AMENDED IN SENATE JULY 3, 2007

AMENDED IN ASSEMBLY MAY 17, 2007

AMENDED IN ASSEMBLY MAY 1, 2007

AMENDED IN ASSEMBLY APRIL 18, 2007

AMENDED IN ASSEMBLY MARCH 29, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 8

Introduced by Assembly Member Nunez
(Principal coauthor: Senator Perata)
(Coauthors: Assembly Members Bass, Berg, De Leon, DeSaulnier, Dymally, *Eng,* Hayashi, Hernandez, and Jones)
(Coauthor: Senator Alquist)

December 4, 2006

An act to amend ~~Section 6254~~ *Sections 6254 and 11126* of, and to add Section 12803.2 to, the Government Code, to amend Sections 1363 and 1378 of, and to add Article 3.11 (commencing with Section 1357.20) *and Article 4.1 (commencing with Section 1366.10)* to Chapter 2.2 of Division 2 of, the Health and Safety Code, to amend Sections 10607, 12693.43, 12693.70, 12693.73, ~~and 12693.755~~ *12693.755, and 12693.76* of, to add Sections 10293.5, *12693.55, 12693.58, 12693.621,* and 12711.1 to, to add *Chapter 1.6 (commencing with Section 10199.10) and* Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to 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~~ *Division 1.2 (commencing with Section 4800)* to, the Unemployment Insurance Code, and to amend Sections 14005.23, 14005.30, *14005.31, 14005.32,* and 14008.85 of, to add Sections 14005.33 ~~and 14005.34~~ *, 14005.34, and 14131.01* to, and to add Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 8, as amended, Nunez. Health care 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~~ *partner and contract with nonprofit organizations, academic institutions, or governmental entities to establish a program to track and assess the health care reforms implemented by the bill's provisions. The bill would create an advisory body, chaired by the secretary of the agency, to guide the assessment and would require annual reports to the Legislature relating to the assessment.* The bill would also require the agency, in consultation with the Board of Administration of the Public Employees' Retirement System *(PERS) to assume lead agency responsibility for professional review and development of best practice standards for high-cost chronic diseases that state health care programs would be required to implement upon their adoption. The bill would additionally require the agency, in consultation with PERS* and health provider groups, to develop health care provider performance measurement benchmarks, as specified.

(2) Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the

Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services *and county welfare departments*. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would, as of January 1, ~~2009~~ *2010*, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a *statewide* purchasing pool for health care coverage by employers and be administered by the Managed Risk Medical Insurance Board. The bill, *as of January 1, 2010,* would generally require employers to make health care expenditures, as specified, in an amount that is equivalent, at a minimum, to 7.5%, *subject to adjustment by the board,* of the employer's total social security wages for ~~either~~ *its* full-time or part-time employees, or both, or, alternatively, to elect to pay an employer fee of that minimum amount for the applicable group of employees, who would be required to enroll in Cal-CHIPP~~, subject to certain exceptions~~. *The bill would require an employer electing to pay the fee to notify the Employment Development Department and comply with other specified requirements and would authorize the department to assess a penalty against an employer who failed to comply with certain reporting requirements or to remit fees within the requisite time period. The bill would require the department to deposit the penalty revenue into a penalty account within the California Health Trust Fund and would specify that the account is not continuously appropriated.* The bill would require employers to set up a pretax Section 125 account under federal law for each employee to pay health insurance premiums. Revenues from the employer fees 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 exempt certain writings of the board from disclosure under the Public Records Act *and would specify that the board may meet in closed session to develop rates and contracting strategy pursuant to Cal-CHIPP*.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program. The bill would also expand the number of persons eligible for the Medi-Cal program. The bill would delete as an eligibility requirement for a child under the Healthy Families Program and the

Medi-Cal program that the child must meet citizen and immigration status requirements applicable to the program under federal law, thereby creating a state-only element of the programs. *The bill would additionally, on and after July 1, 2008, disregard all income over 250% but less than or equal to 300% of the federal poverty level and would apply Medi-Cal program income deductions to a family income greater than 300% of the federal poverty level in determining eligibility for the Healthy Families Program.* The bill would require the State Department of Health Care Services to seek any necessary federal approval to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill would enact other related provisions. Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program. *The bill would provide that the board may implement the provisions of the bill expanding the Healthy Families Program only to the extent that funds are appropriated for these purposes in the annual Budget Act or in another statute.*

(3) The bill would enact various health insurance market reforms, to be operative ~~July 1, 2008~~ *on specified dates*, including requirements for ~~limited guaranteed~~ *guarantee* issue *of individual health care service plan contracts and health insurance policies*, simplified benefit designs, modified small employer coverage, modified disclosures, and other related changes. The bill would require health care service plans and health insurers offering group plans to offer ~~a~~ benchmark ~~plan~~ *plans* or ~~policy~~ *policies* at a rate negotiated with and approved by the Managed Risk Medical Insurance Board that is available to group members and dependents eligible for coverage through the Medi-Cal or Healthy Families Programs~~, or to otherwise arrange for coverage through Cal-CHIPP~~. The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to adopt regulations by July 1, 2008, to require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care services and not on administrative costs. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all health care service plans and

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

(4) Existing law, the California Major Risk Medical Insurance Program, administered by the Managed Risk Medical Insurance Board, provides major risk medical coverage for state residents meeting specified eligibility requirements.

This bill would require the board to establish a list of conditions or diagnoses making an applicant automatically eligible for the program and to develop a standardized questionnaire for carriers in the individual market to identify persons eligible for the program. The bill would prohibit a health insurer and a health care service plan from denying coverage to an individual, except for those who are automatically eligible for the program. Because the bill would specify an additional requirement for a health care service plan, the willful violation of which would be a crime, it would impose a state-mandated local program.

~~(4)~~

(5) 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.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. This act shall be known and may be cited as the California Health Care Reform and Cost Control Act.

~~SECTION 1.~~

SEC. 2. It is the intent of the Legislature to accomplish the goal of universal health care coverage for all California residents within five years. To accomplish this goal, the Legislature proposes to take all of the following steps:

(a) Ensure that Californians have access to affordable, comprehensive health care coverage, including all California

children regardless of immigration status, with subsidies for Californians with low incomes.

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

(c) Maintain and strengthen the health insurance system and improve availability and affordability of private health care coverage for all purchasers through (1) insurance market reforms; (2) enhanced access to effective primary and preventive services, including management of chronic illnesses; (3) promotion of cost-effective health technologies~~,~~*;* and (4) implementation of meaningful, systemwide cost containment strategies.

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

~~SEC. 2.~~

SEC. 3. Section 6254 of the Government Code is amended to read:

6254. Except as provided in Sections 6254.7 and 6254.13, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary course of business, if the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to any of the following:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes. However, state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (b) of Section 13951, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflects the analysis or conclusions of the investigating officer.

Customer lists provided to a state or local police agency by an alarm or security company at the request of the agency shall be construed to be records subject to this subdivision.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a

crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code. However, the address of the victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph may not be used directly or indirectly, or furnished to another, to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury. Nothing in this paragraph shall be construed to prohibit or limit a scholarly, journalistic, political, or government use of address information obtained pursuant to this paragraph.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records, the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(*l*) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's Legal Affairs Secretary. However, public records shall not be transferred to the custody of the Governor's Legal Affairs Secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public database maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application that are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, that reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of

Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. If a contract for inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's Office. The committee and that office shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places and records of Native American places, features, and objects described in Sections 5097.9 and 5097.993 of the Public Resources Code maintained by, or in the possession of, the Native American Heritage Commission, another state agency, or a local agency.

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

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article

8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) (1) Information contained in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant's medical or psychological history or that of members of his or her family.

(2) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(3) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(v) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695) and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

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

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

open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor’s net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1998, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

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

(commencing with Section 12699.50) of Division 2 of the Insurance Code.

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

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

(bb) Critical infrastructure information, as defined in Section 131(3) of Title 6 of the United States Code, that is voluntarily submitted to the California Office of Homeland Security for use by that office, including the identity of the person who or entity that voluntarily submitted the information. As used in this subdivision, "voluntarily submitted" means submitted in the absence of the office exercising any legal authority to compel access to or submission of critical infrastructure information. This subdivision shall not affect the status of information in the possession of any other state or local governmental agency.

(cc) All information provided to the Secretary of State by a person for the purpose of registration in the Advance Health Care Directive Registry, except that those records shall be released at the request of a health care provider, a public guardian, or the registrant's legal representative.

(dd) (1) Records of the Managed Risk Medical Insurance Board relating to activities governed by Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code on or after January 1, 2008, shall be open to inspection one year after they have been fully executed.

(B) If a contract entered into pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code is

amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's Office. The committee and the office shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

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

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act (29 U.S.C. Sec. 158).

SEC. 4. Section 11126 of the Government Code is amended to read:

11126. (a) (1) Nothing in this article shall be construed to prevent a state body from holding closed sessions during a regular or special meeting to consider the appointment, employment, evaluation of performance, or dismissal of a public employee or to hear complaints or charges brought against that employee by another person or employee unless the employee requests a public hearing.

(2) As a condition to holding a closed session on the complaints or charges to consider disciplinary action or to consider dismissal, the employee shall be given written notice of his or her right to have a public hearing, rather than a closed session, and that notice shall be delivered to the employee personally or by mail at least 24 hours before the time for holding a regular or special meeting. If notice is not given, any disciplinary or other action taken against any employee at the closed session shall be null and void.

(3) The state body also may exclude from any public or closed session, during the examination of a witness, any or all other witnesses in the matter being investigated by the state body.

(4) Following the public hearing or closed session, the body may deliberate on the decision to be reached in a closed session.

(b) For the purposes of this section, "employee" does not include any person who is elected to, or appointed to a public office by, any state body. However, officers of the California State University who receive compensation for their services, other than per diem and ordinary and necessary expenses, shall, when engaged in that capacity, be considered employees. Furthermore, for purposes of this section, the term employee includes a person exempt from civil service pursuant to subdivision (e) of Section 4 of Article VII of the California Constitution.

(c) Nothing in this article shall be construed to do any of the following:

(1) Prevent state bodies that administer the licensing of persons engaging in businesses or professions from holding closed sessions to prepare, approve, grade, or administer examinations.

(2) Prevent an advisory body of a state body that administers the licensing of persons engaged in businesses or professions from conducting a closed session to discuss matters that the advisory body has found would constitute an unwarranted invasion of the privacy of an individual licensee or applicant if discussed in an open meeting, provided the advisory body does not include a quorum of the members of the state body it advises. Those matters may include review of an applicant's qualifications for licensure and an inquiry specifically related to the state body's enforcement program concerning an individual licensee or applicant where the inquiry occurs prior to the filing of a civil, criminal, or administrative disciplinary action against the licensee or applicant by the state body.

(3) Prohibit a state body from holding a closed session to deliberate on a decision to be reached in a proceeding required to be conducted pursuant to Chapter 5 (commencing with Section 11500) or similar provisions of law.

(4) Grant a right to enter any correctional institution or the grounds of a correctional institution where that right is not otherwise granted by law, nor shall anything in this article be construed to prevent a state body from holding a closed session when considering and acting upon the determination of a term, parole, or release of any individual or other disposition of an

individual case, or if public disclosure of the subjects under discussion or consideration is expressly prohibited by statute.

(5) Prevent any closed session to consider the conferring of honorary degrees, or gifts, donations, and bequests that the donor or proposed donor has requested in writing to be kept confidential.

(6) Prevent the Alcoholic Beverage Control Appeals Board from holding a closed session for the purpose of holding a deliberative conference as provided in Section 11125.

(7) (A) Prevent a state body from holding closed sessions with its negotiator prior to the purchase, sale, exchange, or lease of real property by or for the state body to give instructions to its negotiator regarding the price and terms of payment for the purchase, sale, exchange, or lease.

(B) However, prior to the closed session, the state body shall hold an open and public session in which it identifies the real property or real properties that the negotiations may concern and the person or persons with whom its negotiator may negotiate.

(C) For purposes of this paragraph, the negotiator may be a member of the state body.

(D) For purposes of this paragraph, "lease" includes renewal or renegotiation of a lease.

(E) Nothing in this paragraph shall preclude a state body from holding a closed session for discussions regarding eminent domain proceedings pursuant to subdivision (e).

(8) Prevent the California Postsecondary Education Commission from holding closed sessions to consider matters pertaining to the appointment or termination of the Director of the California Postsecondary Education Commission.

(9) Prevent the Council for Private Postsecondary and Vocational Education from holding closed sessions to consider matters pertaining to the appointment or termination of the Executive Director of the Council for Private Postsecondary and Vocational Education.

(10) Prevent the Franchise Tax Board from holding closed sessions for the purpose of discussion of confidential tax returns or information the public disclosure of which is prohibited by law, or from considering matters pertaining to the appointment or removal of the Executive Officer of the Franchise Tax Board.

(11) Require the Franchise Tax Board to notice or disclose any confidential tax information considered in closed sessions, or

documents executed in connection therewith, the public disclosure of which is prohibited pursuant to Article 2 (commencing with Section 19542) of Chapter 7 of Part 10.2 of the Revenue and Taxation Code.

(12) Prevent the Board of Corrections from holding closed sessions when considering reports of crime conditions under Section 6027 of the Penal Code.

(13) Prevent the State Air Resources Board from holding closed sessions when considering the proprietary specifications and performance data of manufacturers.

(14) Prevent the State Board of Education or the Superintendent of Public Instruction, or any committee advising the board or the superintendent, from holding closed sessions on those portions of its review of assessment instruments pursuant to Chapter 5 (commencing with Section 60600) of, or pursuant to Chapter 8 (commencing with Section 60850) of, Part 33 of the Education Code during which actual test content is reviewed and discussed. The purpose of this provision is to maintain the confidentiality of the assessments under review.

(15) Prevent the California Integrated Waste Management Board or its auxiliary committees from holding closed sessions for the purpose of discussing confidential tax returns, discussing trade secrets or confidential or proprietary information in its possession, or discussing other data, the public disclosure of which is prohibited by law.

(16) Prevent a state body that invests retirement, pension, or endowment funds from holding closed sessions when considering investment decisions. For purposes of consideration of shareholder voting on corporate stocks held by the state body, closed sessions for the purposes of voting may be held only with respect to election of corporate directors, election of independent auditors, and other financial issues that could have a material effect on the net income of the corporation. For the purpose of real property investment decisions that may be considered in a closed session pursuant to this paragraph, a state body shall also be exempt from the provisions of paragraph (7) relating to the identification of real properties prior to the closed session.

(17) Prevent a state body, or boards, commissions, administrative officers, or other representatives that may properly be designated by law or by a state body, from holding closed

sessions with its representatives in discharging its responsibilities under Chapter 10 (commencing with Section 3500), Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), or Chapter 10.7 (commencing of Section 3540) of Division 4 of Title 1 as the sessions relate to salaries, salary schedules, or compensation paid in the form of fringe benefits. For the purposes enumerated in the preceding sentence, a state body may also meet with a state conciliator who has intervened in the proceedings.

(18) (A) Prevent a state body from holding closed sessions to consider matters posing a threat or potential threat of criminal or terrorist activity against the personnel, property, buildings, facilities, or equipment, including electronic data, owned, leased, or controlled by the state body, where disclosure of these considerations could compromise or impede the safety or security of the personnel, property, buildings, facilities, or equipment, including electronic data, owned, leased, or controlled by the state body.

(B) Notwithstanding any other provision of law, a state body, at any regular or special meeting, may meet in a closed session pursuant to subparagraph (A) upon a two-thirds vote of the members present at the meeting.

(C) After meeting in closed session pursuant to subparagraph (A), the state body shall reconvene in open session prior to adjournment and report that a closed session was held pursuant to subparagraph (A), the general nature of the matters considered, and whether any action was taken in closed session.

(D) After meeting in closed session pursuant to subparagraph (A), the state body shall submit to the Legislative Analyst written notification stating that it held this closed session, the general reason or reasons for the closed session, the general nature of the matters considered, and whether any action was taken in closed session. The Legislative Analyst shall retain for no less than four years any written notification received from a state body pursuant to this subparagraph.

(d) (1) Notwithstanding any other provision of law, any meeting of the Public Utilities Commission at which the rates of entities under the commission's jurisdiction are changed shall be open and public.

(2) Nothing in this article shall be construed to prevent the Public Utilities Commission from holding closed sessions to deliberate on the institution of proceedings, or disciplinary actions against any person or entity under the jurisdiction of the commission.

(e) (1) Nothing in this article shall be construed to prevent a state body, based on the advice of its legal counsel, from holding a closed session to confer with, or receive advice from, its legal counsel regarding pending litigation when discussion in open session concerning those matters would prejudice the position of the state body in the litigation.

(2) For purposes of this article, all expressions of the lawyer-client privilege other than those provided in this subdivision are hereby abrogated. This subdivision is the exclusive expression of the lawyer-client privilege for purposes of conducting closed session meetings pursuant to this article. For purposes of this subdivision, litigation shall be considered pending when any of the following circumstances exist:

(A) An adjudicatory proceeding before a court, an administrative body exercising its adjudicatory authority, a hearing officer, or an arbitrator, to which the state body is a party, has been initiated formally.

(B) (i) A point has been reached where, in the opinion of the state body on the advice of its legal counsel, based on existing facts and circumstances, there is a significant exposure to litigation against the state body.

(ii) Based on existing facts and circumstances, the state body is meeting only to decide whether a closed session is authorized pursuant to clause (i).

(C) (i) Based on existing facts and circumstances, the state body has decided to initiate or is deciding whether to initiate litigation.

(ii) The legal counsel of the state body shall prepare and submit to it a memorandum stating the specific reasons and legal authority for the closed session. If the closed session is pursuant to paragraph (1), the memorandum shall include the title of the litigation. If the closed session is pursuant to subparagraph (A) or (B), the memorandum shall include the existing facts and circumstances on which it is based. The legal counsel shall submit the memorandum to the state body prior to the closed session, if

feasible, and in any case no later than one week after the closed session. The memorandum shall be exempt from disclosure pursuant to Section 6254.25.

(iii) For purposes of this subdivision, "litigation" includes any adjudicatory proceeding, including eminent domain, before a court, administrative body exercising its adjudicatory authority, hearing officer, or arbitrator.

(iv) Disclosure of a memorandum required under this subdivision shall not be deemed as a waiver of the lawyer-client privilege, as provided for under Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code.

(f) In addition to subdivisions (a), (b), and (c), nothing in this article shall be construed to do any of the following:

(1) Prevent a state body operating under a joint powers agreement for insurance pooling from holding a closed session to discuss a claim for the payment of tort liability or public liability losses incurred by the state body or any member agency under the joint powers agreement.

(2) Prevent the examining committee established by the State Board of Forestry and Fire Protection, pursuant to Section 763 of the Public Resources Code, from conducting a closed session to consider disciplinary action against an individual professional forester prior to the filing of an accusation against the forester pursuant to Section 11503.

(3) Prevent an administrative committee established by the California Board of Accountancy pursuant to Section 5020 of the Business and Professions Code from conducting a closed session to consider disciplinary action against an individual accountant prior to the filing of an accusation against the accountant pursuant to Section 11503. Nothing in this article shall be construed to prevent an examining committee established by the California Board of Accountancy pursuant to Section 5023 of the Business and Professions Code from conducting a closed hearing to interview an individual applicant or accountant regarding the applicant's qualifications.

(4) Prevent a state body, as defined in subdivision (b) of Section 11121, from conducting a closed session to consider any matter that properly could be considered in closed session by the state body whose authority it exercises.

(5) Prevent a state body, as defined in subdivision (d) of Section 11121, from conducting a closed session to consider any matter that properly could be considered in a closed session by the body defined as a state body pursuant to subdivision (a) or (b) of Section 11121.

(6) Prevent a state body, as defined in subdivision (c) of Section 11121, from conducting a closed session to consider any matter that properly could be considered in a closed session by the state body it advises.

(7) Prevent the State Board of Equalization from holding closed sessions for either of the following:

(A) When considering matters pertaining to the appointment or removal of the Executive Secretary of the State Board of Equalization.

(B) For the purpose of hearing confidential taxpayer appeals or data, the public disclosure of which is prohibited by law.

(8) Require the State Board of Equalization to disclose any action taken in closed session or documents executed in connection with that action, the public disclosure of which is prohibited by law pursuant to Sections 15619 and 15641 of this code and Sections 833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651, 45982, 46751, 50159, 55381, and 60609 of the Revenue and Taxation Code.

(9) Prevent the California Earthquake Prediction Evaluation Council, or other body appointed to advise the Director of the Office of Emergency Services or the Governor concerning matters relating to volcanic or earthquake predictions, from holding closed sessions when considering the evaluation of possible predictions.

(g) This article does not prevent either of the following:

(1) The Teachers' Retirement Board or the Board of Administration of the Public Employees' Retirement System from holding closed sessions when considering matters pertaining to the recruitment, appointment, employment, or removal of the chief executive officer or when considering matters pertaining to the recruitment or removal of the Chief Investment Officer of the State Teachers' Retirement System or the Public Employees' Retirement System.

(2) The Commission on Teacher Credentialing from holding closed sessions when considering matters relating to the recruitment, appointment, or removal of its executive director.

(h) This article does not prevent the Board of Administration of the Public Employees' Retirement System from holding closed sessions when considering matters relating to the development of rates and competitive strategy for plans offered pursuant to Chapter 15 (commencing with Section 21660) of Part 3 of Division 5 of Title 2.

(i) This article does not prevent the Managed Risk Medical Insurance Board from holding closed sessions when considering matters related to the development of rules and contracting strategy for entities contracting or seeking to contract with the board pursuant ot Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

~~SEC. 3.~~

SEC. 5. 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 act enacting this section in the 2007–08 Regular Session of the Legislature. 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.~~

(b) (1) The Secretary of California Health and Human Services shall seek a partnership and contract with independent, nonprofit groups or foundations, academic institutions, or governmental entities providing grants for health-related activities, to establish and administer a program to track and assess the effects of health care reform as set forth in the California Health Care Reform and Cost Control Act. The assessment shall include, at minimum, the following components:

(A) An assessment of the sustainability and solvency of the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) (Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code). This assessment shall include the number of persons purchasing health care coverage through Cal-CHIPP by income bracket and by the size and type of their employer.

(B) An assessment of the cost and affordability of health care in California. This assessment shall include the cost of health care coverage products for individuals and families obtained through employers, city and county governments, the Medi-Cal program, the Public Employees' Medical and Hospital Care Act, Medicare Advantage plans, and the individual market.

(C) An assessment of the health care coverage market in California, including a review of the various insurers and health care service plans, their offering and underwriting practices, their efficiency in providing health care services, and their financial conditions, including their medical loss ratios. This assessment shall also include an assessment of risk selection by the plans and insurers.

(D) An assessment of the effect on employers and employment, including employer administrative costs, employee turnover rate, and wages categorized by the type of employer and the size of the business.

(E) An assessment of employer-based health care coverage, including the number of employers providing coverage and the number paying into Cal-CHIPP categorized by employer characteristic.

(F) An assessment of the change in access and availability of health care throughout the state, including tracking the availability of health care coverage products in rural and other underserved areas of the state and assessing the adequacy of the health care delivery infrastructure to meet the need for health care services. This assessment shall include a more in-depth review of areas of the state that were determined to be medically underserved in 2007.

(G) An assessment of the impact on the county health care safety net system, including a review of the amount of uncompensated care and emergency room use.

(H) An assessment of health care coverage as compiled in the California Health Interview Survey or other applicable surveys.

(I) An assessment of the wellness and health status of Californians as compiled in the California Health Interview Survey or other applicable surveys.

(J) An assessment of the capacity of the various health care professions to provide care to the population included in health care reform, identifying the number of each profession and their location in the state.

(K) An assessment of the quality of the health care services, as determined by recognized measures, provided in California.

(L) An assessment of the availability and potential for increasing federal funding for health care services and coverage in California.

(M) Any other assessments as determined necessary by the advisory board established pursuant to paragraph (2).

(2) An advisory body chaired by the Secretary of California Health and Human Services shall guide the assessment of health care reform. The Governor shall appoint five members to the advisory body, the Senate President pro Tempore shall appoint two members, and the Speaker of the Assembly shall appoint two members.

(3) To the extent possible, the assessment shall maximize the use of current surveys and databases, and the secretary shall seek partnerships with independent, nonprofit groups or foundations or academic institutions that administer or provide grants for health-related surveys and data collection activities to build on these current surveys and databases.

(4) To the extent feasible, in order to track the effect of health care reform on ongoing trends in the health care field, the assessments shall include data from years prior to the enactment of the California Health Care Reform and Cost Control Act.

(5) The Secretary of California Health and Human Services and the advisory body shall establish a timeline for reporting information to the appropriate policy and fiscal committees of the Legislature. At a minimum, the reporting timeline shall include the release of annual data to serve as a benchmark for the assessment of the health care reform. These annual benchmarks shall include the employer compliance rate and the cost of health care coverage in the state. In addition, the timeline shall include

more in-depth reports addressing the items listed under paragraph (1).

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

(d) The California Health and Human Services Agency, in consultation with the Board of Administration of the Public Employees' Retirement System, shall assume lead agency responsibility for professional review and development of best practice standards in the care and treatment of patients with high-cost chronic diseases, such as asthma, diabetes, and heart disease. Upon adoption of the standards, each state health care program, including, but not limited to, programs offered under the Public Employees' Medical and Hospital Care Act, the Medi-Cal program, the Healthy Families Program, the Major Risk Medical Insurance Program, and the California Cooperative Health Insurance Purchasing Program, shall implement those standards.

~~SEC. 4.~~

SEC. 6. Article 3.11 (commencing with Section 1357.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.11. Insurance Market Reform

1357.20. Effective July 1, 2008, every full-service health care service plan that offers, markets, and sells health plan contracts to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board in consultation with the Department of Insurance and the Department of Managed Health Care. A health care service plan subject to this section may not exclude a potential enrollee from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1 of the Insurance Code. *A health care service plan that is also a participating health plan in the California Cooperative Health Insurance Purchasing Program pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code may not charge a standard rate, with reference to subscribers of any age, family size, and geographical region, that is less than the plan's rate for the same benefit plan design sold through Cal-CHIPP.*

1357.21. (a) Every full-service health care service plan 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) 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).

1357.22. It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient's personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health care service

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

1357.23. Effective ~~January~~ *July* 1, 2008, all requirements in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan's contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health care service plan contracts offered to all employers with 250 or fewer eligible employees, except as follows:

(a) For small employers with 2 to 50, inclusive, eligible employees, all requirements in that article shall apply.

(b) For employers with 51 to 250, inclusive, eligible employees, all requirements in that article shall apply, except that the health care service plan may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 250, inclusive, eligible employees.

(c) Three months after the Managed Risk Medical Insurance Board notifies the department that enrollment in the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code will commence, notwithstanding subdivision (j) of Section 1357, no risk adjustment factor shall be permitted in a contract offered to a small employer, as defined in subdivision (l) of Section 1357, or to an employer with 51 to 250, inclusive, eligible employees. A health care service plan contract shall comply with the requirements of this subdivision on or before the date of enrollment in Cal-CHIPP commences.

~~1357.24. (a) Every group health care service plan shall obtain from each employer or group subscriber contracting with the health care service plan the premium contribution amounts the group makes for each enrolled group member and dependent.~~

~~(b) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a benchmark plan established by the board so that group members and their dependents with family incomes at or below 300 percent of the federal poverty level that are determined eligible~~

~~for coverage through the Medi-Cal or Healthy Families Programs can enroll in the benchmark plan. The benchmark plan of a group health care service plan shall be provided at a rate negotiated with and approved by the board. The health care service plan shall collect the employer's applicable dollar premium contribution for employees, and if applicable, dependents, in the benchmark plan and credit that amount toward the cost of the benchmark plan.~~

~~(2) In lieu of meeting the requirements of paragraph (1), for employees, and, if applicable, dependents eligible for coverage through the Medi-Cal or Healthy Families Programs who have elected to enroll in benchmark coverage, the health care service plan shall collect the employer's applicable dollar premium contribution and credit that amount to the board towards the premium cost of a benchmark plan in Cal-CHIPP.~~

~~(c) Every health care service plan shall include in the plan's evidence of coverage notice of the ability of employees and dependents with family incomes at or below 300 percent of the federal poverty level to enroll in Medi-Cal or Healthy Families coverage through a benchmark plan, with instructions on how to apply for coverage.~~

~~(d) Employees and dependents receiving coverage through the Medi-Cal or Healthy Families Programs pursuant to this section shall make any required premium payments for enrollment in those programs required under the applicable laws governing those programs.~~

~~(e) As used in this section, the following terms have the following meanings:~~

~~(1) "Board" means the Managed Risk Medical Insurance Board.~~

~~(2) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" shall have the same meaning as in subdivision (c) of Section 12699.201 of the Insurance Code.~~

~~(3) "Benchmark plan" shall mean coverage equivalent to coverage provided through the Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.~~

~~(f) This section shall apply to health care service plan contracts issued, amended or renewed on or after July 1, 2008.~~

1357.24. (a) Every group health care service plan shall obtain from each employer or group subscriber contracting with the health care service plan the premium contribution amounts the

employer or group makes for each enrolled group member and dependent using the family tier premium payments made to the group plan.

(b) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a Healthy Families benchmark plan established by the board so that group members and their dependents with family incomes at or below 300 percent of the federal poverty level that are determined eligible for coverage through the Healthy Families Program or who are eligible for Medi-Cal pursuant to Section 14005.33 of the Welfare and Institutions Code can enroll in the Healthy Families benchmark plan. The Healthy Families benchmark plan of a group health care service plan shall be provided at a rate negotiated with and approved by the board. The health care service plan shall collect the employer's applicable dollar premium contribution for employees and, if applicable, dependents in the Healthy Families benchmark plan and credit that amount toward the cost of the Healthy Families benchmark plan.

(2) In lieu of meeting the requirements of paragraph (1), for employees and, if applicable, dependents eligible for coverage through the Healthy Families Program who have elected to enroll in Healthy Families benchmark coverage, the health care service plan shall instead collect an amount determined by the board but not to exceed the employer's applicable dollar premium contribution as identified in subdivision (a) and transmit that amount to the board towards the premium cost of a Healthy Families benchmark plan in Cal-CHIPP.

(c) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a Medi-Cal benchmark plan established by the board so that group members and their dependents that are determined eligible for coverage through the Medi-Cal program, except for coverage pursuant to Section 14005.33 of the Welfare and Institutions Code, can enroll in the Medi-Cal benchmark plan. The Medi-Cal benchmark plan of a group health care service plan shall be provided at a rate negotiated with and approved by the board. The health care service plan shall collect the employer's applicable dollar premium contribution for employees and, if

applicable, dependents, in the Medi-Cal benchmark plan and credit that amount toward the cost of the Medi-Cal benchmark plan.

(2) In lieu of meeting the requirements of paragraph (1), for employees and, if applicable, dependents eligible for coverage through the Medi-Cal program who have elected to enroll in Medi-Cal benchmark coverage, the health care service plan shall instead collect an amount determined by the board but not to exceed the employer's applicable dollar premium contribution as identified in subdivision (a) and transmit that amount to the board towards the premium cost of a Medi-Cal benchmark plan in Cal-CHIPP.

(d) Every health care service plan shall include in the plan's evidence of coverage notice of the ability of employees and dependents with family incomes at or below 300 percent of the federal poverty level to enroll in Medi-Cal or Healthy Families coverage through a Healthy Families benchmark plan or a Medi-Cal benchmark plan, with instructions on how to apply for coverage.

(e) The department, in consultation with the board, may issue regulations, as necessary pursuant to the Administrative Procedure Act, to implement the requirements of this section. Until January 1, 2014, the adoption and readoption of regulations pursuant to this Section shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare.

(f) Employees and dependents receiving coverage through the Medi-Cal program or Healthy Families Program pursuant to this section shall make premium payments, if any, as determined by the board that do not exceed premium payments for enrollment in those programs required under the applicable laws governing those programs.

(g) As used in this section, the following terms have the following meanings:

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

(2) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" shall have the same meaning as in subdivision (c) of Section 12699.201 of the Insurance Code.

(3) "Healthy Families benchmark plan" shall mean coverage equivalent to coverage provided through the Healthy Families

Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(4) "Medi-Cal benchmark plan" shall mean coverage equivalent to coverage provided through the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(h) This section shall apply to health care service plan contracts issued, amended or renewed on or after July 1, 2008.

1357.25. The requirements of this article shall not apply to a specialized health care service plan or a Medicare supplement contract.

1357.26. This article shall become operative on July 1, 2008.

~~SEC. 5.~~

SEC. 7. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

SEC. 8. Article 4.1 (commencing with Section 1366.10) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.1. California Individual Coverage Guarantee Issue

1366.10. It is the intent of the Legislature to do both of the following:

(a) Guarantee the availability and renewability of qualifying health coverage through the private health insurance market to individuals.

(b) Require that health care service plans and health insurers issuing coverage in the individual market compete on the basis of price, quality, and service, and not on risk selection.

1366.104. (a) On or before January 1, 2010, the director and the Insurance Commissioner shall jointly adopt regulations governing five classes of individual health benefit plans that health care service plans and health insurers shall make available.

(b) Within 90 days of the adoption of the regulations required by subdivision (a), the director and the Insurance Commissioner shall jointly approve five classes of individual health benefit plans for each health care service plan and health insurer participating in the individual market, with each class having an increased level of benefits beginning with the lowest class. Within each class, the director and the Insurance Commissioner shall jointly approve one baseline HMO and one baseline PPO, to be issued by health care service plans and health insurers in the individual market.

The classes of benefits jointly approved by the director and the Insurance Commissioner shall reflect a reasonable continuum between the class with the lowest level of benefits and the class with the highest level of benefits, shall permit reasonable benefit variation that will allow for a diverse market within each class, and shall be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(c) In approving the five classes of plans filed by health care service plans and health insurers, the director and the Insurance Commissioner shall do both of the following:

(1) Jointly determine that the plans provide reasonable benefit variation, allowing a diverse market.

(2) Jointly require either (A) that benefits within each class are standard and uniform across all plans and insurers, or (B) that benefits offered in each class are actuarially equivalent across all plans and insurers.

1366.105. At the same time that health care service plans and health insurers participating in the individual market are required to guarantee issue the five classes of approved health benefit plans, health care service plans and health insurers shall discontinue offering and selling health benefit plans other than those within the five approved classes of benefit plans in the individual market.

1366.106. Individuals may purchase a health benefit plan from one of the five classes of approved plans on a guaranteed issue basis. After selecting and purchasing a health benefit plan within a class of benefits, an individual may change plans only as set forth in this section. For individuals enrolled as a family, the subscriber may change classes for himself or herself, or for all dependents:

(a) Annually in the month of the subscriber's birth, an individual may select a different individual plan from another health care service plan or insurer, within the same class of benefits or the next higher class of benefits.

(b) Annually in the month of the subscriber's birth, an individual may move up one class of benefits offered by the same health care service plan or health insurer.

(c) At any time a subscriber may move to a lower class of benefits.

(d) At significant life events, the subscriber may move up to a higher class of benefits as follows:

(1) Upon marriage or entering into a domestic partnership.

(2) Upon divorce.

(3) Upon the death of a spouse or domestic partner, on whose qualifying health coverage an individual was a dependent.

(4) Upon the birth or adoption of a child.

(e) A dependent child may terminate coverage under a parent's plan, and select his or her own account, within the same class of benefits following his or her 18th birthday.

(f) If a subscriber becomes eligible for group benefits, Medicare, or other benefits, and selects those benefits in lieu of his or her individual coverage, the dependent spouse or domestic partner may become the subscriber. If there is no dependent spouse or domestic partner enrolled in the plan, the oldest child may become the subscriber.

1366.107. At the time an individual applies for qualifying health coverage from a health care service plan or health insurer participating in the individual market, an individual shall provide information as required by a standardized health status questionnaire to assist plans and insurers in identifying persons in need of disease management. Health care service plans and health insurers may not use information provided on the questionnaire to decline coverage or to limit an individual's choice of health care benefit plan, except as provided in Section 12711.1 of the Insurance Code.

1366.108. Health benefit plans shall become effective within 31 days of receipt of the individual's application, standardized health status questionnaire, and premium payment.

1366.109. Health care service plans and health insurers may reject an application for health care benefits if the individual does not reside or work in a plan's or insurer's approved service area.

1366.110. The director or the Insurance Commissioner, as applicable, may require a health care service plan or health insurer to discontinue the offering of health care benefits, or acceptance of applications from individuals, upon a determination by the director or commissioner that the plan or insurer does not have sufficient financial viability, or organizational and administrative capacity, to ensure the delivery of health care benefits to its enrollees or insureds.

1366.111. All health care benefits offered to individuals shall be renewable with respect to all individuals and dependents at the option of the subscriber, except:

(a) For nonpayment of the required premiums by the subscriber.

(b) When the plan or insurer withdraws from the individual health care market, subject to rules and requirements jointly approved by the director and the Insurance Commissioner.

1366.112. No health care service plan or health insurer shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract or health insurance policy to be varied because of the health status, claims experience, occupation, or geographic location of the individual, provided the geographic location is within the plan's or insurer's approved service area.

1366.113. This article shall not apply to individual health plan contracts for coverage of Medicare services pursuant to contracts with the United States Government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Family contracts with the Managed Risk Medical Insurance Board, high-risk pool contracts with the Major Risk Medical Insurance Program, Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure coverage from Cal-CHIPP.

1366.114. (a) A health care service plan or health insurer may rate its entire portfolio of health benefit plans in accordance with expected costs or other market considerations, but the rate for each plan or insurer shall be set in relation to the balance of the portfolio as certified by an actuary. Each benefit plan shall be priced as determined by each health care service plan or health insurer to reflect the difference in benefit variation, or the effectiveness of a provider network, but may not adjust the rate for a specific plan for risk selection. A health care service plan's or health insurer's rates shall use the same rating factors for age, family size, and geographic location for each individual health care benefit plan it issues. Rates for health care benefits may vary from applicant to applicant only by any of the following:

(1) Age of the subscriber, as determined by the director and the Insurance Commissioner.

(2) Family size in categories determined by the director and the Insurance Commissioner.

(3) Geographic rate regions as determined by the director and the Insurance Commissioner.

(4) Health improvement discounts. A health care service plan or health insurer may reduce copayments or offer premium discounts for nonsmokers, individuals demonstrating weight loss through a measurable health improvement program, or individuals actively participating in a disease management program, provided discounts are approved by the director and the Insurance Commissioner.

(b) The director and Insurance Commissioner shall take into consideration the age, family size, and geographic region rating categories applicable to small group coverage contracts pursuant to Section 1357 of this code and Section 10700 of the Insurance Code in implementing this section.

1366.115. The first term of each health benefit plan contract or policy issued shall be from the effective date through the last day of the month immediately preceding the subscriber's next birthday. Contracts or policies may be renewed by the subscriber as set forth in this article.

~~SEC. 6.~~

SEC. 9. Section 1378 of the Health and Safety Code is amended to read:

1378. No plan shall expend for administrative costs in any fiscal year an excessive amount of the aggregate dues, fees and other periodic payments received by the plan for providing health care services to its subscribers or enrollees. The term "administrative costs," as used herein, includes costs incurred in connection with the solicitation of subscribers or enrollees for the plan. The director shall adopt regulations no later than July 1, 2008, to define "administrative costs" and "health care services" so that at least 85 percent of aggregate dues, fees, and other periodic payments received by a full-service plan are spent on health care services. This section shall not apply to Medicare supplement contracts.

This section shall not preclude a plan from expending additional sums of money for administrative costs provided such money is not derived from revenue obtained from subscribers or enrollees of the plan.

SEC. 10. Chapter 1.6 (commencing with Section 10199.10) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 1.6. CALIFORNIA INDIVIDUAL COVERAGE GUARANTEE ISSUE

10199.10. It is the intent of the Legislature to do both of the following:

(a) Guarantee the availability and renewability of qualifying health coverage through the private health insurance market to individuals.

(b) Require that health care service plans and health insurers issuing coverage in the individual market compete on the basis of price, quality, and service, and not on risk selection.

10199.104. (a) On or before January 1, 2010, the commissioner and the Director of the Department of Managed Health Care shall jointly adopt regulations governing five classes of individual health benefit plans that health care service plans and health insurers shall make available.

(b) Within 90 days of the adoption of the regulations required by subdivision (a), the commissioner and the Director of the Department of Managed Health Care shall jointly approve five classes of individual health benefit plans for each health care service plan and health insurer participating in the individual market, with each class having an increased level of benefits beginning with the lowest class. Within each class, the commissioner and the Director of the Department of Managed Health Care shall jointly approve one baseline HMO and one baseline PPO, to be issued by health care service plans and health insurers in the individual market. The classes of benefits jointly approved by the commissioner and the Director of the Department of Managed Health Care shall reflect a reasonable continuum between the class with the lowest level of benefits and the class with the highest level of benefits, shall permit reasonable benefit variation that will allow for a diverse market within each class, and shall be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(c) In approving the five classes of plans filed by health care service plans and health insurers, the commissioner and the

Director of the Department of Managed Health Care shall do both of the following:

(1) Jointly determine that the plans provide reasonable benefit variation, allowing a diverse market.

(2) Jointly require either (A) that benefits within each class are standard and uniform across all plans and insurers, or (B) that benefits offered in each class are actuarially equivalent across all plans and insurers.

10199.105. At the same time that health care service plans and health insurers participating in the individual market are required to guarantee issue the five classes of approved health benefit plans, health care service plans and health insurers shall discontinue offering and selling health benefit plans other than those within the five approved classes of benefit plans in the individual market.

10199.106. Individuals may purchase a health benefit plan from one of the five classes of approved plans on a guaranteed issue basis. After selecting and purchasing a health benefit plan within a class of benefits, an individual may change plans only as set forth in this section. For individuals enrolled as a family, the subscriber may change classes for himself or herself, or for all dependents:

(a) Annually in the month of the subscriber's birth, an individual may select a different individual plan from another health care service plan or insurer, within the same class of benefits or the next higher level of benefits.

(b) Annually in the month of the subscriber's birth, an individual may move up one class of benefits offered by the same health care service plan or health insurer.

(c) At any time a subscriber may move to a lower class of benefits.

(d) At significant life events, the subscriber may move up to a higher class of benefits as follows:

(1) Upon marriage or entering into a domestic partnership.

(2) Upon divorce.

(3) Upon the death of a spouse or domestic partner, on whose qualifying health coverage an individual was a dependent.

(4) Upon the birth or adoption of a child.

(e) A dependent child may terminate coverage under a parent's plan, and select his or her own account, within the same class of benefits following his or her 18th birthday.

(f) If a subscriber becomes eligible for group benefits, Medicare, or other benefits, and selects those benefits in lieu of his or her individual coverage, the dependent spouse or domestic partner may become the subscriber. If there is no dependent spouse or domestic partner enrolled in the plan, the oldest child may become the subscriber.

10199.107. At the time an individual applies for qualifying health coverage from a health care service plan or health insurer participating in the individual market, an individual shall provide information as required by a standardized health status questionnaire to assist plans and insurers in identifying persons in need of disease management. Health care service plans and health insurers may not use information provided on the questionnaire to decline coverage, or to limit an individual's choice of health care benefit plan, except as provided in Section 12711.1.

10199.108. Health benefit plans shall become effective within 31 days of receipt of the individual's application, standardized health status questionnaire, and premium payment.

10199.109. Health care service plans and health insurers may reject an application for health care benefits if the individual does not reside or work in a plan's or insurer's approved service area.

10199.110. The commissioner or the Director of the Department of Managed Health Care, as applicable, may require a health care service plan or health insurer to discontinue the offering of health care benefits, or acceptance of applications from individuals, upon a determination by the director or commissioner that the plan or insurer does not have sufficient financial viability, or organizational and administrative capacity, to ensure the delivery of health care benefits to its enrollees or insureds.

10199.111. All health care benefits offered to individuals shall be renewable with respect to all individuals and dependents at the option of the subscriber, except:

(a) For nonpayment of the required premiums by the subscriber.

(b) When the plan or insurer withdraws from the individual health care market, subject to rules and requirements jointly approved by the director and the Insurance Commissioner.

10199.112. No health care service plan or health insurer shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care

service plan contract or health insurance policy to be varied because of the health status, claims experience, occupation, or geographic location of the individual, provided the geographic location is within the plan's or insurer's approved service area.

10199.113. This chapter shall not apply to individual health plan contracts for coverage of Medicare services pursuant to contracts with the United States Government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Family contracts with the Managed Risk Medical Insurance Board, high-risk pool contracts with the Major Risk Medical Insurance Program, Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure coverage from Cal-CHIPP.

10199.114. (a) A health care service plan or health insurer may rate its entire portfolio of health benefit plans in accordance with expected costs or other market considerations, but the rate for each plan or insurer shall be set in relation to the balance of the portfolio as certified by an actuary. Each benefit plan shall be priced as determined by each health care service plan or health insurer to reflect the difference in benefit variation, or the effectiveness of a provider network, but may not adjust the rate for a specific plan for risk selection. A health care service plan's or health insurer's rates shall use the same rating factors for age, family size, and geographic location for each individual health care benefit plan it issues. Rates for health care benefits may vary from applicant to applicant only by any of the following:

(1) Age of the subscriber, as determined by the commissioner and the Director of the Department of Managed Health Care.

(2) Family size in categories determined by the commissioner and the Director of the Department of Managed Health Care.

(3) Geographic rate regions as determined by the commissioner and the Director of the Department of Managed Health Care.

(4) Health improvement discounts. A health care service plan or health insurer may reduce copayments or offer premium discounts for nonsmokers, individuals demonstrating weight loss through a measurable health improvement program, or individuals actively participating in a disease management program, provided discounts are approved by the commissioner and the Director of the Department of Managed Health Care.

(b) The commissioner and the Director of the Department of Managed Health Care shall take into consideration the age, family size, and geographic region rating categories applicable to small group coverage contracts pursuant to Section 1357 of the Health and Safety Code and Section 10700 of this code in implementing this section.

10199.115. The first term of each health benefit plan contract or policy issued shall be from the effective date through the last day of the month immediately preceding the subscriber's next birthday. Contracts or policies may be renewed by the subscriber as set forth in this chapter.

~~SEC. 7.~~

SEC. 11. Section 10293.5 is added to the Insurance Code, to read:

10293.5. (a) The commissioner shall adopt regulations no later than July 1, 2008, to define "administrative costs" and "health care services" so that at least 85 percent of health insurance premium revenue received by a health insurer is spent on health care services.

(b) As used in this section, health insurance shall have the same meaning as in subdivision (b) of Section 106.

(c) The requirements of this chapter shall not apply to a Medicare supplement, vision-only, dental-only, or ~~Champus-supplement~~ *CHAMPUS-supplement* insurance or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

~~SEC. 8.~~

SEC. 12. Section 10607 of the Insurance Code is amended to read:

10607. In addition to the other disclosures required by this chapter, every insurer and their employees or agents shall, when presenting a plan for examination or sale to any individual or the representative of a group, disclose in writing the ratio of incurred claims to earned premiums (loss-ratio) for the insurer's preceding calendar year for policies with individuals and with groups of the same or similar size for the ~~plan's~~ *insurer's* preceding fiscal year.

~~SEC. 9.~~

SEC. 13. Chapter 8.1 (commencing with Section 10760) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 8.1. INSURANCE MARKET REFORM

10760. Effective July 1, 2008, every insurer that offers, markets, and sells health insurance to individuals and conducts medical underwriting to determine whether to issue coverage to a specific individual shall use a standardized health questionnaire developed by the Managed Risk Medical Insurance Board. A health insurer subject to this section may not exclude a potential insured from any individual coverage on the basis of an actual or expected health condition, type of illness, treatment, medical condition, or accident, or for a preexisting condition, except as provided by the board pursuant to Section 12711.1. *A health insurer that is also a participating health insurer in the California Cooperative Health Insurance Purchasing Program pursuant to Part 6.45 (commencing with Section 12699.201) may not charge a standard rate, with reference to subscribers of any age, family size, and geographical region, that is less than the insurer's rate for the same benefit plan design sold through Cal-CHIPP.*

10761. (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).

10762. It is the intent of the Legislature that all health care providers shall participate in an Internet-based personal health record system under which patients have access to their own health care records. A patient's personal health care record shall only be accessible to that patient or other individual as authorized by the patient. It is the intent of the Legislature that all health insurers and providers shall adopt standard electronic medical records by January 1, 2012.

10763. On and after ~~January~~ *July* 1, 2008, all requirements in Chapter 8 (commencing with Section 10700) applicable to offering,

marketing, and selling health benefit plans to small employers as defined in that chapter, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the carrier's health benefit plan designs to all employers, guaranteed renewal of all health benefit plan designs, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that chapter, shall be applicable to all health benefit plan designs offered to all employers with 250 or fewer eligible employees, except as follows:

(a) For small employers with 2 to 50, inclusive, eligible employees, all requirements in that chapter shall apply.

(b) For employers with 51 to 250, inclusive, eligible employees, all requirements in that chapter shall apply, except that the carrier may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 250 eligible employees.

(c) Three months after the Managed Risk Medical Insurance Board notifies the department that enrollment in the Cal-CHIPP pursuant to Part 6.45 (commencing with Section 12699.201) will commence, notwithstanding subdivision (t) of Section 10700, no risk adjustment factor shall be permitted in a policy offered to a small employer, as defined in subdivision (w) of Section 10700, or to an employer with 51 to 250, inclusive, eligible employees. A health insurance policy shall comply with the requirements of this subdivision on or before the date of enrollment in Cal-CHIPP commences.

~~10764. (a) Every health insurer shall obtain from each employer or group policyholder the premium contribution amounts for each insured group member and dependent.~~

~~(b) (1) Every health insurer offering group health plan contracts shall provide as one coverage option of each group policy a benchmark policy established by the board so that group members and their dependents with family incomes at or below 300 percent of the federal poverty level that are determined eligible for coverage through the Medi-Cal or Healthy Families Programs can enroll in the benchmark policy. The benchmark policy of a group health insurer shall be provided at a rate negotiated with and approved by the board. The health insurer shall collect the employer's applicable dollar premium contribution for employees,~~

~~and if applicable, dependents, in the benchmark policy and credit that amount toward the cost of the benchmark policy.~~

~~(2) In lieu of meeting the requirements of paragraph (1), for employees and, if applicable, dependents eligible for coverage through the Medi-Cal or Healthy Families Programs who have elected to enroll in benchmark coverage, the health insurer shall collect the employer's applicable dollar premium contribution and credit that amount to the board towards the premium cost of a benchmark policy in Cal-CHIPP.~~

~~(c) Every group health insurer shall include notice in the evidence of coverage of the ability of employees and dependents with family incomes at or below 300 percent of the federal poverty level to enroll in Medi-Cal or Healthy Families coverage through a benchmark plan, with instructions on how to apply for coverage.~~

~~(d) Employees and dependents receiving coverage through Medi-Cal or Healthy Families Programs pursuant to this section shall make any required premium payments for enrollment in those programs required under the applicable laws governing those programs.~~

~~(e) As used in this section, the following terms have the following meanings:~~

~~(1) "Board" means the Managed Risk Medical Insurance Board.~~

~~(2) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" shall have the same meaning as in subdivision (c) of Section 12699.201.~~

~~(3) "Benchmark policy" shall mean coverage equivalent to coverage provided through the Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.~~

10764. (a) Every group health insurer shall obtain from each employer or group policyholder contracting with the health insurer the premium contribution amounts the employer or group makes for each enrolled group member and dependent using the family tier premium payments made to the group plan.

(b) (1) Every health insurer offering group health insurance policies shall provide as one coverage option of each group policy a Healthy Families benchmark policy established by the board so that group members and their dependents with family incomes at or below 300 percent of the federal poverty level that are determined eligible for coverage through the Healthy Families

Program or who are eligible for Medi-Cal pursuant to Section 14005.33 of the Welfare and Institutions Code can enroll in the Healthy Families benchmark policy. The Healthy Families benchmark policy of a group health insurer shall be provided at a rate negotiated with and approved by the board. The health insurer shall collect the employer's applicable dollar premium contribution for employees and, if applicable, dependents in the Healthy Families benchmark policy and credit that amount toward the cost of the Healthy Families benchmark policy.

(2) In lieu of meeting the requirements of paragraph (1), for employees and, if applicable, dependents eligible for coverage through the Healthy Families Program who have elected to enroll in a Healthy Families benchmark policy, the health insurer shall instead collect an amount determined by the board but not to exceed the employer's applicable dollar premium contribution as identified in subdivision (a) and transmit that amount to the board towards the premium cost of a Healthy Families benchmark policy in Cal-CHIPP.

(c) (1) Every health insurer offering group health policies shall provide as one coverage option of each group contract a Medi-Cal benchmark policy established by the board so that group members and their dependents that are determined eligible for coverage through the Medi-Cal program, except for coverage pursuant to Section 14005.33 of the Welfare and Institutions Code, can enroll in the Medi-Cal benchmark policy. The Medi-Cal benchmark policy of a group health insurer shall be provided at a rate negotiated with and approved by the board. The health insurer shall collect the employer's applicable dollar premium contribution for employees and, if applicable, dependents in the Medi-Cal benchmark plan and credit that amount toward the cost of the Medi-Cal benchmark plan.

(2) In lieu of meeting the requirements of paragraph (1), for employees, and, if applicable, dependents eligible for coverage through the Medi-Cal program who have elected to enroll in Medi-Cal benchmark coverage, the health insurer shall instead collect an amount determined by the board but not to exceed the employer's applicable dollar premium contribution as identified in subdivision (a) and transmit that amount to the board towards the premium cost of a Medi-Cal benchmark policy in Cal-CHIPP.

(d) Every health insurer plan shall include in the plan's evidence of coverage notice of the ability of employees and dependents with family incomes at or below 300 percent of the federal poverty level to enroll in Medi-Cal or Healthy Families coverage through a Healthy Families benchmark policy or a Medi-Cal benchmark policy, with instructions on how to apply for coverage.

(e) The department, in consultation with the board, may issue regulations, as necessary pursuant to the Administrative Procedure Act, to implement the requirements of this section. Until January 1, 2014, the adoption and readoption of regulations pursuant to this part shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or general welfare.

(f) Employees and dependents receiving coverage through the Medi-Cal program or Healthy Families Program pursuant to this section shall make premium payments, if any, as determined by the board that do not exceed premium payments for enrollment in those programs required under the applicable laws governing those programs.

(g) As used in this section, the following terms have the following meanings:

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

(2) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" shall have the same meaning as in subdivision (c) of Section 12699.201.

(3) "Healthy Families benchmark policy" shall mean coverage equivalent to coverage provided through the Healthy Families Program established pursuant to Part 6.2 (commencing with Section 12693).

(4) "Medi-Cal benchmark policy" shall mean coverage equivalent to coverage provided through the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(h) This section shall apply to health insurance policies issued, amended, or renewed on or after July 1, 2008.

10765. (a) As used in this chapter, "health insurance" shall have the same meaning as in subdivision (b) of Section 106.

(b) The requirements of this chapter shall not apply to a Medicare supplement, vision-only, dental-only, or ~~Champus-supplement~~ *CHAMPUS-supplement* insurance or to

hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

10766. This chapter shall become operative on July 1, 2008.

~~SEC. 10.~~

SEC. 14. 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 in a given geographic area.

(b) In each geographic area, the board shall designate one or more 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 paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph

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

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

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

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

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month 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 paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

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

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

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

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

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

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

SEC. 15. Section 12693.55 is added to the Insurance Code, to read:

12693.55. The adoption and readoption of regulations pursuant to this part shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health and safety, or the general welfare.

SEC. 16. Section 12693.58 is added to the Insurance Code, to read:

12693.58. (a) All types of information, whether written or oral, concerning an applicant, subscriber, or household member, made or kept by any public officer or agency in connection with the administration of any provision of this part shall be confidential, and shall not be open to examination other than for purposes directly connected with the administration of the Healthy Families Program or the Medi-Cal program.

(b) Except as provided in this section and to the extent permitted by federal law or regulation, all information about applicants, subscribers, and household members to be safeguarded as provided for in subdivision (a) includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.

(c) Purposes directly connected with the administration of the Healthy Families Program or the Medi-Cal program encompass all activities and responsibilities in which the Managed Risk Medical Insurance Board or State Department of Health Care Services and their agents, officers, trustees, employees, consultants, and contractors engage to conduct program operations.

(d) Nothing in this section shall be construed to prohibit the disclosure of information about the applicant, subscriber, or household member when the applicant, subscriber, or household member to whom the information pertains or the parent or adult with legal custody provides express written authorization.

(e) Nothing in this part shall prohibit the disclosure of protected health information as provided in 45 C.F.R. 164.512.

SEC. 17. Section 12693.621 is added to the Insurance Code, to read:

12693.621. The coverage under this part for a child who is a dependent of an employee of an employer electing to make a payment to the California Health Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a Healthy Families benchmark plan under Part 6.45 (commencing with Section 12699.201).

~~SEC. 11.~~

SEC. 18. Section 12693.70 of the Insurance Code is amended to read:

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

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

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

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

(3) In compliance with Sections 12693.71 and 12693.72.

(4) [Reserved].

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

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

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

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in

the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). Commencing July 1, 2007, eligibility under this subparagraph shall not include infants during any time they are enrolled in employer-sponsored health insurance or are subject to an exclusion pursuant to Section 12693.71 or 12693.72, or are enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program, except during any time on or after July 1, 2007, that the infant is enrolled in employer-sponsored health insurance or is subject to an exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. Except as otherwise specified in this section, this enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level but less than or equal to ~~300~~ *250* percent of the federal poverty level shall be disregarded in calculating annual or monthly household income. *On and after July 1, 2008, all income over 250 percent of the federal poverty level but less than or equal to 300 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.*

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

income to ~~300~~ *250* percent or less of the federal poverty level, subparagraph (B) shall be applied.

(D) On and after July 1, 2008, in a family with an annual or monthly household income greater than 300 percent of the federal poverty level, any income deduction that is applicable to a child under the Medi-Cal program shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 300 percent or less of the federal poverty level, subparagraph (B) shall apply.

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

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

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.

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

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

~~(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. 12.~~

SEC. 19. 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. 13.~~

SEC. 20. Section 12693.755 of the Insurance Code is amended to read:

12693.755. (a) Subject to subdivision (b), but no later than July 1, 2008, the board shall expand eligibility under this part to uninsured parents of, and as defined by the board, adults responsible for, children enrolled to receive coverage under this part whose income does not exceed 300 percent of the federal poverty level, before applying the income disregard provided for in subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70.

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

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

participation is available and funds are appropriated specifically for this purpose.

(c) The coverage under this section for a person who is an employee or, if applicable, an adult dependent of an employee, of an employer electing to make a payment to the California Health Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a Healthy Families benchmark plan under Part 6.45 (commencing with Section 12699.201).

SEC. 21. Section 12693.76 of the Insurance Code is amended to read:

12693.76. (a) Notwithstanding any other provision of law, a child who is a qualified alien as defined in Section 1641 of Title 8 of the United States Code ~~Annotated~~ shall not be determined ineligible solely on the basis of his or her date of entry into the United States.

(b) Notwithstanding any other provision of law, subdivision (a) may only be implemented to the extent provided in the annual Budget Act.

(c) Notwithstanding any other provision of law, any uninsured parent or responsible adult who is a qualified alien, as defined in Section 1641 of Title 8 of the United States Code, shall not be determined to be ineligible solely on the basis of his or her date of entry into the United States.

(d) Notwithstanding any other provision of law, subdivision (c) may only be implemented to the extent of funding provided in the annual Budget Act.

(e) Notwithstanding any other provision of law, a child who is otherwise eligible to participate in the program shall not be determined ineligible solely on the basis of his or her immigration status.

(f) The coverage provided under this section to a child who is a dependent of an employee of an employer electing to make a payment to the California Health Care Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a benchmark plan under Part 6.45 (commencing with Section 12699.201).

~~SEC. 14.~~

SEC. 22. Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM

Chapter 1. General Provisions

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

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

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

(c) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" means the *statewide* purchasing pool established pursuant to this part and administered by the board. ~~The purchasing pool shall only be available to employees of, and, if applicable, dependents of employees of, employers who elect to pay into the California Health Trust Fund in lieu of making health care expenditures for their employees and, if applicable, dependents pursuant to Section 2200 of the Labor Code. Notwithstanding the foregoing, the purchasing pool shall also be available to eligible employees and, if applicable, dependents of eligible employees, receiving coverage through a benchmark plan or policy pursuant to paragraph (2) of subdivision (b) of Section 1357.24 of the Health and Safety Code or paragraph (2) of subdivision (b) of Section 10764. These employees and, if applicable, their dependents shall be limited to the choice of a benchmark plan or policy under Cal-CHIPP and shall not have access to other benefit plan options available to Cal-CHIPP enrollees pursuant to Section 12699.203.~~

(d) "Enrollee" means an individual who is eligible for, and participates in, Cal-CHIPP.

(e) "Fund" means the California Health Trust Fund established pursuant to Section 12699.212.

(f) "Healthy Families benchmark plan" means coverage equivalent to coverage provided through the Healthy Families Program (Part 6.2 (commencing with Section 12693)).

(g) "Medi-Cal benchmark plan" means coverage equivalent to the coverage provided through the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(h) "Participating dental plan" means either a dental insurer holding a valid certificate of authority from the commissioner or a specialized health care service plan, as defined by subdivision (o) of Section 1345 of the Health and Safety Code, that contracts with the board to provide dental coverage to enrollees.

~~(d)~~

(i) "Participating health plan" means ~~a~~ *either a private* health insurer holding a valid outstanding certificate of authority from the ~~Insurance Commissioner~~ *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.

(j) "Participating vision care plan" means either an insurer holding a valid certificate of authority from the commissioner that issues vision-only coverage or a specialized health care service plan, as defined by subdivision (o) of Section 1345 of the Health and Safety Code, that contracts with the board to provide vision coverage to enrollees.

CHAPTER 2. ADMINISTRATION

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

(b) The board may do all of the following consistent with the standards of this part:

(1) Determine eligibility and enrollment criteria and processes for Cal-CHIPP.

(2) Determine the participation requirements for enrollees.

(3) Determine the participation requirements and the standards and selection criteria for participating health, dental, and vision care plans, including reasonable limits on a plan's administrative

costs to ensure that a plan expends on patient care not less than 85 percent of aggregate dues, fees, and other periodic payments received by the plan.

(4) Determine when an enrollee's coverage commences and the extent and scope of coverage.

(5) Determine premium schedules, collect the premiums, and administer subsidies to eligible enrollees with a household income at or below 300 percent of the federal poverty level.

(6) Determine rates paid to participating health, dental, and vision care plans.

(7) Provide, or make available, coverage through participating health plans in Cal-CHIPP.

(8) Provide, or make available, coverage through participating dental and vision care plans in Cal-CHIPP.

(9) Provide for the processing of applications and the enrollment of enrollees.

(10) Determine and approve the benefit designs and copayments for participating health, dental, and vision care plans.

(11) Enter into contracts.

(12) Sue and be sued.

(13) Employ necessary staff.

(14) Authorize expenditures, as necessary, from the fund to pay program expenses that exceed enrollee contributions and to administer Cal-CHIPP.

(15) Issue rules and regulations, as necessary. The adoption and readoption of regulations pursuant to this part shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or the general welfare.

(16) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue available in the fund, and if sufficient revenue is not available to pay the estimated expenditures, the board shall institute appropriate measures to ensure fiscal solvency.

(17) Establish the criteria and procedures through which employers direct employees' premium dollars, withheld under the terms of cafeteria plans pursuant to Chapter 11 (commencing with Section 19900) of Part 10.2 of Division 2 of the Revenue and Taxation Code, to Cal-CHIPP to be credited against the employees' premium obligations.

(18) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by 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~~

*The*board shall develop and offer at least three uniform benefit plan designs to Cal-CHIPP enrollees. *One of the benefit plan designs offered by each participating health plan shall be a Healthy Families benchmark plan and another of the benefit plan designs shall be a Medi-Cal benchmark plan.* 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~~ *comply with* all of the following:

~~(1) Take~~

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

~~(2) Include in all benefit plan designs coverage for primary and preventive care services and prescription drugs~~

(b) All benefit plan designs shall meet the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and shall include prescription drug benefits, combined with enrollee cost-sharing levels that promote prevention and health maintenance, including appropriate cost sharing for physician office visits, diagnostic laboratory services, and maintenance medications to manage chronic diseases, such as asthma, diabetes, and heart disease.

(c) In determining the enrollee and dependent deductibles, coinsurance, and copayment requirements, the board shall consider whether those costs would deter an enrollee or his or her dependents from obtaining appropriate and timely care, including those enrollees with a low- or moderate-family income. The board shall also consider the impact of these costs on an enrollee's ability to afford health care services.

~~(3) Consult~~

(d) The board shall consult with the Insurance Commissioner, the Director of the Department of Managed Health Care, and the Director of the Department of Health Care Services.

12699.204. (a) The board may adjust premiums to ensure that the revenue in the fund derived from employee health coverage contributions is sufficient to pay for the cost of health care coverage provided through this part when combined with federal funds and the funds available pursuant to subdivision (b) of Section 2200 of the Labor Code.

(b) Notwithstanding subdivision (a), the amount of the premium paid by an employee with a household income at or below 300 percent of the federal poverty level shall not exceed 0 to 5 percent of the household income, depending on the income, after taking into account the tax savings the employee is able to realize by using the cafeteria plan made available by his or her employer pursuant to Chapter 11 (commencing with Section 19900) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

12699.205. The board, in its contract with a participating health plan, shall require that the plan utilize efficient practices to improve and control costs. These practices shall include, but are not limited to, the following:

(a) Preventive care.

(b) Care management for chronic diseases.

(c) Promotion of health information technology.

(d) Standardized billing practices.

(e) Reduction of medical errors.

(f) Incentives for healthy lifestyles.

(g) Patient cost-sharing to encourage the use of preventive and appropriate care.

(h) Rational use of new technology.

12699.206. (a) The board shall negotiate with Medi-Cal managed care plans to obtain affordable coverage for eligible enrollees.

(b) The board shall implement the requirements for a benchmark plan or policy as required pursuant to Section 1357.24 of the Health and Safety Code and Section 10764.

(c) The board shall take all reasonable steps necessary to maximize federal funding and support federal claiming in the administration of the purchasing pool created pursuant to this part.

12699.207. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

(b) Participating health, dental, and vision care plans that contract with the board shall be regulated by either the Insurance Commissioner or the Department of Managed Health Care and shall be licensed and in good standing with their respective licensing agency. In their application to Cal-CHIPP and upon request by the board, the participating health, dental, and vision care plans shall provide assurance of their licensure and standing with the appropriate licensing agency.

12699.208. The board shall collect and disseminate, as appropriate and to the extent possible, information on the quality of participating health, dental, and vision care plans and each plan's cost-effectiveness to assist enrollees in selecting a plan.

12699.209. The board shall establish a working group for the purpose of developing recommendations to broaden access to Cal-CHIPP to all self-employed individuals and submit the recommendations to the Legislature on or before January 1, 2009.

12699.210. The provisions of Section 12693.54 shall apply to a contract entered into pursuant to this part.

CHAPTER 3. ELIGIBILITY

12699.211. (a) To be eligible to enroll in Cal-CHIPP, an individual shall meet all of the following requirements:

(1) Is a resident of the state pursuant to Section 244 of the Government Code or is physically present in the state, having entered the state with an employment commitment or to obtain

employment, whether or not employed at the time of application to Cal-CHIPP or after enrollment in Cal-CHIPP.

(2) Is an employee or a dependent of an employee of an employer who elected to pay into the California Health Trust Fund in lieu of making health care expenditures for its employees and, if applicable, dependents pursuant to Section 2200 of the Labor Code.

(b) Notwithstanding paragraph (2) of subdivision (a), eligible employees and, if applicable, dependents of eligible employees, receiving coverage through a Medi-Cal or Healthy Families benchmark plan or policy pursuant to Section 1357.24 of the Health and Safety Code or Section 10764 are eligible for Cal-CHIPP. These employees and, if applicable, their dependents shall be limited to the choice of a benchmark plan or policy under Cal-CHIPP and shall not have access to other benefit plan options available to Cal-CHIPP enrollees pursuant to Section 12699.203.

~~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 under the Public Employees' Medical and Hospital Care Act, Medi-Cal, Healthy Families, the Major Risk Medical Insurance Program, and Cal-CHIPP, shall implement those standards.~~

Chapter 4. Fiscal

~~12699.206.~~

12699.212. The California Health Trust Fund is hereby created in the State Treasury. ~~The~~ *Notwithstanding Section 13340 of the Government Code, the* moneys in the fund shall be continuously appropriated to the board for the purposes of providing health care coverage pursuant to this part. *Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund.*

~~12699.207.~~

12699.213. 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.

~~12699.208. The board shall implement the requirements for a benchmark plan or policy as required pursuant to Section 1357.24 of the Health and Safety Code and Section 10764.~~

12699.214. This part shall become operative on January 1, 2010.

~~SEC. 15.~~

SEC. 23. 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 provide for an objective evaluation of a person's health status by assigning a discrete measure, such as a system of point scoring, to each person. The questionnaire shall be designed to identify the 3 to 5 percent of persons who are the most expensive to treat if covered under an individual health care service plan or an individual health insurance policy, and the board shall obtain from an actuary a certification that the standard health questionnaire meets this requirement.* The questionnaire shall be designed to collect only that information necessary to identify if a person is eligible for coverage in the program pursuant to subdivision (a). Consistent with Section 1357.21 of the Health and Safety Code and Section 10761, health plans and insurers shall not deny coverage for any individual except for those who qualify for automatic eligibility for the program as determined by the board pursuant to this section.

~~SEC. 16.~~

SEC. 24. Part 8.8 (commencing with Section 2200) is added to Division 2 of the Labor Code, to read:

PART 8.8. EMPLOYER ELECTION

~~2200. (a) (1) Each employer shall elect to either (A) make health care expenditures as provided in paragraph (2) for its full-time or part-time employees, or both, and, if applicable, their dependents, or (B) pay an equivalent amount in either or both cases, as applicable, 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.~~

~~(2) (A) An employer's cumulative amount of health care expenditures for the employer's full-time employees working 30 or more hours per week shall be equivalent, at a minimum, to 7.5 percent of social security wages paid by the employer to full-time employees.~~

~~(B) An employer's cumulative amount of health care expenditures for the employer's part-time employees working less than 30 hours per week shall be equivalent, at a minimum, to 7.5 percent of social security wages paid by the employer to part-time employees.~~

2200. (a) (1) Each employer shall elect to take one of the following actions:

(A) Make health care expenditures as provided in subparagraph (A) of paragraph (3) for its full-time employees, and, if applicable, their dependents.

(B) Pay an equivalent amount to the fund as required by Section 976.6 of the Unemployment Insurance Code.

(2) Each employer also shall elect to take one of the following actions:

(A) Make health care expenditures as provided in subparagraph (B) of paragraph (3) for its part-time employees, and, if applicable, their dependents.

(B) Pay an equivalent amount to the fund as required by Section 976.6 of the Unemployment Insurance Code.

(3) (A) An employer's cumulative amount of health care expenditures for the employer's full-time employees working 30 or more hours per week shall be equivalent, at a minimum, to 7.5 percent of wages paid by the employer to its full-time employees. In computing this amount, wages paid to an employee that are in excess of wages subject to withholding by the Social Security Administration shall be excluded.

(B) An employer's cumulative amount of health care expenditures for the employer's part-time employees working less than 30 hours per week shall be equivalent, at a minimum, to 7.5 percent of wages paid by the employer to part-time employees. In computing this amount, wages paid to an employee that are in excess of wages subject to withholding by the Social Security Administration shall be excluded.

(b) (1) The amount payable to the California Health Trust Fund by an employer electing to pay shall be deposited into the fund.

(2) The Employment Development Department, in consultation with the board, shall ensure that funds are deposited in the California Health Trust Fund pursuant to this section and are available to ensure the timely enrollment of eligible employees *and, if applicable, their dependents* in the Cal-CHIPP purchasing pool.

~~(c) (1) The Employment Development Department shall adopt regulations that exempt businesses with payrolls of less than one hundred thousand dollars ($100,000) in a fiscal year, businesses with fewer than two employees, and new businesses during the first three years of the establishment of the business, from the requirements of this part. In adopting these regulations, the department shall deny the exemption to firms that restructure or reincorporate in order to avoid the requirements of this part.~~

~~(2) The Employment Development Department, in consultation with the board, shall adopt regulations determining the minimum number of hours per week a part-time employee must work in order to be subject to subparagraph (B) of paragraph (2) of subdivision (a) for purposes of the employer election in this section. The regulations shall exempt employers of part-time employees not working the required minimum number of hours from the requirements of this part.~~

(c) Notwithstanding subparagraphs (A) and (B) of paragraph (3) of subdivision (a), the board may adjust the health care expenditure amounts required by those subparagraphs. On or before October 31 of each year, the board shall prepare a statement, which shall be a public record, setting forth the adjustments for the next calendar year and shall promptly notify the Employment Development Department of those adjustments.

2203. An employee working for an employer that elects, pursuant to Section 2200, to pay an equivalent amount in lieu of

making health care expenditures shall be required to enroll in the California Cooperative Health Insurance Purchasing Program pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code to receive coverage from a participating health plan contracting with the board through the program. However, an employee is exempt from this requirement if the employee is able to demonstrate that the employee is covered by *individual coverage that is in force on the effective date of this section, a public program, or* other group health care coverage, such as *an employer-sponsored retiree health plan or* group coverage made available by an employer to the employee's spouse that also covers the employee.

2204. Unless the context requires otherwise, the definitions set forth in this section shall govern the construction and meaning of the terms and phrases used in this part:

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

(b) "Employer" means any individual, corporation, association, partnership, or limited liability company~~, or any agent thereof,~~ doing business in this state, deriving income from sources within this state, or in any manner whatsoever subject to the laws of this state, the State of California or any political subdivision or agency thereof, including the Regents of the University of California, any city organized under a freeholders' charter, or any political body not a subdivision or agency of the state, any person, officer, employee, department, or agency thereof, making payment of wages to employees for services performed within this state, consistent with regulations adopted pursuant to Section 2200.

(c) "Fund" means the California Health Trust Fund created pursuant to Section ~~12699.207~~ *12699.212* of the Insurance Code.

(d) *(1)* "Health care expenditures" means any amount paid by an employer subject to this section to, or on behalf of, its employees and dependents, if applicable, to provide health care or health-related services or to reimburse the costs of those services, including, but not limited to, any of the following:

~~(1)~~

(A) Contributions to a health savings account as defined by Section 223 of the Internal Revenue Code.

~~(2)~~

(B) Reimbursement by the employer to its employees, and their dependents, if applicable, for incurred health care expenses, where

those recipients have no entitlement to that reimbursement under any plan, fund, or program maintained by the employer. As used in this ~~paragraph~~ *subparagraph*, "health care expenses" includes, but is not limited to, an expense for which payment is deductible from personal income under Section 213(d) of the Internal Revenue Code.

~~(3)~~

(C) Programs to assist employees to attain and maintain healthy lifestyles, including, but not limited to, onsite wellness programs, reimbursement for attending offsite wellness programs, onsite health fairs and clinics, and financial incentives for participating in health screenings and other wellness activities.

~~(4)~~

(D) Disease management programs.

~~(5)~~

(E) Pharmacy benefit management programs.

~~(6)~~

(F) Care rendered to employees and their dependents by health care providers employed by or under contract to employers, such as employer-sponsored primary care clinics.

~~(7)~~

(G) Purchasing health care coverage from a health care service plan or a health insurer.

(2) "Health care expenditures" does not include a payment made directly or indirectly for workers' compensation, Medicare benefits, or any other health benefit cost, taxes, or assessment that the employer is required to pay by state or federal law, other than as required by Section 2200.

(e) "Public program" means publicly funded health care coverage that is defined as creditable coverage in paragraphs (2) to (10), inclusive, of subdivision (g) of Section 1357 of the Health and Safety Code.

(f) "Wages" means all remuneration, as defined in Article 2 (commencing with Section 926) of Chapter 4 of Part 1 of Division 1 of the Unemployment Insurance Code. "Wages" does not include remuneration described in Sections 930, 930.1, and 930.5 of the Unemployment Insurance Code.

2205. This part shall become operative on January 1, 2010.

~~SEC. 17.~~

SEC. 25. 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 insurance 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. 18.~~

SEC. 26. 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 that are required by this division.

~~SEC. 19. 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. 27. Division 1.2 (commencing with Section 4800) is added to the Unemployment Insurance Code, to read:

DIVISION 1.2. CALIFORNIA HEALTH INSURANCE PURCHASING POOL PROGRAM

4800. The department shall have the powers and duties necessary to administer the enforcement of employer contributions required to be paid pursuant to this division and the reporting and collecting of those contributions and making refunds to the employer.

4801. The following provisions of this code shall apply to any amount required to be deducted, reported, and paid to the department under this division:

(a) Sections 301, 305, 306, 310, 311, 317, and 318, relating to general administrative powers of the department.

(b) Sections 403 to 413, inclusive of Section 1336, and Chapter 8 (commencing with Section 1951) of Part 1 of Division 1, relating to appeals and hearing procedures.

(c) Article 8 (commencing with Section 1126) of Chapter 4 of Part 1 of Division 1, relating to assessments.

(d) Article 9 (commencing with Section 1176), except Section 1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and overpayments.

(e) Article 10 (commencing with Section 1206) of Chapter 4 of Part 1 of Division 1, relating to notice.

(f) Article 11 (commencing with Section 1221) of Chapter 4 of Part 1 of Division 1, relating to administrative appellate review.

(g) Article 12 (commencing with Section 1241) of Chapter 4 of Part 1 of Division 1, relating to judicial review.

(h) Chapter 7 (commencing with Section 1701) of Part 1 of Division 1, relating to collections.

(i) Chapter 10 (commencing with Section 2101) of Part 1 of Division 1, relating to violations.

(j) Sections 1110.6, 1111, 1111.5, 1112, 1113, 1113.1, 1114, 1115, 1116, and 1117 relating to the making of returns or the payment of reported contributions.

4802. For the purposes of this division, the following definitions apply:

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

(b) "California Cooperative Health Insurance Purchasing Program" or "Cal-CHIPP" shall have the same meaning as in Section 12699.201 of the Insurance Code.

(c) "Contribution" means employer fees required by Part 8.8 (commencing with Section 2200) of the Labor Code.

(d) "Employer" has the same meaning as set forth in Section 13005.

(e) "Employment" has the same meaning as set forth in Article 1 (commencing with Section 601) of Chapter 3 of Part 1 of Division 1.

(f) "Wages" means all remuneration as defined in Article 2 (commencing with Section 926) of Chapter 4 of Part 1 of Division 1. As used in this subdivision, "wages" does not include remuneration described in Sections 930, 930.1, and 930.5.

(g) The definitions set forth in Sections 126, 127, 129, 133, and 134 shall apply to this division.

4805. On and after January 1, 2009, in addition to other payments required by this code and consistent with the requirements of Section 2200 of the Labor Code, an employer electing to pay into the California Health Trust Fund pursuant to Section 2200 of the Labor Code shall pay to the department for deposit into that fund the amount required by that section. These contributions shall be collected in the same manner as any contributions required under Part 1 (commencing with Section 100) of Division 1 and Division 6 (commencing with Section 13000). The department shall deposit these contributions in the California Health Trust Fund.

4806. An employer electing to pay a fee pursuant to Section 2200 of the Labor Code shall complete the following actions:

(a) Notify the department of that election by September 15th of the calendar year prior to the inception of coverage in Cal-CHIPP.

(b) Notify the department by September 15th of the intention to terminate employee coverage through Cal-CHIPP for the following year.

(c) Advise all employees of the requirement in Section 2203 of the Labor Code to enroll in Cal-CHIPP to receive coverage from a participating health plan and advise employees of the exemption from that requirement under Section 2203 of the Labor Code.

(d) Report to the department the hiring of an employee who works in this state and to whom the employer anticipates paying wages. The report shall contain the name, address, and social security number of the employee; the employer's name, address, and state employer identification number; and the first date the

employee worked for the employer. An employer shall submit this report within 20 days of hiring or rehiring an employee.

(e) Report to the department the termination of an employee who works in this state within 20 days of the last date of his or her employment.

(f) Remit contributions required by Section 2200 of the Labor Code.

4807. The employer shall provide its employees the option of declining coverage through Cal-CHIPP if the employee certifies that he or she is exempt from this requirement pursuant to Section 2203 of the Labor Code.

4808. The employer shall advise its employees of the right to apply to the board to determine eligibility for a subsidy under Cal-CHIPP if the employee's household income is at or below 300 percent of the federal poverty level.

4809. An employer electing to pay the fee pursuant to Section 2200 of the Labor Code shall remain in Cal-CHIPP for not less than two calendar years and shall not be eligible to rejoin Cal-CHIPP for a minimum of two calendar years after terminating participation in Cal-CHIPP.

4810. The board shall annually publish information describing health plan choices in Cal-CHIPP for the department to disseminate to all participating employers.

4820. (a) The department may assess a penalty against an employer for failure to make the report required by subdivision (d) of Section 4806 within the specified timeframe, unless the failure is due to good cause, as determined by the department. The director shall adopt regulations establishing a schedule of penalties to be imposed depending upon the frequency of violations, the history of previous violations, if any, and the seriousness of the violation. The schedule shall provide for a penalty of up to one hundred dollars ($100) for an initial violation and for the imposition of penalties in progressively higher amounts for the most serious types of violations, to a maximum amount of five thousand dollars ($5,000) per violation.

(b) Notwithstanding any other provision of this code, an employer electing to pay the contribution who fails to file or remit the contribution and employee health care contributions under this division within the time required, shall become liable for a penalty of ____ dollars ($____) and interest on those contributions

at an annual rate of ____ from the due date until the date they are paid.

4825. The department shall deposit all employer and employee contributions in the California Health Trust Fund created pursuant to Section 12699.212 of the Insurance Code. The department shall deposit all fines, penalties, and interest collected pursuant to this division into a penalty account within the California Health Trust Fund. Notwithstanding the provisions of Section 12699.212 of the Insurance Code, the revenue in the penalty account shall not be continuously appropriated to the board and shall be available for expenditure only upon appropriation by the Legislature.

4826. The department shall provide the board with identifying information for employees eligible for Cal-CHIPP whose employer has elected to pay the fee under Section 2200 of the Labor Code.

4830. The department shall adopt rules and regulations to implement the provisions of this division.

4835. The department is authorized to obtain a loan from the General Fund for all necessary and reasonable expenses incurred prior to January 1, 2011 related to implementing this division and administering its provisions. The proceeds of the loan are subject to appropriation in the annual Budget Act. The department shall repay principal and interest, using the pooled money investment account rate of interest, to the General Fund no later than January 1, 2016.

4836. This division shall become operative on January 1, 2010.

~~SEC. 20.~~

SEC. 28. Section 14005.23 of the Welfare and Institutions Code is amended to read:

14005.23. (a) To the extent federal financial participation is available, the department shall, when determining eligibility for children under Section 1396a(*l*)(1)(D) of Title 42 of the United States Code, designate a birth date by which all children who have not attained the age of 19 years will meet the age requirement of Section 1396a(*l*)(1)(D) of Title 42 of the United States Code.

(b) Commencing July 1, 2008, to the extent federal financial participation is available, the department shall apply a less restrictive income deduction described in Section 1396a(r) of Title 42 of the United States Code when determining eligibility for the children identified in subdivision (a). The amount of this deduction

shall be the difference between 133 percent and 100 percent of the federal poverty level applicable to the size of the family.

(c) The coverage under this section for a child who is a dependent of an employee of an employer electing to make a payment to the California Health Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a Medi-Cal benchmark plan under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

~~SEC. 21.~~

SEC. 29. Section 14005.30 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

2 of the Government Code. Beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

SEC. 30. Section 14005.31 of the Welfare and Institutions Code is amended to read:

14005.31. (a) (1) Subject to paragraph (2), for any person whose eligibility for benefits under Section 14005.30 has been determined with a concurrent determination of eligibility for cash aid under Chapter 2 (commencing with Section 11200), loss of eligibility or termination of cash aid under Chapter 2 (commencing with Section 11200) shall not result in a loss of eligibility or termination of benefits under Section 14005.30 absent the existence of a factor that would result in loss of eligibility for benefits under Section 14005.30 for a person whose eligibility under Section 14005.30 was determined without a concurrent determination of eligibility for benefits under Chapter 2 (commencing with Section 11200).

(2) Notwithstanding paragraph (1), a person whose eligibility would otherwise be terminated pursuant to that paragraph shall not have his or her eligibility terminated until the transfer procedures set forth in Section 14005.32 or the redetermination procedures set forth in Section 14005.37 and all due process requirements have been met.

(b) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform Medi-Cal beneficiaries whose eligibility for cash aid under Chapter 2 (commencing with Section 11200) has ended, but whose eligibility for benefits under Section 14005.30 continues pursuant to subdivision (a), that their benefits will continue. To the extent feasible, the notice shall be sent out at the same time as the notice of discontinuation of cash aid, and shall include all of the following:

(1) A statement that Medi-Cal benefits will continue even though cash aid under the CalWORKs program has been terminated.

(2) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(3) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but shall be required to submit a semiannual status report and annual reaffirmation forms, *except that the semiannual status report shall no longer be required on and after July 1, 2008*. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that he or she should review his or her circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

(4) A statement describing the responsibility of the Medi-Cal beneficiary to report to the county, within 10 days, significant changes that may affect eligibility.

(5) A telephone number to call for more information.

(6) A statement that the Medi-Cal beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's eligibility workers can be contacted.

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

SEC. 31. Section 14005.32 of the Welfare and Institutions Code is amended to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30, but is eligible for benefits under this chapter pursuant to other provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(B) The name of the program under which benefits will continue, and an explanation of that program.

(C) A statement that continued receipt of Medi-Cal benefits will not be counted against any time limits in existence for receipt of cash aid under the CalWORKs program.

(D) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but shall be required to submit a semiannual status report and annual reaffirmation forms, *except that the semiannual status report shall no longer be required on and after July 1, 2008*. In addition, if the person or persons to whom the notice is directed has been found eligible for transitional Medi-Cal as described in Section 14005.8, 14005.81, or 14005.85, the statement shall explain the reporting requirements and duration of benefits under those programs, and shall further explain that, at the end of the duration of these benefits, a redetermination, as provided for in Section 14005.37 shall be conducted to determine whether benefits are available under any other provision of law.

(E) A statement describing the beneficiary's responsibility to report to the county, within 10 days, significant changes that may affect eligibility or share of cost.

(F) A telephone number to call for more information.

(G) A statement that the beneficiary's eligibility worker will not change, or, if the case has been reassigned, the new worker's name, address, and telephone number, and the hours during which the county's Medi-Cal eligibility workers can be contacted.

(b) No later than September 1, 2001, the department shall submit a federal waiver application seeking authority to eliminate the

reporting requirements imposed by transitional medicaid under Section 1925 of the federal Social Security Act (Title 42 U.S.C. Sec. 1396r-6).

(c) This section shall be implemented on or before July 1, 2001, but only to the extent that federal financial participation under Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 1396 and following) is available.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Comprehensive implementing instructions shall be issued to the counties no later than March 1, 2001.

~~SEC. 22.~~

SEC. 32. 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 *Healthy Families* 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.~~ *1396u-7) shall be provided to a population composed of parents and other caretaker relatives with a household income at or below 300 percent of the federal poverty level who are not otherwise eligible for full scope benefits with no share of cost.*

~~(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 *Healthy Families* 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.~~

(c) The eligibility determination under this section shall not include an asset test.

(d) To the extent necessary to implement this section, the department shall seek federal approval to modify the definition of "unemployed parent" in Section 14008.85.

(e) The department shall implement this section by means of a state plan amendment. If this section cannot be implemented by a state plan amendment, the department shall seek a waiver or a waiver and a state plan amendment necessary to accomplish the intent of this section.

~~SEC. 23.~~

SEC. 33. Section 14005.34 is added to the Welfare and Institutions Code, to read:

14005.34. *(a)* 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~~ *satisfy either of the following criteria:*

(1) Live in families with countable household income at or below 133 percent of the federal poverty ~~level, or (b) meet~~ *level.*

(2) 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.).

(b) Notwithstanding any other provision of law, an infant under 1 year of age who meets the state residency requirements of the Medi-Cal program shall be eligible for full scope benefits under this chapter if the infant lives in a family with countable household income at or below 200 percent of the federal poverty level, 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.).

(c) The coverage under this section for a child who is an employee or, if applicable, a dependent of an employee of an employer electing to make a payment to the California Health Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a Medi-Cal benchmark plan under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

~~SEC. 24.~~

SEC. 34. 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) The coverage under this section for a person who is an employee or, if applicable, a dependent of an employee, of an employer electing to make a payment to the California Health Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a

Medi-Cal benchmark plan under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

~~(b)~~

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

SEC. 35. Section 14131.01 is added to the Welfare and Institutions Code, to read:

14131.01. The coverage under this chapter to a person who is an employee or, if applicable, a dependent of an employee, of an employer electing to make a payment to the California Health Trust Fund in lieu of making health care expenditures pursuant to Section 2200 of the Labor Code, shall be provided through a Medi-Cal benchmark plan under Part 6.45 (commencing with Section 12699.201) of the Insurance Code.

~~SEC. 25.~~

SEC. 36. Article 7 (commencing with Section 14199.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 7. Coordination with the California Health Trust Fund

14199.10. The department shall seek any necessary federal approval to enable the state to receive federal funds for coverage provided through the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) to persons who would be eligible ~~for 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~~ *for the Medi-Cal program if the state expanded eligibility to a population composed of parents and other caretaker relatives with a household income at or below 300 percent of the federal poverty level who are not otherwise eligible for full-scope benefits with no share of cost. Revenues in the California Health Trust Fund*

created pursuant to Section 12699.206 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 federal approval shall be deposited in the California Health Trust Fund.

~~SEC. 26.~~

SEC. 37. ~~(a)~~ Sections ~~4, 9, 15, and 22~~ *23 and 32* of this act shall become operative on July 1, 2008.

~~(b) Sections 14, 16, and 19 of this act shall become operative on January 1, 2009.~~

~~SEC. 27.~~

SEC. 38. The Legislature finds and declares that Section ~~2~~ *3* of this act, which amends Section 6254 of the Government Code, *and Section 4, which amends Section 11126 of the Government Code,* ~~imposes~~ *impose* a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to maximize the ability of the Managed Risk Medical Insurance Board to implement agreements with health plans and to provide a wide choice of plans at minimal cost under the California Cooperative Health Insurance Purchasing Program created pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, it is necessary and appropriate to provide limited confidentiality to certain writings developed in that regard.

SEC. 39. Notwithstanding any other provision of law, the Managed Risk Medical Insurance Board may implement the provisions of this act expanding the Healthy Families Program only to the extent that funds are appropriated for those purposes in the annual Budget Act or in another statute.

~~SEC. 28.~~

SEC. 40. 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.

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