AMENDED IN ASSEMBLY MARCH 29, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 8

Introduced by Assembly Member Nunez

December 4, 2006

~~An act relating to health care coverage.~~ *An act to add Section 12803.2 to the Government Code, to add Article 3.11 (commencing with Section 1357.20) to Chapter 2.2 of Division 2 of the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, and 12693.755 of, to add Sections 12693.55 and 12711.1 to, to add Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to add Part 8.8 (commencing with Section 2200) to Division 2 of the Labor Code, to add Chapter 11 (commencing with Section 19900) to Part 10.2 of Division 2 of the Revenue and Taxation Code, to amend Section 131 of, and to add Section 976.7 to, the Unemployment Insurance Code, and to amend Sections 14005.23, 14005.30, and 14008.85 of, to add Sections 14005.33, 14005.34, and 14124.915 to, and to add Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 8, as amended, Nunez. ~~Health care coverage.~~ *Health care coverage: employers and employees.*

(1) Existing law creates the California Health and Human Services Agency.

This bill would require the agency to encourage fitness, wellness, and health promotion programs and to evaluate and monitor the state's progress on increasing the coverage of uninsured persons. The bill would also require the agency, in consultation with the Board of Administration of the Public Employees' Retirement System and health provider groups, to develop health care provider performance measurement benchmarks, as specified.

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

This bill would, as of January 1, 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a purchasing pool for health care coverage and be administered by the Managed Risk Medical Insurance Board. The bill would generally require employers to arrange for the provision of health care to employees and dependents that is equivalent to an unspecified percentage of the employer's total social security wages or, alternatively, to elect to have health care coverage provided through Cal-CHIPP upon payment of an employer fee of that equivalent amount. The bill would require employers to set up a pretax Section 125 account under federal law for each employee to pay health benefit costs. Revenues from the employer fees would be collected by the Employment Development Department for deposit in the California Health Trust Fund created by the bill, and moneys in the fund would be continuously appropriated to the board for the purposes of the bill. The bill would require the board to offer Cal-CHIPP enrollees a choice of various health plans. The bill would require individuals who are employed and who are offered health care by their employer to accept that arrangement and would require employers to enroll an employee in the

lowest cost plan offered by the employer if the employee does not select an option.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program. The bill would also expand the number of persons eligible for the Medi-Cal Program. The bill would delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child must meet citizen and immigration status requirements applicable to the program under federal law, thereby creating a state-only element of the programs. The bill would require the State Department of Health Care Services to seek any necessary federal waiver to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill would require the Healthy Families Program and the Medi-Cal program, as of July 1, 2008, and subject to available funding, to offer a premium assistance benefit and a wrap around benefit to certain persons who are eligible for either of the programs and who are offered employer-provided health coverage. The bill would enact other related provisions. Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

(3) The bill would enact various health insurance market reforms, to be operative July 1, 2008, including requirements for limited guaranteed issue, simplified benefit designs, and other related changes. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all health care service plans and health insurers and providers shall adopt standard electric medical records by January 1, 2012.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains

costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

~~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 Care 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 make legislative findings and declarations regarding health care coverage and would declare the intent of the Legislature that affordable, quality health care coverage be made available to all Californians.~~

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

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

SECTION 1. It is the intent of the Legislature to accomplish the goal of universal health care coverage for all California residents within five years. To accomplish this goal, the Legislature proposes to take all of the following steps:

(a) Ensure that Californians have access to affordable, comprehensive health care coverage, including all California children regardless of immigration status, with subsidies for Californians with low incomes.

(b) Leverage available federal funds to the greatest extent possible through existing federal programs such as Medicaid and the State Children's Health Insurance Program in support of health care coverage for low-income and disabled populations.

(c) Maintain and strengthen the employer-based health insurance system and improve availability and affordability of private health care coverage for all purchasers through (1) insurance market reforms; (2) enhanced access to effective primary and preventive services, including management of chronic illnesses; (3) promotion of cost-effective health technologies, and

(4) implementation of meaningful, systemwide cost containment strategies.

(d) Engage in early and systematic evaluation at each step of the implementation process to identify the impacts on state costs, the costs of coverage, employment and insurance markets, health delivery systems, quality of care, and overall progress in moving toward universal coverage.

SEC. 2. Section 12803.2 is added to the Government Code, to read:

12803.2. (a) The California Health and Human Services Agency shall encourage fitness, wellness, and health promotion programs that promote safe workplaces, healthy employer practices, and individual efforts to improve health.

(b) The California Health and Human Services Agency shall establish an aggressive and timely evaluation and oversight effort to carefully monitor progress on key benchmarks and indicators relative to extending health care coverage to uninsured individuals under the California Fair Share Health Care Act. Key indicators shall include, but need not be limited to, annual assessment of the impacts on coverage, the cost of coverage, state costs, employment and insurance markets, health care delivery systems, and quality of care. In 2013, the agency shall conduct a comprehensive evaluation to determine if the goals are being met and what adjustments or additional steps are necessary. The agency shall keep the Legislature informed on a regular basis of its efforts pursuant to this subdivision.

(c) The California Health and Human Services Agency, in consultation with the Board of Administration of the Public Employees' Retirement System, and after consultation with affected health care provider groups, shall develop health care provider performance measurement benchmarks and incorporate these benchmarks into a common pay for performance model to be offered in every state administered health care program, including, but not limited to, the Public Employees' Medical and Hospital Care Act, Healthy Families, the Managed Risk Medical Insurance Program, Medi-Cal, and Cal-CHIPP. These benchmarks shall be developed to advance a common statewide framework for health care quality measurement and reporting, including, but not limited to, measures that have been approved by the National Quality Forum (NQF) such as the Health Plan Employer Data and

Information Set (HEDIS) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and that have been adopted by the Hospitals Quality Alliance and other national and statewide groups concerned with quality.

SEC. 3. Article 3.11 (commencing with Section 1357.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.11. Insurance Market Reform

1357.20. The requirements of this article shall apply notwithstanding any other provision of law.

1357.21. Effective July 1, 2008, every full service health care service plan that offers and sells health plan contracts to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board in consultation with the Department of Insurance and the Department of Managed Health Care. A health care service plan subject to this section may not exclude a potential enrollee from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1 of the Insurance Code.

1357.22. (a) Every full service health care service plan shall offer and sell all of the uniform benefit plan designs made available through Cal-CHIPP pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code to purchasers in each region and in all individual and group markets where the plan offers, markets, and sells health care service plan contracts, consistent with statutory and regulatory rating and underwriting requirements applicable to the respective individual and group markets.

(b) This section shall not preclude a plan from offering other benefit plan designs in addition to those required to be offered under subdivision (a).

1357.23. It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health

care records. A patient's personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health care service plans and providers shall adopt standard electronic medical records by January 1, 2012.

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

CHAPTER 8.1. INSURANCE MARKET REFORM

10760. The requirements of this chapter shall apply notwithstanding any other provision of law.

10761. Effective July 1, 2008, every insurer that offers, markets, and sells health insurance to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board. A health insurer subject to this section may not exclude a potential insured from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1.

10762. (a) Every insurer that provides health insurance to residents of this state shall offer, market, and sell all of the uniform benefit plan designs made available through Cal-CHIPP pursuant to Part 6.45 (commencing with Section 12699.201) to purchasers in each region and all individual and group markets where the insurer offers, markets, and sells health insurance policies, consistent with statutory and regulatory rating and underwriting requirements applicable to the respective individual and group markets.

(b) This section shall not preclude an insurer from offering other benefit plan designs in addition to those required to be offered under subdivision (a).

10763. It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient's personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health insurers

and providers shall adopt standard electronic medical records by January 1, 2012.

SEC. 5. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost ~~Family Value Package~~ *family value package* in a given geographic area.

(b) In each geographic area, the board shall designate one or more ~~Family Value Packages~~ *family value packages* for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this ~~subparagraph~~ *paragraph* shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled

subscribers whose premium will increase on July 1, 2005, pursuant to this ~~subparagraph~~ *paragraph* and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-five dollars ($25) per child with a maximum required contribution of seventy-five dollars ($75) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost ~~Family Value Package~~ *family value package* may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost ~~Family Value Package~~ *family value package* shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to

July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this ~~subparagraph~~ *paragraph* shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this ~~subparagraph~~ *paragraph* and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-two dollars ($22) per child with a maximum required contribution of sixty-six dollars ($66) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for

immediate action and from review by the Office of Administrative Law. For ~~purpose~~ *purposes* of subdivision (e) of Section 11346.1 of the Government ~~code~~ *Code*, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative law, is hereby extended to 180 days.

SEC. 6. Section 12693.55 is added to the Insurance Code, to read:

12693.55. (a) The board shall establish a premium assistance benefit for all individuals eligible under the program with incomes at or below 300 percent of the federal poverty level that maximizes federal financial participation, as follows:

(1) An individual eligible for benefits under the program who is offered health coverage by his or her employer shall enroll in the employer-offered health coverage on his or her own behalf and on behalf of his or her dependents, if any.

(2) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall not be responsible for any premium, deductible, or copayment requirements that are greater than any premium, deductible, or copayment that the individual or dependent would be required to pay under the program, if any.

(3) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall be eligible for a wraparound benefit that covers any gap between the employer-offered health coverage and the benefits provided by the program.

(b) Notwithstanding subdivision (a), an employer of one or more employees who are required to enroll in employer-offered health coverage pursuant to this section may elect to pay the full premium cost of the program on behalf of all employees and their dependents who are eligible for the program. An employee whose employer elects to make this payment shall not be required to enroll in the employer-offered health coverage and shall instead enroll in the program.

(c) The premium assistance benefit under subdivision (a) shall only apply to individuals and their dependents if the board determines that it is cost effective for the state.

(d) Notwithstanding any other provision of law, this section may only be implemented on or after July 1, 2008, and only to the

extent funds are appropriated for the purposes of this section in another statute.

SEC. 7. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) ~~A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.~~ *[Reserved]*.

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). Commencing July 1, 2007, eligibility under this subparagraph shall not include infants during any time they are enrolled in employer-sponsored health insurance or are subject to an exclusion pursuant to Section 12693.71 or 12693.72, or are enrolled in the full scope of benefits under the

Medi-Cal program at no share of cost. For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program, except during any time on or after July 1, 2007, that the infant is enrolled in employer-sponsored health insurance or is subject to an exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. Except as otherwise specified in this section, this enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level but less than or equal to ~~250~~ *300* percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than ~~250~~ *300* percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to ~~250~~ *300* percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) The applicant shall agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the

applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

(f) By January 2008, the board, in consultation with stakeholders, shall implement processes by which applicants for subscribers may certify income at the time of annual eligibility review, including rules concerning which applicants shall be permitted to certify income and the circumstances in which supplemental information or documentation may be required. The board may terminate using these processes not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the termination and shall include all relevant data elements that are applicable to document the reasons for the termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the board shall promptly provide any additional clarifying information regarding implementation of the processes required by this subdivision.

(g) Notwithstanding any other provision of law, the changes to this section made by the act adding this subdivision in the 2007–08 Regular Session of the Legislature may only be implemented on or after July 1, 2008, and only to the extent funds are appropriated for those purposes in another statute.

SEC. 8. Section 12693.73 of the Insurance Code is amended to read:

12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program, except as specified in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 and Section 12693.76, *or except children who otherwise meet eligibility requirements for the program but for their immigration status*.

SEC. 9. Section 12693.755 of the Insurance Code is amended to read:

12693.755. (a) Subject to subdivision (b), ~~commencing four months after the initial federal approval is obtained pursuant to the waiver described in subdivision (b)~~ *but no later than July 1, 2008*, the board shall expand eligibility under this part to uninsured

parents of, and as defined by the board, adults responsible for, children enrolled to receive coverage under this part ~~or who are enrolled to receive the full scope of Medi-Cal services with no share of cost and~~ whose income does not exceed ~~250~~ *300* percent of the federal poverty level, before applying the income disregard provided for in subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70.

(b) (1) The board shall implement a program to provide coverage under this part to any uninsured parent or responsible adult who is eligible pursuant to subdivision (a), pursuant to the waiver *or approval* identified in paragraph (2).

(2) The program shall be implemented only in accordance with a State Child Health Insurance Program waiver *or other federal approval* pursuant to Section 1397gg(e)(2)(A) of Title 42 of the United States Code, *or pursuant to the Deficit Reduction Act of 2005, Section 6044 of Public Law 109-171*, to provide coverage to uninsured parents and responsible adults, and shall be subject to the terms, conditions, and duration of the waiver *or other federal approval*. The services shall be provided under the program only if the waiver *or other federal approval* is approved by the federal Centers for Medicare and Medicaid Services, and, except as provided under the terms and conditions of the waiver *or other federal approval*, only to the extent that federal financial participation is available and funds are appropriated specifically for this purpose.

SEC. 10. Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM

12699.201. For the purposes of this part, the following terms have the following meanings:

(a) "Benefit plan design" means a specific health coverage product offered for sale and includes services covered and the levels of copayments, deductibles, and annual out-of-pocket expenses, and may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services that

has significant incentives for the covered individuals to use the system.

(b) "Board" means the Managed Risk Medical Insurance Board.

(c) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" means the purchasing pool established pursuant to this part and administered by the board. The purchasing pool shall be available to employers who elect to pay into the California Health Trust Fund for coverage of their employees and dependents pursuant to Section 2200 of the Labor Code.

(d) "Participating health plan" means a health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code that contracts with the board to provide coverage in Cal-CHIPP and, pursuant to its contract with the board, provides, arranges, pays for, or reimburses the costs of health services for Cal-CHIPP enrollees.

12699.202. The board shall be responsible for establishing Cal-CHIPP and administering this part.

12699.203. (a) The board shall develop standards for high quality coverage for Cal-CHIPP and negotiate favorable rates and contract with health plans by leveraging its purchasing power. Cal-CHIPP enrollees shall be offered a choice of health plans that provide comprehensive health care coverage, including medical, hospital, and prescription drug benefits. The board may establish health plan premiums and administer subsidies to eligible enrollees with incomes at or below 300 percent of the federal poverty level.

(b) The board shall develop and offer at least three uniform benefit plan designs to Cal-CHIPP enrollees. The three benefit plan designs shall include varying benefit levels, deductibles, coinsurance factors, or copayments, and annual limits on out-of-pocket expenses. In developing the benefit plan designs, the board shall do all of the following:

(1) Take into consideration the levels of health care coverage provided in the state and medical economic factors as may be deemed appropriate. The board shall include coverage and design elements that are reflective of and commensurate with health insurance coverage provided through a representative number of large insured employers in the state.

(2) Include in all benefit plan designs coverage for primary and preventive care services and prescription drugs, combined with enrollee cost-sharing levels that promote prevention and health maintenance, including appropriate cost sharing for maintenance medications to manage chronic diseases, such as asthma, diabetes, and heart disease.

(3) Consult with the Insurance Commissioner, the Director of the Department of Managed Health Care, and the Director of Health Care Services.

(c) The board shall directly mail to each Cal-CHIPP enrollee an information packet containing information about the available health plan choices.

12699.205. The board shall assume lead agency responsibility for professional review and development of best practice standards in the care and treatment of patients with high-cost chronic diseases, such as asthma, diabetes, and heart disease. Upon adoption of the standards, each state health care program, including, but not limited to, programs offered by under the Public Employees' Medical and Hospital Care Act, Medi-Cal, Healthy Families, the Managed Risk Medical Insurance Program, and Cal-CHIPP, shall implement those standards.

12699.206. The California Health Trust Fund is hereby created in the State Treasury. The moneys in the fund shall be continuously appropriated to the board for the purposes of providing health care coverage pursuant to this part.

12699.207. The board, subject to federal approval pursuant to Section 14199.10 of the Welfare and Institutions Code, shall pay the nonfederal share of cost from the California Health Trust Fund for employees and dependents eligible under that federal approval.

SEC. 11. Section 12711.1 is added to the Insurance Code, to read:

12711.1. (a) The board shall establish a list of serious health conditions or diagnoses making an applicant automatically eligible for the program. In developing the list of conditions, the board shall consult with the Director of the Department of Managed Health Care and the commissioner to identify common health plan and insurer underwriting criteria.

(b) The board shall develop a standardized health questionnaire to be used by all health plans and insurers that offer and sell

individual coverage. The questionnaire shall be designed to collect only that information necessary to identify if a person is eligible for coverage in the program pursuant to subdivision (a). Consistent with Section 1357.22 of the Health and Safety Code and Section 10762, health plans and insurers shall not deny coverage for any individual except for those who qualify for automatic eligibility for the program as determined by the board pursuant to this section.

SEC. 12. Part 8.8 (commencing with Section 2200) is added to Division 2 of the Labor Code, to read:

PART 8.8. EMPLOYER ELECTION

2200. Each employer shall elect to either arrange for the provision of health care for its employees, and if applicable, dependents, that is equivalent to at least ____ percent of total social security wages paid by the employer or to pay an equivalent amount to the California Health Trust Fund, created pursuant to Section 12699.207 of the Insurance Code, as required by Section 976.7 of the Unemployment Insurance Code. The amount paid to the California Health Trust Fund by an employer shall be used to enroll the employer's employees and their dependents in the Cal-CHIPP purchasing pool pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

2203. An employee working for an employer that elects to arrange for the provision of health care pursuant to Section 2200 shall be required to accept that arrangement, and an employee who does not select a health care option offered by the employer shall be automatically enrolled in the lowest-cost plan offered by the employer. However, an employee is exempt from this requirement if the employee is able to demonstrate that the employee is covered by other health care coverage, such as coverage made available by an employer to the employee's spouse that also covers the employee. In addition, an employee whose out-of-pocket costs for the employer-offered health care exceed ____ percent of the employee's family income may apply to the Managed Risk Medical Insurance Board to be relieved of this requirement. The board may relieve an employee of this requirement for up to one year if the employee demonstrates to

the satisfaction of the board that the total premium and out-of-pocket costs pose an undue financial hardship.

SEC. 13. Chapter 11 (commencing with Section 19900) is added to Part 10.2 of Division 2 of the Revenue and Taxation Code, to read:

CHAPTER 11. HEALTH CARE CAFETERIA PLAN

19900. This chapter shall be known and may be cited as the Health Care Cafeteria Plan.

19901. Unless federal law or the law of this state provides otherwise, each employer in this state during a taxable year shall adopt and maintain a cafeteria plan, within the meaning of Section 125 of the Internal Revenue Code, to allow employees to pay for health benefits, including premiums, to the extent amounts for such benefits are excludable from the gross income of the employee under Section 106 of the Internal Revenue Code.

SEC. 14. Section 131 of the Unemployment Insurance Code is amended to read:

131. "Contributions" means the money payments to the Unemployment Fund, Employment Training Fund, *California Health Trust Fund,* or Unemployment Compensation Disability Fund ~~which~~ *that* are required by this division.

SEC. 15. Section 976.7 is added to the Unemployment Insurance Code, to read:

976.7. In addition to other contributions required by this division and consistent with the requirements of Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code, an employer shall pay to the department for deposit into the California Health Trust Fund the amount required by Section 2200 of the Labor Code. These contributions shall be collected in the same manner and at the same time as any contributions required under Sections 976 and 1088.

SEC. 16. Section 14005.23 of the Welfare and Institutions Code is amended to read:

14005.23. *(a)* To the extent federal financial participation is available, the department shall, when determining eligibility for children under Section 1396a(*l*)(1)(D) of Title 42 of the United States Code, designate a birth date by which all children who have

not attained the age of 19 years will meet the age requirement of Section 1396a(*l*)(1)(D) of Title 42 of the United States Code.

(b) Commencing July 1, 2008, to the extent federal financial participation is available, the department shall apply a less restrictive income deduction described in Section 1396a(r) of Title 42 of the United States Code when determining eligibility for the children identified in subdivision (a). The amount of this deduction shall be the difference between 133 percent and 100 percent of the federal poverty level applicable to the size of the family.

SEC. 17. Section 14005.30 of the Welfare and Institutions Code is amended to read:

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

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

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

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to ~~expand~~ *simplify* eligibility for Medi-Cal under subdivision (a) by ~~establishing the amount of countable resources individuals or families are allowed to retain at the same amount medically needy individuals and families are allowed to retain, except that a family~~

~~of one shall be allowed to retain countable resources in the amount of three thousand dollars ($3,000)~~ *exempting all resources for applicants and recipients*.

(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

(d) Commencing July 1, 2008, the department shall adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1(b)) and the amount equal to 133 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more generous than, and is substituted for, the earned income disregard available to recipients. Implementation of this subdivision is contingent upon federal financial participation. Upon implementation of this subdivision, the income disregard described in subdivision (c) shall no longer apply.

~~(d)~~

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

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

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

SEC. 18. Section 14005.33 is added to the Welfare and Institutions Code, to read:

14005.33. (a) (1) Notwithstanding Section 14005.30, to the extent that federal financial participation is available, Medi-Cal benefits under a benchmark plan as permitted under Section 6044 of the federal Deficit Reduction Act of 2005 (42 U.S.C. Sec. 1396u-7) shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) of Title 42 of the United State Code made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt an income disregard in an amount that is the difference between the Medi-Cal income eligibility established under subdivision (d) of Section 14005.30 and 300 percent of the federal poverty level applicable to the size of the family.

(b) The benchmark benefit plan referenced in subdivision (a) shall be equivalent to the coverage established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(c) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to simplify eligibility for Medi-Cal under subdivision (a) by exempting all resources for applicants and recipients.

SEC. 19. Section 14005.34 is added to the Welfare and Institutions Code, to read:

14005.34. Notwithstanding any other provision of law, all children under 19 years of age who meet the state residency requirements of the Medi-Cal program shall be eligible for full scope benefits under this chapter if they either (a) live in families with countable household income at or below 133 percent of the federal poverty level, or (b) meet the income and resource requirements of Section 14005.7 or 14005.30, including those children for whom federal financial participation is not available under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

SEC. 20. Section 14008.85 of the Welfare and Institutions Code is amended to read:

14008.85. (a) To the extent federal financial participation is available, a parent who is the principal wage earner shall be considered an unemployed parent for purposes of establishing eligibility based upon deprivation of a child where any of the following applies:

(1) The parent works less than 100 hours per month as determined pursuant to the rules of the Aid to Families with Dependent Children program as it existed on July 16, 1996, including the rule allowing a temporary excess of hours due to intermittent work.

(2) The total net nonexempt earned income for the family is not more than 100 percent of the federal poverty level as most recently calculated by the federal government. The department may adopt additional deductions to be taken from a family's income.

(3) The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under the program established by Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).

(4) The parent is eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available and exercised by the state.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. Thereafter, the department shall adopt regulations in accordance

with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

~~(c) This section shall become operative March 1, 2000.~~

SEC. 21. Section 14124.915 is added to the Welfare and Institutions Code, to read:

14124.915. (a) A premium assistance benefit shall be established that maximizes federal financial participation as follows:

(1) An individual eligible for benefits under this program who is offered health coverage by his or her employer shall enroll in the employer-offered health coverage on his or her own behalf and on behalf of his or her dependents, if any.

(2) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall not be responsible for any premium, deductible, or copayment requirements that are greater than any premium, deductible, or copayment that the individual or dependent would be required to pay under this program, if any.

(3) Individuals and dependents enrolling in employer-offered health coverage pursuant to this section shall be eligible for a wraparound benefit that covers any gap between the employer-offered health coverage and the benefits provided by the program.

(b) Notwithstanding subdivision (a), an employer of an individual who is required to enroll in employer-offered health coverage pursuant to this section may elect to pay the full premium cost of this program on behalf of the employee and his or her dependents who are eligible for the program. An individual whose employer elects to make this payment shall not be required to enroll in the employer-offered health coverage, and shall instead enroll in this program.

(c) The premium assistance benefit under subdivision (a) shall only apply to individuals and their dependents when the State Department of Health Care Services determines that it is cost effective for the state.

SEC. 22. Article 7 (commencing with Section 14199.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 7. Coordination with the California Health Trust Fund

14199.10. The department shall seek any necessary federal waiver to enable the state to receive federal funds for coverage provided through the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) to persons who would be eligible for Medi-Cal if the state adopted an additional income disregard as allowed by Section 1931(b) of the Social Security Act (42 U.S.C. Sec. 1396u-1(b)) sufficient to make persons with income up to 300 percent of the federal poverty level eligible for coverage under that section. Revenues in the California Health Trust Fund created pursuant to Section 12699.206 of the Insurance Code shall be used as state matching funds for receipt of federal funds resulting from the implementation of this section. All federal funds received pursuant to that waiver shall be deposited in the California Health Trust Fund.

SEC. 23. (a) Sections 3, 4, 11, and 21 of this act shall become operative on July 1, 2008.

(b) Sections 10, 12, and 15 of this act shall become operative on January 1, 2009.

SEC. 24. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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

~~(a) With over 6.5 million residents without health care coverage, California has the largest population of individuals without health care coverage in the United States.~~

~~(b) All Californians should have access to health care coverage.~~

~~(c) Addressing this challenge is central to the health and well-being of all Californians as well as the state's economic growth and competitiveness.~~

~~(d) The rate of growth in health care costs is unsustainable and is a key cause of the rising number of individuals without health care coverage.~~

~~(e) Therefore, it is the intent of the Legislature that affordable, quality health care coverage be made available to all Californians.~~

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