Senate Bill No. 2

Passed the Senate September 12, 2003

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Secretary of the Senate

Passed the Assembly September 13, 2003

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of

_____, 2003, at _____ o'clock __M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Section 6254 of the Government Code, to add Article 3.11 (commencing with Section 1357.20) to Chapter 2.2 of Division 2 of the Health and Safety Code, to add Section 12693.55 to, and to add Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, the Insurance Code, to add Part 8.7 (commencing with Section 2120) to Division 2 of the Labor Code, to amend Section 131 of, and to add Section 976.7 to, the Unemployment Insurance Code, and to amend Section 14124.91 of, and to add Sections 14105.981, 14124.915, and 14124.916 to, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 2, 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 create the State Health Purchasing Program, which would be administered by the Managed Risk Medical Insurance Board. The bill would require specified health benefits to be provided directly by employers or through the program. The bill would require the board to arrange health plan coverage for certain employers, who would be required to pay a fee for employee health coverage, except that employers who provide health care coverage directly would receive a credit against the fee. The bill would require employees and dependents of large

employers to be covered beginning January 1, 2006, while it would require employees of medium employers to be covered beginning January 1, 2007, subject to certain conditions. Small employers would be exempt from the requirement to provide coverage and from the fee. The bill would require the board to determine the fee to be paid by employers, and would provide that the associated employee contributions, which employers would be required to collect from employees, may not exceed 20% of the employer fee. The fees, including the employee contributions, would be collected by the Employment Development Department and would be deposited in the newly created State Health Purchasing Fund. The moneys in the fund would be continuously appropriated to the board for the purposes of the program. The bill would authorize the board to coordinate coverage under the program with coverage available under the Medi-Cal program, the Healthy Families Program, and other public programs, and would impose various requirements on the board and the State Department of Health Services in that regard. The bill would authorize a loan from the General Fund to the board for startup costs related to the State Health Purchasing Program, subject to appropriation by the Legislature. The bill would enact other related provisions.

Existing law requires health care service plans and health insurers to comply with various requirements relating to health care coverage for small employers. A willful violation of provisions governing health care service plans is a crime.

This bill would extend the application of these requirements to health care coverage provided directly by employers under the bill, and would impose various other requirements. Because a willful violation of these provisions by health care service plans would be a crime, the bill 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.

This bill would provide that it shall not become operative unless AB 1528 is also enacted and becomes operative.

Appropriation: yes.

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 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.

(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.

(*l*) 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 community 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, 2006.

(b) Medium employers, as defined in Section 2122.4, shall comply with the provisions of this part applicable to medium 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 employer-sponsored plans that are more favorable to the employees than the health care coverage required by this part.

CHAPTER 2. DEFINITIONS

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 entity 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 entity employing for wages or salary at least 20 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) 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).

CHAPTER 3. STATE HEALTH PURCHASING PROGRAM

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 referenced in subdivision (o) 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.

2130.2. The board shall arrange coverage for enrollees, and, if applicable, dependents eligible under this part by establishing and maintaining a purchasing pool. The board shall negotiate contracts with those health care service plans and health insurers that choose to participate for the benefit package described in this part and shall not self-insure or partially self-insure the health care benefits under this part.

2130.3. The health care benefits coverage provided to enrollees, and, if applicable, dependents, shall be equivalent to the coverage required under subdivision (a) or (b) of Section 2160.1.

2130.4. The program shall be funded by employer fees and enrollee contributions as described in this part. The board shall administer the program in a manner that assures that the fees and enrollee contributions collected pursuant to this part are sufficient to fund the program, including administrative costs.

CHAPTER 4. EMPLOYER FEE

2140. Except as otherwise provided in this part, every large employer and every medium employer shall pay a fee as specified in this chapter.

2140.1. The board shall establish the level of the fee by determining the total amount necessary to pay for health care for all enrollees, and, if applicable, their dependents eligible for the program. In setting the fee the board may include costs associated with the administration of the fund, including those costs associated with collection of the fee and its enforcement by the Employment Development Department. The program implemented pursuant to this part shall be fully supported by the fees and enrollee contributions collected pursuant to this part. The fees and enrollee contributions collected pursuant to this part shall not be used for any purpose other than providing health coverage for enrollees and, if applicable, their dependents, as well as costs associated with the administration of the fund and with collection of the fee and its enforcement by the Employment Development Department.

2140.2. The board shall provide notice to the Employment Development Department of the amount of the fee in a time and manner that permits the Employment Development Department to provide notice to all employers of the estimated fee for the budget

year pursuant to Section 976.7 of the Unemployment Insurance Code.

2140.3. The Employment Development Department shall waive the fee of any employer that is entitled to a credit under the terms of this part. The Employment Development Department shall specify the manner and means by which that credit may be claimed by an employer.

2140.4. Revenue from the fee and from the enrollee contributions specified in this part shall be deposited into the fund.

2140.5. The fee paid by employers shall be based on the cost of coverage for all enrollees, and, if applicable, their dependents. The fee to be paid by each employer shall be based on the number of potential enrollees, and if applicable, dependents, using the employer's own workforce on a date specified by the board as the basis for the allocation and such other factors as the board may determine in order to provide coverage that meets the standards of this part. To assist the board in determining the fee, each employer shall provide to the board information as specified by the board regarding potential enrollees, and, if applicable, dependents. To the extent feasible, the board shall work with the Employment Development Department to facilitate the provision of information regarding the number of potential enrollees and dependents.

2140.6. A large employer shall pay a fee to the fund for the purpose of providing health care coverage pursuant to this part. The fee paid by a large employer shall be based on the number of enrollees and dependents.

2140.7. A medium employer shall pay a fee to the fund for the purpose of providing health care coverage pursuant to this part. The fee paid by a medium employer shall be based on the number of enrollees.

2140.8. Coverage of an enrollee or, if applicable, dependents shall not be contingent upon payment of the fee required pursuant to this part by the employer of that enrollee or, if applicable, dependents. If an employer fails to pay the required fee, for whatever reason, the employer shall be responsible to the fund for payment of a penalty of 200 percent of the amount of any fee that would have otherwise been paid by the employer including for the period that the enrollee and, if applicable, dependents should have

received coverage but for the employer's conduct in violation of this section.

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 and paid 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 copayments, 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 coverage provided through the program only and is not intended to apply coverage that is not provided through the program.

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's contribution or to provide enrollment information about an employee affect the employee's coverage arranged pursuant to Chapter 3 (commencing with Section 2130), nor may an employer withhold or collect any amount that is not withheld and transmitted in the manner and at such times as specified by the Employment Development Department pursuant to this part. An employee for whom enrollment information is not otherwise received by the board may demonstrate eligibility for coverage by any reliable means of demonstrating employment as provided for in regulation. To the extent feasible, the board shall work with the Employment Development Department to facilitate the provision of information regarding the eligibility of enrollees and to provide information regarding any failure of an employer to collect or transmit employee contributions as required by this part.

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.

(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.

2160.3. It shall be unlawful for an employer to designate an employee as an independent contractor or temporary employee, reduce an employee's hours of work, or terminate and rehire an employee if a purpose of which is to avoid the employer's obligations under this part. An employer that violates this section shall be responsible to the fund for a penalty of 200 percent of the amount of any fee that would have otherwise been paid by the employer including for the period that the enrollee, and, if applicable, dependents should have received coverage but for the employer's conduct in violation of this section. The rights

established under this section shall not reduce any other rights established under any other provision of law.

2160.4. 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, dependent, or other family member of an employee, other than that information about the employee's employment status otherwise known to the employer consistent with existing state and federal law and regulation. For these purposes, public health benefit programs include, but are not limited to, the Medi-Cal program, Healthy Families Program, Major Risk Medical Insurance Program, and Access for Infants and Mothers program.

2160.5. The Employment Development Department shall adopt regulations to ensure that employers abide by the provisions of this chapter. 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 part until after the requirements of this program are in effect for large and medium employers as provided in Section 2120.1.

2160.7. (a) Any new employer or existing employer that previously was not subject to this part shall begin complying with all applicable provisions of this part within one month of the date it became subject to this part.

(b) Any existing employer previously subject to this part but no longer subject to this part shall notify the Employment Development Department in a manner prescribed by that department within 15 days of this change before discontinuing to comply with the provisions of this part.

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 findings 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-effective 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 prescribed by the board to assist the board in obtaining information necessary 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 consistent 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 determine whether the enrollee or dependents may be eligible for coverage under 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 programs, 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 Chapter 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 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 accordance 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 eligibility 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 provided 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 repayments of enrollee contributions to persons whose coverage is provided under this section, and may also delegate to the State Department of Health Services the authority to repay those contributions.

(e) The State Department of Health Services shall seek all state plan amendments and federal approvals as necessary to maximize the amount of any federal financial participation available.

2190.3. Nothing in this part shall be construed to diminish or otherwise 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 programs, 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 bidding, 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 enrollments 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 provisions of this article shall become inoperative.

1357.21. (a) Notwithstanding any other provision of law, on and after January 1, 2006, except as specified in subdivision (b), 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 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 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 otherwise requires.

(2) For medium employers with 51 or more 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 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 contract 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:

(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 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.

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

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

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

CHAPTER 8.1. INSURANCE MARKET REFORM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Organizations that represent persons with disabilities.

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

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

(5) Employer organizations.

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

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

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

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

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

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 2160) 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 as 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 at county-owned hospitals and clinics, community clinics, and vital institutional safety net providers eligible for Medi-Cal payments under Section 14105.98, including determining the number of Medi-Cal inpatient days and outpatient visits as well as the nature and cost of care provided to Medi-Cal patients.

(b) If Medi-Cal fee-for-service utilization or Medi-Cal fee-for-service payments to county-owned hospitals and clinics, community clinics, and other vital institutional safety net providers eligible for Medi-Cal payments under Section 14105.98 have been reduced, then the department shall review statute, regulations, policies and procedures, payment arrangements or other mechanisms to determine what changes may be necessary to protect Medi-Cal funding and maximize federal financial participation to protect the financial stability of county-owned hospitals and clinics, community clinics, and other vital institutional safety net providers. The department shall consult with representatives of county-owned hospital systems, community clinics, vital institutional safety net providers eligible for Medi-Cal payments under Section 14105.98, legal services advocates, and recognized collective bargaining agents for the specified providers.

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 or financial resources, 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 reduce 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 provided 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 part. Once enrolled in both the premium assistance program and employer-based health care coverage repayment to Medi-Cal covered enrollees of any share of premium shall coincide with the payment by the enrollee of the premium for the available 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 memorandums 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).

(e) 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.

(f) 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 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 division 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, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, 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 response thereto, including, to the extent the information regarding 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 surrounding 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, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be withheld at the victim's request, or at the request of the 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, 261.5, 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 the victim of any crime defined by Section 220, 261, 261.5, 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 purposes. The exemption in this subdivision shall not apply to 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's office or 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 section and for making available to the public 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 a 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, meeting minutes, 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. In the event that a contract for inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

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.

(r) Records of Native American graves, cemeteries, and sacred places maintained by the Native American Heritage Commission.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of Health Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(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 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, 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 for health coverage entered into pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract for health coverage that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment, 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).

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 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, 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) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 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) 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 (2).

(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 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) 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, 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 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, 1998, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract 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 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 are open to inspection pursuant to paragraph (2) or (3).

(5) The exemption from disclosure provided pursuant to this subdivision for the contracts, deliberative processes, discussions, communications, negotiations with health plans, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff shall also apply to the contracts, deliberative processes, discussions, communications, negotiations with health plans, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of applicants pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code.

(z) Records obtained pursuant to paragraph (2) of subdivision (c) of Section 2891.1 of the Public Utilities Code.

(aa) A document prepared by a local agency that assesses its vulnerability to terrorist attack or other criminal acts intended to disrupt the public agency's operations and that is for distribution or consideration in a closed session.

(bb) (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 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.

(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 on or after January 1, 2004, shall be open to inspection one year after they have been fully executed.

(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 are open to inspection pursuant to paragraph (2) or (3).

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act.

SEC. 13. (a) 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, except as provided in subdivision (b) or (c).

(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 Sec. 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 11760) of Part 2 of Division 2 of the Insurance Code shall become inoperative.

SEC. 14. This act shall not become operative unless AB 1528 of the 2003–04 Regular Session is also enacted and becomes operative.

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.

Approved _____, 2003

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Governor