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**SENATE BILL**

**No. 840**

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**Introduced by Senator Kuehl**

**(Principal coauthor: Senator Ortiz)**

(Principal coauthors: Assembly Members Chan, Goldberg, and Leno)

**(Coauthors: Senators Alquist, Cedillo, Chesbro, Escutia, Figueroa, Florez, Lowenthal, Migden, Murray, Perata, Romero, and Soto)**

(Coauthors: Assembly Members ~~Berg~~, ~~Bass~~, ~~Berg~~, ~~Bermudez~~, ~~Chu~~, ~~Chavez~~, ~~Chu~~, ~~Coto~~, Dymally, Evans, Hancock, *Jerome Horton*, Jones, Klehs, Koretz, Laird, Levine, Lieber, ~~Montanez~~, ~~Lieu~~, ~~Montanez~~, ~~Mullin~~, Nava, ~~Oropeza~~, Pavley, Ridley-Thomas, ~~Salinas~~, ~~Torricon~~, Vargas, and Yee)

February 22, 2005

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An act to add Division 112 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

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 ~~an elected~~ *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 health care system to be operational within 2 years of enactment, and would enact various transition provisions.~~ 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 ~~Consumer~~ *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~~

*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.

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

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

- 1 SECTION 1. Division 112 (commencing with Section
- 2 140000) is added to the Health and Safety Code, to read:

1 DIVISION 112. CALIFORNIA HEALTH INSURANCE  
2 RELIABILITY ACT

3  
4 CHAPTER 1. GENERAL PROVISIONS  
5

6 140000. There is hereby established in state government the  
7 California Health Insurance System, which shall be administered  
8 by the California Health Insurance Agency, an independent  
9 agency under the control of the Health Insurance Commissioner.

10 ~~140000.5. The California Health Insurance Agency shall be a~~  
11 ~~separate entity in state government and its decisions shall not be~~  
12 ~~subject to review by any other agency, including, but not limited~~  
13 ~~to, the Department of Finance, the Department of Personnel~~  
14 ~~Administration, the Department of General Services, and the~~  
15 ~~Office of Administrative Law, except as otherwise provided in~~  
16 ~~Section 140307 with respect to that agency.~~

17 140000.6. No health care service plan contract or health  
18 insurance policy, except for the California Health Insurance  
19 System plan, may be sold in California for services provided by  
20 the system.

21 140001. This division shall be known as and may be cited as  
22 the California Health Insurance Reliability Act.

23 140002. This division shall be liberally construed to  
24 accomplish its purposes.

25 140003. The California Health Insurance Agency is hereby  
26 created and designated as the single state agency with full power  
27 to supervise every phase of the administration of the California  
28 Health Insurance System and to receive grants-in-aid made by  
29 the United States government, by the state, or by other sources in  
30 order to secure full compliance with the applicable provisions of  
31 state and federal law.

32 140004. The California Health Insurance Agency shall be  
33 comprised of the following entities:

- 34 (a) The Health Insurance Policy Board.
- 35 (b) The Office of ~~Consumer~~ *Patient* Advocacy.
- 36 (c) The Office of Health Planning.
- 37 (d) The Office of Health Care Quality.
- 38 (e) The Health Insurance Fund.
- 39 (f) The Public Advisory Committee.
- 40 (g) The Payments Board.

- 1 (h) Partnerships for Health.  
2 140005. The Legislature finds and declares all of the  
3 following:
- 4 ~~(a) Between six and seven million Californians lacked health~~  
5 ~~insurance coverage at some time in 2004.~~
  - 6 ~~(b) Since 2001, the number of uninsured Californians has risen~~  
7 ~~significantly.~~
  - 8 ~~(c) More than 10 million Californians have no coverage for~~  
9 ~~prescription drugs. Millions of Californians lacking prescription~~  
10 ~~drug coverage are otherwise insured.~~
  - 11 ~~(d) Efforts to control health care costs and growth of health~~  
12 ~~care spending have been unsuccessful.~~
  - 13 ~~(e) Linkage of health insurance to employment has adversely~~  
14 ~~affected job growth, job mobility, the competitiveness of~~  
15 ~~products produced in California, business investment, and~~  
16 ~~employer-employee relations.~~
  - 17 ~~(f) Effective management of large amounts of information is~~  
18 ~~integral to providing high quality care and to controlling health~~  
19 ~~system costs.~~
  - 20 ~~(g) Discontinuity of care harms patients.~~
  - 21 ~~(h) Employers, retirement funds, and unions that offer and~~  
22 ~~negotiate for health insurance and benefits and individuals who~~  
23 ~~purchase health insurance are experiencing substantial increases~~  
24 ~~in health care costs and decreases in health care benefits.~~
  - 25 ~~(i) Unstable and unaffordable rate increases have caused~~  
26 ~~significant economic hardship for California residents and their~~  
27 ~~employers.~~
  - 28 ~~(j) One in two personal bankruptcies in the United States is the~~  
29 ~~result of health care costs.~~
  - 30 ~~(k) California does not perform well on key standard health~~  
31 ~~outcome measurements.~~
  - 32 ~~(l) Severe health access disparities exist by region, ethnicity,~~  
33 ~~income, and gender.~~
  - 34 ~~(m) Rural communities do not have reliable access to~~  
35 ~~affordable health insurance plans.~~
  - 36 ~~(n) More than 80 percent of all Medi-Cal and uninsured~~  
37 ~~patient visits to emergency facilities are for conditions that could~~  
38 ~~have been treated in a nonemergency setting.~~
  - 39 ~~(o) Advances in medical technology are not available to all~~  
40 ~~Californians who need them.~~

1 ~~(p) Health care providers express significant professional~~  
2 ~~dissatisfaction with the current health care systems, as do health~~  
3 ~~care consumers.~~

4 ~~(q) Uncompensated hospital care totaled over \$1 billion in~~  
5 ~~2000. The burden for providing uncompensated care falls~~  
6 ~~disproportionately on 12 percent of hospitals in California.~~

7 ~~(r) Emergency departments and trauma centers face growing~~  
8 ~~financial losses.~~

9 ~~(s) Increasing patient volume and a decline in the number of~~  
10 ~~emergency rooms have made multiple hour waits for emergency~~  
11 ~~care the norm, and ambulance diversion is becoming a common~~  
12 ~~method of dealing with emergency department overcrowding.~~  
13 ~~These developments pose significant dangers for both insured~~  
14 ~~and uninsured Californians.~~

15 ~~(t) Multiple quantitative analysis including two recent studies~~  
16 ~~by the independent economic consulting firm, Lewin Inc.,~~  
17 ~~indicate that under a single payer health insurance system,~~  
18 ~~California could afford to cover all California residents at no new~~  
19 ~~cost to the state while providing on average savings to California~~  
20 ~~consumers, businesses, and state and local government.~~

21 ~~(u) According to these reports and numerous other studies, by~~  
22 ~~simplifying administration, achieving bulk purchase discounts on~~  
23 ~~pharmaceuticals, and reducing the use of emergency facilities for~~  
24 ~~primary care improvements in care quality, and careful~~  
25 ~~management of health care capital investment, California could~~  
26 ~~divert billions of dollars toward providing direct health care and~~  
27 ~~improved quality and access.~~

28 *(a) An estimated 6.5 million Californians lacked health care*  
29 *coverage at some time in 2004, including one in every five*  
30 *nonelderly Californians.*

31 *(b) Health care spending continues to grow much faster than*  
32 *the economy, and efforts to control health care costs and the*  
33 *growth of health care spending have been unsuccessful.*

34 *(c) On average, the United States spends more than twice as*  
35 *much as all other industrial nations on health care, both per*  
36 *person and as a percentage of its gross domestic product.*

37 *(d) A majority of California residents and businesses support*  
38 *a system of universal publicly-financed health care.*

39 *(e) Consumers can no longer rely on traditional health care*  
40 *coverage due to a continuous decline of employer-offered*

1 coverage, unstable employment trends, and uncontrolled  
2 increases in the amount of premiums and cost sharing, and  
3 increases in benefit gaps.

4 (f) As a result, one-half of all bankruptcies in the United States  
5 now relate to medical costs, though three-fourths of bankrupted  
6 families had health care coverage at the time of sustaining the  
7 injury or illness.

8 (g) Health insurance companies have no business motive to  
9 provide comprehensive and affordable health care coverage to  
10 residents who are likely to require health care services, including  
11 seniors, disabled residents, residents with or at risk of developing  
12 a chronic illness, and women of child-bearing age.

13 (h) Health care quality is rapidly declining, and the United  
14 States Institute of Medicine has declared an epidemic of  
15 substandard health care throughout the nation.

16 (i) The World Health Organization ranks the United States  
17 below all other industrial nations and 37th overall in  
18 population-based health outcomes.

19 (j) Recent emergencies in the South and growing fears of  
20 disease pandemics, underscore the critical importance of a  
21 regular source of health care for all residents and systemwide  
22 health care planning to ensure disaster and emergency  
23 preparedness.

24 (k) Growing epidemics of chronic diseases such as diabetes,  
25 obesity, and asthma require a system of universal health care  
26 and a continuous source of health care for all residents in order  
27 to adequately address the health care needs of all residents.

28 (l) Severe health access disparities exist by region, ethnicity,  
29 income, and gender. These disparities destabilize the overall  
30 health care system throughout the state and reflect a lack of  
31 effective health care planning.

32 (m) Inadequate access to a regular source of care has caused  
33 Medi-Cal and uninsured patients to seek treatment in emergency  
34 facilities for conditions that could have been treated more  
35 appropriately in a nonemergency setting.

36 (n) Emergency departments and trauma centers face growing  
37 financial losses, and uncompensated hospital care totaled over  
38 one billion dollars (\$1,000,000,000) in 2000. The burden for  
39 providing uncompensated care falls disproportionately on a

1 *minority of hospitals in California and leads to significant*  
2 *financial instability for the overall health care system.*

3 *(o) Multiple quantitative analyses indicate that under a single*  
4 *payer health insurance system, the amount currently spent for*  
5 *health care is more than adequate to finance comprehensive high*  
6 *quality health care coverage for every resident of the state while*  
7 *guaranteeing the right of every resident to choose his or her own*  
8 *physician.*

9 *(p) According to these reports and numerous other studies, by*  
10 *simplifying administration, achieving bulk purchase discounts on*  
11 *pharmaceuticals, reducing the use of emergency facilities for*  
12 *primary care, and carefully managing health care capital*  
13 *investment, California could divert billions of dollars toward*  
14 *providing direct health care and improve the quality of, and*  
15 *access to, that care.*

16 ~~140005.1. (a) The Legislature also finds and declares that a~~  
17 ~~relevant aspect of market competition in a health care system~~  
18 ~~exists through the consumer choice of a direct care provider, and~~  
19 ~~that the current health care system stifles this type of market~~  
20 ~~competition in a way that is detrimental to overall health care~~  
21 ~~quality and patient safety.~~

22 *140005.1 (a) It is the intent of the Legislature to establish a*  
23 *system of universal health insurance in this state that covers all*  
24 *residents with comprehensive health insurance benefits,*  
25 *guarantees a single standard of care for all residents, stabilizes*  
26 *the growth in health care spending, and improves the quality of*  
27 *health care for all residents.*

28 *(b) It is the intent of the Legislature that, in order to ensure an*  
29 *adequate supply and distribution of direct care providers in the*  
30 *state, a just and fair return for providers electing to be*  
31 *compensated by the health care system, and a uniform system of*  
32 *payments, the state shall actively supervise and regulate a system*  
33 *of payments whereby groups of fee-for-service physicians are*  
34 *authorized to select representatives of their—specialities*  
35 *specialties to negotiate with the health care system, pursuant to*  
36 *Section 140209. Nothing in this division shall be construed to*  
37 *allow collective action against the health care system.*

38 *140006. This division shall have all of the following*  
39 *purposes:*

1 (a) To provide affordable *and comprehensive* health insurance  
2 coverage *with a single standard of care* for all California  
3 residents.

4 ~~(b) To provide California residents with a comprehensive~~  
5 ~~benefit package.~~

6 ~~(c)~~

7 (b) To control health care costs and the growth of health care  
8 spending, *subject to the obligation described in subdivision (a)*.

9 ~~(d)~~

10 (c) To achieve measurable improvement in the quality of care  
11 and the efficiency of care delivery.

12 ~~(e)~~

13 (d) To prevent disease and disability and to maintain or  
14 improve health and functionality.

15 ~~(f)~~

16 (e) To increase health care provider, consumer, employee, and  
17 employer satisfaction with the health care system.

18 ~~(g)~~

19 (f) To implement policies that strengthen and improve  
20 culturally and linguistically sensitive care.

21 ~~(h)~~

22 (g) To develop an integrated population-based health care  
23 database to support health care planning.

24 140007. As used in this division, the following terms have the  
25 following meanings:

26 (a) “Agency” means the California Health Insurance Agency.

27 (b) “Clinic” means an organized outpatient health facility that  
28 provides direct medical, surgical, dental, optometric, or podiatric  
29 advice, services, or treatment to patients who remain less than 24  
30 hours, and that may also provide diagnostic or therapeutic  
31 services to patients in the home as an ~~incident~~ *alternative* to care  
32 provided at the clinic facility, and includes those facilities  
33 defined under Sections 1200 and 1200.1 ~~of the Health and Safety~~  
34 ~~Code~~.

35 (c) “Commissioner” means the Health Insurance  
36 Commissioner.

37 (d) “Direct care provider” means any licensed health care  
38 professional that provides health care services through direct  
39 contact with the patient, either in person or using approved

1 telemedicine modalities as identified in Section 2290.5 of the  
2 Business and Profession Code.

3 (e) “Essential community provider” means a health facility  
4 that has served as part of the state’s health care safety net for low  
5 income and traditionally undeserved populations in California  
6 and that is one of the following:

7 (1) A “community clinic” as defined under subparagraph (A)  
8 of paragraph (1) of subdivision (a) of Section 1204 ~~of the Health  
9 and Safety Code.~~

10 (2) A “free clinic” as defined under subparagraph (B) of  
11 paragraph (1) of subdivision (a) of Section 1204 ~~of the Health  
12 and Safety Code.~~

13 (3) A “federally qualified health center” as defined under  
14 Section 1395x (aa)(4) or 1396d (l)(2) of Title 42 of the United  
15 States Code.

16 (4) A “rural health clinic” as defined under Section 1395x  
17 (aa)(2) or 1396d (l)(1) of Title 42 of the United States Code.

18 (5) Any clinic conducted, maintained, or operated by a  
19 federally recognized Indian tribe or tribal organization, as  
20 defined in Section 1603 of Title 25 of the United States Code.

21 (6) Any clinic exempt from licensure under subdivision (h) of  
22 Section 1206.

23 (f) “Health care provider” means any professional person,  
24 medical group, independent practice association, organization,  
25 health facility, or other person or institution licensed or  
26 authorized by the state to deliver or furnish health care services.

27 (g) “Health facility” means any facility, place, or building that  
28 is organized, maintained, and operated for the diagnosis, care,  
29 prevention, and treatment of human illness, physical or mental,  
30 including convalescence and rehabilitation and including care  
31 during and after pregnancy, or for any one or more of these  
32 purposes, for one or more persons, and includes those facilities  
33 defined under subdivision (b) of Section 15432 of the  
34 Government Code.

35 (h) “Hospital” means all health facilities to which persons may  
36 be admitted for a 24-hour stay or longer, as defined in Section  
37 1250 ~~of the Health and Safety Code~~, with the exception of  
38 nursing, skilled nursing, intermediate care, and congregate living  
39 health facilities.

1 (i) “Integrated health care delivery system” means a provider  
2 organization that meets all of the following criteria:

3 (1) Is fully integrated operationally and clinically to provide a  
4 broad range of health care services, including preventative care,  
5 prenatal and well-baby care, immunizations, screening  
6 diagnostics, emergency services, hospital and medical services,  
7 surgical services, and ancillary services.

8 (2) Is compensated using capitation or facility budgets, except  
9 for copayments, for the provision of health care services.

10 (3) Provides health care services primarily through direct care  
11 providers who are either employees or partners of the  
12 organization, or through arrangements with direct care providers  
13 or one or more groups of physicians, organized on a group  
14 practice or individual practice basis.

15 (j) “Large employer” means a person, firm, proprietary or  
16 nonprofit corporation, partnership, public agency, or association  
17 that is actively engaged in business or service, that, on at least 50  
18 percent of its working days during the preceding calendar year  
19 employed at least 50 employees, or, if the employer was not in  
20 business during any part of the preceding calendar year,  
21 employed at least 50 employees on at least 50 percent of its  
22 working days during the preceding calendar quarter.

23 (k) “*Premium Commission*” means the *California Health*  
24 *Insurance Premium Commission*.

25 (l) “Primary care provider” means a direct care provider that is  
26 a family physician, internist, general practitioner, pediatrician, an  
27 obstetrician/gynecologist, or a family nurse practitioner or  
28 physician assistant practicing under supervision as defined in  
29 California codes or essential community providers who employ  
30 primary care providers.

31 (†)

32 (m) “Small employer” means a person, firm, proprietary or  
33 nonprofit corporation, partnership, public agency, or association  
34 that is actively engaged in business or service and that, on at least  
35 50 percent of its working days during the preceding calendar year  
36 employed at least two but no more than 49 employees, or, if the  
37 employer was not in business during any part of the preceding  
38 calendar year, employed at least two but no more than 40 eligible  
39 employees on at least 50 percent of its working days during the  
40 preceding calendar quarter.

1 (m)  
 2 (n) “System” or “health insurance system” means the  
 3 California Health Insurance System.  
 4 140008. The definitions contained in Section 140007 shall  
 5 govern the construction of this division, unless the context  
 6 requires otherwise.

7  
 8 CHAPTER 2. GOVERNANCE  
 9

10 ~~140100. (a) Except as otherwise provided in this section and~~  
 11 ~~in Section 140109, the commissioner shall be elected by the~~  
 12 ~~people in the same time, place and manner as the Governor and~~  
 13 ~~shall serve a term of eight years. A person serving as~~  
 14 ~~commissioner may stand twice for election to the position and~~  
 15 ~~may serve a total of 16 years.~~

16 *140100. (a) (1) The commissioner shall be appointed by the*  
 17 *Governor on or before March 1, 2007, subject to confirmation by*  
 18 *the Senate. If in session, the Senate shall act on the appointment*  
 19 *within 30 days of the appointment date. If the Senate does not act*  
 20 *on the appointment within that period, the nominee shall be*  
 21 *deemed confirmed and may take office. If the Senate is not in*  
 22 *session at the time of the appointment, the Senate shall act on the*  
 23 *appointment within 30 days of the commencement of the next*  
 24 *legislative session. If the Senate does not act on the appointment*  
 25 *within that period, the appointee shall be deemed confirmed and*  
 26 *may take office.*

27 *(2) If the Senate by a vote fails to confirm the nominee for*  
 28 *commissioner, the Governor shall make a new appointment*  
 29 *within 30 days of the Senate’s vote. The appointment is subject to*  
 30 *confirmation by the Senate, and the procedures described in*  
 31 *paragraph (1) shall apply to the confirmation process.*

32 *(b) The commissioner is exempt from the State Civil Service*  
 33 *Act (Part 2 (commencing with Section 18500) of Division 5 of*  
 34 *Title 2 of the Government Code).*

35 (b)  
 36 (c) The commissioner may not be a state legislator or a  
 37 member of the United States Congress while holding the position  
 38 of commissioner.

39 (e)

1 (d) The commissioner shall not have been employed in any  
2 capacity by a for-profit insurance, pharmaceutical, or medical  
3 equipment company that sells products to the California Health  
4 Insurance System for a period of two years prior to ~~election~~  
5 *appointment* as commissioner.

6 ~~(d)~~

7 (e) For two years after completing service in the California  
8 Health Insurance System, the commissioner may not receive  
9 payments of any kind from, or be employed in any capacity or  
10 act as a paid consultant to, a for-profit insurance, pharmaceutical,  
11 or medical equipment company that sells products to the  
12 California Health Insurance System.

13 ~~(e) In the event of a vacancy, or inability of the commissioner~~  
14 ~~to perform the duties of office for a period of more than 90 days;~~  
15 ~~an acting commissioner shall be appointed by the Governor and~~  
16 ~~confirmed by the Senate for the balance of the commissioner's~~  
17 ~~term pursuant to the same process provided in Section 5 of~~  
18 ~~Article V of the California Constitution.~~

19 ~~(f) The commissioner is subject to impeachment pursuant to~~  
20 ~~the same process provided in Section 18 of Article IV of the~~  
21 ~~California Constitution.~~

22 ~~(g)~~

23 (f) The compensation and benefits of the commissioner shall  
24 be determined pursuant to the same process as provided in  
25 Section 8 of Article III of the California Constitution.

26 ~~(h)~~

27 (g) The commissioner shall be subject to Title 9 (commencing  
28 with Section 81000) of the Government Code.

29 140101. (a) The commissioner shall be the chief officer of  
30 the California Health Insurance Agency and shall administer all  
31 aspects of the agency.

32 (b) The commissioner shall be responsible for the performance  
33 of all duties, the exercise of all power and jurisdiction, and the  
34 assumption and discharge of all responsibilities vested by law in  
35 the agency. The commissioner shall perform all duties imposed  
36 upon him or her by this division and other laws related to health  
37 care, and shall enforce the execution of those related to the  
38 system, and shall enforce the execution of those provisions and  
39 laws to promote their underlying aims and purposes. These broad  
40 powers shall include, but are not limited to, the power *to*

1 establish the California Health Insurance System budget and to  
2 set rates, to establish California Health Insurance System goals,  
3 standards and priorities, to hire ~~and fire~~, *fire*, and fix the  
4 compensation of agency personnel, *to* make allocations and  
5 reallocations to the health planning regions ~~and~~, *and to*  
6 promulgate generally binding regulations concerning any and all  
7 matters related to the implementation of this division and its  
8 purposes.

9 (c) The commissioner shall appoint the deputy health  
10 insurance commissioner, the Director of the Health Insurance  
11 Fund, the ~~consumer~~ *patient* advocate, the chief medical officer,  
12 the ~~purchasing director, the director of planning, the Director of~~  
13 ~~the Director of the Payments Board, the Director of Health~~  
14 ~~Planning, the Director of the Partnerships for Health, the~~  
15 regional health planning directors, the chief enforcement counsel,  
16 and legal counsel in any action brought by or against the  
17 commissioner under or pursuant to any provision of any law  
18 under the commissioner's jurisdiction, or in which the  
19 commissioner joins or intervenes as to a matter within the  
20 commissioner's jurisdiction, as a friend of the court or otherwise,  
21 and stenographic reporters to take and transcribe the testimony in  
22 any formal hearing or investigation before the commissioner or  
23 before a person authorized by the commissioner.

24 (d) *The commissioner, in accordance with the State Civil*  
25 *Service Act (Part 2 (commencing with Section 18500) of Division*  
26 *5 of Title 2 of the Government Code), may appoint and fix the*  
27 *compensation of clerical, inspection, investigation, evaluation,*  
28 *and auditing personnel as may be necessary to implement this*  
29 *division.*

30 (e) The personnel of the agency shall perform duties as  
31 assigned to them by the commissioner. The commissioner shall  
32 designate certain employees by the rule or order that are to take  
33 and subscribe to the constitutional oath within 15 days after their  
34 appointments, and to file that oath with the Secretary of State.  
35 The commissioner shall also designate those employees that are  
36 to be subject to Title 9 (commencing with Section 81000) of the  
37 Government Code.

38 (e)

39 (f) The commissioner shall adopt a seal bearing the  
40 inscription: "Commissioner, California Health Insurance Agency,

1 State of California.” The seal shall be affixed to or imprinted on  
2 all orders and certificate issued by him or her and other  
3 instruments as he or she directs. All courts shall take notice of  
4 this seal.

5 ~~(f)~~

6 (g) The administration of the agency shall be supported from  
7 the Health Insurance Fund created pursuant to Section 140200.

8 ~~(g)~~

9 (h) The commissioner, as a general rule, shall publish or make  
10 available for public inspection any information filed with or  
11 obtained by the agency, unless the commissioner finds that this  
12 availability or publication is contrary to law. No provision of this  
13 division authorizes the commissioner or any of the  
14 commissioners assistants, clerks, or deputies to disclose any  
15 information withheld from public inspection except among  
16 themselves or when the necessary or appropriate in a proceeding  
17 or investigation under this division or to other federal or state  
18 regulatory agencies. No provision of this division either creates  
19 or ~~derogate~~ *derogates* from any privilege that exists at common  
20 law or otherwise when documentary or other evidence is sought  
21 under a subpoena directed to the commissioner or any of his or  
22 her assistants, clerks, and deputies.

23 ~~(h)~~

24 (i) It is unlawful to the commissioner or any of his or her  
25 assistants, clerks, or deputies to use for personal benefit any  
26 information that is filed with ~~or obtained by~~, or *obtained by*, the  
27 commissioner and that is not then generally available to the  
28 public.

29 ~~(i)~~

30 (j) The commissioner shall avoid political activity that may  
31 create the appearance of political bias or impropriety. Prohibited  
32 activities shall include, but not be limited to, leadership of, or  
33 employment by, a political party or a political organization;  
34 public endorsement of a political candidate; contribution of more  
35 than five hundred dollars (\$500) to any one candidate in a  
36 calendar year or a contribution in excess of an aggregate of one  
37 thousand dollars (\$1,000) in a calendar year for all political  
38 parties or organizations; and attempting to avoid compliance with  
39 this prohibition by making contributions through a spouse or  
40 other family member.

1     ~~(j)~~  
 2     (k) The commissioner shall not participate in making or in any  
 3 way attempt to use his or her official position to influence a  
 4 governmental decision in which he or she knows or has reason to  
 5 know that he or she or a family or a business partner or colleague  
 6 has a financial interest.

7     ~~(k)~~  
 8     (l) The commissioner, in pursuit of his or her duties, shall have  
 9 unlimited access to all nonconfidential and all nonprivileged  
 10 documents in the custody and control of the agency.

11    ~~(l)~~  
 12    (m) The Attorney General shall render to the commissioner  
 13 opinions upon all questions of law, relating to the construction or  
 14 interpretation of any law under the commissioner’s jurisdiction  
 15 or arising in the administration thereof, that may be submitted to  
 16 the Attorney General by the commissioner and upon the  
 17 commissioner’s request shall act as the attorney for the  
 18 commissioner in actions and proceedings brought by or against  
 19 the commissioner or under or pursuant to any provision of any  
 20 law under the commissioner’s jurisdiction.

21    140102. The commissioner shall do all of the following:

22    (a) Oversee the establishment as part of the administration of  
 23 the agency all of the following:

24    (1) The Health Insurance Policy Board, pursuant to Section  
 25 140103.

26    (2) The Office of ~~Consumer~~ *Patient* Advocacy, pursuant to  
 27 Section 140105.

28    (3) The Office of Health Planning, pursuant to Section  
 29 140602.

30    (4) The Office of Health Care Quality pursuant to Section  
 31 140605.

32    (5) The Health Insurance Fund, pursuant to Section ~~410200~~  
 33 *140200*.

34    (6) The Payments Board, pursuant to Section 140208.

35    (7) The Public Advisory Committee pursuant to Section  
 36 140104.

37    (8) Partnerships for Health.

38    (b) Determine California Health Insurance System goals,  
 39 standards, guidelines, and priorities.

40    (c) Establish health care regions, pursuant to Section 140112.

1 (d) Oversee the establishment of real and virtual locally-based  
2 integrated service networks that include physicians in  
3 fee-for-service, solo and group practice, essential community,  
4 and ancillary care providers and facilities in order to pool and  
5 align resources and form interdisciplinary teams that share  
6 responsibility and accountability for patient care and provide a  
7 continuum of coordinated high quality primary to tertiary care to  
8 all California residents. This shall be accomplished in  
9 collaboration with the chief medical officer, the Director of  
10 Health Planning, the regional medical officers, the regional  
11 planning boards, and the ~~consumer~~ *patient* advocate.

12 (e) Establish ~~evidence-based standards~~ *standards based on*  
13 *clinical efficacy* to guide delivery of care and ensure a smooth  
14 transition to clinical ~~decisionmaking~~ *decision making* under  
15 statewide standards.

16 (f) Implement policies to ensure that all Californians receive  
17 culturally and linguistically sensitive care, pursuant to Section  
18 140604, and develop mechanisms and incentives to achieve this  
19 purpose and means to monitor the effectiveness of efforts to  
20 achieve this purpose.

21 (g) Create a systematic approach to the measurement,  
22 management, and accountability for care quality that assures the  
23 delivery of high quality care to all California residents, including  
24 a system of performance contracts that contain measurable goals  
25 and outcomes.

26 (h) Develop methods and a framework to measure the  
27 performance of health insurance and health delivery system  
28 upper level managers, including a system of performance  
29 contracts that contain measurable goals and outcomes.

30 (i) Establish a capital management plan for the California  
31 Health Insurance System, including, but not limited to, a  
32 standardized process and format for the development and  
33 submission of regional operating and regional capital budget  
34 requests.

35 (j) Ensure the establishment of policies that support the public  
36 health.

37 (k) Ensure that health insurance system policies and providers  
38 support all Californians in achieving and maintaining maximum  
39 physical and mental functionality.

- 1 (l) Establish and maintain appropriate statewide and regional
- 2 health care databases.
- 3 (m) Establish a means to identify areas of medical practice
- 4 where standards of care do not exist and establish priorities and a
- 5 timetable for their development.
- 6 (n) Establish standards for mandatory reporting by health care
- 7 providers and penalties for failure to report.
- 8 ~~(o) [Reserved]~~
- 9 (o) *Implement policies to ensure that all residents of this state*
- 10 *have access to medically appropriate, coordinated mental health*
- 11 *services.*
- 12 (p) Establish a comprehensive budget that ensures adequate
- 13 funding to meet the health care needs of the population and the
- 14 compensation for providers for care provided pursuant to this
- 15 division.
- 16 (q) Establish standards and criteria for allocation of operating
- 17 and capital funds from the Health Insurance Fund as described in
- 18 Chapter 3 (commencing with Section 140200).
- 19 (r) Establish standards and criteria for development and
- 20 submission of provider operating and capital budget requests.
- 21 (s) Determine the level of funding to be allocated to each
- 22 health care region.
- 23 (t) Annually assess projected revenues and expenditures to
- 24 assure financial solvency of the system.
- 25 (u) During transition and annually thereafter, determine the
- 26 appropriate level for a health insurance system reserve fund and
- 27 implement policies needed to establish the appropriate reserve.
- 28 (v) Institute necessary cost controls pursuant to Section
- 29 140203 to assure financial solvency of the system.
- 30 (w) Develop separate formulae for budget allocations and
- 31 review the formulae annually to ensure they address disparities in
- 32 service availability and health care outcomes and for sufficiency
- 33 of rates, fees and prices.
- 34 (x) Meet regularly with the chief medical officer, the
- 35 ~~consumer patient~~ *consumer patient* advocate, the Public Advisory Committee, the
- 36 ~~director of planning~~ *Director of Health Planning*, the Director of
- 37 the Payments Board, the Director of the Partnerships for ~~health~~
- 38 *Health*, the Technical Advisory Committee, regional planning
- 39 directors, and regional medical officers to review the impact of

1 the agency and its policies on the health of the population and on  
2 satisfaction with the California Health Insurance System.

3 (y) Negotiate for or set rates, fees, and prices involving any  
4 aspect of the California Health Insurance System and establish  
5 procedures thereto.

6 (z) Establish a capital management framework for the  
7 California Health Insurance System pursuant to Section 140216  
8 to ensure that the needs for capital health care infrastructure are  
9 met, pursuant to the goals of the system.

10 (aa) Ensure a smooth transition to California Health Insurance  
11 System oversight of capital health care planning.

12 (bb) Establish ~~an evidence-based formulary~~ *a formulary based*  
13 *on clinical efficacy* for all prescription drugs and durable and  
14 nondurable medical equipment for use by the California Health  
15 Insurance System.

16 (cc) Establish guidelines for prescribing medications,  
17 nutritional supplements, and durable medical equipment that are  
18 not included in the health system formularies.

19 (dd) Utilize the purchasing power of the state to negotiate  
20 price discounts for prescription drugs and durable and  
21 nondurable medical equipment for use by the California Health  
22 Insurance System.

23 (ee) Ensure that use of state purchasing power achieves the  
24 lowest possible prices for the California Health Insurance System  
25 without adversely affecting needed pharmaceutical research.

26 (ff) Create incentives and guidelines for research needed to  
27 meet the goals of the system and disincentives for research that  
28 does not achieve California Health Insurance System goals.

29 (gg) Implement eligibility standards for the system, including  
30 guidelines to prevent an influx of persons to the state for the  
31 purpose of obtaining medical care.

32 (hh) Determine an appropriate level of, and provide support  
33 during the transition for training and job placement for persons  
34 who are displaced from employment as a result of the initiation  
35 of the new California Health Insurance System.

36 (ii) Establish an enrollment system that ensures all eligible  
37 California residents, including those who travel frequently; those  
38 who have disabilities that limit their mobility, hearing, or vision;  
39 those who cannot read; and those who do not speak or write

1 English are aware of their right to health care and are formally  
2 enrolled.

3 (jj) Oversee the establishment of the system for resolution of  
4 disputes pursuant to Sections 140608 and 140609.

5 (kk) Establish an electronic claims and payments system for  
6 the California Health Insurance System, to which all claims shall  
7 be filed and from which all payments shall be made, and  
8 implement, to the extent permitted by federal law, standardized  
9 claims and reporting methods.

10 (ll) Establish a system of secure electronic medical records  
11 that comply with state and federal privacy laws and that are  
12 compatible across the system.

13 (mm) Establish an electronic referral system that is accessible  
14 to providers and to patients.

15 (nn) Establish guidelines for mandatory reporting by health  
16 care providers.

17 (oo) Establish a Technology Advisory Committee to evaluate  
18 the cost and effectiveness of new medical technology, including  
19 electronic medical technology, and to make recommendations  
20 about the financial and health impact of their inclusion in the  
21 benefit package.

22 (pp) Investigate the costs and benefits to the health of the  
23 population of advances in information technology, including  
24 those that support data collection, analysis, and distribution.

25 (qq) Ensure that consumers of health care have access to  
26 information needed to support choice of physician.

27 (rr) Collaborate with the boards that license health facilities to  
28 ensure that facility performance is monitored and that deficient  
29 practices are recognized and corrected in a timely fashion and  
30 that consumers and providers of health care have access to  
31 information needed to support choice of facility.

32 (ss) Establish a Health Insurance System Internet Web site that  
33 provides information to the public about the California Health  
34 Insurance System that includes, but is not limited to, information  
35 that supports choice of provider and facilities, informs the public  
36 about state and regional health insurance policy board meetings  
37 and activities of the Partnerships for Health.

38 (tt) Procure funds, including loans, lease or purchase of  
39 insurance for the system, its employees and agents.

1 (uu) Collaborate with state and local authorities, including  
2 regional health directors, to plan for needed earthquake retrofits  
3 in a manner that does not disrupt patient care.

4 (vv) Establish a process for the system to receive the concerns,  
5 opinions, ideas, and recommendation of the public regarding all  
6 aspects of the system.

7 (ww) Annually report to the Legislature and the Governor, on  
8 or before October of each year and at other times pursuant to this  
9 division, on the performance of the California Health Insurance  
10 System, its fiscal condition and need for rate adjustments,  
11 consumer copayments or consumer deductible payments,  
12 recommendations for statutory changes, receipt of payments  
13 from the federal government and other sources, whether current  
14 year goals and priorities are met, future goals, and priorities, and  
15 major new technology or prescription drugs or other  
16 circumstances that may affect the cost of health care.

17 140103. (a) The commissioner shall establish a Health  
18 Insurance Policy Board and shall serve as the president of the  
19 board.

20 (b) The board shall do all of the following:

21 (1) Establish health insurance system goals and priorities,  
22 including research and capital investment priorities.

23 (2) Establish the scope of services to be provided to the  
24 population.

25 ~~(3) Determine when an increase in health insurance premium  
26 rates or when a change in the health insurance premium structure  
27 is needed.~~

28 ~~(4)~~

29 (3) Establish guidelines for evaluating the performance of the  
30 health insurance system, health insurance system officers, health  
31 care regions, and health care providers.

32 ~~(5)~~

33 (4) Establish guidelines for ensuring public input on health  
34 insurance system policy, standards, and goals.

35 (c) The board shall consist of the following members:

36 (1) The commissioner.

37 (2) The deputy commissioner.

38 (3) The Health Insurance Fund Director.

39 ~~(4) The consumer patient advocate.~~

40 (5) The chief medical officer.

- 1 (6) The Director of Health Planning.
- 2 (7) The Director of the Partnerships for Health.
- 3 (8) The Director of the Payments Board.
- 4 (9) The state public health officer.
- 5 (10) One member of the Public Advisory Committee who
- 6 shall serve on a rotating basis to be determined by the Public
- 7 Advisory Committee.
- 8 (11) Two representatives from ~~health care~~ regional planning
- 9 boards.
- 10 (A) A regional representative shall serve a term of one year
- 11 and terms shall be rotated in order to allow every region to be
- 12 represented within a five-year period.
- 13 (B) A regional planning director shall appoint the regional
- 14 representative to serve on the board.
- 15 (d) It is unlawful for the board members or any of their
- 16 assistants, clerks, or deputies to use for personal benefit any
- 17 information that is filed with or obtained by the board and that is
- 18 not then generally available to the public.
- 19 140104. (a) The commissioner shall establish a public
- 20 advisory committee to advise the Health Insurance Policy Board
- 21 on all matters of health insurance system policy.
- 22 (b) Members of the ~~public advisory committee~~ *Public*
- 23 *Advisory Committee* shall include all of the following:
- 24 (1) Four physicians all of whom shall be board certified in
- 25 their field and at least one of whom shall be a psychiatrist. The
- 26 Senate Committee on Rules and the Governor shall each appoint
- 27 one member. The Speaker of the Assembly shall appoint two of
- 28 these members, both of whom shall be primary care providers.
- 29 (2) One registered nurse, to be appointed by the ~~Governor~~
- 30 *Senate Committee on Rules*.
- 31 (3) One licensed vocational nurse, to be appointed by the
- 32 Senate Committee on Rules.
- 33 (4) One licensed allied health practitioner, to be appointed by
- 34 the Speaker of the Assembly.
- 35 (5) One mental health care provider, to be appointed by the
- 36 Senate Committee on Rules.
- 37 (6) One dentist, to be appointed by the Governor.
- 38 (7) One representative of private hospitals, to be appointed by
- 39 ~~the Senate Committee on Rules.~~ *the Governor.*

1 (8) One representative of public hospitals, to be appointed by  
2 the Governor.

3 (9) Four consumers of health care. The Governor shall appoint  
4 two of these members, one of whom shall be a member of the  
5 disability community. The Senate Committee on Rules shall  
6 appoint a member who is 65 years of age or older. The Speaker  
7 of the Assembly shall appoint the fourth member.

8 (10) One representative of organized labor, to be appointed by  
9 the Speaker of the Assembly.

10 (11) One representative of essential community providers, to  
11 be appointed by the Senate Committee on Rules.

12 (12) One union member, to be appointed by the Senate  
13 Committee on Rules.

14 (13) One representative of small business, to be appointed by  
15 the Governor.

16 (14) One representative of large business, to be appointed by  
17 the Speaker of the Assembly.

18 (15) One pharmacist, to be appointed by the Speaker of the  
19 Assembly.

20 (c) In making appointments pursuant to this section, the  
21 Governor, the Senate Committee on Rules, and the Speaker of  
22 the Assembly shall make good faith efforts to assure that their  
23 appointments, as a whole, reflect, to the greatest extent feasible,  
24 the social and geographic diversity of the state.

25 (d) Any member appointed by the Governor, the Senate  
26 Committee on Rules, or the Speaker of the Assembly shall serve  
27 for a four-year term. These members may be reappointed for  
28 succeeding four-year terms.

29 (e) Vacancies that occur shall be filled within 30 days after the  
30 occurrence of the vacancy, and shall be filled in the same manner  
31 in which the vacating member was selected or appointed. The  
32 commissioner shall notify the appropriate appointing authority of  
33 any expected vacancies on the board.

34 (f) Members of the advisory committee shall serve without  
35 compensation, but shall be reimbursed for actual and necessary  
36 expenses incurred in the performance of their duties to the extent  
37 that reimbursement for those expenses is not otherwise provided  
38 or payable by another public agency or agencies, and shall  
39 receive \_\_\_ dollars (\$\_\_\_) for each full day of attending meetings  
40 of the board. For purposes of this section, “full day of attending a

1 meeting” means presence at, and participation in, not less than 75  
2 percent of the total meeting time of the board during any  
3 particular 24-hour period.

4 (g) The advisory committee shall meet at least six times a year  
5 in a place convenient to the public. All meetings of the board  
6 shall be open to the public, pursuant to the Bagley-Keene Open  
7 Meeting Act (Article 9 (commencing with Section 11120) of  
8 Chapter 1 of Part 1 of Division 3 of Title 2 of the Government  
9 Code).

10 (h) The advisory committee shall elect a chair who shall serve  
11 for two years and who may be reelected for an additional two  
12 years.

13 (i) Appointed committee members shall have worked in the  
14 field they represent on the committee for a period of at least two  
15 years prior to being appointed to the committee.

16 (j) The advisory committee shall elect a member to serve on  
17 the Health Insurance Policy Board. The elected member shall  
18 serve for one year, and may be recalled by the advisory  
19 committee for cause. In that case a new member shall be elected  
20 to serve on that board. The advisory committee representative  
21 shall represent the views of the advisory committee members to  
22 the board.

23 (k) It is unlawful for the committee members or any of their  
24 assistants, clerks, or deputies to use for personal benefit any  
25 information that is filed with or obtained by the committee and  
26 that is not generally available to the public.

27 140105. (a) (1) There is within the agency an Office of  
28 ~~Consumer~~ *Patient* Advocacy to represent the interests of the  
29 consumers of health care. The goal of the office shall be to help  
30 residents of the state secure the health care services and benefits  
31 to which they are entitled under the laws administered by the  
32 agency and to advocate on behalf of and represent the interests of  
33 consumers in governance bodies created by this division and in  
34 other forums.

35 (2) The office shall be headed by a ~~consumer~~ *patient* advocate  
36 appointed by the commissioner.

37 (3) The ~~consumer~~ *patient* advocate shall establish an office in  
38 the City of Sacramento and other offices throughout the state that  
39 shall provide convenient access to residents.

40 (b) The ~~consumer~~ *patient* advocate shall do all the following:

- 1 (1) Administer all aspects of the ~~office of the consumer~~  
2 ~~advocate~~ *Office of Patient Advocacy*.
- 3 (2) Assure that services of the ~~consumer advocate~~ *Office of*  
4 *Patient Advocacy* are available to all California residents.
- 5 (3) Serve on the Health Insurance Policy Board and participate  
6 in the regional Partnerships for Health.
- 7 (4) Oversee the establishment and maintenance of the  
8 grievance process pursuant to Sections 140608, 140609, and  
9 140610.
- 10 (5) Participate in the grievance process and independent  
11 medical review system on behalf of consumers pursuant to  
12 Sections 140608 and 140609.
- 13 (6) Receive, evaluate, and respond to consumer complaints  
14 about the health insurance system.
- 15 (7) Provide a means to receive recommendations from the  
16 public about ways to improve the health insurance system and  
17 hold public hearings at least once annually to discuss problems  
18 and receive recommendations from the public.
- 19 (8) Develop educational and informational guides for  
20 consumers describing their rights and responsibilities and  
21 informing them about effective ways exercise their rights to  
22 secure health care services and to participate in the health  
23 insurance system. The guides shall be easy to read and  
24 understand, available in English and other languages, including  
25 Braille and formats suitable for those with hearing limitations,  
26 and shall be made available to the public by the agency,  
27 including access on the agency's Internet Web site and through  
28 public outreach and educational programs and displayed in  
29 provider offices and health care facilities.
- 30 (9) Establish a toll-free number to receive complaints  
31 regarding the agency and its services. Those with hearing and  
32 speech limitations may use the California Relay Service's  
33 toll-free telephone numbers to contact the Office of ~~Consumer~~  
34 *Patient Advocacy*. The agency Internet Web site shall have  
35 complaint forms and instructions on their use.
- 36 (10) Report annually to the public, the commissioner, and the  
37 Legislature about the consumer perspective on the performance  
38 of the health insurance system, including recommendations for  
39 needed improvements.

1 (c) Nothing in this division shall prohibit a consumer or class  
2 of consumers or the ~~consumer~~ *patient* advocate from seeking  
3 relief through the judicial system.

4 (d) The ~~consumer~~ *patient* advocate in pursuit of his or her  
5 duties shall have unlimited access to all nonconfidential and all  
6 nonprivileged documents in the custody and control of the  
7 agency.

8 (e) It is unlawful for the ~~consumer~~ *patient* advocate or any of  
9 his or her assistants, clerks, or deputies to use for personal benefit  
10 any information that is filed with ~~or obtained by~~, *or obtained by*,  
11 the agency and that is not then generally available to the public.

12 140106. (a) There is within the Office of the Attorney  
13 General an Office of the Inspector General for the California  
14 Health Insurance System. The Inspector General shall be  
15 appointed by the Governor and subject to Senate confirmation.

16 (b) The Inspector General shall have broad powers to  
17 investigate, audit, and review the financial and business records  
18 of individuals, public and private agencies and institutions, and  
19 private corporations that provide services or products to the  
20 system, the costs of which are reimbursed by the system.

21 (c) The Inspector General shall investigate allegations of  
22 misconduct on the part of an employee or appointee of the  
23 agency and on the part of any health care provider of services  
24 that are reimbursed by the system and shall report any findings of  
25 misconduct to the Attorney General.

26 (d) The Inspector General shall investigate patterns of medical  
27 practice that may indicate fraud and abuse related to over or  
28 under utilization or other inappropriate utilization of medical  
29 products and services.

30 (e) The Inspector General shall arrange for the collection and  
31 analysis of data needed to investigate the inappropriate utilization  
32 of these products and services.

33 (f) The Inspector General shall conduct additional reviews or  
34 investigations of financial and business records when requested  
35 by the Governor or by any Member of the Legislature and shall  
36 report findings of the review or investigation to the Governor and  
37 the Legislature.

38 (g) The Inspector General shall establish a telephone hotline  
39 for anonymous reporting of allegations of failure to make health  
40 insurance premium payments established by this division. The

1 Inspector General shall investigate information provided to the  
2 hotline and shall report any findings of misconduct to the  
3 Attorney General.

4 (h) The Inspector General shall annually report  
5 recommendations for improvements to the system or the agency  
6 to the Governor, the Legislature, and the commissioner.

7 140107. The provisions of the Insurance Fraud Prevention  
8 Act (Chapter 12 (commencing with Section 1871) of Part 2 of  
9 Division 1 of the Insurance Code), and the provisions of Article  
10 6 (commencing with Section 650) of Chapter 1 of Division 2 of  
11 the Business and Professions Code, shall be applicable to health  
12 care providers who receive payments for services through the  
13 system under this division.

14 140108. (a) Nothing contained in this division is intended to  
15 repeal any legislation or regulation governing the professional  
16 conduct of any person licensed by the State of California or any  
17 legislation governing the licensure of any facility licensed by the  
18 State of California.

19 (b) All federal legislation and regulations governing referral  
20 fees and fee-splitting, including, but not limited to, Sections  
21 1320a-7b and 1395nn of Title 42 of the United States Code shall  
22 be applicable to all health care providers of services reimbursed  
23 under this division, whether or not the health care provider is  
24 paid with funds coming from the federal government.

25 (e) [Reserved]

26 ~~140109. (a) A transition commissioner of health insurance~~  
27 ~~shall be appointed by the Governor not less than 75 days~~  
28 ~~following the operative date of this division, and shall be subject~~  
29 ~~to confirmation by the Senate within 30 days of nomination. If~~  
30 ~~the Senate does not take up the nomination within 30 days, the~~  
31 ~~nominee shall be considered to have been confirmed and may~~  
32 ~~take office, except that, if the Senate is not in session at the time~~  
33 ~~the Governor appoints the transition commissioner of health~~  
34 ~~insurance, the Senate shall take up the confirmation of the~~  
35 ~~nominee at the commencement of the next legislative session.~~

36 ~~(b) The transition commissioner of health insurance shall take~~  
37 ~~office within 30 days of confirmation and shall serve until a~~  
38 ~~commissioner of health insurance is elected at the next regularly~~  
39 ~~scheduled election of the Governor. The transition commissioner~~

1 of health insurance may stand for election for commissioner of  
2 health insurance for one term.

3 (e) ~~Should the Senate, by a vote fail to confirm the nominee,~~  
4 ~~the Governor shall appoint a new nominee, subject to the~~  
5 ~~confirmation of the Senate.~~

6 (d) ~~The transition commissioner shall not have been employed~~  
7 ~~in any capacity by a for-profit insurance, pharmaceutical or~~  
8 ~~medical equipment company that plans to sell products to the~~  
9 ~~California Health Insurance System for a period of two years~~  
10 ~~prior to appointment to his or her position.~~

11 (e) ~~For two years after completing service in the California~~  
12 ~~Health Insurance System, the transition commissioner may not~~  
13 ~~receive payments of any kind from, or be employed in any~~  
14 ~~capacity by or act as a paid consultant to, a for-profit insurance,~~  
15 ~~pharmaceutical or medical equipment company that plans to sell~~  
16 ~~products to the California Health Insurance System.~~

17 (f) ~~The transition commissioner shall avoid political activity~~  
18 ~~that may create the appearance of political bias or impropriety.~~  
19 ~~Prohibited activities shall include, but not be limited to,~~  
20 ~~leadership of, or employment by, a political party or a political~~  
21 ~~organization; public endorsement of a political candidate;~~  
22 ~~contribution of more than five hundred dollars to any one~~  
23 ~~candidate in a calendar year or a contribution in excess of an~~  
24 ~~aggregate of one thousand dollars (\$1,000) in a calendar year for~~  
25 ~~all political parties or organizations; and attempting to avoid~~  
26 ~~compliance with this prohibition by making contributions~~  
27 ~~through a spouse or other family member.~~

28 (g) ~~The transition commissioner shall not participate in~~  
29 ~~making or in any way attempt to use his or her official position to~~  
30 ~~influence a governmental decision in which he or she knows or~~  
31 ~~has reason to know that he or she or a family or a business~~  
32 ~~partner or colleague has a financial interest.~~

33 140110. (a) ~~The health insurance system shall be operational~~  
34 ~~no later than two years after the operative date of this division~~  
35 ~~date this division, other than Article 2 (commencing with Section~~  
36 ~~140230) of Chapter 3, becomes operative, as described in~~  
37 ~~Section 140700.~~

38 (b) ~~The transition shall be funded from a loan from the~~  
39 ~~General Fund and from other sources, including private sources~~  
40 ~~identified by the transition commissioner or commissioner.~~

1 ~~(e) The transition commissioner shall attempt to recover~~  
2 ~~moneys held by California foundations created pursuant to~~  
3 ~~Article 11 (commencing with Section 1399.70) of Chapter 2.2 of~~  
4 ~~Division 2 that were created pursuant to conversions of health~~  
5 ~~plans from nonprofit to for-profit status and expended to provide~~  
6 ~~patient care services for which the California health insurance~~  
7 ~~system is now responsible. Moneys recovered from these sources~~  
8 ~~shall be used to fund the transition to the new health insurance~~  
9 ~~system and, to the extent possible, to provide insurance coverage~~  
10 ~~during the transition to uninsured Californians.~~

11 ~~(d) The transition commissioner shall assess health plans and~~  
12 ~~(c) The commissioner shall assess health plans and~~ insurers  
13 for care provided by the system in those cases in which a  
14 person's health care coverage extends into the time period in  
15 which the new system is operative.

16 ~~(e) The transition~~

17 ~~(d) The commissioner shall implement means to assist persons~~  
18 who are displaced from employment as a result of the initiation  
19 of the new health insurance system, including determination of  
20 the period of time during which assistance shall be provided and  
21 possible sources of funds, including health insurance funds, to  
22 support retraining and job placement. That support shall be  
23 provided for a period of five years from the date that this division  
24 becomes operative.

25 140111. ~~(a) The transition~~ commissioner shall appoint a  
26 transition advisory group to assist with the transition to the  
27 system. The transition advisory group shall include, but not be  
28 limited to, the following members:

- 29 (1) ~~The transition~~ commissioner.
- 30 (2) ~~The consumer~~ patient advocate.
- 31 (3) The chief medical officer.
- 32 (4) The Director of Health Planning.
- 33 (5) The Director of the Health Insurance Fund.
- 34 (6) The State Public Health Officer.
- 35 (7) Experts in health care financing and health care  
36 administration.
- 37 (8) Direct care providers.
- 38 (9) Representatives of retirement boards.
- 39 (10) Employer and employee representatives.

1 (11) Hospital, essential community provider, and long-term  
2 care facility representatives.

3 (12) Representatives from state departments and regulatory  
4 bodies that shall or may relinquish some or all parts of their  
5 delivery of health service to the system.

6 (13) Representatives of counties.

7 (14) Consumers of health care.

8 (b) The transition advisory group shall advise the  
9 commissioner on all aspects of the implementation of this  
10 division.

11 (c) The transition advisory group shall make recommendations  
12 to the commissioner, the Governor, and the Legislature on how  
13 to integrate health care delivery services and responsibilities  
14 relating to the delivery of the services of the following  
15 departments and agencies into the system:

16 (1) The State Department of Health Services.

17 (2) The Department of Managed Health Care.

18 (3) The Department of Aging.

19 (4) The Department of Developmental Services.

20 (5) The Health and Welfare Data Center.

21 (6) The Department of Mental Health.

22 (7) The Department of Alcohol and Drugs.

23 (8) The Department of Rehabilitation.

24 (9) The Emergency Medical Services Authority.

25 (10) The Managed Risk Medical Insurance Board.

26 (11) The Office of Statewide Health Planning and  
27 Development.

28 (12) The Department of Insurance.

29 (d) The transition advisory group shall make recommendations  
30 to the Governor, the Legislature, and the ~~transition~~ commissioner  
31 regarding research needed to support transition to the new health  
32 insurance system.

33 140112. (a) The transition advisory group shall make  
34 recommendations to the ~~transition~~ commissioner relative to how  
35 the health insurance system shall be regionalized for the purposes  
36 of local and community-based planning for the delivery of high  
37 quality cost-effective care and efficient service delivery.

38 (b) The commissioner ~~or transition commissioner~~, in  
39 consultation with the Director of Health Planning, shall establish  
40 up to 10 health planning regions composed of geographically

1 contiguous counties grouped on the basis of the following  
2 considerations:

- 3 (1) Patterns of utilization of health care services.
- 4 (2) Health care resources, including workforce resources.
- 5 (3) Health needs of the population, including public health  
6 needs.
- 7 (4) Geography.
- 8 (5) Population and demographic characteristics.
- 9 (6) Other considerations as determined by the commissioner,  
10 Director of Health Planning, or chief medical officer.

11 (c) The commissioner ~~or transitional commissioner~~ shall  
12 appoint a director for each region. Regional planning directors  
13 shall serve at the will of the commissioner and may serve up to  
14 two eight-year terms to coincide with the terms of the  
15 commissioner.

16 (d) Each regional planning director shall appoint a regional  
17 medical officer.

18 (e) Compensation for health system officers and appointees  
19 who are exempt from the civil service shall be established by the  
20 California Citizens Commission in accordance with Section 8 of  
21 Article III of the California Constitution, and shall take into  
22 consideration regional differences in the cost of living.

23 (f) The regional planning director and the regional medical  
24 officer shall be subject to Title 9 (commencing with Section  
25 81000) of the Government Code and shall comply with the  
26 qualifications for office described in subdivisions ~~(b), (c), and (d)~~  
27 *(c), (d), and (e)* of Section 140100 and subdivisions ~~(i) and (j)~~ *(j)*  
28 *and (k)* of Section 140101.

29 140113. (a) Regional planning directors shall administer the  
30 health planning region. The regional planning director shall be  
31 responsible for all duties, the exercise of all powers and  
32 jurisdiction, and the assumptions and discharge of all  
33 responsibilities vested by law in the regional agency. The  
34 regional planning director shall perform all duties imposed upon  
35 him or her by this division and by other laws related to health  
36 care, and shall enforce execution of those provisions and laws to  
37 promote their underlying aims and purposes.

38 (b) The regional planning director shall reside in the region in  
39 which he or she serves.

40 (c) The regional planning director shall do all of the following:

- 1 (1) Establish and administer a regional office of the state  
2 agency. Each regional office shall include, at minimum, an office  
3 of each of the following: ~~Consumer Advocate~~ *Patient Advocacy*,  
4 Health Care Quality, Health Planning, and Partnerships for  
5 Health.
- 6 (2) Establish regional goals and priorities pursuant to  
7 standards, goals, priorities, and guidelines established by the  
8 commissioner.
- 9 (3) Assure that regional administrative costs meet standards  
10 established by the ~~aet~~ *division*.
- 11 (4) Seek innovative means to lower the costs of administration  
12 of the regional planning office and those of regional providers.
- 13 (5) Plan for the delivery of, and equal access to, high quality  
14 and culturally and linguistically sensitive care that meets the  
15 needs of all regional residents pursuant to standards established  
16 by the commissioner.
- 17 (6) Seek innovative and systemic means to improve care  
18 quality and efficiency of care delivery.
- 19 (7) Appoint regional planning board members and serve as  
20 president of the board.
- 21 (8) Recommend means to and implement policies established  
22 by the commissioner to provide support to persons displaced  
23 from employment as a result of the initiation of the new system.
- 24 (9) Make needed revenue sharing arrangements so that  
25 regionalization does not limit a patient's choice of provider.
- 26 (10) Implement procedures established by the commissioner  
27 for the resolution of disputes.
- 28 (11) Implement processes established by the commissioner  
29 and recommend needed changes to permit the public to share  
30 concerns, provide ideas, opinions, and recommendations  
31 regarding all aspects of the system policy.
- 32 (12) Report regularly to the public and, at intervals determined  
33 by the commissioner, and pursuant to this division, to the  
34 commissioner, on the status of the regional planning system,  
35 including evaluating access to care, quality of care delivered, and  
36 provider performance, and other issues related to regional health  
37 care needs, and recommending needed improvements.
- 38 (13) Identify and prioritize regional health care needs and  
39 goals, in collaboration with the regional medical officer, regional

1 health care providers, the regional planning board, and regional  
2 director of Partnerships for Health.

3 (14) Identify or establish guidelines for providers to identify,  
4 maintain, and provide to the regional director inventories of  
5 regional health care assets.

6 (15) Establish and maintain regional health care databases.

7 (16) In collaboration with the regional medical officer, enforce  
8 reporting requirements established by the California Health  
9 Insurance System and make recommendations to the  
10 commissioner, the Director of Health Planning, and the chief  
11 medical officer for needed changes in reporting requirements.

12 (17) Convene meetings of regional health care providers to  
13 facilitate coordinated regional health care planning.

14 (18) Establish and implement a regional capital management  
15 plan pursuant to the capital management plan established by the  
16 commissioner for the system.

17 (19) Implement standards and formats established by the  
18 commissioner for the development and submission of operating  
19 and capital budget requests and make recommendations to the  
20 commissioner and the Director of Health Planning for needed  
21 changes.

22 (20) Support regional providers in developing operating and  
23 capital budget requests.

24 (21) Receive, evaluate, and prioritize provider operating and  
25 capital budget requests pursuant to standards and criteria  
26 established by the commissioner.

27 (22) Prepare a three-year regional operating and capital budget  
28 request that meets the health care needs of the region pursuant to  
29 this division, for submission to the commissioner.

30 (23) Establish a comprehensive three-year regional planning  
31 budget using funds allocated to the region by the commissioner.

32 (24) Regularly assess projected revenues and expenditures to  
33 ensure fiscal solvency of the regional planning system and advise  
34 the commissioner of potential revenue shortfalls and the possible  
35 need for cost controls.

36 140114. (a) The regional medical officers shall do all of the  
37 following:

38 (1) Administer all aspects of the regional office of health care  
39 quality.

40 (2) Serve as a member of the Regional Planning Board.

- 1 (3) Support the delivery of high quality care to all residents of  
2 the region pursuant to this division.
- 3 (4) Ensure a smooth transition to care delivery by regional  
4 providers under ~~evidence-based standards~~ *standards based on*  
5 *clinical efficacy* that guide clinical ~~decisionmaking~~ *decision*  
6 *making*.
- 7 (5) Support the development and distribution of user-friendly  
8 software for use by providers in order to support the delivery of  
9 high quality care.
- 10 (6) In collaboration with the chief medical officer and regional  
11 providers, evaluate ~~evidence-based~~ standards of care in use at the  
12 time the California Health Insurance System becomes operative.
- 13 (7) Ensure the implementation of needed improvements so that  
14 *a single standard of* high quality care is delivered to all residents  
15 under standards that guide clinical ~~decisionmaking~~ *decision*  
16 *making*.
- 17 (8) In collaboration with the commissioner, the chief medical  
18 officer, the regional medical officer, regional planning boards,  
19 the ~~consumer~~ *patient* advocate, regional providers, and  
20 consumers, oversee the establishment of real and virtual  
21 integrated service networks of fee-for-service, solo and group  
22 practice, essential community, and ancillary care providers and  
23 facilities that pool and align resources and form interdisciplinary  
24 teams that share responsibility and accountability for patient care  
25 and provide a continuum of coordinated high quality primary to  
26 tertiary care to all residents of the region.
- 27 (9) Assure the evaluation and measurement of the quality of  
28 care delivered in the region, including assessment of the  
29 performance of individual providers, pursuant to standards and  
30 methods established by the chief medical officer.
- 31 (10) Provide feedback to ~~and support and supervision of,~~ *and*  
32 *support and supervision of,* medical providers to ensure the  
33 delivery of high quality care pursuant to standards established by  
34 the health insurance system.
- 35 (11) Assure the provision of information to assist consumers  
36 in evaluating the performance of health care providers and  
37 facilities.
- 38 (12) Identify areas of medical practice where standards have  
39 not been established and collaborate with the chief medical

1 officer and health care providers, to establish priorities in  
2 developing needed standards.

3 (13) Collaborate with regional public health officers to  
4 establish regional health policies that support the public health.

5 (14) Establish a regional program to monitor and decrease  
6 medical errors and their causes pursuant to standards and  
7 methods established by the chief medical officer.

8 (15) Support the development and implementation of  
9 innovative means to provide high quality care and assist  
10 providers in securing funds for innovative demonstration projects  
11 that seek to improve care quality.

12 (16) Establish means to assess the impact of health insurance  
13 system policies intended to assure the delivery of high quality  
14 care.

15 (17) Collaborate with the chief medical officer and the ~~director~~  
16 ~~of planning~~ *Director of Health Planning* and health care  
17 providers in the development and maintenance of regional health  
18 care databases.

19 (18) Ensure the enforcement of, and recommend needed  
20 changes in, health insurance system reporting requirements.

21 (19) Support providers in developing regional budget requests.

22 (20) Collaborate with the regional director of the Partnerships  
23 for Health to develop patient education on appropriate utilization  
24 of health care services.

25 (21) Annually report to the commissioner, the public, the  
26 regional planning board, and the chief medical officer on the  
27 status of regional health care programs, needed improvements  
28 and plans to implement and evaluate delivery of care  
29 improvements.

30 140115. (a) Each region shall have a regional ~~health~~ planning  
31 board consisting of 13 members who shall be appointed by the  
32 regional planning director. Members shall serve eight-year terms  
33 that coincide with the term of the regional planning director and  
34 may be reappointed for a second term.

35 (b) Regional planning board members shall have resided for a  
36 minimum of two years in the region in which they serve prior to  
37 appointment to the board.

38 (c) Regional planning board members shall reside in the  
39 region they serve while on the board.

40 (d) The board shall consist of the following members:

1 (1) The regional planning director, the regional medical officer  
2 and the regional director of the Partnerships for Health and a  
3 public health officer from one of the regional counties.

4 (2) When there is more than one county in a region, the public  
5 health officer board position shall rotate among the public health  
6 county officers on a timetable to be established by each regional  
7 planning board.

8 (3) A representative from the ~~office of consumer advocacy~~  
9 *Office of Patient Advocacy*.

10 (4) One expert in health care financing.

11 (5) One expert in health care planning.

12 (6) Two members who are direct patient care providers in the  
13 region, *one of whom shall be a registered nurse*.

14 (7) One member who represents ancillary health care workers  
15 in the region.

16 (8) One member representing hospitals in the region.

17 (9) One member representing essential community providers  
18 in the region.

19 (10) One member representing the public.

20 (e) The regional planning director shall serve as chair of the  
21 board.

22 (f) The purpose of the regional planning boards is to advise  
23 and make recommendations to the regional planning director on  
24 all aspects of regional health policy.

25 (g) Meetings of the board shall be open to the public pursuant  
26 to the Bagley-Keene Open Meeting Act (Article 9 (commencing  
27 with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title  
28 2 of the Government Code).

29 140116. The following conflict of interest prohibitions shall  
30 apply to all appointees of the commissioner or transition  
31 commission, including, but not limited to, the ~~consumer patient~~  
32 advocate, the health insurance fund director, the purchasing  
33 director, the planning director, the director of the health director,  
34 *the Director of Health Planning, the Director of the Payments*  
35 Board, the chief medical officer, the Director of Partnerships for  
36 Health, regional directors, and the inspector general:

37 (a) The appointee shall not have been employed in any  
38 capacity by a for-profit insurance, pharmaceutical, or medical  
39 equipment company that sells products to the system for a period  
40 of two years prior to appointment.

1 (b) For two years after completing service in the system, the  
2 appointee may not receive payments of any kind from, or be  
3 employed in any capacity or act as a paid consultant to, a  
4 for-profit insurance, pharmaceutical, or medical equipment  
5 company that sells products to the system.

6 (c) The appointee shall avoid political activity that may create  
7 the appearance of political bias or impropriety. Prohibited  
8 activities shall include, but not be limited to, leadership of, or  
9 employment by, a political party or a political organization;  
10 public endorsement of a political candidate; contribution of more  
11 than five hundred dollars (\$500) to any one candidate in a  
12 calendar year or a contribution in excess of an aggregate of one  
13 thousand dollars (\$1,000) in a calendar year for all political  
14 parties or organizations; and attempting to avoid compliance with  
15 this prohibition by making contributions through a spouse or  
16 other family member.

17 (d) The appointee shall not participate in making or in any  
18 way attempt to use his or her official position to influence a  
19 governmental decision in which he or she or a family or a  
20 business partner or colleague has a financial interest.

21  
22 CHAPTER 3. FUNDING

23  
24 Article 1. General Provisions

25  
26 140200. (a) In order to support the agency effectively in the  
27 administration of this division, there is hereby established in the  
28 State Treasury the Health Insurance Fund. The fund shall be  
29 administered by a director appointed by the commissioner.

30 (b) All moneys collected, received, and transferred pursuant to  
31 this division shall be transmitted to the State Treasury to be  
32 deposited to the credit of the Health Insurance Fund for the  
33 purpose of financing the California Health Insurance System.

34 (c) Moneys deposited in the Health Insurance Fund shall be  
35 used exclusively to support this division.

36 (d) All claims for health care services rendered shall be made  
37 to the Health Insurance Fund through an electronic claims and  
38 payment system. The commissioner shall investigate the costs,  
39 benefits, and means of supporting providers in obtaining  
40 electronic systems for claims and payments transactions;

1 however, alternative provisions shall be made for providers  
2 without electronic systems.

3 (e) All payments made for health care services shall be  
4 disbursed from the Health Insurance Fund through an electronic  
5 claims and payments system; however, alternative provisions  
6 shall be made for providers without electronic systems.

7 (f) The director of the fund shall serve on the Health Insurance  
8 Policy Board.

9 140201. (a) The Director of the Health Insurance Fund shall  
10 establish the following accounts within the Health Insurance  
11 Fund:

12 (1) A system account to provide for all annual state  
13 expenditures for health care.

14 (2) A reserve account.

15 (b) Premiums collected each year shall be roughly sufficient to  
16 cover that year's projected costs.

17 (c) The health insurance system shall at all times hold in  
18 reserve an amount estimated in the aggregate to provide for the  
19 payment of all losses and claims for which the system may be  
20 liable, and to provide for the expense of adjustment or settlement  
21 of losses and claims.

22 (d) During the transition, the commissioner shall work with  
23 the Department of Insurance and other experts to determine an  
24 appropriate level of health system reserves for the first year and  
25 for future years of health insurance system operation.

26 (e) Moneys currently held in reserve by state, city, and county  
27 health programs and federal moneys for health care held in  
28 reserve in federal trust accounts shall be transferred to the state  
29 health care reserve account when the state assumes financial  
30 responsibility for health care under this division that are currently  
31 provided by those programs.

32 (f) The commissioner may implement arrangements to  
33 self-insure the system against unforeseen expenditures or revenue  
34 shortfalls not covered by reserves and may borrow funds to cover  
35 temporary revenue shortfalls not covered by system reserves,  
36 including the issuance of bonds for this purpose, whichever is the  
37 more cost effective.

38 (g) Funds held in the reserve account and other Health  
39 Insurance Fund accounts may be prudently invested to increase

1 their value according to the Department of Insurance’s standards  
2 for liquidity and asset management.

3 ~~(h) During the second year of the transition, the commissioner  
4 may submit to the Legislature a request for a one-time tax  
5 imposition to support development of the health system reserve.~~

6 ~~(i) The commissioner may consider a temporary decrease in  
7 benefits to cover an unforeseen revenue shortfall. In the case of a  
8 temporary benefit decrease, the commissioner may authorize and  
9 regulate the sale of private insurance policies to cover  
10 discontinued services or authorize patients to obtain discontinued  
11 services for an additional fee paid to the health insurance system  
12 and established by the commissioner, or both.~~

13 140203. (a) The Director of the Health Insurance Fund shall  
14 immediately notify the commissioner when regional or statewide  
15 revenue and expenditure trends indicate that expenditures may  
16 exceed revenues.

17 (b) If the commissioner determines that statewide revenue  
18 trends indicate the need for statewide cost control measures, the  
19 commissioner shall convene the Health Insurance Policy Board  
20 to discuss the need for cost control measures and shall  
21 immediately report to the *Legislature and the public* regarding  
22 the possible need for cost control measures.

23 (c) Cost control measures include any or all of the following:

24 (1) Changes in the health insurance system or health facility  
25 administration that improve efficiency.

26 (2) Changes in the delivery of health care services that  
27 improve efficiency and care quality.

28 (3) Postponement of introduction of new benefits or benefit  
29 improvements.

30 ~~(4) Temporary—Seeking statutory authority for a temporary  
31 decrease in benefits.~~

32 (5) Postponement of planned capital expenditures.

33 (6) Adjustments of health care provider payments to correct  
34 for deficiencies in care quality and failure to meet compensation  
35 contract performance goals, pursuant to subdivisions (a) to (f),  
36 inclusive, of Section 140106, paragraph (4) of subdivision (a) of  
37 Section 140204, subdivision (a) of Section 140213, and  
38 subdivisions (c) and (d) of Section 140606.

39 (7) Adjustments on the reimbursement of health insurance  
40 system managerial employees and upper level health system

- 1 managers to correct for deficiencies in management and failure to  
2 meet contract performance goals.
- 3 (8) Limitations on the reimbursement budgets of health system  
4 providers and upper level managers whose compensation is  
5 determined by the Health Insurance System Payment Board.
- 6 (9) Limitations on aggregate reimbursements to manufacturers  
7 of pharmaceutical and durable and nondurable medical  
8 equipment.
- 9 (10) Deferred funding of the reserve account.
- 10 (11) Imposition of copayments or deductible payments. Any  
11 copayment or deductible payments imposed shall be subject to all  
12 of the following requirements:
- 13 (A) No copayment or deductible may be established when  
14 prohibited by federal law.
- 15 (B) All copayments and deductibles shall meet federal  
16 guidelines for copayments and deductible payments that may  
17 lawfully be imposed on persons with low income.
- 18 (C) The commissioner shall establish standards and  
19 procedures for waiving copayments or deductible payments and  
20 a waiver card which shall be issued to a patient or to a family to  
21 indicate the waiver. Procedures for copayment waiver may  
22 include a determination by a patient’s primary care provider that  
23 imposition of a copayment would be a financial hardship.  
24 Copayment and deductible waivers shall be reviewed annually by  
25 the regional planning director.
- 26 (D) Waivers shall not affect the reimbursement of health care  
27 providers.
- 28 (E) Any copayments or deductible payments established  
29 pursuant to this section shall be transmitted to the Treasurer to be  
30 deposited to the credit of the Health Insurance Fund.
- 31 (12) Imposition of an eligibility waiting period and other  
32 means if the commissioner determines that large numbers of  
33 people are emigrating to the state for the purpose of obtaining  
34 health care through the California Health Insurance System.
- 35 (d) Nothing in this division shall be construed to diminish the  
36 benefits that an individual has under a collective bargaining  
37 agreement.
- 38 (e) Nothing in this division shall preclude employees from  
39 receiving benefits available to them under a collective bargaining

1 agreement or other employee-employer agreement that are  
2 superior to benefits under this division.

3 (f) Cost control measures implemented by the commissioner  
4 and the health insurance policy board shall remain in place in the  
5 state until the commissioner and the Health Insurance Policy  
6 Board determine that the cause of a revenue shortfall has been  
7 corrected.

8 (g) If the Health Insurance Policy Board determines that cost  
9 control measures described in subdivision (c) will not be  
10 sufficient to meet a revenue shortfall, the commissioner shall  
11 report to the Legislature and to the public on the causes of the  
12 shortfall and the reasons for the failure of cost controls and shall  
13 recommend measures to correct the shortfall, including an  
14 increase in health insurance system premium payments.

15 140204. (a) If the commissioner or a regional planning  
16 director determines that regional revenue and expenditure trends  
17 indicate a need for regional cost control measures, the regional  
18 planning director shall convene the regional planning board to  
19 discuss the possible need for cost control measures and to make a  
20 recommendation about appropriate measures to control costs.  
21 These may include any of the following:

22 (1) Changes in health insurance system or health facility  
23 administration that improve efficiency.

24 (2) Changes in the delivery of health services and health  
25 system management that improve efficiency or care quality.

26 (3) Postponement of planned regional capital expenditures.

27 (4) Adjustment of payments to health care providers to reflect  
28 deficiencies in care quality and failure to meet compensation  
29 contract performance goals and payments to upper level  
30 managers to reflect deficiencies in management and failure to  
31 meet compensation contract performance goals.

32 (5) Adjustment of payments to health care providers and upper  
33 level managers above a specified amount of aggregate billing.

34 (6) Adjustment of payments to pharmaceutical and medical  
35 equipment manufacturers and others selling goods and services  
36 to the health insurance system above a specified amount of  
37 aggregate billing.

38 (b) In the event a regional planning board is convened to  
39 implement cost control measures, the commissioner shall  
40 participate in the regional planning board meeting.

1 (c) The regional planning director, in consultation with the  
2 commissioner, shall determine if cost control measures are  
3 warranted and those measures that shall be implemented.

4 (d) Imposition of copayments or deductibles, postponement of  
5 new benefits or benefit improvements, deferred funding of the  
6 reserve account, establishment of eligibility waiting periods and  
7 increases in health insurance premium payments may occur on a  
8 statewide basis only and with the concurrence of the  
9 commissioner and the Health Insurance Policy Board.

10 (e) If a regional planning director and regional planning board  
11 are considering imposition of cost control measures, the regional  
12 planning director shall immediately report to the residents of the  
13 region regarding the possible need for cost control measures.

14 (f) Cost control measures shall remain in place in a region  
15 until the regional planning director and the commissioner  
16 determine that the cause of a revenue shortfall has been  
17 corrected.

18 140205. (a) If, on June 30 of any year, the Budget Act for the  
19 fiscal year beginning on July 1 has not been enacted, all moneys  
20 in the reserve account of the Health Insurance Fund shall be used  
21 to implement this division until funds are available through the  
22 Budget Act.

23 (b) Notwithstanding any other provision of law and without  
24 regard to fiscal year, if the annual Budget is not enacted by June  
25 30 of any fiscal year preceding the fiscal year to which the  
26 Budget would apply and if the commissioner determines that  
27 funds in the reserve account are depleted, the following shall  
28 occur:

29 (1) The Controller shall annually transfer from the General  
30 Fund, in the form of one or more loans, an amount not to exceed  
31 a cumulative total of \_\_\_\_\_dollars (\$\_\_\_\_\_) in any fiscal year, to  
32 the Health Insurance Fund for the purpose of making payments  
33 to health care providers and to persons and businesses under  
34 contract with the health insurance system or with health  
35 providers to provide services, medical equipment, and  
36 pharmaceuticals to the California Health Insurance System.

37 (2) Upon enactment of the Budget Act in any fiscal year to  
38 which paragraph (1) applies, the Controller shall transfer all  
39 expenditures and unexpected funds loaned to the Health  
40 Insurance Fund to the appropriate Budget Act item.

1 (3) The amount of any loan made pursuant to paragraph (1) for  
2 which moneys were expended from the Health Insurance Fund  
3 shall be repaid by debiting the appropriate Budget Act item in  
4 accordance with procedures prescribed by the Department of  
5 Finance.

6 140206. (a) The commissioner annually shall prepare a  
7 health insurance system budget that includes all expenditures,  
8 specifies a limit on total annual state expenditures, and  
9 establishes allocations for each health care region that shall cover  
10 a three-year period and that shall be disbursed on a quarterly  
11 basis.

12 (b) The commissioner shall limit the growth of spending on a  
13 statewide and on a regional basis, by reference to average growth  
14 in state domestic product across multiple years; population  
15 growth, actuarial demographics and other demographic  
16 indicators; differences in regional costs of living, advances in  
17 technology and their anticipated adoption into the benefit plan;  
18 improvements in efficiency of administration and care delivery,  
19 improvements in the quality of care and to projected future state  
20 domestic product growth rates.

21 (c) *The commissioner shall adjust the health insurance system*  
22 *budget so that aggregate spending in the state on health care*  
23 *outside of the system shall not exceed spending under this*  
24 *division by more than 5 percent.*

25 (d) The commissioner shall project health insurance system  
26 revenues and expenditures for 3, 6, 9, and 12 years pursuant to  
27 parameters prescribed in subdivision ~~(f)~~ of Section 140206 (g).

28 ~~(d)~~

29 (e) The commissioner shall annually convene a Health  
30 Insurance System Revenue and Expenditure Conference to  
31 discuss revenue and expenditure projections and future health  
32 insurance system policy directions and initiatives, including  
33 means to lower the cost of administration, improve management  
34 of and investment in capital assets, and improve the quality of  
35 care and health system management. Participants shall include  
36 regional health directors and medical officers, directors of the  
37 Health Insurance Fund and Payments Board, the ~~consumer~~  
38 *patient* advocate, state and regional directors of the Partnerships  
39 for Health, and representatives of the health insurance system  
40 facility upper level managers.

1 (e)

2 (f) The California Health Insurance System budget shall  
3 include all of the following:

4 (1) Transition budget.

5 (2) Providers and managers budget.

6 (3) Capitated operating budgets.

7 (4) Noncapitated operating budgets.

8 (5) Capital investment budget.

9 (6) Purchasing budget.

10 (7) Research and innovation budget.

11 (8) Workforce training and development budget.

12 (9) Reserve account.

13 (10) System administration system.

14 (11) Regional budgets.

15 (f)

16 (g) In establishing budgets, the commissioner shall make  
17 adjustments based on all of the following:

18 (1) Costs of transition to the new system.

19 (2) Projections regarding the health services anticipated to be  
20 used by California residents.

21 (3) Differences in cost of living between the regions, including  
22 the overhead costs of maintaining medical practices.

23 (4) Health risk of enrollees.

24 (5) Scope of services provided.

25 (6) Innovative programs that improve care quality,  
26 administrative efficiency, and workplace safety.

27 (7) Unrecovered cost of providing care to persons who are not  
28 members of the California Health Insurance System. The  
29 commissioner shall seek to recover the costs of care provided to  
30 nonhealth insurance system members.

31 (8) Costs of workforce training and development.

32 (9) Costs of correcting health outcome disparities and the  
33 unmet needs of previously uninsured and underinsured enrollees.

34 (10) Relative usage of different health care providers.

35 (11) Needed improvements in access to care.

36 (12) Projected savings in administrative costs.

37 (13) Projected savings due to provision of primary and  
38 preventive care to the population, including savings from  
39 decreases in preventable emergency room visits and  
40 hospitalizations.

- 1 (14) Projected savings from improvements in care quality.
- 2 (15) Projected savings from decreases in medical errors.
- 3 (16) Projected savings from systemwide management of
- 4 capital expenditures.
- 5 (17) Cost of incentives and bonuses to support the delivery of
- 6 high quality care, including incentives and bonuses needed to
- 7 recruit and retain an adequate supply of needed providers and
- 8 managers and to attract providers to medically underserved areas.
- 9 (18) Costs of treating complex illnesses, including disease
- 10 management programs.
- 11 (19) Cost of implementing standards of care, care
- 12 coordination, electronic medical records, and other electronic
- 13 initiatives.
- 14 (20) Costs of new technology.
- 15 (21) Technology research and development costs and costs
- 16 related to health insurance system use of new technologies.
- 17 ~~(g)~~
- 18 (h) Moneys in the Reserve Account shall not be considered as
- 19 available revenues for the purposes of preparing the system
- 20 budget, except when the State Budget has not been enacted by
- 21 June 30 of any fiscal year.
- 22 140207. The commissioner shall annually establish the total
- 23 funds to be allocated for provider and manager compensation
- 24 pursuant to this section. In establishing the provider and manager
- 25 budgets, the commissioner shall allot sufficient funds to assure
- 26 that California can attract and retain those providers and
- 27 managers needed to meet the health needs of the population. In
- 28 establishing provider and manager budgets, the commissioner
- 29 shall allocate funds for both salaries, incentives, bonuses, and
- 30 benefits to be provided to health insurance system officers and
- 31 upper level managers who are exempt from state civil service
- 32 statutes.
- 33 140208. (a) The commissioner shall establish the Payments
- 34 Board and shall appoint a director and members of the board.
- 35 (b) The commissioner shall retain the authority to review,
- 36 approve, reject, and modify all payment contracts and
- 37 compensation plans established pursuant to this section.
- 38 (c) The Payments Board shall be composed of experts in
- 39 health care finance and insurance systems, a designated
- 40 representative of the commissioner, a designated representative

1 the Health Insurance Fund, and a representative of the regional  
2 planning directors. The position of regional representative shall  
3 rotate among the directors of the regional planning boards every  
4 two years.

5 (d) The board shall establish and supervise a uniform  
6 payments system for providers and managers and shall maintain  
7 a compensation plan for all of the following providers and  
8 managers pursuant to the provider and manager budget  
9 established by the commissioner:

10 (1) Upper level managers employed in private health care  
11 facilities, including, but not limited to, hospitals, integrated  
12 health care systems, group and solo medical practices, and  
13 essential community facilities.

14 (2) Appointed California health insurance system managers  
15 and officers who are exempt from statutes governing civil service  
16 employment.

17 (3) Health care providers including, but not limited to,  
18 physicians, osteopathic physicians, dentists, podiatrists, nurse  
19 practitioners, physician assistants, chiropractors, acupuncturists,  
20 psychologists, social workers, marriage, family and child  
21 counselors, and other professional health care providers who are  
22 required by law to be licensed to practice in California and who  
23 provide services pursuant to the act.

24 (4) Health care providers licensed and accredited to provide  
25 services in California may choose, on a case-by-case or on an  
26 aggregate basis, to be compensated for their services either by the  
27 California Health Insurance System or by a person to whom they  
28 provide services.

29 (5) Compensation for health system employees that is  
30 determined through employer-union negotiations before  
31 implementation of this division shall be determined by health  
32 insurance system-union negotiations after that implementation.

33 (6) Providers electing to be compensated by the California  
34 Health Insurance System shall enter into a contract with the  
35 health insurance system pursuant to provisions of this section.

36 (7) Providers electing to be compensated by persons to whom  
37 they provide services, instead of by the California Health  
38 Insurance System, may establish charges for their services.

39 ~~Providers may choose to be reimbursed either by a patient or~~  
40 ~~by the health insurance system for services rendered to a patient.~~

1 ~~Providers may not be reimbursed by a patient and by the health~~  
2 ~~insurance system for the same service.~~

3 *(8) Health care providers who accept any payment under this*  
4 *division shall not bill a patient for any covered service.*

5 (e) Health care providers licensed or accredited to provide  
6 services in California, who choose to be compensated by the  
7 health insurance system instead of by patients to whom they  
8 provide services, may choose how they wish to be compensated  
9 under this division, as fee-for-service providers or as salaried  
10 providers in health care systems that provide comprehensive,  
11 coordinated services.

12 (f) Notwithstanding provisions of the Business and  
13 Professions Code, nurse practitioners, physician assistants, and  
14 others who under California law must be supervised by a  
15 physician, an osteopathic physician, a dentist, or a podiatrist, may  
16 choose fee-for-service compensation while under lawfully  
17 required supervision. However, nothing in this section shall  
18 interfere with the right of a supervising provider to enter into a  
19 contractual arrangement that provides for salaried compensation  
20 for employees who must be supervised under the law by a  
21 physician, an osteopathic physician, a dentist, or a podiatrist.

22 (g) The compensation plan shall include all of the following:

23 (1) Actuarially sound payments that include a just and fair  
24 return for providers in the fee-for-service sector and for providers  
25 working in health systems where comprehensive and coordinated  
26 services are provided, including the actuarial basis for the  
27 payment.

28 (2) Payment schedules which shall be in effect for three years.

29 (3) Bonus and incentive payments, including, but not limited  
30 to, all the following:

31 (A) Bonus payments for providers and upper level managers  
32 who, in providing services and managing facilities, practices and  
33 integrated health systems, pursuant to this division, meet  
34 performance standards and outcome goals established by the  
35 California Health Insurance System.

36 (B) Incentive payments for providers and upper level  
37 managers who provide services to the California Health  
38 Insurance System in areas identified by the Office of Health  
39 Planning as medically underserved.

1 (C) Incentive payments required to achieve the ratio of  
2 generalist to specialist providers needed in order to meet the  
3 standards of care and health needs of the population.

4 (D) Incentive payments required to recruit and retain nurse  
5 practitioners and physician assistants in order to provide primary  
6 and preventive care to the population.

7 (E) No bonus or incentive payment may be made in excess of  
8 the total allocation for provider and manager incentive and bonus  
9 reimbursement established by the commissioner in the health  
10 insurance system budget.

11 (F) No incentive may adversely affect the care a patient  
12 receives or the care a health provider recommends.

13 (h) Providers shall be paid for all services provided pursuant to  
14 this division, including care provided to persons who are  
15 subsequently determined to be ineligible for the California  
16 Health Insurance System.

17 (i) Licensed providers who deliver services not covered under  
18 the California Health Insurance System may establish rates for,  
19 and charge patients for those services.

20 (j) Reimbursement to providers and managers may not exceed  
21 the amount allocated by the commissioner to provider and  
22 manager annual budgets.

23 140209. (a) Fee-for-service providers shall choose  
24 representatives of their specialties to negotiate reimbursement  
25 rates with the Payments Board on their behalf.

26 (b) The Payments Board shall establish a uniform system of  
27 payments for all services provided pursuant to this division.

28 (c) Payment schedules shall be available to providers in  
29 printed and in electronic documents.

30 (d) Payment schedules shall be in effect for three years, at  
31 which time payment schedules may be renegotiated. Payment  
32 adjustments may be made at the discretion of the pay board to  
33 meet the goals of the health insurance system.

34 (e) In establishing a uniform system of payments the Payments  
35 Board shall collaborate with regional health directors and  
36 providers and shall take into consideration regional differences in  
37 the cost of living and the need to recruit and retain skilled  
38 providers in the region.

39 (f) Fee-for-service providers shall submit claims electronically  
40 to the Health Insurance Fund and shall be paid within \_\_\_\_

1 business days for claims filed in compliance with procedures  
2 established by the Health Insurance Fund. In the event that a  
3 properly filed claim for eligible services is not paid within \_\_\_\_  
4 business days, the provider shall be paid interest on the claim at a  
5 rate of \_\_\_\_\_, compounded daily.

6 140210. (a) Compensation for providers and upper level  
7 managers employed by integrated health care systems, group  
8 medical practices and essential community providers that provide  
9 comprehensive, coordinated services shall be determined  
10 according to the following guidelines:

11 (b) Providers and upper level managers employed by systems  
12 that provide comprehensive, coordinated health care services  
13 shall be represented by their respective employers for the  
14 purposes of negotiating reimbursement with the Payments Board.

15 (c) In negotiating reimbursement with systems providing  
16 comprehensive, coordinated services, the Payments Board shall  
17 take into consideration the need for comprehensive systems to  
18 have flexibility in establishing provider and upper level manager  
19 reimbursement.

20 (d) Payment schedules shall be in effect for three years.  
21 However, payment adjustments may be made at the discretion of  
22 the Payments Board to meet the goals of the health insurance  
23 system.

24 (e) The Payments Board shall take into consideration regional  
25 differences in the cost of living and the need to recruit and retain  
26 skilled providers and upper level managers to the regions.

27 (f) The Payments Board shall establish a timetable for  
28 reimbursement for fee-for-service providers negotiations. In the  
29 event that an agreement on reimbursement is not reached  
30 according to the timetable established by the Payments Board,  
31 the Payments Board shall establish reimbursement rates, which  
32 shall be binding.

33 (g) Reimbursement negotiations shall be conducted consistent  
34 with the state action doctrine of the antitrust laws.

35 140211. (a) The Payments Board shall annually report to the  
36 commissioner on the status of provider and upper level manager  
37 reimbursement, including satisfaction with reimbursement levels  
38 and the sufficiency of funds allocated by the commissioner for  
39 provider and upper level manager reimbursement. The Payments

1 Board shall recommend needed adjustments in the allocation for  
2 provider payments.

3 (b) The Office of Health Care Quality shall annually report to  
4 the commissioner on the impact of the bonus payments in  
5 improving quality of care, health outcomes and management  
6 effectiveness. The Payments Board shall recommend needed  
7 adjustments in bonus allocations.

8 (c) The Office of Health Planning shall annually report to the  
9 commissioner on the impact of the incentive payments in  
10 recruiting health professionals and upper level managers to  
11 underserved areas, in establishing the needed ratio of generalist  
12 to specialist providers and in attracting and retaining nurse  
13 practitioners and physician assistants to the state and shall  
14 recommend needed adjustments.

15 140212. (a) The commissioner shall establish an allocation  
16 for each region to fund regional operating and capital budgets for  
17 a period of three years. Allocations shall be disbursed to the  
18 regions on a quarterly basis.

19 (b) Integrated health care systems, essential community  
20 providers and group medical practices that provide  
21 comprehensive, coordinated services may choose to be  
22 reimbursed on the basis of a capitated system operating budget or  
23 a noncapitated system operating budget that covers all costs of  
24 providing health care services.

25 (c) Providers choosing to function on the basis of a capitated  
26 or a noncapitated system operating budget shall submit  
27 three-year operating budget requests to the regional planning  
28 director, pursuant to standards and guidelines established by the  
29 commissioner.

30 (1) Providers may include in their operating budget requests  
31 reimbursement for ancillary health care or social services that  
32 were previously funded by money now received and disbursed by  
33 the Health Insurance Fund.

34 (2) No payment may be made from a capitated or noncapitated  
35 budget for a capital expense except as stipulated in Section  
36 140216.

37 (d) Regional planning directors shall negotiate operating  
38 budgets with regional health care entities, which shall cover a  
39 period of three years.

1 (e) Operating and capitated budgets shall include health care  
2 workforce labor costs other than those described in paragraphs  
3 (1), (2), and (3) of subdivision (d) of Section 140208. Where  
4 unions represent employees working in systems functioning  
5 under capitated or noncapitated budgets, unions shall represent  
6 those employees in negotiations with the regional planning  
7 director and the Payments Board for the purpose of establishing  
8 their reimbursement.

9 140213. (a) Health systems and medical practices  
10 functioning under capitated and noncapitated operating budgets  
11 shall immediately report any projected operating deficit to the  
12 regional planning director. The regional planning director shall  
13 determine whether projected deficits reflect appropriate increases  
14 in expenditures, in which case the director shall make an  
15 adjustment to the operating budget. If the director determines that  
16 deficits are not justifiable, no adjustment shall be made.

17 (b) If a regional planning director determines that adjustments  
18 to operating budgets will cause a regional revenue shortfall and  
19 that cost control measures may be required, the regional planning  
20 director shall report the possible revenue shortfall to the  
21 commissioner and take actions required pursuant to Section  
22 140203.

23 140215. (a) Margins generated by a facility operating under  
24 a health system operating budget may be retained and used to  
25 meet the health care needs of the population.

26 (b) No margin may be retained if that margin was generated  
27 through inappropriate limitations on access to care or  
28 compromises in the quality of care or in any way that adversely  
29 affected or is likely to adversely affect the health of the persons  
30 receiving services from a facility, integrated health care system,  
31 group medical practice or essential community provider  
32 functioning under a health insurance system operating budget.

33 (1) The chief medical officer shall evaluate the source of  
34 margin generation and report violations of this section to the  
35 commissioner.

36 (2) The commissioner shall establish and enforce penalties for  
37 violations of this section.

38 (3) Penalty payments collected pursuant to violations of  
39 section shall be remitted to the Health Insurance Fund for use in  
40 the California Health Insurance System.

1 (c) Facilities operating under health insurance system  
2 operating budgets may raise and expend funds from sources other  
3 than the California Health Insurance System including, but not  
4 limited to, private or foundation donors and other non-California  
5 Health Insurance System sources for purposes related to the goals  
6 of this division and in accordance with provisions of this  
7 division.

8 140216. (a) During the transition the commissioner shall  
9 develop a Capital Management Plan that shall include  
10 conflict-of-interest standards and that shall govern all capital  
11 investments and acquisitions undertaken in the California Health  
12 Insurance System. The plan shall include a framework, standards,  
13 and guidelines for all of the following:

14 (1) Standards whereby the office of health care planning shall  
15 oversee, assist in the implementation of, and ensure that the  
16 provisions of the capital management plan are enforced.

17 (2) Assessment and prioritization of short- and long-term  
18 California Health Insurance System capital needs on statewide  
19 and regional bases.

20 (3) Assessment of capital health care assets and capital health  
21 care asset shortages on a regional and statewide basis at the time  
22 this division is first implemented.

23 (4) Development by the commissioner of a multiyear system  
24 capital development plan that supports health insurance system  
25 goals, priorities and performance standards and meets the health  
26 needs of the population.

27 (5) Development, as part of the California Health Insurance  
28 System capital budget, of regional capital allocations that shall  
29 cover a period of three years.

30 (6) Evaluation of, and support for, noninvestment means to  
31 meet health care needs, including, but not limited to,  
32 improvements in administrative efficiency, care quality, and  
33 innovative service delivery, use, adaptation or refurbishment of  
34 existing land and property and identification of publicly owned  
35 land or property that may be available to the California Health  
36 Insurance System and that may meet a capital need.

37 (7) Development and maintenance of capital inventories on a  
38 regional basis, including the condition, utilization capacity,  
39 maintenance plan and costs, deferred maintenance of existing  
40 capital inventory and excess capital capacity.

1 (8) A process whereby those intending to make capital  
2 investments or acquisitions shall prepare a business case for  
3 making the investment or acquisition, including the full life-cycle  
4 costs of the project or acquisition, an environmental impact  
5 report that meets existing state standards, and a demonstration of  
6 how the investment or acquisition meets the health needs of the  
7 population it is intended to serve. Acquisitions include, but are  
8 not limited to, the acquisition of land, operational property, or  
9 administrative office space.

10 (9) Standards and a process whereby the regional planning  
11 directors shall evaluate, accept, reject, or modify a business plan  
12 for a capital investment or acquisition. Decisions of a regional  
13 planning director may be appealed through a dispute resolution  
14 process established by the commissioner.

15 (10) Standards for binding project contracts between the  
16 Health Insurance System and the party developing a capital  
17 project or making a capital acquisition that shall govern all terms  
18 and conditions of capital investments and acquisitions, including  
19 terms and conditions for Health Insurance System grants, loans,  
20 lines of credit, and lease-purchase arrangements.

21 (11) A process and standards whereby the Health Insurance  
22 Fund shall negotiate terms and conditions of the California  
23 Health Insurance System liens, grants, lines of credit and  
24 lease-purchase arrangements for capital investments and  
25 acquisitions. Terms and conditions negotiated by the Health  
26 Insurance Fund shall be included in project contracts.

27 (12) A plan for the commissioner and for the regional planning  
28 directors to issue requests for proposals and to oversee a process  
29 of competitive bidding for the development of capital projects  
30 that meet the needs of the California Health Insurance System  
31 and to fund, partially fund, or participate in seeking funding for  
32 those capital projects.

33 (13) Responses to requests for proposals and competitive bids  
34 shall include a description of how a project meets the service  
35 needs of the region and addresses the environmental impact  
36 report and shall include the full life-cycle costs of a capital asset.

37 (14) Requests for proposals shall address how intellectual  
38 property will be handled and shall include conflict-of-interest  
39 guidelines that meet standards established by the commissioner  
40 as part of the capital management plan.

1 (15) A process and standards for periodic revisions in the  
2 Capital Management Plan, including annual meetings in each  
3 region to discuss the plan and make recommendations for  
4 improvements in the plan.

5 (16) Standards for determining when a violation of these  
6 provisions shall be referred to the Attorney General for  
7 investigation and possible prosecution of the violation.

8 (b) No registered lobbyist shall participate in or in any way  
9 attempt to influence the request for proposals or competitive bid  
10 process.

11 (c) Development of performance standards and a process to  
12 monitor and measure performance of those making capital health  
13 care investments and acquisitions, including those making capital  
14 investments pursuant to a state competitive bidding process.

15 (d) A process for earned autonomy from state capital  
16 investment oversight for those who demonstrate the ability to  
17 manage capital investment and capital assets effectively in  
18 accordance with California Health Insurance System standards,  
19 and standards for loss of earned autonomy when capital  
20 management is ineffective.

21 (e) Terms and conditions of capital project oversight by the  
22 California Health Insurance System shall be based on the  
23 performance history of the project developer. Providers may earn  
24 autonomy from oversight if they demonstrate effective capital  
25 planning and project management, pursuant to the goals and  
26 guidelines established by the commissioner. Providers who do  
27 not demonstrate such proficiency shall remain subject to  
28 oversight by the regional planning director or shall lose  
29 autonomy from oversight.

30 (f) In general, no capital investment may be made from an  
31 operating budget. However, guidelines shall be established for  
32 the types and levels of small capital investments that may be  
33 undertaken from an operating budget without the approval of the  
34 regional planning director.

35 (g) Any capital investments required for compliance with  
36 federal, state, or local regulatory requirements or quality  
37 assurance standards shall be exempt from paragraph (2) of  
38 subdivision (c) of Section 140212.

39 140217. (a) Regional planning directors shall develop a  
40 regional capital development plan pursuant to the California

1 Health Insurance System capital management plan established by  
2 the commissioner. In developing the regional capital  
3 development plan, the regional planning director shall do all of  
4 the following:

5 (1) Implement the standards and requirements of the capital  
6 management plan established by the commissioner.

7 (2) Develop a multiyear regional capital health management  
8 plan that supports regional health insurance system goals and the  
9 state capital management plan.

10 (3) Assist regional providers to develop capital budget  
11 requests pursuant to the regional capital budget plan and the  
12 California Health Insurance System capital management plan  
13 established by the commissioner.

14 (4) Receive and evaluate capital budget requests from regional  
15 providers.

16 (5) Establish ranking criteria to assess competing demands for  
17 capital.

18 (6) Participate in planning for needed earthquake retrofits.  
19 However, the cost of mandatory earthquake retrofits of health  
20 care facilities shall not be the responsibility of the California  
21 Health Insurance System.

22 (7) Conduct ongoing project evaluation to assure that terms  
23 and conditions of project funding are met.

24 (b) Services provided as a result of capital investments or  
25 acquisitions that do not meet the terms of the regional capital  
26 development plan and the capital management plan developed by  
27 the commissioner shall not be reimbursed by the California  
28 Health Insurance System.

29 140218. (a) Assets financed by state grants, loans and lines  
30 of credit and lease-purchase arrangements, shall be owned,  
31 operated and maintained by the recipient of the grant, loan, line  
32 of credit or lease-purchase arrangements, according to terms  
33 established at the time of issuance of the grant, loan or line of  
34 credit, or lease-purchase arrangement.

35 (b) Assets financed under long-term leases with the California  
36 Health Insurance System shall be transferred to public ownership  
37 at the end of the lease, unless the commissioner determines that  
38 an alternative disposition would be of greater benefit to the  
39 health insurance system, in which case the commissioner may  
40 authorize an alternative disposition.

1 (c) When an asset, which was in whole or in part financed by  
2 the health insurance system, is to be sold or transferred by a party  
3 that received health insurance system financing for purchase,  
4 lease, or construction of the asset, an impartial estimate of the  
5 fair market value of the asset shall be undertaken. The system  
6 shall receive a share of the fair market value of the asset at the  
7 time of its sale or transfer that is in proportion to the system's  
8 original investment. The system may elect to postpone receipt of  
9 its share of the value of the asset if the commissioner determines  
10 that the postponement meets the needs of the system.

11 140219. The health regions must make financial information  
12 available to the public when the California Health Insurance  
13 System contribution to a capital project is greater than  
14 twenty-five million dollars (\$25,000,000). Information shall  
15 include the purpose of the project or acquisition, its relation to  
16 California Health Insurance System goals, the project budget and  
17 the timetable for completion, environmental impact reports, any  
18 terms-related conflicts of interest, and performance standards and  
19 benchmarks.

20 140220. (a) The commissioner shall establish a budget for  
21 the purchase of prescription drugs and durable and nondurable  
22 medical equipment for the health insurance system.

23 (b) The commissioner shall use the purchasing power of the  
24 state to obtain the lowest possible prices for prescription drugs  
25 and durable and nondurable medical equipment.

26 (c) The commissioner shall make discounted prices available  
27 to all California residents, licensed and accredited providers and  
28 facilities under the terms of their licenses and accreditation,  
29 health care providers, prescription drug and medical equipment  
30 wholesalers and retailers of products approved for use in and  
31 included in the benefit package of the California Health  
32 Insurance System.

33 140221. (a) The commissioner shall establish a budget to  
34 support research and innovation that has been recommended by  
35 the chief medical officer, the director of planning, the ~~consumer~~  
36 *patient* advocates, the Partnerships for Health, the Technical  
37 Advisory Committee, and others as required by the  
38 commissioner.

39 (b) The research and innovation budget shall support the goals  
40 and standards of the California Health Insurance System.

1 140222. (a) The commissioner shall establish a budget to  
2 support the training, development and continuing education of  
3 health care providers and the health care workforce needed to  
4 meet the health care needs of the population and the goals and  
5 standards of the health insurance system.

6 (b) During the transition, the commissioner shall determine an  
7 appropriate level and duration of spending to support the  
8 retraining and job placement of persons who have been displaced  
9 from employment as a result of the transition to the new health  
10 insurance system.

11 (c) The commissioner shall establish guidelines for giving  
12 special consideration for employment to persons who have been  
13 displaced as a result of the transition to the new health insurance  
14 system.

15 140223. (a) The commissioner shall establish a Reserve  
16 Budget pursuant to this section.

17 (b) The Reserve Budget may be used only for purposes set  
18 forth in this division.

19 140224. (a) The commissioner shall establish a budget that  
20 covers all costs of administering the California Health Insurance  
21 System.

22 (b) Administrative costs on a systemwide basis shall be  
23 limited to 10 percent of system costs within five years of  
24 completing the transition to the California Health Insurance  
25 System.

26 (c) Administrative costs on a systemwide basis shall be limited  
27 to 5 percent of system costs within 10 years of completing the  
28 transition to the California Health Insurance System.

29 (d) The commissioner shall ensure that the percentage of the  
30 budget allocated to support system administration stays within  
31 the allowable limits and shall continually seek means to lower  
32 system administrative cost.

33 (e) The commissioner shall report to the public, the regional  
34 planning directors and others attending the annual Health  
35 Insurance System Revenue and Expenditures Conference  
36 pursuant to Section 140205 on the costs of administering the  
37 system and the regions and shall make recommendations for  
38 lowering administrative costs and receive recommendations for  
39 lowering administrative costs.

1 Article 2. ~~Revenues.~~ *California Health Insurance Premium*  
2 *Commission.*

3  
4 ~~140230. [Reserved]~~

5 *140230. (a) There is hereby created the California Health*  
6 *Insurance Premium Commission.*

7 *(b) The Premium Commission shall be composed of the*  
8 *following members:*

9 *(1) Three health economists with experience relevant to the*  
10 *functions of the Premium Commission. One shall be appointed by*  
11 *the Speaker of the Assembly, one shall be appointed by the*  
12 *Senate Committee on Rules, and one shall be appointed by the*  
13 *Governor.*

14 *(2) Two representatives of California's business community,*  
15 *with one representing small business. One shall be appointed by*  
16 *the Governor, and the representative of small business shall be*  
17 *appointed by the Senate Committee on Rules.*

18 *(3) Two representatives from organized labor. One shall be*  
19 *appointed by the Senate Committee on Rules, and one shall be*  
20 *appointed the Speaker of the Assembly.*

21 *(4) Two representatives of nonprofit organizations whose*  
22 *principal purpose includes promoting the establishment of a*  
23 *system of universal health care in California. One shall be*  
24 *appointed by the Senate Committee on Rules, and one shall be*  
25 *appointed by the Speaker of the Assembly.*

26 *(5) One representative of a nonprofit advocacy organization*  
27 *with expertise in taxation policy whose principal purpose*  
28 *includes advocating for sustainable funding for the public*  
29 *infrastructure. This person shall be appointed by the Speaker of*  
30 *the Assembly.*

31 *(6) Two members of the Legislature who shall be members of*  
32 *a policy committee having jurisdiction over health care issues.*  
33 *One shall be appointed by the Senate Committee on Rules, and*  
34 *one shall be appointed by the Speaker of the Assembly.*

35 *(7) The Executive Officer of the Franchise Tax Board.*

36 *(8) The Chair of the State Board of Equalization.*

37 *(9) The Director of the Employment Development Department.*

38 *(10) The Legislative Analyst.*

39 *(11) The Secretary of the California Health and Human*  
40 *Services Agency.*

1     (12) *The Director of the Department of Finance.*

2     (13) *The State Controller.*

3     (14) *The State Treasurer.*

4     (15) *The Lieutenant Governor.*

5     (c) *Upon appointment, the Premium Commission shall meet at*  
6 *least once a month. The Premium Commission shall elect a chair*  
7 *from its membership during its first meeting. The Premium*  
8 *Commission shall receive public comments during a portion of*  
9 *each of its meetings, and all of its meetings shall be conducted*  
10 *pursuant to the Bagley-Keene Open Meeting Act (Article 9*  
11 *(commencing with Section 11120) of Chapter 1 of Part 1 of*  
12 *Division 3 of Title 2 of the Government Code).*

13     140231. (a) *The Premium Commission shall perform the*  
14 *following functions:*

15         (1) *Determine the aggregate costs of providing health*  
16 *insurance coverage pursuant to this division.*

17         (2) *Develop an equitable and affordable premium structure*  
18 *that will generate adequate revenue for the Health Insurance*  
19 *Fund established pursuant to Section 140200 and ensure stable*  
20 *and actuarially sound funding for the health insurance system.*

21     (b) *The Premium Commission shall perform the functions*  
22 *described in this section by considering existing financial*  
23 *simulations and analyses of universal health care proposals,*  
24 *including, but not limited to, the analysis completed by the Lewin*  
25 *Group in January 2005, of Senate Bill No. 921 of the 2003–04*  
26 *Regular Session.*

27     140232. (a) *The premium structure developed by the*  
28 *Premium Commission shall satisfy the following criteria:*

29         (1) *Be means-based and generate adequate revenue to*  
30 *implement this division.*

31         (2) *To the greatest extent possible, ensure that all income*  
32 *earners and all employers contribute a premium amount that is*  
33 *affordable and that is consistent with existing funding sources for*  
34 *health care in California.*

35         (3) *Maintain the current ratio for aggregate health care*  
36 *contributions among the traditional health care funding sources,*  
37 *including employers, individuals, government, and other sources.*

38         (4) *Provide a fair distribution of monetary savings achieved*  
39 *from the establishment of a universal health care system.*

1 (5) Coordinate with existing, ongoing funding sources from  
2 federal and state programs.

3 (6) Be consistent with state and federal requirements  
4 governing financial contributions for persons eligible for existing  
5 public programs.

6 (7) Comply with federal requirements.

7 (b) The Premium Commission shall seek expert and legal  
8 advice regarding the best method to structure premium payments  
9 consistent with existing employer-employee health care financing  
10 structures.

11 140233. The Premium Commission may take all of the  
12 following actions:

13 (a) Obtain grants from, and contract with, individuals and  
14 with private, local, state, and federal agencies, organizations,  
15 and institutions, including institutions of higher education.

16 (b) Receive charitable contributions or any other source of  
17 income that may be lawfully received.

18 140234. (a) The Premium Commission may consult with  
19 additional persons, advisory entities, governmental agencies,  
20 members of the Legislature, and legislative staff as it deems  
21 necessary to perform its functions.

22 (b) The Premium Commission shall seek structured input from  
23 representatives of stakeholder organizations, policy institutes,  
24 and other persons with expertise in health care, health care  
25 financing, or universal health care models in order to ensure that  
26 it has the necessary information, expertise, and experience to  
27 perform its functions.

28 (c) The Premium Commission shall be supported by a  
29 reasonable amount of staff time, which shall be provided by the  
30 state agencies with membership on the Premium Commission.  
31 The Premium Commission may request data from, and utilize the  
32 technical expertise of, other state agencies.

33 140235. (a) On or before January 1, 2009, the Premium  
34 Commission shall submit to the Governor and the Legislature a  
35 detailed recommendation for a premium structure.

36 (b) The Premium Commission shall submit a draft  
37 recommendation to the Governor, Legislature, and the public at  
38 least 90 days prior to submission of the final recommendation  
39 described in subdivision (a). The Premium Commission shall  
40 seek input from the public on the draft recommendation.

1     140236. *The Premium Commission shall be funded upon an*  
2 *appropriation in the Budget Act of 2007.*

3  
4             Article 3. Governmental Payments  
5

6     140240. (a) (1) The commissioner shall seek all necessary  
7 waivers, exemptions, agreements, or legislation, so that all  
8 current federal payments to the state for health care be paid  
9 directly to the California Health Insurance System, which shall  
10 then assume responsibility for all benefits and services  
11 previously paid for by the federal government with those funds.

12     (2) In obtaining the waivers, exemptions, agreements, or  
13 legislation, the commissioner shall seek from the federal  
14 government a contribution for health care services in California  
15 that shall not decrease in relation to the contribution to other  
16 states as a result of the waivers, exemptions, agreements, or  
17 legislation.

18     (b) (1) The commissioner shall seek all necessary waivers,  
19 exemptions, agreements, or legislation, so that all current state  
20 payments for health care shall be paid directly to the system,  
21 which shall then assume responsibility for all benefits and  
22 services previously paid for by state government with those  
23 funds.

24     (2) In obtaining the waivers, exemptions, agreements, or  
25 legislation, the commissioner shall seek from the Legislature a  
26 contribution for health care services that shall not decrease in  
27 relation to state government expenditures for health care services  
28 in the year that this division was enacted, except that it may be  
29 corrected for change in state gross domestic product, the size and  
30 age of population, and the number of residents living below the  
31 federal poverty level.

32     (c) The commissioner shall establish formulas for equitable  
33 contributions to the California Health Insurance System from all  
34 California counties and other local government agencies.

35     (d) The commissioner shall seek all necessary waivers,  
36 exemptions, agreements, or legislation, so that all county or other  
37 local government agency payments shall be paid directly to the  
38 California Health Insurance System.

39     140241. The system's responsibility for providing care shall  
40 be secondary to existing federal, state, or local governmental

1 programs for health care services to the extent that funding for  
2 these programs ~~are~~ *is* not transferred to the Health Insurance  
3 Fund or that the transfer is delayed beyond the date on which  
4 initial benefits are provided under the system.

5 140242. In order to minimize the administrative burden of  
6 maintaining eligibility records for programs transferred to the  
7 system, the commissioner shall strive to reach an agreement with  
8 federal, state, and local governments in which their contributions  
9 to the Health Insurance Fund shall be fixed to the rate of change  
10 of the state gross domestic product, the size and age of  
11 population, and the number of residents living below the federal  
12 poverty level.

13 140243. If, and to the extent that, federal law and regulations  
14 allow the transfer of Medi-Cal funding to the system, the  
15 commissioner shall pay from the Health Insurance Fund all  
16 premiums, deductible payments, and coinsurance for qualified  
17 Medicare beneficiaries who are receiving benefits pursuant to  
18 Chapter 3 (commencing with Section 12000) of Part 3 of  
19 Division 9 of the Welfare and Institutions Code.

20 140244. In the event and to the extent that the commissioner  
21 obtains authorization to incorporate Medicare revenues into the  
22 Health Insurance Fund, Medicare Part B payments that  
23 previously were made by individuals or the commissioner shall  
24 be paid by the system for all individuals eligible for both the  
25 system and the Medicare Program.

26  
27 Article 4. Federal Preemption  
28

29 140300. (a) The commissioner shall pursue all reasonable  
30 means to secure a repeal or a waiver of any provision of federal  
31 law that preempts any provision of this division.

32 (b) In the event that a repeal or a waiver of law or regulations  
33 cannot be secured, the commissioner shall exercise his or her  
34 powers to promulgate rules and regulations, or seek conforming  
35 state legislation, consistent with federal law, in an effort to best  
36 fulfill the purposes of this division.

37 140301. (a) To the extent permitted by federal law, an  
38 employee entitled to health or related benefits under a contract or  
39 plan that, under federal law, preempts provisions of this division,

1 shall first seek benefits under that contract or plan before  
2 receiving benefits from the system under this division.

3 (b) No benefits shall be denied under the system created by  
4 this division unless the employee has failed to take reasonable  
5 steps to secure like benefits from the contract or plan, if those  
6 benefits are available.

7 (c) Nothing in this section shall preclude a person from  
8 receiving benefits from the system under this division that are  
9 superior to benefits available to the person under an existing  
10 contract or plan.

11 (d) Nothing in this division is intended, nor shall this division  
12 be construed, to discourage recourse to contracts or plans that are  
13 protected by federal law.

14 (e) To the extent permitted by federal law, a health care  
15 provider shall first seek payment from the contract or plan,  
16 before submitting bills to the California Health Insurance  
17 System.

18

19

#### Article 5. Subrogation

20

21 140302. (a) It is the intent of this division to establish a  
22 single public payer for all health care in the State of California.  
23 However, until such time as the role of all other payers for health  
24 care have been terminated, health care costs shall be collected  
25 from collateral sources whenever medical services provided to an  
26 individual are, or may be, covered services under a policy of  
27 insurance, health care service plan, or other collateral source  
28 available to that individual, or for which the individual has a  
29 right of action for compensation to the extent permitted by law.

30 (b) As used in this article, collateral source includes all of the  
31 following:

32 (1) Insurance policies written by insurers, including the  
33 medical components of automobile, homeowners, and other  
34 forms of insurance.

35 (2) Health care service plans and pension plans.

36 (3) Employers.

37 (4) Employee benefit contracts.

38 (5) Government benefit programs.

39 (6) A judgment for damages for personal injury.

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

3 (c) “Collateral source” does not include either of the  
4 following:

5 (1) A contract or plan that is subject to federal preemption.

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

11 (d) The commissioner shall attempt to negotiate waivers, seek  
12 federal legislation, or make other arrangements to incorporate  
13 collateral sources in California into the California Health  
14 Insurance System.

15 140303. Whenever an individual receives health care services  
16 under the system and he or she is entitled to coverage,  
17 reimbursement, indemnity, or other compensation from a  
18 collateral source, he or she shall notify the health care provider  
19 and provide information identifying the collateral source, the  
20 nature and extent of coverage or entitlement, and other relevant  
21 information. The health care provider shall forward this  
22 information to the commissioner. The individual entitled to  
23 coverage, reimbursement, indemnity, or other compensation from  
24 a collateral source shall provide additional information as  
25 requested by the commissioner.

26 140304. (a) The system shall seek reimbursement from the  
27 collateral source for services provided to the individual, and may  
28 institute appropriate action, including suit, to recover the  
29 reimbursement. Upon demand, the collateral source shall pay to  
30 the Health Insurance Fund the sums it would have paid or  
31 expended on behalf of the individual for the health care services  
32 provided by the system.

33 (b) In addition to any other right to recovery provided in this  
34 article, the commissioner shall have the same right to recover the  
35 reasonable value of benefits from a collateral source as provided  
36 to the Director of Health Services by Article 3.5 (commencing  
37 with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of  
38 the Welfare and Institutions Code, in the manner so provided.

39 140305. (a) If a collateral source is exempt from subrogation  
40 or the obligation to reimburse the system as provided in this

1 article, the commissioner may require that an individual who is  
2 entitled to medical services from the source first seek those  
3 services from that source before seeking those services from the  
4 system.

5 (b) To the extent permitted by federal law, contractual retiree  
6 health benefits provided by employers shall be subject to the  
7 same subrogation as other contracts, allowing the California  
8 Health Insurance System to recover the cost of services provided  
9 to individuals covered by the retiree benefits, unless and until  
10 arrangements are made to transfer the revenues of the benefits  
11 directly to the California Health Insurance System.

12 140306. (a) Default, underpayment, or late payment of any  
13 tax or other obligation imposed by this division shall result in the  
14 remedies and penalties provided by law, except as provided in  
15 this section.

16 (b) Eligibility for benefits under Chapter 4 (commencing with  
17 Section 140400) shall not be impaired by any default,  
18 underpayment, or late payment of any tax or other obligation  
19 imposed by this chapter.

20 140307. The agency and the commissioner shall be exempt  
21 from the regulatory oversight and review procedures empowered  
22 to the Office of Administrative Law pursuant to Chapter 3.5  
23 (commencing with Section 11340) of Division 3 of Title 2 of the  
24 Government Code. Actions taken by the agency, including, but  
25 not limited to, the negotiating or setting of rates, fees, or prices,  
26 and the promulgation of any and all regulations, shall be exempt  
27 from any review by the Office of Administrative Law, except for  
28 Sections 11344.1, 11344.2, 11344.3, and 11344.6 of the  
29 Government Code, addressing the publication of regulations.

30 140308. The California Health Insurance Agency shall adopt  
31 regulations to implement the provisions of this division. The  
32 regulations may initially be adopted as emergency regulations in  
33 accordance with the Administrative Procedure Act (Chapter 3.5  
34 (commencing with Section 11340) of Part 1 of Division 3 of Title  
35 2 of the Government Code), but those emergency regulations  
36 shall be in effect only from the effective date of this division  
37 until the conclusion of the transition period.

CHAPTER 4. ELIGIBILITY

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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

1 Health Care Fund, which shall assume financial responsibility for  
2 care provided under the terms of the contract.

3 (b) The commissioner may establish financial arrangements  
4 with states and foreign countries in order to facilitate meeting the  
5 terms of the contracts described in subdivision (a), except that  
6 payments for care provided by non-California providers to  
7 California retirees shall be reimbursed at rates established by the  
8 commissioner.

9 140405. Unmarried, unemancipated minors shall be deemed  
10 to have the residency of their parent or guardian. If a minor's  
11 parents are deceased and a legal guardian has not been appointed,  
12 or if a minor has been emancipated by court order, the minor may  
13 establish his or her own residency.

14 140406. (a) An individual shall be presumed to be eligible if  
15 he or she arrives at a health facility and is unconscious,  
16 comatose, or otherwise unable, because of his or her physical or  
17 mental condition, to document eligibility or to act in his or her  
18 own behalf, or if the patient is a minor, the patient shall be  
19 presumed to be eligible, and the health facility shall provide care  
20 as if the patient were eligible.

21 (b) Any individual shall be presumed to be eligible when  
22 brought to a health facility pursuant to any provision of Section  
23 5150 of the Welfare and Institutions Code.

24 (c) Any individual involuntarily committed to an acute  
25 psychiatric facility or to a hospital with psychiatric beds pursuant  
26 to any provision of Section 5150 of the Welfare and Institutions  
27 Code, providing for involuntary commitment, shall be presumed  
28 eligible.

29 (d) All health facilities subject to state and federal provisions  
30 governing emergency medical treatment shall continue to comply  
31 with those provisions.

32 (e) In the event of an influx of people into the state for the  
33 purposes of receiving medical care, the commissioner shall  
34 establish an eligibility waiting period and other criteria needed to  
35 ensure the fiscal stability of the health insurance system.

36

37

#### CHAPTER 5. BENEFITS

38

39 140500. Any eligible individual may choose to receive  
40 services under the California Health Insurance System from any

1 willing professional health care provider participating in the  
2 system. No health care provider may refuse to care for a patient  
3 solely on any basis that is specified in the prohibition of  
4 employment discrimination contained in the Fair Employment  
5 and Housing Act beginning with Section 12940 of the  
6 Government Code.

7 140501. Covered benefits in this chapter shall include all  
8 medical care determined to be medically appropriate by the  
9 consumer's health care provider, but are subject to limitations set  
10 forth in Section 140503. Covered benefits include, but are not  
11 limited to, all of the following:

- 12 (a) Inpatient and outpatient health facility services.
- 13 (b) Inpatient and outpatient professional health care provider  
14 services by licensed health care professionals.
- 15 (c) Diagnostic imaging, laboratory services, and other  
16 diagnostic and evaluative services.
- 17 (d) Durable medical equipment, appliances, and assistive  
18 technology, including prosthetics, eyeglasses, and hearing aids  
19 and their repair.
- 20 (e) Rehabilitative care.
- 21 (f) Emergency transportation and necessary transportation for  
22 health care services for disabled and indigent persons.
- 23 (g) Language interpretation and translation for health care  
24 services, including sign language for those unable to speak, or  
25 hear, or who are language impaired, and Braille translation or  
26 other services for those with no or low vision.
- 27 (h) Child and adult immunizations and preventive care.
- 28 (i) Health education.
- 29 (j) Hospice care.
- 30 (k) Home health care.
- 31 (l) Prescription drugs that are listed on the system formulary.  
32 Nonformulary prescription drugs may be included where  
33 standards and criteria established by the commissioner are met.
- 34 (m) Mental and behavioral health care.
- 35 (n) Dental care.
- 36 (o) Podiatric care.
- 37 (p) Chiropractic care.
- 38 (q) Acupuncture.
- 39 (r) Blood and blood products.
- 40 (s) Emergency care services.

- 1 (t) Vision care.
- 2 (u) Adult day care.
- 3 (v) Case management and coordination to ensure services
- 4 necessary to enable a person to remain safely in the least
- 5 restrictive setting.
- 6 (w) Substance abuse treatment.
- 7 (x) Care of up to 100 days in a skilled nursing facility
- 8 following hospitalization.
- 9 (y) Dialysis.
- 10 (z) Benefits offered by a bona fide church, sect, denomination,
- 11 or organization whose principles include healing entirely by
- 12 prayer or spiritual means provided by a duly authorized and
- 13 accredited practitioner or nurse of that bona fide church, sect,
- 14 denomination, or organization.
- 15 140502. The commissioner may expand benefits beyond the
- 16 minimum benefits described in this chapter when expansion
- 17 meets the intent of this division and when there are sufficient
- 18 funds to cover the expansion.
- 19 140503. The following health care services shall be excluded
- 20 from coverage by the system:
- 21 (a) Health care services determined to have no medical
- 22 indication by the commissioner and the chief medical officer.
- 23 (b) Surgery, dermatology, orthodontia, prescription drugs, and
- 24 other procedures primarily for cosmetic purposes, unless required
- 25 to correct a congenital defect, restore or correct a part of the body
- 26 that has been altered as a result of injury, disease, or surgery, or
- 27 determined to be medically necessary by a qualified, licensed
- 28 health care provider in the system.
- 29 (c) Private rooms in inpatient health facilities where
- 30 appropriate nonprivate rooms are available, unless determined to
- 31 be medically necessary by a qualified, licensed health care
- 32 provider in the system.
- 33 (d) Services of a professional health care provider or facility
- 34 that is not licensed or accredited by the state except for approved
- 35 services provided to a California resident who is temporarily out
- 36 of the state.
- 37 140504. (a) No copayments or deductible payments may be
- 38 established for preventive care as determined by a patient's
- 39 primary care provider.

1 (b) No copayments or deductible payments may be established  
 2 when prohibited by federal law.

3 (c) The commissioner shall establish standards and procedures  
 4 for waiving copayments or deductible payments. Waivers of  
 5 copayments or deductible payments shall not affect the  
 6 reimbursement of health care providers.

7 (d) Any copayments established pursuant to this section and  
 8 collected by health care providers shall be transmitted to the  
 9 Treasurer to be deposited to the credit of the Health Insurance  
 10 Fund.

11 (e) Nothing in this division shall be construed to diminish the  
 12 benefits that an individual has under a collective bargaining  
 13 agreement.

14 (f) Nothing in this division shall preclude employees from  
 15 receiving benefits available to them under a collective bargaining  
 16 agreement or other employee-employer agreement that are  
 17 superior to benefits under this division.

18  
 19 CHAPTER 6. DELIVERY OF CARE  
 20

21 140600. (a) All health care providers licensed or accredited  
 22 to practice in California may participate in the California Health  
 23 Insurance System.

24 (b) No health care provider whose license or accreditation is  
 25 suspended or revoked may be a participating health care  
 26 provider.

27 (c) ~~(1) [Reserved]~~  
 28 ~~(2)~~ If a health care provider is on probation, the licensing or  
 29 the accrediting agency shall monitor the health care provider in  
 30 question, pursuant to applicable California law. The licensing or  
 31 accrediting agency shall report to the chief medical officer at  
 32 intervals established by the chief medical officer, on the status of  
 33 providers who are on probation, on measures undertaken to assist  
 34 providers to return to practice and to resolve complaints made by  
 35 patients.

36 (d) Health care providers may accept eligible persons for care  
 37 according to the provider’s ability to provide services needed by  
 38 the applicant and according to the number of patients a provider  
 39 can treat without compromising safety and care quality. A  
 40 provider may accept patients in the order of time of application.

1 (e) A health care provider shall not refuse to care for a patient  
2 solely on any basis that is specified in the prohibition of  
3 employment discrimination contained in the Fair Employment  
4 and Housing Act (Part 2.8 (commencing with Section 129000) of  
5 Division 3 of Title 2 of the Government Code).

6 (f) Choice of provider:

7 (1) Persons eligible for health care services under this division  
8 may choose a primary care provider.

9 (A) Primary care providers include family practitioners,  
10 general practitioners, internists and pediatricians, nurse  
11 practitioners and physician assistants practicing under  
12 supervision as defined in California codes and Doctors of  
13 Osteopathy licensed to practice as general doctors.

14 (B) Women may choose an obstetrician-gynecologist, in  
15 addition to a primary provider.

16 (2) Persons who choose to enroll with integrated health care  
17 systems, group medical practices or essential community  
18 providers that offer comprehensive services, shall retain  
19 membership for at least one year after an initial three-month  
20 evaluation period during which time they may withdraw for any  
21 reason.

22 (A) The three-month period shall commence on the date when  
23 an enrollee first sees a primary provider.

24 (B) Persons who want to withdraw after the initial three-month  
25 period shall request a withdrawal pursuant to dispute resolution  
26 procedures established by the commissioner and may request  
27 assistance from the ~~consumer~~ *patient* advocate in the dispute  
28 process. The dispute shall be resolved in a timely fashion and  
29 shall have no adverse effect on the care a patient receives.

30 (3) Persons needing to change primary providers because of  
31 health care needs that their primary provider cannot meet may  
32 change primary providers at any time.

33 140601. (a) Primary care providers shall coordinate the care  
34 a patient receives or shall ensure that a patient's care is  
35 coordinated.

36 (b) (1) Patients shall have a referral from their primary care  
37 provider, or from an emergency provider rendering care to them  
38 in the emergency room or other accredited emergency setting, or  
39 from a provider treating a patient for an emergency condition in  
40 any setting, or from their obstetrician/gynecologist, to see a

1 physician or nonphysician specialist whose services are covered  
2 by this division, unless the patient agrees to assume the costs of  
3 care, in which case a referral is not needed. A referral shall not be  
4 required to see a dentist.

5 (2) Referrals shall be based on the medical needs of the patient  
6 and on guidelines, which shall be established by the chief  
7 medical officer to support clinical—~~decisionmaking~~ *decision*  
8 *making*.

9 (3) Referrals shall not be restricted or provided solely because  
10 of financial considerations. The chief medical officer shall  
11 monitor referral patterns and intervene as necessary to assure that  
12 referrals are neither restricted nor provided solely because of  
13 financial considerations.

14 (4) For the first six months of system operation, no specialist  
15 referral shall be required for patients who had been receiving care  
16 from a specialist prior to the initiation of the system. Beginning  
17 with the seventh month of system operation, all patients shall be  
18 required to obtain a referral from a primary or emergency care  
19 provider for specialty care if the care is to be paid for by the  
20 system. No referral is required if a patient pays the full cost of  
21 the specialty care and the specialist accepts that payment  
22 arrangement.

23 (5) Where referral systems are in place prior to the initiation of  
24 the system, the chief medical officer shall review the referral  
25 systems to assure that they meet health insurance system  
26 standards for care quality and shall assure needed changes are  
27 implemented so that all Californians receive the same standards  
28 of care quality.

29 (6) A specialist may serve as the primary provider if the  
30 patient and the provider agree to this arrangement and if the  
31 provider agrees to coordinate the patient's care or to ensure that  
32 the care the patient receives is coordinated.

33 (7) The commissioner shall establish or ensure the  
34 establishment of a computerized referral registry to facilitate the  
35 referral process and to allow a specialist and a patient to easily  
36 determine whether a referral has been made pursuant to this  
37 division.

38 (8) A patient may appeal the denial of a referral through the  
39 dispute resolution procedures established by the commissioner

1 and may request the assistance of the ~~consumer~~ *patient* advocate  
2 during the dispute resolution process.

3 140602. (a) The purpose of the Office of Health Planning is  
4 to plan for the short- and long-term health needs of the  
5 population pursuant to the health care and finance standards  
6 established by the commissioner and by this division.

7 (b) The office shall be headed by a director appointed by the  
8 commissioner. The director shall serve pursuant to provisions of  
9 subdivisions ~~(b)~~, ~~(c)~~, and ~~(d)~~ *(c)*, *(d)*, and *(e)* of Section 140100  
10 and subdivisions ~~(i)~~ and ~~(j)~~ *(j)* and *(k)* of Section 140101.

11 (c) The director shall do all the following:

12 (1) Administer all aspects of the Office of Health Planning.

13 (2) Serve on the Health Insurance Policy Board.

14 (3) Establish performance criteria in measurable terms for  
15 health care goals in consultation with the chief medical officer,  
16 the regional health officers and directors and others with  
17 experience in health care outcomes measurement and evaluation.

18 (4) Evaluate the effectiveness of performance criteria in  
19 accurately measuring quality of care, administration, and  
20 planning.

21 (5) Assist the health care regions to develop operating and  
22 capital requests pursuant to health care and finance guidelines  
23 established by the commissioner and by this division. In assisting  
24 regions, the director shall do all of the following:

25 (A) Identify medically undeserved areas and health service  
26 and asset shortages.

27 (B) Identify disparities in health outcomes.

28 (C) Establish conventions for the definition, collection,  
29 storage, analysis, and transmission of data for use by the health  
30 insurance system.

31 (D) Establish electronic systems that support dissemination of  
32 information to providers and patients about integrated health  
33 network and integrated care systems community-based health  
34 care resources.

35 (E) Support establishment of comprehensive health care  
36 databases using uniform methodology that is compatible between  
37 the regions and between the regions and the state health  
38 insurance agency.

39 (F) Provide information to support effective regional planning  
40 and innovation.

1 (G) Provide information to support interregional planning,  
2 including planning for access to specialized centers that perform  
3 a high volume of procedures for conditions requiring highly  
4 specialized treatments, including emergency and trauma and  
5 other interregional access to needed care, and planning for  
6 coordinated interregional capital investment.

7 (H) Provide information for, and participate in, earthquake  
8 retrofit planning.

9 (I) Evaluate regional budget requests and make  
10 recommendations to the commissioner about regional revenue  
11 allocations.

12 (6) Estimate the health care workforce required to meet the  
13 health needs of the population pursuant to the standards and  
14 goals established by the commissioner, the costs of providing the  
15 needed workforce, and, in collaboration with regional planners,  
16 educational institutions, the Governor and the Legislature,  
17 develop short- and long-term plans to meet those needs,  
18 including a plan to finance needed training.

19 (7) Estimate the number and types of health facilities required  
20 to meet the short- and long-term health needs of the population  
21 and the projected costs of needed facilities. In collaboration with  
22 the commissioner, regional planning directors and health officers,  
23 the chief medical officer, the Governor and the Legislature,  
24 develop plans to finance and build needed facilities.

25 140603. The Technical Advisory Group shall explore the  
26 feasibility and the value to the health of the population of the  
27 following electronic initiatives:

28 (a) Establish integrated statewide health care databases to  
29 support health care planning and determine which databases  
30 which should be established on a statewide basis and which  
31 should be established on a regional basis.

32 (b) Assure that databases have uniform methodology and  
33 formats that are compatible between regions and between the  
34 regions and the state insurance agency.

35 (c) Establish mandatory database reporting requirements and  
36 penalties for noncompliance. Monitor the effectiveness of  
37 reporting and make needed improvements.

38 (d) Establish means for anonymous reporting to the chief  
39 medical officer and regional medical officers of medical errors  
40 and other related problems, and for anonymous reporting to the

1 commissioner and regional planning directors of problems  
2 related to ineffective management, and establish guidelines for  
3 protection of persons coming forward to report these problems.

4 (e) In collaboration with the chief medical officer and state  
5 and regional ~~consumer~~ *patient* advocates, investigate the costs  
6 and benefits of electronic and on-line scheduling systems and  
7 means of provider-patient communication that allow for  
8 electronic visits, and make recommendations to the chief medical  
9 officer regarding the use of these concepts in the health insurance  
10 system.

11 (f) In collaboration with the chief medical officer, establish  
12 electronic systems and other means that support the use of  
13 ~~evidence-based~~ standards of care *based on clinical efficacy* to  
14 guide clinical ~~decisionmaking~~ *decision making* by all who  
15 provide services in the California Health Insurance System.

16 (g) In collaboration with the chief medical officer, support the  
17 development of disease management programs and their use in  
18 the health insurance system.

19 (h) Establish electronic initiatives that lower administration  
20 costs.

21 (i) Collaborate with the chief medical officer and regional  
22 medical officers to assure the development of software systems  
23 that link clinical guidelines to individual patient conditions, and  
24 guide clinicians through diagnosis and treatment algorithms  
25 ~~based on evidence-based research and best medical practices.~~  
26 *derived from research based on clinical efficacy and best*  
27 *medical practices.*

28 (j) Collaborate with the chief medical officer and regional  
29 medical officers to assure the development of software systems  
30 that offer providers access to guidelines that are appropriate for  
31 their specialty and that include current information on prevention  
32 and treatment of disease.

33 (k) In collaboration with the Partnerships for Health and  
34 regional health officers, establish Web-based patient-centered  
35 information systems that assist people to promote and maintain  
36 health and provide information on health conditions and recent  
37 developments in treatment.

38 (l) Establish electronic systems and other means to provide  
39 patients with easily understandable information about the  
40 performance of health care providers. This shall include, but not

1 be limited to, information about the experience that providers  
2 have in the field or fields in which they deliver care, the number  
3 of years they have practiced in their field and, in the case of  
4 medical and surgical procedures, the number of procedures they  
5 have performed in their area or areas of specialization.

6 (m) Establish electronic systems that facilitate provider  
7 continuing medical education that meets licensure requirements.

8 (n) Recommend to the commissioner means to link health care  
9 research with the goals and priorities of the health insurance  
10 system.

11 140604. (a) The Director of Health Planning shall establish  
12 standards for culturally and linguistically competent care, which  
13 shall include, but not be limited to, all of the following:

14 (1) State Department of Health Services and the Department  
15 of Managed Care guidelines for culturally and linguistically  
16 sensitive care.

17 (2) Medi-Cal Managed Care Division (MMCD) Policy Letters  
18 99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural  
19 and Linguistic.

20 (3) Subchapter 5 of the Civil Rights Act of 1964 (42 U.S.C.  
21 Sec. 2000d).

22 (4) United States Department of Health and Human Services'  
23 Office of Civil Rights; Title VI of the Civil Rights Act of 1964;  
24 Policy Guidance on Prohibition Against National Origin  
25 Discrimination as It Affects Persons with Limited English  
26 Proficiency (February 1, 2002).

27 (5) United States Department of Health and Human Services'  
28 Office of Minority Health; National Standards on Culturally and  
29 Linguistically Appropriate Services (CLAS) in Health  
30 Care—Final Report (December 22, 2000).

31 (b) The director shall annually evaluate the effectiveness of  
32 standards for culturally and linguistically competent care and  
33 make recommendations to the commissioner, the ~~consumer~~  
34 *advocate patient advocate*, and the chief medical officer for  
35 needed improvements. In evaluating the standards for culturally  
36 and linguistically sensitive care, the director shall establish a  
37 process to receive concerns and comments from consumers.

38 (c) The director shall pursue available federal financial  
39 participation for the provision of a language services program  
40 that supports health insurance system goals.

1 140605. (a) Within the agency, the commissioner shall  
2 establish the Office of Health Care Quality.

3 (b) The office shall be headed by the chief medical officer  
4 who shall serve pursuant to provisions of subdivisions ~~(b), (e),~~  
5 ~~and (d) of Section 140100 and subdivisions (i) and (j) of Section~~  
6 ~~(c), (d), and (e) of Section 140100 and subdivisions (j) and (k) of~~  
7 *Section 140101* regarding qualifications for appointed health  
8 insurance system officers.

9 (c) The purpose of the Office of Health Care Quality is the  
10 following:

11 (1) Support the delivery of high quality, coordinated health  
12 care services that enhance health, prevent illness, disease and  
13 disability, slow the progression of chronic diseases and improve  
14 personal health management.

15 (2) Promote efficient care delivery.

16 (3) Establish processes for measuring, monitoring, and  
17 evaluating the quality of care delivered in the health insurance  
18 system, including the performance of individual providers.

19 (4) Establish means to make changes needed to improve care  
20 quality, including innovative programs that improve quality.

21 (5) Promote patient, provider, and employer satisfaction with  
22 the health insurance system.

23 (6) Assist regional planning directors and medical officers in  
24 the development and evaluation of regional operating and capital  
25 budget requests.

26 140606. (a) In supporting the goals of the Office of Health  
27 Care Quality, the chief medical officer shall do all of the  
28 following:

29 (1) Administer all aspects of the office.

30 (2) Serve on the Health Insurance Policy Board.

31 (3) Collaborate with regional medical officers, directors,  
32 health care providers, and consumers, the director of planning,  
33 ~~the consumer patient advocate and Partnership Partnerships for~~  
34 ~~Health~~ directors to develop community-based networks of solo  
35 providers, small group practices, essential community providers  
36 and providers of patient care support services in order to offer  
37 comprehensive, multidisciplinary, coordinated services to  
38 patients.

39 (4) Establish ~~evidence-based~~ standards of care *based on*  
40 *clinical efficacy* for the health insurance system which shall serve

1 as guidelines to support providers in the delivery of high quality  
2 care. Standards shall be based on the best evidence available at  
3 the time and shall be continually updated. Standards are intended  
4 to support the clinical judgment of individual providers, not to  
5 replace it and to support clinical decisions based on the needs of  
6 individual patients.

7 (b) In establishing standards, the chief medical officer shall do  
8 all of the following:

9 (1) Draw on existing standards established by California  
10 health care institutions, on peer-created standards, and on  
11 standards developed by others institutions that have had a  
12 positive impact on care quality, such as the Centers for Disease  
13 Control, the National Quality Forum, and the Agency for Health  
14 Care Quality and Research.

15 (2) Collaborate with regional medical officers in establishing  
16 regional goals, priorities, and a timetable for implementation of  
17 standards of care.

18 (3) Assure a process for patients to provide their views on  
19 standards of care to the ~~consumer~~ *patient* advocate who shall  
20 report those views to the chief medical officer.

21 (4) Collaborate with the ~~director of planning~~ *Director of*  
22 *Health Planning* and regional medical officers to support the  
23 development of computer software systems that link clinical  
24 guidelines to individual patient conditions, guide clinicians  
25 through diagnosis and treatment algorithms based on  
26 ~~evidence-based~~ research and best medical practices *based on*  
27 *clinical efficacy*, offer access to guidelines appropriate to each  
28 medical specialty and offer current information on disease  
29 prevention and treatment and that support continuing medical  
30 education.

31 (5) Where referral systems for access to specialty care are in  
32 place prior to the initiation of the health insurance system, the  
33 chief medical officer shall review the referral systems to assure  
34 that they meet health insurance system standards for care quality  
35 and shall assure that needed changes are implemented so that all  
36 Californians receive the same standards of care quality.

37 (c) In collaboration with the ~~director of planning~~ *Director of*  
38 *Health Planning* and regional medical officer, the chief medical  
39 officer shall implement means to measure and monitor the  
40 quality of care delivered in the health insurance system.

1 Monitoring systems shall include, but shall not be limited to, peer  
2 and patient performance reviews.

3 (d) The chief medical officer shall establish means to support  
4 individual providers and health systems in correcting quality of  
5 care problems, including timeframes for making needed  
6 improvements and means to evaluate the effectiveness of  
7 interventions.

8 (e) In collaboration with regional medical officers and  
9 directors and the ~~director of planning~~ *Director of Health*  
10 *Planning*, the chief medical officer shall establish means to  
11 identify medical errors and their causes and develop plans to  
12 prevent them. Means shall include a system for anonymous  
13 reporting of errors, and guidelines to protect those who report the  
14 errors against recrimination, including job demotion, promotion  
15 discrimination, or job loss.

16 (f) The chief medical officer shall convene an annual  
17 statewide conference to discuss medical errors that occurred  
18 during the year, their causes, means to prevent errors, and the  
19 effectiveness of efforts to decrease errors.

20 (g) The chief medical officer shall recommend to the  
21 commissioner ~~an evidence-based~~ *a benefits package based on*  
22 *clinical efficacy* for the health insurance system, including  
23 priorities for needed benefit improvements. In making  
24 recommendations, the chief medical officer shall do all of the  
25 following:

26 (1) Identify safe and effective treatments.

27 (2) Evaluate and draw on existing benefit packages.

28 (3) Receive comments and recommendations from health care  
29 providers about benefits that meet the needs of their patients.

30 (4) Receive comments and recommendations made directly by  
31 patients or indirectly through the ~~consumer~~ *patient* advocate.

32 (5) Identify and recommend to the commissioner and the  
33 Health Insurance Policy Board innovative approaches to health  
34 promotion, disease and injury prevention, education, research  
35 and care delivery for possible inclusion in the benefit package.

36 (6) Identify complementary and alternative modalities that  
37 have been shown by the National Institutes of Health, Division of  
38 Complementary and Alternative Medicine to be safe and  
39 effective for possible inclusion as covered benefits.

1 (7) Recommend to the commissioner and update as  
2 appropriate, an ~~evidence-based~~ pharmaceutical and durable and  
3 nondurable medical equipment formularies *based on clinical*  
4 *efficacy*. In establishing the formularies the chief medical officer  
5 shall establish a Pharmacy and Therapeutics Committee  
6 composed of pharmacy and medical health care providers,  
7 representatives of health facilities and organizations have system  
8 formularies in place at the time the system is implemented and  
9 other experts that shall do all the following:

10 (8) Identify safe and effective pharmaceutical agents for use in  
11 the California Health Insurance System.

12 (9) Draw on existing standards and formularies.

13 (10) Identify experimental drugs and drug treatment protocols  
14 for possible inclusion in the formulary.

15 (11) Review formularies in a timely fashion to ensure that safe  
16 and effective drugs are available and that unsafe drugs are  
17 removed from use.

18 (12) Assure the timely dissemination of information needed to  
19 prescribe safely and effectively to all California providers and the  
20 development and utilization of electronic dispensing systems that  
21 decrease pharmaceutical dispensing errors.

22 (13) Establish standards and criteria and a process for  
23 providers to seek authorization for prescribing pharmaceutical  
24 agents and durable and nondurable medical equipment that are  
25 not included in the system formulary. No standard or criteria  
26 shall impose an undue administrative burden on patients, health  
27 care providers, including pharmacies and pharmacists, and none  
28 shall delay care a patient needs.

29 (14) Develop standards and criteria and a process for providers  
30 to request authorization for services and treatments, including  
31 experimental treatments that are not included in the system  
32 benefit package.

33 (A) Where such processes are in place when the health  
34 insurance system is initiated, the chief medical officer shall  
35 review the systems to assure that they meet health insurance  
36 system standards for care quality and shall assure that needed  
37 changes are implemented so that all Californians receive the  
38 same standards of care quality.

1 (B) No standard or criteria shall impose an undue  
2 administrative burden on a provider or a patient and none shall  
3 delay the care a patient needs.

4 (15) In collaboration with the ~~director of planning~~ *Director of*  
5 *Health Planning*, regional planning directors and regional  
6 medical officers, identify appropriate ratios of general medical  
7 providers to specialty medical providers on a regional basis in  
8 order to meet the health care needs of the population and the  
9 goals of the health insurance system.

10 (16) Recommend to the commissioner and to the Payment  
11 Board, financial and nonfinancial incentives and other means to  
12 achieve recommended provider ratios.

13 (17) Collaborate with the ~~director of planning~~ *Director of*  
14 *Health Planning* and regional medical officers and ~~consumer~~  
15 *patient* advocates in development of electronic initiatives,  
16 pursuant to Section 140603.

17 (18) Collaborate with the commissioner, the regional health  
18 officers, the directors of the Payments Board and the Health  
19 Insurance Fund to formulate a provider reimbursement model  
20 that promotes the delivery of coordinated, high quality health  
21 services in all sectors of the health insurance system and creates  
22 financial and other incentives for the delivery of high quality  
23 care.

24 (19) Establish or assure the establishment of continuing  
25 medical education programs about advances in the delivery of  
26 high quality of care.

27 (20) Convene an annual statewide quality of care conference  
28 to discuss problems with care quality and to make  
29 recommendations for changes needed to improve care quality.  
30 Participants shall include regional medical directors, health care  
31 providers, providers, patients, policy experts, experts in quality  
32 of care measurement and others.

33 (21) Annually report to the commissioner, the Health  
34 Insurance Policy Board and the public on the quality of care  
35 delivered in the health insurance system, including improvements  
36 that have been made and problems that have been identified  
37 during the year, goals for care improvement in the coming year  
38 and plans to meet these goals.

39 (h) No person working within the agency, or on a pharmacy  
40 and therapeutics committee or serving as a consultant to the

1 agency or a pharmacy and therapeutics committee, may receive  
2 fees or remuneration of any kind from a pharmaceutical  
3 company.

4 140607. (a) The ~~consumer~~ *patient* advocate, in collaboration  
5 with the chief medical officer, the regional ~~consumer~~ *patient*  
6 advocates, medical officers, and directors, shall establish a  
7 program in the state health insurance agency and in each region  
8 called the “Partnerships for Health”.

9 (b) The purpose of the Partnerships for Health is to improve  
10 health through community health initiatives, to support the  
11 development of innovative means to improve care quality, to  
12 promote efficient, coordinated care delivery, and to educate the  
13 public about the following:

14 (1) Personal maintenance of health.

15 (2) Prevention of disease.

16 (3) Improvement in communication between patients and  
17 providers.

18 (4) Improving quality of care.

19 (c) The ~~consumer~~ *patient* advocate shall work with the  
20 community and health care providers in proposing Partnerships  
21 for Health projects and in developing project budget requests that  
22 shall be included in the regional budget request to the  
23 commissioner.

24 (d) In developing educational programs, the Partnerships for  
25 Health shall collaborate with educators in the region.

26 (e) Partnerships for Health shall support the coordination of  
27 California Health Insurance System and public health system  
28 programs.

29 140608. (a) The ~~consumer~~ *patient* advocate shall establish a  
30 grievance system for all grievances except those involving the  
31 delay, denial, or modification of health care services. The  
32 ~~consumer~~ *patient* advocate shall do the following with regard to  
33 the grievance system:

34 (1) Establish and maintain a grievance system approved by the  
35 ~~health-care~~ commissioner under which members of the system  
36 may submit their grievances to the system. The system shall  
37 provide reasonable procedures that shall ensure adequate  
38 consideration of member grievances and rectification when  
39 appropriate.

1 (2) Inform members of the system upon enrollment in the  
2 system and annually hereafter of the procedure for processing  
3 and resolving grievances. The information shall include the  
4 location and telephone number where grievances may be  
5 submitted.

6 (3) Provide printed and electronic access for members who  
7 wish to register grievances. The forms used by the system shall  
8 be approved by the commissioner in advance as to format.

9 (4) (A) Provide for a written acknowledgment within five  
10 calendar days of the receipt of a grievance, except as noted in  
11 subparagraph (B). The acknowledgment shall advise the  
12 complainant of the following:

13 (i) That the grievance has been received.

14 (ii) The date of receipt.

15 (iii) The name of the system representative and the telephone  
16 number and address of the system representative who may be  
17 contacted about the grievance.

18 (B) Grievances received by telephone, by facsimile, by e-mail,  
19 or online through the system's Web site that are resolved by the  
20 next business day following receipt are exempt from the  
21 requirements of subparagraph (A) and paragraph (5). The  
22 ~~consumer~~ *patient* advocate shall maintain a log of all these  
23 grievances. The log shall be periodically reviewed by the  
24 ~~consumer~~ *patient* advocate and shall include the following  
25 information for each complaint:

26 (i) The date of the call.

27 (ii) The name of the complainant.

28 (iii) The complainant's system identification number.

29 (iv) The nature of the grievance.

30 (v) The nature of the resolution.

31 (vi) The name of the system representative who took the call  
32 and resolved the grievance.

33 (5) Provide members of the system with written responses to  
34 grievances, with a clear and concise explanation of the reasons  
35 for the system's response.

36 (6) Keep in its files all copies of grievances, and the responses  
37 thereto, for a period of five years.

38 (7) Establish and maintain a Web site that shall provide an  
39 online form that members of the system can use to file with a  
40 grievance online.

1 (b) The ~~consumer~~ *patient* advocate may refer any grievance  
2 that does not pertain to compliance with this division to the  
3 federal Health Care Financing Administration, or any other  
4 appropriate local, state, and federal governmental entity for  
5 investigation and resolution.

6 (c) If the member is a minor, or is incompetent or  
7 incapacitated, the parent, guardian, conservator, relative, or other  
8 designee of the member, as appropriate, may submit the  
9 grievance to the ~~consumer~~ *patient* advocate as a designated agent  
10 of the member. Further, a provider may join with, or otherwise  
11 assist, an enrollee, or the agent, to submit the grievance to the  
12 ~~consumer~~ *patient* advocate. In addition, following submission of  
13 the grievance to the ~~consumer~~ *patient* advocate, the member, or  
14 the agent, may authorize the provider to assist, including  
15 advocating on behalf of the member. For purposes of this section,  
16 a “relative” includes the parent, stepparent, spouse, domestic  
17 partner, adult son or daughter, grandparent, brother, sister, uncle,  
18 or aunt of the member.

19 (d) The ~~consumer~~ *patient* advocate shall review the written  
20 documents submitted with the member’s request for review. The  
21 ~~consumer~~ *patient* advocate may ask for additional information,  
22 and may hold an informal meeting with the involved parties,  
23 including providers who have joined in submitting the grievance  
24 or who are otherwise assisting or advocating on behalf of the  
25 member.

26 (e) The ~~consumer~~ *patient* advocate shall send a written notice  
27 of the final disposition of the grievance, and the reasons  
28 therefore, to the member, to any provider that has joined with or  
29 is otherwise assisting the member, and to the commissioner,  
30 within 30 calendar days of receipt of the request for review  
31 unless the ~~consumer~~ *patient* advocate, in his or her discretion,  
32 determines that additional time is reasonably necessary to fully  
33 and fairly evaluate the relevant grievance. The ~~consumer~~ *patient*  
34 advocate’s written notice shall include, at a minimum, the  
35 following:

36 (1) A summary of findings and the reasons why the ~~consumer~~  
37 *patient* advocate found the system to be, or not to be, in  
38 compliance with any applicable laws, regulations, or orders of  
39 the commissioner.

1 (2) A discussion of the ~~consumer~~ *patient* advocate's contact  
2 with any medical provider, or any other independent expert relied  
3 on by the ~~consumer~~ *patient* advocate, along with a summary of  
4 the views and qualifications of that provider or expert.

5 (3) If the member's grievance is sustained in whole or in part,  
6 information about any corrective action taken.

7 (f) The ~~consumer~~ *patient* advocate's order shall be binding on  
8 the system.

9 (g) The ~~consumer~~ *patient* advocate shall establish and  
10 maintain a system of aging of grievances that are pending and  
11 unresolved for 30 days or more that shall include a brief  
12 explanation of the reasons each grievance is pending and  
13 unresolved for 30 days or more.

14 140610. (a) The chief medical officer shall establish a  
15 grievance system for all grievances involving the delay, denial,  
16 or modification of health care services. The chief medical officer  
17 shall do all of the following with regard to the grievance  
18 regarding delay, denial, or modification of health care services:

19 (1) Establish and maintain a grievance system approved by the  
20 ~~health care~~ commissioner under which members of the system  
21 may submit their grievances to the system. The system shall  
22 provide reasonable procedures that shall ensure adequate  
23 consideration of member grievances and rectification when  
24 appropriate.

25 (2) Inform members of the system upon enrollment in the  
26 system and annually hereafter of the procedure for processing  
27 and resolving grievances. The information shall include the  
28 location and telephone number where grievances may be  
29 submitted.

30 (3) Provide printed and electronic access for members who  
31 wish to register grievances. The forms used by the system shall  
32 be approved by the commissioner in advance as to format.

33 (4) (A) Provide for a written acknowledgment within five  
34 calendar days of the receipt of a grievance. The acknowledgment  
35 shall advise the complainant of the following:

36 (i) That the grievance has been received.

37 (ii) The date of receipt.

38 (iii) The name of the system representative and the telephone  
39 number and address of the system representative who may be  
40 contacted about the grievance.

1 (B) The chief medical officer shall maintain a log of all these  
2 grievances. The log shall be periodically reviewed by the chief  
3 medical officer and shall include the following information for  
4 each complaint:  
5 (i) The date of the call.  
6 (ii) The name of the complainant.  
7 (iii) The complainant’s system identification number.  
8 (iv) The nature of the grievance.  
9 (v) The nature of the resolution.  
10 (vi) The name of the system representative who took the call  
11 and resolved the grievance.  
12 (5) Provide members of the system with written responses to  
13 grievances, with a clear and concise explanation of the reasons  
14 for the system’s response. The system response shall describe the  
15 criteria used and the clinical reasons for its decision including all  
16 criteria used and the clinical reasons for its decision including all  
17 criteria and clinical reasons related to medical necessity.  
18 (6) Keep in its files all copies of grievances, and the responses  
19 thereto, for a period of five years.  
20 (7) Establish and maintain a Web site that shall provide an  
21 online form that members of the system can use to file with a  
22 grievance online.  
23 (b) In any case determined by the chief medical officer to be a  
24 case involving an imminent and serious threat to the health of the  
25 member, including, but not limited to, severe pain, the potential  
26 loss of life, limb, or major bodily function, or in any other case  
27 where the chief medical officer determines that an earlier review  
28 is warranted, a member shall not be required to complete the  
29 grievance process.  
30 (c) If the member is a minor, or is incompetent or  
31 incapacitated, the parent, guardian, conservator, relative, or other  
32 designee of the member, as appropriate, may submit the  
33 grievance to the chief medical officer as a designated agent of the  
34 member. Further, a provider may join with, or otherwise assist,  
35 an enrollee, or the agent, to submit the grievance to the chief  
36 medical officer. In addition, following submission of the  
37 grievance to the chief medical officer, the member, or the agent,  
38 may authorize the provider to assist, including advocating on  
39 behalf of the member. For purposes of this section, a “relative”  
40 includes the parent, stepparent, spouse, domestic partner, adult

1 son or daughter, grandparent, brother, sister, uncle, or aunt of the  
2 member.

3 (d) The chief medical officer shall review the written  
4 documents submitted with the member's request for review. The  
5 chief medical officer may ask for additional information, and  
6 may hold an informal meeting with the involved parties,  
7 including providers who have joined in submitting the grievance  
8 or who are otherwise assisting or advocating on behalf of the  
9 member. If after reviewing the record, the chief medical officer  
10 concludes that the grievance, in whole or in part, is eligible for  
11 review under the independent medical review system, the chief  
12 medical officer shall immediately notify the member of that  
13 option and shall, if requested orally or in writing, assist the  
14 member in participating in the independent medical review  
15 system.

16 (e) The chief medical officer shall send a written notice of the  
17 final disposition of the grievance, and the reasons therefore, to  
18 the member, to any provider that has joined with or is otherwise  
19 assisting the member, and to the commissioner, within 30  
20 calendar days of receipt of the request for review unless the chief  
21 medical officer, in his or her discretion, determines that  
22 additional time is reasonably necessary to fully and fairly  
23 evaluate the relevant grievance. In any case not eligible for  
24 independent medical review, the chief medical officer's written  
25 notice shall include, at a minimum, the following:

26 (1) A summary of findings and the reasons why the chief  
27 medical officer found the system to be, or not to be, in  
28 compliance with any applicable laws, regulations, or orders of  
29 the commissioner.

30 (2) A discussion of the chief medical officer's contact with  
31 any medical provider, or any other independent expert relied on  
32 by the ~~consumer~~ *patient* advocate, along with a summary of the  
33 views and qualifications of that provider or expert.

34 (3) If the member's grievance is sustained in whole or in part,  
35 information about any corrective action taken.

36 (f) The chief medical officer's order shall be binding on the  
37 system.

38 (g) The chief medical officer shall establish and maintain a  
39 system of aging of grievances that are pending and unresolved  
40 for 30 days or more that shall include a brief explanation of the

1 reasons each grievance is pending and unresolved for 30 days or  
2 more.

3 (h) The grievance or resolution procedures authorized by this  
4 section shall be in addition to any other procedures that may be  
5 available to any person, and failure to pursue, exhaust, or engage  
6 in the procedures described in this section shall not preclude the  
7 use of any other remedy provided by law.

8 (i) Nothing in this section shall be construed to allow the  
9 submission to the chief medical officer of any provider grievance  
10 under this section. However, as part of a provider's duty to  
11 advocate for medically appropriate health care for his or her  
12 patients pursuant to Sections 510 and 2056 of the Business and  
13 Professions Code, nothing in this subdivision shall be construed  
14 to prohibit a provider from contacting and informing the chief  
15 medical officer about any concerns he or she has regarding  
16 compliance with or enforcement of this act.

17 140612. (a) The chief medical officer shall establish an  
18 independent medical review system to act as an independent,  
19 external medical review process for the health care system to  
20 provide timely examinations of disputed health care services and  
21 coverage decisions regarding experimental and investigational  
22 therapies to ensure the system provides efficient, appropriate,  
23 high quality health care, and that the health care system is  
24 responsive to member disputes.

25 (b) For the purposes of this section, "disputed health care  
26 service" means any health care service eligible for coverage and  
27 payment under the benefits package of the health care system  
28 that has been denied, modified, or delayed by a decision of the  
29 system, or by one of its contracting providers, in whole or in part  
30 due to a finding that the service is not medically necessary. A  
31 decision regarding a disputed health care service relates to the  
32 practice of medicine and is not a coverage decision. If the  
33 system, or one of its contracting providers, issues a decision  
34 denying, modifying, or delaying health care services, based in  
35 whole or in part on a finding that the proposed health care  
36 services are not a covered benefit under the system, the statement  
37 of decision shall clearly specify the provisions of the system that  
38 exclude coverage.

39 (c) For the purposes of this section, "coverage decision"  
40 means the approval or denial of the health care system, or by one

1 of its contracting entities, substantially based on a finding that the  
2 provision of a particular service is included or excluded as a  
3 covered benefit under the terms and conditions of the health care  
4 system.

5 (d) Coverage decisions regarding experimental or  
6 investigational therapies for individual members who meet all of  
7 the following criteria are eligible for review by the independent  
8 medical review system:

9 (1) (A) The member has a life-threatening or seriously  
10 debilitating condition.

11 (B) For purposes of this section, “life-threatening” means  
12 either or both of the following:

13 (i) Diseases or conditions where the likelihood of death is high  
14 unless the course of the disease is interrupted.

15 (ii) Diseases or conditions with potentially fatal outcomes,  
16 where the end point of clinical intervention is survival.

17 (C) For purposes of this section, “seriously debilitating”  
18 means diseases or conditions that cause major irreversible  
19 morbidity.

20 (2) The member’s physician certifies that the member has a  
21 condition, as defined in paragraph (1), for which standard  
22 therapies have not been effective in improving the condition of  
23 the enrollee, for which standard therapies would not be medically  
24 appropriate for the member, or for which there is no more  
25 beneficial standard therapy covered by the system than the  
26 therapy proposed pursuant to paragraph (3).

27 (3) Either (A) the member’s physician, who is under contract  
28 with or employed by the system, has recommended a drug,  
29 device, procedure or other therapy that the physician certifies in  
30 writing is likely to be more beneficial to the member than any  
31 available standard therapies, or (B) the member, or the member’s  
32 physician who is a licensed, board-certified or board-eligible  
33 physician qualified to practice in the area of practice appropriate  
34 to treat the member’s condition, has requested a therapy that,  
35 based on two documents from the medical and scientific  
36 evidence, is likely to be more beneficial for the member than any  
37 available standard therapy. The physician certification pursuant  
38 to this section shall include a statement of the evidence relied  
39 upon by the physician in certifying his or her recommendation.  
40 Nothing in this subdivision shall be construed to require the

1 system to pay for the services of a nonparticipating physician  
2 provided pursuant to this act, that are not otherwise covered  
3 pursuant to system benefits package.

4 (4) The member has been denied coverage by the system for a  
5 drug, device, procedure, or other therapy recommended or  
6 requested pursuant to paragraph (3).

7 (5) The specific drug, device, procedure, or other therapy  
8 recommended pursuant to paragraph (3) would be a covered  
9 service, except for the system's determination that the therapy is  
10 experimental or investigational.

11 (e) (1) All member grievances involving a disputed health  
12 care service are eligible for review under the independent  
13 medical review system if the requirements of this section are met.  
14 If the chief medical officer finds that a patient grievance  
15 involving a disputed health care service does not meet the  
16 requirements of this section for review under the independent  
17 medical review system, the enrollee request for review shall be  
18 treated as a request for the chief medical officer to review the  
19 grievance. All other enrollee grievances, including grievances  
20 involving coverage decisions, remain eligible for review by the  
21 chief medical officer.

22 (2) In any case in which an enrollee or provider asserts that a  
23 decision to deny, modify, or delay health care services was  
24 based, in whole or in part, on consideration of medical  
25 appropriateness, the chief medical officer shall have the final  
26 authority to determine whether the grievance is more properly  
27 resolved pursuant to an independent medical review as provided  
28 under this act.

29 (3) The chief medical officer shall be the final arbiter when  
30 there is a question as to whether an enrollee grievance is a  
31 disputed health care service or a coverage decision. The chief  
32 medical officer shall establish a process to complete an initial  
33 screening of an enrollee grievance. If there appears to be any  
34 medical appropriateness issue, the grievance shall be resolved  
35 pursuant to an independent medical review.

36 (f) For purposes of this ~~article~~ *chapter*, an enrollee may  
37 designate an agent to act on his or her behalf. The provider may  
38 join with or otherwise assist the enrollee in seeking an  
39 independent medical review, and may advocate on behalf of the  
40 enrollee.

1 (g) The independent medical review process authorized by this  
2 section is in addition to any other procedures or remedies that  
3 may be available.

4 (h) The office of the chief medical officer shall prominently  
5 display in every relevant informational brochure, on copies of  
6 health care system procedures for resolving grievances, on letters  
7 of denials issued by either the health care system or its  
8 contracting providers, on the grievance forms, and on all written  
9 responses to grievances, information concerning the right of an  
10 enrollee to request an independent medical review in cases where  
11 the enrollee believes that health care services have been  
12 improperly denied, modified, or delayed by the health care  
13 system, or by one of its contracting providers.

14 (i) An enrollee may apply to the chief medical officer for an  
15 independent medical review when all of the following conditions  
16 are met:

17 (1) (A) The enrollee's health care provider has recommended  
18 a health care service as medically appropriate.

19 (B) The enrollee has received urgent care or emergency  
20 services that a provider determined was medically appropriate.

21 (C) The enrollee, in accordance with Section 1370.4 of the  
22 ~~Health and Safety Code~~, seeks coverage for experimental or  
23 investigational therapies.

24 (D) The enrollee, in the absence of a provider recommendation  
25 under subparagraph (A) or the receipt of urgent care or  
26 emergency services by a provider under subparagraph (B), has  
27 been seen by a system provider for the diagnosis or treatment of  
28 the medical condition for which the enrollee seeks independent  
29 review. The health care system shall expedite access to a system  
30 provider upon request of an enrollee. The system provider need  
31 not recommend the disputed health care service as a condition for  
32 the enrollee to be eligible for an independent review.

33 (2) The disputed health care service has been denied,  
34 modified, or delayed by the health care system, or by one of its  
35 contracting providers, based in whole or in part on a decision that  
36 the health care service is not medically appropriate.

37 (3) The enrollee has filed a grievance with the chief medical  
38 officer and the disputed decision is upheld or the grievance  
39 remains unresolved after 30 days. The enrollee shall not be  
40 required to participate in the health care system's grievance

1 process for more than 30 days. In the case of a grievance that  
2 requires expedited review, the enrollee shall not be required to  
3 participate in the health care system's grievance process for more  
4 than three days.

5 (j) An enrollee may apply to the chief medical officer for an  
6 independent medical review of a decision to deny, modify, or  
7 delay health care services, based in whole or in part on a finding  
8 that the disputed health care services are not medically  
9 appropriate, within six months of any of the qualifying periods or  
10 events. The chief medical officer may extend the application  
11 deadline beyond six months if the circumstances of a case  
12 warrant the extension.

13 (k) The enrollee shall pay no application or processing fees of  
14 any kind.

15 (l) Upon notice from the chief medical officer that the enrollee  
16 has applied for an independent medical review, the health care  
17 system or its contracting providers shall provide to the  
18 independent medical review organization designated by the chief  
19 medical officer a copy of all of the following documents within  
20 three business days of the health care system's receipt of the  
21 chief medical officer's notice of a request by an enrollee for an  
22 independent review:

23 (1) (A) A copy of all of the enrollee's medical records in the  
24 possession of the health care system or its contracting providers  
25 relevant to each of the following:

26 (i) The enrollee's medical condition.

27 (ii) The health care services being provided by the health care  
28 system and its contracting providers for the condition.

29 (iii) The disputed health care services requested by the  
30 enrollee for the condition.

31 (B) Any newly developed or discovered relevant medical  
32 records in the possession of the health care system or its  
33 contracting providers after the initial documents are provided to  
34 the independent medical review organization shall be forwarded  
35 immediately to the independent medical review organization.  
36 The system shall concurrently provide a copy of medical records  
37 required by this subparagraph to the enrollee or the enrollee's  
38 provider, if authorized by the enrollee, unless the offer of  
39 medical records is declined or otherwise prohibited by law. The

1 confidentiality of all medical record information shall be  
2 maintained pursuant to applicable state and federal laws.

3 (2) A copy of all information provided to the enrollee by the  
4 system and any of its contracting providers concerning health  
5 care system and provider decisions regarding the enrollee's  
6 condition and care, and a copy of any materials the enrollee or  
7 the enrollee's provider submitted to the health care system and to  
8 the health care system's contracting providers in support of the  
9 enrollee's request for disputed health care services. This  
10 documentation shall include the written response to the enrollee's  
11 grievance. The confidentiality of any enrollee medical  
12 information shall be maintained pursuant to applicable state and  
13 federal laws.

14 (3) A copy of any other relevant documents or information  
15 used by the health care system or its contracting providers in  
16 determining whether disputed health care services should have  
17 been provided, and any statements by the system and its  
18 contracting providers explaining the reasons for the decision to  
19 deny, modify, or delay disputed health care services on the basis  
20 of medical necessity. The system shall concurrently provide a  
21 copy of documents required by this paragraph, except for any  
22 information found by the chief medical officer to be legally  
23 privileged information, to the enrollee and the enrollee's  
24 provider.

25 The chief medical officer and the independent review  
26 organization shall maintain the confidentiality of any information  
27 found by the chief medical officer to be the proprietary  
28 information of the health care system.

29 140614. (a) If there is an imminent and serious threat to the  
30 health of the enrollee, all necessary information and documents  
31 shall be delivered to an independent medical review organization  
32 within 24 hours of approval of the request for review. In  
33 reviewing a request for review, the chief medical officer may  
34 waive the requirement that the enrollee follow the system's  
35 grievance process in extraordinary and compelling cases, where  
36 the chief medical officer finds that the enrollee has acted  
37 reasonably.

38 (b) The chief medical officer shall expeditiously review  
39 requests and immediately notify the enrollee in writing as to  
40 whether the request for an independent medical review has been

1 approved, in whole or in part, and, if not approved, the reasons  
2 therefore. The health care system shall promptly issue a  
3 notification to the enrollee, after submitting all of the required  
4 material to the independent medical review organization that  
5 includes an annotated list of documents submitted and offer the  
6 enrollee the opportunity to request copies of those documents  
7 from the health care system. The chief medical officer shall  
8 promptly approve enrollee requests whenever the health care  
9 system has agreed that the case is eligible for an independent  
10 medical review. To the extent an enrollee request for independent  
11 review is not approved by the chief medical officer, the enrollee  
12 request shall be treated as an immediate request for the chief  
13 medical officer to review the grievance.

14 (c) An independent medical review organization, specified in  
15 ~~Section 1374.32 of the Health and Safety Code~~, shall conduct the  
16 review in accordance with Section 1374.33 and any regulations  
17 or orders of the chief medical officer adopted pursuant thereto.  
18 The organization's review shall be limited to an examination of  
19 the medical necessity of the disputed health care services and  
20 shall not include any consideration of coverage decisions or other  
21 contractual issues.

22 (d) The chief medical officer shall contract with one or more  
23 independent medical review organizations in the state to conduct  
24 reviews for purposes of this section. The independent medical  
25 review organizations shall be independent of the health care  
26 system. The chief medical officer may establish additional  
27 requirements, including conflict-of-interest standards, consistent  
28 with the purposes of this section that an organization shall be  
29 required to meet in order to qualify for participation in the  
30 independent medical review system and to assist the chief  
31 medical officer in carrying out its responsibilities.

32 (e) The independent medical review organizations and the  
33 medical professionals retained to conduct reviews shall be  
34 deemed to be medical consultants for purposes of Section 43.98  
35 of the Civil Code.

36 (f) The independent medical review organization, any experts  
37 it designates to conduct a review, or any officer, chief medical  
38 officer, or employee of the independent medical review  
39 organization shall not have any material professional, familial, or

1 financial affiliation, as determined by the ~~consumer~~ *patient*  
2 advocate, with any of the following:

- 3 (1) The health care system.
- 4 (2) Any officer or employee of the health care system.
- 5 (3) A physician, the physician's medical group, or the  
6 independent practice association involved in the health care  
7 service in dispute.
- 8 (4) The facility or institution at which either the proposed  
9 health care service, or the alternative service, if any,  
10 recommended by the health care system, would be provided.
- 11 (5) The development or manufacture of the principal drug,  
12 device, procedure, or other therapy proposed by the patient  
13 whose treatment is under review, or the alternative therapy, if  
14 any, recommended by the health care system.
- 15 (6) The enrollee or the enrollee's immediate family.
- 16 (g) In order to contract with the chief medical officer for  
17 purposes of this section, an independent medical review  
18 organization shall meet all of the requirements pursuant to  
19 subdivision (d) of Section 1374.32 ~~of the Health and Safety~~  
20 ~~Code.~~

21 140616. (a) Upon receipt of information and documents  
22 related to a case, the medical professional reviewer or reviewers  
23 selected to conduct the review by the independent medical  
24 review organization shall promptly review all pertinent medical  
25 records of the enrollee, provider reports, as well as any other  
26 information submitted to the organization as authorized by the  
27 chief medical officer or requested from any of the parties to the  
28 dispute by the reviewers. If reviewers request information from  
29 any of the parties, a copy of the request and the response shall be  
30 provided to all of the parties. The reviewer or reviewers shall  
31 also review relevant information related to the criteria set forth in  
32 subdivision (b).

33 (b) Following its review, the reviewer or reviewers shall  
34 determine whether the disputed health care service was medically  
35 appropriate based on the specific medical needs of the patient  
36 and any of the following:

- 37 (1) Peer-reviewed scientific and medical evidence regarding  
38 the effectiveness of the disputed service.
- 39 (2) Nationally recognized professional standards.
- 40 (3) Expert opinion.

1 (4) Generally accepted standards of medical practice.

2 (5) Treatments likely to provide a benefit to an enrollee for  
3 conditions for which other treatments are not clinically  
4 efficacious.

5 (c) The organization shall complete its review and make its  
6 determination in writing, and in layperson's terms to the  
7 maximum extent practicable, within 30 days of the receipt of the  
8 application for review and supporting documentation, or within  
9 less time as prescribed by the chief medical officer. If the  
10 disputed health care service has not been provided and the  
11 enrollee's provider or the chief medical officer certifies in  
12 writing that an imminent and serious threat to the health of the  
13 enrollee may exist, including, but not limited to, serious pain, the  
14 potential loss of life, limb, or major bodily function, or the  
15 immediate and serious deterioration of the health of the enrollee,  
16 the analyses and determinations of the reviewers shall be  
17 expedited and rendered within three days of the receipt of the  
18 information. Subject to the approval of the chief medical officer,  
19 the deadlines for analyses and determinations involving both  
20 regular and expedited reviews may be extended by the chief  
21 medical officer for up to three days in extraordinary  
22 circumstances or for good cause.

23 (d) The medical professionals' analyses and determinations  
24 shall state whether the disputed health care service is medically  
25 appropriate. Each analysis shall cite the enrollee's medical  
26 condition, the relevant documents in the record, and the relevant  
27 findings associated with the provisions of subdivision (b) to  
28 support the determination. If more than one medical professional  
29 reviews the case, the recommendation of the majority shall  
30 prevail. If the medical professionals reviewing the case are  
31 evenly split as to whether the disputed health care service should  
32 be provided, the decision shall be in favor of providing the  
33 service.

34 (e) The independent medical review organization shall provide  
35 the chief medical officer, the health care system, the enrollee, and  
36 the enrollee's provider with the analyses and determinations of  
37 the medical professionals reviewing the case, and a description of  
38 the qualifications of the medical professionals. The independent  
39 medical review organization shall keep the names of the  
40 reviewers confidential in all communications with entities or

1 individuals outside the independent medical review organization,  
2 except in cases where the reviewer is called to testify and in  
3 response to court orders. If more than one medical professional  
4 reviewed the case and the result was differing determinations, the  
5 independent medical review organization shall provide each of  
6 the separate reviewer's analyses and determinations.

7 (f) The chief medical officer shall immediately adopt the  
8 determination of the independent medical review organization,  
9 and shall promptly issue a written decision to the parties that  
10 shall be binding on the health care system.

11 (g) After removing the names of the parties, including, but not  
12 limited to, the enrollee and all medical providers, the chief  
13 medical officer's decisions adopting a determination of an  
14 independent medical review organization shall be made available  
15 by the chief medical officer to the public upon request, at the  
16 chief medical officer's cost and after considering applicable laws  
17 governing disclosure of public records, confidentiality, and  
18 personal privacy.

19 140618. (a) Upon receiving the decision adopted by the chief  
20 medical officer that a disputed health care service is medically  
21 appropriate, the health care system shall promptly implement the  
22 decision. In the case of reimbursement for services already  
23 rendered, the health care provider or enrollee, whichever applies,  
24 shall be paid within five working days. In the case of services not  
25 yet rendered, the health care system shall authorize the services  
26 within five working days of receipt of the written decision from  
27 the chief medical officer, or sooner if appropriate for the nature  
28 of the enrollee's medical condition, and shall inform the enrollee  
29 and provider of the authorization.

30 (b) The health care system shall not engage in any conduct  
31 that has the effect of prolonging the independent review process.

32 (c) The chief medical officer shall require the health care  
33 system to promptly reimburse the enrollee for any reasonable  
34 costs associated with those services when the chief medical  
35 officer finds that the disputed health care services were a covered  
36 benefit and the services are found by the independent medical  
37 review organization to have been medically appropriate and the  
38 enrollee's decision to secure the services outside of the health  
39 care system provider network was reasonable under the  
40 emergency or urgent medical circumstances.

1 140619. (a) The chief medical officer shall utilize a  
 2 competitive bidding process and use any other information on  
 3 program costs reasonable to establish a per-case reimbursement  
 4 schedule to pay the costs of independent medical review  
 5 organization reviews, which may vary depending on the type of  
 6 medical condition under review and on other relevant factors.

7 (b) The costs of the independent medical review system for  
 8 enrollees shall be borne by the health care system.

9

10 CHAPTER 7. OTHER PROVISIONS

11

12 ~~140700. The operative date of this division, as identified in~~  
 13 ~~Section 140110, shall be the date the Secretary of Health and~~

14 *140700. Notwithstanding any other provisions of law, the*  
 15 *operative date of this division, other than Article 2 (commencing*  
 16 *with Section 140230) of Chapter 3, shall be the date the*  
 17 *Secretary of Health. Human Services notifies the Secretary of the*  
 18 *Senate and the Chief Clerk of the Assembly that he or she has*  
 19 *determined that the Health Insurance Fund will have sufficient*  
 20 *revenues to fund the costs of implementing this division.*

21 No state entity shall incur any transition or planning costs prior  
 22 ~~to the operative date of this division. to that date Article 2~~  
 23 ~~(commencing with Section 140230) of Chapter 3 of this division~~  
 24 ~~shall become operative on January 1, 2007.~~

25 SEC. 2. No reimbursement is required by this act pursuant to  
 26 Section 6 of Article XIII B of the California Constitution because  
 27 the only costs that may be incurred by a local agency or school  
 28 district will be incurred because this act creates a new crime or  
 29 infraction, eliminates a crime or infraction, or changes the  
 30 penalty for a crime or infraction, within the meaning of Section  
 31 17556 of the Government Code, or changes the definition of a  
 32 crime within the meaning of Section 6 of Article XIII B of the  
 33 California Constitution.