2008, the director and the Insurance Commissioner shall jointly adopt regulations governing five classes of individual health benefit plans that health care service plans and health insurers shall make available.

(b) Within 90 days of the adoption of the regulations required by subdivision (a), the director and the Insurance Commissioner shall jointly approve five classes of individual health benefit plans for each health care service plan and health insurer participating in the individual market, with each class having an increased level of benefits beginning with the lowest class. Within each class, the director and the Insurance Commissioner shall jointly approve one baseline HMO and one baseline PPO, to be issued by health care service plans and health insurers in the individual market. The classes of benefits jointly approved by the director and the Insurance Commissioner shall reflect a reasonable continuum between the class with the lowest level of benefits and the class with the highest level of benefits, shall permit reasonable benefit variation that will allow for a diverse market within each class, and shall be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(c) In approving the five classes of plans filed by health care service plans and health insurers, the director and the Insurance Commissioner shall do both of the following:

(1) Jointly determine that the plans provide reasonable benefit variation, allowing a diverse market.

(2) Jointly require either (A) that benefits within each class are standard and uniform across all plans and insurers, or (B) that benefits offered in each class are actuarially equivalent across all plans and insurers.

1366.105. On and after January 1, 2009, health care service plans and health insurers participating in the individual market shall, except as provided in Section 12711.1 of the Insurance Code, guarantee issue the five classes of approved health benefit plans and shall, at the same time, discontinue offering and selling health benefit plans other than those within the five approved classes of benefit plans in the individual market.
1 1366.106. (a) Individuals may purchase a health benefit plan
2 from one of the five classes of approved plans on a guaranteed
3 issue basis. After selecting and purchasing a health benefit plan
4 within a class of benefits, an individual may change plans only as
5 set forth in this section. For individuals enrolled as a family, the
6 subscriber may change classes for himself or herself, or for all
7 dependents:
8   (1) Annually in the month of the subscriber’s birth, an individual
9      may select a different individual plan from another health care
10      service plan or insurer, within the same class of benefits or the
11      next higher class of benefits.
12   (2) Annually in the month of the subscriber’s birth, an individual
13      may move up one class of benefits offered by the same health care
14      service plan or health insurer.
15   (3) At any time a subscriber may move to a lower class of
16      benefits.
17   (4) At significant life events, the enrollee may move up to a
18      higher class of benefits as follows:
19      (A) Upon marriage or entering into a domestic partnership.
20      (B) Upon divorce.
21      (C) Upon the death of a spouse or domestic partner, on whose
22         health coverage an individual was a dependent.
23      (D) Upon the birth or adoption of a child.
24   (5) A dependent child may terminate coverage under a parent’s
25      plan, and select coverage for his or her own account following his
26      or her 18th birthday.
27   (6) If a subscriber becomes eligible for group benefits, Medicare,
28      or other benefits, and selects those benefits in lieu of his or her
29      individual coverage, the dependent spouse or domestic partner
30      may become the subscriber. If there is no dependent spouse or
31      domestic partner enrolled in the plan, the oldest child may become
32      the subscriber.
33  (b) This section shall not apply to an individual included within
34      the group of the 3 to 5 percent of individuals identified pursuant
35      to Section 12711.1 of the Insurance Code as the most expensive
to treat.
37 1366.107. At the time an individual applies for health coverage
38 from a health care service plan or health insurer participating in
39 the individual market, an individual shall provide information as
40 required by a standardized health status questionnaire to assist
plans and insurers in identifying persons in need of disease
management. Health care service plans and health insurers may
not use information provided on the questionnaire to decline
coverage or to limit an individual’s choice of health care benefit
plan, except as provided in Section 12711.1 of the Insurance Code.

1366.108. Health benefit plans shall become effective within
31 days of receipt of the individual’s application, standardized
health status questionnaire, and premium payment.

1366.109. Health care service plans and health insurers may
reject an application for health care benefits if the individual does
not reside or work in a plan’s or insurer’s approved service area.

1366.110. The director or the Insurance Commissioner, as
applicable, may require a health care service plan or health insurer
to discontinue the offering of health care benefits, or acceptance
of applications from individuals, upon a determination by the
director or commissioner that the plan or insurer does not have
sufficient financial viability, or organizational and administrative
capacity, to ensure the delivery of health care benefits to its
enrollees or insureds.

1366.111. All health care benefits offered to individuals shall
be renewable with respect to all individuals and dependents at the
option of the subscriber, except:
(a) For nonpayment of the required premiums by the subscriber.
(b) When the plan or insurer withdraws from the individual
health care market, subject to rules and requirements jointly
approved by the director and the Insurance Commissioner.

1366.112. No health care service plan or health insurer shall,
directly or indirectly, enter into any contract, agreement, or
arrangement with a solicitor that provides for or results in the
compensation paid to a solicitor for the sale of a health care service
plan contract or health insurance policy to be varied because of
the health status, claims experience, occupation, or geographic
location of the individual, provided the geographic location is
within the plan’s or insurer’s approved service area.

1366.113. This article shall not apply to individual health plan
contracts for coverage of Medicare services pursuant to contracts
with the United States Government, Medi-Cal contracts with the
State Department of Health Care Services, Healthy Family
contracts with the Managed Risk Medical Insurance Board, high
risk pool contracts with the Major Risk Medical Insurance Program,
Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure coverage from Cal-CHIPP.

1366.114. (a) A health care service plan or health insurer may rate its entire portfolio of health benefit plans in accordance with expected costs or other market considerations, but the rate for each plan or insurer shall be set in relation to the balance of the portfolio as certified by an actuary. Each benefit plan shall be priced as determined by each health care service plan or health insurer to reflect the difference in benefit variation, or the effectiveness of a provider network, but may not adjust the rate for a specific plan for risk selection. A health care service plan’s or health insurer’s rates shall use the same rating factors for age, family size, and geographic location for each individual health care benefit plan it issues. Rates for health care benefits may vary from applicant to applicant only by any of the following:

(1) Age of the subscriber, as determined by the director and the Insurance Commissioner.

(2) Family size in categories determined by the director and the Insurance Commissioner.

(3) Geographic rate regions as determined by the director and the Insurance Commissioner.

(4) Health improvement discounts. A health care service plan or health insurer may reduce copayments or offer premium discounts for nonsmokers, individuals demonstrating weight loss through a measurable health improvement program, or individuals actively participating in a disease management program, provided discounts are approved by the director and the Insurance Commissioner.

(b) The director and Insurance Commissioner shall take into consideration the age, family size, and geographic region rating categories applicable to small group coverage contracts pursuant to Section 1357 of this code and Section 10700 of the Insurance Code in implementing this section.

1366.115. The first term of each health benefit plan contract or policy issued shall be from the effective date through the last day of the month immediately preceding the subscriber’s next birthday. Contracts or policies may be renewed by the subscriber as set forth in this article.
SEC. 9. Section 1378 of the Health and Safety Code is amended to read:

1378. No plan shall expend for administrative costs in any fiscal year an excessive amount of the aggregate dues, fees and other periodic payments received by the plan for providing health care services to its subscribers or enrollees. The term “administrative costs,” as used herein, includes costs incurred in connection with the solicitation of subscribers or enrollees for the plan. The director shall adopt regulations no later than July 1, 2008, requiring that at least 85 percent of aggregate dues, fees, and other periodic payments received by a full-service plan be spent on health care services. The regulations shall also define “health care services.” This section shall not apply to Medicare supplement contracts.

This section shall not preclude a plan from expending additional sums of money for administrative costs provided such money is not derived from revenue obtained from subscribers or enrollees of the plan.

SEC. 9.5. Chapter 4 (commencing with Section 128850) is added to Part 5 of Division 107 of the Health and Safety Code, to read:

Chapter 4. Health Care Cost and Quality Transparency


128850. The Legislature hereby finds and declares that:
(a) The steady rise in health costs is eroding health access, undermining wages and pensions, straining public health and finance systems, and placing an undue burden on the state’s economy. Health care that costs more is not necessarily health care that improves life expectancy, reduces death rates, improves health or minimizes illness and chronic conditions.
(b) Although there are existing voluntary efforts to report on health care quality at various levels of the health care system in California, the collection of performance data on a voluntary basis is inconsistent and incomplete and does not meet the needs of policymakers, purchasers, consumers, or the health industry for reliable comparisons of provider cost and quality.
(c) Data that is collected through existing state programs is not collected or analyzed with the goal of reducing health care costs in the system, monitoring performance, or ensuring quality patient outcomes.

(d) The present day overall lack of transparency of health outcomes and the factors affecting health care costs limits the ability of consumers, purchasers, and policymakers to seek out and reward high quality providers, or to make quality improvements where they are needed.

(e) The effective use and distribution of health care data and meaningful analysis of that data will lead to greater transparency in the health care system resulting in improved health care quality and outcomes, more cost-effective care and improvements in life expectancy, reduced death rates, and improved overall public health.

(f) Hospitals, physicians, health care providers, and health insurers who have access to systemwide performance data can use the information to improve patient safety, efficiency of health care delivery, and quality of care, leading to quality improvement and costs savings throughout the health care system.

(g) Without comprehensive, systemwide data that is adequately analyzed and reported widely, the Legislature cannot effectively evaluate the health care system, establish appropriate regulatory standards, or identify the most effective use and value for state health care dollars. Moreover, consumers and purchasers cannot exercise informed choice in the market or identify the most cost-effective quality providers and services.

(h) The State of California is uniquely positioned to collect, analyze, and report all payer data on health care utilization, quality, and costs in the state in order to facilitate value-based purchasing of health care and to support and promote continuous quality improvement among health care plans and providers.

(i) It is therefore the intent of the Legislature to assume a leadership role in measuring performance and value in the health care system. By establishing statewide data and common measurement and analyses of health care costs, quality, and outcomes, and by establishing a statewide leadership organization with sufficient revenues to adequately analyze and report meaningful performance measures related to health care costs and quality, the Legislature intends to promote competition, identify
appropriate health care utilization, and ensure the highest quality
of health care services for all Californians.

(j) The Legislature further intends to reduce duplication and
inconsistency in the collection, analysis, and dissemination of
health care performance information within state government and
among both public and private entities by establishing one
state-level commission with primary responsibility for coordinating
health care data development, collection, analysis, evaluation, and
dissemination.

(k) The Legislature intends for the commission to ensure the
availability of reliable data to measure and compare performance
within the health care system along each of the domains identified
by the Institute of Medicine: safety, timeliness, effectiveness,
efficiency, equity and patient-centeredness.

(l) It is further the intent of the Legislature that the data collected
be used for the transparent public reporting of quality and cost
efficiency information regarding all levels of the health care
system, including health care service plans and health insurers,
hospitals and other health facilities, and medical groups and
physicians, so that health care plans and providers can improve
their performance and deliver safer, better health care more
affordably; so that purchasers can know which health care services
reduce morbidity, mortality, and other adverse health outcomes;
so that consumers can choose whether and where to have health
care provided; and so that the Legislature can effectively regulate
and monitor the health care delivery system to ensure quality and
value for all purchasers and consumers.

128851. As used in this chapter, the following terms have the
following meanings:

(a) “Administrative claims data” means data that is submitted
electronically or otherwise to, or collected by, health insurers,
health care service plans, administrators, or other payers of health
care services, and which are submitted to, or collected for, the
purposes of payment to any physician, physician group, laboratory,
pharmacy, hospital of any type, imaging center, or any other facility
or person that is requesting payment for the provision of medical
care.

(b) “Ambulatory surgery center” means a facility where
procedures are performed on an outpatient basis in general
operating rooms, ambulatory surgery rooms, endoscopy units, or
cardiac catheterization laboratories of a hospital or a freestanding
ambulatory surgery clinic.
(c) “Commission” means the California Health Care Cost and
Quality Transparency Commission.
(d) “Data source” means any physician, physician group, health
facility, health care service plan, health insurer, any state agency
providing or paying for health care or collecting health care data
or information, or any other payer for health care services in
California.
(e) “Encounter data” means data relating to treatment or services
rendered by providers to patients which may be reimbursed on a
fee-for-service or capitation basis.
(f) “Group” or “physician group” means an affiliation of
physicians and other health care professionals, whether a
partnership, corporation, or other legal form, with the primary
purpose of providing medical care.
(g) “Healthcare-associated infection” means a localized or
systemic condition that (1) results from adverse reaction to the
presence of an infectious agent or its toxin and (2) was not present
or incubating at the time of admission to the hospital.
(h) “Health care provider” means a physician, physician group,
or health facility.
(i) “Health facility” or “health facilities” means health facilities
required to be licensed pursuant to Chapter 2 (commencing with
Section 1250) of Division 2.
(j) “Office” means the Office of Statewide Health Planning and
Development.
(k) “Risk-adjusted outcomes” means the clinical outcomes of
patients grouped by diagnoses or procedures that have been
adjusted for demographic and clinical factors.
128852. Notwithstanding the provisions of Chapter 1
(commencing with Section 128675), commencing July 1, 2009,
the responsibilities of the office with respect to determining the
data to be collected and the analysis and reporting of the data
collected pursuant to Chapter 1 (commencing with Section 128675)
shall be transferred to the commission, as determined by the
commission and as reported to the Secretary of Health and Welfare
and the Legislature no later than January 1, 2009. Any limitations
on the collection, analysis, and use of data in that chapter shall be
inapplicable to the extent determined necessary by the commission
to implement its responsibilities under this chapter. All data
collected by the office shall be available to the commission for the
purposes of carrying out its responsibilities under this chapter.
During the initial development of the data plan pursuant to Section
128675, the office shall make available to the commission any and
all data files, information, and staff resources as may be necessary
to assist in and support the plan’s development.
128853. This chapter shall be operative on July 1, 2008.

Article 2. Health Care Cost and Quality Transparency
Commission

128855. There is hereby created in the Health and Human
Services Agency, the California Health Care Cost and Quality
Transparency Commission composed of 13 members, each of
whom shall have demonstrated knowledge and experience in the
measurement and analysis of health care quality or cost data, in
deploying that data on behalf of consumers and purchasers, or in
health care or other issues relevant to the commission’s
responsibilities. The appointments shall be made as follows:
(a) The Governor shall appoint seven members as follows:
(1) One academic with experience in health care data and cost
efficiency research.
(2) One representative of hospitals.
(3) One representative of an integrated multispecialty medical
group.
(4) One representative of physician and surgeons.
(5) One representative of large employers that purchase group
health care coverage for employees and that is not also a supplier
or broker in health care coverage.
(6) One representative of a labor union.
(7) One representative of employers that purchase group health
care coverage for their employees or a representative of a nonprofit
organization that demonstrates experience working with employers
to enhance value and affordability of health care coverage.
(b) The Senate Committee on Rules shall appoint three members
as follows:
(1) One representative of a labor union.
(2) One representative of consumers with a demonstrated record
of advocating health care issues on behalf of consumers.
3. One representative of health insurers or health care service plans.
4. (c) The Assembly Speaker shall appoint three members as follows:
5. (1) One representative of consumers with a demonstrated record of advocating health care issues on behalf of consumers.
6. (2) One representative of small employers that purchase group health care coverage for employees and that is not also a supplier or broker in health care coverage.
7. (3) One representative of a nonprofit labor-management purchaser coalition that has a demonstrated record of working with employers and employee associations to enhance value and affordability in health care.
8. (d) The following members shall serve in an ex officio, nonvoting capacity:
9. (1) The Secretary of Health and Human Services or a designee.
10. (2) A designee of the California Public Employees’ Retirement System.
11. (3) The director of the Department of Managed Health Care or a designee.
12. (4) The executive director of the Managed Risk Medical Insurance Board or a designee.
13. (5) The Insurance Commissioner or a designee.
14. (e) The Governor shall designate a member to serve as chairperson for a two-year term. No member may serve more than two, two-year terms as chairperson. All appointments shall be for four-year terms; provided, however, that the initial term shall be two years for members initially filling the positions set forth in paragraphs 1, 2, 4, and 6 of subdivision (a), paragraph 2 of subdivision (b), and paragraph 2 of subdivision (c).
15. 128856. The commission shall meet at least once every two months, or more often if necessary to fulfill its duties.
16. 128857. The members of the commission shall receive a per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.
17. 128858. The commission shall appoint an executive director, who shall serve at the pleasure of the commission. The executive director shall receive the salary established by the Department of
Personnel Administration for exempt officials. The executive
director shall administer the affairs of the commission as directed
by the commission and shall direct the staff of the commission.
The executive director may appoint, with the approval of the
commission, staff necessary to carry out the functions and duties
of the commission.

128859. The commission shall be authorized to do the
following:
(a) Enter into contracts.
(b) Sue and be sued.
(c) Employ necessary staff.
(d) Authorize expenditures from the fund or from other moneys
appropriated in the annual budget act or other public or private
revenues as necessary to carry out its responsibilities under this
chapter.
(e) Adopt, amend, and rescind such regulations, forms, and
orders as are necessary to carry out its responsibilities under this
chapter.
(f) Require any data source to submit data necessary to
implement the health care cost and quality transparency plan,
provided the health care cost and quality transparency plan is
adopted by regulation, pursuant to Chapter 3.5 (commencing with
Section 11340) of Part 1 of Division 3 of Title 2 of the Government
Code.
(g) Determine the data elements to be collected, the reporting
formats for data submitted, and the use and reporting by the
commission of any data submitted.
(h) Audit the accuracy of all data submitted and require entities
submitting financial data for the purposes of this part to submit
proof that financial data submitted has been audited in accordance
with generally accepted auditing principles.
(i) Exercise all powers reasonably necessary to carry out the
powers and responsibilities expressly granted or imposed upon it
under this chapter.

128860. The commission shall have no authority to disclose
any confidential information concerning contracted rates between
health care providers and any data source, but nothing in this
section shall prevent the commission from publicly disclosing
information on the relative or comparative cost to payers or
purchasers of health care or the costs for a specific course of
treatment or episode, as applicable for the reporting.

128861. (a) No later than January 1, 2009, the commission
shall determine the functions currently performed by the office
that are necessary to the commission’s activities and report to the
Secretary of Health and Welfare and the Legislature those functions
that shall be transferred to the commission effective July 1, 2009.
(b) All regulations adopted by the office that relate to functions
vested in the commission and that are in effect immediately
preceding July 1, 2009, shall remain in effect and shall be fully
enforceable unless and until readopted, amended, or repealed by
the commission.
(c) The commission may use the unexpended balance of funds
available for use in connection with the performance of the
functions of the office transferred to the commission.
(d) All officers and employees of the office who, on July 1,
2009, are serving in the state civil service, other than as temporary
employees, and engaged in the performance of a function vested
in the commission shall be transferred to the commission. The
status, positions, and rights of these persons shall not be affected
by the transfer except as to positions exempted from civil service.
(e) The commission shall have possession and control of all
records, papers, offices, equipment, supplies, moneys, funds,
appropriations, land or other property, real or personal, held for
the benefit or use of the office for the performance of functions
transferred to the commission.

128862. The functions and duties of the commission shall
include the following:
(a) Develop, implement, and periodically update a health care
quality and cost containment plan, including data collection,
performance measurement, and reporting methods, that provides
for effective measurement of the safety and quality of an array of
health care services provided to Californians.
(b) Determine the data to be collected, and method of collection,
to implement the data collection and reporting requirements set
forth in this chapter.
(c) Determine the measures necessary to implement the reporting
requirements in the plan developed pursuant to 128864 in a manner
that is cost-effective and reasonable for data sources and timely,
relevant, and reliable for consumers and purchasers.
(d) Determine the reports and data to be made available to the public in order to accomplish the purposes of this chapter, including conducting studies and reporting the results of the studies.

(e) Seek to establish agreements for voluntary reporting of health care claims and data from any and all health care payors who are not subject to mandatory reporting to the commission pursuant to this chapter, and its subsequent regulations, in order to ensure availability of the most comprehensive, systemwide data on health care costs and quality.

(f) Collect, aggregate, and timely distribute performance data on quality, health outcomes, cost, utilization, and pricing in a manner accessible for purchasers, consumers, and policymakers.

(g) Fully protect patient privacy, in compliance with state and federal medical privacy laws, while preserving the ability to analyze data using date of birth, ethnicity, and sex where the disclosure of this information will not identify an individual.

(h) Create technical advisory committees and clinical advisory committees, as necessary, to advise the commission on technical or clinical issues.

(i) Annually report to the Governor and the Legislature, on or before March 1, on the status of implementing this chapter, the resources necessary to fully implement this chapter, and any recommendations for statutory changes that would advance the purposes of this chapter.

(j) Provide state leadership and coordination of public and private health care quality and performance measurements to ensure efficiency, cost-effectiveness, transparency, and informed choice by purchasers and consumers.

128863. (a) The commission shall appoint at least one technical advisory committee, and may appoint additional technical advisory committees as the commission deems appropriate, and shall include on each such committee academic and professional experts with expertise related to the activities of the commission.

(b) The commission shall appoint at least one clinical advisory committee and may appoint additional advisory committees specific to issues that require additional or different clinical expertise. Each clinical advisory committee shall include clinicians and others with expertise related to the activities of the commission and any issue under consideration.
The commission shall, as appropriate, refer technical and clinical issues, including issues related to risk adjustment methodology, to an advisory committee for recommendation. The advisory committee shall, within the time period specified by the commission, issue to the commission a written recommendation concerning the issue referred to the advisory committee. The commission shall consider the recommendation of the advisory committee. If the commission rejects the recommendation, it shall issue a written finding and rationale for rejecting the recommendation. If the advisory committee fails to issue a recommendation within the time period prescribed by the commission, the commission may appoint another advisory committee or take such other action it deems necessary to obtain the needed technical or clinical information required to carry out its responsibilities.

The members of the technical and clinical advisory committees appointed by the commission shall receive no compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the advisory committee.

The commission shall provide opportunities for participation from consumers, purchasers, and providers at all advisory committee meetings.

The commission shall develop and implement a conflict-of-interest policy applicable to all employees, contractors, and advisory committee members that will ensure, at a minimum, that persons advising the commission disclose any material financial interest in the outcome of the work performed on behalf of the commission.

Article 3. Health Care Cost and Quality Transparency Plan

The Commission shall, by December 1, 2009, develop and, by regulation adopt, a health care cost and quality transparency plan that will, when implemented, result in the transparent public reporting of safety, quality, and cost efficiency information at all levels of the health care system. The plan shall:

1. Include specific strategies to measure and collect data related to health care safety and quality, utilization, cost to payers, and
health outcomes and shall focus on data elements that foster quality improvement and peer group comparisons.
(2) Facilitate value-based, cost-effective purchasing of health care services by public and private purchasers.
(3) Result in useable information that allows health care purchasers, consumers, and data sources to identify and compare health plans and insurers as well as individual health facilities, physicians, and other health care providers, on the extent to which they provide safe, cost-effective, high quality health care services.
(4) Be designed to measure each of the performance domains identified by the Institute of Medicine: safety, timeliness, effectiveness, efficiency, equity and patient-centeredness.
(5) Use and build on existing data collection standards and methods to the greatest extent possible to accomplish the goals of the commission in a cost-effective manner, which may include, but not be limited to, collecting and disseminating one or more nationally recognized methodologies for measuring and quantifying provider quality, cost and service effectiveness, and implementing systemwide mandatory collection of data elements otherwise being collected in existing voluntary public and private reporting programs in California.
(6) Incorporate and utilize administrative claims data to the extent it is the most cost-efficient method of collecting data in order to minimize the cost and administrative burden on data sources. The commission may incorporate and utilize data other than administrative claims data, provided it is necessary to measure and analyze a significant health care quality, safety, or cost issue that cannot be adequately measured with the use of administrative claims data.
(b) The plan shall include all of the following:
(1) The reports, analyses, and data that will be made available to data sources, purchasers, and consumers on the performance of health plans and insurers, medical groups, health facilities, and physicians, the format in which the reports and data will be made available, and the planned implementation dates.
(2) The data elements necessary to produce the reports and data to be made available. The plan shall address the extent to which standardized electronic reporting of administrative claims data can provide the information necessary for the purposes of this chapter,
and the most efficient, least burdensome method of collecting other
necessary data, including systemwide encounter data.

(3) The data elements to be collected and how they will be
collected.

(4) A unique patient identifier to permit analysis of health care
utilization patterns that indicate inadequate quality of care, such
as hospital readmissions and repetitive service utilization.

(5) The manner in which patient confidentiality will be
maintained in compliance with state and federal medical and patient
privacy laws.

(6) The administration of data collection, quality assurance, and
reporting functions.

(7) The funding necessary to implement the plan and
recommendations for revenue sources to provide that funding.

(8) A review of existing public and private health performance
data collection and reporting standards and practices, at the state
and federal level, and strategies for incorporating or coordinating
with existing mandatory and voluntary measurement and reporting
activities as the commission determines necessary to accomplish
the goal of this chapter in a cost-effective manner. The review of
state programs shall include, at a minimum, review of data
collection programs administered by the office and the Office of
the Patient Advocate.

(9) The timeline for implementation of the plan and a specific
timeline and process for updating the plan on a regular basis.

128866. The commission may contract with a qualified public
or private agency or academic institution to assist in the review of
existing data collection programs or to conduct other research or
analysis the commission deems necessary to complete and
implement the plan required pursuant to Section 128865 or to meet
any of its obligations under this chapter.

128867. The commission shall review and, where appropriate,
incorporate into the plan required by Section 128865 health care
data collection and reporting required under other state laws,
including, but not limited to, Chapter 1 (commencing with Section
128675), Article 3.5 (commencing with Section 1288.10) of
Chapter 2 of Division 2, and Sections 1279.1, 1279.3, and 1368.02,
and shall recommend any modification of these statutes necessary
to be consistent with the plan developed pursuant to Section
128865. Data collection and reporting required by these provisions
shall not be delayed pending the development and implementation of the plan.

128868. (a) No later than December 1, 2008, and annually thereafter, the commission shall publicly report the federal Agency for Healthcare Research and Quality Patient Safety Indicators and Inpatient Quality Indicators for each acute care hospital licensed in California using administrative discharge data that hospitals report pursuant to this part.

(b) No later than July 1, 2010, the commission shall publish an initial report of health care associated infection rates in general acute care hospitals. The types of infection to be included and the methods to be used shall be determined by the commission, in consultation with the state Department of Public Health and the committee established pursuant to Section 1288.5. The report shall be based on data collected for a period of 12 months, and thereafter shall be updated quarterly.

Article 4. Fees

128870. (a) The commission shall, to the extent possible, recover the cost of implementing this chapter from fees charged to data sources and data users. As part of the plan adopted pursuant to Article 3 (commencing with Section 128865), the commission shall promulgate a schedule of fees that will, to the extent possible, recover the cost of implementing centralized data collection, effective analysis, and reporting activities under this chapter. The schedule of fees shall be based on the relative need to collect and analyze information from various data sources, and the relative value to data sources and users, in order to correct the adverse health effects that have resulted from the lack of transparency of health care cost and quality information. The fee schedule shall ensure appropriate access to data at a reasonable cost for academic researchers. Notwithstanding this section, the commission shall not fail to publish reports for the public consistent with the plan and shall not otherwise charge members of the public for access to the reports generated and published by the commission.

(b) The commission may seek and accept contributions to support the work of the commission from any foundation or other public or private entity that does not have a financial interest in
the outcome of the work of the commission, as defined in the
conflict-of-interest policy adopted pursuant to Section 128864.
128871. There is hereby established in the State Treasury, the
Health Care Cost and Quality Transparency Fund to support the
work of the commission. All fees and contributions collected by
the commission pursuant to Section 128870 shall be deposited in
this fund and used to support the work of the commission.

Article 5. Penalties

128875. (a) Any data source that fails to file any report as
required by this chapter or by the health care cost and quality
transparency plan adopted pursuant to this chapter, shall be liable
for a civil penalty of one hundred dollars ($100) to one thousand
dollars ($1,000) per day. The commission shall, as part of the plan
developed pursuant to section 128865, promulgate a schedule of
civil penalties that will be assessed for reporting violations that
varies from one hundred dollars ($100) per day for the least serious
violation, up to one thousand dollars ($1,000) for the most serious
violation.

(b) Civil penalties shall be assessed and recovered in a civil
action brought by the commission in the name of the people of the
State of California. Assessment of a civil penalty may, at the
request of a health care provider, be reviewed on appeal and the
penalty may be reduced or waived by the commission for good
cause.

(c) Any money received by the commission pursuant to this
section shall be paid into the General Fund.

SEC. 10. Chapter 1.6 (commencing with Section 10199.10) is
added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 1.6. California Individual Coverage Guarantee
Issue

10199.10. It is the intent of the Legislature to do both of the
following:

(a) Guarantee the availability and renewability of health
coverage through the private health insurance market to individuals.
(b) Require that health care service plans and health insurers issuing coverage in the individual market compete on the basis of price, quality, and service, and not on risk selection.

10199.104. (a) On or before September 1, 2008, the commissioner and the Director of the Department of Managed Health Care shall jointly adopt regulations governing five classes of individual health benefit plans that health care service plans and health insurers shall make available.

(b) Within 90 days of the adoption of the regulations required by subdivision (a), the commissioner and the Director of the Department of Managed Health Care shall jointly approve five classes of individual health benefit plans for each health care service plan and health insurer participating in the individual market, with each class having an increased level of benefits beginning with the lowest class. Within each class, the commissioner and the Director of the Department of Managed Health Care shall jointly approve one baseline HMO and one baseline PPO, to be issued by health care service plans and health insurers in the individual market. The classes of benefits jointly approved by the commissioner and the Director of the Department of Managed Health Care shall reflect a reasonable continuum between the class with the lowest level of benefits and the class with the highest level of benefits, shall permit reasonable benefit variation that will allow for a diverse market within each class, and shall be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(c) In approving the five classes of plans filed by health care service plans and health insurers, the commissioner and the Director of the Department of Managed Health Care shall do both of the following:

(1) Jointly determine that the plans provide reasonable benefit variation, allowing a diverse market.

(2) Jointly require either (A) that benefits within each class are standard and uniform across all plans and insurers, or (B) that benefits offered in each class are actuarially equivalent across all plans and insurers.

10199.105. On and after January 1, 2009, health care service plans and health insurers participating in the individual market shall, except as provided in Section 12711.1, guarantee issue the
five classes of approved health benefit plans and shall, at the same
time, discontinue offering and selling health benefit plans other
than those within the five approved classes of benefit plans in the
individual market.

10199.106. (a) Individuals may purchase a health benefit plan
from one of the five classes of approved plans on a guaranteed
issue basis. After selecting and purchasing a health benefit plan
within a class of benefits, an individual may change plans only as
set forth in this section. For individuals enrolled as a family, the
subscriber may change classes for himself or herself, or for all
dependents:
   (1) Annually in the month of the subscriber’s birth, an individual
may select a different individual plan from another health care
service plan or insurer, within the same class of benefits or the
next higher level of benefits.
   (2) Annually in the month of the subscriber’s birth, an individual
may move up one class of benefits offered by the same health care
service plan or health insurer.
   (3) At any time a subscriber may move to a lower class of
benefits.
   (4) At significant life events, the insured may move up to a
higher class of benefits as follows:
      (A) Upon marriage or entering into a domestic partnership.
      (B) Upon divorce.
      (C) Upon the death of a spouse or domestic partner, on whose
health coverage an individual was a dependent.
      (D) Upon the birth or adoption of a child.
   (5) A dependent child may terminate coverage under a parent’s
plan, and select coverage for his or her own account following his
or her 18th birthday.
   (6) If a subscriber becomes eligible for group benefits, Medicare,
or other benefits, and selects those benefits in lieu of his or her
individual coverage, the dependent spouse or domestic partner
may become the subscriber. If there is no dependent spouse or
domestic partner enrolled in the plan, the oldest child may become
the subscriber.
   (b) This section shall not apply to an individual included within
the group of the 3 to 5 percent of individuals identified pursuant
to Section 12711.1 as the most expensive to treat.
10199.107. At the time an individual applies for health coverage from a health care service plan or health insurer participating in the individual market, an individual shall provide information as required by a standardized health status questionnaire to assist plans and insurers in identifying persons in need of disease management. Health care service plans and health insurers may not use information provided on the questionnaire to decline coverage, or to limit an individual's choice of health care benefit plan, except as provided in Section 12711.1.

10199.108. Health benefit plans shall become effective within 31 days of receipt of the individual’s application, standardized health status questionnaire, and premium payment.

10199.109. Health care service plans and health insurers may reject an application for health care benefits if the individual does not reside or work in a plan’s or insurer’s approved service area.

10199.110. The commissioner or the Director of the Department of Managed Health Care, as applicable, may require a health care service plan or health insurer to discontinue the offering of health care benefits, or acceptance of applications from individuals, upon a determination by the director or commissioner that the plan or insurer does not have sufficient financial viability, or organizational and administrative capacity, to ensure the delivery of health care benefits to its enrollees or insureds.

10199.111. All health care benefits offered to individuals shall be renewable with respect to all individuals and dependents at the option of the subscriber, except:

(a) For nonpayment of the required premiums by the subscriber.

(b) When the plan or insurer withdraws from the individual health care market, subject to rules and requirements jointly adopted by the director and the Insurance Commissioner.

10199.112. No health care service plan or health insurer shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract or health insurance policy to be varied because of the health status, claims experience, occupation, or geographic location of the individual, provided the geographic location is within the plan’s or insurer’s approved service area.

10199.113. This chapter shall not apply to individual health plan contracts for coverage of Medicare services pursuant to
contracts with the United States Government, Medi-Cal contracts
with the State Department of Health Care Services, Healthy Family
contracts with the Managed Risk Medical Insurance Board,
high-risk pool contracts with the Major Risk Medical Insurance
Program, Medicare supplement policies, long-term care policies,
specialized health plan contracts, or contracts issued to individuals
who secure coverage from Cal-CHIPP.

10199.114. (a) A health care service plan or health insurer
may rate its entire portfolio of health benefit plans in accordance
with expected costs or other market considerations, but the rate
for each plan or insurer shall be set in relation to the balance of
the portfolio as certified by an actuary. Each benefit plan shall be
priced as determined by each health care service plan or health
insurer to reflect the difference in benefit variation, or the
effectiveness of a provider network, but may not adjust the rate
for a specific plan for risk selection. A health care service plan’s
or health insurer’s rates shall use the same rating factors for age,
family size, and geographic location for each individual health
care benefit plan it issues. Rates for health care benefits may vary
from applicant to applicant only by any of the following:

(1) Age of the subscriber, as determined by the commissioner
and the Director of the Department of Managed Health Care.

(2) Family size in categories determined by the commissioner
and the Director of the Department of Managed Health Care.

(3) Geographic rate regions as determined by the commissioner
and the Director of the Department of Managed Health Care.

(4) Health improvement discounts. A health care service plan
or health insurer may reduce copayments or offer premium
discounts for nonsmokers, individuals demonstrating weight loss
through a measurable health improvement program, or individuals
actively participating in a disease management program, provided
discounts are approved by the commissioner and the Director of
the Department of Managed Health Care.

(b) The commissioner and the Director of the Department of
Managed Health Care shall take into consideration the age, family
size, and geographic region rating categories applicable to small
group coverage contracts pursuant to Section 1357 of the Health
and Safety Code and Section 10700 of this code in implementing
this section.
10199.115. The first term of each health benefit plan contract or policy issued shall be from the effective date through the last day of the month immediately preceding the subscriber’s next birthday. Contracts or policies may be renewed by the subscriber as set forth in this chapter.

SEC. 11. Section 10293.5 is added to the Insurance Code, to read:

10293.5. (a) The commissioner shall adopt regulations no later than July 1, 2008, requiring that at least 85 percent of health insurance premium revenue received by a health insurer be spent on health care services. The regulations shall also define “health care services.”

(b) As used in this section, health insurance shall have the same meaning as in subdivision (b) of Section 106.

(c) The requirements of this chapter shall not apply to a Medicare supplement, vision-only, dental-only, or CHAMPUS-supplement insurance or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 12. Section 10607 of the Insurance Code is amended to read:

10607. In addition to the other disclosures required by this chapter, every insurer and their employees or agents shall, when presenting a plan for examination or sale to any individual or the representative of a group, disclose in writing the ratio of incurred claims to earned premiums (loss-ratio) for the insurer’s preceding calendar year for policies with individuals and with groups of the same or similar size for the insurer’s preceding fiscal year.

SEC. 13. Section 10700 of the Insurance Code is amended to read:

10700. As used in this chapter:

(a) “Agent or broker” means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who
are to provide those services and the sites where those services are
to be provided. A benefit plan design may also be an integrated
system for the financing and delivery of quality health care services
which has significant incentives for the covered individuals to use
the system.

(c) "Board" means the Major Risk Medical Insurance Board.

(d) "Carrier" means any disability insurance company or any
other entity that writes, issues, or administers health benefit plans
that cover the employees of small employers, regardless of the
situs of the contract or master policyholder. For the purposes of
Articles 3 (commencing with Section 10719) and 4 (commencing
with Section 10730), "carrier" also includes health care service
plans.

(e) "Dependent" means the spouse or child of an eligible
employee, subject to applicable terms of the health benefit plan
covering the employee, and includes dependents of guaranteed
association members if the association elects to include dependents
under its health coverage at the same time it determines its
membership composition pursuant to subdivision (z).

(f) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a
full-time basis in the conduct of the business of the small employer
with a normal workweek of at least 30 hours, in the small
employer’s regular place of business, who has met any statutorily
authorized applicable waiting period requirements. The term
includes sole proprietors or partners of a partnership, if they are
actively engaged on a full-time basis in the small employer’s
business, and they are included as employees under a health benefit
plan of a small employer, but does not include employees who
work on a part-time, temporary, or substitute basis. It includes any
eligible employee as defined in this paragraph who obtains
coverage through a guaranteed association. Employees of
employers purchasing through a guaranteed association shall be
deemed to be eligible employees if they would otherwise meet the
definition except for the number of persons employed by the
employer. A permanent employee who works at least 20 hours but
not more than 29 hours is deemed to be an eligible employee if all
four of the following apply:

(A) The employee otherwise meets the definition of an eligible
employee except for the number of hours worked.
(B) The employer offers the employee health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (z).

(g) “Enrollee” means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

(h) “Financially impaired” means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(i) “Fund” means the California Small Group Reinsurance Fund.

(j) “Health benefit plan” means a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(k) “In force business” means an existing health benefit plan issued by the carrier to a small employer.

(l) “Late enrollee” means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment.
period provided under the terms of the health benefit plan, and
who subsequently requests enrollment in a health benefit plan of
that small employer, provided that the initial enrollment period
shall be a period of at least 30 days. It also means any member of
an association that is a guaranteed association as well as any other
person eligible to purchase through the guaranteed association
when that person has failed to purchase coverage during the initial
enrollment period provided under the terms of the guaranteed
association’s health benefit plan and who subsequently requests
enrollment in the plan, provided that the initial enrollment period
shall be a period of at least 30 days. However, an eligible
employee, another person eligible for coverage through a
guaranteed association pursuant to subdivision (z), or an eligible
dependent shall not be considered a late enrollee if any of the
following is applicable:
(1) The individual meets all of the following requirements:
(A) He or she was covered under another employer health
benefit plan, the Healthy Families Program, or no share-of-cost
Medi-Cal coverage at the time the individual was eligible to enroll.
(B) He or she certified at the time of the initial enrollment that
coverage under another employer health benefit plan, the Healthy
Families Program, or no share-of-cost Medi-Cal coverage was the
reason for declining enrollment provided that, if the individual
was covered under another employer health plan, the individual
was given the opportunity to make the certification required by
this subdivision and was notified that failure to do so could result
in later treatment as a late enrollee.
(C) He or she has lost or will lose coverage under another
employer health benefit plan as a result of termination of
employment of the individual or of a person through whom the
individual was covered as a dependent, change in employment
status of the individual, or of a person through whom the individual
was covered as a dependent, the termination of the other plan’s
coverage, cessation of an employer’s contribution toward an
employee or dependent’s coverage, death of the person through
whom the individual was covered as a dependent, legal separation,
divorce, loss of coverage under the Healthy Families Program as
a result of exceeding the program’s income or age limits, or loss
of no share-of-cost Medi-Cal coverage.
(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee’s health benefit plan.

(4) (A) In the case of an eligible employee as defined in paragraph (1) of subdivision (f), the carrier cannot produce a written statement from the employer stating that the individual or the person through whom an individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual’s later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) In the case of an eligible employee who is a guaranteed association member, the plan cannot produce a written statement from the guaranteed association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member’s later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph
(2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for coverage was made within 30 days of the change.

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of “COBRA” set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program as a result of exceeding the program’s income or age limits or no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf, and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health
coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(m) “New business” means a health benefit plan issued to a small employer that is not the carrier’s in force business.

(n) “Participating carrier” means a carrier that has entered into a contract with the program to provide health benefits coverage under this part.

(o) “Plan of operation” means the plan of operation of the fund, including articles, bylaws and operating rules adopted by the fund pursuant to Article 3 (commencing with Section 10719).

(p) “Program” means the Health Insurance Plan of California.

(q) “Preexisting condition provision” means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured’s effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(r) “Creditable coverage” means:
1. Any individual or group policy, contract, or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
(3) The Medicaid program pursuant to Title XIX of the Social Security Act.
(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).
(6) A medical care program of the Indian Health Service or of a tribal organization.
(7) A state health benefits risk pool.
(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).
(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(s) “Rating period” means the period for which premium rates established by a carrier are in effect and shall be no less than six months.
(t) “Risk adjusted employee risk rate” means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.
(u) “Risk adjustment factor” means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. On and after January 1, 2010, no risk adjustment factor shall be applied.
(v) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.
(1) No more than the following age categories may be used in determining premium rates:

- Under 30
- 30–39
- 40–49
- 50–54
- 55–59
- 60–64
- 65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

- (A) Single.
- (B) Married couple.
- (C) One adult and child or children.
- (D) Married couple and child or children.

(3) (A) In determining rates for small employers, a carrier that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and shall divide no county into more than two regions. Carriers shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state’s population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

- (B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties which are included in their entirety in a carrier’s service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three
digits of all its ZIP Codes are in common within a county and no
county may be divided into more than two regions. The area
encompassed in a geographic region shall be separate and distinct
from areas encompassed in other geographic regions. Geographic
regions may be noncontiguous. No carrier shall have less than one
geographic area.

(w) “Small employer” means either of the following:
(1) Any person, proprietary or nonprofit firm, corporation,
partnership, public agency, or association that is actively engaged
in business or service that, on at least 50 percent of its working
days during the preceding calendar quarter, or preceding calendar
year, employed at least two, but not more than 50, eligible
employees, the majority of whom were employed within this state,
that was not formed primarily for purposes of buying health
insurance and in which a bona fide employer-employee relationship
exists. In determining whether to apply the calendar quarter or
calendar year test, the insurer shall use the test that ensures
eligibility if only one test would establish eligibility. However,
for purposes of subdivisions (b) and (h) of Section 10705, the
definition shall include employers with at least three eligible
employees until July 1, 1997, and two eligible employees
thereafter. In determining the number of eligible employees,
companies that are affiliated companies and that are eligible to file
a combined income tax return for purposes of state taxation shall
be considered one employer. Subsequent to the issuance of a health
benefit plan to a small employer pursuant to this chapter, and for
the purpose of determining eligibility, the size of a small employer
shall be determined annually. Except as otherwise specifically
provided, provisions of this chapter that apply to a small employer
shall continue to apply until the health benefit plan anniversary
following the date the employer no longer meets the requirements
of this definition. It includes any small employer as defined in this
paragraph who purchases coverage through a guaranteed
association, and any employer purchasing coverage for employees
through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (y),
that purchases health coverage for members of the association.

(x) “Standard employee risk rate” means the rate applicable to
an eligible employee in a particular risk category in a small
employer group.
(y) “Guaranteed association” means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a master policy by an admitted insurer is delivered directly to the association or a trust formed for or sponsored by an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(z) “Members of a guaranteed association” means any individual or employer meeting the association’s membership criteria if that
person is a member of the association and chooses to purchase
health coverage through the association. At the association’s
discretion, it may also include employees of association members,
association staff, retired members, retired employees of members,
and surviving spouses and dependents of deceased members.
However, if an association chooses to include those persons as
members of the guaranteed association, the association must so
elect in advance of purchasing coverage from a plan. Health plans
may require an association to adhere to the membership
composition it selects for up to 12 months.

(aa) “Affiliation period” means a period that, under the terms
of the health benefit plan, must expire before health care services
under the plan become effective.

SEC. 14. Section 10714 of the Insurance Code is amended to
read:

10714. Premiums for benefit plan designs written, issued, or
administered by carriers on or after the effective date of this act,
shall be subject to the following requirements:
(a) (1) The premium for new business shall be determined for
an eligible employee in a particular risk category after applying a
risk adjustment factor to the carrier’s standard employee risk rates.
The risk adjusted employee risk rate may not be more than 120
percent or less than 80 percent of the carrier’s applicable standard
employee risk rate until July 1, 1996. Effective July 1, 1996, the
risk adjusted employee risk rate may not be more than 110 percent
or less than 90 percent. On and after January 1, 2010, no risk
adjustment factor shall be applied.
(2) The premium charged a small employer for new business
shall be equal to the sum of the risk adjusted employee risk rates.
(b) (1) The premium for in force business shall be determined
for an eligible employee in a particular risk category after applying
a risk adjustment factor to the carrier’s standard employee risk
rates. The risk adjusted employee risk rates may not be more than
120 percent or less than 80 percent of the carrier’s applicable
standard employee risk rate until July 1, 1996. Effective July 1,
1996, the risk adjusted employee risk rate may not be more than
110 percent or less than 90 percent. The factor effective July 1,
1996, shall apply to in force business at the earlier of either the
time of renewal or July 1, 1997. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months. On and after January 1, 2010, no risk adjustment factor shall be applied.

(2) The premium charged a small employer for in force business shall be equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for no less than six months.

(3) For a benefit plan design that a carrier has discontinued offering, the risk adjustment factor applied to the standard employee risk rates for the first rating period of the new benefit plan design that the small employer elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued benefit plan design. However, the risk adjusted employee rate may not be more than 120 percent or less than 80 percent of the carrier’s applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, the risk adjusted employee rate may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the time of renewal or July 1, 1997. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months. On and after January 1, 2010, no risk adjustment factor shall be applied.

(c) (1) For any small employer, a carrier may, with the consent of the small employer, establish composite employee and dependent rates for either new business or renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivisions (a) and (b). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.

(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of no less than six months, nor more than 12 months, except that a carrier may reserve the right to redetermine the composite rates if the enrollment under the health benefit plan changes by more than a specified percentage during the rating period. Any redetermination of the composite
rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period.

If a carrier reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the carrier shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A carrier reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

(d) Nothing in this section shall be construed to prevent an insurer from changing the standard employee risk rates applied to a small employer in order to ensure that the insurer’s rates for a standard benefit plan design sold pursuant to Section 10761 are not less than the insurer’s rates for the same benefit plan design sold through the California Cooperative Health Insurance Purchasing Program (Part 6.45 (commencing with Section 12699.201)).

SEC. 15. 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. Effective July 1, 2008, every insurer that offers, markets, and sells health insurance to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board. A health insurer subject to this section may not exclude a potential insured from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1.

10761. The department, in consultation with the Department of Managed Health Care, shall require each health insurer with one million or more insureds in California, based on the insurer’s enrollment in the prior year, to submit a good faith bid to the Managed Risk Medical Insurance Board in order to be a participating plan through the California Cooperative Health
Insurance Purchasing Program (Cal-CHIPP) pursuant to Part 6.45 (commencing with Section 12699.201).

10762. It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient’s personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health insurers and providers shall adopt standard electronic medical records by January 1, 2012.

10763. On and after July 1, 2008, 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 carrier’s health benefit plan designs to all employers, guaranteed renewal of all health benefit plan designs, 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 plan designs offered to all employers with 100 or fewer eligible employees, except as follows:

(a) For small employers with 2 to 50, inclusive, eligible employees, all requirements in that chapter shall apply.

(b) For employers with 51 to 100, inclusive, eligible employees, all requirements in that chapter shall apply, except that the carrier may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 100 eligible employees.

(c) On and after January 1, 2010, no risk adjustment factor shall be applied to a policy offered to an employer with 51 to 100, inclusive, eligible employees.

10764. (a) Every group health insurer shall obtain from each employer or group policyholder contracting with the health insurer the premium contribution amounts the employer or group makes for each enrolled group member and dependent using the family size categories premium payments made to the group plan.

(b) (1) Every health insurer offering group health insurance policies shall provide as one coverage option of each group policy a Cal CHIP Healthy Families plan established by the board so that group members and their dependents with family incomes at
or below 300 percent of the federal poverty level that are
determined eligible for coverage through the Healthy Families
Program or who are eligible for Medi-Cal pursuant to Section
14005.301 of the Welfare and Institutions Code can enroll in the
Cal-CHIPP Healthy Families plan. The Cal-CHIPP Healthy
Families plan of a group health insurer shall be provided at a rate
negotiated with and approved by the board. The health insurer
shall collect the employer’s applicable dollar premium contribution
for employees and, if applicable, dependents in the Cal-CHIPP
Healthy Families plan and credit that amount toward the cost of
the Cal-CHIPP Healthy Families plan.

(2) In lieu of meeting the requirements of paragraph (1), for
employees and, if applicable, dependents eligible for coverage
through the Healthy Families Program who have elected to enroll
in a Cal-CHIPP Healthy Families plan, the health insurer shall
instead collect an amount determined by the board but not to
exceed the employer’s applicable dollar premium contribution as
identified in subdivision (a) and transmit that amount to the board
towards the premium cost of a Cal-CHIPP Healthy Families plan.

(c) (1) Every health insurer offering group health policies shall
provide as one coverage option of each group contract a Cal-CHIPP
Medi-Cal plan established by the board so that group members
and their dependents that are determined eligible for coverage
through the Medi-Cal program, except for coverage pursuant to
Section 14005.301 of the Welfare and Institutions Code, can enroll
in the Cal-CHIPP Medi-Cal plan. The Cal-CHIPP Medi-Cal plan
of a group health insurer shall be provided at a rate negotiated with
and approved by the board. The health insurer shall collect the
employer’s applicable dollar premium contribution for employees
and, if applicable, dependents in the Cal-CHIPP Medi-Cal plan
and credit that amount toward the cost of the Cal-CHIPP Medi-Cal
plan.

(2) In lieu of meeting the requirements of paragraph (1), for
employees, and, if applicable, dependents eligible for coverage
through the Medi-Cal program who have elected to enroll in a
Cal-CHIPP Medi-Cal plan, the health insurer shall instead collect
an amount determined by the board but not to exceed the
employer’s applicable dollar premium contribution as identified
in subdivision (a) and transmit that amount to the board towards
the premium cost of a Cal-CHIPP Medi-Cal plan in Cal-CHIPP.
Every health insurer plan shall include in the plan’s evidence of coverage notice of the ability of employees and dependents with family incomes at or below 300 percent of the federal poverty level to enroll in Medi-Cal or Healthy Families coverage through a Cal-CHIPP Healthy Families plan or a Cal-CHIPP Medi-Cal plan, with instructions on how to apply for coverage.

10764. (a) For employees and, if applicable, dependents who are currently enrolled in or determined eligible for coverage through the Healthy Families Program or the Medi-Cal program and who are offered group coverage, the group health insurer shall collect the employer’s applicable dollar premium contribution for those employees and, if applicable, dependents and transmit that amount to the board toward the premium cost of the applicable Cal-CHIPP plan.

(b) The department, in consultation with the board, may issue regulations, as necessary pursuant to the Administrative Procedure Act, to implement the requirements of this section. Until January 1, 2012, the adoption and readoption of regulations pursuant to this chapter shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare.

(f) Employees and dependents receiving coverage through the Medi-Cal program or Healthy Families Program pursuant to this section shall make premium payments, if any, as determined by the board and shall pay other cost sharing amounts. The amount of the premium payments and cost sharing shall not exceed premium payments or cost sharing levels for enrollment in those programs required under the applicable state laws governing those programs. The board shall consider using the process in effect on January 1, 2008, for determining eligibility for the Medi-Cal program, including the eligibility determination made by the counties.

(c) As used in this section, the following terms have the following meanings:

(1) “Board” means the Managed Risk Medical Insurance Board.

(2) “California Cooperative Health Insurance Purchasing Program” or “Cal-CHIPP” shall have the same meaning as in subdivision (c) of Section 12699.201.
1 (3) “Cal-CHIPP Healthy Families plan” shall have the same
2 meaning as in Section 12699.201.
3 (4) “Cal-CHIPP Medi-Cal plan” shall mean a health insurance
4 policy providing the same amount, duration, scope, and level of
5 coverage provided through the Medi-Cal program (Chapter 7
6 (commencing with Section 14000) of Part 3 of Division 9 of the
7 Welfare and Institutions Code).
8 (h) This section shall apply to health insurance policies issued,
9 amended, or renewed on or after January 1, 2010.
10 10765. (a) As used in this chapter, “health insurance” shall
11 have the same meaning as in subdivision (b) of Section 106.
12 (b) The requirements of this chapter shall not apply to a
13 Medicare supplement, vision-only, dental-only, or
14 CHAMPUS-supplement insurance or to hospital indemnity,
15 hospital-only, accident-only, or specified disease insurance that
16 does not pay benefits on a fixed benefit, cash payment only basis.
17 10766. This chapter shall become operative on July 1, 2008.
18 SEC. 16. Section 12693.43 of the Insurance Code is amended
19 to read:
20 12693.43. (a) Applicants applying to the purchasing pool shall
21 agree to pay family contributions, unless the applicant has a family
22 contribution sponsor. Family contribution amounts consist of the
23 following two components:
24 (1) The flat fees described in subdivision (b) or (d).
25 (2) Any amounts that are charged to the program by participating
26 health, dental, and vision plans selected by the applicant that exceed
27 the cost to the program of the highest cost family value package
28 in a given geographic area.
29 (b) In each geographic area, the board shall designate one or
30 more family value packages for which the required total family
31 contribution is:
32 (1) Seven dollars ($7) per child with a maximum required
33 contribution of fourteen dollars ($14) per month per family for
34 applicants with annual household incomes up to and including 150
35 percent of the federal poverty level.
36 (2) Nine dollars ($9) per child with a maximum required
37 contribution of twenty-seven dollars ($27) per month per family
38 for applicants with annual household incomes greater than 150
39 percent and up to and including 200 percent of the federal poverty
40
level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-five dollars ($25) per child with a maximum required contribution of seventy-five dollars ($75) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost family value package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost family value package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month
(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-two dollars ($22) per child with a maximum required contribution of sixty-six dollars ($66) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.
(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

SEC. 17. Section 12693.57 is added to the Insurance Code, to read:

12693.57. Every person administering or providing benefits under the program shall perform his or her duties in such a manner as to secure for every subscriber the amount of assistance to which the subscriber is entitled, without attempting to elicit any information that is not required to carry out the provisions of law applicable to the program.

SEC. 18. Section 12693.58 is added to the Insurance Code, to read:

12693.58. (a) All types of information, whether written or oral, concerning an applicant, subscriber, or household member, made or kept by any public officer or agency in connection with the administration of any provision of this part shall be confidential, and shall not be open to examination other than for purposes directly connected with the administration of the Healthy Families Program or the Medi-Cal program.

(b) Except as provided in this section and to the extent permitted by federal law or regulation, all information about applicants, subscribers, and household members to be safeguarded as provided
for in subdivision (a) includes, but is not limited to, names and
addresses, medical services provided, social and economic
conditions or circumstances, agency evaluation of personal
information, and medical data, including diagnosis and past history
of disease or disability.
(c) Purposes directly connected with the administration of the
Healthy Families Program or the Medi-Cal program encompass
all activities and responsibilities in which the Managed Risk
Medical Insurance Board or State Department of Health Care
Services and their agents, officers, trustees, employees, consultants,
and contractors engage to conduct program operations.
(d) Nothing in this section shall be construed to prohibit the
disclosure of information about the applicant, subscriber, or
household member when the applicant, subscriber, or household
member to whom the information pertains or the parent or adult
with legal custody provides express written authorization.
(e) Nothing in this part shall prohibit the disclosure of protected
health information as provided in 45 C.F.R. 164.512.
SEC. 19. Section 12693.59 is added to the Insurance Code, to
read:
12693.59. Nothing in this part shall preclude the board from
soliciting voluntary participation by applicants and subscribers in
communicating with the board, or with any other party, concerning
their needs as well as the needs of others who are not adequately
covered by existing private and public health care delivery systems
or concerning means of ensuring the availability of adequate health
care services. The board shall inform applicants and subscribers
that their participation is voluntary and shall inform them of the
uses for which the information is intended.
SEC. 20. Section 12693.621 is added to the Insurance Code, to
read:
12693.621. On and after January 1, 2010, the coverage under
this part for a child who is a dependent of an employee of an
employer electing to make a payment to the California Health
Trust Fund in lieu of making health expenditures pursuant to
Section 4802.1 of the Unemployment Insurance Code, shall be
provided through a Cal-CHIP Healthy Families plan under Part
6.45 (commencing with Section 12699.201). The requirement that
an individual enroll in a Cal-CHIP Healthy Families plan shall
apply to an individual enrolled in the Healthy Families Program
at the individual’s next annual redetermination of eligibility for
the Healthy Families Program, or earlier upon request.

SEC. 21. Section 12693.70 of the Insurance Code is amended
to read:

12693.70. To be eligible to participate in the program, an
applicant shall meet all of the following requirements:
(a) Be an applicant applying on behalf of an eligible child, which
means a child who is all of the following:
(1) Less than 19 years of age. An application may be made on
behalf of a child not yet born up to three months prior to the
expected date of delivery. Coverage shall begin as soon as
administratively feasible, as determined by the board, after the
board receives notification of the birth. However, no child less
than 12 months of age shall be eligible for coverage until 90 days
after the enactment of the Budget Act of 1999.
(2) Not eligible for no-cost full-scope Medi-Cal or Medicare
coverage at the time of application.
(3) In compliance with Sections 12693.71 and 12693.72.
(4) [Reserved].
(5) A resident of the State of California pursuant to Section 244
of the Government Code; or, if not a resident pursuant to Section
244 of the Government Code, is physically present in California
and entered the state with a job commitment or to seek
employment, whether or not employed at the time of application
to or after acceptance in, the program.
(6) (A) In either of the following:
(i) In a family with an annual or monthly household income
equal to or less than 200 percent of the federal poverty level.
(ii) When implemented by the board, subject to subdivision (b)
of Section 12693.765 and pursuant to this section, a child under
the age of two years who was delivered by a mother enrolled in
the Access for Infants and Mothers Program as described in Part
6.3 (commencing with Section 12695). Commencing July 1, 2007,
eligibility under this subparagraph shall not include infants during
any time they are enrolled in employer-sponsored health insurance
or are subject to an exclusion pursuant to Section 12693.71 or
12693.72, or are enrolled in the full scope of benefits under the
Medi-Cal program at no share of cost. For purposes of this clause,
any infant born to a woman whose enrollment in the Access for
Infants and Mothers Program begins after June 30, 2004, shall be
automatically enrolled in the Healthy Families Program, except
during any time on or after July 1, 2007, that the infant is enrolled
in employer-sponsored health insurance or is subject to an
exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled
in the full scope of benefits under the Medi-Cal program at no
share of cost. Except as otherwise specified in this section, this
enrollment shall cover the first 12 months of the infant’s life. At
the end of the 12 months, as a condition of continued eligibility,
the applicant shall provide income information. The infant shall
be disenrolled if the gross annual household income exceeds the
income eligibility standard that was in effect in the Access for
Infants and Mothers Program at the time the infant’s mother
became eligible, or following the two-month period established
in Section 12693.981 if the infant is eligible for Medi-Cal with no
share of cost. At the end of the second year, infants shall again be
screened for program eligibility pursuant to this section, with
income eligibility evaluated pursuant to clause (i), subparagraphs
(B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level
but less than or equal to 250 percent of the federal poverty level
shall be disregarded in calculating annual or monthly household
income. On and after July 1, 2008, all income over 250 percent of
the federal poverty level but less than or equal to 300 percent of
the federal poverty level shall be disregarded in calculating annual
or monthly household income.

(C) In a family with an annual or monthly household income
greater than 250 percent of the federal poverty level, any income
deduction that is applicable to a child under Medi-Cal shall be
applied in determining the annual or monthly household income.
If the income deductions reduce the annual or monthly household
income to 250 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(D) On and after July 1, 2008, in a family with an annual or
monthly household income greater than 300 percent of the federal
poverty level, any income deduction that is applicable to a child
under the Medi-Cal program shall be applied in determining the
annual or monthly household income. If the income deductions
reduce the annual or monthly household income to 300 percent or
less of the federal poverty level, subparagraph (B) shall apply.
(b) The applicant shall agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant’s eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant’s income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant’s signed statement as to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

(f) By January 2008, the board, in consultation with stakeholders, shall implement processes by which applicants for subscribers may certify income at the time of annual eligibility review, including rules concerning which applicants shall be permitted to certify income and the circumstances in which supplemental information or documentation may be required. The board may terminate using these processes not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the termination and shall include all relevant data elements that are applicable to document the reasons for the termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the board shall promptly provide any additional clarifying information regarding implementation of the processes required by this subdivision.

SEC. 22. Section 12693.73 of the Insurance Code is amended to read:

12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program, except as specified in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 and Section 12693.76, or except children who otherwise meet eligibility requirements for the program but for their immigration status.

SEC. 23. Section 12693.755 of the Insurance Code is amended to read:
Subject to subdivision (b), but no later than July 1, 2008, the board shall expand eligibility under this part to uninsured parents of, and as defined by the board, adults responsible for, children enrolled to receive coverage under this part whose income does not exceed 300 percent of the federal poverty level, before applying the income disregard provided for in subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70.

(b) (1) The board shall implement a program to provide coverage under this part to any uninsured parent or responsible adult who is eligible pursuant to subdivision (a), pursuant to the waiver or approval identified in paragraph (2).

(2) The program shall be implemented only in accordance with a State Child Health Insurance Program waiver or other federal approval pursuant to Section 1397gg(e)(2)(A) of Title 42 of the United States Code, or pursuant to the Deficit Reduction Act of 2005, Section 6044 of Public Law 109-171, to provide coverage to uninsured parents and responsible adults, and shall be subject to the terms, conditions, and duration of the waiver or other federal approval. The services shall be provided under the program only if the waiver or other federal approval is approved by the federal Centers for Medicare and Medicaid Services, and, except as provided under the terms and conditions of the waiver or other federal approval, only to the extent that federal financial participation is available and funds are appropriated specifically for this purpose.

(c) The coverage under this section for a person who is an employee or, if applicable, an adult dependent of an employee, of an employer electing to make a payment to the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code, shall be provided through a Cal-CHIPP Healthy Families plan under Part 6.45 (commencing with Section 12699.201).

SEC. 24. Section 12693.76 of the Insurance Code is amended to read:

12693.76. (a) Notwithstanding any other provision of law, a child shall not be determined ineligible solely on the basis of his or her date of entry into the United States.
(b) Notwithstanding any other provision of law, subdivision (a) may only be implemented to the extent provided in the annual Budget Act.

(c) Notwithstanding any other provision of law, any uninsured parent or responsible adult who is a qualified alien, as defined in Section 1641 of Title 8 of the United States Code, shall not be determined to be ineligible solely on the basis of his or her date of entry into the United States.

(d) Notwithstanding any other provision of law, subdivision (c) may only be implemented to the extent of funding provided in the annual Budget Act.

(e) Notwithstanding any other provision of law, a child who is otherwise eligible to participate in the program shall not be determined ineligible solely on the basis of his or her immigration status.

SEC. 25. Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM

Chapter 1. General Provisions

12699.201. For the purposes of this part, the following terms have the following meanings:

(a) “Benefit plan design” means a specific health coverage product offered for sale and includes services covered and the levels of copayments, deductibles, and annual out-of-pocket expenses, and may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services that has significant incentives for the covered individuals to use the system.

(b) “Board” means the Managed Risk Medical Insurance Board.

(c) “California Cooperative Health Insurance Purchasing Program” or “Cal-CHIPP” means the statewide purchasing pool established pursuant to this part and administered by the board.

(d) “Dependent” shall have the same meaning as in Section 4800.02 of the Unemployment Insurance Code.
(e) “Enrollee” means an individual who is eligible for, and participates in, Cal-CHIPP.

(f) “Fund” means the California Health Trust Fund established pursuant to Section 12699.212.

(g) “Cal-CHIPP Healthy Families plan” shall mean health care coverage provided through a health care service plan or a health insurer that provides either of the following:

1. For individuals less than 19 years of age, the same amount, duration, scope, and level of coverage provided through the Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2.

2. For individuals eligible pursuant to Section 12693.755 or Section 14005.301 of the Welfare and Institutions Code, coverage that meets the requirements of federal law and that, at a minimum, provides the same covered services and benefits required under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) plus prescription drugs.

(h) “Cal-CHIPP Medi-Cal plan” shall mean health care coverage provided through a health care service plan or health insurer that provides the same amount, duration, scope, and level of coverage provided through the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(i) “Participating dental plan” means either a dental insurer holding a valid certificate of authority from the commissioner or a specialized health care service plan, as defined by subdivision (o) of Section 1345 of the Health and Safety Code, that contracts with the board to provide dental coverage to enrollees.

(j) “Participating health plan” means either a private health insurer holding a valid outstanding certificate of authority from the commissioner or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code that contracts with the board to provide coverage in Cal-CHIPP and, pursuant to its contract with the board, provides, arranges, pays for, or reimburses the costs of health services for Cal-CHIPP enrollees.

(k) “Participating vision care plan” means either an insurer holding a valid certificate of authority from the commissioner that issues vision-only coverage or a specialized health care service...
plan, as defined by subdivision (o) of Section 1345 of the Health and Safety Code, that contracts with the board to provide vision coverage to enrollees.

Chapter 2. Administration

12699.202. (a) The board shall be responsible for establishing Cal-CHIPP and administering this part.

(b) The board may do all of the following consistent with the standards of this part:

1. Determine eligibility and enrollment criteria and processes for Cal-CHIPP consistent with the eligibility standards in Chapter 3 (commencing with Section 12699.211).

2. Determine the participation requirements for enrollees.

3. Determine the participation requirements and the standards and selection criteria for participating health, dental, and vision care plans, including reasonable limits on a plan’s administrative costs to ensure that a plan expends on patient care not less than 85 percent of aggregate dues, fees, and other periodic payments received by the plan.

4. Determine when an enrollee’s coverage commences and the extent and scope of coverage.

5. Determine premium schedules, collect the premiums, and administer subsidies to eligible enrollees.

6. Determine rates paid to participating health, dental, and vision care plans.

7. Provide, or make available, coverage through participating health plans in Cal-CHIPP.

8. Provide, or make available, coverage through participating dental and vision care plans in Cal-CHIPP.

9. Provide for the processing of applications and the enrollment of enrollees.

10. Determine and approve the benefit designs and copayments for participating health, dental, and vision care plans.

11. Enter into contracts.

12. Sue and be sued.

13. Employ necessary staff.

14. Authorize expenditures, as necessary, from the fund to pay program expenses that exceed enrollee contributions and to administer Cal-CHIPP.
(15) Issue rules and regulations, as necessary.

(16) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue available in the fund, and if sufficient revenue is not available to pay the estimated expenditures, the board shall institute appropriate measures to ensure fiscal solvency. This paragraph shall not be construed to allow the board to deny enrollment of a person who otherwise meets the eligibility requirements of Chapter 3 (commencing with Section 12699.211) in order to ensure the fiscal solvency of the fund.

(17) Establish the criteria and procedures through which employers direct employees’ premium dollars, withheld under the terms of cafeteria plans pursuant to Section 4809 of the Unemployment Insurance Code, to Cal-CHIPP to be credited against the employees’ premium obligations.

(18) Share information obtained pursuant to this part with the Employment Development Department solely for the purpose of the administration and enforcement of this part.

(19) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

12699.203. The board shall develop and offer a variety of benefit plan designs, including low-cost plans for Cal-CHIPP enrollees who are adults with family incomes below 300 percent of the federal poverty level who are ineligible for coverage through the Healthy Families Program or the Medi-Cal program. In addition to these benefit plan designs, each participating health plan and health insurer shall offer a Cal-CHIPP Healthy Families plan and a Cal-CHIPP Medi-Cal plan, and the board shall limit enrollment in these plans only to eligible individuals. For purposes of the Cal-CHIPP Medi-Cal plan, the board shall enter into an agreement with the State Department of Health Care Services for the provision of the Cal-CHIPP Medi-Cal plan by the Medi-Cal program. The benefit plan designs shall include varying benefit levels, deductibles, coinsurance factors, or copayments, and annual limits on out-of-pocket expenses. In developing the benefit plan designs, the board shall comply with all of the following:

(a) The board shall take into consideration the levels of health care coverage provided in the state and medical economic factors as may be deemed appropriate. The board shall include coverage
and design elements that are reflective of and commensurate with
health insurance coverage provided through a representative
number of large insured employers in the state.

(b) All benefit plan designs shall meet the requirements of the
Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
(commencing with Section 1340) of Division 2 of the Health and
Safety Code) and shall include prescription drug benefits, combined
with enrollee cost-sharing levels that promote prevention and health
maintenance, including appropriate cost sharing for physician
office visits, diagnostic laboratory services, and maintenance
medications to manage chronic diseases, such as asthma, diabetes,
and heart disease.

(c) In determining the enrollee and dependent deductibles,
coinsurance, and copayment requirements, the board shall consider
whether those costs would deter an enrollee or his or her
dependents from obtaining appropriate and timely care, including
those enrollees with a low- or moderate-family income. The board
shall also consider the impact of these costs on an enrollee’s ability
to afford health care services.

(d) The board shall consult with the Insurance Commissioner,
the Director of the Department of Managed Health Care, and the
Director of the Department of Health Care Services.

12699.204. (a) The board may adjust premiums at a public
meeting of the board after providing, at minimum, 30 days’ public
notice of the adjustment. In making the adjustment, the board shall
take into account the costs of health care typically paid for by
employers and employees in California.

(b) Notwithstanding subdivision (a), the amount of the premium
paid by an employee with a household income at or below 300
percent of the federal poverty level shall not exceed 0 to 5 percent
of the household income, depending on the income, after taking
into account the tax savings the employee is able to realize by
using the cafeteria plan made available by his or her employer
pursuant to Section 4809 of the Unemployment Insurance Code.

(c) An employer may pay all, or a portion of, the premium
payment required of its employees enrolled in Cal-CHIP.

(d) Employees and dependents receiving coverage through the
Medi-Cal program or the Healthy Families Program pursuant to
this part shall make premium payments, if any, as determined by
the board, and pay other cost sharing amounts that do not exceed
premium payments and cost sharing levels for enrollment in those
programs required under the applicable state laws governing those
programs. The board shall consider using the process in effect on
January 1, 2008, for determining eligibility for the Medi-Cal
program including the eligibility determination made by the
counties.

12699.205. The board, in its contract with a participating health
plan, shall require that the plan utilize efficient practices to improve
and control costs. These practices shall include, but are not limited
to, the following:
(a) Preventive care.
(b) Care management for chronic diseases.
(c) Promotion of health information technology.
(d) Standardized billing practices.
(e) Reduction of medical errors.
(f) Incentives for healthy lifestyles.
(g) Patient cost-sharing to encourage the use of preventive and
appropriate care.
(h) Rational use of new technology.

12699.206. (a) The board shall negotiate with Medi-Cal
managed care plans to obtain affordable coverage for eligible
enrollees.
(b) The board shall implement the requirements for a Cal-CHIPP
Medi-Cal plan or a Cal-CHIPP Healthy Families plan as required
pursuant to Section 1357.24 of the Health and Safety Code and
Section 10764, and shall limit enrollment in these plans only to
eligible individuals.
(c) The board, in consultation with the State Department of
Health Care Services, shall take all reasonable steps necessary to
maximize federal funding and support federal claiming in the
administration of the purchasing pool created pursuant to this part.

12699.206.1. (a) To provide prescription drug coverage for
Cal-CHIPP enrollees, the board may take any of the following
actions:
(1) Contract directly with health care service plans or health
insurers for prescription drug coverage as a component of a health
care service plan contract or a health insurance policy.
(2) Contract with a pharmacy benefits manager (PBM) if the
PBM meets transparency and disclosure requirements established
by the board.
(3) Procure products directly through the prescription drug purchasing program established pursuant to Chapter 12 (commencing with Section 14977) of Part 5.5 of Division 3 of Title 2 of the Government Code.

(b) The board may engage in any of the activities described in subdivision (a), or in any cost-effective combination of those activities.

(c) If the board enters into a prescription drug purchasing arrangement pursuant to paragraph (2) or (3) of subdivision (a), the board may allow any of the following entities to participate in that arrangement:

(1) Any state, district, county, city, municipal, or other public agency or governmental entity.

(2) A board or administrator responsible for providing or delivering health care coverage pursuant to a collective bargaining agreement, memorandum of understanding, or other similar agreement with a labor organization.

12699.206.2. (a) All information, whether written or oral, concerning an applicant to Cal-CHIPP, an enrollee in Cal-CHIPP, or a household member of the applicant or enrollee, created or maintained by a public officer or agency in connection with the administration of this part shall be confidential and shall not be open to examination other than for purposes directly connected with the administration of this part. “Purposes directly connected with the administration of this part” includes all activities and responsibilities in which the board or the State Department of Health Care Services and their agents, officers, trustees, employees, consultants, and contractors engage to conduct program operations.

(b) Information subject to the provisions of this section includes, but is not limited to, names and addresses, medical services provided to an enrollee, social and economic conditions or circumstances, agency evaluation of personal information, and medical data, such as diagnosis and health history.

(c) Nothing in this section shall be construed to prohibit the disclosure of information about applicants and enrollees, or their household members, if express written authorization for the disclosure has been provided by the person to whom the information pertains or, if that person is a minor, authorization has been provided by the minor’s parent or other adult with legal custody of the minor.
(d) Nothing in this part shall prohibit the disclosure of protected health information as provided in Section 164.152 of Title 45 of the Code of Federal Regulations.

12699.207. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

(b) Participating health, dental, and vision care plans that contract with the board shall be regulated by either the Insurance Commissioner or the Department of Managed Health Care and shall be licensed and in good standing with their respective licensing agency. In their application to Cal-CHIPP and upon request by the board, the participating health, dental, and vision care plans shall provide assurance of their licensure and standing with the appropriate licensing agency.

12699.208. The board shall collect and disseminate, as appropriate and to the extent possible, information on the quality of participating health, dental, and vision care plans and each plan’s cost-effectiveness to assist enrollees in selecting a plan.

12699.209. The board shall establish a working group for the purpose of developing recommendations to broaden access to Cal-CHIPP to all self-employed individuals and submit the recommendations to the Legislature on or before January 1, 2009.

12699.210. The provisions of Section 12693.54 shall apply to a contract entered into pursuant to this part.

Chapter 3. Eligibility

12699.211. (a) To be eligible to enroll in Cal-CHIPP, an individual shall meet all of the following requirements:

(1) Is a resident of the state pursuant to Section 244 of the Government Code or is physically present in the state, having entered the state with an employment commitment or to obtain employment, whether or not employed at the time of application to Cal-CHIPP or after enrollment in Cal-CHIPP.

(2) Is an employee or a dependent of an employee of an employer who elected to pay into the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code. To the extent an employer elects to pay into the California Health Trust Fund only for either
the employer’s part-time or full-time employees, only employees and dependents in the category of employees for which the employer has elected to pay shall be eligible to enroll in Cal-CHIP.

(b) Notwithstanding paragraph (2) of subdivision (a), eligible employees and, if applicable, dependents of eligible employees, eligible for coverage through a Cal-CHIP Medi-Cal plan or Cal-CHIP Healthy Families plan pursuant to paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) of Section 1357.24 of the Health and Safety Code or paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) of Section 10764 are eligible for Cal-CHIP. These employees and, if applicable, their dependents shall be limited to the choice of a Cal-CHIP Medi-Cal plan or a Cal-CHIP Healthy Families plan and shall not have access to other benefit plan options available to Cal-CHIP enrollees pursuant to Section 12699.203.

12699.211.01. (a) The failure of an employer to continue to pay the fee required by Section 4802.1 of the Unemployment Insurance Code shall not make an enrollee employed by that employer and the employee’s dependents, if any, ineligible for participation in Cal-CHIP until the last day of the second month following the month in which the employer failed to make the fee payment.

(b) If an employer fails to make the fee payment by the 15th day of each month, the board shall notify the employer and its employees enrolled in Cal-CHIP of the following information within 15 days of the employer’s failure to make the required fee payment:

(1) The employer’s failure to pay the fee by the 15th day of the month.

(2) The coverage of the employee and his or her dependents, if any, will terminate on the last day of the second month following the month in which the employer failed to make the fee payment, and the employee and his or her dependents, if any, shall be ineligible for Cal-CHIP.

(3) Their rights and remedies under law.

(c) The board may, through regulations adopted pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, allow an employee and his or her dependents, if any, whose employer failed to pay the fee
required by Section 4802.1 of the Unemployment Insurance Code,
to continue coverage for up to 36 months from the date of
ineligibility described in subdivision (b) if the employee pays the
total cost for the coverage. Subject to the availability of funds,
the board may, upon appropriation by the Legislature, use revenue
in the penalty account in the fund to subsidize the cost of coverage
under this subdivision.

Chapter 4. Fiscal

12699.212. (a) The California Health Trust Fund is hereby
created in the State Treasury. Notwithstanding Section 13340 of
the Government Code, the moneys in the fund shall be continuously
appropriated to the board, without regard to fiscal year, for the
purposes of providing health care coverage pursuant to this part.
Any moneys in the fund that are unexpended or unencumbered at
the end of a fiscal year, may be carried forward to the next
succeeding fiscal year.
(b) The board shall establish a prudent reserve in the fund.
(c) Notwithstanding Section 16305.7 of the Government Code,
all interest earned on the moneys that have been deposited into the
fund shall be retained in the fund.
12699.213. The board, subject to the approval of the
Department of Finance, may obtain loans from the General Fund
for all necessary and reasonable expenses related to the
administration of the fund.
12699.214. The board shall authorize, for the purposes of this
part, the expenditure from the fund of any state or federal revenue
or other revenue received from any source.
12699.215. The board may solicit and accept gifts,
contributions, and grants from any source, public or private, to
administer the program and shall deposit all revenue from those
sources into the fund.
12699.216. The board, subject to federal approval pursuant to
Section 14199.10 of the Welfare and Institutions Code, shall pay
the nonfederal share of cost from the fund for employees and
dependents eligible under that federal approval.
12699.217. This part shall become operative on January 1,
2009. The board shall provide health coverage pursuant to this
part on and after January 1, 2010.
SEC. 26. Section 12711.1 is added to the Insurance Code, to read:

12711.1. (a) The board shall establish a list of serious health conditions or diagnoses making an applicant automatically eligible for the program based on the standardized health questionnaire developed pursuant to subdivision (b). In developing the list of conditions, the board shall consult with the Director of the Department of Managed Health Care and the commissioner to identify common health plan and insurer underwriting criteria.

(b) The board shall develop a standardized health questionnaire to be used by all health plans and insurers that offer and sell individual coverage. The questionnaire shall provide for an objective evaluation of a person’s health status by assigning a discrete measure, such as a system of point scoring, to each person. The questionnaire shall be designed to identify the 3 to 5 percent of persons who are the most expensive to treat if covered under an individual health care service plan or an individual health insurance policy, and the board shall obtain from an actuary a certification that the standard health questionnaire meets this requirement. The questionnaire shall be designed to collect only that information necessary to identify if a person is eligible for coverage in the program pursuant to subdivision (a). Consistent with Section 1357.21 of the Health and Safety Code and Section 10761, health plans and insurers shall not deny coverage for any individual except for those who qualify for automatic eligibility for the program as determined by the board pursuant to this section.

(c) This section shall become operative on July 1, 2008.

SEC. 27. Section 131.1 is added to the Unemployment Insurance Code, to read:

131.1. “Contributions” also means the money payments to the California Health Trust Fund that are required by Division 1.2 (commencing with Section 4800).

SEC. 28. Section 144 of the Unemployment Insurance Code is amended to read:

144. “Worker contributions,” “contributions by workers,” “employee contributions,” or “contributions by employees” mean contributions to the Disability Fund or to the California Health Trust Fund.

SEC. 28.5. Section 683.5 is added to the Unemployment Insurance Code, to read:
683.5. (a) Commencing January 1, 2010, for the purposes of Division 1.2 (commencing with Section 4800), “employer” means the employer of record established by each county pursuant to Section 12302.25 of the Welfare and Institutions Code.

(b) Notwithstanding any other provision of law, recipients of in-home supportive services under Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code shall not be the employer for the purposes of Division 1.2 (commencing with Section 4800).

SEC. 29. Section 1095.1 is added to the Unemployment Insurance Code, to read:

1095.1. The director shall permit the use of any information in his or her possession to the extent necessary to provide information obtained in the administration and enforcement of the California Health Insurance Purchasing Pool Program (Division 1.2 (commencing with Section 4800)) to the Managed Risk Medical Insurance Board for the purpose of administering the California Health Care Reform and Cost Control Act, and may require reimbursement for all direct costs incurred in providing any and all information specified in this section.

SEC. 30. Division 1.2 (commencing with Section 4800) is added to the Unemployment Insurance Code, to read:

DIVISION 1.2. CALIFORNIA HEALTH INSURANCE PURCHASING POOL PROGRAM

Chapter 1. Administration and General Provisions

4800. The Employment Development Department shall administer and enforce this division. The department, in conjunction with other state entities, shall establish a process to resolve complaints regarding the administration of this division, including a toll-free telephone hotline number and an Internet Web site for employers, employees, and their dependents to access information and file complaints.

4800.01. The following provisions of this code shall apply to any amount required to be reported and paid under this division:

(a) Sections 301, 305, 306, 310, 311, 317, and 318, relating to general administrative powers of the department.
(b) Sections 403 to 413, inclusive, Section 1336, and Chapter 8 (commencing with Section 1951) of Part 1 of Division 1, relating to appeals and hearing procedures.

c) Article 7 (commencing with Section 1110) of Chapter 4 of Part 1 of Division 1 relating to making of returns or payment of reported contributions.

d) Article 8 (commencing with Section 1126) of Chapter 4 of Part 1 of Division 1, relating to assessments.

e) Article 9 (commencing with Section 1176), except Section 1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and overpayments.

(f) Article 10 (commencing with Section 1206) of Chapter 4 of Part 1 of Division 1, relating to notice.

g) Article 11 (commencing with Section 1221) of Chapter 4 of Part 1 of Division 1, relating to administrative appellate review.

(h) Article 12 (commencing with Section 1241) of Chapter 4 of Part 1 of Division 1, relating to judicial review.

(i) Chapter 7 (commencing with Section 1701) of Part 1 of Division 1, relating to collections.

(j) Chapter 10 (commencing with Section 2101) of Part 1 of Division 1, relating to violations.

4800.02. For the purposes of this division, the following definitions apply:

(a) “Board” means the Managed Risk Medical Insurance Board.

(b) “California Cooperative Health Insurance Purchasing Program” or “Cal-CHIPP” shall have the same meaning as in Section 12699.201 of the Insurance Code.

(c) “Department” means the Employment Development Department.

(d) “Dependent” means any of the following persons:

1. The spouse or registered domestic partner of an employee.

2. (A) An unmarried child under 23 years of age who is the natural child of the employee or an adopted child or a stepchild of the employee, as described in subparagraph (B), and who meets either of the following criteria:

   i. Lives with the employee.

   ii. Is economically dependent upon the employee.

   (B) (i) A child shall be considered to be adopted from the date on which the adoptive child’s birth parents, or other appropriate legal authority, sign a written document, including, but not limited
to, a health facility minor release report, a medical authorization
form, or a relinquishment form, granting the employee, or the
spouse of the employee, the right to control health care for the
adoptive child or, absent this written document, on the date
evidence exists of the right of the employee, or the spouse of the
employee, to control the health care of the child placed for
adoption.
(ii) A child shall be considered a stepchild upon the employee’s
marriage to the natural or adopted stepchild’s parent.
(3) An unmarried child 23 years of age or older who is an
adopted child or stepchild, as described in subparagraph (B) of
paragraph (2), of the enrollee or a natural child of the enrollee and
who at the time of attaining 23 years of age was incapable of
self-support because of a physical or mental disability that existed
continuously from a date prior to the child’s attainment of 23 years
of age.
(e) “Director” means the Director of Employment Development.
(f) “Employee” has the same meaning as set forth in Article 1.5
(commencing with Section 621).
(g) “Employer” has the meaning set forth in Section 683.5.
(h) (1) “Employer fee” means the payment required of an
employer electing to pay an equivalent amount into the fund
pursuant to subdivision (a) of Section 4802.1.
(2) For purposes of Part 1 (commencing with Section 100) of
Division 1 and Division 6, “employer fee” also means “employer
contributions” or “contributions.”
(i) “Employing unit” has the same meaning as set forth in
Section 135.
(j) “Employment” has the same meaning as set forth in Article
1 (commencing with Section 601) of Chapter 3 of Part 1 of
Division 1. Employment does not include services provided
pursuant to Sections 629 to 657, inclusive.
(k) “Fund” means the California Health Trust Fund established
pursuant to Section 12699.212 of the Insurance Code.
(l) (1) “Health expenditures” means any amount paid by an
employer subject to this division to, or on behalf of, its employees
and their dependents, if applicable, to provide health care or
health-related services or to reimburse the costs of those services, including, but not limited to, any of the following:

(A) Contributions to a health savings account as defined by Section 223 of the Internal Revenue Code or any other account having substantially the same purpose or effect.

(B) Reimbursement by the employer to its employees, and their dependents, if applicable, for incurred health care expenses, if those recipients have no entitlement to that reimbursement under any plan, fund, or program maintained by the employer. As used in this subparagraph, “health care expenses” includes, but is not limited to, an expense for which payment is deductible from personal income under Section 213(d) of the Internal Revenue Code.

(C) Programs to assist employees to attain and maintain healthy lifestyles, including, but not limited to, onsite wellness programs, reimbursement for attending offsite wellness programs, onsite health fairs and clinics, and financial incentives for participating in health screenings and other wellness activities.

(D) Disease management programs.

(E) Pharmacy benefit management programs.

(F) Care rendered to employees and their dependents by health care providers employed by or under contract to employers, such as employer-sponsored primary care clinics.

(G) Contributions made pursuant to Section 302 (c)(5) of the Labor Management Relations Act, under a collective bargaining agreement.

(H) Purchasing health care coverage from a health care service plan or a health insurer.

(2) “Health expenditures” does not include a payment made directly or indirectly for workers’ compensation, Medicare benefits, or any other health benefit cost or taxes, penalties, or assessment that the employer is required to pay by state or federal law, other than as required by Section 4802.1. “Health expenditures” does not include penalties imposed pursuant to this division.

(m) “Public program” means publicly funded health care coverage that is defined as creditable coverage in paragraphs (2) to (10), inclusive, of subdivision (g) of Section 1357 of the Health and Safety Code.

(n) “Wages” means all remuneration, as defined in Section 13009.5. Wages paid to an employee that are in excess of the
applicable contribution and benefit base, as determined under Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for the calendar year shall be excluded for the purposes of Section 4802.1.

(o) The definitions set forth in Sections 126, 127, 129, 133, and 134 shall apply to this division.

4800.03. The board shall annually publish information describing health plan choices in Cal-CHIPP for the department to disseminate to all employers making employer fee payments to the fund. The employer shall provide this information to all of its employees.

4800.04. The director shall provide to each employer a notice pursuant to Section 1089 and the employer shall post and distribute it in accordance with Section 1089 to inform employees and their dependents of the requirements of this division.

4800.05. The department shall provide information obtained in the administration and enforcement of this division to the board for the purpose of administering Cal-CHIPP.

4800.06. The department shall adopt rules and regulations to implement the provisions of this division.

4800.07. An employer shall file all forms required by this division by electronic means and shall remit all moneys owed pursuant to this division by electronic funds transfer. If an employer demonstrates to the director’s satisfaction that undue hardship would be imposed on it by this section, the director may authorize an exemption from this requirement. The director may assess a penalty of twenty-five dollars ($25) for each remittance that is not filed electronically.

Chapter 2. Employer Election

4802.1. (a) (1) Each employer shall elect to take one of the following actions:

(A) Make health expenditures as provided in subparagraph (A) of paragraph (3) for its full-time employees, and, if applicable, their dependents.

(B) Pay an equivalent amount into the fund.

(2) Each employer also shall elect to take one of the following actions:
(A) Make health expenditures as provided in subparagraph (B) of paragraph (3) for its part-time employees, and, if applicable, their dependents.

(B) Pay an equivalent amount into the fund.

(3) (A) An employer’s cumulative amount of health expenditures for the employer’s full-time employees working 120 or more hours per month shall be equivalent, at a minimum, to 7.5 percent of wages paid by the employer to its full-time employees. In computing this amount, wages paid to an employee that are in excess of the applicable contribution and benefit base, as determined under Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for the calendar year shall be excluded.

(B) An employer’s cumulative amount of health expenditures for the employer’s part-time employees working less than 120 hours per month shall be equivalent, at a minimum, to 7.5 percent of wages paid by the employer to its part-time employees. In computing this amount, wages paid to an employee that are in excess of the applicable contribution and benefit base, as determined under Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for the calendar year shall be excluded.

(b) (1) The amount payable to the fund by an employer electing to pay shall be deposited into the fund.

(2) The department, in consultation with the board, shall ensure that the employer fees paid pursuant to this section are deposited in the fund and are available to ensure the timely enrollment of eligible employees and their dependents, if any, in Cal-CHIPP.

(c) Notwithstanding subparagraphs (A) and (B) of paragraph (3) of subdivision (a), the board may adjust the health expenditure amounts required by those subparagraphs. The adjustments shall be made by the board at a public meeting of the board. On or before October 31 of each year, the board shall prepare a statement, which shall be a public record, setting forth the adjustments for the next calendar year and shall promptly notify the department of those adjustments.

4802.2. (a) If an employer is required by a collective bargaining agreement to make health expenditures on behalf of bargaining unit employees pursuant to Section 302 (c)(5) of the Labor Management Relations Act that, in the aggregate, equal or exceed the percentage of wages set forth in paragraph (3) of subdivision (a) of Section 4802.1 for those bargaining unit
employees, the employer shall be deemed to have satisfied the
requirements of subdivision (a) of Section 4802.1 with respect to
those bargaining unit employees.
(b) For purposes of the health expenditures requirement in
subdivision (a) of Section 4802.1, the department shall not accept
any employer fees made to the fund by an employer on behalf of
bargaining unit employees represented by a labor organization for
purposes of collective bargaining if notified by the labor
organization that the expenditures were made without express
written mutual agreement of the employer and the applicable labor
organization.
(c) An employer with employees represented by a labor
organization for purposes of collective bargaining shall participate
in the elections required by subdivision (a) of Section 4802.1
separately for each bargaining unit unless otherwise provided for
in the collective bargaining agreement.
(d) For all non-bargaining unit employees, the employer shall
participate in the elections as set forth in subdivision (a) of Section
4802.1.
4802.3. (a) An employee of an employer that elects, pursuant
to Section 4802.1, to pay an employer fee in lieu of making health
expenditures shall be required to enroll in Cal-CHIPP to receive
coverage under Cal-CHIPP. To the extent an employer elects,
pursuant to Section 4802.1, to pay an employer fee only for either
the employer’s part-time or full-time employees, only employees
and dependents in the category of employees for which the
employer has elected to pay shall be required to enroll in
Cal-CHIPP.
(b) (1) Notwithstanding subdivision (a), an employee is exempt
from enrolling in Cal-CHIPP if the employee is able to demonstrate
that he or she is covered by individual coverage that is in force on
the effective date of this section, a public program, or other group
health care coverage. An employee who is exempt under this
subdivision from enrolling in Cal-CHIPP may choose to enroll in
that program, however.
(2) Notwithstanding subdivision (a), an employee is exempt
from enrolling in Cal-CHIPP if the cost of coverage through
Cal-CHIPP exceeds 5 percent of wages paid by the electing
employer for coverage with a maximum out-of-pocket cost of one
thousand five hundred dollars ($1,500).
(c) (1) An employee of an employer that elects, pursuant to Section 4802.1, to make health expenditures shall accept the health expenditures made by the employer. However, for any employee with a household income of earning wages equivalent to 300 percent of the federal poverty level or less, if accepting an employer’s health expenditures would result in annual health expenditures by that employee in excess of 5 percent of his or her household income after taking into account any tax savings the employee is able to realize wages paid by the electing employer, that employee shall be exempt from the requirement to accept health expenditures made by his or her employer. For an employee earning wages equivalent to more than 300 percent of the federal poverty level, if accepting an employer’s health expenditures would result in annual health expenditures by that employee in excess of 5 percent of his or her wages paid by the electing employer, the employee shall be exempt from the requirement to accept health expenditures made by his or her employer.

(2) An employee that shows evidence of other group health care coverage or is covered by individual coverage that is in force on the effective date of this section shall not be required to accept health expenditures made by his or her employer. For an employee earning wages equivalent to more than 300 percent of the federal poverty level, if accepting an employer’s health expenditures would result in annual health expenditures by that employee in excess of 5 percent of his or her wages paid by the electing employer, the employee shall be exempt from the requirement to accept health expenditures made by his or her employer.

4803. (a) Each employer, prior to July 1, 2009, shall make an election pursuant to subdivision (a) of Section 4802.1 for its full-time employees and its part-time employees and notify the department of its election. An employer that fails to make an election by August 1, 2009, shall, within 30 days of that date be deemed to be an employer electing to pay an employer fee into the fund, unless the employer is able to demonstrate to the satisfaction of the department good cause for failure to make the election and that it is making health expenditures as described in Section 4802.1.

(b) After January 1, 2010, each employer shall notify the department on or before September 15 of each year of its election pursuant to subdivision (a) of Section 4802.1 for the subsequent calendar year, if different from the current year, on a form and in a format required by the department.

(c) A new employer, on and after July 1, 2009, within 30 days of paying total wages of one hundred dollars ($100) or more, shall make an election pursuant to subdivision (a) of Section 4802.1 for its full-time employees and its part-time employees. For purposes
of this subdivision, “new employer” shall have the same meaning
as set forth in Section 675. A new employer that fails to make an
election shall, within 30 days of the date of paying total wages of
one hundred dollars ($100) or more, be deemed to be an employer
electing to pay an employer fee into the fund, unless the new
employer is able to demonstrate to the satisfaction of the
department good cause for failure to make the election and that it
is making health expenditures as described in Section 4802.1.

4804. (a) On and after October 1, 2009, an employer electing
to pay an employer fee into the fund pursuant to subdivision (a)
of Section 4802.1 shall complete all of the following actions:
(1) File a monthly return with the department by the 15th day
of each month based on wages paid in the prior month. If an
employer paid no wages, the employer shall file a no payroll return
with the department.
(2) File with the department an annual return by January 31 of
each year on wages paid that month and in the prior calendar year.
(3) Remit the employer fee required by Section 4802.1 to the
department by the 15th day of each month based on wages paid
in the prior month.
(4) Notify all employees annually through a written notice to
each employee of the requirement in Section 4802.3 to enroll in
Cal-CHIPP and advise employees of the exemption from that
requirement under that section.
(5) Notify employees annually, through a written notice to each
employee, of the right to apply to the board to determine eligibility
for a subsidy under Cal-CHIPP.
(6) Comply with the requirements of Section 4807.
(b) An employer shall use the format developed by the
department for making the returns required by paragraphs (1) and
(2) of subdivision (a) and the remittance of the employer fee
required by paragraph (3) of subdivision (a).

4805. An employer that elects to pay an employer fee into the
fund pursuant to subdivision (a) of Section 4802.1 shall not change
that election for, at minimum, 24 months from the date of its first
payment into the fund.

4806. (a) On and after October 1, 2009, an employer electing
to make health expenditures pursuant to subdivision (a) of Section
4802.1 shall complete the following actions:
(1) File a quarterly return with the department on April 15, July 15, October 15, and January 15 of each year, reporting its wages and health expenditures for the prior quarter.

(2) File an annual return with the department by January 31 of each year reporting wages and health expenditures paid in the prior calendar year.

(3) Notify all employees annually through a written notice to each employee that employees with a family income at or below 300 percent of the federal poverty level are eligible to apply for the Medi-Cal program or the Healthy Families Program, including instructions on the application process for those programs.

(4) Comply with the requirements of subdivisions (a) and (b) of Section 4807.

(b) An employer shall use the format developed by the department to make the returns required by paragraphs (1) and (2) of subdivision (a).

4807. (a) An employer shall notify its employees of its election pursuant to subdivision (a) of Section 4802.1 to make health expenditures or to pay an employer fee into the fund within five business days of making the election and shall notify an employee hired after the date of that notification within five days of the employee’s date of hire.

(b) The employer shall notify its employees within five business days of the date it makes a change to its election decision.

(c) (1) An employer electing pursuant to subdivision (a) of Section 4802.1 to pay an employer fee shall within five business days of making that election notify its employees of the following:

(A) The employee’s requirement to enroll in Cal-CHIPP pursuant to Section 4802.3 and the exemption from enrollment in that section.

(B) The employee’s right to apply for a subsidy under Cal-CHIPP.

(2) The employer shall provide the notice required by this subdivision to an employee hired after the timeframe described in paragraph (1), within five business days of the employee’s date of hire.
Chapter 3. Cafeteria Plan

4809. (a) Unless provided otherwise by state or federal law, each employer in this state during a calendar year shall adopt and retain a cafeteria plan, within the meaning of Section 125 of the Internal Revenue Code, to allow employees to pay premiums for health care coverage, to the extent those payments are excludable from the gross income of the employee under Section 106 of the Internal Revenue Code.

(b) An employer that fails to adopt and retain a cafeteria plan is subject to a penalty of one hundred dollars ($100) for each of its employees during the calendar year unless the employer establishes, to the department’s satisfaction, good cause for the failure to adopt and retain the plan. An employer who willfully fails to adopt and retain a cafeteria plan is subject to a penalty of five hundred dollars ($500) for each of its employees during the calendar year.

Chapter 4. Enforcement

4811. (a) An employer that without good cause, as determined by the department, fails to complete any of the following actions shall be subject to assessment of a penalty as described in subdivision (b):

(1) Notify the department of its election pursuant to Section 4803.
(2) File returns required by Sections 4804 and 4806.
(3) Provide notices to its employees as required by Sections 4804, 4806, and 4807.

(b) The amount of the penalty for a first violation shall be twenty-five dollars ($25) for each of the employer’s employees at the time of the violation. The amount of the penalty for a second violation shall be fifty dollars ($50) for each of the employer’s employees at the time of the violation. The amount of the penalty for all subsequent violations shall be one hundred dollars ($100) for each of the employer’s employees at the time of the violation.

(c) The amount of the penalty described in subdivision (b) shall be increased by 10 percent if the employer without good cause, as determined by the department, fails to complete any of the actions
described in subdivision (a) within 60 days of the date it is required to be completed.

(d) (1) An employer that, without good cause, as determined by the department, fails to make any payments required of it or of its employees within the time required by this division, shall be assessed a penalty equaling 10 percent of the amount of the payment it failed to make or equaling 10 percent of the unpaid payment amount, if the employer failed to make the payment in its entirety.

(2) The amount of the penalty described in paragraph (1) shall be increased by 10 percent if the employer without good cause, as determined by the department, fails to make the payment required by this division within 60 days of the date the employer is required to make the payment.

(e) An employer that fails to file the annual return required by Sections 4804 and 4806 within 30 days of the date the employer was notified of its failure to file the return shall, in addition to any other penalties imposed by this code, be assessed an additional penalty of up to one hundred dollars ($100) for each of its employees at the time the return was due, unless the employer demonstrates, to the department’s satisfaction, good cause for its failure to file the return.

4812. If the director determines a return made by an employer inaccurately reports the amount of health expenditures or the amount of its employer fee payment required pursuant to Section 4802.1, he or she shall assess a penalty. The penalty amount shall be determined by the director based on the facts contained in the return or on his or her estimate of the correct amount of health expenditures or employer fees based on any information in his or her possession or that may come into his or her possession. If any part of the deficiency in the health expenditures or employer fee amount is due to negligence or intentional disregard of this division or the regulations adopted pursuant to it, the penalty shall be increased by an amount equaling 10 percent of the amount of the deficiency in the amount of the health expenditures or employer fees.

4813. If the employer’s failure to file a return or to make a payment within the time required by this division, and the regulations adopted pursuant to it, is due to fraud or to an intent to evade the provisions of this division, or of the regulations
adopted pursuant to it, a penalty equaling 50 percent of the amount
of the payment or of the health expenditures the employer was
required to make shall be assessed against the employer.

4814. (a) An employer that elects to pay the employer fee and
fails to withhold premium payment amounts authorized by an
employee pursuant to Section 12699.203 of the Insurance Code
and Section 4809 of this code is subject to a penalty equaling 200
percent of the amount the employer failed to withhold.

(b) An employer that fails to remit premium payment amounts
it withheld as authorized by an employee is subject to a penalty
equaling 200 percent of the amount the employer failed to remit.

(c) In addition to the penalties set forth in subdivisions (a) and
(b), the employer shall reimburse the employee for any health care
expenses incurred by the employee and his or her dependents
because of a lapse or cancellation of health care coverage resulting
from the employer’s failure to withhold or remit the employee’s
premium payment amounts.

4815. (a) An employer electing to make health expenditures
pursuant to Section 4802.1 that fails to make expenditures in the
amount required by that section shall be subject to a penalty in an
amount equaling 10 percent of the balance between the amount
required by Section 4802.1 and the amount of the health
expenditures made by the employer and shall be subject to a
penalty in an amount equaling 20 percent of that balance amount
if the amount of health expenditures made by the employer is less
than 80 percent of the amount required by Section 4802.1.

(b) If the employer fails to pay the penalty assessed pursuant to
subdivision (a) within 60 days of its assessment date, an additional
penalty shall be assessed against the employer in an amount
equaling 10 percent of the penalty assessed under subdivision (a).

(c) Notwithstanding subdivisions (a) and (b), an employer that
demonstrates good cause, as determined by the department, for its
failure to make the health expenditures amount required by Section
4802.1 is not subject to a penalty under this section.

(d) Penalties shall be assessed under this section pursuant to an
annual reconciliation and review process by the department.

4816. If the director is not satisfied with the accuracy or the
sufficiency of a return filed by an employer or of an employer fee
paid by an employer, he or she may assess a civil penalty in the
sum of _____ dollars ($____).
4817. It shall be unlawful for an employer to take any of the following actions if a purpose for the action is to avoid the requirements of this division:
(a) Designate an employee as a temporary employee.
(b) Reduce the number of hours of work of an employee.
(c) Terminate and rehire an employee.
4818. It is unlawful for a person to take any of the following actions.
(a) Willfully misclassify an employee as an independent contractor which misclassification results in avoiding the requirements of this division.
(b) Procure, counsel, advise, or coerce another to willfully make a false statement or representation or to knowingly fail to disclose a material fact in order to avoid the requirements of this division.
4819. An employer that takes any of the actions described in Section 4818 shall, in addition to any other fees or penalties imposed pursuant to this code, pay a penalty equaling 50 percent of the amount of all employer fees that would be required by this division if the employer elected to pay the employer fee or a penalty equaling 50 percent of the amount of all health expenditures that would be required by this division if the employer elected to make health care expenditures.
4821. (a) The director shall provide to each service recipient, as defined in paragraph (1) of subdivision (b) of Section 1088.8, a notice informing each service provider, as defined in paragraph (2) of subdivision (b) of Section 1088.8, of their rights, responsibilities, and the differences in workplace benefit coverage as an independent contractor, including their right to file for a status determination with the department. This notice shall be given by every service recipient required pursuant to Section 1088.8 to report payments equal to, or in excess of, six hundred dollars ($600) in any year to a service provider when the first payment is made.
(b) In order to ensure the proper implementation of this division, the department shall adopt regulations for accelerating the appeal process for issues relating to misclassification of an employee as an independent contractor pursuant to this division.
4822. The penalties and remedies provided pursuant to this division are cumulative and in addition to any other penalties or remedies provided by law.
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4823. The department shall deposit all employer fees and employee premium payments into the fund. The department shall deposit all fines, penalties, and interest collected pursuant to this division into a penalty account within the fund. Notwithstanding the provisions of Section 12699.212 of the Insurance Code, the revenue in the penalty account shall not be continuously appropriated to the board and shall be available for expenditure only upon appropriation by the Legislature.

4824. The department is authorized to obtain a loan from the General Fund for all necessary and reasonable expenses incurred prior to January 1, 2011, related to implementing this division and administering its provisions. The proceeds of the loan are subject to appropriation in the annual Budget Act. The department shall repay principal and interest, using the pooled money investment account rate of interest, to the General Fund no later than January 1, 2016.


4829. This division shall become operative on January 1, 2009.

SEC. 31. Section 14005.23 of the Welfare and Institutions Code is amended to read:

14005.23. (a) To the extent federal financial participation is available, the department shall, when determining eligibility for children under Section 1396a(l)(1)(D) of Title 42 of the United States Code, designate a birth date by which all children who have not attained the age of 19 years will meet the age requirement of Section 1396a(l)(1)(D) of Title 42 of the United States Code.

(b) Commencing July 1, 2008, to the extent federal financial participation is available, the department shall apply a less restrictive income deduction described in Section 1396a(r) of Title 42 of the United States Code when determining eligibility for the children identified in subdivision (a). The amount of this deduction shall be the difference between 133 percent and 100 percent of the federal poverty level applicable to the size of the family.

(c) For children enrolled in the Healthy Families Program as of July 1, 2008, the income limit in subdivision (b) shall be applied in determining eligibility at the next annual redetermination for
that program, or earlier upon request of the beneficiary. The
coverage under this section for a child who is a dependent of an
employee of an employer electing to make a payment to the
California Health Trust Fund in lieu of making health expenditures
pursuant to Section 4802.1 of the Unemployment Insurance Code,
shall be provided through a Cal-CHIPP Medi-Cal plan under Part
6.45 (commencing with Section 12699.201) of Division 2 of the
Insurance Code.

SEC. 32. Section 14005.30 of the Welfare and Institutions
Code is amended to read:

14005.30. (a) (1) To the extent that federal financial
participation is available, Medi-Cal benefits under this chapter
shall be provided to individuals eligible for services under Section
1396u-1 of Title 42 of the United States Code, including any
options under Section 1396u-1(b)(2)(C) made available to and
exercised by the state.

(2) The department shall exercise its option under Section
1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
less restrictive income and resource eligibility standards and
methodologies to the extent necessary to allow all recipients of
benefits under Chapter 2 (commencing with Section 11200) to be
eligible for Medi-Cal under paragraph (1).

(3) To the extent federal financial participation is available, the
department shall exercise its option under Section 1396u-1(b)(2)(C)
of Title 42 of the United States Code authorizing the state to
disregard all changes in income or assets of a beneficiary until the
next annual redetermination under Section 14012. The department
shall implement this paragraph only if, and to the extent that the
State Child Health Insurance Program waiver described in Section
12693.755 of the Insurance Code extending Healthy Families
Program eligibility to parents and certain other adults is approved
and implemented.

(b) To the extent that federal financial participation is available,
the department shall exercise its option under Section
1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
to simplify eligibility for Medi-Cal under subdivision (a) by
exempting all resources for applicants and recipients.

(c) To the extent federal financial participation is available, the
department shall, commencing March 1, 2000, adopt an income
disregard for applicants equal to the difference between the income
standard under the program adopted pursuant to Section 1931(b) 
of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and 
the amount equal to 100 percent of the federal poverty level 
applicable to the size of the family. A recipient shall be entitled 
to the same disregard, but only to the extent it is more beneficial 
than, and is substituted for, the earned income disregard available 
to recipients.

(d) Commencing July 1, 2008, the department shall adopt an 
income disregard for applicants equal to the difference between 
the income standard under the program adopted pursuant to Section 
1931(b) of the federal Social Security Act (42 U.S.C. Sec. 
1396u-1(b)) and the amount equal to 133 percent of the federal 
poverty level applicable to the size of the family. A recipient shall 
be entitled to the same disregard, but only to the extent it is more 
generous than, and is substituted for, the earned income disregard 
available to recipients. Implementation of this subdivision is 
contingent upon federal financial participation. Upon 
implementation of this subdivision, the income disregard described 
in subdivision (c) shall no longer apply.

(e) For purposes of calculating income under this section during 
any calendar year, increases in social security benefit payments 
under Title II of the federal Social Security Act (42 U.S.C. Sec. 
401 and following) arising from cost-of-living adjustments shall 
be disregarded commencing in the month that these social security 
benefit payments are increased by the cost-of-living adjustment 
through the month before the month in which a change in the 
federal poverty level requires the department to modify the income 
disregard pursuant to subdivision (c) and in which new income 
limits for the program established by this section are adopted by 
the department.

(f) Notwithstanding Chapter 3.5 (commencing with Section 
11340) of Part 1 of Division 3 of Title 2 of the Government Code, 
the department shall implement, without taking regulatory action, 
subdivisions (a) and (b) of this section by means of an all county 
letter or similar instruction. Thereafter, the department shall adopt 
regulations in accordance with the requirements of Chapter 3.5 
(commencing with Section 11340) of Part 1 of Division 3 of Title 
2 of the Government Code. Beginning six months after the effective 
date of this section, the department shall provide a status report to
the Legislature on a semiannual basis until regulations have been
adopted.

SEC. 33. Section 14005.31 of the Welfare and Institutions
Code is amended to read:

14005.31. (a) (1) Subject to paragraph (2), for any person
whose eligibility for benefits under Section 14005.30 has been
determined with a concurrent determination of eligibility for cash
aid under Chapter 2 (commencing with Section 11200), loss of
eligibility or termination of cash aid under Chapter 2 (commencing
with Section 11200) shall not result in a loss of eligibility or
termination of benefits under Section 14005.30 absent the existence
of a factor that would result in loss of eligibility for benefits under
Section 14005.30 for a person whose eligibility under Section
14005.30 was determined without a concurrent determination of
eligibility for benefits under Chapter 2 (commencing with Section
11200).

(2) Notwithstanding paragraph (1), a person whose eligibility
would otherwise be terminated pursuant to that paragraph shall
not have his or her eligibility terminated until the transfer
procedures set forth in Section 14005.32 or the redetermination
procedures set forth in Section 14005.37 and all due process
requirements have been met.

(b) The department, in consultation with the counties and
representatives of consumers, managed care plans, and Medi-Cal
providers, shall prepare a simple, clear, consumer-friendly notice
to be used by the counties, to inform Medi-Cal beneficiaries whose
eligibility for cash aid under Chapter 2 (commencing with Section
11200) has ended, but whose eligibility for benefits under Section
14005.30 continues pursuant to subdivision (a), that their benefits
will continue. To the extent feasible, the notice shall be sent out
at the same time as the notice of discontinuation of cash aid, and
shall include all of the following:

(1) A statement that Medi-Cal benefits will continue even though
cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will
not be counted against any time limits in existence for receipt of
cash aid under the CalWORKs program.

(3) A statement that the Medi-Cal beneficiary does not need to
fill out monthly status reports in order to remain eligible for
Medi-Cal, but shall be required to submit a semiannual status report
and annual reaffirmation forms, except that the semiannual status report shall no longer be required on and after July 1, 2008. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that he or she should review his or her circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

(4) A statement describing the responsibility of the Medi-Cal beneficiary to report to the county, within 10 days, significant changes that may affect eligibility.

(5) A telephone number to call for more information.

(6) A statement that the Medi-Cal beneficiary’s eligibility worker will not change, or, if the case has been reassigned, the new worker’s name, address, and telephone number, and the hours during which the county’s eligibility workers can be contacted.

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 34. Section 14005.32 of the Welfare and Institutions Code is amended to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice
to be used by the counties, to inform beneficiaries that their
Medi-Cal benefits have been transferred pursuant to paragraph (1)
and to inform them about the program to which they have been
transferred. To the extent feasible, the notice shall be issued with
the notice of discontinuance from cash aid, and shall include all
of the following:
(A) A statement that Medi-Cal benefits will continue under
another program, even though aid under Chapter 2 (commencing
with Section 11200) has been terminated.
(B) The name of the program under which benefits will continue,
and an explanation of that program.
(C) A statement that continued receipt of Medi-Cal benefits will
not be counted against any time limits in existence for receipt of
cash aid under the CalWORKs program.
(D) A statement that the Medi-Cal beneficiary does not need to
fill out monthly status reports in order to remain eligible for
Medi-Cal, but shall be required to submit a semiannual status report
and annual reaffirmation forms, except that the semiannual status
report shall no longer be required on and after July 1, 2008. In
addition, if the person or persons to whom the notice is directed
has been found eligible for transitional Medi-Cal as described in
Section 14005.8, 14005.81, or 14005.85, the statement shall explain
the reporting requirements and duration of benefits under those
programs, and shall further explain that, at the end of the duration
of these benefits, a redetermination, as provided for in Section
14005.37 shall be conducted to determine whether benefits are
available under any other provision of law.
(E) A statement describing the beneficiary’s responsibility to
report to the county, within 10 days, significant changes that may
affect eligibility or share of cost.
(F) A telephone number to call for more information.
(G) A statement that the beneficiary’s eligibility worker will
not change, or, if the case has been reassigned, the new worker’s
name, address, and telephone number, and the hours during which
the county’s Medi-Cal eligibility workers can be contacted.
(b) No later than September 1, 2001, the department shall submit
a federal waiver application seeking authority to eliminate the
reporting requirements imposed by transitional medicaid under
Section 1925 of the federal Social Security Act (Title 42 U.S.C.
Sec. 1396r-6).
(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 35. Section 14005.301 is added to the Welfare and Institutions Code, to read:

14005.301. (a) Notwithstanding Section 14005.30, to the extent that federal financial participation is available, Medi-Cal benefits under a Cal-CHIPP Healthy Families plan as permitted under Section 6044 of the federal Deficit Reduction Act of 2005 (42 U.S.C. Sec. 1396u-7) shall be provided to a population composed of parents and other caretaker relatives with a household income at or below 300 percent of the federal poverty level who are not otherwise eligible for full scope benefits with no share of cost.

(b) The Cal-CHIPP Healthy Families plan referenced in subdivision (a) shall be health plan coverage provided through a health care service plan or a health insurer that meets the requirements of federal law and that provides the same covered services and benefits required under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) plus prescription drugs.

(c) The eligibility determination under this section shall not include an asset test.

(d) To the extent necessary to implement this section, the department shall seek federal approval to modify the definition of “unemployed parent” in Section 14008.85.

(e) The department shall implement this section by means of a state plan amendment. If this section cannot be implemented by a state plan amendment, the department shall seek a waiver or a
waiver and a state plan amendment necessary to accomplish the
intent of this section.

(f) This section shall become operative on July 1, 2008.

SEC. 36. Section 14005.331 is added to the Welfare and
Institutions Code, to read:

14005.331. (a) All children under 19 years of age who meet
the state residency requirements of the Medi-Cal program or the
Healthy Families Program shall be eligible for health care coverage
in accordance with subdivision (b) if they either (1) live in families
with countable household income at or below 300 percent of the
federal poverty level, or (2) meet the income and resource
requirements of Section 14005.7 of the Welfare and Institutions
Code or the income requirements of Section 14005.30 of the
Welfare and Institutions Code. The children described in this
section include all children for whom federal financial participation
under Title XIX of the federal Social Security Act (42 U.S.C. Sec.
1396 et seq.) or Title XXI of the federal Social Security Act (42
U.S.C. Sec. 1397 et seq.) is not available due to their immigration
status or date of entry into the United States, but does not include
children who are ineligible for Title XIX and Title XXI funds
based on other grounds. Nothing in this section shall be construed
to limit a child’s right to Medi-Cal eligibility under existing law.

(b) Children described in subdivision (a) in families whose
household income would render them ineligible for no-cost
Medi-Cal, and who are in compliance with Sections 12693.71 and
12693.72 of the Insurance Code, shall be eligible for the Healthy
Families Program and shall also be eligible for Medi-Cal with a
share of cost in accordance with Section 14005.7 of the Welfare
and Institutions Code. Other children described in this section shall
be eligible for Medi-Cal with no share of cost.

(c) On and after January 1, 2010, the coverage under this
section for a child who is an employee or, if applicable, a dependent
of an employee of an employer electing to make a payment to the
California Health Trust Fund in lieu of making health expenditures
pursuant to Section 4802.1 of the Unemployment Insurance Code,
shall be provided through a Cal-CHIPP Medi-Cal plan under Part
6.45 (commencing with Section 12699.201) of Division 2 of the
Insurance Code.

SEC. 37. Section 14005.82 is added to the Welfare and
Institutions Code, to read:
14005.82. (a) The department shall exercise its options under Section 1906 of Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396e) to require, as a condition of an individual becoming or remaining eligible for the Medi-Cal program, that the individual, or if a child, the child’s parent, offered the option of enrolling in a Cal-CHIPP Medi-Cal plan pursuant to Section 1357.24 of the Health and Safety Code or Section 10764 of the Insurance Code enroll in that Cal-CHIPP Medi-Cal plan. If the individual is eligible for the Medi-Cal program under Section 14005.301 and the individual is offered the option of enrolling in a Cal-CHIPP Healthy Families plan pursuant to Section 1357.24 of the Health and Safety Code or Section 10764 of the Insurance Code, the individual shall, as a condition of the individual becoming or remaining eligible for the Medi-Cal program, enroll in the Cal-CHIPP Healthy Families plan.

(b) The requirement that an individual enroll in a Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy Families plan, as described in subdivision (a), shall apply to an individual enrolled in the Medi-Cal program or in the Healthy Families Program at the individual’s next annual redetermination of eligibility for the Medi-Cal program or the Healthy Families Program, or before that time if requested by the beneficiary or subscriber.

SEC. 38. Section 14008.85 of the Welfare and Institutions Code is amended to read:

14008.85. (a) To the extent federal financial participation is available, a parent who is the principal wage earner shall be considered an unemployed parent for purposes of establishing eligibility based upon deprivation of a child where any of the following applies:

1. The parent works less than 100 hours per month as determined pursuant to the rules of the Aid to Families with Dependent Children program as it existed on July 16, 1996, including the rule allowing a temporary excess of hours due to intermittent work.

2. The total net nonexempt earned income for the family is not more than 100 percent of the federal poverty level as most recently calculated by the federal government. The department may adopt additional deductions to be taken from a family’s income.

3. The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under
the program established by Section 1931(b) of the federal Social
Security Act (42 U.S.C. Sec. 1396u-1).
(b) The department shall seek any federal approval required to
waive or to increase the income limit in paragraph (2) of
subdivision (a) to the extent necessary to implement Sections
14005.30 and 14005.301.
(c) Notwithstanding Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code,
the department shall implement this section by means of an all
county letter or similar instruction without taking regulatory action.
Thereafter, the department shall adopt regulations in accordance
with the requirements of Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 39. Section 14011.16 of the Welfare and Institutions
Code is amended to read:
14011.16. (a) Commencing August 1, 2003, the department
shall implement a requirement for beneficiaries to file semiannual
status reports as part of the department’s procedures to ensure that
beneficiaries make timely and accurate reports of any change in
circumstance that may affect their eligibility. The department shall
develop a simplified form to be used for this purpose. The
department shall explore the feasibility of using a form that allows
a beneficiary who has not had any changes to so indicate by
checking a box and signing and returning the form.
(b) Beneficiaries who have been granted continuous eligibility
under Section 14005.25 shall not be required to submit semiannual
status reports. To the extent federal financial participation is
available, all children under 19 years of age shall be exempt from
the requirement to submit semiannual status reports.
(c) Beneficiaries whose eligibility is based on a determination
of disability or on their status as aged or blind shall be exempt
from the semiannual status report requirement described in
subdivision (a). The department may exempt other groups from
the semiannual status report requirement as necessary for simplicity
of administration.
(d) When a beneficiary has completed, signed, and filed a
semiannual status report that indicated a change in circumstance,
eligibility shall be redetermined.
(e) Notwithstanding Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code,
the department shall implement this section by means of all county
letters or similar instructions without taking regulatory action.
Thereafter, the department shall adopt regulations in accordance
with the requirements of Chapter 3.5 (commencing with Section
11340) of Part 1 of Division 3 of Title 2 of the Government Code.
(f) This section shall be implemented only if and to the extent
federal financial participation is available.
(g) This section shall become inoperative on July 1, 2008, and,
as of January 1, 2009, is repealed, unless a later enacted statute
that is enacted before January 1, 2009, deletes or extends the dates
on which it becomes inoperative and is repealed.
SEC. 40. Section 14131.01 is added to the Welfare and
Institutions Code, to read:
14131.01. On and after January 1, 2010, the coverage under
this chapter to a person who is an employee or, if applicable, a
dependent of an employee, of an employer electing to make a
payment to the California Health Trust Fund in lieu of making
health expenditures pursuant to Section 4802.1 of the
Unemployment Insurance Code, shall be provided through a
Cal-CHIPP Medi-Cal plan under Part 6.45 (commencing with
Section 12699.201) of the Insurance Code.
SEC. 41. Article 7 (commencing with Section 14199.10) is
added to Chapter 7 of Part 3 of Division 9 of the Welfare and
Institutions Code, to read:
Article 7. Coordination with the California Health Trust Fund
14199.10. The department shall seek any necessary federal
approval to enable the state to receive federal funds for coverage
provided through the California Cooperative Health Insurance
Purchasing Program (Cal-CHIPP) to persons who would be eligible
for the Medi-Cal program if the state expanded eligibility to a
population composed of parents and other caretaker relatives with
a household income at or below 300 percent of the federal poverty
level who are not otherwise eligible for full scope benefits with
no share of cost. Revenues in the California Health Trust Fund
created pursuant to Section 12699.212 of the Insurance Code shall
be used as state matching funds for receipt of federal funds
resulting from the implementation of this section. All federal funds
received pursuant to that federal approval shall be deposited in the
California Health Trust Fund.

SEC. 42. Section 6254.28 is added to the Government Code, to read:

6254.28. (a) Nothing in this chapter or any other provision of
law shall require the disclosure of records of the Managed Risk
Medical Insurance Board relating to activities governed by Part
6.45 (commencing with Section 12699.201) of Division 2 of the
Insurance Code, and that reveal the deliberative processes,
discussions, communications, or any other portion of the
negotiations with entities contracting or seeking to contract with
the board, or the impressions, opinions, recommendations, meeting
minutes, research, work product, theories, or strategy of the board
or its staff, or records that provide instructions, advice, or training
to employees.

(b) (1) Except for the portion of a contract that contains the
rates of payment, contracts entered into pursuant to Part 6.45
(commencing with Section 12699.201) of Division 2 of the
Insurance Code on or after January 1, 2008, shall be open to
inspection one year after they have been fully executed.

(2) If a contract entered into pursuant to Part 6.45 (commencing
with Section 12699.201) of Division 2 of the Insurance Code is
amended, the amendment shall be open to inspection one year after
the amendment has been fully executed.

(c) Three years after a contract or amendment is open to
inspection pursuant to this section, the portion of the contract or
amendment containing the rates of payment shall be open to
inspection.

(d) Notwithstanding any other provision of law, the entire
contract or amendments to a contract shall be open to inspection
by the Joint Legislative Audit Committee and the Legislative
Analyst’s Office. The committee and the office shall maintain the
confidentiality of the contracts and amendments thereto until the
contract or amendments to a contract are open to inspection
pursuant to subdivision (b) or (c).

SEC. 43. Section 11126 of the Government Code is amended
to read:

11126. (a) (1) Nothing in this article shall be construed to
prevent a state body from holding closed sessions during a regular
or special meeting to consider the appointment, employment,
evaluation of performance, or dismissal of a public employee or
to hear complaints or charges brought against that employee by
another person or employee unless the employee requests a public
hearing.
(2) As a condition to holding a closed session on the complaints
or charges to consider disciplinary action or to consider dismissal,
the employee shall be given written notice of his or her right to
have a public hearing, rather than a closed session, and that notice
shall be delivered to the employee personally or by mail at least
24 hours before the time for holding a regular or special meeting.
If notice is not given, any disciplinary or other action taken against
any employee at the closed session shall be null and void.
(3) The state body also may exclude from any public or closed
session, during the examination of a witness, any or all other
witnesses in the matter being investigated by the state body.
(4) Following the public hearing or closed session, the body
may deliberate on the decision to be reached in a closed session.
(b) For the purposes of this section, “employee” does not include
any person who is elected to, or appointed to a public office by,
any state body. However, officers of the California State University
who receive compensation for their services, other than per diem
and ordinary and necessary expenses, shall, when engaged in that
capacity, be considered employees. Furthermore, for purposes of
this section, the term employee includes a person exempt from
civil service pursuant to subdivision (e) of Section 4 of Article VII
of the California Constitution.
(c) Nothing in this article shall be construed to do any of the
following:
(1) Prevent state bodies that administer the licensing of persons
engaging in businesses or professions from holding closed sessions
to prepare, approve, grade, or administer examinations.
(2) Prevent an advisory body of a state body that administers
the licensing of persons engaged in businesses or professions from
conducting a closed session to discuss matters that the advisory
body has found would constitute an unwarranted invasion of the
privacy of an individual licensee or applicant if discussed in an
open meeting, provided the advisory body does not include a
quorum of the members of the state body it advises. Those matters
may include review of an applicant’s qualifications for licensure
and an inquiry specifically related to the state body’s enforcement
program concerning an individual licensee or applicant where the inquiry occurs prior to the filing of a civil, criminal, or administrative disciplinary action against the licensee or applicant by the state body.

(3) Prohibit a state body from holding a closed session to deliberate on a decision to be reached in a proceeding required to be conducted pursuant to Chapter 5 (commencing with Section 11500) or similar provisions of law.

(4) Grant a right to enter any correctional institution or the grounds of a correctional institution where that right is not otherwise granted by law, nor shall anything in this article be construed to prevent a state body from holding a closed session when considering and acting upon the determination of a term, parole, or release of any individual or other disposition of an individual case, or if public disclosure of the subjects under discussion or consideration is expressly prohibited by statute.

(5) Prevent any closed session to consider the conferring of honorary degrees, or gifts, donations, and bequests that the donor or proposed donor has requested in writing to be kept confidential.

(6) Prevent the Alcoholic Beverage Control Appeals Board from holding a closed session for the purpose of holding a deliberative conference as provided in Section 11125.

(7) (A) Prevent a state body from holding closed sessions with its negotiator prior to the purchase, sale, exchange, or lease of real property by or for the state body to give instructions to its negotiator regarding the price and terms of payment for the purchase, sale, exchange, or lease.

(B) However, prior to the closed session, the state body shall hold an open and public session in which it identifies the real property or real properties that the negotiations may concern and the person or persons with whom its negotiator may negotiate.

(C) For purposes of this paragraph, the negotiator may be a member of the state body.

(D) For purposes of this paragraph, “lease” includes renewal or renegotiation of a lease.

(E) Nothing in this paragraph shall preclude a state body from holding a closed session for discussions regarding eminent domain proceedings pursuant to subdivision (e).

(8) Prevent the California Postsecondary Education Commission from holding closed sessions to consider matters pertaining to the
appointment or termination of the Director of the California Postsecondary Education Commission.

(9) Prevent the Council for Private Postsecondary and Vocational Education from holding closed sessions to consider matters pertaining to the appointment or termination of the Executive Director of the Council for Private Postsecondary and Vocational Education.

(10) Prevent the Franchise Tax Board from holding closed sessions for the purpose of discussion of confidential tax returns or information the public disclosure of which is prohibited by law, or from considering matters pertaining to the appointment or removal of the Executive Officer of the Franchise Tax Board.

(11) Require the Franchise Tax Board to notice or disclose any confidential tax information considered in closed sessions, or documents executed in connection therewith, the public disclosure of which is prohibited pursuant to Article 2 (commencing with Section 19542) of Chapter 7 of Part 10.2 of the Revenue and Taxation Code.

(12) Prevent the Board of Corrections from holding closed sessions when considering reports of crime conditions under Section 6027 of the Penal Code.

(13) Prevent the State Air Resources Board from holding closed sessions when considering the proprietary specifications and performance data of manufacturers.

(14) Prevent the State Board of Education or the Superintendent of Public Instruction, or any committee advising the board or the Superintendent, from holding closed sessions on those portions of its review of assessment instruments pursuant to Chapter 5 (commencing with Section 60600) of, or pursuant to Chapter 8 (commencing with Section 60850) of, Part 33 of the Education Code during which actual test content is reviewed and discussed. The purpose of this provision is to maintain the confidentiality of the assessments under review.

(15) Prevent the California Integrated Waste Management Board or its auxiliary committees from holding closed sessions for the purpose of discussing confidential tax returns, discussing trade secrets or confidential or proprietary information in its possession, or discussing other data, the public disclosure of which is prohibited by law.
(16) Prevent a state body that invests retirement, pension, or endowment funds from holding closed sessions when considering investment decisions. For purposes of consideration of shareholder voting on corporate stocks held by the state body, closed sessions for the purposes of voting may be held only with respect to election of corporate directors, election of independent auditors, and other financial issues that could have a material effect on the net income of the corporation. For the purpose of real property investment decisions that may be considered in a closed session pursuant to this paragraph, a state body shall also be exempt from the provisions of paragraph (7) relating to the identification of real properties prior to the closed session.

(17) Prevent a state body, or boards, commissions, administrative officers, or other representatives that may properly be designated by law or by a state body, from holding closed sessions with its representatives in discharging its responsibilities under Chapter 10 (commencing with Section 3500), Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), or Chapter 10.7 (commencing with Section 3540) of Division 4 of Title 1 as the sessions relate to salaries, salary schedules, or compensation paid in the form of fringe benefits. For the purposes enumerated in the preceding sentence, a state body may also meet with a state conciliator who has intervened in the proceedings.

(18) (A) Prevent a state body from holding closed sessions to consider matters posing a threat or potential threat of criminal or terrorist activity against the personnel, property, buildings, facilities, or equipment, including electronic data, owned, leased, or controlled by the state body, where disclosure of these considerations could compromise or impede the safety or security of the personnel, property, buildings, facilities, or equipment, including electronic data, owned, leased, or controlled by the state body.

(B) Notwithstanding any other provision of law, a state body, at any regular or special meeting, may meet in a closed session pursuant to subparagraph (A) upon a two-thirds vote of the members present at the meeting.

(C) After meeting in closed session pursuant to subparagraph (A), the state body shall reconvene in open session prior to adjournment and report that a closed session was held pursuant to
subparagraph (A), the general nature of the matters considered, and whether any action was taken in closed session.

(D) After meeting in closed session pursuant to subparagraph (A), the state body shall submit to the Legislative Analyst written notification stating that it held this closed session, the general reason or reasons for the closed session, the general nature of the matters considered, and whether any action was taken in closed session. The Legislative Analyst shall retain for no less than four years any written notification received from a state body pursuant to this subparagraph.

(d) (1) Notwithstanding any other provision of law, any meeting of the Public Utilities Commission at which the rates of entities under the commission’s jurisdiction are changed shall be open and public.

(2) Nothing in this article shall be construed to prevent the Public Utilities Commission from holding closed sessions to deliberate on the institution of proceedings, or disciplinary actions against any person or entity under the jurisdiction of the commission.

(e) (1) Nothing in this article shall be construed to prevent a state body, based on the advice of its legal counsel, from holding a closed session to confer with, or receive advice from, its legal counsel regarding pending litigation when discussion in open session concerning those matters would prejudice the position of the state body in the litigation.

(2) For purposes of this article, all expressions of the lawyer-client privilege other than those provided in this subdivision are hereby abrogated. This subdivision is the exclusive expression of the lawyer-client privilege for purposes of conducting closed session meetings pursuant to this article. For purposes of this subdivision, litigation shall be considered pending when any of the following circumstances exist:

(A) An adjudicatory proceeding before a court, an administrative body exercising its adjudicatory authority, a hearing officer, or an arbitrator, to which the state body is a party, has been initiated formally.

(B) (i) A point has been reached where, in the opinion of the state body on the advice of its legal counsel, based on existing facts and circumstances, there is a significant exposure to litigation against the state body.
(ii) Based on existing facts and circumstances, the state body is meeting only to decide whether a closed session is authorized pursuant to clause (i).

(C) (i) Based on existing facts and circumstances, the state body has decided to initiate or is deciding whether to initiate litigation.

(ii) The legal counsel of the state body shall prepare and submit to it a memorandum stating the specific reasons and legal authority for the closed session. If the closed session is pursuant to paragraph (1), the memorandum shall include the title of the litigation. If the closed session is pursuant to subparagraph (A) or (B), the memorandum shall include the existing facts and circumstances on which it is based. The legal counsel shall submit the memorandum to the state body prior to the closed session, if feasible, and in any case no later than one week after the closed session. The memorandum shall be exempt from disclosure pursuant to Section 6254.25.

(iii) For purposes of this subdivision, “litigation” includes any adjudicatory proceeding, including eminent domain, before a court, administrative body exercising its adjudicatory authority, hearing officer, or arbitrator.

(iv) Disclosure of a memorandum required under this subdivision shall not be deemed as a waiver of the lawyer-client privilege, as provided for under Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code.

(f) In addition to subdivisions (a), (b), and (c), nothing in this article shall be construed to do any of the following:

(1) Prevent a state body operating under a joint powers agreement for insurance pooling from holding a closed session to discuss a claim for the payment of tort liability or public liability losses incurred by the state body or any member agency under the joint powers agreement.

(2) Prevent the examining committee established by the State Board of Forestry and Fire Protection, pursuant to Section 763 of the Public Resources Code, from conducting a closed session to consider disciplinary action against an individual professional forester prior to the filing of an accusation against the forester pursuant to Section 11503.

(3) Prevent an administrative committee established by the California Board of Accountancy pursuant to Section 5020 of the
Business and Professions Code from conducting a closed session
to consider disciplinary action against an individual accountant
prior to the filing of an accusation against the accountant pursuant
to Section 11503. Nothing in this article shall be construed to
prevent an examining committee established by the California
Board of Accountancy pursuant to Section 5023 of the Business
and Professions Code from conducting a closed hearing to
interview an individual applicant or accountant regarding the
applicant’s qualifications.

(4) Prevent a state body, as defined in subdivision (b) of Section
11121, from conducting a closed session to consider any matter
that properly could be considered in closed session by the state
body whose authority it exercises.

(5) Prevent a state body, as defined in subdivision (d) of Section
11121, from conducting a closed session to consider any matter
that properly could be considered in a closed session by the body
defined as a state body pursuant to subdivision (a) or (b) of Section
11121.

(6) Prevent a state body, as defined in subdivision (c) of Section
11121, from conducting a closed session to consider any matter
that properly could be considered in a closed session by the state
body it advises.

(7) Prevent the State Board of Equalization from holding closed
sessions for either of the following:
(A) When considering matters pertaining to the appointment or
removal of the Executive Secretary of the State Board of
Equalization.
(B) For the purpose of hearing confidential taxpayer appeals or
data, the public disclosure of which is prohibited by law.

(8) Require the State Board of Equalization to disclose any
action taken in closed session or documents executed in connection
with that action, the public disclosure of which is prohibited by
law pursuant to Sections 15619 and 15641 of this code and Sections
833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651,
45982, 46751, 50159, 55381, and 60609 of the Revenue and
Taxation Code.

(9) Prevent the California Earthquake Prediction Evaluation
Council, or other body appointed to advise the Director of the
Office of Emergency Services or the Governor concerning matters
relating to volcanic or earthquake predictions, from holding closed
sessions when considering the evaluation of possible predictions.
(g) This article does not prevent either of the following:
(1) The Teachers’ Retirement Board or the Board of
Administration of the Public Employees’ Retirement System from
holding closed sessions when considering matters pertaining to
the recruitment, appointment, employment, or removal of the chief
executive officer or when considering matters pertaining to the
recruitment or removal of the Chief Investment Officer of the State
Teachers’ Retirement System or the Public Employees’ Retirement
System.
(2) The Commission on Teacher Credentialing from holding
closed sessions when considering matters relating to the
recruitment, appointment, or removal of its executive director.
(h) This article does not prevent the Board of Administration
of the Public Employees’ Retirement System from holding closed
sessions when considering matters relating to the development of
rates and competitive strategy for plans offered pursuant to Chapter
15 (commencing with Section 21660) of Part 3 of Division 5 of
Title 2.
(i) This article does not prevent the Managed Risk Medical
Insurance Board from holding closed sessions when considering
matters related to the development of rates and contracting strategy
for entities contracting or seeking to contract with the board
pursuant to Part 6.45 (commencing with Section 12699.201) of
Division 2 of the Insurance Code.
SEC. 44. The State Department of Health Care Services, in
consultation with the Managed Risk Medical Insurance Board,
shall take all reasonable steps that are required to obtain the
maximum amount of federal funds and to support federal claiming
procedures in the administration of this act.
SEC. 45. Notwithstanding Chapter 3.5 (commencing with
Section 11340) of Part 1 of Division 3 of Title 2 of the Government
Code, during the period January 1, 2008, to December 31, 2011,
inclusive, the State Department of Health Care Services may
implement this act by means of all county letters or similar
instructions without taking regulatory action. After December 31,
2011, the department shall adopt all necessary regulations in
accordance with the requirements of Chapter 3.5 (commencing
with Section 11340) of Part 1 of Division 3 of Title 2 of the
Government Code.

SEC. 46. The Legislature finds and declares that Section 42 of
this act, which adds Section 6254.28 to the Government Code, and
Section 43, which amends Section 11126 of the Government Code,
impose a limitation on the public’s right of access to the meetings
of public bodies or the writings of public officials and agencies
within the meaning of Section 3 of Article I of the California
Constitution. Pursuant to that constitutional provision, the
Legislature makes the following findings to demonstrate the interest
protected by this limitation and the need for protecting that interest:
In order to maximize the ability of the Managed Risk Medical
Insurance Board to implement agreements with health plans and
to provide a wide choice of plans at minimal cost under the
California Cooperative Health Insurance Purchasing Program
created pursuant to Part 6.45 (commencing with Section
12699.201) of Division 2 of the Insurance Code, it is necessary
and appropriate to provide limited confidentiality to certain writings
developed in that regard and meetings related thereto.

SEC. 47. Notwithstanding any other provision of law, the
Managed Risk Medical Insurance Board may implement the
provisions of this act expanding the Healthy Families Program
only to the extent that funds are appropriated for those purposes
in the annual Budget Act or in another statute.

SEC. 48. During the period from January 1, 2008 to December
31, 2011, inclusive, the adoption of regulations pursuant to this
act by the Managed Risk Medical Insurance Board shall be deemed
to be an emergency and necessary for the immediate preservation
of public peace, health, and safety, or the general welfare.

SEC. 49. No reimbursement is required by this act pursuant to
Section 6 of Article XIII B of the California Constitution for certain
costs that may be incurred by a local agency or school district
because, in that regard, this act creates a new crime or infraction,
eliminates a crime or infraction, or changes the penalty for a crime
or infraction, within the meaning of Section 17556 of the
Government Code, or changes the definition of a crime within the
meaning of Section 6 of Article XIII B of the California
Constitution.
However, if the Commission on State Mandates determines that
this act contains other costs mandated by the state, reimbursement
to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.
An act relating to health care.

LEGISLATIVE COUNSEL’S DIGEST

SB 236, as amended, Runner. Health care: Cal CARE program.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, an employer in this state is not required to provide health care coverage for its employees, and residents are not required to obtain and maintain such coverage for themselves.

This bill would express the Legislature’s intent to enact the Cal CARE program to improve access to health care services for the residents of this state, as specified. The bill would declare that the Legislature shall enact specified legislation and would declare the Legislature’s intent to accomplish specified acts in order to improve access and affordability to health care.


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

SECTION 1. (a) The Legislature finds and declares the following:
(1) Cal CARE is a program that will improve the current health care system in this state and provide the most effective means of making health care more affordable and accessible to the residents of California.

(2) Cal CARE will create more consumer options and cultivate marketplace competition by eliminating regulatory hurdles in the health care system.

(3) Cal CARE will provide new incentives for hospitals and private industry to increase the number of primary care clinics, thereby improving accessibility to health care services in rural and medically underserved areas of this state. It will also provide less expensive alternatives to treatment provided by emergency rooms, which treatment contributes to increasing health care costs.

(4) Cal CARE will increase the number of Californians with health care coverage by offering incentives to employers who offer health care coverage to their employees, and it will prioritize funding for children’s health care initiatives provided by First 5 California pursuant to Division 108 of the Health and Safety Code.

(5) Cal CARE will require Californians to take personal responsibility for their health care, providing an individual the same tax benefits as an employer who provides health care coverage to its employees.

(6) Cal CARE will not require Californians to pay for health care provided to illegal immigrants and will bill the federal government for the costs California taxpayers already must pay for illegal immigrants’ health care.

(b) It is the intent of the Legislature to enact the Cal CARE program to improve access to health care services for the residents of this state.

SEC. 2. (a) The Legislature shall enact legislation, in order to improve access and affordability to health care for Californians, to do the following:

(1) Allow employers who offer health insurance coverage to their employees to enter into employer-employee agreed upon flex-time work schedules.

(2) Allow hospitals to offer “preventive health services only” coverage where the actual care is delivered through a hospital’s primary care or community-based clinics.

(3) Allow nurse practitioners to establish and run primary care clinics.
(4) Provide a partial tax credit directly to providers for the cost of providing care to the uninsured.

(5) Realign and extend health care coverage for the “uninsurable” population by using Proposition 99 (the Tobacco Tax and Health Protection Act of 1988) funds.

(6) Conform California’s laws to federal law with respect to providing tax deductions for businesses and individuals who use health savings accounts.

(7) Allow health care coverage benefit designs that conform to existing federal requirements for Health Savings Accounts-eligible High Deductible Health Plans.

(8) Provide a tax credit to employers who contribute to their employees’ Health Savings Accounts.

(9) Provide a tax credit for hospitals and physicians and surgeons who purchase cost-saving and quality-improving technologies such as electronic medical records and telemedicine and establish a low-interest loan program to assist nonprofit hospitals and medical groups make health care technology purchase.

(10) Establish a new prioritization system that will focus on seismically retrofitting the most at-risk hospitals first.

(11) Require the Department of Managed Health Care and the Department of Insurance to allow health care service plans and health insurers increased flexibility regarding product design, including, but not limited to, co-payments, deductibles, networks, mandates, and benefits so that health care service plans and health insurers can better and more quickly respond to consumer demand for affordable products that provide health care coverage and benefits appropriate to specific segments of the population.

(12) Allow rate flexibility in the small market to consider lifestyle behaviors in order to offer more affordable health care coverage options.

(13) Require the Public Employees’ Retirement System to offer high deductible health care service plans and health savings accounts to state employees.

(b) It is the intent of the Legislature to do all the following in order to improve access and affordability to health care for Californians:

(1) Reallocate Proposition 10 (the California Families and Children Act of 1998) funding and direct all funds to children’s
health care initiatives provided by First 5 California pursuant to Division 108 of the Health and Safety Code.

(2) Redirect a majority of the funding currently dedicated to state-only programs that provide health care services to uninsured or underinsured individuals to community clinics and health centers in order to allow a greater number of low-income individuals who are unable to purchase health care coverage and do not qualify for government programs to receive primary care services.

(3) Increase Medi-Cal rates towards parity with Medicare rates over the next eight fiscal years and make it a first priority to increase the rates that are currently the lowest.

(4) Direct a portion of the $2 billion allocated annually to disproportionate share hospitals to be used towards additional clinic creation and expansion.

(5) Require hospitals and providers for different health services to make pricing information become more readily available for consumers.

(6) Align Medi-Cal more closely with private health care benefits and require the Department of Health Care Services to make the changes needed to accomplish this and seek the necessary federal waivers.

(7) Call on the federal government to pay for the mandated health care costs for illegal immigrants.

(8) Make available health care coverage be driven by market demand rather than regulatory restrictions.

(9) Encourage employers to offer their employees pretax Section 125 plans.
An act to add Division 112 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.
SB 840, as amended, Kuehl. Single-payer health care coverage.

Existing law does not provide a system of universal health care coverage for California residents. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program administered by the State Department of Health Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would establish the California Health Insurance System to be administered by the newly created California Health Insurance Agency under the control of a Health Insurance Commissioner appointed by the Governor and subject to confirmation by the Senate. The bill would make all California residents eligible for specified health care benefits under the California Health Insurance System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California Health Insurance System, which would then assume responsibility for all benefits and services previously paid for with those funds.

The bill would create a health insurance policy board to establish policy on medical issues and various other matters relating to the health care system. The bill would create the Office of Patient Advocacy within the agency to represent the interests of health care consumers relative to the health care system. The bill would create within the agency the Office of Health Planning to plan for the health care needs of the population, and the Office of Health Care Quality, headed by the chief medical officer, to support the delivery of high quality care and promote provider and patient satisfaction. The bill would create the Office of Inspector General for the California Health Insurance System within the Attorney General’s office, which would have various oversight powers. The bill would prohibit health care service plan contracts or health insurance policies from being issued.
for services covered by the California Health Insurance System. The bill would create the Health Insurance Fund and the Payments Board to administer the finances of the California Health Insurance System. The bill would create the California Health Insurance Premium Commission (Premium Commission) to determine the cost of the California Health Insurance System and to develop a premium structure for the system that complies with specified standards. The bill would require the Premium Commission to recommend a premium structure to the Governor and Legislature on or before January 1, 2009, and to make a draft recommendation to the Governor, the Legislature, and the public 90 days before submitting its final premium structure recommendation. The bill would specify that only its provisions relating to the Premium Commission would become operative on January 1, 2007, with its remaining provisions becoming operative on the date the Secretary of Health and Human Services notifies the Legislature, as specified, that sufficient funding exists to implement the California Health Insurance System. The bill would require that system to be operative within 2 years of that date and would provide for various transition processes for that period.

The bill would extend the application of certain insurance fraud laws to providers of services and products under the health care system, thereby imposing a state-mandated local program by revising the definition of a crime. The bill would enact other related provisions relative to budgeting, regional entities, federal preemption, subrogation, collective bargaining agreements, compensation of health care providers, conflict of interest, patient grievances, independent medical review, and associated matters.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.


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

1  SECTION 1. Division 112 (commencing with Section 140000) is added to the Health and Safety Code, to read:
DIVISION 112. CALIFORNIA HEALTH INSURANCE
RELIABILITY ACT

Chapter 1. General Provisions

140000. There is hereby established in state government the California Health Insurance System, which shall be administered by the California Health Insurance Agency, an independent agency under the control of the Health Insurance Commissioner. 140000.6. No health care service plan contract or health insurance policy, except for the California Health Insurance System plan, may be sold in California for services provided by the system. 140001. This division shall be known as and may be cited as the California Health Insurance Reliability Act. 140002. This division shall be liberally construed to accomplish its purposes. 140003. The California Health Insurance Agency is hereby created and designated as the single state agency with full power to supervise every phase of the administration of the California Health Insurance System and to receive grants-in-aid made by the United States government, by the state, or by other sources in order to secure full compliance with the applicable provisions of state and federal law. 140004. The California Health Insurance Agency shall be comprised of the following entities: (a) The Health Insurance Policy Board. (b) The Office of Patient Advocacy. (c) The Office of Health Planning. (d) The Office of Health Care Quality. (e) The Health Insurance Fund. (f) The Public Advisory Committee. (g) The Payments Board. (h) Partnerships for Health. 140005. The Legislature finds and declares all of the following: (a) An estimated 6.5 million Californians lacked health care coverage at some time in 2004, including one in every five nonelderly Californians.
(b) Health care spending continues to grow much faster than the economy, and efforts to control health care costs and the growth of health care spending have been unsuccessful.

(c) On average, the United States spends more than twice as much as all other industrial nations on health care, both per person and as a percentage of its gross domestic product.

(d) A majority of California residents and businesses support a system of universal publicly financed health care.

(e) Consumers can no longer rely on traditional health care coverage due to a continuous decline of employer-offered coverage, unstable employment trends, and uncontrolled increases in the amount of premiums and cost sharing, and increases in benefit gaps.

(f) As a result, one-half of all bankruptcies in the United States now relate to medical costs, though three-fourths of bankrupted families had health care coverage at the time of sustaining the injury or illness.

(g) Health insurance companies have no business motive to provide comprehensive and affordable health care coverage to residents who are likely to require health care services, including seniors, disabled residents, residents with or at risk of developing a chronic illness, and women of child-bear age.

(h) Health care quality is rapidly declining, and the United States Institute of Medicine has declared an epidemic of substandard health care throughout the nation.

(i) The World Health Organization ranks the United States below all other industrial nations and 37th overall in population-based health outcomes.

(j) Recent emergencies in the South and growing fears of disease pandemics, underscore the critical importance of a regular source of health care for all residents and systemwide health care planning to ensure disaster and emergency preparedness.

(k) Growing epidemics of chronic diseases such as diabetes, obesity, and asthma require a system of universal health care and a continuous source of health care for all residents in order to adequately address the health care needs of all residents.

(l) Severe health access disparities exist by region, ethnicity, income, and gender. These disparities destabilize the overall
health care system throughout the state and reflect a lack of effective health care planning.

(m) Inadequate access to a regular source of care has caused Medi-Cal and uninsured patients to seek treatment in emergency facilities for conditions that could have been treated more appropriately in a nonemergency setting.

(n) Emergency departments and trauma centers face growing financial losses, and uncompensated hospital care totaled over one billion dollars ($1,000,000,000) in 2000. The burden for providing uncompensated care falls disproportionately on a minority of hospitals in California and leads to significant financial instability for the overall health care system.

(o) Multiple quantitative analyses indicate that under a single payer health insurance system, the amount currently spent for health care is more than adequate to finance comprehensive high quality health care coverage for every resident of the state while guaranteeing the right of every resident to choose his or her own physician.

(p) According to these reports and numerous other studies, by simplifying administration, achieving bulk purchase discounts on pharmaceuticals, reducing the use of emergency facilities for primary care, and carefully managing health care capital investment, California could divert billions of dollars toward providing direct health care and improve the quality of, and access to, that care.

140005.1 (a) It is the intent of the Legislature to establish a system of universal health insurance in this state that covers all residents with comprehensive health insurance benefits, guarantees a single standard of care for all residents, stabilizes the growth in health care spending, and improves the quality of health care for all residents.

(b) It is the intent of the Legislature that, in order to ensure an adequate supply and distribution of direct care providers in the state, a just and fair return for providers electing to be compensated by the health care system, and a uniform system of payments, the state shall actively supervise and regulate a system of payments whereby groups of fee-for-service physicians are authorized to select representatives of their specialties to negotiate with the health care system, pursuant to Section
140209. Nothing in this division shall be construed to allow
collective action against the health care system.
140006. This division shall have all of the following
purposes:
(a) To provide affordable and comprehensive health insurance
coverage with a single standard of care for all California
residents.
(b) To control health care costs and the growth of health care
spending, subject to the obligation described in subdivision (a).
(c) To achieve measurable improvement in the quality of care
and the efficiency of care delivery.
(d) To prevent disease and disability and to maintain or
improve health and functionality.
(e) To increase health care provider, consumer, employee, and
employer satisfaction with the health care system.
(f) To implement policies that strengthen and improve
culturally and linguistically sensitive care.
(g) To develop an integrated population-based health care
database to support health care planning.
140007. As used in this division, the following terms have the
following meanings:
(a) “Agency” means the California Health Insurance Agency.
(b) “Clinic” means an organized outpatient health facility that
provides direct medical, surgical, dental, optometric, or podiatric
advice, services, or treatment to patients who remain less than 24
hours, and that may also provide diagnostic or therapeutic
services to patients in the home as an alternative to care provided
at the clinic facility, and includes those facilities defined under
Sections 1200 and 1200.1.
(c) “Commissioner” means the Health Insurance
Commissioner.
(d) “Direct care provider” means any licensed health care
professional that provides health care services through direct
contact with the patient, either in person or using approved
telemedicine modalities as identified in Section 2290.5 of the
Business and Profession Code.
(e) “Essential community provider” means a health facility
that has served as part of the state’s health care safety net for low
income and traditionally underserved populations in California
and that is one of the following:
A “community clinic” as defined under subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204.

(2) A “free clinic” as defined under subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204.

(3) A “federally qualified health center” as defined under Section 1395x (aa)(4) or 1396d (l)(2) of Title 42 of the United States Code.

(4) A “rural health clinic” as defined under Section 1395x (aa)(2) or 1396d (l)(1) of Title 42 of the United States Code.

(5) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 1603 of Title 25 of the United States Code.

(6) Any clinic exempt from licensure under subdivision (h) of Section 1206.

(f) “Health care provider” means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

(g) “Health facility” means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, and includes those facilities defined under subdivision (b) of Section 15432 of the Government Code.

(h) “Hospital” means all health facilities to which persons may be admitted for a 24-hour stay or longer, as defined in Section 1250, with the exception of nursing, skilled nursing, intermediate care, and congregate living health facilities.

(i) “Integrated health care delivery system” means a provider organization that meets all of the following criteria:

1. Is fully integrated operationally and clinically to provide a broad range of health care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics, emergency services, hospital and medical services, surgical services, and ancillary services.

2. Is compensated using capitation or facility budgets, except for copayments, for the provision of health care services.
(3) Provides health care services primarily through direct care providers who are either employees or partners of the organization, or through arrangements with direct care providers or one or more groups of physicians, organized on a group practice or individual practice basis.

(j) “Large employer” means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar year employed at least 50 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least 50 employees on at least 50 percent of its working days during the preceding calendar quarter.

(k) “Premium Commission” means the California Health Insurance Premium Commission.

(l) “Primary care provider” means a direct care provider that is a family physician, internist, general practitioner, pediatrician, an obstetrician/gynecologist, or a family nurse practitioner or physician assistant practicing under supervision as defined in California codes or essential community providers who employ primary care providers.

(m) “Small employer” means a person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service and that, on at least 50 percent of its working days during the preceding calendar year employed at least two but no more than 49 employees, or, if the employer was not in business during any part of the preceding calendar year, employed at least two but no more than 40 eligible employees on at least 50 percent of its working days during the preceding calendar quarter.

(n) “System” or “health insurance system” means the California Health Insurance System.

140008. The definitions contained in Section 140007 shall govern the construction of this division, unless the context requires otherwise.

Chapter 2. Governance

140100. (a) (1) The commissioner shall be appointed by the Governor on or before March 1, 2007, subject to confirmation by
the Senate. If in session, the Senate shall act on the appointment within 30 days of the appointment date. If the Senate does not act on the appointment within that period, the nominee shall be deemed confirmed and may take office. If the Senate is not in session at the time of the appointment, the Senate shall act on the appointment within 30 days of the commencement of the next legislative session. If the Senate does not act on the appointment within that period, the appointee shall be deemed confirmed and may take office.

(2) If the Senate by a vote fails to confirm the nominee for commissioner, the Governor shall make a new appointment within 30 days of the Senate’s vote. The appointment is subject to confirmation by the Senate, and the procedures described in paragraph (1) shall apply to the confirmation process.

(b) The commissioner is exempt from the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code).

(c) The commissioner may not be a state legislator or a Member of the United States Congress while holding the position of commissioner.

(d) The commissioner shall not have been employed in any capacity by a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the California Health Insurance System for a period of two years prior to appointment as commissioner.

(e) For two years after completing service in the California Health Insurance System, the commissioner may not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the California Health Insurance System.

(f) The compensation and benefits of the commissioner shall be determined pursuant to the same process as provided in Section 8 of Article III of the California Constitution.

(g) The commissioner shall be subject to Title 9 (commencing with Section 81000) of the Government Code.

140101. (a) The commissioner shall be the chief officer of the California Health Insurance Agency and shall administer all aspects of the agency.
(b) The commissioner shall be responsible for the performance of all duties, the exercise of all power and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the agency. The commissioner shall perform all duties imposed upon him or her by this division and other laws related to health care, and shall enforce the execution of those related to the system, and shall enforce the execution of those provisions and laws to promote their underlying aims and purposes. These broad powers shall include, but are not limited to, the power to establish the California Health Insurance System budget and to set rates, to establish California Health Insurance System goals, standards and priorities, to hire, fire, and fix the compensation of agency personnel, to make allocations and reallocations to the health planning regions, and to promulgate generally binding regulations concerning any and all matters related to the implementation of this division and its purposes.

(c) The commissioner shall appoint the deputy health insurance commissioner, the Director of the Health Insurance Fund, the patient advocate, the chief medical officer, the Director of the Payments Board, the Director of Health Planning, the Director of the Partnerships for Health, the regional health planning directors, the chief enforcement counsel, and legal counsel in any action brought by or against the commissioner under or pursuant to any provision of any law under the commissioner’s jurisdiction, or in which the commissioner joins or intervenes as to a matter within the commissioner’s jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the commissioner or before a person authorized by the commissioner.

(d) The commissioner, in accordance with the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code), may appoint and fix the compensation of clerical, inspection, investigation, evaluation, and auditing personnel as may be necessary to implement this division.

(e) The personnel of the agency shall perform duties as assigned to them by the commissioner. The commissioner shall designate certain employees by the rule or order that are to take and subscribe to the constitutional oath within 15 days after their
appointments, and to file that oath with the Secretary of State. The commissioner shall also designate those employees that are to be subject to Title 9 (commencing with Section 81000) of the Government Code. (f) The commissioner shall adopt a seal bearing the inscription: “Commissioner, California Health Insurance Agency, State of California.” The seal shall be affixed to or imprinted on all orders and certificate issued by him or her and other instruments as he or she directs. All courts shall take notice of this seal.

(g) The administration of the agency shall be supported from the Health Insurance Fund created pursuant to Section 140200. (h) The commissioner, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the agency, unless the commissioner finds that this availability or publication is contrary to law. No provision of this division authorizes the commissioner or any of the commissioner’s assistants, clerks, or deputies to disclose any information withheld from public inspection except among themselves or when necessary or appropriate in a proceeding or investigation under this division or to other federal or state regulatory agencies. No provision of this division either creates or derogates from any privilege that exists at common law or otherwise when documentary or other evidence is sought under a subpoena directed to the commissioner or any of his or her assistants, clerks, and deputies.

(i) It is unlawful for the commissioner or any of his or her assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the commissioner and that is not then generally available to the public.

(j) The commissioner shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate; contribution of more than five hundred dollars ($500) to any one candidate in a calendar year or a contribution in excess of an aggregate of one thousand dollars ($1,000) in a calendar year for all political parties or organizations; and attempting to avoid compliance with
this prohibition by making contributions through a spouse or
other family member.
(k) The commissioner shall not participate in making or in any
way attempt to use his or her official position to influence a
governmental decision in which he or she knows or has reason to
know that he or she or a family or a business partner or colleague
has a financial interest.
(l) The commissioner, in pursuit of his or her duties, shall have
unlimited access to all nonconfidential and all nonprivileged
documents in the custody and control of the agency.
(m) The Attorney General shall render to the commissioner
opinions upon all questions of law, relating to the construction or
interpretation of any law under the commissioner’s jurisdiction
or arising in the administration thereof, that may be submitted to
the Attorney General by the commissioner and upon the
commissioner’s request shall act as the attorney for the
commissioner in actions and proceedings brought by or against
the commissioner or under or pursuant to any provision of any
law under the commissioner’s jurisdiction.
140102. The commissioner shall do all of the following:
(a) Oversee the establishment as part of the administration of
the agency all of the following:
(1) The Health Insurance Policy Board, pursuant to Section
140103.
(2) The Office of Patient Advocacy, pursuant to Section
140105.
(3) The Office of Health Planning, pursuant to Section
140602.
(4) The Office of Health Care Quality pursuant to Section
140605.
(5) The Health Insurance Fund, pursuant to Section 140200.
(6) The Payments Board, pursuant to Section 140208.
(7) The Public Advisory Committee pursuant to Section
140104.
(8) Partnerships for Health.
(b) Determine California Health Insurance System goals,
standards, guidelines, and priorities.
(c) Establish health care regions, pursuant to Section 140112.
(d) Oversee the establishment of real and virtual locally-based
integrated service networks that include physicians in
fee-for-service, solo and group practice, essential community, and ancillary care providers and facilities in order to pool and align resources and form interdisciplinary teams that share responsibility and accountability for patient care and provide a continuum of coordinated high quality primary to tertiary care to all California residents. This shall be accomplished in collaboration with the chief medical officer, the Director of Health Planning, the regional medical officers, the regional planning boards, and the patient advocate.

(e) Establish standards based on clinical efficacy to guide delivery of care and ensure a smooth transition to clinical decisionmaking under statewide standards.

(f) Implement policies to ensure that all Californians receive culturally and linguistically sensitive care, pursuant to Section 140604, and develop mechanisms and incentives to achieve this purpose and means to monitor the effectiveness of efforts to achieve this purpose.

(g) Create a systematic approach to the measurement, management, and accountability for care quality that assures the delivery of high quality care to all California residents, including a system of performance contracts that contain measurable goals and outcomes.

(h) Develop methods and a framework to measure the performance of health insurance and health delivery system upper level managers, including a system of performance contracts that contain measurable goals and outcomes.

(i) Establish a capital management plan for the California Health Insurance System, including, but not limited to, a standardized process and format for the development and submission of regional operating and regional capital budget requests.

(j) Ensure the establishment of policies that support the public health.

(k) Ensure that health insurance system policies and providers support all Californians in achieving and maintaining maximum physical and mental functionality.

(l) Establish and maintain appropriate statewide and regional health care databases.
(m) Establish a means to identify areas of medical practice where standards of care do not exist and establish priorities and a timetable for their development.
(n) Establish standards for mandatory reporting by health care providers and penalties for failure to report.
(o) Implement policies to ensure that all residents of this state have access to medically appropriate, coordinated mental health services.
(p) Establish a comprehensive budget that ensures adequate funding to meet the health care needs of the population and the compensation for providers for care provided pursuant to this division.
(q) Establish standards and criteria for allocation of operating and capital funds from the Health Insurance Fund as described in Chapter 3 (commencing with Section 140200).
(r) Establish standards and criteria for development and submission of provider operating and capital budget requests.
(s) Determine the level of funding to be allocated to each health care region.
(t) Annually assess projected revenues and expenditures to assure financial solvency of the system.
(u) During transition and annually thereafter, determine the appropriate level for a health insurance system reserve fund and implement policies needed to establish the appropriate reserve.
(v) Institute necessary cost controls pursuant to Section 140203 to assure financial solvency of the system.
(w) Develop separate formulae for budget allocations and review the formulae annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees and prices.
(x) Meet regularly with the chief medical officer, the patient advocate, the Public Advisory Committee, the Director of Health Planning, the Director of the Payments Board, the Director of the Partnerships for Health, the Technical Advisory Committee, regional planning directors, and regional medical officers to review the impact of the agency and its policies on the health of the population and on satisfaction with the California Health Insurance System.
(y) Negotiate for or set rates, fees, and prices involving any aspect of the California Health Insurance System and establish procedures thereto.

(z) Establish a capital management framework for the California Health Insurance System pursuant to Section 140216 to ensure that the needs for capital health care infrastructure are met, pursuant to the goals of the system.

(aa) Ensure a smooth transition to California Health Insurance System oversight of capital health care planning.

(bb) Establish a formulary based on clinical efficacy for all prescription drugs and durable and nondurable medical equipment for use by the California Health Insurance System.

(cc) Establish guidelines for prescribing medications, nutritional supplements, and durable medical equipment that are not included in the health system formularies.

(dd) Utilize the purchasing power of the state to negotiate price discounts for prescription drugs and durable and nondurable medical equipment for use by the California Health Insurance System.

(ee) Ensure that use of state purchasing power achieves the lowest possible prices for the California Health Insurance System without adversely affecting needed pharmaceutical research.

(ff) Create incentives and guidelines for research needed to meet the goals of the system and disincentives for research that does not achieve California Health Insurance System goals.

(gg) Implement eligibility standards for the system, including guidelines to prevent an influx of persons to the state for the purpose of obtaining medical care.

(hh) Determine an appropriate level of, and provide support during the transition for training and job placement for persons who are displaced from employment as a result of the initiation of the new California Health Insurance System.

(ii) Establish an enrollment system that ensures all eligible California residents, including those who travel frequently; those who have disabilities that limit their mobility, hearing, or vision; those who cannot read; and those who do not speak or write English are aware of their right to health care and are formally enrolled.

(jj) Oversee the establishment of the system for resolution of disputes pursuant to Sections 140608 and 140609.
(kk) Establish an electronic claims and payments system for the California Health Insurance System, to which all claims shall be filed and from which all payments shall be made, and implement, to the extent permitted by federal law, standardized claims and reporting methods.

(ll) Establish a system of secure electronic medical records that comply with state and federal privacy laws and that are compatible across the system.

(mm) Establish an electronic referral system that is accessible to providers and to patients.

(nn) Establish guidelines for mandatory reporting by health care providers.

(oo) Establish a Technology Advisory Committee to evaluate the cost and effectiveness of new medical technology, including electronic medical technology, and to make recommendations about the financial and health impact of their inclusion in the benefit package.

(pp) Investigate the costs and benefits to the health of the population of advances in information technology, including those that support data collection, analysis, and distribution.

(qq) Ensure that consumers of health care have access to information needed to support choice of physician.

(rr) Collaborate with the boards that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely fashion and that consumers and providers of health care have access to information needed to support choice of facility.

(ss) Establish a Health Insurance System Internet Web site that provides information to the public about the California Health Insurance System that includes, but is not limited to, information that supports choice of provider and facilities, informs the public about state and regional health insurance policy board meetings and activities of the Partnerships for Health.

(tt) Procure funds, including loans, lease or purchase of insurance for the system, its employees and agents.

(uu) Collaborate with state and local authorities, including regional health directors, to plan for needed earthquake retrofits in a manner that does not disrupt patient care.
(vv) Establish a process for the system to receive the concerns, opinions, ideas, and recommendation of the public regarding all aspects of the system.

(ww) Annually report to the Legislature and the Governor, on or before October of each year and at other times pursuant to this division, on the performance of the California Health Insurance System, its fiscal condition and need for rate adjustments, consumer copayments or consumer deductible payments, recommendations for statutory changes, receipt of payments from the federal government and other sources, whether current year goals and priorities are met, future goals, and priorities, and major new technology or prescription drugs or other circumstances that may affect the cost of health care.

140103. (a) The commissioner shall establish a Health Insurance Policy Board and shall serve as the president of the board.

(b) The board shall do all of the following:

(1) Establish health insurance system goals and priorities, including research and capital investment priorities.

(2) Establish the scope of services to be provided to the population.

(3) Establish guidelines for evaluating the performance of the health insurance system, health insurance system officers, health care regions, and health care providers.

(4) Establish guidelines for ensuring public input on health insurance system policy, standards, and goals.

(c) The board shall consist of the following members:

(1) The commissioner.

(2) The deputy commissioner.

(3) The Health Insurance Fund Director.

(4) The patient advocate.

(5) The chief medical officer.

(6) The Director of Health Planning.

(7) The Director of the Partnerships for Health.

(8) The Director of the Payments Board.

(9) The state public health officer.

(10) One member of the Public Advisory Committee who shall serve on a rotating basis to be determined by the Public Advisory Committee.

(11) Two representatives from regional planning boards.
(A) A regional representative shall serve a term of one year and terms shall be rotated in order to allow every region to be represented within a five-year period.

(B) A regional planning director shall appoint the regional representative to serve on the board.

d) It is unlawful for the board members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the board and that is not then generally available to the public.

140104. (a) The commissioner shall establish a public advisory committee to advise the Health Insurance Policy Board on all matters of health insurance system policy.

(b) Members of the Public Advisory Committee shall include all of the following:

1. Four physicians all of whom shall be board certified in their field and at least one of whom shall be a psychiatrist. The Senate Committee on Rules and the Governor shall each appoint one member. The Speaker of the Assembly shall appoint two of these members, both of whom shall be primary care providers.

2. One registered nurse, to be appointed by the Senate Committee on Rules.

3. One licensed vocational nurse, to be appointed by the Senate Committee on Rules.

4. One licensed allied health practitioner, to be appointed by the Speaker of the Assembly.

5. One mental health care provider, to be appointed by the Senate Committee on Rules.

6. One dentist, to be appointed by the Governor.

7. One representative of private hospitals, to be appointed by the Governor.

8. One representative of public hospitals, to be appointed by the Governor.

9. Four consumers of health care. The Governor shall appoint two of these members, one of whom shall be a member of the disability community. The Senate Committee on Rules shall appoint a member who is 65 years of age or older. The Speaker of the Assembly shall appoint the fourth member.

10. One representative of organized labor, to be appointed by the Speaker of the Assembly.
(11) One representative of essential community providers, to be appointed by the Senate Committee on Rules.

(12) One union member, to be appointed by the Senate Committee on Rules.

(13) One representative of small business, to be appointed by the Governor.

(14) One representative of large business, to be appointed by the Speaker of the Assembly.

(15) One pharmacist, to be appointed by the Speaker of the Assembly.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall make good faith efforts to assure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(d) Any member appointed by the Governor, the Senate Committee on Rules, or the Speaker of the Assembly shall serve for a four-year term. These members may be reappointed for succeeding four-year terms.

(e) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was selected or appointed. The commissioner shall notify the appropriate appointing authority of any expected vacancies on the board.

(f) Members of the advisory committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive one hundred dollars ($100) for each full day of attending meetings of the board. For purposes of this section, “full day of attending a meeting” means presence at, and participation in, not less than 75 percent of the total meeting time of the board during any particular 24-hour period.

(g) The advisory committee shall meet at least six times a year in a place convenient to the public. All meetings of the board shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).
(h) The advisory committee shall elect a chair who shall serve for two years and who may be reelected for an additional two years.

(i) Appointed committee members shall have worked in the field they represent on the committee for a period of at least two years prior to being appointed to the committee.

(j) The advisory committee shall elect a member to serve on the Health Insurance Policy Board. The elected member shall serve for one year, and may be recalled by the advisory committee for cause. In that case a new member shall be elected to serve on that board. The advisory committee representative shall represent the views of the advisory committee members to the board.

(k) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the committee and that is not generally available to the public.

140105. (a) (1) There is within the agency an Office of Patient Advocacy to represent the interests of the consumers of health care. The goal of the office shall be to help residents of the state secure the health care services and benefits to which they are entitled under the laws administered by the agency and to advocate on behalf of and represent the interests of consumers in governance bodies created by this division and in other forums.

(2) The office shall be headed by a patient advocate appointed by the commissioner.

(3) The patient advocate shall establish an office in the City of Sacramento and other offices throughout the state that shall provide convenient access to residents.

(b) The patient advocate shall do all the following:

(1) Administer all aspects of the Office of Patient Advocacy.

(2) Assure that services of the Office of Patient Advocacy are available to all California residents.

(3) Serve on the Health Insurance Policy Board and participate in the regional Partnerships for Health.

(4) Oversee the establishment and maintenance of the grievance process pursuant to Sections 140608, 140609, and 140610.
(5) Participate in the grievance process and independent medical review system on behalf of consumers pursuant to Sections 140608 and 140609.

(6) Receive, evaluate, and respond to consumer complaints about the health insurance system.

(7) Provide a means to receive recommendations from the public about ways to improve the health insurance system and hold public hearings at least once annually to discuss problems and receive recommendations from the public.

(8) Develop educational and informational guides for consumers describing their rights and responsibilities and informing them about effective ways to exercise their rights to secure health care services and to participate in the health insurance system. The guides shall be easy to read and understand, available in English and other languages, including Braille and formats suitable for those with hearing limitations, and shall be made available to the public by the agency, including access on the agency’s Internet Web site and through public outreach and educational programs and displayed in provider offices and health care facilities.

(9) Establish a toll-free number to receive complaints regarding the agency and its services. Those with hearing and speech limitations may use the California Relay Service’s toll-free telephone numbers to contact the Office of Patient Advocacy. The agency Internet Web site shall have complaint forms and instructions on their use.

(10) Report annually to the public, the commissioner, and the Legislature about the consumer perspective on the performance of the health insurance system, including recommendations for needed improvements.

(c) Nothing in this division shall prohibit a consumer or class of consumers or the patient advocate from seeking relief through the judicial system.

(d) The patient advocate in pursuit of his or her duties shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(e) It is unlawful for the patient advocate or any of his or her assistants, clerks, or deputies to use for personal benefit any
information that is filed with, or obtained by, the agency and that
is not then generally available to the public.

140106. (a) There is within the Office of the Attorney
General an Office of the Inspector General for the California
Health Insurance System. The Inspector General shall be
appointed by the Governor and subject to Senate confirmation.

(b) The Inspector General shall have broad powers to
investigate, audit, and review the financial and business records
of individuals, public and private agencies and institutions, and
private corporations that provide services or products to the
system, the costs of which are reimbursed by the system.

(c) The Inspector General shall investigate allegations of
misconduct on the part of an employee or appointee of the
agency and on the part of any health care provider of services
that are reimbursed by the system and shall report any findings of
misconduct to the Attorney General.

(d) The Inspector General shall investigate patterns of medical
practice that may indicate fraud and abuse related to over or
under utilization or other inappropriate utilization of medical
products and services.

(e) The Inspector General shall arrange for the collection and
analysis of data needed to investigate the inappropriate utilization
of these products and services.

(f) The Inspector General shall conduct additional reviews or
investigations of financial and business records when requested
by the Governor or by any Member of the Legislature and shall
report findings of the review or investigation to the Governor and
the Legislature.

(g) The Inspector General shall establish a telephone hotline
for anonymous reporting of allegations of failure to make health
insurance premium payments established by this division. The
Inspector General shall investigate information provided to the
hotline and shall report any findings of misconduct to the
Attorney General.

(h) The Inspector General shall annually report
recommendations for improvements to the system or the agency
to the Governor, the Legislature, and the commissioner.

140107. The provisions of the Insurance Fraud Prevention
Act (Chapter 12 (commencing with Section 1871) of Part 2 of
Division 1 of the Insurance Code), and the provisions of Article
6 (commencing with Section 650) of Chapter 1 of Division 2 of
the Business and Professions Code, shall be applicable to health
care providers who receive payments for services through the
system under this division.

140108. (a) Nothing contained in this division is intended to
repeal any legislation or regulation governing the professional
conduct of any person licensed by the State of California or any
legislation governing the licensure of any facility licensed by the
State of California.

(b) All federal legislation and regulations governing referral
fees and fee-splitting, including, but not limited to, Sections
1320a-7b and 1395nn of Title 42 of the United States Code shall
be applicable to all health care providers of services reimbursed
under this division, whether or not the health care provider is
paid with funds coming from the federal government.

140110. (a) The health insurance system shall be operational
no later than two years after the date this division, other than
Article 2 (commencing with Section 140230) of Chapter 3,
becomes operative, as described in Section 140700.

(b) The transition shall be funded from a loan from the
General Fund and from other sources, including private sources
identified by the commissioner.

(c) The commissioner shall assess health plans and insurers for
care provided by the system in those cases in which a person’s
health care coverage extends into the time period in which the
new system is operative.

(d) The commissioner shall implement means to assist persons
who are displaced from employment as a result of the initiation
of the new health insurance system, including determination of
the period of time during which assistance shall be provided and
possible sources of funds, including health insurance funds, to
support retraining and job placement. That support shall be
provided for a period of five years from the date that this division
becomes operative.

140111. (a) The commissioner shall appoint a transition
advisory group to assist with the transition to the system. The
transition advisory group shall include, but not be limited to, the
following members:

(1) The commissioner.

(2) The patient advocate.
(3) The chief medical officer.  
(4) The Director of Health Planning.  
(5) The Director of the Health Insurance Fund.  
(6) The State Public Health Officer.  
(7) Experts in health care financing and health care administration.  
(8) Direct care providers.  
(9) Representatives of retirement boards.  
(10) Employer and employee representatives.  
(11) Hospital, essential community provider, and long-term care facility representatives.  
(12) Representatives from state departments and regulatory bodies that shall or may relinquish some or all parts of their delivery of health service to the system.  
(13) Representatives of counties.  
(14) Consumers of health care.  
(b) The transition advisory group shall advise the commissioner on all aspects of the implementation of this division.  
(c) The transition advisory group shall make recommendations to the commissioner, the Governor, and the Legislature on how to integrate health care delivery services and responsibilities relating to the delivery of the services of the following departments and agencies into the system:  
(1) The State Department of Health Services.  
(2) The Department of Managed Health Care.  
(3) The Department of Aging.  
(4) The Department of Developmental Services.  
(6) The Department of Mental Health.  
(7) The Department of Alcohol and Drugs.  
(8) The Department of Rehabilitation.  
(9) The Emergency Medical Services Authority.  
(10) The Managed Risk Medical Insurance Board.  
(11) The Office of Statewide Health Planning and Development.  
(12) The Department of Insurance.  
(d) The transition advisory group shall make recommendations to the Governor, the Legislature, and the commissioner regarding
research needed to support transition to the new health insurance system.

140112. (a) The transition advisory group shall make recommendations to the commissioner relative to how the health insurance system shall be regionalized for the purposes of local and community-based planning for the delivery of high quality cost-effective care and efficient service delivery.

(b) The commissioner, in consultation with the Director of Health Planning, shall establish up to 10 health planning regions composed of geographically contiguous counties grouped on the basis of the following considerations:

1. Patterns of utilization of health care services.
2. Health care resources, including workforce resources.
3. Health needs of the population, including public health needs.
4. Geography.
5. Population and demographic characteristics.
6. Other considerations as determined by the commissioner, Director of Health Planning, or chief medical officer.

(c) The commissioner shall appoint a director for each region. Regional planning directors shall serve at the will of the commissioner and may serve up to two eight-year terms to coincide with the terms of the commissioner.

(d) Each regional planning director shall appoint a regional medical officer.

(e) Compensation for health system officers and appointees who are exempt from the civil service shall be established by the California Citizens Commission in accordance with Section 8 of Article III of the California Constitution, and shall take into consideration regional differences in the cost of living.

(f) The regional planning director and the regional medical officer shall be subject to Title 9 (commencing with Section 81000) of the Government Code and shall comply with the qualifications for office described in subdivisions (c), (d), and (e) of Section 140100 and subdivisions (j) and (k) of Section 140101.

140113. (a) Regional planning directors shall administer the health planning region. The regional planning director shall be responsible for all duties, the exercise of all powers and jurisdiction, and the assumptions and discharge of all
responsibilities vested by law in the regional agency. The regional planning director shall perform all duties imposed upon him or her by this division and by other laws related to health care, and shall enforce execution of those provisions and laws to promote their underlying aims and purposes.

(b) The regional planning director shall reside in the region in which he or she serves.

(c) The regional planning director shall do all of the following:
(1) Establish and administer a regional office of the state agency. Each regional office shall include, at minimum, an office of each of the following: Patient Advocacy, Health Care Quality, Health Planning, and Partnerships for Health.
(2) Establish regional goals and priorities pursuant to standards, goals, priorities, and guidelines established by the commissioner.
(3) Assure that regional administrative costs meet standards established by the division.
(4) Seek innovative means to lower the costs of administration of the regional planning office and those of regional providers.
(5) Plan for the delivery of, and equal access to, high quality and culturally and linguistically sensitive care that meets the needs of all regional residents pursuant to standards established by the commissioner.
(6) Seek innovative and systemic means to improve care quality and efficiency of care delivery.
(7) Appoint regional planning board members and serve as president of the board.
(8) Recommend means to and implement policies established by the commissioner to provide support to persons displaced from employment as a result of the initiation of the new system.
(9) Make needed revenue sharing arrangements so that regionalization does not limit a patient’s choice of provider.
(10) Implement procedures established by the commissioner for the resolution of disputes.
(11) Implement processes established by the commissioner and recommend needed changes to permit the public to share concerns, provide ideas, opinions, and recommendations regarding all aspects of the system policy.
(12) Report regularly to the public and, at intervals determined by the commissioner, and pursuant to this division, to the
commissioner, on the status of the regional planning system, including evaluating access to care, quality of care delivered, and provider performance, and other issues related to regional health care needs, and recommending needed improvements.

(13) Identify and prioritize regional health care needs and goals, in collaboration with the regional medical officer, regional health care providers, the regional planning board, and regional director of Partnerships for Health.

(14) Identify or establish guidelines for providers to identify, maintain, and provide to the regional director inventories of regional health care assets.

(15) Establish and maintain regional health care databases.

(16) In collaboration with the regional medical officer, enforce reporting requirements established by the California Health Insurance System and make recommendations to the commissioner, the Director of Health Planning, and the chief medical officer for needed changes in reporting requirements.

(17) Convene meetings of regional health care providers to facilitate coordinated regional health care planning.

(18) Establish and implement a regional capital management plan pursuant to the capital management plan established by the commissioner for the system.

(19) Implement standards and formats established by the commissioner for the development and submission of operating and capital budget requests and make recommendations to the commissioner and the Director of Health Planning for needed changes.

(20) Support regional providers in developing operating and capital budget requests.

(21) Receive, evaluate, and prioritize provider operating and capital budget requests pursuant to standards and criteria established by the commissioner.

(22) Prepare a three-year regional operating and capital budget request that meets the health care needs of the region pursuant to this division, for submission to the commissioner.

(23) Establish a comprehensive three-year regional planning budget using funds allocated to the region by the commissioner.

(24) Regularly assess projected revenues and expenditures to ensure fiscal solvency of the regional planning system and advise
the commissioner of potential revenue shortfalls and the possible need for cost controls.

140114. (a) The regional medical officers shall do all of the following:

1. Administer all aspects of the regional office of health care quality.
2. Serve as a member of the Regional Planning Board.
3. Support the delivery of high quality care to all residents of the region pursuant to this division.
4. Ensure a smooth transition to care delivery by regional providers under standards based on clinical efficacy that guide clinical decisionmaking.
5. Support the development and distribution of user-friendly software for use by providers in order to support the delivery of high quality care.
6. In collaboration with the chief medical officer and regional providers, evaluate standards of care in use at the time the California Health Insurance System becomes operative.
7. Ensure the implementation of needed improvements so that a single standard of high quality care is delivered to all residents under standards that guide clinical decisionmaking.
8. In collaboration with the commissioner, the chief medical officer, the regional medical officer, regional planning boards, the patient advocate, regional providers, and consumers oversee the establishment of real and virtual integrated service networks of fee-for-service, solo and group practice, essential community, and ancillary care providers and facilities that pool and align resources and form interdisciplinary teams that share responsibility and accountability for patient care and provide a continuum of coordinated high quality primary to tertiary care to all residents of the region.
9. Assure the evaluation and measurement of the quality of care delivered in the region, including assessment of the performance of individual providers, pursuant to standards and methods established by the chief medical officer.
10. Provide feedback to, and support and supervision of, medical providers to ensure the delivery of high quality care pursuant to standards established by the health insurance system.
(11) Assure the provision of information to assist consumers in evaluating the performance of health care providers and facilities.

(12) Identify areas of medical practice where standards have not been established and collaborate with the chief medical officer and health care providers, to establish priorities in developing needed standards.

(13) Collaborate with regional public health officers to establish regional health policies that support the public health.

(14) Establish a regional program to monitor and decrease medical errors and their causes pursuant to standards and methods established by the chief medical officer.

(15) Support the development and implementation of innovative means to provide high quality care and assist providers in securing funds for innovative demonstration projects that seek to improve care quality.

(16) Establish means to assess the impact of health insurance system policies intended to assure the delivery of high quality care.

(17) Collaborate with the chief medical officer and the Director of Health Planning and health care providers in the development and maintenance of regional health care databases.

(18) Ensure the enforcement of, and recommend needed changes in, health insurance system reporting requirements.

(19) Support providers in developing regional budget requests.

(20) Collaborate with the regional director of the Partnerships for Health to develop patient education on appropriate utilization of health care services.

(21) Annually report to the commissioner, the public, the regional planning board, and the chief medical officer on the status of regional health care programs, needed improvements and plans to implement and evaluate delivery of care improvements.

140115. (a) Each region shall have a regional planning board consisting of 13 members who shall be appointed by the regional planning director. Members shall serve eight-year terms that coincide with the term of the regional planning director and may be reappointed for a second term.
(b) Regional planning board members shall have resided for a minimum of two years in the region in which they serve prior to appointment to the board.

(c) Regional planning board members shall reside in the region they serve while on the board.

(d) The board shall consist of the following members:

1. The regional planning director, the regional medical officer and the regional director of the Partnerships for Health and a public health officer from one of the regional counties.

2. When there is more than one county in a region, the public health officer board position shall rotate among the public health county officers on a timetable to be established by each regional planning board.

3. A representative from the Office of Patient Advocacy.

4. One expert in health care financing.

5. One expert in health care planning.

6. Two members who are direct patient care providers in the region, one of whom shall be a registered nurse.

7. One member who represents ancillary health care workers in the region.

8. One member representing hospitals in the region.

9. One member representing essential community providers in the region.

10. One member representing the public.

(e) The regional planning director shall serve as chair of the board.

(f) The purpose of the regional planning boards is to advise and make recommendations to the regional planning director on all aspects of regional health policy.

(g) Meetings of the board shall be open to the public pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

140116. The following conflict of interest prohibitions shall apply to all appointees of the commissioner or transition commission, including, but not limited to, the patient advocate, the health insurance fund director, the purchasing director, the Director of Health Planning, the Director of the Payments Board, the chief medical officer, the Director of Partnerships for Health, regional directors, and the inspector general:
(a) The appointee shall not have been employed in any capacity by a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the system for a period of two years prior to appointment.

(b) For two years after completing service in the system, the appointee may not receive payments of any kind from, or be employed in any capacity or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment company that sells products to the system.

(c) The appointee shall avoid political activity that may create the appearance of political bias or impropriety. Prohibited activities shall include, but not be limited to, leadership of, or employment by, a political party or a political organization; public endorsement of a political candidate; contribution of more than five hundred dollars ($500) to any one candidate in a calendar year or a contribution in excess of an aggregate of one thousand dollars ($1,000) in a calendar year for all political parties or organizations; and attempting to avoid compliance with this prohibition by making contributions through a spouse or other family member.

(d) The appointee shall not participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she or a family or a business partner or colleague has a financial interest.

Chapter 3. Funding


140200. (a) In order to support the agency effectively in the administration of this division, there is hereby established in the State Treasury the Health Insurance Fund. The fund shall be administered by a director appointed by the commissioner.

(b) All moneys collected, received, and transferred pursuant to this division shall be transmitted to the State Treasury to be deposited to the credit of the Health Insurance Fund for the purpose of financing the California Health Insurance System.

(c) Moneys deposited in the Health Insurance Fund shall be used exclusively to support this division.
(d) All claims for health care services rendered shall be made to the Health Insurance Fund through an electronic claims and payment system. The commissioner shall investigate the costs, benefits, and means of supporting providers in obtaining electronic systems for claims and payments transactions; however, alternative provisions shall be made for providers without electronic systems.

(e) All payments made for health care services shall be disbursed from the Health Insurance Fund through an electronic claims and payments system; however, alternative provisions shall be made for providers without electronic systems.

(f) The director of the fund shall serve on the Health Insurance Policy Board.

140201. (a) The Director of the Health Insurance Fund shall establish the following accounts within the Health Insurance Fund:

1. A system account to provide for all annual state expenditures for health care.
2. A reserve account.

(b) Premiums collected each year shall be roughly sufficient to cover that year’s projected costs.

(c) The health insurance system shall at all times hold in reserve an amount estimated in the aggregate to provide for the payment of all losses and claims for which the system may be liable, and to provide for the expense of adjustment or settlement of losses and claims.

(d) During the transition, the commissioner shall work with the Department of Insurance and other experts to determine an appropriate level of health system reserves for the first year and for future years of health insurance system operation.

(e) Moneys currently held in reserve by state, city, and county health programs and federal moneys for health care held in reserve in federal trust accounts shall be transferred to the state health care reserve account when the state assumes financial responsibility for health care under this division that are currently provided by those programs.

(f) The commissioner may implement arrangements to self-insure the system against unforeseen expenditures or revenue shortfalls not covered by reserves and may borrow funds to cover temporary revenue shortfalls not covered by system reserves,
including the issuance of bonds for this purpose, whichever is the
more cost effective.

(g) Funds held in the reserve account and other Health
Insurance Fund accounts may be prudently invested to increase
their value according to the Department of Insurance’s standards
for liquidity and asset management.

140203. (a) The Director of the Health Insurance Fund shall
immediately notify the commissioner when regional or statewide
revenue and expenditure trends indicate that expenditures may
exceed revenues.

(b) If the commissioner determines that statewide revenue
trends indicate the need for statewide cost control measures, the
commissioner shall convene the Health Insurance Policy Board
to discuss the need for cost control measures and shall
immediately report to the Legislature and the public regarding
the possible need for cost control measures.

(c) Cost control measures include any or all of the following:

(1) Changes in the health insurance system or health facility
administration that improve efficiency.

(2) Changes in the delivery of health care services that
improve efficiency and care quality.

(3) Postponement of introduction of new benefits or benefit
improvements.

(4) Seeking statutory authority for a temporary decrease in
benefits.

(5) Postponement of planned capital expenditures.

(6) Adjustments of health care provider payments to correct
for deficiencies in care quality and failure to meet compensation
contract performance goals, pursuant to subdivisions (a) to (f),
inclusive, of Section 140106, paragraph (4) of subdivision (a) of
Section 140204, subdivision (a) of Section 140213, and
subdivisions (c) and (d) of Section 140606.

(7) Adjustments on the reimbursement of health insurance
system managerial employees and upper level health system
managers to correct for deficiencies in management and failure to
meet contract performance goals.

(8) Limitations on the reimbursement budgets of health system
providers and upper level managers whose compensation is
determined by the Health Insurance System Payment Board.
(9) Limitations on aggregate reimbursements to manufacturers of pharmaceutical and durable and nondurable medical equipment.

(10) Deferred funding of the reserve account.

(11) Imposition of copayments or deductible payments. Any copayment or deductible payments imposed shall be subject to all of the following requirements:

(A) No copayment or deductible may be established when prohibited by federal law.

(B) All copayments and deductibles shall meet federal guidelines for copayments and deductible payments that may lawfully be imposed on persons with low income.

(C) The commissioner shall establish standards and procedures for waiving copayments or deductible payments and a waiver card which shall be issued to a patient or to a family to indicate the waiver. Procedures for copayment waiver may include a determination by a patient’s primary care provider that imposition of a copayment would be a financial hardship. Copayment and deductible waivers shall be reviewed annually by the regional planning director.

(D) Waivers shall not affect the reimbursement of health care providers.

(E) Any copayments or deductible payments established pursuant to this section shall be transmitted to the Treasurer to be deposited to the credit of the Health Insurance Fund.

(12) Imposition of an eligibility waiting period and other means if the commissioner determines that large numbers of people are emigrating to the state for the purpose of obtaining health care through the California Health Insurance System.

(d) Nothing in this division shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(e) Nothing in this division shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this division.

(f) Cost control measures implemented by the commissioner and the health insurance policy board shall remain in place in the state until the commissioner and the Health Insurance Policy
Board determine that the cause of a revenue shortfall has been corrected.

(g) If the Health Insurance Policy Board determines that cost control measures described in subdivision (c) will not be sufficient to meet a revenue shortfall, the commissioner shall report to the Legislature and to the public on the causes of the shortfall and the reasons for the failure of cost controls and shall recommend measures to correct the shortfall, including an increase in health insurance system premium payments.

140204. (a) If the commissioner or a regional planning director determines that regional revenue and expenditure trends indicate a need for regional cost control measures, the regional planning director shall convene the regional planning board to discuss the possible need for cost control measures and to make a recommendation about appropriate measures to control costs. These may include any of the following:

(1) Changes in health insurance system or health facility administration that improve efficiency.

(2) Changes in the delivery of health services and health system management that improve efficiency or care quality.

(3) Postponement of planned regional capital expenditures.

(4) Adjustment of payments to health care providers to reflect deficiencies in care quality and failure to meet compensation contract performance goals and payments to upper level managers to reflect deficiencies in management and failure to meet compensation contract performance goals.

(5) Adjustment of payments to health care providers and upper level managers above a specified amount of aggregate billing.

(6) Adjustment of payments to pharmaceutical and medical equipment manufacturers and others selling goods and services to the health insurance system above a specified amount of aggregate billing.

(b) In the event a regional planning board is convened to implement cost control measures, the commissioner shall participate in the regional planning board meeting.

(c) The regional planning director, in consultation with the commissioner, shall determine if cost control measures are warranted and those measures that shall be implemented.

(d) Imposition of copayments or deductibles, postponement of new benefits or benefit improvements, deferred funding of the
reserve account, establishment of eligibility waiting periods and
increases in health insurance premium payments may occur on a
statewide basis only and with the concurrence of the
commissioner and the Health Insurance Policy Board.
(e) If a regional planning director and regional planning board
are considering imposition of cost control measures, the regional
planning director shall immediately report to the residents of the
region regarding the possible need for cost control measures.
(f) Cost control measures shall remain in place in a region
until the regional planning director and the commissioner
determine that the cause of a revenue shortfall has been
corrected.
140205. (a) If, on June 30 of any year, the Budget Act for the
fiscal year beginning on July 1 has not been enacted, all moneys
in the reserve account of the Health Insurance Fund shall be used
to implement this division until funds are available through the
Budget Act.
(b) Notwithstanding any other provision of law and without
regard to fiscal year, if the annual Budget is not enacted by June
30 of any fiscal year preceding the fiscal year to which the
Budget would apply and if the commissioner determines that
funds in the reserve account are depleted, the following shall
occur:
(1) The Controller shall annually transfer from the General
Fund, in the form of one or more loans, an amount to the Health
Insurance Fund for the purpose of making payments to health
care providers and to persons and businesses under contract with
the health insurance system or with health providers to provide
services, medical equipment, and pharmaceuticals to the
California Health Insurance System.
(2) Upon enactment of the Budget Act in any fiscal year to
which paragraph (1) applies, the Controller shall transfer all
expenditures and unexpected funds loaned to the Health
Insurance Fund to the appropriate Budget Act item.
(3) The amount of any loan made pursuant to paragraph (1) for
which moneys were expended from the Health Insurance Fund
shall be repaid by debiting the appropriate Budget Act item in
accordance with procedures prescribed by the Department of
Finance.
(a) The commissioner annually shall prepare a health insurance system budget that includes all expenditures, specifies a limit on total annual state expenditures, and establishes allocations for each health care region that shall cover a three-year period and that shall be disbursed on a quarterly basis.

(b) The commissioner shall limit the growth of spending on a statewide and on a regional basis, by reference to average growth in state domestic product across multiple years; population growth, actuarial demographics and other demographic indicators; differences in regional costs of living, advances in technology and their anticipated adoption into the benefit plan; improvements in efficiency of administration and care delivery, improvements in the quality of care and to projected future state domestic product growth rates.

(c) The commissioner shall adjust the health insurance system budget so that aggregate spending in the state on health care outside of the system shall not exceed spending under this division by more than 5 percent.

(d) The commissioner shall project health insurance system revenues and expenditures for 3, 6, 9, and 12 years pursuant to parameters prescribed in subdivision (g).

(e) The commissioner shall annually convene a Health Insurance System Revenue and Expenditure Conference to discuss revenue and expenditure projections and future health insurance system policy directions and initiatives, including means to lower the cost of administration, improve management of and investment in capital assets, and improve the quality of care and health system management. Participants shall include regional health directors and medical officers, directors of the Health Insurance Fund and Payments Board, the patient advocate, state and regional directors of the Partnerships for Health, and representatives of the health insurance system facility upper level managers.

(f) The California Health Insurance System budget shall include all of the following:

1. Transition budget.
2. Providers and managers budget.
3. Capitated operating budgets.
4. Noncapitated operating budgets.
In establishing budgets, the commissioner shall make adjustments based on all of the following:

1. Costs of transition to the new system.
2. Projections regarding the health services anticipated to be used by California residents.
3. Differences in cost of living between the regions, including the overhead costs of maintaining medical practices.
4. Health risk of enrollees.
5. Scope of services provided.
6. Innovative programs that improve care quality, administrative efficiency, and workplace safety.
7. Unrecovered cost of providing care to persons who are not members of the California Health Insurance System. The commissioner shall seek to recover the costs of care provided to non-health insurance system members.
8. Costs of workforce training and development.
9. Costs of correcting health outcome disparities and the unmet needs of previously uninsured and underinsured enrollees.
10. Relative usage of different health care providers.
11. Needed improvements in access to care.
12. Projected savings in administrative costs.
13. Projected savings due to provision of primary and preventive care to the population, including savings from decreases in preventable emergency room visits and hospitalizations.
15. Projected savings from decreases in medical errors.
16. Projected savings from systemwide management of capital expenditures.
17. Cost of incentives and bonuses to support the delivery of high quality care, including incentives and bonuses needed to recruit and retain an adequate supply of needed providers and managers and to attract providers to medically underserved areas.
(18) Costs of treating complex illnesses, including disease management programs.


(20) Costs of new technology.

(21) Technology research and development costs and costs related to health insurance system use of new technologies.

(h) Moneys in the Reserve Account shall not be considered as available revenues for the purposes of preparing the system budget, except when the State Budget has not been enacted by June 30 of any fiscal year.

140207. The commissioner shall annually establish the total funds to be allocated for provider and manager compensation pursuant to this section. In establishing the provider and manager budgets, the commissioner shall allot sufficient funds to assure that California can attract and retain those providers and managers needed to meet the health needs of the population. In establishing provider and manager budgets, the commissioner shall allocate funds for both salaries, incentives, bonuses, and benefits to be provided to health insurance system officers and upper level managers who are exempt from state civil service statutes.

140208. (a) The commissioner shall establish the Payments Board and shall appoint a director and members of the board.

(b) The commissioner shall retain the authority to review, approve, reject, and modify all payment contracts and compensation plans established pursuant to this section.

(c) The Payments Board shall be composed of experts in health care finance and insurance systems, a designated representative of the commissioner, a designated representative the Health Insurance Fund, and a representative of the regional planning directors. The position of regional representative shall rotate among the directors of the regional planning boards every two years.

(d) The board shall establish and supervise a uniform payments system for providers and managers and shall maintain a compensation plan for all of the following providers and managers pursuant to the provider and manager budget established by the commissioner:
(1) Upper level managers employed in private health care facilities, including, but not limited to, hospitals, integrated health care systems, group and solo medical practices, and essential community facilities.

(2) Appointed California health insurance system managers and officers who are exempt from statutes governing civil service employment.

(3) Health care providers including, but not limited to, physicians, osteopathic physicians, dentists, podiatrists, nurse practitioners, physician assistants, chiropractors, acupuncturists, psychologists, social workers, marriage, family and child counselors, and other professional health care providers who are required by law to be licensed to practice in California and who provide services pursuant to the act.

(4) Health care providers licensed and accredited to provide services in California may choose, on a case-by-case or on an aggregate basis, to be compensated for their services either by the California Health Insurance System or by a person to whom they provide services.

(5) Compensation for health system employees that is determined through employer-union negotiations before implementation of this division shall be determined by health insurance system-union negotiations after that implementation.

(6) Providers electing to be compensated by the California Health Insurance System shall enter into a contract with the health insurance system pursuant to provisions of this section.

(7) Providers electing to be compensated by persons to whom they provide services, instead of by the California Health Insurance System, may establish charges for their services.

(8) Health care providers who accept any payment under this division shall not bill a patient for any covered service.

(e) Health care providers licensed or accredited to provide services in California, who choose to be compensated by the health insurance system instead of by patients to whom they provide services, may choose how they wish to be compensated under this division, as fee-for-service providers or as salaried providers in health care systems that provide comprehensive, coordinated services.

(f) Notwithstanding provisions of the Business and Professions Code, nurse practitioners, physician assistants, and
others who under California law must be supervised by a
physician, an osteopathic physician, a dentist, or a podiatrist, may
choose fee-for-service compensation while under lawfully
required supervision. However, nothing in this section shall
interfere with the right of a supervising provider to enter into a
contractual arrangement that provides for salaried compensation
for employees who must be supervised under the law by a
physician, an osteopathic physician, a dentist, or a podiatrist.

(g) The compensation plan shall include all of the following:
(1) Actuarially sound payments that include a just and fair
return for providers in the fee-for-service sector and for providers
working in health systems where comprehensive and coordinated
services are provided, including the actuarial basis for the
payment.
(2) Payment schedules which shall be in effect for three years.
(3) Bonus and incentive payments, including, but not limited
to, all the following:
(A) Bonus payments for providers and upper level managers
who, in providing services and managing facilities, practices and
integrated health systems, pursuant to this division, meet
performance standards and outcome goals established by the
California Health Insurance System.
(B) Incentive payments for providers and upper level
managers who provide services to the California Health
Insurance System in areas identified by the Office of Health
Planning as medically underserved.
(C) Incentive payments required to achieve the ratio of
generalist to specialist providers needed in order to meet the
standards of care and health needs of the population.
(D) Incentive payments required to recruit and retain nurse
practitioners and physician assistants in order to provide primary
and preventive care to the population.
(E) No bonus or incentive payment may be made in excess of
the total allocation for provider and manager incentive and bonus
reimbursement established by the commissioner in the health
insurance system budget.
(F) No incentive may adversely affect the care a patient
receives or the care a health provider recommends.
(h) Providers shall be paid for all services provided pursuant to
this division, including care provided to persons who are
subsequently determined to be ineligible for the California Health Insurance System.

(i) Licensed providers who deliver services not covered under the California Health Insurance System may establish rates for, and charge patients for those services.

(j) Reimbursement to providers and managers may not exceed the amount allocated by the commissioner to provider and manager annual budgets.

140209. (a) Fee-for-service providers shall choose representatives of their specialties to negotiate reimbursement rates with the Payments Board on their behalf.

(b) The Payments Board shall establish a uniform system of payments for all services provided pursuant to this division.

(c) Payment schedules shall be available to providers in printed and in electronic documents.

(d) Payment schedules shall be in effect for three years, at which time payment schedules may be renegotiated. Payment adjustments may be made at the discretion of the pay board to meet the goals of the health insurance system.

(e) In establishing a uniform system of payments the Payments Board shall collaborate with regional health directors and providers and shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers in the region.

(f) Fee-for-service providers shall submit claims electronically to the Health Insurance Fund and shall be paid within 30 business days for claims filed in compliance with procedures established by the Health Insurance Fund.

140210. (a) Compensation for providers and upper level managers employed by integrated health care systems, group medical practices and essential community providers that provide comprehensive, coordinated services shall be determined according to the following guidelines:

(b) Providers and upper level managers employed by systems that provide comprehensive, coordinated health care services shall be represented by their respective employers for the purposes of negotiating reimbursement with the Payments Board.

(c) In negotiating reimbursement with systems providing comprehensive, coordinated services, the Payments Board shall take into consideration the need for comprehensive systems to
have flexibility in establishing provider and upper level manager reimbursement.
(d) Payment schedules shall be in effect for three years. However, payment adjustments may be made at the discretion of the Payments Board to meet the goals of the health insurance system.
(e) The Payments Board shall take into consideration regional differences in the cost of living and the need to recruit and retain skilled providers and upper level managers to the regions.
(f) The Payments Board shall establish a timetable for reimbursement for fee-for-service providers negotiations. In the event that an agreement on reimbursement is not reached according to the timetable established by the Payments Board, the Payments Board shall establish reimbursement rates, which shall be binding.
(g) Reimbursement negotiations shall be conducted consistent with the state action doctrine of the antitrust laws.

140211. (a) The Payments Board shall annually report to the commissioner on the status of provider and upper level manager reimbursement, including satisfaction with reimbursement levels and the sufficiency of funds allocated by the commissioner for provider and upper level manager reimbursement. The Payments Board shall recommend needed adjustments in the allocation for provider payments.
(b) The Office of Health Care Quality shall annually report to the commissioner on the impact of the bonus payments in improving quality of care, health outcomes and management effectiveness. The Payments Board shall recommend needed adjustments in bonus allocations.
(c) The Office of Health Planning shall annually report to the commissioner on the impact of the incentive payments in recruiting health professionals and upper level managers to underserved areas, in establishing the needed ratio of generalist to specialist providers and in attracting and retaining nurse practitioners and physician assistants to the state and shall recommend needed adjustments.

140212. (a) The commissioner shall establish an allocation for each region to fund regional operating and capital budgets for a period of three years. Allocations shall be disbursed to the regions on a quarterly basis.
(b) Integrated health care systems, essential community providers and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

(c) Providers choosing to function on the basis of a capitated or a noncapitated system operating budget shall submit three-year operating budget requests to the regional planning director, pursuant to standards and guidelines established by the commissioner.

(1) Providers may include in their operating budget requests reimbursement for ancillary health care or social services that were previously funded by money now received and disbursed by the Health Insurance Fund.

(2) No payment may be made from a capitated or noncapitated budget for a capital expense except as stipulated in Section 140216.

(d) Regional planning directors shall negotiate operating budgets with regional health care entities, which shall cover a period of three years.

(e) Operating and capitated budgets shall include health care workforce labor costs other than those described in paragraphs (1), (2), and (3) of subdivision (d) of Section 140208. Where unions represent employees working in systems functioning under capitated or noncapitated budgets, unions shall represent those employees in negotiations with the regional planning director and the Payments Board for the purpose of establishing their reimbursement.

140213. (a) Health systems and medical practices functioning under capitated and noncapitated operating budgets shall immediately report any projected operating deficit to the regional planning director. The regional planning director shall determine whether projected deficits reflect appropriate increases in expenditures, in which case the director shall make an adjustment to the operating budget. If the director determines that deficits are not justifiable, no adjustment shall be made.

(b) If a regional planning director determines that adjustments to operating budgets will cause a regional revenue shortfall and that cost control measures may be required, the regional planning
director shall report the possible revenue shortfall to the
commissioner and take actions required pursuant to Section
140203.

140215. (a) Margins generated by a facility operating under
a health system operating budget may be retained and used to
meet the health care needs of the population.
(b) No margin may be retained if that margin was generated
through inappropriate limitations on access to care or
compromises in the quality of care or in any way that adversely
affected or is likely to adversely affect the health of the persons
receiving services from a facility, integrated health care system,
group medical practice or essential community provider
functioning under a health insurance system operating budget.
(1) The chief medical officer shall evaluate the source of
margin generation and report violations of this section to the
commissioner.
(2) The commissioner shall establish and enforce penalties for
violations of this section.
(3) Penalty payments collected pursuant to violations of
section shall be remitted to the Health Insurance Fund for use in
the California Health Insurance System.
(c) Facilities operating under health insurance system
operating budgets may raise and expend funds from sources other
than the California Health Insurance System including, but not
limited to, private or foundation donors and other non-California
Health Insurance System sources for purposes related to the goals
of this division and in accordance with provisions of this
division.

140216. (a) During the transition the commissioner shall
develop a Capital Management Plan that shall include
conflict-of-interest standards and that shall govern all capital
investments and acquisitions undertaken in the California Health
Insurance System. The plan shall include a framework, standards,
and guidelines for all of the following:
(1) Standards whereby the office of health care planning shall
oversee, assist in the implementation of, and ensure that the
provisions of the capital management plan are enforced.
(2) Assessment and prioritization of short- and long-term
California Health Insurance System capital needs on statewide
and regional bases.
(3) Assessment of capital health care assets and capital health care asset shortages on a regional and statewide basis at the time this division is first implemented.

(4) Development by the commissioner of a multiyear system capital development plan that supports health insurance system goals, priorities and performance standards and meets the health needs of the population.

(5) Development, as part of the California Health Insurance System capital budget, of regional capital allocations that shall cover a period of three years.

(6) Evaluation of, and support for, noninvestment means to meet health care needs, including, but not limited to, improvements in administrative efficiency, care quality, and innovative service delivery, use, adaptation or refurbishment of existing land and property and identification of publicly owned land or property that may be available to the California Health Insurance System and that may meet a capital need.

(7) Development and maintenance of capital inventories on a regional basis, including the condition, utilization capacity, maintenance plan and costs, deferred maintenance of existing capital inventory and excess capital capacity.

(8) A process whereby those intending to make capital investments or acquisitions shall prepare a business case for making the investment or acquisition, including the full life-cycle costs of the project or acquisition, an environmental impact report that meets existing state standards, and a demonstration of how the investment or acquisition meets the health needs of the population it is intended to serve. Acquisitions include, but are not limited to, the acquisition of land, operational property, or administrative office space.

(9) Standards and a process whereby the regional planning directors shall evaluate, accept, reject, or modify a business plan for a capital investment or acquisition. Decisions of a regional planning director may be appealed through a dispute resolution process established by the commissioner.

(10) Standards for binding project contracts between the Health Insurance System and the party developing a capital project or making a capital acquisition that shall govern all terms and conditions of capital investments and acquisitions, including
terms and conditions for Health Insurance System grants, loans, 
lines of credit, and lease-purchase arrangements.

(11) A process and standards whereby the Health Insurance 
Fund shall negotiate terms and conditions of the California 
Health Insurance System liens, grants, lines of credit and 
lease-purchase arrangements for capital investments and 
acquisitions. Terms and conditions negotiated by the Health 
Insurance Fund shall be included in project contracts.

(12) A plan for the commissioner and for the regional planning 
directors to issue requests for proposals and to oversee a process 
of competitive bidding for the development of capital projects 
that meet the needs of the California Health Insurance System 
and to fund, partially fund, or participate in seeking funding for 
those capital projects.

(13) Responses to requests for proposals and competitive bids 
shall include a description of how a project meets the service 
needs of the region and addresses the environmental impact 
report and shall include the full life-cycle costs of a capital asset.

(14) Requests for proposals shall address how intellectual 
property will be handled and shall include conflict-of-interest 
guidelines that meet standards established by the commissioner 
as part of the capital management plan.

(15) A process and standards for periodic revisions in the 
Capital Management Plan, including annual meetings in each 
region to discuss the plan and make recommendations for 

eimprovements in the plan.

(16) Standards for determining when a violation of these 
provisions shall be referred to the Attorney General for 
investigation and possible prosecution of the violation.

(b) No registered lobbyist shall participate in or in any way 
attempt to influence the request for proposals or competitive bid 
process.

(c) Development of performance standards and a process to 
monitor and measure performance of those making capital health 
care investments and acquisitions, including those making capital 
investments pursuant to a state competitive bidding process.

(d) A process for earned autonomy from state capital 
investment oversight for those who demonstrate the ability to 
manage capital investment and capital assets effectively in 
accordance with California Health Insurance System standards,
and standards for loss of earned autonomy when capital
management is ineffective.

(e) Terms and conditions of capital project oversight by the
California Health Insurance System shall be based on the
performance history of the project developer. Providers may earn
autonomy from oversight if they demonstrate effective capital
planning and project management, pursuant to the goals and
guidelines established by the commissioner. Providers who do
not demonstrate such proficiency shall remain subject to
oversight by the regional planning director or shall lose
autonomy from oversight.

(f) In general, no capital investment may be made from an
operating budget. However, guidelines shall be established for
the types and levels of small capital investments that may be
undertaken from an operating budget without the approval of the
regional planning director.

(g) Any capital investments required for compliance with
federal, state, or local regulatory requirements or quality
assurance standards shall be exempt from paragraph (2) of
subdivision (c) of Section 140212.

140217. (a) Regional planning directors shall develop a
regional capital development plan pursuant to the California
Health Insurance System capital management plan established by
the commissioner. In developing the regional capital
development plan, the regional planning director shall do all of
the following:

(1) Implement the standards and requirements of the capital
management plan established by the commissioner.

(2) Develop a multiyear regional capital health management
plan that supports regional health insurance system goals and the
state capital management plan.

(3) Assist regional providers to develop capital budget
requests pursuant to the regional capital budget plan and the
California Health Insurance System capital management plan
established by the commissioner.

(4) Receive and evaluate capital budget requests from regional
providers.

(5) Establish ranking criteria to assess competing demands for
capital.
(6) Participate in planning for needed earthquake retrofits. However, the cost of mandatory earthquake retrofits of health care facilities shall not be the responsibility of the California Health Insurance System.

(7) Conduct ongoing project evaluation to assure that terms and conditions of project funding are met.

(b) Services provided as a result of capital investments or acquisitions that do not meet the terms of the regional capital development plan and the capital management plan developed by the commissioner shall not be reimbursed by the California Health Insurance System.

140218. (a) Assets financed by state grants, loans and lines of credit and lease-purchase arrangements, shall be owned, operated and maintained by the recipient of the grant, loan, line of credit or lease-purchase arrangements, according to terms established at the time of issuance of the grant, loan or line of credit, or lease-purchase arrangement.

(b) Assets financed under long-term leases with the California Health Insurance System shall be transferred to public ownership at the end of the lease, unless the commissioner determines that an alternative disposition would be of greater benefit to the health insurance system, in which case the commissioner may authorize an alternative disposition.

(c) When an asset, which was in whole or in part financed by the health insurance system, is to be sold or transferred by a party that received health insurance system financing for purchase, lease, or construction of the asset, an impartial estimate of the fair market value of the asset shall be undertaken. The system shall receive a share of the fair market value of the asset at the time of its sale or transfer that is in proportion to the system’s original investment. The system may elect to postpone receipt of its share of the value of the asset if the commissioner determines that the postponement meets the needs of the system.

140219. The health regions must make financial information available to the public when the California Health Insurance System contribution to a capital project is greater than twenty-five million dollars ($25,000,000). Information shall include the purpose of the project or acquisition, its relation to California Health Insurance System goals, the project budget and the timetable for completion, environmental impact reports, any
1 140220. (a) The commissioner shall establish a budget for the purchase of prescription drugs and durable and nondurable medical equipment for the health insurance system.
2 (b) The commissioner shall use the purchasing power of the state to obtain the lowest possible prices for prescription drugs and durable and nondurable medical equipment.
3 (c) The commissioner shall make discounted prices available to all California residents, licensed and accredited providers and facilities under the terms of their licenses and accreditation, health care providers, prescription drug and medical equipment wholesalers and retailers of products approved for use in and included in the benefit package of the California Health Insurance System.
4 140221. (a) The commissioner shall establish a budget to support research and innovation that has been recommended by the chief medical officer, the director of planning, the patient advocates, the Partnerships for Health, the Technical Advisory Committee, and others as required by the commissioner.
5 (b) The research and innovation budget shall support the goals and standards of the California Health Insurance System.
6 140222. (a) The commissioner shall establish a budget to support the training, development and continuing education of health care providers and the health care workforce needed to meet the health care needs of the population and the goals and standards of the health insurance system.
7 (b) During the transition, the commissioner shall determine an appropriate level and duration of spending to support the retraining and job placement of persons who have been displaced from employment as a result of the transition to the new health insurance system.
8 (c) The commissioner shall establish guidelines for giving special consideration for employment to persons who have been displaced as a result of the transition to the new health insurance system.
9 140223. (a) The commissioner shall establish a Reserve Budget pursuant to this section.
10 (b) The Reserve Budget may be used only for purposes set forth in this division.
140224. (a) The commissioner shall establish a budget that covers all costs of administering the California Health Insurance System.

(b) Administrative costs on a systemwide basis shall be limited to 10 percent of system costs within five years of completing the transition to the California Health Insurance System.

(c) Administrative costs on a systemwide basis shall be limited to 5 percent of system costs within 10 years of completing the transition to the California Health Insurance System.

(d) The commissioner shall ensure that the percentage of the budget allocated to support system administration stays within the allowable limits and shall continually seek means to lower system administrative cost.

(e) The commissioner shall report to the public, the regional planning directors and others attending the annual Health Insurance System Revenue and Expenditures Conference pursuant to Section 140205 on the costs of administering the system and the regions and shall make recommendations for lowering administrative costs and receive recommendations for lowering administrative costs.

Article 2. California Health Insurance Premium Commission

140230. (a) There is hereby created the California Health Insurance Premium Commission.

(b) The Premium Commission shall be composed of the following members:

(1) Three health economists with experience relevant to the functions of the Premium Commission. One shall be appointed by the Speaker of the Assembly, one shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Governor.

(2) Two representatives of California’s business community, with one representing small business. One shall be appointed by the Governor, and the representative of small business shall be appointed by the Senate Committee on Rules.

(3) Two representatives from organized labor. One shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Speaker of the Assembly.
(4) Two representatives of nonprofit organizations whose principal purpose includes promoting the establishment of a system of universal health care in California. One shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Speaker of the Assembly.

(5) One representative of a nonprofit advocacy organization with expertise in taxation policy whose principal purpose includes advocating for sustainable funding for the public infrastructure. This person shall be appointed by the Speaker of the Assembly.

(6) Two members of the Legislature who shall be members of a policy committee having jurisdiction over health care issues. One shall be appointed by the Senate Committee on Rules, and one shall be appointed by the Speaker of the Assembly.

(7) The Executive Officer of the Franchise Tax Board.

(8) The Chair of the State Board of Equalization.

(9) The Director of the Employment Development Department.

(10) The Legislative Analyst.

(11) The Secretary of the California Health and Human Services Agency.

(12) The Director of the Department of Finance.

(13) The State Controller.

(14) The State Treasurer.

(15) The Lieutenant Governor.

(c) Upon appointment, the Premium Commission shall meet at least once a month. The Premium Commission shall elect a chair from its membership during its first meeting. The Premium Commission shall receive public comments during a portion of each of its meetings, and all of its meetings shall be conducted pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

140231. (a) The Premium Commission shall perform the following functions:

(1) Determine the aggregate costs of providing health insurance coverage pursuant to this division.

(2) Develop an equitable and affordable premium structure that will generate adequate revenue for the Health Insurance
Fund established pursuant to Section 140200 and ensure stable
and actuarially sound funding for the health insurance system.
(b) The Premium Commission shall perform the functions
described in this section by considering existing financial
simulations and analyses of universal health care proposals,
including, but not limited to, the analysis completed by the
Lewin Group in January 2005, of Senate Bill No. 921 of the
2003–04 Regular Session.
140232. (a) The premium structure developed by the
Premium Commission shall satisfy the following criteria:
(1) Be means-based and generate adequate revenue to
implement this division.
(2) To the greatest extent possible, ensure that all income
earners and all employers contribute a premium amount that is
affordable and that is consistent with existing funding sources for
health care in California.
(3) Maintain the current ratio for aggregate health care
contributions among the traditional health care funding sources,
including employers, individuals, government, and other sources.
(4) Provide a fair distribution of monetary savings achieved
from the establishment of a universal health care system.
(5) Coordinate with existing, ongoing funding sources from
federal and state programs.
(6) Be consistent with state and federal requirements
governing financial contributions for persons eligible for existing
public programs.
(7) Comply with federal requirements.
(b) The Premium Commission shall seek expert and legal
advice regarding the best method to structure premium payments
consistent with existing employer-employee health care
financing structures.
140233. The Premium Commission may take all of the
following actions:
(a) Obtain grants from, and contract with, individuals and with
private, local, state, and federal agencies, organizations, and
institutions, including institutions of higher education.
(b) Receive charitable contributions or any other source of
income that may be lawfully received.
140234. (a) The Premium Commission may consult with
additional persons, advisory entities, governmental agencies,
Members of the Legislature, and legislative staff as it deems necessary to perform its functions.
(b) The Premium Commission shall seek structured input from representatives of stakeholder organizations, policy institutes, and other persons with expertise in health care, health care financing, or universal health care models in order to ensure that it has the necessary information, expertise, and experience to perform its functions.
(c) The Premium Commission shall be supported by a reasonable amount of staff time, which shall be provided by the state agencies with membership on the Premium Commission. The Premium Commission may request data from, and utilize the technical expertise of, other state agencies.

140235. (a) On or before January 1, 2009, the Premium Commission shall submit to the Governor and the Legislature a detailed recommendation for a premium structure.
(b) The Premium Commission shall submit a draft recommendation to the Governor, Legislature, and the public at least 90 days prior to submission of the final recommendation described in subdivision (a). The Premium Commission shall seek input from the public on the draft recommendation.


Article 3. Governmental Payments

140240. (a) (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current federal payments to the state for health care be paid directly to the California Health Insurance System, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds.
(2) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution for health care services in California that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.
(b) (1) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current state
payments for health care shall be paid directly to the system, which shall then assume responsibility for all benefits and services previously paid for by state government with those funds.

(2) In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the Legislature a contribution for health care services that shall not decrease in relation to state government expenditures for health care services in the year that this division was enacted, except that it may be corrected for change in state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

c) The commissioner shall establish formulas for equitable contributions to the California Health Insurance System from all California counties and other local government agencies.

d) The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all county or other local government agency payments shall be paid directly to the California Health Insurance System.

140241. The system’s responsibility for providing care shall be secondary to existing federal, state, or local governmental programs for health care services to the extent that funding for these programs is not transferred to the Health Insurance Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the system.

140242. In order to minimize the administrative burden of maintaining eligibility records for programs transferred to the system, the commissioner shall strive to reach an agreement with federal, state, and local governments in which their contributions to the Health Insurance Fund shall be fixed to the rate of change of the state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

140243. If, and to the extent that, federal law and regulations allow the transfer of Medi-Cal funding to the system, the commissioner shall pay from the Health Insurance Fund all premiums, deductible payments, and coinsurance for qualified Medicare beneficiaries who are receiving benefits pursuant to Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 of the Welfare and Institutions Code.
140244. In the event and to the extent that the commissioner obtains authorization to incorporate Medicare revenues into the Health Insurance Fund, Medicare Part B payments that previously were made by individuals or the commissioner shall be paid by the system for all individuals eligible for both the system and the Medicare Program.

Article 4. Federal Preemption

140300. (a) The commissioner shall pursue all reasonable means to secure a repeal or a waiver of any provision of federal law that preempts any provision of this division.

(b) In the event that a repeal or a waiver of law or regulations cannot be secured, the commissioner shall exercise his or her powers to promulgate rules and regulations, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this division.

140301. (a) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan that, under federal law, preempts provisions of this division, shall first seek benefits under that contract or plan before receiving benefits from the system under this division.

(b) No benefits shall be denied under the system created by this division unless the employee has failed to take reasonable steps to secure like benefits from the contract or plan, if those benefits are available.

(c) Nothing in this section shall preclude a person from receiving benefits from the system under this division that are superior to benefits available to the person under an existing contract or plan.

(d) Nothing in this division is intended, nor shall this division be construed, to discourage recourse to contracts or plans that are protected by federal law.

(e) To the extent permitted by federal law, a health care provider shall first seek payment from the contract or plan, before submitting bills to the California Health Insurance System.
Article 5. Subrogation

140302. (a) It is the intent of this division to establish a single public payer for all health care in the State of California. However, until such time as the role of all other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(b) As used in this article, collateral source includes all of the following:

(1) Insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance.

(2) Health care service plans and pension plans.

(3) Employers.

(4) Employee benefit contracts.

(5) Government benefit programs.

(6) A judgment for damages for personal injury.

(7) Any third party who is or may be liable to an individual for health care services or costs.

(c) “Collateral source” does not include either of the following:

(1) A contract or plan that is subject to federal preemption.

(2) Any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in subdivision (b) is not excluded from the obligations imposed by this article by virtue of a contract or relationship with a governmental unit, agency, or service.

(d) The commissioner shall attempt to negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources in California into the California Health Insurance System.

140303. Whenever an individual receives health care services under the system and he or she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and provide information identifying the collateral source, the
nature and extent of coverage or entitlement, and other relevant
information. The health care provider shall forward this
information to the commissioner. The individual entitled to
coverage, reimbursement, indemnity, or other compensation from
a collateral source shall provide additional information as
requested by the commissioner.

140304. (a) The system shall seek reimbursement from the
collateral source for services provided to the individual, and may
institute appropriate action, including suit, to recover the
reimbursement. Upon demand, the collateral source shall pay to
the Health Insurance Fund the sums it would have paid or
expended on behalf of the individual for the health care services
provided by the system.

(b) In addition to any other right to recovery provided in this
article, the commissioner shall have the same right to recover the
reasonable value of benefits from a collateral source as provided
to the Director of Health Services by Article 3.5 (commencing
with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of
the Welfare and Institutions Code, in the manner so provided.

140305. (a) If a collateral source is exempt from subrogation
or the obligation to reimburse the system as provided in this
article, the commissioner may require that an individual who is
entitled to medical services from the source first seek those
services from that source before seeking those services from the
system.

(b) To the extent permitted by federal law, contractual retiree
health benefits provided by employers shall be subject to the
same subrogation as other contracts, allowing the California
Health Insurance System to recover the cost of services provided
to individuals covered by the retiree benefits, unless and until
arrangements are made to transfer the revenues of the benefits
directly to the California Health Insurance System.

140306. (a) Default, underpayment, or late payment of any
tax or other obligation imposed by this division shall result in the
remedies and penalties provided by law, except as provided in
this section.

(b) Eligibility for benefits under Chapter 4 (commencing with
Section 140400) shall not be impaired by any default,
underpayment, or late payment of any tax or other obligation
imposed by this chapter.
140307. The agency and the commissioner shall be exempt from the regulatory oversight and review procedures empowered to the Office of Administrative Law pursuant to Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code. Actions taken by the agency, including, but not limited to, the negotiating or setting of rates, fees, or prices, and the promulgation of any and all regulations, shall be exempt from any review by the Office of Administrative Law, except for Sections 11344.1, 11344.2, 11344.3, and 11344.6 of the Government Code, addressing the publication of regulations.

140308. The California Health Insurance Agency shall adopt regulations to implement the provisions of this division. The regulations may initially be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), but those emergency regulations shall be in effect only from the effective date of this division until the conclusion of the transition period.

Chapter 4. Eligibility

140400. All California residents shall be eligible for the California Health Insurance System. Residency shall be based upon physical presence in the state with the intent to reside. The commissioner shall establish standards and a simplified procedure to demonstrate proof of residency.

140401. The commissioner shall establish a procedure to enroll eligible residents and provide each eligible individual with identification that can be used by health care providers to determine eligibility for services.

140402. (a) It is the intent of the Legislature for the California Health Insurance System to provide health care coverage to California residents who are temporarily out of the state. The commissioner shall determine eligibility standards for residents temporarily out of state for longer than 90 days who intend to return and reside in California and for nonresidents temporarily employed in California.

(b) Coverage for emergency care obtained out of state shall be at prevailing local rates. Coverage for nonemergency care obtained out of state shall be according to rates and conditions...
established by the commissioner. The commissioner may require
that a resident be transported back to California when prolonged
treatment of an emergency condition is necessary and when that
transport will not adversely affect a patient’s care or condition.

140403. Visitors to California shall be billed for all services
received under the system. The commissioner may establish
intergovernmental arrangements with other states and countries
to provide reciprocal coverage for temporary visitors.

140404. All persons eligible for health benefits from
California employers but who are working in another jurisdiction
shall be eligible for health benefits under this division providing
that they make payments equivalent to the payments they would
be required to make if they were residing in California.

140404.1. (a) All persons who under an employer-employee
contract are eligible for retiree medical benefits, including
retirees who elect to reside outside of California, shall remain
eligible for those benefits providing that the contractually
mandated payments for those benefits are made to the California
Health Care Fund, which shall assume financial responsibility for
care provided under the terms of the contract.

(b) The commissioner may establish financial arrangements
with states and foreign countries in order to facilitate meeting the
terms of the contracts described in subdivision (a), except that
payments for care provided by non-California providers to
California retirees shall be reimbursed at rates established by the
commissioner.

140405. Unmarried, unemancipated minors shall be deemed
to have the residency of their parent or guardian. If a minor’s
parents are deceased and a legal guardian has not been appointed,
or if a minor has been emancipated by court order, the minor may
establish his or her own residency.

140406. (a) An individual shall be presumed to be eligible if
he or she arrives at a health facility and is unconscious,
comatose, or otherwise unable, because of his or her physical or
mental condition, to document eligibility or to act in his or her
own behalf, or if the patient is a minor, the patient shall be
presumed to be eligible, and the health facility shall provide care
as if the patient were eligible.
(b) Any individual shall be presumed to be eligible when brought to a health facility pursuant to any provision of Section 5150 of the Welfare and Institutions Code.

c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds pursuant to any provision of Section 5150 of the Welfare and Institutions Code, providing for involuntary commitment, shall be presumed eligible.

d) All health facilities subject to state and federal provisions governing emergency medical treatment shall continue to comply with those provisions.

e) In the event of an influx of people into the state for the purposes of receiving medical care, the commissioner shall establish an eligibility waiting period and other criteria needed to ensure the fiscal stability of the health insurance system.

Chapter 5. Benefits

140500. Any eligible individual may choose to receive services under the California Health Insurance System from any willing professional health care provider participating in the system. No health care provider may refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination contained in the Fair Employment and Housing Act beginning with Section 12940 of the Government Code.

140501. Covered benefits in this chapter shall include all medical care determined to be medically appropriate by the consumer’s health care provider, but are subject to limitations set forth in Section 140503. Covered benefits include, but are not limited to, all of the following:

(a) Inpatient and outpatient health facility services.

(b) Inpatient and outpatient professional health care provider services by licensed health care professionals.

(c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(d) Durable medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and their repair.

(e) Rehabilitative care.
(f) Emergency transportation and necessary transportation for health care services for disabled and indigent persons.

(g) Language interpretation and translation for health care services, including sign language for those unable to speak, or hear, or who are language impaired, and Braille translation or other services for those with no or low vision.

(h) Child and adult immunizations and preventive care.

(i) Health education.

(j) Hospice care.

(k) Home health care.

(l) Prescription drugs that are listed on the system formulary. Nonformulary prescription drugs may be included where standards and criteria established by the commissioner are met.

(m) Mental and behavioral health care.

(n) Dental care.

(o) Podiatric care.

(p) Chiropractic care.

(q) Acupuncture.

(r) Blood and blood products.

(s) Emergency care services.

(t) Vision care.

(u) Adult day care.

(v) Case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting.

(w) Substance abuse treatment.

(x) Care of up to 100 days in a skilled nursing facility following hospitalization.

(y) Dialysis.

(z) Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization.

140502. The commissioner may expand benefits beyond the minimum benefits described in this chapter when expansion meets the intent of this division and when there are sufficient funds to cover the expansion.

140503. The following health care services shall be excluded from coverage by the system:
(a) Health care services determined to have no medical indication by the commissioner and the chief medical officer.
(b) Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care provider in the system.
(c) Private rooms in inpatient health facilities where appropriate nonprivate rooms are available, unless determined to be medically necessary by a qualified, licensed health care provider in the system.
(d) Services of a professional health care provider or facility that is not licensed or accredited by the state except for approved services provided to a California resident who is temporarily out of the state.

140504. (a) No copayments or deductible payments may be established for preventive care as determined by a patient’s primary care provider.
(b) No copayments or deductible payments may be established when prohibited by federal law.
(c) The commissioner shall establish standards and procedures for waiving copayments or deductible payments. Waivers of copayments or deductible payments shall not affect the reimbursement of health care providers.
(d) Any copayments established pursuant to this section and collected by health care providers shall be transmitted to the Treasurer to be deposited to the credit of the Health Insurance Fund.
(e) Nothing in this division shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.
(f) Nothing in this division shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this division.
140600. (a) All health care providers licensed or accredited to practice in California may participate in the California Health Insurance System. (b) No health care provider whose license or accreditation is suspended or revoked may be a participating health care provider.

(c) If a health care provider is on probation, the licensing or the accrediting agency shall monitor the health care provider in question, pursuant to applicable California law. The licensing or accrediting agency shall report to the chief medical officer at intervals established by the chief medical officer, on the status of providers who are on probation, on measures undertaken to assist providers to return to practice and to resolve complaints made by patients.

(d) Health care providers may accept eligible persons for care according to the provider’s ability to provide services needed by the applicant and according to the number of patients a provider can treat without compromising safety and care quality. A provider may accept patients in the order of time of application.

(e) A health care provider shall not refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination contained in the Fair Employment and Housing Act (Part 2.8 (commencing with Section 129000) of Division 3 of Title 2 of the Government Code).

(f) Choice of provider:

(1) Persons eligible for health care services under this division may choose a primary care provider.

(A) Primary care providers include family practitioners, general practitioners, internists and pediatricians, nurse practitioners and physician assistants practicing under supervision as defined in California codes and Doctors of Osteopathy licensed to practice as general doctors.

(B) Women may choose an obstetrician-gynecologist, in addition to a primary provider.

(2) Persons who choose to enroll with integrated health care systems, group medical practices or essential community providers that offer comprehensive services, shall retain
membership for at least one year after an initial three-month
evaluation period during which time they may withdraw for any
reason.
(A) The three-month period shall commence on the date when
an enrollee first sees a primary provider.
(B) Persons who want to withdraw after the initial three-month
period shall request a withdrawal pursuant to dispute resolution
procedures established by the commissioner and may request
assistance from the patient advocate in the dispute process. The
dispute shall be resolved in a timely fashion and shall have no
adverse effect on the care a patient receives.
(3) Persons needing to change primary providers because of
health care needs that their primary provider cannot meet may
change primary providers at any time.
140601. (a) Primary care providers shall coordinate the care
a patient receives or shall ensure that a patient’s care is
coordinated.
(b) (1) Patients shall have a referral from their primary care
provider, or from an emergency provider rendering care to them
in the emergency room or other accredited emergency setting, or
from a provider treating a patient for an emergency condition in
any setting, or from their obstetrician/gynecologist, to see a
physician or nonphysician specialist whose services are covered
by this division, unless the patient agrees to assume the costs of
care, in which case a referral is not needed. A referral shall not be
required to see a dentist.
(2) Referrals shall be based on the medical needs of the patient
and on guidelines, which shall be established by the chief
medical officer to support clinical decisionmaking.
(3) Referrals shall not be restricted or provided solely because
of financial considerations. The chief medical officer shall
monitor referral patterns and intervene as necessary to assure that
referrals are neither restricted nor provided solely because of
financial considerations.
(4) For the first six months of system operation, no specialist
referral shall be required for patients who had been receiving care
from a specialist prior to the initiation of the system. Beginning
with the seventh month of system operation, all patients shall be
required to obtain a referral from a primary or emergency care
provider for specialty care if the care is to be paid for by the
system. No referral is required if a patient pays the full cost of the specialty care and the specialist accepts that payment arrangement.

(5) Where referral systems are in place prior to the initiation of the system, the chief medical officer shall review the referral systems to assure that they meet health insurance system standards for care quality and shall assure needed changes are implemented so that all Californians receive the same standards of care quality.

(6) A specialist may serve as the primary provider if the patient and the provider agree to this arrangement and if the provider agrees to coordinate the patient’s care or to ensure that the care the patient receives is coordinated.

(7) The commissioner shall establish or ensure the establishment of a computerized referral registry to facilitate the referral process and to allow a specialist and a patient to easily determine whether a referral has been made pursuant to this division.

(8) A patient may appeal the denial of a referral through the dispute resolution procedures established by the commissioner and may request the assistance of the patient advocate during the dispute resolution process.

140602. (a) The purpose of the Office of Health Planning is to plan for the short- and long-term health needs of the population pursuant to the health care and finance standards established by the commissioner and by this division. (b) The office shall be headed by a director appointed by the commissioner. The director shall serve pursuant to provisions of subdivisions (c), (d), and (e) of Section 140100 and subdivisions (j) and (k) of Section 140101. (c) The director shall do all the following:

1. Administer all aspects of the Office of Health Planning.
2. Serve on the Health Insurance Policy Board.
3. Establish performance criteria in measurable terms for health care goals in consultation with the chief medical officer, the regional health officers and directors and others with experience in health care outcomes measurement and evaluation.
4. Evaluate the effectiveness of performance criteria in accurately measuring quality of care, administration, and planning.
(5) Assist the health care regions to develop operating and
capital requests pursuant to health care and finance guidelines
established by the commissioner and by this division. In assisting
regions, the director shall do all of the following:
(A) Identify medically undeserved areas and health service
and asset shortages.
(B) Identify disparities in health outcomes.
(C) Establish conventions for the definition, collection,
storage, analysis, and transmission of data for use by the health
insurance system.
(D) Establish electronic systems that support dissemination of
information to providers and patients about integrated health
network and integrated care systems community-based health
care resources.
(E) Support establishment of comprehensive health care
databases using uniform methodology that is compatible between
the regions and between the regions and the state health
insurance agency.
(F) Provide information to support effective regional planning
and innovation.
(G) Provide information to support interregional planning,
including planning for access to specialized centers that perform
a high volume of procedures for conditions requiring highly
specialized treatments, including emergency and trauma and
other interregional access to needed care, and planning for
coordinated interregional capital investment.
(H) Provide information for, and participate in, earthquake
retrofit planning.
(I) Evaluate regional budget requests and make
recommendations to the commissioner about regional revenue
allocations.
(6) Estimate the health care workforce required to meet the
health needs of the population pursuant to the standards and
goals established by the commissioner, the costs of providing the
needed workforce, and, in collaboration with regional planners,
educational institutions, the Governor and the Legislature,
develop short- and long-term plans to meet those needs,
including a plan to finance needed training.
(7) Estimate the number and types of health facilities required
to meet the short- and long-term health needs of the population
and the projected costs of needed facilities. In collaboration with
the commissioner, regional planning directors and health officers,
the chief medical officer, the Governor and the Legislature,
develop plans to finance and build needed facilities.

140603. The Technical Advisory Group shall explore the
feasibility and the value to the health of the population of the
following electronic initiatives:

(a) Establish integrated statewide health care databases to
support health care planning and determine which databases
which should be established on a statewide basis and which
should be established on a regional basis.

(b) Assure that databases have uniform methodology and
formats that are compatible between regions and between the
regions and the state insurance agency.

(c) Establish mandatory database reporting requirements and
penalties for noncompliance. Monitor the effectiveness of
reporting and make needed improvements.

(d) Establish means for anonymous reporting to the chief
medical officer and regional medical officers of medical errors
and other related problems, and for anonymous reporting to the
commissioner and regional planning directors of problems
related to ineffective management, and establish guidelines for
protection of persons coming forward to report these problems.

(e) In collaboration with the chief medical officer and state
and regional patient advocates, investigate the costs and benefits
of electronic and online scheduling systems and means of
provider-patient communication that allow for electronic visits,
and make recommendations to the chief medical officer
regarding the use of these concepts in the health insurance
system.

(f) In collaboration with the chief medical officer, establish
electronic systems and other means that support the use of
standards of care based on clinical efficacy to guide clinical
decisionmaking by all who provide services in the California
Health Insurance System.

(g) In collaboration with the chief medical officer, support the
development of disease management programs and their use in
the health insurance system.

(h) Establish electronic initiatives that lower administration
costs.
(i) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that link clinical guidelines to individual patient conditions, and guide clinicians through diagnosis and treatment algorithms derived from research based on clinical efficacy and best medical practices.

(j) Collaborate with the chief medical officer and regional medical officers to assure the development of software systems that offer providers access to guidelines that are appropriate for their specialty and that include current information on prevention and treatment of disease.

(k) In collaboration with the Partnerships for Health and regional health officers, establish Web-based patient-centered information systems that assist people to promote and maintain health and provide information on health conditions and recent developments in treatment.

(l) Establish electronic systems and other means to provide patients with easily understandable information about the performance of health care providers. This shall include, but not be limited to, information about the experience that providers have in the field or fields in which they deliver care, the number of years they have practiced in their field and, in the case of medical and surgical procedures, the number of procedures they have performed in their area or areas of specialization.

(m) Establish electronic systems that facilitate provider continuing medical education that meets licensure requirements.

(n) Recommend to the commissioner means to link health care research with the goals and priorities of the health insurance system.

140604. (a) The Director of Health Planning shall establish standards for culturally and linguistically competent care, which shall include, but not be limited to, all of the following:

(1) State Department of Health Services and the Department of Managed Care guidelines for culturally and linguistically sensitive care.

(2) Medi-Cal Managed Care Division (MMCD) Policy Letters 99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural and Linguistic.


(b) The director shall annually evaluate the effectiveness of standards for culturally and linguistically competent care and make recommendations to the commissioner, the patient advocate, and the chief medical officer for needed improvements. In evaluating the standards for culturally and linguistically sensitive care, the director shall establish a process to receive concerns and comments from consumers.

(c) The director shall pursue available federal financial participation for the provision of a language services program that supports health insurance system goals.

140605. (a) Within the agency, the commissioner shall establish the Office of Health Care Quality.

(b) The office shall be headed by the chief medical officer who shall serve pursuant to provisions of subdivisions (c), (d), and (e) of Section 140100 and subdivisions (j) and (k) of Section 140101 regarding qualifications for appointed health insurance system officers.

(c) The purpose of the Office of Health Care Quality is the following:

(1) Support the delivery of high quality, coordinated health care services that enhance health, prevent illness, disease and disability, slow the progression of chronic diseases and improve personal health management.

(2) Promote efficient care delivery.

(3) Establish processes for measuring, monitoring, and evaluating the quality of care delivered in the health insurance system, including the performance of individual providers.

(4) Establish means to make changes needed to improve care quality, including innovative programs that improve quality.

(5) Promote patient, provider, and employer satisfaction with the health insurance system.
(6) Assist regional planning directors and medical officers in the development and evaluation of regional operating and capital budget requests.

140606. (a) In supporting the goals of the Office of Health Care Quality, the chief medical officer shall do all of the following:

1. Administer all aspects of the office.
2. Serve on the Health Insurance Policy Board.
3. Collaborate with regional medical officers, directors, health care providers, and consumers, the director of planning, the patient advocate and Partnerships for Health directors to develop community-based networks of solo providers, small group practices, essential community providers and providers of patient care support services in order to offer comprehensive, multidisciplinary, coordinated services to patients.
4. Establish standards of care based on clinical efficacy for the health insurance system which shall serve as guidelines to support providers in the delivery of high quality care. Standards shall be based on the best evidence available at the time and shall be continually updated. Standards are intended to support the clinical judgment of individual providers, not to replace it and to support clinical decisions based on the needs of individual patients.

(b) In establishing standards, the chief medical officer shall do all of the following:

1. Draw on existing standards established by California health care institutions, on peer-created standards, and on standards developed by others institutions that have had a positive impact on care quality, such as the Centers for Disease Control, the National Quality Forum, and the Agency for Health Care Quality and Research.
2. Collaborate with regional medical officers in establishing regional goals, priorities, and a timetable for implementation of standards of care.
3. Assure a process for patients to provide their views on standards of care to the patient advocate who shall report those views to the chief medical officer.
4. Collaborate with the Director of Health Planning and regional medical officers to support the development of computer software systems that link clinical guidelines to individual patient
conditions, guide clinicians through diagnosis and treatment
algorithms based on research and best medical practices based on
clinical efficacy, offer access to guidelines appropriate to each
medical specialty and offer current information on disease
prevention and treatment and that support continuing medical
education.

(5) Where referral systems for access to specialty care are in
place prior to the initiation of the health insurance system, the
chief medical officer shall review the referral systems to assure
that they meet health insurance system standards for care quality
and shall assure that needed changes are implemented so that all
Californians receive the same standards of care quality.

(c) In collaboration with the Director of Health Planning and
regional medical officer, the chief medical officer shall
implement means to measure and monitor the quality of care
delivered in the health insurance system. Monitoring systems
shall include, but shall not be limited to, peer and patient
performance reviews.

(d) The chief medical officer shall establish means to support
individual providers and health systems in correcting quality of
care problems, including timeframes for making needed
improvements and means to evaluate the effectiveness of
interventions.

(e) In collaboration with regional medical officers and
directors and the Director of Health Planning, the chief medical
officer shall establish means to identify medical errors and their
causes and develop plans to prevent them. Means shall include a
system for anonymous reporting of errors, and guidelines to
protect those who report the errors against recrimination,
including job demotion, promotion discrimination, or job loss.

(f) The chief medical officer shall convene an annual
statewide conference to discuss medical errors that occurred
during the year, their causes, means to prevent errors, and the
effectiveness of efforts to decrease errors.

(g) The chief medical officer shall recommend to the
commissioner a benefits package based on clinical efficacy for
the health insurance system, including priorities for needed
benefit improvements. In making recommendations, the chief
medical officer shall do all of the following:

(1) Identify safe and effective treatments.
(2) Evaluate and draw on existing benefit packages.
(3) Receive comments and recommendations from health care providers about benefits that meet the needs of their patients.
(4) Receive comments and recommendations made directly by patients or indirectly through the patient advocate.
(5) Identify and recommend to the commissioner and the Health Insurance Policy Board innovative approaches to health promotion, disease and injury prevention, education, research and care delivery for possible inclusion in the benefit package.
(6) Identify complementary and alternative modalities that have been shown by the National Institutes of Health, Division of Complementary and Alternative Medicine to be safe and effective for possible inclusion as covered benefits.
(7) Recommend to the commissioner and update as appropriate, pharmaceutical and durable and nondurable medical equipment formularies based on clinical efficacy. In establishing the formularies the chief medical officer shall establish a Pharmacy and Therapeutics Committee composed of pharmacy and medical health care providers, representatives of health facilities and organizations have system formularies in place at the time the system is implemented and other experts that shall do all the following:
(8) Identify safe and effective pharmaceutical agents for use in the California Health Insurance System.
(9) Draw on existing standards and formularies.
(10) Identify experimental drugs and drug treatment protocols for possible inclusion in the formulary.
(11) Review formularies in a timely fashion to ensure that safe and effective drugs are available and that unsafe drugs are removed from use.
(12) Assure the timely dissemination of information needed to prescribe safely and effectively to all California providers and the development and utilization of electronic dispensing systems that decrease pharmaceutical dispensing errors.
(13) Establish standards and criteria and a process for providers to seek authorization for prescribing pharmaceutical agents and durable and nondurable medical equipment that are not included in the system formulary. No standard or criteria shall impose an undue administrative burden on patients, health
care providers, including pharmacies and pharmacists, and none
shall delay care a patient needs.
(14) Develop standards and criteria and a process for providers
to request authorization for services and treatments, including
experimental treatments that are not included in the system
benefit package.
(A) Where such processes are in place when the health
insurance system is initiated, the chief medical officer shall
review the systems to assure that they meet health insurance
system standards for care quality and shall assure that needed
changes are implemented so that all Californians receive the
same standards of care quality.
(B) No standard or criteria shall impose an undue
administrative burden on a provider or a patient and none shall
delay the care a patient needs.
(15) In collaboration with the Director of Health Planning,
regional planning directors and regional medical officers,
identify appropriate ratios of general medical providers to
specialty medical providers on a regional basis in order to meet
the health care needs of the population and the goals of the health
insurance system.
(16) Recommend to the commissioner and to the Payment
Board, financial and nonfinancial incentives and other means to
achieve recommended provider ratios.
(17) Collaborate with the Director of Health Planning and
regional medical officers and patient advocates in development
of electronic initiatives, pursuant to Section 140603.
(18) Collaborate with the commissioner, the regional health
officers, the directors of the Payments Board and the Health
Insurance Fund to formulate a provider reimbursement model
that promotes the delivery of coordinated, high quality health
services in all sectors of the health insurance system and creates
financial and other incentives for the delivery of high quality
care.
(19) Establish or assure the establishment of continuing
medical education programs about advances in the delivery of
high quality of care.
(20) Convene an annual statewide quality of care conference
to discuss problems with care quality and to make
recommendations for changes needed to improve care quality.
Participants shall include regional medical directors, health care providers, providers, patients, policy experts, experts in quality of care measurement and others.

(21) Annually report to the commissioner, the Health Insurance Policy Board and the public on the quality of care delivered in the health insurance system, including improvements that have been made and problems that have been identified during the year, goals for care improvement in the coming year and plans to meet these goals.

(h) No person working within the agency, or on a pharmacy and therapeutics committee or serving as a consultant to the agency or a pharmacy and therapeutics committee, may receive fees or remuneration of any kind from a pharmaceutical company.

140607. (a) The patient advocate, in collaboration with the chief medical officer, the regional patient advocates, medical officers, and directors, shall establish a program in the state health insurance agency and in each region called the “Partnerships for Health”.

(b) The purpose of the Partnerships for Health is to improve health through community health initiatives, to support the development of innovative means to improve care quality, to promote efficient, coordinated care delivery, and to educate the public about the following:

(1) Personal maintenance of health.

(2) Prevention of disease.

(3) Improvement in communication between patients and providers.

(4) Improving quality of care.

(c) The patient advocate shall work with the community and health care providers in proposing Partnerships for Health projects and in developing project budget requests that shall be included in the regional budget request to the commissioner.

(d) In developing educational programs, the Partnerships for Health shall collaborate with educators in the region.

(e) Partnerships for Health shall support the coordination of California Health Insurance System and public health system programs.

140608. (a) The patient advocate shall establish a grievance system for all grievances except those involving the delay,
denial, or modification of health care services. The patient advocate shall do the following with regard to the grievance system:

1. Establish and maintain a grievance system approved by the commissioner under which members of the system may submit their grievances to the system. The system shall provide reasonable procedures that shall ensure adequate consideration of member grievances and rectification when appropriate.

2. Inform members of the system upon enrollment in the system and annually hereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

3. Provide printed and electronic access for members who wish to register grievances. The forms used by the system shall be approved by the commissioner in advance as to format.

4. (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
   (i) That the grievance has been received.
   (ii) The date of receipt.
   (iii) The name of the system representative and the telephone number and address of the system representative who may be contacted about the grievance.

   (B) Grievances received by telephone, by facsimile, by e-mail, or online through the system’s Web site that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The patient advocate shall maintain a log of all these grievances. The log shall be periodically reviewed by the patient advocate and shall include the following information for each complaint:
   (i) The date of the call.
   (ii) The name of the complainant.
   (iii) The complainant’s system identification number.
   (iv) The nature of the grievance.
   (v) The nature of the resolution.
   (vi) The name of the system representative who took the call and resolved the grievance.
(5) Provide members of the system with written responses to grievances, with a clear and concise explanation of the reasons for the system’s response.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(7) Establish and maintain a Web site that shall provide an online form that members of the system can use to file with a grievance online.

(b) The patient advocate may refer any grievance that does not pertain to compliance with this division to the federal Health Care Financing Administration, or any other appropriate local, state, and federal governmental entity for investigation and resolution.

(c) If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the grievance to the patient advocate as a designated agent of the member. Further, a provider may join with, or otherwise assist, an enrollee, or the agent, to submit the grievance to the patient advocate. In addition, following submission of the grievance to the patient advocate, the member, or the agent, may authorize the provider to assist, including advocating on behalf of the member. For purposes of this section, a “relative” includes the parent, stepparent, spouse, domestic partner, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the member.

(d) The patient advocate shall review the written documents submitted with the member’s request for review. The patient advocate may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the member.

(e) The patient advocate shall send a written notice of the final disposition of the grievance, and the reasons therefore, to the member, to any provider that has joined with or is otherwise assisting the member, and to the commissioner, within 30 calendar days of receipt of the request for review unless the patient advocate, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. The patient advocate’s written notice shall include, at a minimum, the following:
(1) A summary of findings and the reasons why the patient advocate found the system to be, or not to be, in compliance with any applicable laws, regulations, or orders of the commissioner.

(2) A discussion of the patient advocate’s contact with any medical provider, or any other independent expert relied on by the patient advocate, along with a summary of the views and qualifications of that provider or expert.

(3) If the member’s grievance is sustained in whole or in part, information about any corrective action taken.

(f) The patient advocate’s order shall be binding on the system.

(g) The patient advocate shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

140610. (a) The chief medical officer shall establish a grievance system for all grievances involving the delay, denial, or modification of health care services. The chief medical officer shall do all of the following with regard to the grievance regarding delay, denial, or modification of health care services:

(1) Establish and maintain a grievance system approved by the commissioner under which members of the system may submit their grievances to the system. The system shall provide reasonable procedures that shall ensure adequate consideration of member grievances and rectification when appropriate.

(2) Inform members of the system upon enrollment in the system and annually hereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.

(3) Provide printed and electronic access for members who wish to register grievances. The forms used by the system shall be approved by the commissioner in advance as to format.

(4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance. The acknowledgment shall advise the complainant of the following:

(i) That the grievance has been received.

(ii) The date of receipt.
(iii) The name of the system representative and the telephone number and address of the system representative who may be contacted about the grievance.

(B) The chief medical officer shall maintain a log of all these grievances. The log shall be periodically reviewed by the chief medical officer and shall include the following information for each complaint:

(i) The date of the call.
(ii) The name of the complainant.
(iii) The complainant’s system identification number.
(iv) The nature of the grievance.
(v) The nature of the resolution.
(vi) The name of the system representative who took the call and resolved the grievance.

(5) Provide members of the system with written responses to grievances, with a clear and concise explanation of the reasons for the system’s response. The system response shall describe the criteria used and the clinical reasons for its decision including all criteria used and the clinical reasons for its decision including all criteria and clinical reasons related to medical necessity.

(6) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(7) Establish and maintain a Web site that shall provide an online form that members of the system can use to file with a grievance online.

(b) In any case determined by the chief medical officer to be a case involving an imminent and serious threat to the health of the member, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or in any other case where the chief medical officer determines that an earlier review is warranted, a member shall not be required to complete the grievance process.

(c) If the member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the member, as appropriate, may submit the grievance to the chief medical officer as a designated agent of the member. Further, a provider may join with, or otherwise assist, an enrollee, or the agent, to submit the grievance to the chief medical officer. In addition, following submission of the grievance to the chief medical officer, the member, or the agent,
may authorize the provider to assist, including advocating on behalf of the member. For purposes of this section, a “relative” includes the parent, stepparent, spouse, domestic partner, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the member.

(d) The chief medical officer shall review the written documents submitted with the member’s request for review. The chief medical officer may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the member. If after reviewing the record, the chief medical officer concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system, the chief medical officer shall immediately notify the member of that option and shall, if requested orally or in writing, assist the member in participating in the independent medical review system.

(e) The chief medical officer shall send a written notice of the final disposition of the grievance, and the reasons therefore, to the member, to any provider that has joined with or is otherwise assisting the member, and to the commissioner, within 30 calendar days of receipt of the request for review unless the chief medical officer, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for independent medical review, the chief medical officer’s written notice shall include, at a minimum, the following:

(1) A summary of findings and the reasons why the chief medical officer found the system to be, or not to be, in compliance with any applicable laws, regulations, or orders of the commissioner.

(2) A discussion of the chief medical officer’s contact with any medical provider, or any other independent expert relied on by the patient advocate, along with a summary of the views and qualifications of that provider or expert.

(3) If the member’s grievance is sustained in whole or in part, information about any corrective action taken.

(f) The chief medical officer’s order shall be binding on the system.
(g) The chief medical officer shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(h) The grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(i) Nothing in this section shall be construed to allow the submission to the chief medical officer of any provider grievance under this section. However, as part of a provider’s duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the chief medical officer about any concerns he or she has regarding compliance with or enforcement of this act.

140612. (a) The chief medical officer shall establish an independent medical review system to act as an independent, external medical review process for the health care system to provide timely examinations of disputed health care services and coverage decisions regarding experimental and investigational therapies to ensure the system provides efficient, appropriate, high quality health care, and that the health care system is responsive to member disputes.

(b) For the purposes of this section, “disputed health care service” means any health care service eligible for coverage and payment under the benefits package of the health care system that has been denied, modified, or delayed by a decision of the system, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. If the system, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the system, the statement
of decision shall clearly specify the provisions of the system that exclude coverage.

(c) For the purposes of this section, “coverage decision” means the approval or denial of the health care system, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care system.

(d) Coverage decisions regarding experimental or investigational therapies for individual members who meet all of the following criteria are eligible for review by the independent medical review system:

(1) (A) The member has a life-threatening or seriously debilitating condition.

(B) For purposes of this section, “life-threatening” means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(C) For purposes of this section, “seriously debilitating” means diseases or conditions that cause major irreversible morbidity.

(2) The member’s physician certifies that the member has a condition, as defined in paragraph (1), for which standard therapies have not been effective in improving the condition of the enrollee, for which standard therapies would not be medically appropriate for the member, or for which there is no more beneficial standard therapy covered by the system than the therapy proposed pursuant to paragraph (3).

(3) Either (A) the member’s physician, who is under contract with or employed by the system, has recommended a drug, device, procedure or other therapy that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (B) the member, or the member’s physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member’s condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial for the member than any
available standard therapy. The physician certification pursuant
to this section shall include a statement of the evidence relied
upon by the physician in certifying his or her recommendation.
Nothing in this subdivision shall be construed to require the
system to pay for the services of a nonparticipating physician
provided pursuant to this act, that are not otherwise covered
pursuant to system benefits package.

(4) The member has been denied coverage by the system for a
drug, device, procedure, or other therapy recommended or
requested pursuant to paragraph (3).

(5) The specific drug, device, procedure, or other therapy
recommended pursuant to paragraph (3) would be a covered
service, except for the system’s determination that the therapy is
experimental or investigational.

(e) (1) All member grievances involving a disputed health
care service are eligible for review under the independent
medical review system if the requirements of this section are met.
If the chief medical officer finds that a patient grievance
involving a disputed health care service does not meet the
requirements of this section for review under the independent
medical review system, the enrollee request for review shall be
treated as a request for the chief medical officer to review the
grievance. All other enrollee grievances, including grievances
involving coverage decisions, remain eligible for review by the
chief medical officer.

(2) In any case in which an enrollee or provider asserts that a
decision to deny, modify, or delay health care services was
based, in whole or in part, on consideration of medical
appropriateness, the chief medical officer shall have the final
authority to determine whether the grievance is more properly
resolved pursuant to an independent medical review as provided
under this act.

(3) The chief medical officer shall be the final arbiter when
there is a question as to whether an enrollee grievance is a
disputed health care service or a coverage decision. The chief
medical officer shall establish a process to complete an initial
screening of an enrollee grievance. If there appears to be any
medical appropriateness issue, the grievance shall be resolved
pursuant to an independent medical review.
(f) For purposes of this chapter, an enrollee may designate an
agent to act on his or her behalf. The provider may join with or
otherwise assist the enrollee in seeking an independent medical
review, and may advocate on behalf of the enrollee.
(g) The independent medical review process authorized by this
section is in addition to any other procedures or remedies that
may be available.
(h) The office of the chief medical officer shall prominently
display in every relevant informational brochure, on copies of
health care system procedures for resolving grievances, on letters
of denials issued by either the health care system or its
contracting providers, on the grievance forms, and on all written
responses to grievances, information concerning the right of an
enrollee to request an independent medical review in cases where
the enrollee believes that health care services have been
improperly denied, modified, or delayed by the health care
system, or by one of its contracting providers.
(i) An enrollee may apply to the chief medical officer for an
independent medical review when all of the following conditions
are met:
   (1) (A) The enrollee’s health care provider has recommended
        a health care service as medically appropriate.
        (B) The enrollee has received urgent care or emergency
        services that a provider determined was medically appropriate.
        (C) The enrollee, in accordance with Section 1370.4, seeks
        coverage for experimental or investigational therapies.
        (D) The enrollee, in the absence of a provider recommendation
        under subparagraph (A) or the receipt of urgent care or
        emergency services by a provider under subparagraph (B), has
        been seen by an system provider for the diagnosis or treatment of
        the medical condition for which the enrollee seeks independent
        review. The health care system shall expedite access to a system
        provider upon request of an enrollee. The system provider need
        not recommend the disputed health care service as a condition for
        the enrollee to be eligible for an independent review.
   (2) The disputed health care service has been denied,
        modified, or delayed by the health care system, or by one of its
        contracting providers, based in whole or in part on a decision that
        the health care service is not medically appropriate.
(3) The enrollee has filed a grievance with the chief medical officer and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the health care system’s grievance process for more than 30 days. In the case of a grievance that requires expedited review, the enrollee shall not be required to participate in the health care system’s grievance process for more than three days.

(j) An enrollee may apply to the chief medical officer for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically appropriate, within six months of any of the qualifying periods or events. The chief medical officer may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(k) The enrollee shall pay no application or processing fees of any kind.

(l) Upon notice from the chief medical officer that the enrollee has applied for an independent medical review, the health care system or its contracting providers shall provide to the independent medical review organization designated by the chief medical officer a copy of all of the following documents within three business days of the health care system’s receipt of the chief medical officer’s notice of a request by an enrollee for an independent review:

1. (A) A copy of all of the enrollee’s medical records in the possession of the health care system or its contracting providers relevant to each of the following:
   (i) The enrollee’s medical condition.
   (ii) The health care services being provided by the health care system and its contracting providers for the condition.
   (iii) The disputed health care services requested by the enrollee for the condition.

2. (B) Any newly developed or discovered relevant medical records in the possession of the health care system or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The system shall concurrently provide a copy of medical records
required by this subparagraph to the enrollee or the enrollee’s
provider, if authorized by the enrollee, unless the offer of
medical records is declined or otherwise prohibited by law. The
confidentiality of all medical record information shall be
maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the enrollee by the
system and any of its contracting providers concerning health
care system and provider decisions regarding the enrollee’s
condition and care, and a copy of any materials the enrollee or
the enrollee’s provider submitted to the health care system and to
the health care system’s contracting providers in support of the
enrollee’s request for disputed health care services. This
documentation shall include the written response to the enrollee’s
grievance. The confidentiality of any enrollee medical
information shall be maintained pursuant to applicable state and
federal laws.

(3) A copy of any other relevant documents or information
used by the health care system or its contracting providers in
determining whether disputed health care services should have
been provided, and any statements by the system and its
contracting providers explaining the reasons for the decision to
deny, modify, or delay disputed health care services on the basis
of medical necessity. The system shall concurrently provide a
copy of documents required by this paragraph, except for any
information found by the chief medical officer to be legally
privileged information, to the enrollee and the enrollee’s
provider.

The chief medical officer and the independent review
organization shall maintain the confidentiality of any information
found by the chief medical officer to be the proprietary
information of the health care system.

140614. (a) If there is an imminent and serious threat to the
health of the enrollee, all necessary information and documents
shall be delivered to an independent medical review organization
within 24 hours of approval of the request for review. In
reviewing a request for review, the chief medical officer may
waive the requirement that the enrollee follow the system’s
grievance process in extraordinary and compelling cases, where
the chief medical officer finds that the enrollee has acted
reasonably.
(b) The chief medical officer shall expeditiously review requests and immediately notify the enrollee in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefore. The health care system shall promptly issue a notification to the enrollee, after submitting all of the required material to the independent medical review organization that includes an annotated list of documents submitted and offer the enrollee the opportunity to request copies of those documents from the health care system. The chief medical officer shall promptly approve enrollee requests whenever the health care system has agreed that the case is eligible for an independent medical review. To the extent an enrollee request for independent review is not approved by the chief medical officer, the enrollee request shall be treated as an immediate request for the chief medical officer to review the grievance.

(c) An independent medical review organization, specified in Section 1374.32, shall conduct the review in accordance with Section 1374.33 and any regulations or orders of the chief medical officer adopted pursuant thereto. The organization’s review shall be limited to an examination of the medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other contractual issues.

(d) The chief medical officer shall contract with one or more independent medical review organizations in the state to conduct reviews for purposes of this section. The independent medical review organizations shall be independent of the health care system. The chief medical officer may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this section that an organization shall be required to meet in order to qualify for participation in the independent medical review system and to assist the chief medical officer in carrying out its responsibilities.

(e) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be medical consultants for purposes of Section 43.98 of the Civil Code.

(f) The independent medical review organization, any experts it designates to conduct a review, or any officer, chief medical
officer, or employee of the independent medical review organization shall not have any material professional, familial, or financial affiliation, as determined by the patient advocate, with any of the following:

(1) The health care system.
(2) Any officer or employee of the health care system.
(3) A physician, the physician’s medical group, or the independent practice association involved in the health care service in dispute.
(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the health care system, would be provided.
(5) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the patient whose treatment is under review, or the alternative therapy, if any, recommended by the health care system.
(6) The enrollee or the enrollee’s immediate family.

(g) In order to contract with the chief medical officer for purposes of this section, an independent medical review organization shall meet all of the requirements pursuant to subdivision (d) of Section 1374.32.

140616. (a) Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the chief medical officer or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b).

(b) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically appropriate based on the specific medical needs of the patient and any of the following:

(1) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
(2) Nationally recognized professional standards.
(3) Expert opinion.
(4) Generally accepted standards of medical practice.
(5) Treatments likely to provide a benefit to an enrollee for conditions for which other treatments are not clinically efficacious.
(c) The organization shall complete its review and make its determination in writing, and in layperson’s terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the chief medical officer. If the disputed health care service has not been provided and the enrollee’s provider or the chief medical officer certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information. Subject to the approval of the chief medical officer, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the chief medical officer for up to three days in extraordinary circumstances or for good cause.
(d) The medical professionals’ analyses and determinations shall state whether the disputed health care service is medically appropriate. Each analysis shall cite the enrollee’s medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (b) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.
(e) The independent medical review organization shall provide the chief medical officer, the health care system, the enrollee, and the enrollee’s provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the
reviewers confidential in all communications with entities or
individuals outside the independent medical review organization,
except in cases where the reviewer is called to testify and in
response to court orders. If more than one medical professional
reviewed the case and the result was differing determinations, the
independent medical review organization shall provide each of
the separate reviewer’s analyses and determinations.
(f) The chief medical officer shall immediately adopt the
determination of the independent medical review organization,
and shall promptly issue a written decision to the parties that
shall be binding on the health care system.
(g) After removing the names of the parties, including, but not
limited to, the enrollee and all medical providers, the chief
medical officer’s decisions adopting a determination of an
independent medical review organization shall be made available
by the chief medical officer to the public upon request, at the
chief medical officer’s cost and after considering applicable laws
governing disclosure of public records, confidentiality, and
personal privacy.

140618. (a) Upon receiving the decision adopted by the chief
medical officer that a disputed health care service is medically
appropriate, the health care system shall promptly implement the
decision. In the case of reimbursement for services already
rendered, the health care provider or enrollee, whichever applies,
shall be paid within five working days. In the case of services not
yet rendered, the health care system shall authorize the services
within five working days of receipt of the written decision from
the chief medical officer, or sooner if appropriate for the nature
of the enrollee’s medical condition, and shall inform the enrollee
and provider of the authorization.
(b) The health care system shall not engage in any conduct
that has the effect of prolonging the independent review process.
(c) The chief medical officer shall require the health care
system to promptly reimburse the enrollee for any reasonable
costs associated with those services when the chief medical
officer finds that the disputed health care services were a covered
benefit and the services are found by the independent medical
review organization to have been medically appropriate and the
enrollee’s decision to secure the services outside of the health
care system provider network was reasonable under the emergency or urgent medical circumstances.

140619. (a) The chief medical officer shall utilize a competitive bidding process and use any other information on program costs reasonable to establish a per-case reimbursement schedule to pay the costs of independent medical review organization reviews, which may vary depending on the type of medical condition under review and on other relevant factors.

(b) The costs of the independent medical review system for enrollees shall be borne by the health care system.

Chapter 7. Other Provisions

140700. Notwithstanding any other provisions of law, the operative date of this division, other than Article 2 (commencing with Section 140230) of Chapter 3, shall be the date the Secretary of Health and Human Services notifies the Secretary of the Senate and the Chief Clerk of the Assembly that he or she has determined that the Health Insurance Fund will have sufficient revenues to fund the costs of implementing this division.

No state entity shall incur any transition or planning costs prior to that date. However, this prohibition shall not apply to activities of the California Health Insurance Premium Commission, and Article 2 (commencing with Section 140230) of Chapter 3 of this division shall become operative on January 1, 2007.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.