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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 Sections 6254 and 11126 of, and to add Section 12803.2 to, the Government Code, to amend Sections ~~1363~~ 1357, 1357.12, 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, 10700, 10714, 12693.43, 12693.70, 12693.73, 12693.755, and 12693.76 of, to add Sections 10293.5, ~~12693.58~~, 12693.57, 12693.58, 12693.59, 12693.621, and 12711.1 to, to add Chapter 1.6 (commencing with Section 10199.10) and Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of,

the Insurance Code, to 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 Sections 131, 144, and 1095 of, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 14005.23, 14005.30, 14005.31, 14005.32, and 14008.85 of, to amend and repeal Section 14011.16 of, to add Sections 14005.33, 14005.34, 14005.33, 14005.331, 14005.82, and 14131.01 to, and to add Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 8, as amended, Nunez. Health care 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 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, ~~2010~~ 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a statewide purchasing pool for health care coverage by employers and be administered by the Managed Risk Medical Insurance Board. The bill, ~~as of January 1, 2010,~~ would generally require employers to ~~make~~ *elect prior to July 1, 2009, 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 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. *The bill would require an employer to commence paying the employer fee or making the health expenditures on October 1, 2009.* The bill would make it unlawful for an employer to take certain actions for the purpose of avoiding this requirement. *By creating a new crime, the bill would impose a state-mandated local program.* The bill would require ~~an employer electing to pay the fee to notify employers to provide~~ the Employment Development Department *with specified wage and health expenditures information* and comply with other specified requirements ~~and~~. *The bill would authorize the department to assess a penalty against an employer who failed to comply with certain reporting those requirements or to remit fees within the requisite time period failed to remit the employer fees and employee premium payments.* ~~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 *and penalties, and employee premiums* would be collected by the Employment Development Department for deposit in the California Health Trust Fund created by the bill, and moneys in the fund, *other than penalty revenues,* would be continuously appropriated to the board for the purposes of the bill. The bill would

require the board to offer Cal-CHIPP enrollees a choice of various health plans. The bill would exempt certain writings of the board from disclosure under the Public Records Act and would specify that the board may meet in closed session to develop rates and contracting strategy pursuant to Cal-CHIPP.

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

(3) The bill would enact various health insurance market reforms, to be operative on specified dates, including requirements for guarantee issue of individual health care service plan contracts and health insurance policies, simplified benefit designs, modified small employer coverage, modified disclosures, and other related changes. *The bill would prohibit the application, on and after January 1, 2010, of a risk adjustment factor to plans and contracts issued to employers with not more than 250 employees.* The bill would require health care service plans and health insurers offering group plans to offer benchmark plans or 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. The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to adopt regulations by July 1, 2008, to require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care services and not on administrative costs. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all health care service plans and health insurers and providers shall adopt standard electronic medical records by January 1, 2012.

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

This bill would require the board to establish a list of conditions or diagnoses making an applicant automatically eligible for the program and to develop a standardized questionnaire for carriers in the individual market to identify persons eligible for the program. The bill would prohibit a health insurer and a health care service plan from denying coverage to an individual, except for those who are automatically eligible for the program.

(5) The 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:

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

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

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

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

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

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

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

27 ~~6254. Except as provided in Sections 6254.7 and 6254.13,~~
28 ~~nothing in this chapter shall be construed to require disclosure of~~
29 ~~records that are any of the following:~~

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

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

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

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

- 1 ~~(1) Applications filed with any state agency responsible for the~~
2 ~~regulation or supervision of the issuance of securities or of financial~~
3 ~~institutions, including, but not limited to, banks, savings and loan~~
4 ~~associations, industrial loan companies, credit unions, and~~
5 ~~insurance companies.~~
6 ~~(2) Examination, operating, or condition reports prepared by,~~
7 ~~on behalf of, or for the use of, any state agency referred to in~~
8 ~~paragraph (1).~~
9 ~~(3) Preliminary drafts, notes, or interagency or intra-agency~~
10 ~~communications prepared by, on behalf of, or for the use of, any~~
11 ~~state agency referred to in paragraph (1).~~
12 ~~(4) Information received in confidence by any state agency~~
13 ~~referred to in paragraph (1).~~
14 ~~(e) Geological and geophysical data, plant production data, and~~
15 ~~similar information relating to utility systems development, or~~
16 ~~market or crop reports, that are obtained in confidence from any~~
17 ~~person.~~
18 ~~(f) Records of complaints to, or investigations conducted by,~~
19 ~~or records of intelligence information or security procedures of,~~
20 ~~the office of the Attorney General and the Department of Justice,~~
21 ~~and any state or local police agency, or any investigatory or security~~
22 ~~files compiled by any other state or local police agency, or any~~
23 ~~investigatory or security files compiled by any other state or local~~
24 ~~agency for correctional, law enforcement, or licensing purposes.~~
25 ~~However, state and local law enforcement agencies shall disclose~~
26 ~~the names and addresses of persons involved in, or witnesses other~~
27 ~~than confidential informants to, the incident, the description of~~
28 ~~any property involved, the date, time, and location of the incident,~~
29 ~~all diagrams, statements of the parties involved in the incident, the~~
30 ~~statements of all witnesses, other than confidential informants, to~~
31 ~~the victims of an incident, or an authorized representative thereof,~~
32 ~~an insurance carrier against which a claim has been or might be~~
33 ~~made, and any person suffering bodily injury or property damage~~
34 ~~or loss, as the result of the incident caused by arson, burglary, fire,~~
35 ~~explosion, larceny, robbery, carjacking, vandalism, vehicle theft,~~
36 ~~or a crime as defined by subdivision (b) of Section 13951, unless~~
37 ~~the disclosure would endanger the safety of a witness or other~~
38 ~~person involved in the investigation, or unless disclosure would~~
39 ~~endanger the successful completion of the investigation or a related~~
40 ~~investigation. However, nothing in this division shall require the~~

1 disclosure of that portion of those investigative files that reflects
2 the analysis or conclusions of the investigating officer.

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

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

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

21 (2) Subject to the restrictions imposed by Section 841.5 of the
22 Penal Code, the time, substance, and location of all complaints or
23 requests for assistance received by the agency and the time and
24 nature of the response thereto, including, to the extent the
25 information regarding crimes alleged or committed or any other
26 incident investigated is recorded, the time, date, and location of
27 occurrence, the time and date of the report, the name and age of
28 the victim, the factual circumstances surrounding the crime or
29 incident, and a general description of any injuries, property, or
30 weapons involved. The name of a victim of any crime defined by
31 Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286,
32 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code
33 may be withheld at the victim's request, or at the request of the
34 victim's parent or guardian if the victim is a minor. When a person
35 is the victim of more than one crime, information disclosing that
36 the person is a victim of a crime defined by Section 220, 261,
37 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6,
38 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the
39 request of the victim, or the victim's parent or guardian if the
40 victim is a minor, in making the report of the crime, or of any

1 crime or incident accompanying the crime, available to the public
2 in compliance with the requirements of this paragraph.

3 ~~(3) Subject to the restrictions of Section 841.5 of the Penal Code
4 and this subdivision, the current address of every individual
5 arrested by the agency and the current address of the victim of a
6 crime, where the requester declares under penalty of perjury that
7 the request is made for a scholarly, journalistic, political, or
8 governmental purpose, or that the request is made for investigation
9 purposes by a licensed private investigator as described in Chapter
10 11.3 (commencing with Section 7512) of Division 3 of the Business
11 and Professions Code. However, the address of the victim of any
12 crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a,
13 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9
14 of the Penal Code shall remain confidential. Address information
15 obtained pursuant to this paragraph may not be used directly or
16 indirectly, or furnished to another, to sell a product or service to
17 any individual or group of individuals, and the requester shall
18 execute a declaration to that effect under penalty of perjury.
19 Nothing in this paragraph shall be construed to prohibit or limit a
20 scholarly, journalistic, political, or government use of address
21 information obtained pursuant to this paragraph.~~

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

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

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

38 ~~(j) Library circulation records kept for the purpose of identifying
39 the borrower of items available in libraries, and library and museum
40 materials made or acquired and presented solely for reference or~~

1 ~~exhibition purposes. The exemption in this subdivision shall not~~
2 ~~apply to records of fines imposed on the borrowers.~~

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

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

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

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

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

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

1 activities governed by the employee relations acts referred to in
2 this subdivision.

3 ~~(q) Records of state agencies related to activities governed by
4 Article 2.6 (commencing with Section 14081), Article 2.8
5 (commencing with Section 14087.5), and Article 2.91
6 (commencing with Section 14089) of Chapter 7 of Part 3 of
7 Division 9 of the Welfare and Institutions Code, that reveal the
8 special negotiator's deliberative processes, discussions,
9 communications, or any other portion of the negotiations with
10 providers of health care services, impressions, opinions,
11 recommendations, meeting minutes, research, work product,
12 theories, or strategy, or that provide instruction, advice, or training
13 to employees.~~

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

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

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

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

39 ~~(s) A final accreditation report of the Joint Commission on
40 Accreditation of Hospitals that has been transmitted to the State~~

1 Department of Public Health pursuant to subdivision (b) of Section
2 1282 of the Health and Safety Code.

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

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

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

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

29 ~~(v) (1) Records of the Major Risk Medical Insurance Program~~
30 ~~related to activities governed by Part 6.3 (commencing with Section~~
31 ~~12695) and Part 6.5 (commencing with Section 12700) of Division~~
32 ~~2 of the Insurance Code, and that reveal the deliberative processes,~~
33 ~~discussions, communications, or any other portion of the~~
34 ~~negotiations with health plans, or the impressions, opinions,~~
35 ~~recommendations, meeting minutes, research, work product,~~
36 ~~theories, or strategy of the board or its staff, or records that provide~~
37 ~~instructions, advice, or training to employees.~~

38 ~~(2) (A) Except for the portion of a contract that contains the~~
39 ~~rates of payment, contracts for health coverage entered into~~
40 ~~pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5~~

1 ~~(commencing with Section 12700) of Division 2 of the Insurance~~
2 ~~Code, on or after July 1, 1991, shall be open to inspection one year~~
3 ~~after they have been fully executed.~~

4 ~~(B) If a contract for health coverage that is entered into prior to~~
5 ~~July 1, 1991, is amended on or after July 1, 1991, the amendment,~~
6 ~~except for any portion containing the rates of payment, shall be~~
7 ~~open to inspection one year after the amendment has been fully~~
8 ~~executed.~~

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

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

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

28 ~~(2) Except for the portion of a contract that contains the rates~~
29 ~~of payment, contracts for health coverage entered into pursuant to~~
30 ~~Chapter 14 (commencing with Section 10700) of Part 2 of Division~~
31 ~~2 of the Insurance Code, on or after January 1, 1993, shall be open~~
32 ~~to inspection one year after they have been fully executed.~~

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

39 ~~(x) Financial data contained in applications for registration, or~~
40 ~~registration renewal, as a service contractor filed with the Director~~

1 of Consumer Affairs pursuant to Chapter 20 (commencing with
2 Section 9800) of Division 3 of the Business and Professions Code,
3 for the purpose of establishing the service contractor's net worth,
4 or financial data regarding the funded accounts held in escrow for
5 service contracts held in force in this state by a service contractor.

6 ~~(y) (1) Records of the Managed Risk Medical Insurance Board~~
7 ~~related to activities governed by Part 6.2 (commencing with Section~~
8 ~~12693) or Part 6.4 (commencing with Section 12699.50) of~~
9 ~~Division 2 of the Insurance Code, and that reveal the deliberative~~
10 ~~processes, discussions, communications, or any other portion of~~
11 ~~the negotiations with health plans, or the impressions, opinions,~~
12 ~~recommendations, meeting minutes, research, work product,~~
13 ~~theories, or strategy of the board or its staff, or records that provide~~
14 ~~instructions, advice, or training to employees.~~

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

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

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

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

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

1 apply to the contracts, deliberative processes, discussions,
2 communications, negotiations with health plans, impressions,
3 opinions, recommendations, meeting minutes, research, work
4 product, theories, or strategy of applicants pursuant to Part 6.4
5 (commencing with Section 12699.50) of Division 2 of the
6 Insurance Code.

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

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

13 (bb) Critical infrastructure information, as defined in Section
14 131(3) of Title 6 of the United States Code, that is voluntarily
15 submitted to the California Office of Homeland Security for use
16 by that office, including the identity of the person who or entity
17 that voluntarily submitted the information. As used in this
18 subdivision, "voluntarily submitted" means submitted in the
19 absence of the office exercising any legal authority to compel
20 access to or submission of critical infrastructure information. This
21 subdivision shall not affect the status of information in the
22 possession of any other state or local governmental agency.

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

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

37 (2) (A) Except for the portion of a contract that contains the
38 rates of payment, contracts entered into pursuant to Part 6.45
39 (commencing with Section 12699.201) of Division 2 of the

1 Insurance Code on or after January 1, 2008, shall be open to
2 inspection one year after they have been fully executed.

3 (B) If a contract entered into pursuant to Part 6.45 (commencing
4 with Section 12699.201) of Division 2 of the Insurance Code is
5 amended, the amendment shall be open to inspection one year after
6 the amendment has been fully executed.

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

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

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

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

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

27 11126. (a) (1) Nothing in this article shall be construed to
28 prevent a state body from holding closed sessions during a regular
29 or special meeting to consider the appointment, employment,
30 evaluation of performance, or dismissal of a public employee or
31 to hear complaints or charges brought against that employee by
32 another person or employee unless the employee requests a public
33 hearing.

34 (2) As a condition to holding a closed session on the complaints
35 or charges to consider disciplinary action or to consider dismissal,
36 the employee shall be given written notice of his or her right to
37 have a public hearing, rather than a closed session, and that notice
38 shall be delivered to the employee personally or by mail at least
39 24 hours before the time for holding a regular or special meeting.

1 If notice is not given, any disciplinary or other action taken against
2 any employee at the closed session shall be null and void.

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

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

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

17 ~~(e) Nothing in this article shall be construed to do any of the~~
18 ~~following:~~

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

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

35 ~~(3) Prohibit a state body from holding a closed session to~~
36 ~~deliberate on a decision to be reached in a proceeding required to~~
37 ~~be conducted pursuant to Chapter 5 (commencing with Section~~
38 ~~11500) or similar provisions of law.~~

39 ~~(4) Grant a right to enter any correctional institution or the~~
40 ~~grounds of a correctional institution where that right is not~~

1 otherwise granted by law, nor shall anything in this article be
2 construed to prevent a state body from holding a closed session
3 when considering and acting upon the determination of a term,
4 parole, or release of any individual or other disposition of an
5 individual case, or if public disclosure of the subjects under
6 discussion or consideration is expressly prohibited by statute.

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

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

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

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

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

24 (D) For purposes of this paragraph, “lease” includes renewal or
25 renegotiation of a lease.

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

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

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

38 (10) Prevent the Franchise Tax Board from holding closed
39 sessions for the purpose of discussion of confidential tax returns
40 or information the public disclosure of which is prohibited by law,

1 or from considering matters pertaining to the appointment or
2 removal of the Executive Officer of the Franchise Tax Board.

3 (11) Require the Franchise Tax Board to notice or disclose any
4 confidential tax information considered in closed sessions, or
5 documents executed in connection therewith, the public disclosure
6 of which is prohibited pursuant to Article 2 (commencing with
7 Section 19542) of Chapter 7 of Part 10.2 of the Revenue and
8 Taxation Code.

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

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

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

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

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

1 provisions of paragraph (7) relating to the identification of real
2 properties prior to the closed session:

3 (17) Prevent a state body, or boards, commissions,
4 administrative officers, or other representatives that may properly
5 be designated by law or by a state body, from holding closed
6 sessions with its representatives in discharging its responsibilities
7 under Chapter 10 (commencing with Section 3500), Chapter 10.3
8 (commencing with Section 3512), Chapter 10.5 (commencing with
9 Section 3525), or Chapter 10.7 (commencing of Section 3540) of
10 Division 4 of Title 1 as the sessions relate to salaries, salary
11 schedules, or compensation paid in the form of fringe benefits.
12 For the purposes enumerated in the preceding sentence, a state
13 body may also meet with a state conciliator who has intervened
14 in the proceedings.

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

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

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

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

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

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

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

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

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

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

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

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

37 ~~(ii) The legal counsel of the state body shall prepare and submit~~
38 ~~to it a memorandum stating the specific reasons and legal authority~~
39 ~~for the closed session. If the closed session is pursuant to paragraph~~
40 ~~(1), the memorandum shall include the title of the litigation. If the~~

1 closed session is pursuant to subparagraph (A) or (B), the
2 memorandum shall include the existing facts and circumstances
3 on which it is based. The legal counsel shall submit the
4 memorandum to the state body prior to the closed session, if
5 feasible, and in any case no later than one week after the closed
6 session. The memorandum shall be exempt from disclosure
7 pursuant to Section 6254.25.

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

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

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

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

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

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

- 1 ~~(4) Prevent a state body, as defined in subdivision (b) of Section~~
2 ~~11121, from conducting a closed session to consider any matter~~
3 ~~that properly could be considered in closed session by the state~~
4 ~~body whose authority it exercises.~~
- 5 ~~(5) Prevent a state body, as defined in subdivision (d) of Section~~
6 ~~11121, from conducting a closed session to consider any matter~~
7 ~~that properly could be considered in a closed session by the body~~
8 ~~defined as a state body pursuant to subdivision (a) or (b) of Section~~
9 ~~11121.~~
- 10 ~~(6) Prevent a state body, as defined in subdivision (e) of Section~~
11 ~~11121, from conducting a closed session to consider any matter~~
12 ~~that properly could be considered in a closed session by the state~~
13 ~~body it advises.~~
- 14 ~~(7) Prevent the State Board of Equalization from holding closed~~
15 ~~sessions for either of the following:~~
- 16 ~~(A) When considering matters pertaining to the appointment or~~
17 ~~removal of the Executive Secretary of the State Board of~~
18 ~~Equalization.~~
- 19 ~~(B) For the purpose of hearing confidential taxpayer appeals or~~
20 ~~data, the public disclosure of which is prohibited by law.~~
- 21 ~~(8) Require the State Board of Equalization to disclose any~~
22 ~~action taken in closed session or documents executed in connection~~
23 ~~with that action, the public disclosure of which is prohibited by~~
24 ~~law pursuant to Sections 15619 and 15641 of this code and Sections~~
25 ~~833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651,~~
26 ~~45982, 46751, 50159, 55381, and 60609 of the Revenue and~~
27 ~~Taxation Code.~~
- 28 ~~(9) Prevent the California Earthquake Prediction Evaluation~~
29 ~~Council, or other body appointed to advise the Director of the~~
30 ~~Office of Emergency Services or the Governor concerning matters~~
31 ~~relating to volcanic or earthquake predictions, from holding closed~~
32 ~~sessions when considering the evaluation of possible predictions.~~
- 33 ~~(g) This article does not prevent either of the following:~~
- 34 ~~(1) The Teachers' Retirement Board or the Board of~~
35 ~~Administration of the Public Employees' Retirement System from~~
36 ~~holding closed sessions when considering matters pertaining to~~
37 ~~the recruitment, appointment, employment, or removal of the chief~~
38 ~~executive officer or when considering matters pertaining to the~~
39 ~~recruitment or removal of the Chief Investment Officer of the State~~

1 Teachers' Retirement System or the Public Employees' Retirement
2 System:

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

6 ~~(h) This article does not prevent the Board of Administration~~
7 ~~of the Public Employees' Retirement System from holding closed~~
8 ~~sessions when considering matters relating to the development of~~
9 ~~rates and competitive strategy for plans offered pursuant to Chapter~~
10 ~~15 (commencing with Section 21660) of Part 3 of Division 5 of~~
11 ~~Title 2.~~

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

18 ~~SEC. 5.~~

19 *SEC. 3.* Section 12803.2 is added to the Government Code, to
20 read:

21 12803.2. (a) The California Health and Human Services
22 Agency shall encourage fitness, wellness, and health promotion
23 programs that promote safe workplaces, healthy employer practices,
24 and individual efforts to improve health.

25 (b) (1) The Secretary of California Health and Human Services
26 shall establish and administer a program to track and assess the
27 effects of health care reform as set forth in the California Health
28 Care Reform and Cost Control Act. The secretary shall either
29 complete the assessment or contract for its preparation. If the
30 secretary determines to contract for the preparation of the
31 assessment, he or she shall seek a partnership and contract with
32 independent, nonprofit groups or foundations, academic
33 institutions, or governmental entities providing grants for
34 health-related activities. The secretary may seek other sources of
35 funding, including grants, to fund the assessment. The assessment
36 shall include, at minimum, the following components:

37 (A) An assessment of the sustainability and solvency of the
38 California Cooperative Health Insurance Purchasing Program
39 (Cal-CHIPP) (Part 6.45 (commencing with Section 12699.201) of
40 Division 2 of the Insurance Code). This assessment shall include

1 the number of persons purchasing health care coverage through
2 Cal-CHIP by income bracket and by the size and type of their
3 employer.

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

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

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

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

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

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

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

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

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

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

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

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

11 (2) An advisory body of individuals with knowledge and
12 expertise in health care *policy* reflecting the broad range of interests
13 in health policy that is chaired by the Secretary of California Health
14 and Human Services shall guide the assessment of health care
15 reform. The Governor shall appoint five members to the advisory
16 body, the Senate Committee on Rules shall appoint two members,
17 and the Speaker of the Assembly shall appoint two members.

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

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

28 (5) The Secretary of California Health and Human Services and
29 the advisory body shall establish a timeline for reporting
30 information to the appropriate policy and fiscal committees of the
31 Legislature. At a minimum, the reporting timeline shall include
32 the release of annual data to serve as a benchmark for the
33 assessment of the health care reform. These annual benchmarks
34 shall include the employer compliance rate and the cost of health
35 care coverage in the state. In addition, the timeline shall include
36 more in-depth reports addressing the items listed under paragraph
37 (1).

38 (c) The California Health and Human Services Agency, in
39 consultation with the Board of Administration of the Public
40 Employees' Retirement System, and after consultation with

1 affected health care provider groups, shall develop health care
2 provider performance measurement benchmarks and incorporate
3 these benchmarks into a common pay for performance model to
4 be offered in every state-administered health care program,
5 including, but not limited to, the Public Employees’ Medical and
6 Hospital Care Act, the Healthy Families Program, the Major Risk
7 Medical Insurance Program, the Medi-Cal program, and
8 Cal-CHIPP. These benchmarks shall be developed to advance a
9 common statewide framework for health care quality measurement
10 and reporting, including, but not limited to, measures that have
11 been approved by the National Quality Forum (NQF) such as the
12 Health Plan Employer Data and Information Set (HEDIS) and the
13 Joint Commission on Accreditation of Health Care Organizations
14 (JCAHO), and that have been adopted by the Hospitals Quality
15 Alliance and other national and statewide groups concerned with
16 quality.

17 (d) The California Health and Human Services Agency, in
18 consultation with the Board of Administration of the Public
19 Employees’ Retirement System, shall assume lead agency
20 responsibility for professional review and development of best
21 practice standards in the care and treatment of patients with
22 high-cost chronic diseases, such as asthma, diabetes, and heart
23 disease. *In developing the best practice standards, the agency shall*
24 *consider the use of an annual health assessment for patients.* Upon
25 adoption of the standards, each state health care program, including,
26 but not limited to, programs offered under the Public Employees’
27 Medical and Hospital Care Act, the Medi-Cal program, the Healthy
28 Families Program, the Major Risk Medical Insurance Program,
29 and the California Cooperative Health Insurance Purchasing
30 Program, shall implement those standards.

31 *SEC. 4. Section 1357 of the Health and Safety Code is amended*
32 *to read:*

33 1357. As used in this article:

34 (a) “Dependent” means the spouse or child of an eligible
35 employee, subject to applicable terms of the health care plan
36 contract covering the employee, and includes dependents of
37 guaranteed association members if the association elects to include
38 dependents under its health coverage at the same time it determines
39 its membership composition pursuant to subdivision (o).

40 (b) “Eligible employee” means either of the following:

1 (1) Any permanent employee who is actively engaged on a
2 full-time basis in the conduct of the business of the small employer
3 with a normal workweek of at least 30 hours, at the small
4 employer's regular places of business, who has met any statutorily
5 authorized applicable waiting period requirements. The term
6 includes sole proprietors or partners of a partnership, if they are
7 actively engaged on a full-time basis in the small employer's
8 business and included as employees under a health care plan
9 contract of a small employer, but does not include employees who
10 work on a part-time, temporary, or substitute basis. It includes any
11 eligible employee, as defined in this paragraph, who obtains
12 coverage through a guaranteed association. Employees of
13 employers purchasing through a guaranteed association shall be
14 deemed to be eligible employees if they would otherwise meet the
15 definition except for the number of persons employed by the
16 employer. Permanent employees who work at least 20 hours but
17 not more than 29 hours are deemed to be eligible employees if all
18 four of the following apply:

19 (A) They otherwise meet the definition of an eligible employee
20 except for the number of hours worked.

21 (B) The employer offers the employees health coverage under
22 a health benefit plan.

23 (C) All similarly situated individuals are offered coverage under
24 the health benefit plan.

25 (D) The employee must have worked at least 20 hours per
26 normal workweek for at least 50 percent of the weeks in the
27 previous calendar quarter. The health care service plan may request
28 any necessary information to document the hours and time period
29 in question, including, but not limited to, payroll records and
30 employee wage and tax filings.

31 (2) Any member of a guaranteed association as defined in
32 subdivision (o).

33 (c) "In force business" means an existing health benefit plan
34 contract issued by the plan to a small employer.

35 (d) "Late enrollee" means an eligible employee or dependent
36 who has declined enrollment in a health benefit plan offered by a
37 small employer at the time of the initial enrollment period provided
38 under the terms of the health benefit plan and who subsequently
39 requests enrollment in a health benefit plan of that small employer,
40 provided that the initial enrollment period shall be a period of at

1 least 30 days. It also means any member of an association that is
2 a guaranteed association as well as any other person eligible to
3 purchase through the guaranteed association when that person has
4 failed to purchase coverage during the initial enrollment period
5 provided under the terms of the guaranteed association's plan
6 contract and who subsequently requests enrollment in the plan,
7 provided that the initial enrollment period shall be a period of at
8 least 30 days. However, an eligible employee, any other person
9 eligible for coverage through a guaranteed association pursuant to
10 subdivision (o), or an eligible dependent shall not be considered
11 a late enrollee if any of the following is applicable:

12 (1) The individual meets all of the following requirements:

13 (A) He or she was covered under another employer health
14 benefit plan, the Healthy Families Program, or no share-of-cost
15 Medi-Cal coverage at the time the individual was eligible to enroll.

16 (B) He or she certified at the time of the initial enrollment that
17 coverage under another employer health benefit plan, the Healthy
18 Families Program, or no share-of-cost Medi-Cal coverage was the
19 reason for declining enrollment, provided that, if the individual
20 was covered under another employer health plan, the individual
21 was given the opportunity to make the certification required by
22 this subdivision and was notified that failure to do so could result
23 in later treatment as a late enrollee.

24 (C) He or she has lost or will lose coverage under another
25 employer health benefit plan as a result of termination of
26 employment of the individual or of a person through whom the
27 individual was covered as a dependent, change in employment
28 status of the individual or of a person through whom the individual
29 was covered as a dependent, termination of the other plan's
30 coverage, cessation of an employer's contribution toward an
31 employee or dependent's coverage, death of the person through
32 whom the individual was covered as a dependent, legal separation,
33 divorce, loss of coverage under the Healthy Families Program as
34 a result of exceeding the program's income or age limits, or loss
35 of no share-of-cost Medi-Cal coverage.

36 (D) He or she requests enrollment within 30 days after
37 termination of coverage or employer contribution toward coverage
38 provided under another employer health benefit plan.

39 (2) The employer offers multiple health benefit plans and the
40 employee elects a different plan during an open enrollment period.

1 (3) A court has ordered that coverage be provided for a spouse
2 or minor child under a covered employee's health benefit plan.

3 (4) (A) In the case of an eligible employee, as defined in
4 paragraph (1) of subdivision (b), the plan cannot produce a written
5 statement from the employer stating that the individual or the
6 person through whom the individual was eligible to be covered as
7 a dependent, prior to declining coverage, was provided with, and
8 signed, acknowledgment of an explicit written notice in boldface
9 type specifying that failure to elect coverage during the initial
10 enrollment period permits the plan to impose, at the time of the
11 individual's later decision to elect coverage, an exclusion from
12 coverage for a period of 12 months as well as a six-month
13 preexisting condition exclusion, unless the individual meets the
14 criteria specified in paragraph (1), (2), or (3).

15 (B) In the case of an association member who did not purchase
16 coverage through a guaranteed association, the plan cannot produce
17 a written statement from the association stating that the association
18 sent a written notice in boldface type to all potentially eligible
19 association members at their last known address prior to the initial
20 enrollment period informing members that failure to elect coverage
21 during the initial enrollment period permits the plan to impose, at
22 the time of the member's later decision to elect coverage, an
23 exclusion from coverage for a period of 12 months as well as a
24 six-month preexisting condition exclusion unless the member can
25 demonstrate that he or she meets the requirements of subparagraphs
26 (A), (C), and (D) of paragraph (1) or meets the requirements of
27 paragraph (2) or (3).

28 (C) In the case of an employer or person who is not a member
29 of an association, was eligible to purchase coverage through a
30 guaranteed association, and did not do so, and would not be eligible
31 to purchase guaranteed coverage unless purchased through a
32 guaranteed association, the employer or person can demonstrate
33 that he or she meets the requirements of subparagraphs (A), (C),
34 and (D) of paragraph (1), or meets the requirements of paragraph
35 (2) or (3), or that he or she recently had a change in status that
36 would make him or her eligible and that application for enrollment
37 was made within 30 days of the change.

38 (5) The individual is an employee or dependent who meets the
39 criteria described in paragraph (1) and was under a COBRA
40 continuation provision and the coverage under that provision has

1 been exhausted. For purposes of this section, the definition of
2 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
3 apply.

4 (6) The individual is a dependent of an enrolled eligible
5 employee who has lost or will lose his or her coverage under the
6 Healthy Families Program as a result of exceeding the program’s
7 income or age limits or no share-of-cost Medi-Cal coverage and
8 requests enrollment within 30 days after notification of this loss
9 of coverage.

10 (7) The individual is an eligible employee who previously
11 declined coverage under an employer health benefit plan and who
12 has subsequently acquired a dependent who would be eligible for
13 coverage as a dependent of the employee through marriage, birth,
14 adoption, or placement for adoption, and who enrolls for coverage
15 under that employer health benefit plan on his or her behalf and
16 on behalf of his or her dependent within 30 days following the
17 date of marriage, birth, adoption, or placement for adoption, in
18 which case the effective date of coverage shall be the first day of
19 the month following the date the completed request for enrollment
20 is received in the case of marriage, or the date of birth, or the date
21 of adoption or placement for adoption, whichever applies. Notice
22 of the special enrollment rights contained in this paragraph shall
23 be provided by the employer to an employee at or before the time
24 the employee is offered an opportunity to enroll in plan coverage.

25 (8) The individual is an eligible employee who has declined
26 coverage for himself or herself or his or her dependents during a
27 previous enrollment period because his or her dependents were
28 covered by another employer health benefit plan at the time of the
29 previous enrollment period. That individual may enroll himself or
30 herself or his or her dependents for plan coverage during a special
31 open enrollment opportunity if his or her dependents have lost or
32 will lose coverage under that other employer health benefit plan.
33 The special open enrollment opportunity shall be requested by the
34 employee not more than 30 days after the date that the other health
35 coverage is exhausted or terminated. Upon enrollment, coverage
36 shall be effective not later than the first day of the first calendar
37 month beginning after the date the request for enrollment is
38 received. Notice of the special enrollment rights contained in this
39 paragraph shall be provided by the employer to an employee at or

1 before the time the employee is offered an opportunity to enroll
2 in plan coverage.

3 (e) “New business” means a health care service plan contract
4 issued to a small employer that is not the plan’s in force business.

5 (f) “Preexisting condition provision” means a contract provision
6 that excludes coverage for charges or expenses incurred during a
7 specified period following the employee’s effective date of
8 coverage, as to a condition for which medical advice, diagnosis,
9 care, or treatment was recommended or received during a specified
10 period immediately preceding the effective date of coverage.

11 (g) “Creditable coverage” means:

12 (1) Any individual or group policy, contract, or program that is
13 written or administered by a disability insurer, health care service
14 plan, fraternal benefits society, self-insured employer plan, or any
15 other entity, in this state or elsewhere, and that arranges or provides
16 medical, hospital, and surgical coverage not designed to supplement
17 other private or governmental plans. The term includes continuation
18 or conversion coverage but does not include accident only, credit,
19 coverage for onsite medical clinics, disability income, Medicare
20 supplement, long-term care, dental, vision, coverage issued as a
21 supplement to liability insurance, insurance arising out of a
22 workers’ compensation or similar law, automobile medical payment
23 insurance, or insurance under which benefits are payable with or
24 without regard to fault and that is statutorily required to be
25 contained in any liability insurance policy or equivalent
26 self-insurance.

27 (2) The federal Medicare program pursuant to Title XVIII of
28 the Social Security Act.

29 (3) The ~~medicaid~~ *Medicaid* program pursuant to Title XIX of
30 the Social Security Act.

31 (4) Any other publicly sponsored program, provided in this state
32 or elsewhere, of medical, hospital, and surgical care.

33 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
34 (Civilian Health and Medical Program of the Uniformed Services
35 (CHAMPUS)).

36 (6) A medical care program of the Indian Health Service or of
37 a tribal organization.

38 (7) A state health benefits risk pool.

1 (8) A health plan offered under 5 U.S.C. Chapter 89
2 (commencing with Section 8901) (Federal Employees Health
3 Benefits Program (FEHBP)).

4 (9) A public health plan as defined in federal regulations
5 authorized by Section 2701(c)(1)(I) of the Public Health Service
6 Act, as amended by Public Law 104-191, the Health Insurance
7 Portability and Accountability Act of 1996.

8 (10) A health benefit plan under Section 5(e) of the Peace Corps
9 Act (22 U.S.C. Sec. 2504(e)).

10 (11) Any other creditable coverage as defined by subdivision
11 (c) of Section 2701 of Title XXVII of the federal Public Health
12 Services Act (42 U.S.C. Sec. 300gg(c)).

13 (h) “Rating period” means the period for which premium rates
14 established by a plan are in effect and shall be no less than six
15 months.

16 (i) “Risk adjusted employee risk rate” means the rate determined
17 for an eligible employee of a small employer in a particular risk
18 category after applying the risk adjustment factor.

19 (j) “Risk adjustment factor” means the percentage adjustment
20 to be applied equally to each standard employee risk rate for a
21 particular small employer, based upon any expected deviations
22 from standard cost of services. This factor may not be more than
23 120 percent or less than 80 percent until July 1, 1996. Effective
24 July 1, 1996, this factor may not be more than 110 percent or less
25 than 90 percent. *On and after January 1, 2010, no risk adjustment*
26 *factor shall be applied.*

27 (k) “Risk category” means the following characteristics of an
28 eligible employee: age, geographic region, and family composition
29 of the employee, plus the health benefit plan selected by the small
30 employer.

31 (1) No more than the following age categories may be used in
32 determining premium rates:

33 Under 30

34 30–39

35 40–49

36 50–54

37 55–59

38 60–64

39 65 and over

1 However, for the 65 and over age category, separate premium
2 rates may be specified depending upon whether coverage under
3 the plan contract will be primary or secondary to benefits provided
4 by the federal Medicare program pursuant to Title XVIII of the
5 federal Social Security Act.

6 (2) Small employer health care service plans shall base rates to
7 small employers using no more than the following family size
8 categories:

9 (A) Single.

10 (B) Married couple.

11 (C) One adult and child or children.

12 (D) Married couple and child or children.

13 (3) (A) In determining rates for small employers, a plan that
14 operates statewide shall use no more than nine geographic regions
15 in the state, have no region smaller than an area in which the first
16 three digits of all its ZIP Codes are in common within a county,
17 and divide no county into more than two regions. Plans shall be
18 deemed to be operating statewide if their coverage area includes
19 90 percent or more of the state's population. Geographic regions
20 established pursuant to this section shall, as a group, cover the
21 entire state, and the area encompassed in a geographic region shall
22 be separate and distinct from areas encompassed in other
23 geographic regions. Geographic regions may be noncontiguous.

24 (B) (i) In determining rates for small employers, a plan that
25 does not operate statewide shall use no more than the number of
26 geographic regions in the state that is determined by the following
27 formula: the population, as determined in the last federal census,
28 of all counties that are included in their entirety in a plan's service
29 area divided by the total population of the state, as determined in
30 the last federal census, multiplied by nine. The resulting number
31 shall be rounded to the nearest whole integer. No region may be
32 smaller than an area in which the first three digits of all its ZIP
33 Codes are in common within a county and no county may be
34 divided into more than two regions. The area encompassed in a
35 geographic region shall be separate and distinct from areas
36 encompassed in other geographic regions. Geographic regions
37 may be noncontiguous. No plan shall have less than one geographic
38 area.

39 (ii) If the formula in clause (i) results in a plan that operates in
40 more than one county having only one geographic region, then the

1 formula in clause (i) shall not apply and the plan may have two
2 geographic regions, provided that no county is divided into more
3 than one region.

4 Nothing in this section shall be construed to require a plan to
5 establish a new service area or to offer health coverage on a
6 statewide basis, outside of the plan's existing service area.

7 (l) "Small employer" means either of the following:

8 (1) Any person, firm, proprietary or nonprofit corporation,
9 partnership, public agency, or association that is actively engaged
10 in business or service, that, on at least 50 percent of its working
11 days during the preceding calendar quarter or preceding calendar
12 year, employed at least two, but no more than 50, eligible
13 employees, the majority of whom were employed within this state,
14 that was not formed primarily for purposes of buying health care
15 service plan contracts, and in which a bona fide employer-employee
16 relationship exists. In determining whether to apply the calendar
17 quarter or calendar year test, a health care service plan shall use
18 the test that ensures eligibility if only one test would establish
19 eligibility. However, for purposes of subdivisions (a), (b), and (c)
20 of Section 1357.03, the definition shall include employers with at
21 least three eligible employees until July 1, 1997, and two eligible
22 employees thereafter. In determining the number of eligible
23 employees, companies that are affiliated companies and that are
24 eligible to file a combined tax return for purposes of state taxation
25 shall be considered one employer. Subsequent to the issuance of
26 a health care service plan contract to a small employer pursuant
27 to this article, and for the purpose of determining eligibility, the
28 size of a small employer shall be determined annually. Except as
29 otherwise specifically provided in this article, provisions of this
30 article that apply to a small employer shall continue to apply until
31 the plan contract anniversary following the date the employer no
32 longer meets the requirements of this definition. It includes any
33 small employer as defined in this paragraph who purchases
34 coverage through a guaranteed association, and any employer
35 purchasing coverage for employees through a guaranteed
36 association.

37 (2) Any guaranteed association, as defined in subdivision (n),
38 that purchases health coverage for members of the association.

1 (m) “Standard employee risk rate” means the rate applicable to
2 an eligible employee in a particular risk category in a small
3 employer group.

4 (n) “Guaranteed association” means a nonprofit organization
5 comprised of a group of individuals or employers who associate
6 based solely on participation in a specified profession or industry,
7 accepting for membership any individual or employer meeting its
8 membership criteria, and that (1) includes one or more small
9 employers as defined in paragraph (1) of subdivision (l), (2) does
10 not condition membership directly or indirectly on the health or
11 claims history of any person, (3) uses membership dues solely for
12 and in consideration of the membership and membership benefits,
13 except that the amount of the dues shall not depend on whether
14 the member applies for or purchases insurance offered to the
15 association, (4) is organized and maintained in good faith for
16 purposes unrelated to insurance, (5) has been in active existence
17 on January 1, 1992, and for at least five years prior to that date,
18 (6) has included health insurance as a membership benefit for at
19 least five years prior to January 1, 1992, (7) has a constitution and
20 bylaws, or other analogous governing documents that provide for
21 election of the governing board of the association by its members,
22 (8) offers any plan contract that is purchased to all individual
23 members and employer members in this state, (9) includes any
24 member choosing to enroll in the plan contracts offered to the
25 association provided that the member has agreed to make the
26 required premium payments, and (10) covers at least 1,000 persons
27 with the health care service plan with which it contracts. The
28 requirement of 1,000 persons may be met if component chapters
29 of a statewide association contracting separately with the same
30 carrier cover at least 1,000 persons in the aggregate.

31 This subdivision applies regardless of whether a contract issued
32 by a plan is with an association or a trust formed for, or sponsored
33 by, an association to administer benefits for association members.

34 For purposes of this subdivision, an association formed by a
35 merger of two or more associations after January 1, 1992, and
36 otherwise meeting the criteria of this subdivision shall be deemed
37 to have been in active existence on January 1, 1992, if its
38 predecessor organizations had been in active existence on January
39 1, 1992, and for at least five years prior to that date and otherwise
40 met the criteria of this subdivision.

1 (o) “Members of a guaranteed association” means any individual
2 or employer meeting the association’s membership criteria if that
3 person is a member of the association and chooses to purchase
4 health coverage through the association. At the association’s
5 discretion, it also may include employees of association members,
6 association staff, retired members, retired employees of members,
7 and surviving spouses and dependents of deceased members.
8 However, if an association chooses to include these persons as
9 members of the guaranteed association, the association shall make
10 that election in advance of purchasing a plan contract. Health care
11 service plans may require an association to adhere to the
12 membership composition it selects for up to 12 months.

13 (p) “Affiliation period” means a period that, under the terms of
14 the health care service plan contract, must expire before health
15 care services under the contract become effective.

16 *SEC. 5. Section 1357.12 of the Health and Safety Code is*
17 *amended to read:*

18 1357.12. Premiums for contracts offered or delivered by plans
19 on or after the effective date of this article shall be subject to the
20 following requirements:

21 (a) (1) The premium for new business shall be determined for
22 an eligible employee in a particular risk category after applying a
23 risk adjustment factor to the plan’s standard employee risk rates.
24 The risk adjusted employee risk rate may not be more than 120
25 percent or less than 80 percent of the plan’s applicable standard
26 employee risk rate until July 1, 1996. Effective July 1, 1996, this
27 factor may not be more than 110 percent or less than 90 percent.
28 *On and after January 1, 2010, no risk adjustment factor shall be*
29 *applied.*

30 (2) The premium charged a small employer for new business
31 shall be equal to the sum of the risk adjusted employee risk rates.

32 (3) The standard employee risk rates applied to a small employer
33 for new business shall be in effect for no less than six months.

34 (b) (1) The premium for in force business shall be determined
35 for an eligible employee in a particular risk category after applying
36 a risk adjustment factor to the plan’s standard employee risk rates.
37 The risk adjusted employee risk rates may not be more than 120
38 percent or less than 80 percent of the plan’s applicable standard
39 employee risk rate until July 1, 1996. Effective July 1, 1996, this
40 factor may not be more than 110 percent or less than 90 percent.

1 The factor effective July 1, 1996, shall apply to in force business
2 at the earlier of either the time of renewal or July 1, 1997. The risk
3 adjustment factor applied to a small employer may not increase
4 by more than 10 percentage points from the risk adjustment factor
5 applied in the prior rating period. The risk adjustment factor for a
6 small employer may not be modified more frequently than every
7 12 months. *On and after January 1, 2010, no risk adjustment factor*
8 *shall be applied.*

9 (2) The premium charged a small employer for in force business
10 shall be equal to the sum of the risk adjusted employee risk rates.
11 The standard employee risk rates shall be in effect for no less than
12 six months.

13 (3) For a contract that a plan has discontinued offering, the risk
14 adjustment factor applied to the standard employee risk rates for
15 the first rating period of the new contract that the small employer
16 elects to purchase shall be no greater than the risk adjustment factor
17 applied in the prior rating period to the discontinued contract.
18 However, the risk adjusted employee risk rate may not be more
19 than 120 percent or less than 80 percent of the plan's applicable
20 standard employee risk rate until July 1, 1996. Effective July 1,
21 1996, this factor may not be more than 110 percent or less than 90
22 percent. The factor effective July 1, 1996, shall apply to in force
23 business at the earlier of either the time of renewal or July 1, 1997.
24 The risk adjustment factor for a small employer may not be
25 modified more frequently than every 12 months. *On and after*
26 *January 1, 2010, no risk adjustment factor shall be applied.*

27 (c) (1) For any small employer, a plan may, with the consent
28 of the small employer, establish composite employee and
29 dependent rates for either new business or renewal of in force
30 business. The composite rates shall be determined as the average
31 of the risk adjusted employee risk rates for the small employer, as
32 determined in accordance with the requirements of subdivisions
33 (a) and (b). The sum of the composite rates so determined shall be
34 equal to the sum of the risk adjusted employee risk rates for the
35 small employer.

36 (2) The composite rates shall be used for all employees and
37 dependents covered throughout a rating period of no less than six
38 months nor more than 12 months, except that a plan may reserve
39 the right to redetermine the composite rates if the enrollment under
40 the contract changes by more than a specified percentage during

1 the rating period. Any redetermination of the composite rates shall
2 be based on the same risk adjusted employee risk rates used to
3 determine the initial composite rates for the rating period. If a plan
4 reserves the right to redetermine the rates and the enrollment
5 changes more than the specified percentage, the plan shall
6 redetermine the composite rates if the redetermined rates would
7 result in a lower premium for the small employer. A plan reserving
8 the right to redetermine the composite rates based upon a change
9 in enrollment shall use the same specified percentage to measure
10 that change with respect to all small employers electing composite
11 rates.

12 *(d) Nothing in this section shall be construed to prevent a plan*
13 *from changing the standard employee risk rates applied to a small*
14 *employer in order to ensure that the plan's rates for a standard*
15 *benefit plan design sold pursuant to Section 1357.21 are not less*
16 *than the plan's rates for the same benefit plan design sold through*
17 *the California Cooperative Health Insurance Purchasing Program*
18 *(Part 6.45 (commencing with Section 12699.201) of Division 2 of*
19 *the Insurance Code).*

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

23
24 Article 3.11. Insurance Market Reform
25

26 1357.20. Effective July 1, 2008, every full-service health care
27 service plan that offers, markets, and sells health plan contracts to
28 individuals and conducts medical underwriting to determine
29 whether to issue coverage to a specific individual shall use a
30 standardized health questionnaire developed by the Managed Risk
31 Medical Insurance Board in consultation with the Department of
32 Insurance and the Department of Managed Health Care. A health
33 care service plan subject to this section may not exclude a potential
34 enrollee from any individual coverage on the basis of an actual or
35 expected health condition, type of illness, treatment, medical
36 condition, or accident, or for a preexisting condition, except as
37 provided by the board pursuant to Section 12711.1 of the Insurance
38 Code. ~~A health care service plan that is also a participating health~~
39 ~~plan in the California Cooperative Health Insurance Purchasing~~
40 ~~Program pursuant to Part 6.45 (commencing with Section~~

1 ~~12699.201) of Division 2 of the Insurance Code may not charge~~
2 ~~a standard rate, with reference to subscribers of any age, family~~
3 ~~size, and geographical region, that is less than the plan's rate for~~
4 ~~the same benefit plan design sold through Cal-CHIPP. Code.~~

5 1357.21. (a) Every full-service health care service plan shall
6 offer, market, and sell all of the uniform benefit plan designs made
7 available through ~~Cal-CHIPP~~ *the California Cooperative Health*
8 *Insurance Purchasing Program (Cal-CHIPP)* pursuant to Part
9 6.45 (commencing with Section 12699.201) of Division 2 of the
10 Insurance Code to purchasers in each region and in all individual
11 and group markets where the plan offers, markets, and sells health
12 care service plan contracts, consistent with statutory and regulatory
13 rating and underwriting requirements applicable to the respective
14 individual and group markets. *A health care service plan that is*
15 *also a participating health plan in Cal-CHIPP may not charge a*
16 *standard rate, with reference to subscribers of any age, family*
17 *size, and geographical region, that is less than the plan's rate for*
18 *the same benefit plan design sold through Cal-CHIPP.*

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

22 1357.22. It is the intent of the Legislature that all health care
23 providers shall participate in an Internet-based personal health
24 record system under which patients have access to their own health
25 care records. A patient's personal health care record shall only be
26 accessible to that patient or other individual as authorized by the
27 patient. It is the intent of the Legislature that all health care service
28 plans and providers shall adopt standard electronic medical records
29 by January 1, 2012.

30 1357.23. Effective July 1, 2008, all requirements in Article 3.1
31 (commencing with Section 1357) applicable to offering, marketing,
32 and selling health care service plan contracts to small employers
33 as defined in that article, including, but not limited to, the
34 obligation to fairly and affirmatively offer, market, and sell all of
35 the plan's contracts to all employers, guaranteed renewal of all
36 health care service plan contracts, use of the risk adjustment factor,
37 and the restriction of risk categories to age, geographic region, and
38 family composition as described in that article, shall be applicable
39 to all health care service plan contracts offered to all employers
40 with 250 or fewer eligible employees, except as follows:

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

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

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

19 *(c) On and after January 1, 2010, no risk adjustment factor*
20 *shall be applied to a plan contract offered to an employer with 51*
21 *to 250, inclusive, eligible employees.*

22 1357.24. (a) Every group health care service plan shall obtain
23 from each employer or group subscriber contracting with the health
24 care service plan the premium contribution amounts the employer
25 or group makes for each enrolled group member and dependent
26 using the family-tier *size categories* premium payments made to
27 the group plan.

28 (b) (1) Every health care service plan offering group health
29 plan contracts shall provide as one coverage option of each group
30 contract a Healthy Families benchmark plan established by the
31 board so that group members and their dependents with family
32 incomes at or below 300 percent of the federal poverty level that
33 are determined eligible for coverage through the Healthy Families
34 Program or who are eligible for Medi-Cal pursuant to Section
35 14005.33 of the Welfare and Institutions Code can enroll in the
36 Healthy Families benchmark plan. The Healthy Families
37 benchmark plan of a group health care service plan shall be
38 provided at a rate negotiated with and approved by the board. The
39 health care service plan shall collect the employer's applicable
40 dollar premium contribution for employees and, if applicable,

1 dependents in the Healthy Families benchmark plan and credit that
2 amount toward the cost of the Healthy Families benchmark plan.

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

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

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

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

1 (e) The department, in consultation with the board, may issue
2 regulations, as necessary pursuant to the Administrative Procedure
3 Act, to implement the requirements of this section. Until January
4 1, ~~2014~~ 2012, the adoption and readoption of regulations pursuant
5 to this ~~Section~~ section shall be deemed to be an emergency and
6 necessary for the immediate preservation of public peace, health
7 and safety, or general welfare.

8 (f) Employees and dependents receiving coverage through the
9 Medi-Cal program or Healthy Families Program pursuant to this
10 section shall make premium payments, if any, as determined by
11 the board and shall pay other cost sharing amounts. The amount
12 of the premium payments and cost sharing shall not exceed
13 premium payments or cost sharing levels for enrollment in those
14 programs required under the applicable state laws governing those
15 programs. The board shall consider using the process in effect on
16 January 1, 2008, for determining eligibility for the Medi-Cal
17 program, including the eligibility determination made by the
18 counties.

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

21 (1) “Board” means the Managed Risk Medical Insurance Board.

22 (2) “California Cooperative Health Insurance Purchasing
23 Program” or “Cal-CHIP” shall have the same meaning as in
24 subdivision (c) of Section 12699.201 of the Insurance Code.

25 (3) “Healthy Families benchmark plan” shall mean coverage
26 equivalent to coverage provided through the Healthy Families
27 Program established pursuant to Part 6.2 (commencing with Section
28 12693) of Division 2 of the Insurance Code.

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

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

35 1357.25. The requirements of this article shall not apply to a
36 specialized health care service plan or a Medicare supplement
37 contract.

38 1357.26. This article shall become operative on July 1, 2008.

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

1 1363. (a) The director shall require the use by each plan of
2 disclosure forms or materials containing information regarding
3 the benefits, services, and terms of the plan contract as the director
4 may require, so as to afford the public, subscribers, and enrollees
5 with a full and fair disclosure of the provisions of the plan in
6 readily understood language and in a clearly organized manner.
7 The director may require that the materials be presented in a
8 reasonably uniform manner so as to facilitate comparisons between
9 plan contracts of the same or other types of plans. Nothing
10 contained in this chapter shall preclude the director from permitting
11 the disclosure form to be included with the evidence of coverage
12 or plan contract.

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

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

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

21 (3) The full premium cost of the plan.

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

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

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

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

35 (ii) States, with respect to individual plan contracts, small group
36 plan contracts, and any other group plan contracts for which health
37 care services are not negotiated, that the applicant has a right to
38 view the evidence of coverage prior to enrollment, and, if the
39 evidence of coverage is not combined with the disclosure form,

1 the notice shall specify where the evidence of coverage can be
2 obtained prior to enrollment.

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

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

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

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

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

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

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

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

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

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

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

4 (14) Conditions and procedures for disenrollment.

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

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

11 (17) A notice as required by Section 1364.5.

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

20 (A) Deductibles.

21 (B) Lifetime maximums.

22 (C) Professional services.

23 (D) Outpatient services.

24 (E) Hospitalization services.

25 (F) Emergency health coverage.

26 (G) Ambulance services.

27 (H) Prescription drug coverage.

28 (I) Durable medical equipment.

29 (J) Mental health services.

30 (K) Chemical dependency services.

31 (L) Home health services.

32 (M) Other.

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

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

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

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

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

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

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

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

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

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

4
5 Article 4.1. California Individual Coverage Guarantee Issue

6
7 1366.10. It is the intent of the Legislature to do both of the
8 following:

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

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

15 1366.104. (a) On or before September 1, 2008, the director
16 and the Insurance Commissioner shall jointly adopt regulations
17 governing five classes of individual health benefit plans that health
18 care service plans and health insurers shall make available.

19 (b) Within 90 days of the adoption of the regulations required
20 by subdivision (a), the director and the Insurance Commissioner
21 shall jointly approve five classes of individual health benefit plans
22 for each health care service plan and health insurer participating
23 in the individual market, with each class having an increased level
24 of benefits beginning with the lowest class. Within each class, the
25 director and the Insurance Commissioner shall jointly approve one
26 baseline HMO and one baseline PPO, to be issued by health care
27 service plans and health insurers in the individual market. The
28 classes of benefits jointly approved by the director and the
29 Insurance Commissioner shall reflect a reasonable continuum
30 between the class with the lowest level of benefits and the class
31 with the highest level of benefits, shall permit reasonable benefit
32 variation that will allow for a diverse market within each class,
33 and shall be enforced consistently between health care service
34 plans and health insurers in the same marketplace regardless of
35 licensure.

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

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

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

5 1366.105. On and after January 1, 2009, health care service
6 plans and health insurers participating in the individual market
7 shall, *except as provided in Section 12711.1 of the Insurance Code*,
8 guarantee issue the five classes of approved health benefit plans
9 and shall, at the same time, discontinue offering and selling health
10 benefit plans other than those within the five approved classes of
11 benefit plans in the individual market.

12 1366.106. (a) Individuals may purchase a health benefit plan
13 from one of the five classes of approved plans on a guaranteed
14 issue basis. After selecting and purchasing a health benefit plan
15 within a class of benefits, an individual may change plans only as
16 set forth in this section. For individuals enrolled as a family, the
17 subscriber may change classes for himself or herself, or for all
18 dependents:

19 (a)

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

24 (b)

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

28 (c)

29 (3) At any time a subscriber may move to a lower class of
30 benefits.

31 (d)

32 (4) At significant life events, the enrollee may move up to a
33 higher class of benefits as follows:

34 (1)

35 (A) Upon marriage or entering into a domestic partnership.

36 (2)

37 (B) Upon divorce.

38 (3)

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

1 ~~(4)~~
 2 (D) Upon the birth or adoption of a child.

3 ~~(e)~~
 4 (5) A dependent child may terminate coverage under a parent’s
 5 plan, and select coverage for his or her own account following his
 6 or her 18th birthday.

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

14 (b) *This section shall not apply to an individual included within*
 15 *the group of the 3 to 5 percent of individuals identified pursuant*
 16 *to Section 12711.1 of the Insurance Code as the most expensive*
 17 *to treat.*

18 1366.107. At the time an individual applies for health coverage
 19 from a health care service plan or health insurer participating in
 20 the individual market, an individual shall provide information as
 21 required by a standardized health status questionnaire to assist
 22 plans and insurers in identifying persons in need of disease
 23 management. Health care service plans and health insurers may
 24 not use information provided on the questionnaire to decline
 25 coverage or to limit an individual’s choice of health care benefit
 26 plan, except as provided in Section 12711.1 of the Insurance Code.

27 1366.108. Health benefit plans shall become effective within
 28 31 days of receipt of the individual’s application, standardized
 29 health status questionnaire, and premium payment.

30 1366.109. Health care service plans and health insurers may
 31 reject an application for health care benefits if the individual does
 32 not reside or work in a plan’s or insurer’s approved service area.

33 1366.110. The director or the Insurance Commissioner, as
 34 applicable, may require a health care service plan or health insurer
 35 to discontinue the offering of health care benefits, or acceptance
 36 of applications from individuals, upon a determination by the
 37 director or commissioner that the plan or insurer does not have
 38 sufficient financial viability, or organizational and administrative
 39 capacity, to ensure the delivery of health care benefits to its
 40 enrollees or insureds.

1 1366.111. All health care benefits offered to individuals shall
2 be renewable with respect to all individuals and dependents at the
3 option of the subscriber, except:

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

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

8 1366.112. No health care service plan or health insurer shall,
9 directly or indirectly, enter into any contract, agreement, or
10 arrangement with a solicitor that provides for or results in the
11 compensation paid to a solicitor for the sale of a health care service
12 plan contract or health insurance policy to be varied because of
13 the health status, claims experience, occupation, or geographic
14 location of the individual, provided the geographic location is
15 within the plan's or insurer's approved service area.

16 1366.113. This article shall not apply to individual health plan
17 contracts for coverage of Medicare services pursuant to contracts
18 with the United States Government, Medi-Cal contracts with the
19 State Department of Health Care Services, Healthy Family
20 contracts with the Managed Risk Medical Insurance Board,
21 ~~high risk~~ *high risk* pool contracts with the Major Risk Medical
22 Insurance Program, Medicare supplement policies, long-term care
23 policies, specialized health plan contracts, or contracts issued to
24 individuals who secure coverage from Cal-CHIPP.

25 1366.114. (a) A health care service plan or health insurer may
26 rate its entire portfolio of health benefit plans in accordance with
27 expected costs or other market considerations, but the rate for each
28 plan or insurer shall be set in relation to the balance of the portfolio
29 as certified by an actuary. Each benefit plan shall be priced as
30 determined by each health care service plan or health insurer to
31 reflect the difference in benefit variation, or the effectiveness of
32 a provider network, but may not adjust the rate for a specific plan
33 for risk selection. A health care service plan's or health insurer's
34 rates shall use the same rating factors for age, family size, and
35 geographic location for each individual health care benefit plan it
36 issues. Rates for health care benefits may vary from applicant to
37 applicant only by any of the following:

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

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

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

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

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

17 1366.115. The first term of each health benefit plan contract
18 or policy issued shall be from the effective date through the last
19 day of the month immediately preceding the subscriber’s next
20 birthday. Contracts or policies may be renewed by the subscriber
21 as set forth in this article.

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

24 1378. No plan shall expend for administrative costs in any
25 fiscal year an excessive amount of the aggregate dues, fees and
26 other periodic payments received by the plan for providing health
27 care services to its subscribers or enrollees. The term
28 “administrative costs,” as used herein, includes costs incurred in
29 connection with the solicitation of subscribers or enrollees for the
30 plan. The director shall adopt regulations no later than July 1, 2008,
31 to define “administrative costs” and “health care services” so that
32 at least 85 percent of aggregate dues, fees, and other periodic
33 payments received by a full-service plan are spent on health care
34 services. This section shall not apply to Medicare supplement
35 contracts.

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

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

3
4 CHAPTER 1.6. CALIFORNIA INDIVIDUAL COVERAGE GUARANTEE
5 ISSUE
6

7 10199.10. It is the intent of the Legislature to do both of the
8 following:

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

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

15 10199.104. (a) On or before September 1, 2008, the
16 commissioner and the Director of the Department of Managed
17 Health Care shall jointly adopt regulations governing five classes
18 of individual health benefit plans that health care service plans and
19 health insurers shall make available.

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

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

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

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

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

9 10199.105. On and after January 1, 2009, health care service
 10 plans and health insurers participating in the individual market
 11 shall, *except as provided in Section 12711.1*, guarantee issue the
 12 five classes of approved health benefit plans and shall, at the same
 13 time, discontinue offering and selling health benefit plans other
 14 than those within the five approved classes of benefit plans in the
 15 individual market.

16 10199.106. (a) Individuals may purchase a health benefit plan
 17 from one of the five classes of approved plans on a guaranteed
 18 issue basis. After selecting and purchasing a health benefit plan
 19 within a class of benefits, an individual may change plans only as
 20 set forth in this section. For individuals enrolled as a family, the
 21 subscriber may change classes for himself or herself, or for all
 22 dependents:

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

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

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

35 (d)
 36 (4) At significant life events, the insured may move up to a
 37 higher class of benefits as follows:

38 (1)
 39 (A) Upon marriage or entering into a domestic partnership.

40 (2)

1 (B) Upon divorce.

2 ~~(3)~~

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

5 ~~(4)~~

6 (D) Upon the birth or adoption of a child.

7 ~~(e)~~

8 (5) A dependent child may terminate coverage under a parent's
9 plan, and select coverage for his or her own account following his
10 or her 18th birthday.

11 ~~(f)~~

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

18 (b) *This section shall not apply to an individual included within*
19 *the group of the 3 to 5 percent of individuals identified pursuant*
20 *to Section 12711.1 as the most expensive to treat.*

21 10199.107. At the time an individual applies for health
22 coverage from a health care service plan or health insurer
23 participating in the individual market, an individual shall provide
24 information as required by a standardized health status
25 questionnaire to assist plans and insurers in identifying persons in
26 need of disease management. Health care service plans and health
27 insurers may not use information provided on the questionnaire
28 to decline coverage, or to limit an individual's choice of health
29 care benefit plan, except as provided in Section 12711.1.

30 10199.108. Health benefit plans shall become effective within
31 31 days of receipt of the individual's application, standardized
32 health status questionnaire, and premium payment.

33 10199.109. Health care service plans and health insurers may
34 reject an application for health care benefits if the individual does
35 not reside or work in a plan's or insurer's approved service area.

36 10199.110. The commissioner or the Director of the
37 Department of Managed Health Care, as applicable, may require
38 a health care service plan or health insurer to discontinue the
39 offering of health care benefits, or acceptance of applications from
40 individuals, upon a determination by the director or commissioner

1 that the plan or insurer does not have sufficient financial viability,
2 or organizational and administrative capacity, to ensure the delivery
3 of health care benefits to its enrollees or insureds.

4 10199.111. All health care benefits offered to individuals shall
5 be renewable with respect to all individuals and dependents at the
6 option of the subscriber, except:

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

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

11 10199.112. No health care service plan or health insurer shall,
12 directly or indirectly, enter into any contract, agreement, or
13 arrangement with a solicitor that provides for or results in the
14 compensation paid to a solicitor for the sale of a health care service
15 plan contract or health insurance policy to be varied because of
16 the health status, claims experience, occupation, or geographic
17 location of the individual, provided the geographic location is
18 within the plan's or insurer's approved service area.

19 10199.113. This chapter shall not apply to individual health
20 plan contracts for coverage of Medicare services pursuant to
21 contracts with the United States Government, Medi-Cal contracts
22 with the State Department of Health Care Services, Healthy Family
23 contracts with the Managed Risk Medical Insurance Board,
24 high-risk pool contracts with the Major Risk Medical Insurance
25 Program, Medicare supplement policies, long-term care policies,
26 specialized health plan contracts, or contracts issued to individuals
27 who secure coverage from Cal-CHIPP.

28 10199.114. (a) A health care service plan or health insurer
29 may rate its entire portfolio of health benefit plans in accordance
30 with expected costs or other market considerations, but the rate
31 for each plan or insurer shall be set in relation to the balance of
32 the portfolio as certified by an actuary. Each benefit plan shall be
33 priced as determined by each health care service plan or health
34 insurer to reflect the difference in benefit variation, or the
35 effectiveness of a provider network, but may not adjust the rate
36 for a specific plan for risk selection. A health care service plan's
37 or health insurer's rates shall use the same rating factors for age,
38 family size, and geographic location for each individual health
39 care benefit plan it issues. Rates for health care benefits may vary
40 from applicant to applicant only by any of the following:

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

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

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

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

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

20 10199.115. The first term of each health benefit plan contract
21 or policy issued shall be from the effective date through the last
22 day of the month immediately preceding the subscriber's next
23 birthday. Contracts or policies may be renewed by the subscriber
24 as set forth in this chapter.

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

27 10293.5. (a) The commissioner shall adopt regulations no later
28 than July 1, 2008, to define "administrative costs" and "health care
29 services" so that at least 85 percent of health insurance premium
30 revenue received by a health insurer is spent on health care
31 services.

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

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

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

1 10607. In addition to the other disclosures required by this
2 chapter, every insurer and their employees or agents shall, when
3 presenting a plan for examination or sale to any individual or the
4 representative of a group, disclose in writing the ratio of incurred
5 claims to earned premiums (loss-ratio) for the insurer's preceding
6 calendar year for policies with individuals and with groups of the
7 same or similar size for the insurer's preceding fiscal year.

8 *SEC. 13. Section 10700 of the Insurance Code is amended to*
9 *read:*

10 10700. As used in this chapter:

11 (a) "Agent or broker" means a person or entity licensed under
12 Chapter 5 (commencing with Section 1621) of Part 2 of Division
13 1.

14 (b) "Benefit plan design" means a specific health coverage
15 product issued by a carrier to small employers, to trustees of
16 associations that include small employers, or to individuals if the
17 coverage is offered through employment or sponsored by an
18 employer. It includes services covered and the levels of copayment
19 and deductibles, and it may include the professional providers who
20 are to provide those services and the sites where those services are
21 to be provided. A benefit plan design may also be an integrated
22 system for the financing and delivery of quality health care services
23 which has significant incentives for the covered individuals to use
24 the system.

25 (c) "Board" means the Major Risk Medical Insurance Board.

26 (d) "Carrier" means any disability insurance company or any
27 other entity that writes, issues, or administers health benefit plans
28 that cover the employees of small employers, regardless of the
29 situs of the contract or master policyholder. For the purposes of
30 Articles 3 (commencing with Section 10719) and 4 (commencing
31 with Section 10730), "carrier" also includes health care service
32 plans.

33 (e) "Dependent" means the spouse or child of an eligible
34 employee, subject to applicable terms of the health benefit plan
35 covering the employee, and includes dependents of guaranteed
36 association members if the association elects to include dependents
37 under its health coverage at the same time it determines its
38 membership composition pursuant to subdivision (z).

39 (f) "Eligible employee" means either of the following:

1 (1) Any permanent employee who is actively engaged on a
2 full-time basis in the conduct of the business of the small employer
3 with a normal workweek of at least 30 hours, in the small
4 employer's regular place of business, who has met any statutorily
5 authorized applicable waiting period requirements. The term
6 includes sole proprietors or partners of a partnership, if they are
7 actively engaged on a full-time basis in the small employer's
8 business, and they are included as employees under a health benefit
9 plan of a small employer, but does not include employees who
10 work on a part-time, temporary, or substitute basis. It includes any
11 eligible employee as defined in this paragraph who obtains
12 coverage through a guaranteed association. Employees of
13 employers purchasing through a guaranteed association shall be
14 deemed to be eligible employees if they would otherwise meet the
15 definition except for the number of persons employed by the
16 employer. A permanent employee who works at least 20 hours but
17 not more than 29 hours is deemed to be an eligible employee if all
18 four of the following apply:

19 (A) The employee otherwise meets the definition of an eligible
20 employee except for the number of hours worked.

21 (B) The employer offers the employee health coverage under a
22 health benefit plan.

23 (C) All similarly situated individuals are offered coverage under
24 the health benefit plan.

25 (D) The employee must have worked at least 20 hours per
26 normal workweek for at least 50 percent of the weeks in the
27 previous calendar quarter. The insurer may request any necessary
28 information to document the hours and time period in question,
29 including, but not limited to, payroll records and employee wage
30 and tax filings.

31 (2) Any member of a guaranteed association as defined in
32 subdivision (z).

33 (g) "Enrollee" means an eligible employee or dependent who
34 receives health coverage through the program from a participating
35 carrier.

36 (h) "Financially impaired" means, for the purposes of this
37 chapter, a carrier that, on or after the effective date of this chapter,
38 is not insolvent and is either:

39 (1) Deemed by the commissioner to be potentially unable to
40 fulfill its contractual obligations.

1 (2) Placed under an order of rehabilitation or conservation by
2 a court of competent jurisdiction.

3 (i) “Fund” means the California Small Group Reinsurance Fund.

4 (j) “Health benefit plan” means a policy or contract written or
5 administered by a carrier that arranges or provides health care
6 benefits for the covered eligible employees of a small employer
7 and their dependents. The term does not include accident only,
8 credit, disability income, coverage of Medicare services pursuant
9 to contracts with the United States government, Medicare
10 supplement, long-term care insurance, dental, vision, coverage
11 issued as a supplement to liability insurance, automobile medical
12 payment insurance, or insurance under which benefits are payable
13 with or without regard to fault and that is statutorily required to
14 be contained in any liability insurance policy or equivalent
15 self-insurance.

16 (k) “In force business” means an existing health benefit plan
17 issued by the carrier to a small employer.

18 (l) “Late enrollee” means an eligible employee or dependent
19 who has declined health coverage under a health benefit plan
20 offered by a small employer at the time of the initial enrollment
21 period provided under the terms of the health benefit plan, and
22 who subsequently requests enrollment in a health benefit plan of
23 that small employer, provided that the initial enrollment period
24 shall be a period of at least 30 days. It also means any member of
25 an association that is a guaranteed association as well as any other
26 person eligible to purchase through the guaranteed association
27 when that person has failed to purchase coverage during the initial
28 enrollment period provided under the terms of the guaranteed
29 association’s health benefit plan and who subsequently requests
30 enrollment in the plan, provided that the initial enrollment period
31 shall be a period of at least 30 days. However, an eligible
32 employee, another person eligible for coverage through a
33 guaranteed association pursuant to subdivision (z), or an eligible
34 dependent shall not be considered a late enrollee if any of the
35 following is applicable:

36 (1) The individual meets all of the following requirements:

37 (A) He or she was covered under another employer health
38 benefit plan, the Healthy Families Program, or no share-of-cost
39 Medi-Cal coverage at the time the individual was eligible to enroll.

1 (B) He or she certified at the time of the initial enrollment that
2 coverage under another employer health benefit plan, the Healthy
3 Families Program, or no share-of-cost Medi-Cal coverage was the
4 reason for declining enrollment provided that, if the individual
5 was covered under another employer health plan, the individual
6 was given the opportunity to make the certification required by
7 this subdivision and was notified that failure to do so could result
8 in later treatment as a late enrollee.

9 (C) He or she has lost or will lose coverage under another
10 employer health benefit plan as a result of termination of
11 employment of the individual or of a person through whom the
12 individual was covered as a dependent, change in employment
13 status of the individual, or of a person through whom the individual
14 was covered as a dependent, the termination of the other plan's
15 coverage, cessation of an employer's contribution toward an
16 employee or dependent's coverage, death of the person through
17 whom the individual was covered as a dependent, legal separation,
18 divorce, loss of coverage under the Healthy Families Program as
19 a result of exceeding the program's income or age limits, or loss
20 of no share-of-cost Medi-Cal coverage.

21 (D) He or she requests enrollment within 30 days after
22 termination of coverage or employer contribution toward coverage
23 provided under another employer health benefit plan.

24 (2) The individual is employed by an employer who offers
25 multiple health benefit plans and the individual elects a different
26 plan during an open enrollment period.

27 (3) A court has ordered that coverage be provided for a spouse
28 or minor child under a covered employee's health benefit plan.

29 (4) (A) In the case of an eligible employee as defined in
30 paragraph (1) of subdivision (f), the carrier cannot produce a
31 written statement from the employer stating that the individual or
32 the person through whom an individual was eligible to be covered
33 as a dependent, prior to declining coverage, was provided with,
34 and signed acknowledgment of, an explicit written notice in
35 boldface type specifying that failure to elect coverage during the
36 initial enrollment period permits the carrier to impose, at the time
37 of the individual's later decision to elect coverage, an exclusion
38 from coverage for a period of 12 months as well as a six-month
39 preexisting condition exclusion unless the individual meets the
40 criteria specified in paragraph (1), (2), or (3).

1 (B) In the case of an eligible employee who is a guaranteed
2 association member, the plan cannot produce a written statement
3 from the guaranteed association stating that the association sent a
4 written notice in boldface type to all potentially eligible association
5 members at their last known address prior to the initial enrollment
6 period informing members that failure to elect coverage during
7 the initial enrollment period permits the plan to impose, at the time
8 of the member's later decision to elect coverage, an exclusion from
9 coverage for a period of 12 months as well as a six-month
10 preexisting condition exclusion unless the member can demonstrate
11 that he or she meets the requirements of subparagraphs (A), (C),
12 and (D) of paragraph (1) or meets the requirements of paragraph
13 (2) or (3).

14 (C) In the case of an employer or person who is not a member
15 of an association, was eligible to purchase coverage through a
16 guaranteed association, and did not do so, and would not be eligible
17 to purchase guaranteed coverage unless purchased through a
18 guaranteed association, the employer or person can demonstrate
19 that he or she meets the requirements of subparagraphs (A), (C),
20 and (D) of paragraph (1), or meets the requirements of paragraph
21 (2) or (3), or that he or she recently had a change in status that
22 would make him or her eligible and that application for coverage
23 was made within 30 days of the change.

24 (5) The individual is an employee or dependent who meets the
25 criteria described in paragraph (1) and was under a COBRA
26 continuation provision and the coverage under that provision has
27 been exhausted. For purposes of this section, the definition of
28 "COBRA" set forth in subdivision (e) of Section ~~4373.62~~ 1373.621
29 shall apply.

30 (6) The individual is a dependent of an enrolled eligible
31 employee who has lost or will lose his or her coverage under the
32 Healthy Families Program as a result of exceeding the program's
33 income or age limits or no share-of-cost Medi-Cal coverage and
34 requests enrollment within 30 days after notification of this loss
35 of coverage.

36 (7) The individual is an eligible employee who previously
37 declined coverage under an employer health benefit plan and who
38 has subsequently acquired a dependent who would be eligible for
39 coverage as a dependent of the employee through marriage, birth,
40 adoption, or placement for adoption, and who enrolls for coverage

1 under that employer health benefit plan on his or her behalf, and
2 on behalf of his or her dependent within 30 days following the
3 date of marriage, birth, adoption, or placement for adoption, in
4 which case the effective date of coverage shall be the first day of
5 the month following the date the completed request for enrollment
6 is received in the case of marriage, or the date of birth, or the date
7 of adoption or placement for adoption, whichever applies. Notice
8 of the special enrollment rights contained in this paragraph shall
9 be provided by the employer to an employee at or before the time
10 the employee is offered an opportunity to enroll in plan coverage.

11 (8) The individual is an eligible employee who has declined
12 coverage for himself or herself or his or her dependents during a
13 previous enrollment period because his or her dependents were
14 covered by another employer health benefit plan at the time of the
15 previous enrollment period. That individual may enroll himself or
16 herself or his or her dependents for plan coverage during a special
17 open enrollment opportunity if his or her dependents have lost or
18 will lose coverage under that other employer health benefit plan.
19 The special open enrollment opportunity shall be requested by the
20 employee not more than 30 days after the date that the other health
21 coverage is exhausted or terminated. Upon enrollment, coverage
22 shall be effective not later than the first day of the first calendar
23 month beginning after the date the request for enrollment is
24 received. Notice of the special enrollment rights contained in this
25 paragraph shall be provided by the employer to an employee at or
26 before the time the employee is offered an opportunity to enroll
27 in plan coverage.

28 (m) “New business” means a health benefit plan issued to a
29 small employer that is not the carrier’s in force business.

30 (n) “Participating carrier” means a carrier that has entered into
31 a contract with the program to provide health benefits coverage
32 under this part.

33 (o) “Plan of operation” means the plan of operation of the fund,
34 including articles, bylaws and operating rules adopted by the fund
35 pursuant to Article 3 (commencing with Section 10719).

36 (p) “Program” means the Health Insurance Plan of California.

37 (q) “Preexisting condition provision” means a policy provision
38 that excludes coverage for charges or expenses incurred during a
39 specified period following the insured’s effective date of coverage,
40 as to a condition for which medical advice, diagnosis, care, or

1 treatment was recommended or received during a specified period
2 immediately preceding the effective date of coverage.

3 (r) “Creditable coverage” means:

4 (1) Any individual or group policy, contract, or program, that
5 is written or administered by a disability insurer, health care service
6 plan, fraternal benefits society, self-insured employer plan, or any
7 other entity, in this state or elsewhere, and that arranges or provides
8 medical, hospital, and surgical coverage not designed to supplement
9 other private or governmental plans. The term includes continuation
10 or conversion coverage but does not include accident only, credit,
11 coverage for onsite medical clinics, disability income, Medicare
12 supplement, long-term care, dental, vision, coverage issued as a
13 supplement to liability insurance, insurance arising out of a
14 workers’ compensation or similar law, automobile medical payment
15 insurance, or insurance under which benefits are payable with or
16 without regard to fault and that is statutorily required to be
17 contained in any liability insurance policy or equivalent
18 self-insurance.

19 (2) The federal Medicare program pursuant to Title XVIII of
20 the Social Security Act.

21 (3) The ~~medicaid~~ *Medicaid* program pursuant to Title XIX of
22 the Social Security Act.

23 (4) Any other publicly sponsored program, provided in this state
24 or elsewhere, of medical, hospital, and surgical care.

25 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
26 (Civilian Health and Medical Program of the Uniformed Services
27 (CHAMPUS)).

28 (6) A medical care program of the Indian Health Service or of
29 a tribal organization.

30 (7) A state health benefits risk pool.

31 (8) A health plan offered under 5 U.S.C. Chapter 89
32 (commencing with Section 8901) (Federal Employees Health
33 Benefits Program (FEHBP)).

34 (9) A public health plan as defined in federal regulations
35 authorized by Section 2701(c)(1)(I) of the Public Health Service
36 Act, as amended by Public Law 104-191, the Health Insurance
37 Portability and Accountability Act of 1996.

38 (10) A health benefit plan under Section 5(e) of the Peace Corps
39 Act (22 U.S.C. Sec. 2504(e)).

1 (11) Any other creditable coverage as defined by subdivision
2 (c) of Section 2701 of Title XXVII of the federal Public Health
3 Services Act (42 U.S.C. Sec. 300gg(c)).

4 (s) “Rating period” means the period for which premium rates
5 established by a carrier are in effect and shall be no less than six
6 months.

7 (t) “Risk adjusted employee risk rate” means the rate determined
8 for an eligible employee of a small employer in a particular risk
9 category after applying the risk adjustment factor.

10 (u) “Risk adjustment factor” means the percent adjustment to
11 be applied equally to each standard employee risk rate for a
12 particular small employer, based upon any expected deviations
13 from standard claims. This factor may not be more than 120 percent
14 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
15 this factor may not be more than 110 percent or less than 90
16 percent. *On and after January 1, 2010, no risk adjustment factor*
17 *shall be applied.*

18 (v) “Risk category” means the following characteristics of an
19 eligible employee: age, geographic region, and family size of the
20 employee, plus the benefit plan design selected by the small
21 employer.

22 (1) No more than the following age categories may be used in
23 determining premium rates:

- 24 Under 30
- 25 30–39
- 26 40–49
- 27 50–54
- 28 55–59
- 29 60–64
- 30 65 and over

31 However, for the 65 and over age category, separate premium
32 rates may be specified depending upon whether coverage under
33 the health benefit plan will be primary or secondary to benefits
34 provided by the federal Medicare program pursuant to Title XVIII
35 of the federal Social Security Act.

36 (2) Small employer carriers shall base rates to small employers
37 using no more than the following family size categories:

- 38 (A) Single.
- 39 (B) Married couple.
- 40 (C) One adult and child or children.

1 (D) Married couple and child or children.

2 (3) (A) In determining rates for small employers, a carrier that
3 operates statewide shall use no more than nine geographic regions
4 in the state, have no region smaller than an area in which the first
5 three digits of all its ZIP Codes are in common within a county
6 and shall divide no county into more than two regions. Carriers
7 shall be deemed to be operating statewide if their coverage area
8 includes 90 percent or more of the state's population. Geographic
9 regions established pursuant to this section shall, as a group, cover
10 the entire state, and the area encompassed in a geographic region
11 shall be separate and distinct from areas encompassed in other
12 geographic regions. Geographic regions may be noncontiguous.

13 (B) In determining rates for small employers, a carrier that does
14 not operate statewide shall use no more than the number of
15 geographic regions in the state than is determined by the following
16 formula: the population, as determined in the last federal census,
17 of all counties which are included in their entirety in a carrier's
18 service area divided by the total population of the state, as
19 determined in the last federal census, multiplied by nine. The
20 resulting number shall be rounded to the nearest whole integer.
21 No region may be smaller than an area in which the first three
22 digits of all its ZIP Codes are in common within a county and no
23 county may be divided into more than two regions. The area
24 encompassed in a geographic region shall be separate and distinct
25 from areas encompassed in other geographic regions. Geographic
26 regions may be noncontiguous. No carrier shall have less than one
27 geographic area.

28 (w) "Small employer" means either of the following:

29 (1) Any person, proprietary or nonprofit firm, corporation,
30 partnership, public agency, or association that is actively engaged
31 in business or service that, on at least 50 percent of its working
32 days during the preceding calendar quarter, or preceding calendar
33 year, employed at least two, but not more than 50, eligible
34 employees, the majority of whom were employed within this state,
35 that was not formed primarily for purposes of buying health
36 insurance and in which a bona fide employer-employee relationship
37 exists. In determining whether to apply the calendar quarter or
38 calendar year test, the insurer shall use the test that ensures
39 eligibility if only one test would establish eligibility. However,
40 for purposes of subdivisions (b) and (h) of Section 10705, the

1 definition shall include employers with at least three eligible
2 employees until July 1, 1997, and two eligible employees
3 thereafter. In determining the number of eligible employees,
4 companies that are affiliated companies and that are eligible to file
5 a combined income tax return for purposes of state taxation shall
6 be considered one employer. Subsequent to the issuance of a health
7 benefit plan to a small employer pursuant to this chapter, and for
8 the purpose of determining eligibility, the size of a small employer
9 shall be determined annually. Except as otherwise specifically
10 provided, provisions of this chapter that apply to a small employer
11 shall continue to apply until the health benefit plan anniversary
12 following the date the employer no longer meets the requirements
13 of this definition. It includes any small employer as defined in this
14 paragraph who purchases coverage through a guaranteed
15 association, and any employer purchasing coverage for employees
16 through a guaranteed association.

17 (2) Any guaranteed association, as defined in subdivision (y),
18 that purchases health coverage for members of the association.

19 (x) “Standard employee risk rate” means the rate applicable to
20 an eligible employee in a particular risk category in a small
21 employer group.

22 (y) “Guaranteed association” means a nonprofit organization
23 comprised of a group of individuals or employers who associate
24 based solely on participation in a specified profession or industry,
25 accepting for membership any individual or employer meeting its
26 membership criteria which (1) includes one or more small
27 employers as defined in paragraph (1) of subdivision (w), (2) does
28 not condition membership directly or indirectly on the health or
29 claims history of any person, (3) uses membership dues solely for
30 and in consideration of the membership and membership benefits,
31 except that the amount of the dues shall not depend on whether
32 the member applies for or purchases insurance offered by the
33 association, (4) is organized and maintained in good faith for
34 purposes unrelated to insurance, (5) has been in active existence
35 on January 1, 1992, and for at least five years prior to that date,
36 (6) has been offering health insurance to its members for at least
37 five years prior to January 1, 1992, (7) has a constitution and
38 bylaws, or other analogous governing documents that provide for
39 election of the governing board of the association by its members,
40 (8) offers any benefit plan design that is purchased to all individual

1 members and employer members in this state, (9) includes any
2 member choosing to enroll in the benefit plan design offered to
3 the association provided that the member has agreed to make the
4 required premium payments, and (10) covers at least 1,000 persons
5 with the carrier with which it contracts. The requirement of 1,000
6 persons may be met if component chapters of a statewide
7 association contracting separately with the same carrier cover at
8 least 1,000 persons in the aggregate.

9 This subdivision applies regardless of whether a master policy
10 by an admitted insurer is delivered directly to the association or a
11 trust formed for or sponsored by an association to administer
12 benefits for association members.

13 For purposes of this subdivision, an association formed by a
14 merger of two or more associations after January 1, 1992, and
15 otherwise meeting the criteria of this subdivision shall be deemed
16 to have been in active existence on January 1, 1992, if its
17 predecessor organizations had been in active existence on January
18 1, 1992, and for at least five years prior to that date and otherwise
19 met the criteria of this subdivision.

20 (z) “Members of a guaranteed association” means any individual
21 or employer meeting the association’s membership criteria if that
22 person is a member of the association and chooses to purchase
23 health coverage through the association. At the association’s
24 discretion, it may also include employees of association members,
25 association staff, retired members, retired employees of members,
26 and surviving spouses and dependents of deceased members.
27 However, if an association chooses to include those persons as
28 members of the guaranteed association, the association must so
29 elect in advance of purchasing coverage from a plan. Health plans
30 may require an association to adhere to the membership
31 composition it selects for up to 12 months.

32 (aa) “Affiliation period” means a period that, under the terms
33 of the health benefit plan, must expire before health care services
34 under the plan become effective.

35 *SEC. 14. Section 10714 of the Insurance Code is amended to*
36 *read:*

37 10714. Premiums for benefit plan designs written, issued, or
38 administered by carriers on or after the effective date of this act,
39 shall be subject to the following requirements:

1 (a) (1) The premium for new business shall be determined for
2 an eligible employee in a particular risk category after applying a
3 risk adjustment factor to the carrier's standard employee risk rates.
4 The risk adjusted employee risk rate may not be more than 120
5 percent or less than 80 percent of the carrier's applicable standard
6 employee risk rate until July 1, 1996. Effective July 1, 1996, the
7 risk adjusted employee risk rate may not be more than 110 percent
8 or less than 90 percent. *On and after January 1, 2010, no risk*
9 *adjustment factor shall be applied.*

10 (2) The premium charged a small employer for new business
11 shall be equal to the sum of the risk adjusted employee risk rates.

12 (3) The standard employee risk rates applied to a small employer
13 for new business shall be in effect for no less than six months.

14 (b) (1) The premium for in force business shall be determined
15 for an eligible employee in a particular risk category after applying
16 a risk adjustment factor to the carrier's standard employee risk
17 rates. The risk adjusted employee risk rates may not be more than
18 120 percent or less than 80 percent of the carrier's applicable
19 standard employee risk rate until July 1, 1996. Effective July 1,
20 1996, the risk adjusted employee risk rate may not be more than
21 110 percent or less than 90 percent. The factor effective July 1,
22 1996, shall apply to in force business at the earlier of either the
23 time of renewal or July 1, 1997. The risk adjustment factor applied
24 to a small employer may not increase by more than 10 percentage
25 points from the risk adjustment factor applied in the prior rating
26 period. The risk adjustment factor for a small employer may not
27 be modified more frequently than every 12 months. *On and after*
28 *January 1, 2010, no risk adjustment factor shall be applied.*

29 (2) The premium charged a small employer for in force business
30 shall be equal to the sum of the risk adjusted employee risk rates.
31 The standard employee risk rates shall be in effect for no less than
32 six months.

33 (3) For a benefit plan design that a carrier has discontinued
34 offering, the risk adjustment factor applied to the standard
35 employee risk rates for the first rating period of the new benefit
36 plan design that the small employer elects to purchase shall be no
37 greater than the risk adjustment factor applied in the prior rating
38 period to the discontinued benefit plan design. However, the risk
39 adjusted employee rate may not be more than 120 percent or less
40 than 80 percent of the carrier's applicable standard employee risk

1 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted
2 employee risk rate may not be more than 110 percent or less than
3 90 percent. The factor effective July 1, 1996, shall apply to in force
4 business at the earlier of either the time of renewal or July 1, 1997.
5 The risk adjustment factor for a small employer may not be
6 modified more frequently than every 12 months. *On and after*
7 *January 1, 2010, no risk adjustment factor shall be applied.*

8 (c) (1) For any small employer, a carrier may, with the consent
9 of the small employer, establish composite employee and
10 dependent rates for either new business or renewal of in force
11 business. The composite rates shall be determined as the average
12 of the risk adjusted employee risk rates for the small employer, as
13 determined in accordance with the requirements of subdivisions
14 (a) and (b). The sum of the composite rates so determined shall be
15 equal to the sum of the risk adjusted employee risk rates for the
16 small employer.

17 (2) The composite rates shall be used for all employees and
18 dependents covered throughout a rating period of no less than six
19 months, nor more than 12 months, except that a carrier may reserve
20 the right to redetermine the composite rates if the enrollment under
21 the health benefit plan changes by more than a specified percentage
22 during the rating period. Any redetermination of the composite
23 rates shall be based on the same risk adjusted employee risk rates
24 used to determine the initial composite rates for the rating period.
25 If a carrier reserves the right to redetermine the rates and the
26 enrollment changes more than the specified percentage, the carrier
27 shall redetermine the composite rates if the redetermined rates
28 would result in a lower premium for the small employer. A carrier
29 reserving the right to redetermine the composite rates based upon
30 a change in enrollment shall use the same specified percentage to
31 measure that change with respect to all small employers electing
32 composite rates.

33 (d) *Nothing in this section shall be construed to prevent an*
34 *insurer from changing the standard employee risk rates applied*
35 *to a small employer in order to ensure that the insurer's rates for*
36 *a standard benefit plan design sold pursuant to Section 10761 are*
37 *not less than the insurer's rates for the same benefit plan design*
38 *sold through the California Cooperative Health Insurance*
39 *Purchasing Program (Part 6.45 (commencing with Section*
40 *12699.201)).*

1 ~~SEC. 13.~~

2 *SEC. 15.* Chapter 8.1 (commencing with Section 10760) is
3 added to Part 2 of Division 2 of the Insurance Code, to read:

4

5

CHAPTER 8.1. INSURANCE MARKET REFORM

6

7 10760. Effective July 1, 2008, every insurer that offers,
8 markets, and sells health insurance to individuals and conducts
9 medical underwriting to determine whether to issue coverage to a
10 specific individual shall use a standardized health questionnaire
11 developed by the Managed Risk Medical Insurance Board. A health
12 insurer subject to this section may not exclude a potential insured
13 from any individual coverage on the basis of an actual or expected
14 health condition, type of illness, treatment, medical condition, or
15 accident, or for a preexisting condition, except as provided by the
16 board pursuant to Section 12711.1. ~~A health insurer that is also a~~
17 ~~participating health insurer in the California Cooperative Health~~
18 ~~Insurance Purchasing Program pursuant to Part 6.45 (commencing~~
19 ~~with Section 12699.201) may not charge a standard rate, with~~
20 ~~reference to subscribers of any age, family size, and geographical~~
21 ~~region, that is less than the insurer's rate for the same benefit plan~~
22 ~~design sold through Cal-CHIPP.~~

23 10761. (a) Every insurer that provides health insurance to
24 residents of this state shall offer, market, and sell all of the uniform
25 benefit plan designs made available through ~~Cal-CHIPP~~ *the*
26 *California Cooperative Health Insurance Purchasing Program*
27 *(Cal-CHIPP)* pursuant to Part 6.45 (commencing with Section
28 12699.201) to purchasers in each region and all individual and
29 group markets where the insurer offers, markets, and sells health
30 insurance policies, consistent with statutory and regulatory rating
31 and underwriting requirements applicable to the respective
32 individual and group markets. *A health insurer that is also a*
33 *participating health plan in Cal-CHIPP may not charge a standard*
34 *rate, with reference to insureds of any age, family size, and*
35 *geographical region, that is less than the insurer's rate for the*
36 *same benefit plan design sold through Cal-CHIPP.*

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

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

9 10763. On and after July 1, 2008, all requirements in Chapter
10 8 (commencing with Section 10700) applicable to offering,
11 marketing, and selling health benefit plans to small employers as
12 defined in that chapter, including, but not limited to, the obligation
13 to fairly and affirmatively offer, market, and sell all of the carrier's
14 health benefit plan designs to all employers, guaranteed renewal
15 of all health benefit plan designs, use of the risk adjustment factor,
16 and the restriction of risk categories to age, geographic region, and
17 family composition as described in that chapter, shall be applicable
18 to all health benefit plan designs offered to all employers with 250
19 or fewer eligible employees, except as follows:

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

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

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

37 (c) *On and after January 1, 2010, no risk adjustment factor*
38 *shall be applied to a policy offered to an employer with 51 to 250,*
39 *inclusive, eligible employees.*

1 10764. (a) Every group health insurer shall obtain from each
2 employer or group policyholder contracting with the health insurer
3 the premium contribution amounts the employer or group makes
4 for each enrolled group member and dependent using the family
5 *tier size categories* premium payments made to the group plan.

6 (b) (1) Every health insurer offering group health insurance
7 policies shall provide as one coverage option of each group policy
8 a Healthy Families benchmark policy established by the board so
9 that group members and their dependents with family incomes at
10 or below 300 percent of the federal poverty level that are
11 determined eligible for coverage through the Healthy Families
12 Program or who are eligible for Medi-Cal pursuant to Section
13 14005.33 of the Welfare and Institutions Code can enroll in the
14 Healthy Families benchmark policy. The Healthy Families
15 benchmark policy of a group health insurer shall be provided at a
16 rate negotiated with and approved by the board. The health insurer
17 shall collect the employer's applicable dollar premium contribution
18 for employees and, if applicable, dependents in the Healthy
19 Families benchmark policy and credit that amount toward the cost
20 of the Healthy Families benchmark policy.

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

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

1 benchmark plan and credit that amount toward the cost of the
2 Medi-Cal benchmark plan.

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

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

17 (e) The department, in consultation with the board, may issue
18 regulations, as necessary pursuant to the Administrative Procedure
19 Act, to implement the requirements of this section. Until January
20 1, ~~2014~~ 2012, the adoption and readoption of regulations pursuant
21 to this ~~part~~ chapter shall be deemed to be an emergency and
22 necessary for the immediate preservation of public peace, health
23 and safety, or general welfare.

24 (f) Employees and dependents receiving coverage through the
25 Medi-Cal program or Healthy Families Program pursuant to this
26 section shall make premium payments, if any, as determined by
27 the board and shall pay other cost sharing amounts. The amount
28 of the premium payments and cost sharing shall not exceed
29 premium payments or cost sharing levels for enrollment in those
30 programs required under the applicable state laws governing those
31 programs. The board shall consider using the process in effect on
32 January 1, 2008, for determining eligibility for the Medi-Cal
33 program, including the eligibility determination made by the
34 counties.

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

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

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

1 (3) “Healthy Families benchmark policy” shall mean coverage
2 equivalent to coverage provided through the Healthy Families
3 Program established pursuant to Part 6.2 (commencing with Section
4 12693).

5 (4) “Medi-Cal benchmark policy” shall mean coverage
6 equivalent to coverage provided through the Medi-Cal program
7 (Chapter 7 (commencing with Section 14000) of Part 3 of Division
8 9 of the Welfare and Institutions Code).

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

11 10765. (a) As used in this chapter, “health insurance” shall
12 have the same meaning as in subdivision (b) of Section 106.

13 (b) The requirements of this chapter shall not apply to a
14 Medicare supplement, vision-only, dental-only, or
15 CHAMPUS-supplement insurance or to hospital indemnity,
16 hospital-only, accident-only, or specified disease insurance that
17 does not pay benefits on a fixed benefit, cash payment only basis.

18 10766. This chapter shall become operative on July 1, 2008.

19 ~~SEC. 14.~~

20 *SEC. 16.* Section 12693.43 of the Insurance Code is amended
21 to read:

22 12693.43. (a) Applicants applying to the purchasing pool shall
23 agree to pay family contributions, unless the applicant has a family
24 contribution sponsor. Family contribution amounts consist of the
25 following two components:

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

27 (2) Any amounts that are charged to the program by participating
28 health, dental, and vision plans selected by the applicant that exceed
29 the cost to the program of the highest cost family value package
30 in a given geographic area.

31 (b) In each geographic area, the board shall designate one or
32 more family value packages for which the required total family
33 contribution is:

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

38 (2) Nine dollars (\$9) per child with a maximum required
39 contribution of twenty-seven dollars (\$27) per month per family
40 for applicants with annual household incomes greater than 150

1 percent and up to and including 200 percent of the federal poverty
2 level and for applicants on behalf of children described in clause
3 (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of
4 Section 12693.70.

5 (3) On and after July 1, 2005, fifteen dollars (\$15) per child
6 with a maximum required contribution of forty-five dollars (\$45)
7 per month per family for applicants with annual household income
8 to which subparagraph (B) of paragraph (6) of subdivision (a) of
9 Section 12693.70 is applicable. Notwithstanding any other
10 provision of law, if an application with an effective date prior to
11 July 1, 2005, was based on annual household income to which
12 subparagraph (B) of paragraph (6) of subdivision (a) of Section
13 12693.70 is applicable, then this paragraph shall be applicable to
14 the applicant on July 1, 2005, unless subparagraph (B) of paragraph
15 (6) of subdivision (a) of Section 12693.70 is no longer applicable
16 to the relevant family income. The program shall provide prior
17 notice to any applicant for currently enrolled subscribers whose
18 premium will increase on July 1, 2005, pursuant to this paragraph
19 and, prior to the date the premium increase takes effect, shall
20 provide that applicant with an opportunity to demonstrate that
21 subparagraph (B) of paragraph (6) of subdivision (a) of Section
22 12693.70 is no longer applicable to the relevant family income.

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

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

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

39 (1) A family contribution of four dollars (\$4) per child with a
40 maximum required contribution of eight dollars (\$8) per month

1 per family for applicants with annual household incomes up to and
2 including 150 percent of the federal poverty level.

3 (2) Six dollars (\$6) per child with a maximum required
4 contribution of eighteen dollars (\$18) per month per family for
5 applicants with annual household incomes greater than 150 percent
6 and up to and including 200 percent of the federal poverty level
7 and for applicants on behalf of children described in clause (ii) of
8 subparagraph (A) of paragraph (6) of subdivision (a) of Section
9 12693.70.

10 (3) On and after July 1, 2005, twelve dollars (\$12) per child
11 with a maximum required contribution of thirty-six dollars (\$36)
12 per month per family for applicants with annual household income
13 to which subparagraph (B) of paragraph (6) of subdivision (a) of
14 Section 12693.70 is applicable. Notwithstanding any other
15 provision of law, if an application with an effective date prior to
16 July 1, 2005, was based on annual household income to which
17 subparagraph (B) of paragraph (6) of subdivision (a) of Section
18 12693.70 is applicable, then this paragraph shall be applicable to
19 the applicant on July 1, 2005, unless subparagraph (B) of paragraph
20 (6) of subdivision (a) of Section 12693.70 is no longer applicable
21 to the relevant family income. The program shall provide prior
22 notice to any applicant for currently enrolled subscribers whose
23 premium will increase on July 1, 2005, pursuant to this paragraph
24 and, prior to the date the premium increase takes effect, shall
25 provide that applicant with an opportunity to demonstrate that
26 subparagraph (B) of paragraph (6) of subdivision (a) of Section
27 12693.70 is no longer applicable to the relevant family income.

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

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

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

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

8 (h) The adoption and one readoption of regulations to implement
9 paragraph (3) of subdivision (b) and paragraph (3) of subdivision
10 (d) shall be deemed to be an emergency and necessary for the
11 immediate preservation of public peace, health, and safety, or
12 general welfare for purposes of Sections 11346.1 and 11349.6 of
13 the Government Code, and the board is hereby exempted from the
14 requirement that it describe specific facts showing the need for
15 immediate action and from review by the Office of Administrative
16 Law. For purposes of subdivision (e) of Section 11346.1 of the
17 Government Code, the 120-day period, as applicable to the
18 effective period of an emergency regulatory action and submission
19 of specified materials to the Office of Administrative Law, is
20 hereby extended to 180 days.

21 *SEC. 17. Section 12693.57 is added to the Insurance Code, to*
22 *read:*

23 *12693.57. Every person administering or providing benefits*
24 *under the program shall perform his or her duties in such a manner*
25 *as to secure for every subscriber the amount of assistance to which*
26 *the subscriber is entitled, without attempting to elicit any*
27 *information that is not required to carry out the provisions of law*
28 *applicable to the program.*

29 ~~SEC. 15.~~

30 *SEC. 18. Section 12693.58 is added to the Insurance Code, to*
31 *read:*

32 *12693.58. (a) All types of information, whether written or*
33 *oral, concerning an applicant, subscriber, or household member,*
34 *made or kept by any public officer or agency in connection with*
35 *the administration of any provision of this part shall be confidential,*
36 *and shall not be open to examination other than for purposes*
37 *directly connected with the administration of the Healthy Families*
38 *Program or the Medi-Cal program.*

39 (b) Except as provided in this section and to the extent permitted
40 by federal law or regulation, all information about applicants,

1 subscribers, and household members to be safeguarded as provided
2 for in subdivision (a) includes, but is not limited to, names and
3 addresses, medical services provided, social and economic
4 conditions or circumstances, agency evaluation of personal
5 information, and medical data, including diagnosis and past history
6 of disease or disability.

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

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

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

20 *SEC. 19. Section 12693.59 is added to the Insurance Code, to*
21 *read:*

22 *12693.59. Nothing in this part shall preclude the board from*
23 *soliciting voluntary participation by applicants and subscribers*
24 *in communicating with the board, or with any other party,*
25 *concerning their needs as well as the needs of others who are not*
26 *adequately covered by existing private and public health care*
27 *delivery systems or concerning means of ensuring the availability*
28 *of adequate health care services. The board shall inform applicants*
29 *and subscribers that their participation is voluntary and shall*
30 *inform them of the uses for which the information is intended.*

31 ~~SEC. 16.~~

32 *SEC. 20. Section 12693.621 is added to the Insurance Code,*
33 *to read:*

34 *12693.621. The coverage under this part for a child who is a*
35 *dependent of an employee of an employer electing to make a*
36 *payment to the California Health Trust Fund in lieu of making*
37 *health-care expenditures pursuant to Section 2200 of the Labor*
38 *4802.1 of the Unemployment Insurance Code, shall be provided*
39 *through a Healthy Families benchmark plan under Part 6.45*
40 *(commencing with Section 12699.201).*

1 ~~SEC. 17.~~

2 *SEC. 21.* Section 12693.70 of the Insurance Code is amended
3 to read:

4 12693.70. To be eligible to participate in the program, an
5 applicant shall meet all of the following requirements:

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

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

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

17 (3) In compliance with Sections 12693.71 and 12693.72.

18 (4) [Reserved].

19 (5) A resident of the State of California pursuant to Section 244
20 of the Government Code; or, if not a resident pursuant to Section
21 244 of the Government Code, is physically present in California
22 and entered the state with a job commitment or to seek
23 employment, whether or not employed at the time of application
24 to or after acceptance in, the program.

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

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

28 (ii) When implemented by the board, subject to subdivision (b)
29 of Section 12693.765 and pursuant to this section, a child under
30 the age of two years who was delivered by a mother enrolled in
31 the Access for Infants and Mothers Program as described in Part
32 6.3 (commencing with Section 12695). Commencing July 1, 2007,
33 eligibility under this subparagraph shall not include infants during
34 any time they are enrolled in employer-sponsored health insurance
35 or are subject to an exclusion pursuant to Section 12693.71 or
36 12693.72, or are enrolled in the full scope of benefits under the
37 Medi-Cal program at no share of cost. For purposes of this clause,
38 any infant born to a woman whose enrollment in the Access for
39 Infants and Mothers Program begins after June 30, 2004, shall be
40 automatically enrolled in the Healthy Families Program, except

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

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

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

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

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

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

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

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

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

29 ~~SEC. 18.~~

30 *SEC. 22.* Section 12693.73 of the Insurance Code is amended
31 to read:

32 12693.73. Notwithstanding any other provision of law, children
33 excluded from coverage under Title XXI of the Social Security
34 Act are not eligible for coverage under the program, except as
35 specified in clause (ii) of subparagraph (A) of paragraph (6) of
36 subdivision (a) of Section 12693.70 and Section 12693.76, or
37 except children who otherwise meet eligibility requirements for
38 the program but for their immigration status.

1 ~~SEC. 19.~~

2 *SEC. 23.* Section 12693.755 of the Insurance Code is amended
3 to read:

4 12693.755. (a) Subject to subdivision (b), but no later than
5 July 1, 2008, the board shall expand eligibility under this part to
6 uninsured parents of, and as defined by the board, adults
7 responsible for, children enrolled to receive coverage under this
8 part whose income does not exceed 300 percent of the federal
9 poverty level, before applying the income disregard provided for
10 in subparagraph (B) of paragraph (6) of subdivision (a) of Section
11 12693.70.

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

16 (2) The program shall be implemented only in accordance with
17 a State Child Health Insurance Program waiver or other federal
18 approval pursuant to Section 1397gg(e)(2)(A) of Title 42 of the
19 United States Code, or pursuant to the Deficit Reduction Act of
20 2005, Section 6044 of Public Law 109-171, to provide coverage
21 to uninsured parents and responsible adults, and shall be subject
22 to the terms, conditions, and duration of the waiver or other federal
23 approval. The services shall be provided under the program only
24 if the waiver or other federal approval is approved by the federal
25 Centers for Medicare and Medicaid Services, and, except as
26 provided under the terms and conditions of the waiver or other
27 federal approval, only to the extent that federal financial
28 participation is available and funds are appropriated specifically
29 for this purpose.

30 (c) The coverage under this section for a person who is an
31 employee or, if applicable, an adult dependent of an employee, of
32 an employer electing to make a payment to the California Health
33 Trust Fund in lieu of making health-care expenditures pursuant to
34 ~~Section 2200 of the Labor Code~~ *4802.1 of the Unemployment Insurance*
35 Code, shall be provided through a Healthy Families benchmark
36 plan under Part 6.45 (commencing with Section 12699.201).

37 ~~SEC. 20.~~

38 *SEC. 24.* Section 12693.76 of the Insurance Code is amended
39 to read:

1 12693.76. (a) Notwithstanding any other provision of law, a
2 child who is a qualified alien as defined in Section 1641 of Title
3 8 of the United States Code shall not be determined ineligible
4 solely on the basis of his or her date of entry into the United States.

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

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

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

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

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

26 ~~SEC. 21:~~

27 ~~SEC. 25.~~ Part 6.45 (commencing with Section 12699.201) is
28 added to Division 2 of the Insurance Code, to read:

29

30 PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH
31 INSURANCE PURCHASING PROGRAM

32

33 CHAPTER 1. GENERAL PROVISIONS

34

35 12699.201. For the purposes of this part, the following terms
36 have the following meanings:

37 (a) “Benefit plan design” means a specific health coverage
38 product offered for sale and includes services covered and the
39 levels of copayments, deductibles, and annual out-of-pocket
40 expenses, and may include the professional providers who are to

1 provide those services and the sites where those services are to be
2 provided. A benefit plan design may also be an integrated system
3 for the financing and delivery of quality health care services that
4 has significant incentives for the covered individuals to use the
5 system.

6 (b) “Board” means the Managed Risk Medical Insurance Board.

7 (c) “California Cooperative Health Insurance Purchasing
8 Program” or “Cal-CHIPP” means the statewide purchasing pool
9 established pursuant to this part and administered by the board.

10 (d) “Enrollee” means an individual who is eligible for, and
11 participates in, Cal-CHIPP.

12 (e) “Fund” means the California Health Trust Fund established
13 pursuant to Section 12699.212.

14 (f) “Healthy Families benchmark plan” means coverage
15 equivalent to coverage provided through the Healthy Families
16 Program (Part 6.2 (commencing with Section 12693)).

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

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

26 (i) “Participating health plan” means either a private health
27 insurer holding a valid outstanding certificate of authority from
28 the commissioner or a health care service plan as defined under
29 subdivision (f) of Section 1345 of the Health and Safety Code that
30 contracts with the board to provide coverage in Cal-CHIPP and,
31 pursuant to its contract with the board, provides, arranges, pays
32 for, or reimburses the costs of health services for Cal-CHIPP
33 enrollees.

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

CHAPTER 2. ADMINISTRATION

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

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

(1) Determine eligibility and enrollment criteria and processes for Cal-CHIPP consistent with the eligibility standards in Chapter 3 (commencing with Section 12699.211).

(2) Determine the participation requirements for enrollees.

(3) Determine the participation requirements and the standards and selection criteria for participating health, dental, and vision care plans, including reasonable limits on a plan’s administrative costs to ensure that a plan expends on patient care not less than 85 percent of aggregate dues, fees, and other periodic payments received by the plan.

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

(5) Determine premium schedules, collect the premiums, and administer subsidies to eligible enrollees ~~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. ~~During the period from January 1, 2008, to December 31, 2011, inclusive, the adoption and readoption of regulations pursuant to the California~~

1 ~~Health Care Reform and Cost Control Act shall be deemed to be~~
2 ~~an emergency and necessary for the immediate preservation of~~
3 ~~public peace, health, and safety, or the general welfare.~~

4 (16) Maintain enrollment and expenditures to ensure that
5 expenditures do not exceed the amount of revenue available in the
6 fund, and if sufficient revenue is not available to pay the estimated
7 expenditures, the board shall institute appropriate measures to
8 ensure fiscal solvency. This paragraph shall not be construed to
9 allow the board to deny enrollment of a person who otherwise
10 meets the eligibility requirements of Chapter 3 (commencing with
11 Section 12699.211) in order to ensure the fiscal solvency of the
12 fund.

13 (17) Establish the criteria and procedures through which
14 employers direct employees' premium dollars, withheld under the
15 ~~terms of cafeteria plans pursuant to Chapter 11 (commencing with~~
16 ~~Section 19900) of Part 10.2 of Division 2 of the Revenue and~~
17 ~~Taxation Code~~ *terms of cafeteria plans pursuant to Section 4809*
18 *of the Unemployment Insurance Code*, to Cal-CHIPP to be credited
19 against the employees' premium obligations.

20 (18) Share information obtained pursuant to this part with the
21 Employment Development Department solely for the purpose of
22 the administration and enforcement of this part.

23 (19) Exercise all powers reasonably necessary to carry out the
24 powers and responsibilities expressly granted or imposed by this
25 part.

26 12699.203. The board shall develop and offer at least three
27 uniform benefit plan designs to Cal-CHIPP enrollees. ~~One of the~~
28 ~~benefit plan designs offered by each participating health plan shall~~
29 ~~be a Healthy Families benchmark plan and another of the benefit~~
30 ~~plan designs shall be a Medi-Cal benchmark plan. The~~ *In addition*
31 *to the three uniform benefit plan designs, each participating health*
32 *plan shall offer a Healthy Families benchmark plan and a*
33 *Medi-Cal benchmark plan. For purposes of the Medi-Cal*
34 *benchmark plan offered in Cal-CHIPP, the board shall enter into*
35 *an agreement with the State Department of Health Care Services*
36 *for the provision of the Medi-Cal benchmark plan by the Medi-Cal*
37 *program. The three uniform benefit plan designs shall include*
38 *varying benefit levels, deductibles, coinsurance factors, or*
39 *copayments, and annual limits on out-of-pocket expenses. In*

1 developing the benefit plan designs, the board shall comply with
2 all of the following:

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

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

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

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

28 12699.204. (a) The board may adjust premiums at a public
29 meeting of the board after providing, at minimum, 30 days’ public
30 notice of the adjustment. In making the adjustment, the board shall
31 take into account the costs of health care typically paid for by
32 employers and employees in California.

33 (b) Notwithstanding subdivision (a), the amount of the premium
34 paid by an employee with a household income at or below 300
35 percent of the federal poverty level shall not exceed 0 to 5 percent
36 of the household income, depending on the income, after taking
37 into account the tax savings the employee is able to realize by
38 using the cafeteria plan made available by his or her employer
39 pursuant to Chapter 11 (commencing with Section 19900) of Part

1 ~~10.2 of Division 2 of the Revenue and Taxation Code.~~ *pursuant*
2 *to Section 4809 of the Unemployment Insurance Code.*

3 (c) An employer may pay all, or a portion of, the premium
4 payment required of its employees enrolled in Cal-CHIPP.

5 (d) Employees and dependents receiving coverage through the
6 Medi-Cal program or the Healthy Families Program pursuant to
7 this part shall make premium payments, if any, as determined by
8 the board, and pay other cost sharing amounts that do not exceed
9 premium payments and cost sharing levels for enrollment in those
10 programs required under the applicable state laws governing those
11 programs. The board shall consider using the process in effect on
12 January 1, 2008, for determining eligibility for the Medi-Cal
13 program including the eligibility determination made by the
14 counties.

15 12699.205. The board, in its contract with a participating health
16 plan, shall require that the plan utilize efficient practices to improve
17 and control costs. These practices shall include, but are not limited
18 to, the following:

19 (a) Preventive care.

20 (b) Care management for chronic diseases.

21 (c) Promotion of health information technology.

22 (d) Standardized billing practices.

23 (e) Reduction of medical errors.

24 (f) Incentives for healthy lifestyles.

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

27 (h) Rational use of new technology.

28 12699.206. (a) The board shall negotiate with Medi-Cal
29 managed care plans to obtain affordable coverage for eligible
30 enrollees.

31 (b) The board shall implement the requirements for a benchmark
32 plan or policy as required pursuant to Section 1357.24 of the Health
33 and Safety Code and Section 10764, *and shall limit enrollment in*
34 *these plans or policies only to eligible individuals.*

35 (c) The board, in consultation with the State Department of
36 Health Care Services, shall take all reasonable steps necessary to
37 maximize federal funding and support federal claiming in the
38 administration of the purchasing pool created pursuant to this part.

1 12699.206.1. (a) To provide prescription drug coverage for
2 Cal-CHIPP enrollees, the board may take any of the following
3 actions:

4 (1) Contract directly with health care service plans or health
5 insurers for prescription drug coverage as a component of a health
6 care service plan contract or a health insurance policy.

7 (2) Contract with a pharmacy benefits manager (PBM) if the
8 PBM meets transparency and disclosure requirements established
9 by the board.

10 (3) Procure products directly through the prescription drug
11 purchasing program established pursuant to Chapter 12
12 (commencing with Section 14977) of Part 5.5 of Division 3 of Title
13 2 of the Government Code.

14 (b) The board may engage in any of the activities described in
15 subdivision (a), or in any cost-effective combination of those
16 activities.

17 (c) If the board enters into a prescription drug purchasing
18 arrangement pursuant to paragraph (2) or (3) of subdivision (a),
19 the board may allow any of the following entities to participate in
20 that arrangement:

21 (1) Employers.

22 (2) Any state, district, county, city, municipal, or other public
23 agency or governmental entity.

24 (3) A board or administrator responsible for providing or
25 delivering health care coverage pursuant to a collective bargaining
26 agreement, memorandum of understanding, or other similar
27 agreement with a labor organization.

28 12699.206.2. (a) All information, whether written or oral,
29 concerning an applicant to Cal-CHIPP, an enrollee in Cal-CHIPP,
30 or a household member of the applicant or enrollee, created or
31 maintained by a public officer or agency in connection with the
32 administration of this part shall be confidential and shall not be
33 open to examination other than for purposes directly connected
34 with the administration of this part. "Purposes directly connected
35 with the administration of this part" includes all activities and
36 responsibilities in which the board or the State Department of
37 Health Care Services and their agents, officers, trustees,
38 employees, consultants, and contractors engage to conduct
39 program operations.

1 (b) Information subject to the provisions of this section includes,
2 but is not limited to, names and addresses, medical services
3 provided to an enrollee, social and economic conditions or
4 circumstances, agency evaluation of personal information, and
5 medical data, such as diagnosis and health history.

6 (c) Nothing in this section shall be construed to prohibit the
7 disclosure of information about applicants and enrollees, or their
8 household members, if express written authorization for the
9 disclosure has been provided by the person to whom the
10 information pertains or, if that person is a minor, authorization
11 has been provided by the minor's parent or other adult with legal
12 custody of the minor.

13 (d) Nothing in this part shall prohibit the disclosure of protected
14 health information as provided in Section 164.152 of Title 45 of
15 the Code of Federal Regulations.

16 12699.207. (a) Notwithstanding any other provision of law,
17 the board shall not be subject to licensure or regulation by the
18 Department of Insurance or the Department of Managed Health
19 Care.

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

28 12699.208. The board shall collect and disseminate, as
29 appropriate and to the extent possible, information on the quality
30 of participating health, dental, and vision care plans and each plan's
31 cost-effectiveness to assist enrollees in selecting a plan.

32 12699.209. The board shall establish a working group for the
33 purpose of developing recommendations to broaden access to
34 Cal-CHIPP to all self-employed individuals and submit the
35 recommendations to the Legislature on or before January 1, 2009.

36 12699.210. The provisions of Section 12693.54 shall apply to
37 a contract entered into pursuant to this part.

CHAPTER 3. ELIGIBILITY

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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. *pursuant to Section 4802.1 of the Unemployment Insurance Code.*

(b) Notwithstanding paragraph (2) of subdivision (a), eligible employees and, if applicable, dependents of eligible employees, ~~receiving~~ *eligible for* coverage through a Medi-Cal or Healthy Families benchmark plan or policy pursuant to paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) of Section 1357.24 of the Health and Safety Code or paragraph (2) of subdivision (b) and paragraph (2) of subdivision (c) of Section 10764 are eligible for Cal-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.

12699.211.01. ~~(e)~~ *(a)* The failure of an employer *to continue* to pay the fee required by Section ~~4805~~ *4802.1* of the Unemployment Insurance Code shall not make an enrollee employed by that employer and, ~~if applicable, the employee's dependents~~ *the employee's dependents, if any,* ineligible for participation in Cal-CHIPP *until the last day of the second month following the month in which the employer failed to make the fee payment.*

(b) If an employer fails to make the fee payment by the 15th day of each month, the board shall notify the employer and its employees enrolled in Cal-CHIPP of the following information within 15 days of the employer's failure to make the required fee payment:

1 (1) *The employer's failure to pay the fee by the 15th day of the*
2 *month.*

3 (2) *The coverage of the employee and his or her dependents, if*
4 *any, will terminate on the last day of the second month following*
5 *the month in which the employer failed to make the fee payment,*
6 *and the employee and his or her dependents, if any, shall be*
7 *ineligible for Cal-CHIPP.*

8 (3) *Their rights and remedies under law.*

9 (c) *The board may, through regulations adopted pursuant to*
10 *Chapter 3.5 (commencing with Section 11340) of Part 1 of Division*
11 *3 of Title 2 of the Government Code, allow an employee and his*
12 *or her dependents, if any, whose employer failed to pay the fee*
13 *required by Section 4802.1 of the Unemployment Insurance Code,*
14 *to continue coverage for up to 36 months from the date of*
15 *ineligibility described in subdivision (b) if the employee pays the*
16 *entire cost for the coverage. Subject to the availability of funds,*
17 *the board may, upon appropriation by the Legislature, use revenue*
18 *in the penalty account in the fund to subsidize the cost of coverage*
19 *under this subdivision.*

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CHAPTER 4. FISCAL

22

23 12699.212. (a) *The California Health Trust Fund is hereby*
24 *created in the State Treasury. Notwithstanding Section 13340 of*
25 *the Government Code, the moneys in the fund shall be continuously*
26 *appropriated to the board, without regard to fiscal year, for the*
27 *purposes of providing health care coverage pursuant to this part.*
28 ~~Notwithstanding~~ *Any moneys in the fund that are unexpended or*
29 *unencumbered at the end of a fiscal year, may be carried forward*
30 *to the next succeeding fiscal year.*

31 (b) *The board shall establish a prudent reserve in the fund.*

32 (c) *Notwithstanding Section 16305.7 of the Government Code,*
33 *all interest earned on the moneys that have been deposited into the*
34 *fund shall be retained in the fund.*

35 12699.213. *The board, subject to the approval of the*
36 *Department of Finance, may obtain loans from the General Fund*
37 *for all necessary and reasonable expenses related to the*
38 *administration of the fund.*

1 12699.214. *The board shall authorize, for the purposes of this*
 2 *part, the expenditure from the fund of any state or federal revenue*
 3 *or other revenue received from any source.*

4 12699.215. *The board may solicit and accept gifts,*
 5 *contributions, and grants from any source, public or private, to*
 6 *administer the program and shall deposit all revenue from those*
 7 *sources into the fund.*

8 ~~12699.213.~~

9 12699.216. The board, subject to federal approval pursuant to
 10 Section 14199.10 of the Welfare and Institutions Code, shall pay
 11 the nonfederal share of cost from the ~~California Health Trust Fund~~
 12 *fund* for employees and dependents eligible under that federal
 13 approval.

14 ~~12699.214.~~

15 12699.217. This part shall become operative on January 1,
 16 ~~2010~~ 2009.

17 ~~SEC. 22.~~

18 SEC. 26. Section 12711.1 is added to the Insurance Code, to
 19 read:

20 12711.1. (a) The board shall establish a list of serious health
 21 conditions or diagnoses making an applicant automatically eligible
 22 for the program *based on the standardized health questionnaire*
 23 *developed pursuant to subdivision (b)*. In developing the list of
 24 conditions, the board shall consult with the Director of the
 25 Department of Managed Health Care and the commissioner to
 26 identify common health plan and insurer underwriting criteria.

27 (b) The board shall develop a standardized health questionnaire
 28 to be used by all health plans and insurers that offer and sell
 29 individual coverage. The questionnaire shall provide for an
 30 objective evaluation of a person’s health status by assigning a
 31 discrete measure, such as a system of point scoring, to each person.
 32 The questionnaire shall be designed to identify the 3 to 5 percent
 33 of persons who are the most expensive to treat if covered under
 34 an individual health care service plan or an individual health
 35 insurance policy, and the board shall obtain from an actuary a
 36 certification that the standard health questionnaire meets this
 37 requirement. The questionnaire shall be designed to collect only
 38 that information necessary to identify if a person is eligible for
 39 coverage in the program pursuant to subdivision (a). Consistent
 40 with Section 1357.21 of the Health and Safety Code and Section

1 10761, health plans and insurers shall not deny coverage for any
2 individual except for those who qualify for automatic eligibility
3 for the program as determined by the board pursuant to this section.

4 (c) *This section shall become operative on July 1, 2008.*

5 SEC. 23. ~~Part 8.8 (commencing with Section 2200) is added~~
6 ~~to Division 2 of the Labor Code, to read:~~

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~~PART 8.8. EMPLOYER ELECTION~~

10 ~~2200. (a) (1) Each employer shall elect to take one of the~~
11 ~~following actions:~~

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

15 ~~(B) Pay an equivalent amount into the California Health Trust~~
16 ~~Fund.~~

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

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

22 ~~(B) Pay an equivalent amount into the California Health Trust~~
23 ~~Fund.~~

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

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

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

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

7 ~~(e) Notwithstanding subparagraphs (A) and (B) of paragraph~~
8 ~~(3) of subdivision (a), the board may adjust the health care~~
9 ~~expenditure amounts required by those subparagraphs. The~~
10 ~~adjustments shall be made by the board at a public meeting of the~~
11 ~~board. On or before October 31 of each year, the board shall~~
12 ~~prepare a statement, which shall be a public record, setting forth~~
13 ~~the adjustments for the next calendar year and shall promptly notify~~
14 ~~the Employment Development Department of those adjustments.~~

15 ~~2203. An employee working for an employer that elects,~~
16 ~~pursuant to Section 2200, to pay an equivalent amount in lieu of~~
17 ~~making health care expenditures shall be required to enroll in the~~
18 ~~California Cooperative Health Insurance Purchasing Program~~
19 ~~pursuant to Part 6.45 (commencing with Section 12699.201) of~~
20 ~~Division 2 of the Insurance Code to receive coverage from a~~
21 ~~participating health plan contracting with the board through the~~
22 ~~program. However, an employee is exempt from this requirement~~
23 ~~if the employee is able to demonstrate that the employee is covered~~
24 ~~by individual coverage that is in force on the effective date of this~~
25 ~~section, a public program, or other group health care coverage,~~
26 ~~such as an employer-sponsored retiree health plan or group~~
27 ~~coverage made available by an employer to the employee's spouse~~
28 ~~that also covers the employee. An employee who is exempt under~~
29 ~~this section from the requirement to enroll in the California~~
30 ~~Cooperative Health Insurance Purchasing Program may choose to~~
31 ~~enroll in that program.~~

32 ~~2204. Unless the context requires otherwise, the definitions~~
33 ~~set forth in this section shall govern the construction and meaning~~
34 ~~of the terms and phrases used in this part:~~

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

36 ~~(b) "Employer" means any individual, corporation, association,~~
37 ~~partnership, or limited liability company doing business in this~~
38 ~~state, deriving income from sources within this state, or in any~~
39 ~~manner whatsoever subject to the laws of this state, the State of~~
40 ~~California or any political subdivision or agency thereof, including~~

1 the Regents of the University of California, any city organized
2 under a freeholders' charter, or any political body not a subdivision
3 or agency of the state, any person, officer, employee, department,
4 or agency thereof, making payment of wages to employees for
5 services performed within this state.

6 (e) "Fund" means the California Health Trust Fund created
7 pursuant to Section 12699.212 of the Insurance Code.

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

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

15 (B) Reimbursement by the employer to its employees, and their
16 dependents, if applicable, for incurred health care expenses, where
17 those recipients have no entitlement to that reimbursement under
18 any plan, fund, or program maintained by the employer. As used
19 in this subparagraph, "health care expenses" includes, but is not
20 limited to, an expense for which payment is deductible from
21 personal income under Section 213(d) of the Internal Revenue
22 Code.

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

28 (D) Disease management programs.

29 (E) Pharmacy benefit management programs.

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

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

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

1 not include penalties imposed pursuant to Section 4820 of the
2 Unemployment Insurance Code.

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

7 (f) “Wages” means all remuneration, as defined in Article 2
8 (commencing with Section 926) of Chapter 4 of Part 1 of Division
9 1 of the Unemployment Insurance Code. “Wages” does not include
10 remuneration described in Sections 930, 930.1, and 930.5 of the
11 Unemployment Insurance Code.

12 2205. This part shall become operative on January 1, 2010.

13 SEC. 24. Chapter 11 (commencing with Section 19900) is
14 added to Part 10.2 of Division 2 of the Revenue and Taxation
15 Code, to read:

16

17 CHAPTER 11. HEALTH CARE CAFETERIA PLAN

18

19 19900. This chapter shall be known and may be cited as the
20 Health Care Cafeteria Plan.

21 19901. Unless federal law or the law of this state provides
22 otherwise, each employer in this state during a taxable year shall
23 adopt and maintain a cafeteria plan, within the meaning of Section
24 125 of the Internal Revenue Code, to allow employees to pay for
25 health insurance premiums, to the extent amounts for such benefits
26 are excludable from the gross income of the employee under
27 Section 106 of the Internal Revenue Code.

28 SEC. 25.

29 SEC. 27. Section 131 of the Unemployment Insurance Code
30 is amended to read:

31 131. “Contributions” means the money payments to the
32 Unemployment Fund, Employment Training Fund, California
33 Health Trust Fund, or Unemployment Compensation Disability
34 Fund that are required by this division code.

35 SEC. 28. Section 144 of the Unemployment Insurance Code is
36 amended to read:

37 144. “Worker contributions,” “contributions by workers,”
38 “employee contributions,” or “contributions by employees” mean
39 contributions to the Disability Fund and to the California Health
40 Trust Fund.

1 ~~SEC. 26.~~

2 *SEC. 29.* Section 1095 of the Unemployment Insurance Code
3 is amended to read:

4 1095. The director shall permit the use of any information in
5 his or her possession to the extent necessary for any of the
6 following purposes and may require reimbursement for all direct
7 costs incurred in providing any and all information specified in
8 this section, except information specified in subdivisions (a) to
9 (e), inclusive:

10 (a) To enable the director or his or her representative to carry
11 out his or her responsibilities under this code.

12 (b) To properly present a claim for benefits.

13 (c) To acquaint a worker or his or her authorized agent with his
14 or her existing or prospective right to benefits.

15 (d) To furnish an employer or his or her authorized agent with
16 information to enable him or her to fully discharge his or her
17 obligations or safeguard his or her rights under this division or
18 Division 3 (commencing with Section 9000).

19 (e) To enable an employer to receive a reduction in contribution
20 rate.

21 (f) To enable federal, state, or local government departments
22 or agencies, subject to federal law, to verify or determine the
23 eligibility or entitlement of an applicant for, or a recipient of, public
24 social services provided pursuant to Division 9 (commencing with
25 Section 10000) of the Welfare and Institutions Code, or Part A of
26 Title IV of the Social Security Act, where the verification or
27 determination is directly connected with, and limited to, the
28 administration of public social services.

29 (g) To enable county administrators of general relief or
30 assistance, or their representatives, to determine entitlement to
31 locally provided general relief or assistance, where the
32 determination is directly connected with, and limited to, the
33 administration of general relief or assistance.

34 (h) To enable state or local governmental departments or
35 agencies to seek criminal, civil, or administrative remedies in
36 connection with the unlawful application for, or receipt of, relief
37 provided under Division 9 (commencing with Section 10000) of
38 the Welfare and Institutions Code or to enable the collection of
39 expenditures for medical assistance services pursuant to Part 5

1 (commencing with Section 17000) of Division 9 of the Welfare
2 and Institutions Code.

3 (i) To provide any law enforcement agency with the name,
4 address, telephone number, birth date, social security number,
5 physical description, and names and addresses of present and past
6 employers, of any victim, suspect, missing person, potential
7 witness, or person for whom a felony arrest warrant has been
8 issued, when a request for this information is made by any
9 investigator or peace officer as defined by Sections 830.1 and
10 830.2 of the Penal Code, or by any federal law enforcement officer
11 to whom the Attorney General has delegated authority to enforce
12 federal search warrants, as defined under Sections 60.2 and 60.3
13 of Title 28 of the Code of Federal Regulations, as amended, and
14 when the requesting officer has been designated by the head of
15 the law enforcement agency and requests this information in the
16 course of and as a part of an investigation into the commission of
17 a crime when there is a reasonable suspicion that the crime is a
18 felony and that the information would lead to relevant evidence.
19 The information provided pursuant to this subdivision shall be
20 provided to the extent permitted by federal law and regulations,
21 and to the extent the information is available and accessible within
22 the constraints and configurations of existing department records.
23 Any person who receives any information under this subdivision
24 shall make a written report of the information to the law
25 enforcement agency that employs him or her, for filing under the
26 normal procedures of that agency.

27 (1) This subdivision shall not be construed to authorize the
28 release to any law enforcement agency of a general list identifying
29 individuals applying for or receiving benefits.

30 (2) The department shall maintain records pursuant to this
31 subdivision only for periods required under regulations or statutes
32 enacted for the administration of its programs.

33 (3) This subdivision shall not be construed as limiting the
34 information provided to law enforcement agencies to that pertaining
35 only to applicants for, or recipients of, benefits.

36 (4) The department shall notify all applicants for benefits that
37 release of confidential information from their records will not be
38 protected should there be a felony arrest warrant issued against
39 the applicant or in the event of an investigation by a law
40 enforcement agency into the commission of a felony.

1 (j) To provide public employee retirement systems in California
2 with information relating to the earnings of any person who has
3 applied for or is receiving a disability income, disability allowance,
4 or disability retirement allowance, from a public employee
5 retirement system. The earnings information shall be released only
6 upon written request from the governing board specifying that the
7 person has applied for or is receiving a disability allowance or
8 disability retirement allowance from its retirement system. The
9 request may be made by the chief executive officer of the system
10 or by an employee of the system so authorized and identified by
11 name and title by the chief executive officer in writing.

12 (k) To enable the Division of Labor Standards Enforcement in
13 the Department of Industrial Relations to seek criminal, civil, or
14 administrative remedies in connection with the failure to pay, or
15 the unlawful payment of, wages pursuant to Chapter 1
16 (commencing with Section 200) of Part 1 of Division 2 of, and
17 Chapter 1 (commencing with Section 1720) of Part 7 of Division
18 2 of, the Labor Code.

19 (l) To enable federal, state, or local governmental departments
20 or agencies to administer child support enforcement programs
21 under Title IV of the Social Security Act (42 U.S.C. Sec. 651 et
22 seq.).

23 (m) To provide federal, state, or local governmental departments
24 or agencies with wage and claim information in its possession that
25 will assist those departments and agencies in the administration
26 of the Victims of Crime Program or in the location of victims of
27 crime who, by state mandate or court order, are entitled to
28 restitution that has been or can be recovered.

29 (n) To provide federal, state, or local governmental departments
30 or agencies with information concerning any individuals who are
31 or have been:

32 (1) Directed by state mandate or court order to pay restitution,
33 fines, penalties, assessments, or fees as a result of a violation of
34 law.

35 (2) Delinquent or in default on guaranteed student loans or who
36 owe repayment of funds received through other financial assistance
37 programs administered by those agencies. The information released
38 by the director for the purposes of this paragraph shall not include
39 unemployment insurance benefit information.

1 (o) To provide an authorized governmental agency with any or
2 all relevant information that relates to any specific workers'
3 compensation insurance fraud investigation. The information shall
4 be provided to the extent permitted by federal law and regulations.
5 For the purposes of this subdivision, "authorized governmental
6 agency" means the district attorney of any county, the office of
7 the Attorney General, the Department of Industrial Relations, and
8 the Department of Insurance. An authorized governmental agency
9 may disclose this information to the State Bar, the Medical Board
10 of California, or any other licensing board or department whose
11 licensee is the subject of a workers' compensation insurance fraud
12 investigation. This subdivision shall not prevent any authorized
13 governmental agency from reporting to any board or department
14 the suspected misconduct of any licensee of that body.

15 (p) To enable the Director of the Bureau for Private
16 Postsecondary and Vocational Education, or his or her
17 representatives, to access unemployment insurance quarterly wage
18 data on a case-by-case basis to verify information on school
19 administrators, school staff, and students provided by those schools
20 who are being investigated for possible violations of Chapter 7
21 (commencing with Section 94700) of Part 59 of the Education
22 Code.

23 (q) To provide employment tax information to the tax officials
24 of Mexico, if a reciprocal agreement exists. For purposes of this
25 subdivision, "reciprocal agreement" means a formal agreement to
26 exchange information between national taxing officials of Mexico
27 and taxing authorities of the State Board of Equalization, the
28 Franchise Tax Board, and the Employment Development
29 Department. Furthermore, the reciprocal agreement shall be limited
30 to the exchange of information that is essential for tax
31 administration purposes only. Taxing authorities of the State of
32 California shall be granted tax information only on California
33 residents. Taxing authorities of Mexico shall be granted tax
34 information only on Mexican nationals.

35 (r) To enable city and county planning agencies to develop
36 economic forecasts for planning purposes. The information shall
37 be limited to businesses within the jurisdiction of the city or county
38 whose planning agency is requesting the information, and shall
39 not include information regarding individual employees.

1 (s) To provide the State Department of Developmental Services
2 with wage and employer information that will assist in the
3 collection of moneys owed by the recipient, parent, or any other
4 legally liable individual for services and supports provided pursuant
5 to Chapter 9 (commencing with Section 4775) of Division 4.5 of,
6 and Chapter 2 (commencing with Section 7200) and Chapter 3
7 (commencing with Section 7500) of Division 7 of, the Welfare
8 and Institutions Code.

9 (t) Nothing in this section shall be construed to authorize or
10 permit the use of information obtained in the administration of this
11 code by any private collection agency.

12 (u) The disclosure of the name and address of an individual or
13 business entity that was issued an assessment that included
14 penalties under Section 1128 or 1128.1 shall not be in violation
15 of Section 1094 if the assessment is final. The disclosure may also
16 include any of the following:

17 (1) The total amount of the assessment.

18 (2) The amount of the penalty imposed under Section 1128 or
19 1128.1 that is included in the assessment.

20 (3) The facts that resulted in the charging of the penalty under
21 Section 1128 or 1128.1.

22 (v) To enable the Contractors' State License Board to verify
23 the employment history of an individual applying for licensure
24 pursuant to Section 7068 of the Business and Professions Code.

25 (w) To provide any peace officer with the Division of
26 Investigation in the Department of Consumer Affairs information
27 pursuant to subdivision (i) when the requesting peace officer has
28 been designated by the Chief of the Division of Investigations and
29 requests this information in the course of and in part of an
30 investigation into the commission of a crime or other unlawful act
31 when there is reasonable suspicion to believe that the crime or act
32 may be connected to the information requested and would lead to
33 relevant information regarding the crime or unlawful act.

34 (x) To provide information obtained in the administration and
35 enforcement of the California Health Insurance Purchasing Pool
36 Program (Division 1.2 (commencing with Section 4800) to the
37 Managed Risk Medical Insurance Board for the purpose of
38 administering the California Health Care Reform and Cost Control
39 Act.

1 ~~SEC. 27.~~

2 ~~SEC. 30.~~ Division 1.2 (commencing with Section 4800) is
3 added to the Unemployment Insurance Code, to read:

4

5 DIVISION 1.2. CALIFORNIA HEALTH INSURANCE
6 PURCHASING POOL PROGRAM
7

8 ~~4800.~~— The department shall have the powers and duties
9 necessary to administer the enforcement of employer contributions
10 required to be paid pursuant to this division and the reporting and
11 collecting of those contributions and making refunds to the
12 employer.

13 ~~4801.~~ The following provisions of this code shall apply to any
14 amount required to be deducted, reported, and paid to the
15 department under this division:

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

18 (b) ~~Sections 403 to 413, inclusive of Section 1336, and Chapter~~
19 ~~8 (commencing with Section 1951) of Part 1 of Division 1, relating~~
20 ~~to appeals and hearing procedures:~~

21 (c) ~~Article 8 (commencing with Section 1126) of Chapter 4 of~~
22 ~~Part 1 of Division 1, relating to assessments:~~

23 (d) ~~Article 9 (commencing with Section 1176), except Section~~
24 ~~1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and~~
25 ~~overpayments:~~

26 (e) ~~Article 10 (commencing with Section 1206) of Chapter 4 of~~
27 ~~Part 1 of Division 1, relating to notice:~~

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

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

32 (h) ~~Chapter 7 (commencing with Section 1701) of Part 1 of~~
33 ~~Division 1, relating to collections:~~

34 (i) ~~Chapter 10 (commencing with Section 2101) of Part 1 of~~
35 ~~Division 1, relating to violations:~~

36 (j) ~~Sections 1110.6, 1111, 1111.5, 1112, 1113, 1113.1, 1114,~~
37 ~~1115, 1116, and 1117 relating to the making of returns or the~~
38 ~~payment of reported contributions:~~

39 ~~4802.~~ For the purposes of this division, the following
40 definitions apply:

1 (a) ~~“Board” means the Managed Risk Medical Insurance Board.~~

2 (b) ~~“California Cooperative Health Insurance Purchasing~~
3 ~~Program” or “Cal-CHIPP” shall have the same meaning as in~~
4 ~~Section 12699.201 of the Insurance Code.~~

5 (c) ~~“Contribution” means employer fees required by Part 8.8~~
6 ~~(commencing with Section 2200) of the Labor Code.~~

7 (d) ~~“Employer” has the same meaning as set forth in Section~~
8 ~~13005.~~

9 (e) ~~“Employment” has the same meaning as set forth in Article~~
10 ~~1 (commencing with Section 601) of Chapter 3 of Part 1 of~~
11 ~~Division 1.~~

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

16 (g) ~~The definitions set forth in Sections 126, 127, 129, 133, and~~
17 ~~134 shall apply to this division.~~

18 ~~4805. On and after October 1, 2009, in addition to other~~
19 ~~payments required by this code and consistent with the~~
20 ~~requirements of Section 2200 of the Labor Code, an employer~~
21 ~~electing to pay into the California Health Trust Fund pursuant to~~
22 ~~Section 2200 of the Labor Code shall pay to the department for~~
23 ~~deposit into that fund the amount required by that section. These~~
24 ~~contributions shall be collected in the same manner as any~~
25 ~~contributions required under Part 1 (commencing with Section~~
26 ~~100) of Division 1 and Division 6 (commencing with Section~~
27 ~~13000). The department shall deposit these contributions in the~~
28 ~~California Health Trust Fund.~~

29 ~~4806. An employer electing to pay a fee pursuant to Section~~
30 ~~2200 of the Labor Code shall complete the following actions:~~

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

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

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

1 ~~(d) Report to the department the hiring of an employee who~~
2 ~~works in this state and to whom the employer anticipates paying~~
3 ~~wages. The report shall contain the name, address, and social~~
4 ~~security number of the employee; the employer's name, address,~~
5 ~~and state employer identification number; and the first date the~~
6 ~~employee worked for the employer. An employer shall submit this~~
7 ~~report within 20 days of hiring or rehiring an employee.~~

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

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

13 ~~4807. The employer shall provide its employees the option of~~
14 ~~declining coverage through Cal-CHIPP if the employee certifies~~
15 ~~that he or she is exempt from this requirement pursuant to Section~~
16 ~~2203 of the Labor Code.~~

17 ~~4808. The employer shall advise its employees of the right to~~
18 ~~apply to the board to determine eligibility for a subsidy under~~
19 ~~Cal-CHIPP if the employee's household income is at or below 300~~
20 ~~percent of the federal poverty level.~~

21 ~~4809. An employer electing to pay the fee pursuant to Section~~
22 ~~2200 of the Labor Code shall remain in Cal-CHIPP for not less~~
23 ~~than two calendar years and shall not be eligible to rejoin~~
24 ~~Cal-CHIPP for a minimum of two calendar years after terminating~~
25 ~~participation in Cal-CHIPP.~~

26 ~~4810. The board shall annually publish information describing~~
27 ~~health plan choices in Cal-CHIPP for the department to disseminate~~
28 ~~to all participating employers.~~

29 ~~4820. (a) The department may assess a penalty against an~~
30 ~~employer for failure to make the report required by subdivision~~
31 ~~(d) of Section 4806 within the specified timeframe, unless the~~
32 ~~failure is due to good cause, as determined by the department. The~~
33 ~~director shall adopt regulations establishing a schedule of penalties~~
34 ~~to be imposed depending upon the frequency of violations, the~~
35 ~~history of previous violations, if any, and the seriousness of the~~
36 ~~violation. The schedule shall provide for a penalty of up to one~~
37 ~~hundred dollars (\$100) for an initial violation and for the imposition~~
38 ~~of penalties in progressively higher amounts for the most serious~~
39 ~~types of violations, to a maximum amount of five thousand dollars~~
40 ~~(\$5,000) per violation.~~

1 ~~(b) Notwithstanding any other provision of this code, an~~
2 ~~employer electing to pay the contribution who fails to file or remit~~
3 ~~the contribution and employee health care contributions under this~~
4 ~~division within the time required, shall become liable for a penalty~~
5 ~~of _____ dollars (\$_____) and interest on those contributions at an~~
6 ~~annual rate of _____ from the due date until the date they are paid.~~

7 ~~4821. It shall be unlawful for an employer to take any of the~~
8 ~~following actions if a purpose for the action is to avoid the~~
9 ~~requirements of this division:~~

10 ~~(a) Designate an employee as an independent contractor or~~
11 ~~temporary employee.~~

12 ~~(b) Reduce the number of hours of work of an employee.~~

13 ~~(c) Terminate and rehire an employee.~~

14 ~~4825. The department shall deposit all employer and employee~~
15 ~~contributions in the California Health Trust Fund created pursuant~~
16 ~~to Section 12699.212 of the Insurance Code. The department shall~~
17 ~~deposit all fines, penalties, and interest collected pursuant to this~~
18 ~~division into a penalty account within the California Health Trust~~
19 ~~Fund. Notwithstanding the provisions of Section 12699.212 of the~~
20 ~~Insurance Code, the revenue in the penalty account shall not be~~
21 ~~continuously appropriated to the board and shall be available for~~
22 ~~expenditure only upon appropriation by the Legislature.~~

23 ~~4826. The department shall provide the board with identifying~~
24 ~~information for employees eligible for Cal-CHIPP whose employer~~
25 ~~has elected to pay the fee under Section 2200 of the Labor Code.~~

26 ~~4830. The department shall adopt rules and regulations to~~
27 ~~implement the provisions of this division.~~

28 ~~4835. The department is authorized to obtain a loan from the~~
29 ~~General Fund for all necessary and reasonable expenses incurred~~
30 ~~prior to January 1, 2011 related to implementing this division and~~
31 ~~administering its provisions. The proceeds of the loan are subject~~
32 ~~to appropriation in the annual Budget Act. The department shall~~
33 ~~repay principal and interest, using the pooled money investment~~
34 ~~account rate of interest, to the General Fund no later than January~~
35 ~~1, 2016.~~

36 ~~4836. This division shall become operative on January 1, 2010.~~

1 CHAPTER 1. ADMINISTRATION AND GENERAL PROVISIONS

2
3 4800. The Employment Development Department shall
4 administer and enforce this division. The department, in
5 conjunction with other state entities, shall establish a process to
6 resolve complaints regarding the administration of this division,
7 including a toll-free telephone hotline number and an Internet
8 Web site for employers, employees, and their dependents to access
9 information and file complaints.

10 4800.01. The following provisions of this code shall apply to
11 any amount required to be reported and paid under this division:

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

14 (b) Sections 403 to 413, inclusive, Section 1336, and Chapter
15 8 (commencing with Section 1951) of Part 1 of Division 1, relating
16 to appeals and hearing procedures.

17 (c) Article 7 (commencing with Section 1110) of Chapter 4 of
18 Part 1 of Division 1 relating to making of returns or payment of
19 reported contributions.

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

22 (e) Article 9 (commencing with Section 1176), except Section
23 1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and
24 overpayments.

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

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

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

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

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

35 4800.02. For the purposes of this division, the following
36 definitions apply:

37 (a) “Board” means the Managed Risk Medical Insurance Board.

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

1 (c) “Department” means the Employment Development
2 Department.

3 (d) “Dependent” means any of the following persons:

4 (1) The spouse or registered domestic partner of an employee.

5 (2) (A) An unmarried child under 26 years of age who is the
6 natural child of the employee or an adopted child or a stepchild
7 of the employee, as described in subparagraph (B), and who meets
8 either of the following criteria:

9 (i) Lives with the employee.

10 (ii) Is economically dependent upon the employee.

11 (B) (i) A child shall be considered to be adopted from the date
12 on which the adoptive child’s birth parents, or other appropriate
13 legal authority, sign a written document, including, but not limited
14 to, a health facility minor release report, a medical authorization
15 form, or a relinquishment form, granting the employee, or the
16 spouse of the employee, the right to control health care for the
17 adoptive child or, absent this written document, on the date
18 evidence exists of the right of the employee, or the spouse of the
19 employee, to control the health care of the child placed for
20 adoption.

21 (ii) A child shall be considered a stepchild upon the employee’s
22 marriage to the natural or adopted stepchild’s parent.

23 (3) An unmarried child 26 years of age or older who is an
24 adopted child or stepchild, as described in subparagraph (B) of
25 paragraph (2), of the enrollee or a natural child of the enrollee
26 and who at the time of attaining 26 years of age was incapable of
27 self-support because of a physical or mental disability that existed
28 continuously from a date prior to the child’s attainment of 26 years
29 of age.

30 (e) “Director” means the Director of Employment Development.

31 (f) “Employer” has the same meaning as set forth in Article 3
32 (commencing with Section 675) of Chapter 3 of Part 1 of Division
33 1.

34 (g) “Employer fee” means the payment required of an employer
35 electing to pay an equivalent amount into the fund pursuant to
36 subdivision (a) of Section 4802.1.

37 (h) “Employing unit” has the same meaning as set forth in
38 Section 135.

39 (i) “Employment” has the same meaning as set forth in Article
40 1 (commencing with Section 601) of Chapter 3 of Part 1 of Division

1 *1. Employment does not include services provided pursuant to*
2 *Sections 629 to 657, inclusive.*

3 *(j) “Fund” means the California Health Trust Fund established*
4 *pursuant to Section 12699.212 of the Insurance Code.*

5 *(k) (1) “Health expenditures” means any amount paid by an*
6 *employer subject to this division to, or on behalf of, its employees*
7 *and their dependents, if applicable, to provide health care or*
8 *health-related services or to reimburse the costs of those services,*
9 *including, but not limited to, any of the following:*

10 *(A) Contributions to a health savings account as defined by*
11 *Section 223 of the Internal Revenue Code or any other account*
12 *having substantially the same purpose or effect.*

13 *(B) Reimbursement by the employer to its employees, and their*
14 *dependents, if applicable, for incurred health care expenses, if*
15 *those recipients have no entitlement to that reimbursement under*
16 *any plan, fund, or program maintained by the employer. As used*
17 *in this subparagraph, “health care expenses” includes, but is not*
18 *limited to, an expense for which payment is deductible from*
19 *personal income under Section 213(d) of the Internal Revenue*
20 *Code.*

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

26 *(D) Disease management programs.*

27 *(E) Pharmacy benefit management programs.*

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

31 *(G) Contributions made pursuant to Section 302 (c)(5) of the*
32 *Labor Management Relations Act, under a collective bargaining*
33 *agreement.*

34 *(H) Purchasing health care coverage from a health care service*
35 *plan or a health insurer.*

36 *(2) “Health expenditures” does not include a payment made*
37 *directly or indirectly for workers’ compensation, Medicare benefits,*
38 *or any other health benefit cost or taxes, penalties, or assessment*
39 *that the employer is required to pay by state or federal law, other*

1 *than as required by Section 4802.1. “Health expenditures” does*
2 *not include penalties imposed pursuant to this division.*

3 *(l) “Public program” means publicly funded health care*
4 *coverage that is defined as creditable coverage in paragraphs (2)*
5 *to (10), inclusive, of subdivision (g) of Section 1357 of the Health*
6 *and Safety Code.*

7 *(m) “Wages” means all remuneration, as defined in Section*
8 *13009.5. Wages paid to an employee that are in excess of the*
9 *applicable contribution and benefit base, as determined under*
10 *Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for*
11 *the calendar year subject to withholding by the Social Security*
12 *Administration shall be excluded for the purposes of Section*
13 *4802.1.*

14 *(n) The definitions set forth in Sections 126, 127, 129, 133, and*
15 *134 shall apply to this division.*

16 *4800.03. The board shall annually publish information*
17 *describing health plan choices in Cal-CHIPP for the department*
18 *to disseminate to all employers making employer fee payments to*
19 *the fund. The employer shall provide this information to all of its*
20 *employees.*

21 *4800.04. The director shall provide to each employer a notice*
22 *pursuant to Section 1089 and the employer shall post and distribute*
23 *it in accordance with Section 1089 to inform employees and their*
24 *dependents of the requirements of this division.*

25 *4800.05. The department shall provide information obtained*
26 *in the administration and enforcement of this division to the board*
27 *for the purpose of administering Cal-CHIPP.*

28 *4800.06. The department shall adopt rules and regulations to*
29 *implement the provisions of this division.*

30 *4800.07. An employer shall file all forms required by this*
31 *division by electronic means and shall remit all moneys owed*
32 *pursuant to this division by electronic funds transfer. If an*
33 *employer demonstrates to the director’s satisfaction that undue*
34 *hardship would be imposed on it by this section, the director may*
35 *authorize an exemption from this requirement. The director may*
36 *assess a penalty of twenty-five dollars (\$25) for each remittance*
37 *that is not filed electronically.*

CHAPTER 2. EMPLOYER ELECTION

1
 2
 3 4802.1. (a) (1) Each employer shall elect to take one of the
 4 following actions:
 5 (A) Make health expenditures as provided in subparagraph (A)
 6 of paragraph (3) for its full-time employees, and, if applicable,
 7 their dependents.
 8 (B) Pay an equivalent amount into the fund.
 9 (2) Each employer also shall elect to take one of the following
 10 actions:
 11 (A) Make health expenditures as provided in subparagraph (B)
 12 of paragraph (3) for its part-time employees, and, if applicable,
 13 their dependents.
 14 (B) Pay an equivalent amount into the fund.
 15 (3) (A) An employer’s cumulative amount of health expenditures
 16 for the employer’s full-time employees working 120 or more hours
 17 per month shall be equivalent, at a minimum, to 7.5 percent of
 18 wages paid by the employer to its full-time employees. In computing
 19 this amount, wages paid to an employee that are in excess of the
 20 applicable contribution and benefit base, as determined under
 21 Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for
 22 the calendar year subject to withholding by the Social Security
 23 Administration shall be excluded.
 24 (B) An employer’s cumulative amount of health expenditures
 25 for the employer’s part-time employees working less than 120
 26 hours per month shall be equivalent, at a minimum, to 7.5 percent
 27 of wages paid by the employer to its part-time employees. In
 28 computing this amount, wages paid to an employee that are in
 29 excess of the applicable contribution and benefit base, as
 30 determined under Section 230 of the Social Security Act (42 U.S.C.
 31 Sec. 430), for the calendar year subject to withholding by the Social
 32 Security Administration shall be excluded.
 33 (b) (1) The amount payable to the fund by an employer electing
 34 to pay shall be deposited into the fund.
 35 (2) The department, in consultation with the board, shall ensure
 36 that the employer fees paid pursuant to this section are deposited
 37 in the fund and are available to ensure the timely enrollment of
 38 eligible employees and their dependents, if any, in Cal-CHIPP.
 39 (c) Notwithstanding subparagraphs (A) and (B) of paragraph
 40 (3) of subdivision (a), the board may adjust the health expenditure

1 amounts required by those subparagraphs. The adjustments shall
2 be made by the board at a public meeting of the board. On or
3 before October 31 of each year, the board shall prepare a
4 statement, which shall be a public record, setting forth the
5 adjustments for the next calendar year and shall promptly notify
6 the department of those adjustments.

7 4802.2. (a) If an employer is required by a collective
8 bargaining agreement to make health expenditures on behalf of
9 bargaining unit employees pursuant to Section 302 (c)(5) of the
10 Labor Management Relations Act that, in the aggregate, equal or
11 exceed the percentage of wages set forth in paragraph (3) of
12 subdivision (a) of Section 4802.1 for those bargaining unit
13 employees, the employer shall be deemed to have satisfied the
14 requirements of subdivision (a) of Section 4802.1 with respect to
15 those bargaining unit employees.

16 (b) For purposes of the health expenditures requirement in
17 subdivision (a) of Section 4802.1, the department shall not accept
18 any employer fees made to the fund by an employer on behalf of
19 bargaining unit employees represented by a labor organization
20 for purposes of collective bargaining if notified by the labor
21 organization that the expenditures were made without express
22 written mutual agreement of the employer and the applicable labor
23 organization.

24 (c) An employer with employees represented by a labor
25 organization for purposes of collective bargaining shall participate
26 in the elections required by subdivision (a) of Section 4802.1
27 separately for each bargaining unit unless otherwise provided for
28 in the collective bargaining agreement.

29 (d) For all non-bargaining unit employees, the employer shall
30 participate in the elections as set forth in subdivision (a) of Section
31 4802.1.

32 4802.3. (a) An employee of an employer that elects, pursuant
33 to Section 4802.1, to pay an employer fee in lieu of making health
34 expenditures shall be required to enroll in Cal-CHIPP to receive
35 coverage under Cal-CHIPP.

36 (b) Notwithstanding subdivision (a), an employee is exempt
37 from enrolling in Cal-CHIPP if the employee is able to demonstrate
38 that he or she is covered by individual coverage that is in force
39 on the effective date of this section, a public program, or other
40 group health care coverage. An employee who is exempt under

1 *this subdivision from enrolling in Cal-CHIPP may choose to enroll*
2 *in that program, however.*

3 *(c) (1) An employee of an employer that elects, pursuant to*
4 *Section 4802.1, to make health expenditures shall accept the health*
5 *expenditures made by the employer. However, for any employee*
6 *with a household income of 300 percent of the federal poverty*
7 *level or less, if accepting an employer's health expenditures would*
8 *result in annual health expenditures by that employee in excess of*
9 *5 percent of his or her household income after taking into account*
10 *any tax savings the employee is able to realize, that employee shall*
11 *be exempt from the requirement to accept health expenditures*
12 *made by his or her employer.*

13 *(2) An employee that shows evidence of other group health care*
14 *coverage or is covered by individual coverage that is in force on*
15 *the effective date of this section shall not be required to accept*
16 *health expenditures made by his or her employer.*

17 *4803. (a) Each employer, prior to July 1, 2009, shall make an*
18 *election pursuant to subdivision (a) of Section 4802.1 for its*
19 *full-time employees and its part-time employees and notify the*
20 *department of its election. An employer that fails to make an*
21 *election by August 1, 2009, shall, within 30 days of that date be*
22 *deemed to be an employer electing to pay an employer fee into the*
23 *fund, unless the employer is able to demonstrate to the satisfaction*
24 *of the department good cause for failure to make the election and*
25 *that it is making health expenditures as described in Section*
26 *4802.1.*

27 *(b) After January 1, 2010, each employer shall notify the*
28 *department on or before September 15 of each year of its election*
29 *pursuant to subdivision (a) of Section 4802.1 for the subsequent*
30 *calendar year, if different from the current year, on a form and in*
31 *a format required by the department.*

32 *(c) A new employer, on and after July 1, 2009, within 30 days*
33 *of paying total wages of one hundred dollars (\$100) or more, shall*
34 *make an election pursuant to subdivision (a) of Section 4802.1 for*
35 *its full-time employees and its part-time employees. For purposes*
36 *of this subdivision, "new employer" shall have the same meaning*
37 *as set forth in Section 675. A new employer that fails to make an*
38 *election shall, within 30 days of the date of paying total wages of*
39 *one hundred dollars (\$100) or more, be deemed to be an employer*
40 *electing to pay an employer fee into the fund, unless the new*

1 employer is able to demonstrate to the satisfaction of the
2 department good cause for failure to make the election and that
3 it is making health expenditures as described in Section 4802.1.

4 4804. (a) On and after October 1, 2009, an employer electing
5 to pay an employer fee into the fund pursuant to subdivision (a)
6 of Section 4802.1 shall complete all of the following actions:

7 (1) File a monthly return with the department by the 15th day
8 of each month based on wages paid in the prior month. If an
9 employer paid no wages, the employer shall file a no payroll return
10 with the department.

11 (2) File with the department an annual return by January 31 of
12 each year on wages paid that month and in the prior calendar
13 year.

14 (3) Remit the employer fee required by Section 4802.1 to the
15 department by the 15th day of each month based on wages paid
16 in the prior month.

17 (4) Notify all employees annually through a written notice to
18 each employee of the requirement in Section 4802.3 to enroll in
19 Cal-CHIPP and advise employees of the exemption from that
20 requirement under that section.

21 (5) Notify employees annually, through a written notice to each
22 employee, of the right to apply to the board to determine eligibility
23 for a subsidy under Cal-CHIPP.

24 (6) Comply with the requirements of Section 4807.

25 (b) An employer shall use the format developed by the
26 department for making the returns required by paragraphs (1) and
27 (2) of subdivision (a) and the remittance of the employer fee
28 required by paragraph (3) of subdivision (a).

29 4805. An employer that elects to pay an employer fee into the
30 fund pursuant to subdivision (a) of Section 4802.1 shall not change
31 that election for, at minimum, 24 months from the date of its first
32 payment into the fund.

33 4806. (a) On and after October 1, 2009, an employer electing
34 to make health expenditures pursuant to subdivision (a) of Section
35 4802.1 shall complete the following actions:

36 (1) File a quarterly return with the department on April 15, July
37 15, October 15, and January 15 of each year, reporting its wages
38 and health expenditures for the prior quarter.

1 (2) *File an annual return with the department by January 31 of*
2 *each year reporting wages and health expenditures paid in the*
3 *prior calendar year.*

4 (3) *Notify all employees annually through a written notice to*
5 *each employee that employees with a family income at or below*
6 *300 percent of the federal poverty level are eligible to apply for*
7 *the Medi-Cal program or the Healthy Families Program, including*
8 *instructions on the application process for those programs.*

9 (4) *Comply with the requirements of subdivisions (a) and (b)*
10 *of Section 4807.*

11 (b) *An employer shall use the format developed by the*
12 *department to make the returns required by paragraphs (1) and*
13 *(2) of subdivision (a).*

14 4807. (a) *An employer shall notify its employees of its election*
15 *pursuant to subdivision (a) of Section 4802.1 to make health*
16 *expenditures or to pay an employer fee into the fund within five*
17 *business days of making the election and shall notify an employee*
18 *hired after the date of that notification within five days of the*
19 *employee's date of hire.*

20 (b) *The employer shall notify its employees within five business*
21 *days of the date it makes a change to its election decision.*

22 (c) (1) *An employer electing pursuant to subdivision (a) of*
23 *Section 4802.1 to pay an employer fee shall within five business*
24 *days of making that election notify its employees of the following:*

25 (A) *The employee's requirement to enroll in Cal-CHIPP*
26 *pursuant to Section 4802.3 and the exemption from enrollment in*
27 *that section.*

28 (B) *The employee's right to apply for a subsidy under*
29 *Cal-CHIPP.*

30 (2) *The employer shall provide the notice required by this*
31 *subdivision to an employee hired after the timeframe described in*
32 *paragraph (1), within five business days of the employee's date of*
33 *hire.*

34

35 CHAPTER 3. CAFETERIA PLAN

36

37 4809. (a) *Unless provided otherwise by state or federal law,*
38 *each employer in this state during a taxable year shall adopt and*
39 *retain a cafeteria plan, within the meaning of Section 125 of the*
40 *Internal Revenue Code, to allow employees to pay premiums for*

1 *health care coverage, to the extent those payments are excludable*
2 *from the gross income of the employee under Section 106 of the*
3 *Internal Revenue Code.*

4 *(b) An employer that fails to establish a cafeteria plan is subject*
5 *to a penalty of one hundred dollars (\$100) for each of its employees*
6 *during the taxable year unless the employer establishes, to the*
7 *department's satisfaction, good cause for the failure to establish*
8 *the plan. An employer who willfully fails to establish a cafeteria*
9 *plan is subject to a penalty of five hundred dollars (\$500) for each*
10 *of its employees during the taxable year.*

11
12 *CHAPTER 4. ENFORCEMENT*
13

14 *4811. (a) An employer that without good cause, as determined*
15 *by the department, fails to complete any of the following actions*
16 *shall be subject to assessment of a penalty as described in*
17 *subdivision (b):*

18 *(1) Notify the department of its election pursuant to Section*
19 *4803.*

20 *(2) File returns required by Sections 4804 and 4806.*

21 *(3) Provide notices to its employees as required by Sections*
22 *4804, 4806, and 4807.*

23 *(b) The amount of the penalty for a first violation shall be*
24 *twenty-five dollars (\$25) for each of the employer's employees at*
25 *the time of the violation. The amount of the penalty for a second*
26 *violation shall be fifty dollars (\$50) for each of the employer's*
27 *employees at the time of the violation. The amount of the penalty*
28 *for all subsequent violations shall be one hundred dollars (\$100)*
29 *for each of the employer's employees at the time of the violation.*

30 *(c) The amount of the penalty described in subdivision (b) shall*
31 *be increased by 10 percent if the employer without good cause, as*
32 *determined by the department, fails to complete any of the actions*
33 *described in subdivision (a) within 60 days of the date it is required*
34 *to be completed.*

35 *(d) (1) An employer that, without good cause, as determined*
36 *by the department, fails to make any payments required of it or of*
37 *its employees within the time required by this division, shall be*
38 *assessed a penalty equaling 10 percent of the amount of the*
39 *payment it failed to make or equaling 10 percent of the unpaid*

1 *payment amount, if the employer failed to make the payment in its*
2 *entirety.*

3 *(2) The amount of the penalty described in paragraph (1) shall*
4 *be increased by 10 percent if the employer without good cause, as*
5 *determined by the department, fails to make the payment required*
6 *by this division within 60 days of the date the employer is required*
7 *to make the payment.*

8 *(e) An employer that fails to file the annual return required by*
9 *Sections 4804 and 4806 within 30 days of the date the employer*
10 *was notified of its failure to file the return shall, in addition to any*
11 *other penalties imposed by this code, be assessed an additional*
12 *penalty of up to one hundred dollars (\$100) for each of its*
13 *employees at the time the return was due, unless the employer*
14 *demonstrates, to the department's satisfaction, good cause for its*
15 *failure to file the return.*

16 *4812. If the director determines a return made by an employer*
17 *inaccurately reports the amount of health expenditures or the*
18 *amount of its employer fee payment required pursuant to Section*
19 *4802.1, he or she shall assess a penalty. The penalty amount shall*
20 *be determined by the director based on the facts contained in the*
21 *return or on his or her estimate of the correct amount of health*
22 *expenditures or employer fees based on any information in his or*
23 *her possession or that may come into his or her possession. If any*
24 *part of the deficiency in the health expenditures or employer fee*
25 *amount is due to negligence or intentional disregard of this division*
26 *or the regulations adopted pursuant to it, the penalty shall be*
27 *increased by an amount equaling 10 percent of the amount of the*
28 *deficiency in the amount of the health expenditures or employer*
29 *fees.*

30 *4813. If the employer's failure to file a return or to make a*
31 *payment within the time required by this division, and the*
32 *regulations adopted pursuant to it, is due to fraud or to an intent*
33 *to evade the provisions of this division, or of the regulations*
34 *adopted pursuant to it, a penalty equaling 50 percent of the amount*
35 *of the payment or of the health expenditures the employer was*
36 *required to make shall be assessed against the employer.*

37 *4814. (a) An employer that elects to pay the employer fee and*
38 *fails to withhold premium payment amounts authorized by an*
39 *employee pursuant to Section 12699.203 of the Insurance Code*

1 and Section 4809 of this code is subject to a penalty equaling 200
2 percent of the amount the employer failed to withhold.

3 (b) An employer that fails to remit premium payment amounts
4 it withheld as authorized by an employee is subject to a penalty
5 equaling 200 percent of the amount the employer failed to remit.

6 (c) In addition to the penalties set forth in subdivisions (a) and
7 (b), the employer shall reimburse the employee for any health care
8 expenses incurred by the employee and his or her dependents
9 because of a lapse or cancellation of health care coverage resulting
10 from the employer's failure to withhold or remit the employee's
11 premium payment amounts.

12 4815. (a) An employer electing to make health expenditures
13 pursuant to Section 4802.1 that fails to make expenditures in the
14 amount required by that section shall be subject to a penalty in an
15 amount equaling 10 percent of the balance between the amount
16 required by Section 4802.1 and the amount of the health
17 expenditures made by the employer and shall be subject to a
18 penalty in an amount equaling 20 percent of that balance amount
19 if the amount of health expenditures made by the employer is less
20 than 80 percent of the amount required by Section 4802.1.

21 (b) If the employer fails to pay the penalty assessed pursuant
22 to subdivision (a) within 60 days of its assessment date, an
23 additional penalty shall be assessed against the employer the
24 employer in an amount equaling 10 percent of the penalty assessed
25 under subdivision (a).

26 (c) Notwithstanding subdivisions (a) and (b), an employer that
27 demonstrates good cause, as determined by the department, for
28 its failure to make the health expenditures amount required by
29 Section 4802.1 is not subject to a penalty under this section.

30 (d) Penalties shall be assessed under this section pursuant to
31 an annual reconciliation and review process by the department.

32 4816. If the director is not satisfied with the accuracy or the
33 sufficiency of a return filed by an employer or of an employer fee
34 paid by an employer, he or she may assess a civil penalty in the
35 sum of _____ dollars (\$_____).

36 4817. It shall be unlawful for an employer to take any of the
37 following actions if a purpose for the action is to avoid the
38 requirements of this division:

39 (a) Designate an employee as a temporary employee.

40 (b) Reduce the number of hours of work of an employee.

1 (c) *Terminate and rehire an employee.*

2 4818. *It is unlawful for a person to take any of the following*
3 *actions.*

4 (a) *Willfully misclassify an employee as an independent*
5 *contractor which misclassification results in avoiding the*
6 *requirements of this division.*

7 (b) *Procure, counsel, advise, or coerce another to willfully make*
8 *a false statement or representation or to knowingly fail to disclose*
9 *a material fact in order to avoid the requirements of this division.*

10 4819. *An employer that takes any of the actions described in*
11 *Section 4818 shall, in addition to any other fees or penalties*
12 *imposed pursuant to this code, pay a penalty equaling 50 percent*
13 *of the amount of all employer fees that would be required by this*
14 *division if the employer elected to pay the employer fee or a penalty*
15 *equaling 50 percent of the amount of all health expenditures that*
16 *would be required by this division if the employer elected to make*
17 *health care expenditures.*

18 4821. (a) *The director shall provide to each service recipient,*
19 *as defined in paragraph (1) of subdivision (b) of Section 1088.8,*
20 *a notice informing each service provider, as defined in paragraph*
21 *(2) of subdivision (b) of Section 1088.8, of their rights,*
22 *responsibilities, and the differences in workplace benefit coverage*
23 *as an independent contractor, including their right to file for a*
24 *status determination with the department. This notice shall be*
25 *given by every service recipient required pursuant to Section*
26 *1088.8 to report payments equal to, or in excess of, six hundred*
27 *dollars (\$600) in any year to a service provider when the first*
28 *payment is made.*

29 (b) *In order to ensure the proper implementation of this division,*
30 *the department shall adopt regulations for accelerating the appeal*
31 *process for issues relating to misclassification of an employee as*
32 *an independent contractor pursuant to this division.*

33 4822. *The penalties and remedies provided pursuant to this*
34 *division are cumulative and in addition to any other penalties or*
35 *remedies provided by law.*

36

37

CHAPTER 5. FISCAL

38

39 4823. *The department shall deposit all employer fees and*
40 *employee premium payments into the fund. The department shall*

1 *deposit all fines, penalties, and interest collected pursuant to this*
2 *division into a penalty account within the fund. Notwithstanding*
3 *the provisions of Section 12699.212 of the Insurance Code, the*
4 *revenue in the penalty account shall not be continuously*
5 *appropriated to the board and shall be available for expenditure*
6 *only upon appropriation by the Legislature.*

7 4824. *The department is authorized to obtain a loan from the*
8 *General Fund for all necessary and reasonable expenses incurred*
9 *prior to January 1, 2011, related to implementing this division*
10 *and administering its provisions. The proceeds of the loan are*
11 *subject to appropriation in the annual Budget Act. The department*
12 *shall repay principal and interest, using the pooled money*
13 *investment account rate of interest, to the General Fund no later*
14 *than January 1, 2016.*

15
16 CHAPTER 6. OPERATIVE PROVISIONS

17
18 4829. *This division shall become operative on January 1, 2009.*

19 ~~SEC. 28.~~

20 SEC. 31. Section 14005.23 of the Welfare and Institutions
21 Code is amended to read:

22 14005.23. (a) To the extent federal financial participation is
23 available, the department shall, when determining eligibility for
24 children under Section 1396a(l)(1)(D) of Title 42 of the United
25 States Code, designate a birth date by which all children who have
26 not attained the age of 19 years will meet the age requirement of
27 Section 1396a(l)(1)(D) of Title 42 of the United States Code.

28 (b) Commencing July 1, 2008, to the extent federal financial
29 participation is available, the department shall apply a less
30 restrictive income deduction described in Section 1396a(r) of Title
31 42 of the United States Code when determining eligibility for the
32 children identified in subdivision (a). The amount of this deduction
33 shall be the difference between 133 percent and 100 percent of the
34 federal poverty level applicable to the size of the family.

35 (c) *For children enrolled in the Healthy Families Program as*
36 *of July 1, 2008, the income limit in subdivision (b) shall be applied*
37 *in determining eligibility at the next annual redetermination for*
38 *that program, or earlier upon request of the beneficiary. The*
39 *coverage under this section for a child who is a dependent of an*
40 *employee of an employer electing to make a payment to the*

1 California Health Trust Fund in lieu of making health-care
2 expenditures pursuant to Section ~~2200~~ of the Labor *4802.1 of the*
3 *Unemployment Insurance* Code, shall be provided through a
4 Medi-Cal benchmark plan under Part 6.45 (commencing with
5 Section 12699.201) of Division 2 of the Insurance Code.

6 ~~SEC. 29.~~

7 *SEC. 32.* Section 14005.30 of the Welfare and Institutions
8 Code is amended to read:

9 14005.30. (a) (1) To the extent that federal financial
10 participation is available, Medi-Cal benefits under this chapter
11 shall be provided to individuals eligible for services under Section
12 1396u-1 of Title 42 of the United States Code, including any
13 options under Section 1396u-1(b)(2)(C) made available to and
14 exercised by the state.

15 (2) The department shall exercise its option under Section
16 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
17 less restrictive income and resource eligibility standards and
18 methodologies to the extent necessary to allow all recipients of
19 benefits under Chapter 2 (commencing with Section 11200) to be
20 eligible for Medi-Cal under paragraph (1).

21 (3) To the extent federal financial participation is available, the
22 department shall exercise its option under Section 1396u-1(b)(2)(C)
23 of Title 42 of the United States Code authorizing the state to
24 disregard all changes in income or assets of a beneficiary until the
25 next annual redetermination under Section 14012. The department
26 shall implement this paragraph only if, and to the extent that the
27 State Child Health Insurance Program waiver described in Section
28 12693.755 of the Insurance Code extending Healthy Families
29 Program eligibility to parents and certain other adults is approved
30 and implemented.

31 (b) To the extent that federal financial participation is available,
32 the department shall exercise its option under Section
33 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
34 to simplify eligibility for Medi-Cal under subdivision (a) by
35 exempting all resources for applicants and recipients.

36 (c) To the extent federal financial participation is available, the
37 department shall, commencing March 1, 2000, adopt an income
38 disregard for applicants equal to the difference between the income
39 standard under the program adopted pursuant to Section 1931(b)
40 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and

1 the amount equal to 100 percent of the federal poverty level
2 applicable to the size of the family. A recipient shall be entitled
3 to the same disregard, but only to the extent it is more beneficial
4 than, and is substituted for, the earned income disregard available
5 to recipients.

6 (d) Commencing July 1, 2008, the department shall adopt an
7 income disregard for applicants equal to the difference between
8 the income standard under the program adopted pursuant to Section
9 1931(b) of the federal Social Security Act (42 U.S.C. Sec.
10 1396u-1(b)) and the amount equal to 133 percent of the federal
11 poverty level applicable to the size of the family. A recipient shall
12 be entitled to the same disregard, but only to the extent it is more
13 generous than, and is substituted for, the earned income disregard
14 available to recipients. Implementation of this subdivision is
15 contingent upon federal financial participation. Upon
16 implementation of this subdivision, the income disregard described
17 in subdivision (c) shall no longer apply.

18 (e) For purposes of calculating income under this section during
19 any calendar year, increases in social security benefit payments
20 under Title II of the federal Social Security Act (42 U.S.C. Sec.
21 401 and following) arising from cost-of-living adjustments shall
22 be disregarded commencing in the month that these social security
23 benefit payments are increased by the cost-of-living adjustment
24 through the month before the month in which a change in the
25 federal poverty level requires the department to modify the income
26 disregard pursuant to subdivision (c) and in which new income
27 limits for the program established by this section are adopted by
28 the department.

29 (f) Notwithstanding Chapter 3.5 (commencing with Section
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
31 the department shall implement, without taking regulatory action,
32 subdivisions (a) and (b) of this section by means of an all county
33 letter or similar instruction. Thereafter, the department shall adopt
34 regulations in accordance with the requirements of Chapter 3.5
35 (commencing with Section 11340) of Part 1 of Division 3 of Title
36 2 of the Government Code. Beginning six months after the effective
37 date of this section, the department shall provide a status report to
38 the Legislature on a semiannual basis until regulations have been
39 adopted.

1 ~~SEC. 30.~~

2 *SEC. 33.* Section 14005.31 of the Welfare and Institutions
3 Code is amended to read:

4 14005.31. (a) (1) Subject to paragraph (2), for any person
5 whose eligibility for benefits under Section 14005.30 has been
6 determined with a concurrent determination of eligibility for cash
7 aid under Chapter 2 (commencing with Section 11200), loss of
8 eligibility or termination of cash aid under Chapter 2 (commencing
9 with Section 11200) shall not result in a loss of eligibility or
10 termination of benefits under Section 14005.30 absent the existence
11 of a factor that would result in loss of eligibility for benefits under
12 Section 14005.30 for a person whose eligibility under Section
13 14005.30 was determined without a concurrent determination of
14 eligibility for benefits under Chapter 2 (commencing with Section
15 11200).

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

22 (b) The department, in consultation with the counties and
23 representatives of consumers, managed care plans, and Medi-Cal
24 providers, shall prepare a simple, clear, consumer-friendly notice
25 to be used by the counties, to inform Medi-Cal beneficiaries whose
26 eligibility for cash aid under Chapter 2 (commencing with Section
27 11200) has ended, but whose eligibility for benefits under Section
28 14005.30 continues pursuant to subdivision (a), that their benefits
29 will continue. To the extent feasible, the notice shall be sent out
30 at the same time as the notice of discontinuation of cash aid, and
31 shall include all of the following:

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

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

37 (3) A statement that the Medi-Cal beneficiary does not need to
38 fill out monthly status reports in order to remain eligible for
39 Medi-Cal, but shall be required to submit a semiannual status report
40 and annual reaffirmation forms, except that the semiannual status

1 report shall no longer be required on and after July 1, 2008. The
2 notice shall remind individuals whose cash aid ended under the
3 CalWORKs program as a result of not submitting a status report
4 that he or she should review his or her circumstances to determine
5 if changes have occurred that should be reported to the Medi-Cal
6 eligibility worker.

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

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

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

15 (c) This section shall be implemented on or before July 1, 2001,
16 but only to the extent that federal financial participation under
17 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.
18 1396 and following) is available.

19 (d) Notwithstanding Chapter 3.5 (commencing with Section
20 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
21 the department shall, without taking any regulatory action,
22 implement this section by means of all county letters or similar
23 instructions. Thereafter, the department shall adopt regulations in
24 accordance with the requirements of Chapter 3.5 (commencing
25 with Section 11340) of Part 1 of Division 3 of Title 2 of the
26 Government Code. Comprehensive implementing instructions
27 shall be issued to the counties no later than March 1, 2001.

28 ~~SEC. 31.~~

29 *SEC. 34.* Section 14005.32 of the Welfare and Institutions
30 Code is amended to read:

31 14005.32. (a) (1) If the county has evidence clearly
32 demonstrating that a beneficiary is not eligible for benefits under
33 this chapter pursuant to Section 14005.30, but is eligible for
34 benefits under this chapter pursuant to other provisions of law, the
35 county shall transfer the individual to the corresponding Medi-Cal
36 program. Eligibility under Section 14005.30 shall continue until
37 the transfer is complete.

38 (2) The department, in consultation with the counties and
39 representatives of consumers, managed care plans, and Medi-Cal
40 providers, shall prepare a simple, clear, consumer-friendly notice

1 to be used by the counties, to inform beneficiaries that their
2 Medi-Cal benefits have been transferred pursuant to paragraph (1)
3 and to inform them about the program to which they have been
4 transferred. To the extent feasible, the notice shall be issued with
5 the notice of discontinuance from cash aid, and shall include all
6 of the following:

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

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

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

15 (D) A statement that the Medi-Cal beneficiary does not need to
16 fill out monthly status reports in order to remain eligible for
17 Medi-Cal, but shall be required to submit a semiannual status report
18 and annual reaffirmation forms, except that the semiannual status
19 report shall no longer be required on and after July 1, 2008. In
20 addition, if the person or persons to whom the notice is directed
21 has been found eligible for transitional Medi-Cal as described in
22 Section 14005.8, 14005.81, or 14005.85, the statement shall explain
23 the reporting requirements and duration of benefits under those
24 programs, and shall further explain that, at the end of the duration
25 of these benefits, a redetermination, as provided for in Section
26 14005.37 shall be conducted to determine whether benefits are
27 available under any other provision of law.

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

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

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

36 (b) No later than September 1, 2001, the department shall submit
37 a federal waiver application seeking authority to eliminate the
38 reporting requirements imposed by transitional medicaid under
39 Section 1925 of the federal Social Security Act (Title 42 U.S.C.
40 Sec. 1396r-6).

1 (c) This section shall be implemented on or before July 1, 2001,
2 but only to the extent that federal financial participation under
3 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.
4 1396 and following) is available.

5 (d) Notwithstanding Chapter 3.5 (commencing with Section
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
7 the department shall, without taking any regulatory action,
8 implement this section by means of all county letters or similar
9 instructions. Thereafter, the department shall adopt regulations in
10 accordance with the requirements of Chapter 3.5 (commencing
11 with Section 11340) of Part 1 of Division 3 of Title 2 of the
12 Government Code. Comprehensive implementing instructions
13 shall be issued to the counties no later than March 1, 2001.

14 ~~SEC. 32.~~

15 *SEC. 35.* Section 14005.33 is added to the Welfare and
16 Institutions Code, to read:

17 14005.33. (a) Notwithstanding Section 14005.30, to the extent
18 that federal financial participation is available, Medi-Cal benefits
19 under a Healthy Families benchmark plan as permitted under
20 Section 6044 of the federal Deficit Reduction Act of 2005 (42
21 U.S.C. Sec. 1396u-7) shall be provided to a population composed
22 of parents and other caretaker relatives with a household income
23 at or below 300 percent of the federal poverty level who are not
24 otherwise eligible for full scope benefits with no share of cost.

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

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

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

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

39 (f) *This section shall become operative on July 1, 2008.*

40 ~~SEC. 33.~~ Section 14005.34

1 *SEC. 36. Section 14005.331 is added to the Welfare and*
2 *Institutions Code, to read:*

3 ~~14005.34. (a) Notwithstanding any other provision of law, all~~
4 ~~children under 19 years of age who meet the state residency~~
5 ~~requirements of the Medi-Cal program shall be eligible for full~~
6 ~~scope benefits under this chapter if they satisfy either of the~~
7 ~~following criteria:~~

8 ~~(1) Live in families with countable household income at or~~
9 ~~below 133 percent of the federal poverty level.~~

10 ~~(2) Meet the income and resource requirements of Section~~
11 ~~14005.7 or 14005.30, including those children for whom federal~~
12 ~~financial participation is not available under Title XXI of the~~
13 ~~federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or under~~
14 ~~Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1397aa~~
15 ~~et seq.).~~

16 ~~(b) Notwithstanding any other provision of law, an infant under~~
17 ~~1 year of age who meets the state residency requirements of the~~
18 ~~Medi-Cal program shall be eligible for full scope benefits under~~
19 ~~this chapter if the infant lives in a family with countable household~~
20 ~~income at or below 200 percent of the federal poverty level,~~
21 ~~including those children for whom federal financial participation~~
22 ~~is not available under Title XXI of the federal Social Security Act~~
23 ~~(42 U.S.C. Sec. 1396 et seq.) or under Title XIX of the federal~~
24 ~~Social Security Act (42 U.S.C. Sec. 1397aa et seq.).~~

25 *14005.331. (a) Notwithstanding any other provision of law,*
26 *all individuals under 19 years of age with a countable family*
27 *income at or below 133 percent of the federal poverty level who*
28 *would be eligible for full-scope benefits under the Medi-Cal*
29 *program without a share of cost if not for their immigration status,*
30 *shall be eligible for full-scope benefits under the Medi-Cal program*
31 *if the individual meets the state residency requirements of the*
32 *Medi-Cal program.*

33 *(b) Notwithstanding any other provision of law, all infants under*
34 *1 year of age with a countable family income at or below 200*
35 *percent of the federal poverty level who would be eligible for*
36 *full-scope benefits under the Medi-Cal program if not for their*
37 *immigration status, shall be eligible for full-scope benefits under*
38 *the Medi-Cal program if the infant meets the state residency*
39 *requirements of the Medi-Cal program.*

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

8
9 *SEC. 37. Section 14005.82 is added to the Welfare and
10 Institutions Code, to read:*

11 *14005.82. (a) The department shall exercise its options under
12 Section 1906 of Title 19 of the federal Social Security Act (42
13 U.S.C. Sec. 1396e) to require, as a condition of an individual
14 becoming or remaining eligible for the Medi-Cal program, that
15 the individual, or if a child, the child's parent, offered the option
16 of enrolling in a Medi-Cal benchmark plan pursuant to Section
17 1357.24 of the Health and Safety Code or Section 10764 of the
18 Insurance Code enroll in that benchmark plan. If the individual
19 is eligible for the Medi-Cal program under Section 14005.33 and
20 the individual is offered the option of enrolling in a Healthy
21 Families benchmark plan pursuant to Section 1357.24 of the Health
22 and Safety Code or Section 10764 of the Insurance Code, the
23 individual shall, as a condition of the individual becoming or
24 remaining eligible for the Medi-Cal program, enroll in the Healthy
25 Families Program benchmark plan.*

26 *(b) The requirement that an individual enroll in a benchmark
27 plan, as described in subdivision (a), shall apply to an individual
28 enrolled in the Medi-Cal program or in the Healthy Families
29 Program at the individual's next annual redetermination of
30 eligibility for the Medi-Cal program or the Healthy Families
31 Program, or before that time if requested by the beneficiary or
32 subscriber.*

33 ~~SEC. 34.~~

34 *SEC. 38. Section 14008.85 of the Welfare and Institutions
35 Code is amended to read:*

36 *14008.85. (a) To the extent federal financial participation is
37 available, a parent who is the principal wage earner shall be
38 considered an unemployed parent for purposes of establishing
39 eligibility based upon deprivation of a child where any of the
40 following applies:*

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

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

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

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

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

25 ~~(b) The department shall seek any federal approval required to~~
26 ~~wave or to increase the income limit in paragraph (2) of~~
27 ~~subdivision (a) to the extent necessary to implement Sections~~
28 ~~14005.30 and 14005.33.~~

29 (c) Notwithstanding Chapter 3.5 (commencing with Section
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
31 the department shall implement this section by means of an all
32 county letter or similar instruction without taking regulatory action.
33 Thereafter, the department shall adopt regulations in accordance
34 with the requirements of Chapter 3.5 (commencing with Section
35 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

36 *SEC. 39. Section 14011.16 of the Welfare and Institutions Code*
37 *is amended to read:*

38 14011.16. (a) Commencing August 1, 2003, the department
39 shall implement a requirement for beneficiaries to file semiannual
40 status reports as part of the department's procedures to ensure that

1 beneficiaries make timely and accurate reports of any change in
2 circumstance that may affect their eligibility. The department shall
3 develop a simplified form to be used for this purpose. The
4 department shall explore the feasibility of using a form that allows
5 a beneficiary who has not had any changes to so indicate by
6 checking a box and signing and returning the form.

7 (b) Beneficiaries who have been granted continuous eligibility
8 under Section 14005.25 shall not be required to submit semiannual
9 status reports. To the extent federal financial participation is
10 available, all children under 19 years of age shall be exempt from
11 the requirement to submit semiannual status reports.

12 (c) Beneficiaries whose eligibility is based on a determination
13 of disability or on their status as aged or blind shall be exempt
14 from the semiannual status report requirement described in
15 subdivision (a). The department may exempt other groups from
16 the semiannual status report requirement as necessary for simplicity
17 of administration.

18 (d) When a beneficiary has completed, signed, and filed a
19 semiannual status report that indicated a change in circumstance,
20 eligibility shall be redetermined.

21 (e) Notwithstanding Chapter 3.5 (commencing with Section
22 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
23 the department shall implement this section by means of all county
24 letters or similar instructions without taking regulatory action.
25 Thereafter, the department shall adopt regulations in accordance
26 with the requirements of Chapter 3.5 (commencing with Section
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

28 (f) This section shall be implemented only if and to the extent
29 federal financial participation is available.

30 (g) *This section shall become inoperative on July 1, 2008, and,
31 as of January 1, 2009, is repealed, unless a later enacted statute
32 that is enacted before January 1, 2009, deletes or extends the dates
33 on which it becomes inoperative and is repealed.*

34 ~~SEC. 35.~~

35 *SEC. 40.* Section 14131.01 is added to the Welfare and
36 Institutions Code, to read:

37 14131.01. The coverage under this chapter to a person who is
38 an employee or, if applicable, a dependent of an employee, of an
39 employer electing to make a payment to the California Health
40 Trust Fund in lieu of making health-care expenditures pursuant to

1 Section ~~2200 of the Labor~~ 4802.1 of the *Unemployment Insurance*
 2 Code, shall be provided through a Medi-Cal benchmark plan under
 3 Part 6.45 (commencing with Section 12699.201) of the Insurance
 4 Code.

5 ~~SEC. 36.~~

6 *SEC. 41.* Article 7 (commencing with Section 14199.10) is
 7 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
 8 Institutions Code, to read:

9

10 Article 7. Coordination with the California Health Trust Fund
 11

12 14199.10. The department shall seek any necessary federal
 13 approval to enable the state to receive federal funds for coverage
 14 provided through the California Cooperative Health Insurance
 15 Purchasing Program (Cal-CHIPP) to persons who would be eligible
 16 for the Medi-Cal program if the state expanded eligibility to a
 17 population composed of parents and other caretaker relatives with
 18 a household income at or below 300 percent of the federal poverty
 19 level who are not otherwise eligible for ~~fullscope~~ *full scope* benefits
 20 with no share of cost. Revenues in the California Health Trust
 21 Fund created pursuant to Section 12699.212 of the Insurance Code
 22 shall be used as state matching funds for receipt of federal funds
 23 resulting from the implementation of this section. All federal funds
 24 received pursuant to that federal approval shall be deposited in the
 25 California Health Trust Fund.

26 *SEC. 42. Section 6254 of the Government Code is amended to*
 27 *read:*

28 6254. Except as provided in Sections 6254.7 and 6254.13,
 29 nothing in this chapter shall be construed to require disclosure of
 30 records that are any of the following:

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

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

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

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

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

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

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

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

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

19 (f) Records of complaints to, or investigations conducted by,
20 or records of intelligence information or security procedures of,
21 the office of the Attorney General and the Department of Justice,
22 and any state or local police agency, or any investigatory or security
23 files compiled by any other state or local police agency, or any
24 investigatory or security files compiled by any other state or local
25 agency for correctional, law enforcement, or licensing purposes.
26 However, state and local law enforcement agencies shall disclose
27 the names and addresses of persons involved in, or witnesses other
28 than confidential informants to, the incident, the description of
29 any property involved, the date, time, and location of the incident,
30 all diagrams, statements of the parties involved in the incident, the
31 statements of all witnesses, other than confidential informants, to
32 the victims of an incident, or an authorized representative thereof,
33 an insurance carrier against which a claim has been or might be
34 made, and any person suffering bodily injury or property damage
35 or loss, as the result of the incident caused by arson, burglary, fire,
36 explosion, larceny, robbery, carjacking, vandalism, vehicle theft,
37 or a crime as defined by subdivision (b) of Section 13951, unless
38 the disclosure would endanger the safety of a witness or other
39 person involved in the investigation, or unless disclosure would
40 endanger the successful completion of the investigation or a related

1 investigation. However, nothing in this division shall require the
2 disclosure of that portion of those investigative files that reflects
3 the analysis or conclusions of the investigating officer.

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

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

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

22 (2) Subject to the restrictions imposed by Section 841.5 of the
23 Penal Code, the time, substance, and location of all complaints or
24 requests for assistance received by the agency and the time and
25 nature of the response thereto, including, to the extent the
26 information regarding crimes alleged or committed or any other
27 incident investigated is recorded, the time, date, and location of
28 occurrence, the time and date of the report, the name and age of
29 the victim, the factual circumstances surrounding the crime or
30 incident, and a general description of any injuries, property, or
31 weapons involved. The name of a victim of any crime defined by
32 Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286,
33 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code
34 may be withheld at the victim's request, or at the request of the
35 victim's parent or guardian if the victim is a minor. When a person
36 is the victim of more than one crime, information disclosing that
37 the person is a victim of a crime defined by Section 220, 261,
38 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6,
39 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the
40 request of the victim, or the victim's parent or guardian if the

1 victim is a minor, in making the report of the crime, or of any
2 crime or incident accompanying the crime, available to the public
3 in compliance with the requirements of this paragraph.

4 (3) Subject to the restrictions of Section 841.5 of the Penal Code
5 and this subdivision, the current address of every individual
6 arrested by the agency and the current address of the victim of a
7 crime, where the requester declares under penalty of perjury that
8 the request is made for a scholarly, journalistic, political, or
9 governmental purpose, or that the request is made for investigation
10 purposes by a licensed private investigator as described in Chapter
11 11.3 (commencing with Section 7512) of Division 3 of the Business
12 and Professions Code. However, the address of the victim of any
13 crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a,
14 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9
15 of the Penal Code shall remain confidential. Address information
16 obtained pursuant to this paragraph may not be used directly or
17 indirectly, or furnished to another, to sell a product or service to
18 any individual or group of individuals, and the requester shall
19 execute a declaration to that effect under penalty of perjury.
20 Nothing in this paragraph shall be construed to prohibit or limit a
21 scholarly, journalistic, political, or government use of address
22 information obtained pursuant to this paragraph.

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

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

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

39 (j) Library circulation records kept for the purpose of identifying
40 the borrower of items available in libraries, and library and museum

1 materials made or acquired and presented solely for reference or
2 exhibition purposes. The exemption in this subdivision shall not
3 apply to records of fines imposed on the borrowers.

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

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

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

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

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

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

1 activities governed by the employee relations acts referred to in
2 this subdivision.

3 (q) Records of state agencies related to activities governed by
4 Article 2.6 (commencing with Section 14081), Article 2.8
5 (commencing with Section 14087.5), and Article 2.91
6 (commencing with Section 14089) of Chapter 7 of Part 3 of
7 Division 9 of the Welfare and Institutions Code, that reveal the
8 special negotiator's deliberative processes, discussions,
9 communications, or any other portion of the negotiations with
10 providers of health care services, impressions, opinions,
11 recommendations, meeting minutes, research, work product,
12 theories, or strategy, or that provide instruction, advice, or training
13 to employees.

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

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

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

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

39 (s) A final accreditation report of the Joint Commission on
40 Accreditation of Hospitals that has been transmitted to the State

1 Department of ~~Health Services~~ *Public Health* pursuant to
2 subdivision (b) of Section 1282 of the Health and Safety Code.

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

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

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

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

29 (v) (1) Records of the Major Risk Medical Insurance Program
30 related to activities governed by Part 6.3 (commencing with Section
31 12695) and Part 6.5 (commencing with Section 12700) of Division
32 2 of the Insurance Code, and that reveal the deliberative processes,
33 discussions, communications, or any other portion of the
34 negotiations with health plans, or the impressions, opinions,
35 recommendations, meeting minutes, research, work product,
36 theories, or strategy of the board or its staff, or records that provide
37 instructions, advice, or training to employees.

38 (2) (A) Except for the portion of a contract that contains the
39 rates of payment, contracts for health coverage entered into
40 pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5

1 (commencing with Section 12700) of Division 2 of the Insurance
2 Code, on or after July 1, 1991, shall be open to inspection one year
3 after they have been fully executed.

4 (B) If a contract for health coverage that is entered into prior to
5 July 1, 1991, is amended on or after July 1, 1991, the amendment,
6 except for any portion containing the rates of payment, shall be
7 open to inspection one year after the amendment has been fully
8 executed.

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

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

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

28 (2) Except for the portion of a contract that contains the rates
29 of payment, contracts for health coverage entered into pursuant to
30 Chapter 14 (commencing with Section 10700) of Part 2 of Division
31 2 of the Insurance Code, on or after January 1, 1993, shall be open
32 to inspection one year after they have been fully executed.

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

39 (x) Financial data contained in applications for registration, or
40 registration renewal, as a service contractor filed with the Director

1 of Consumer Affairs pursuant to Chapter 20 (commencing with
2 Section 9800) of Division 3 of the Business and Professions Code,
3 for the purpose of establishing the service contractor's net worth,
4 or financial data regarding the funded accounts held in escrow for
5 service contracts held in force in this state by a service contractor.

6 (y) (1) Records of the Managed Risk Medical Insurance Board
7 related to activities governed by Part 6.2 (commencing with Section
8 12693) or Part 6.4 (commencing with Section 12699.50) of
9 Division 2 of the Insurance Code, and that reveal the deliberative
10 processes, discussions, communications, or any other portion of
11 the negotiations with health plans, or the impressions, opinions,
12 recommendations, meeting minutes, research, work product,
13 theories, or strategy of the board or its staff, or records that provide
14 instructions, advice, or training to employees.

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

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

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

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

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

1 apply to the contracts, deliberative processes, discussions,
2 communications, negotiations with health plans, impressions,
3 opinions, recommendations, meeting minutes, research, work
4 product, theories, or strategy of applicants pursuant to Part 6.4
5 (commencing with Section 12699.50) of Division 2 of the
6 Insurance Code.

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

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

13 (bb) Critical infrastructure information, as defined in Section
14 131(3) of Title 6 of the United States Code, that is voluntarily
15 submitted to the California Office of Homeland Security for use
16 by that office, including the identity of the person who or entity
17 that voluntarily submitted the information. As used in this
18 subdivision, "voluntarily submitted" means submitted in the
19 absence of the office exercising any legal authority to compel
20 access to or submission of critical infrastructure information. This
21 subdivision shall not affect the status of information in the
22 possession of any other state or local governmental agency.

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

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

37 (2) (A) *Except for the portion of a contract that contains the*
38 *rates of payment, contracts entered into pursuant to Part 6.45*
39 *(commencing with Section 12699.201) of Division 2 of the*

1 *Insurance Code on or after January 1, 2008, shall be open to*
2 *inspection one year after they have been fully executed.*

3 *(B) If a contract entered into pursuant to Part 6.45 (commencing*
4 *with Section 12699.201) of Division 2 of the Insurance Code is*
5 *amended, the amendment shall be open to inspection one year*
6 *after the amendment has been fully executed.*

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

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

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

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

25 *SEC. 43. Section 11126 of the Government Code is amended*
26 *to read:*

27 *11126. (a) (1) Nothing in this article shall be construed to*
28 *prevent a state body from holding closed sessions during a regular*
29 *or special meeting to consider the appointment, employment,*
30 *evaluation of performance, or dismissal of a public employee or*
31 *to hear complaints or charges brought against that employee by*
32 *another person or employee unless the employee requests a public*
33 *hearing.*

34 *(2) As a condition to holding a closed session on the complaints*
35 *or charges to consider disciplinary action or to consider dismissal,*
36 *the employee shall be given written notice of his or her right to*
37 *have a public hearing, rather than a closed session, and that notice*
38 *shall be delivered to the employee personally or by mail at least*
39 *24 hours before the time for holding a regular or special meeting.*

1 If notice is not given, any disciplinary or other action taken against
2 any employee at the closed session shall be null and void.

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

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

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

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

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

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

35 (3) Prohibit a state body from holding a closed session to
36 deliberate on a decision to be reached in a proceeding required to
37 be conducted pursuant to Chapter 5 (commencing with Section
38 11500) or similar provisions of law.

39 (4) Grant a right to enter any correctional institution or the
40 grounds of a correctional institution where that right is not

1 otherwise granted by law, nor shall anything in this article be
2 construed to prevent a state body from holding a closed session
3 when considering and acting upon the determination of a term,
4 parole, or release of any individual or other disposition of an
5 individual case, or if public disclosure of the subjects under
6 discussion or consideration is expressly prohibited by statute.

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

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

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

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

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

24 (D) For purposes of this paragraph, “lease” includes renewal or
25 renegotiation of a lease.

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

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

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

38 (10) Prevent the Franchise Tax Board from holding closed
39 sessions for the purpose of discussion of confidential tax returns
40 or information the public disclosure of which is prohibited by law,

1 or from considering matters pertaining to the appointment or
2 removal of the Executive Officer of the Franchise Tax Board.

3 (11) Require the Franchise Tax Board to notice or disclose any
4 confidential tax information considered in closed sessions, or
5 documents executed in connection therewith, the public disclosure
6 of which is prohibited pursuant to Article 2 (commencing with
7 Section 19542) of Chapter 7 of Part 10.2 of the Revenue and
8 Taxation Code.

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

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

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

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

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

1 provisions of paragraph (7) relating to the identification of real
2 properties prior to the closed session.

3 (17) Prevent a state body, or boards, commissions,
4 administrative officers, or other representatives that may properly
5 be designated by law or by a state body, from holding closed
6 sessions with its representatives in discharging its responsibilities
7 under Chapter 10 (commencing with Section 3500), Chapter 10.3
8 (commencing with Section 3512), Chapter 10.5 (commencing with
9 Section 3525), or Chapter 10.7 (commencing of Section 3540) of
10 Division 4 of Title 1 as the sessions relate to salaries, salary
11 schedules, or compensation paid in the form of fringe benefits.
12 For the purposes enumerated in the preceding sentence, a state
13 body may also meet with a state conciliator who has intervened
14 in the proceedings.

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

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

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

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

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

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

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

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

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

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

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

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

37 (ii) The legal counsel of the state body shall prepare and submit
38 to it a memorandum stating the specific reasons and legal authority
39 for the closed session. If the closed session is pursuant to paragraph
40 (1), the memorandum shall include the title of the litigation. If the

1 closed session is pursuant to subparagraph (A) or (B), the
2 memorandum shall include the existing facts and circumstances
3 on which it is based. The legal counsel shall submit the
4 memorandum to the state body prior to the closed session, if
5 feasible, and in any case no later than one week after the closed
6 session. The memorandum shall be exempt from disclosure
7 pursuant to Section 6254.25.

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

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

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

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

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

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

1 (4) Prevent a state body, as defined in subdivision (b) of Section
2 11121, from conducting a closed session to consider any matter
3 that properly could be considered in closed session by the state
4 body whose authority it exercises.

5 (5) Prevent a state body, as defined in subdivision (d) of Section
6 11121, from conducting a closed session to consider any matter
7 that properly could be considered in a closed session by the body
8 defined as a state body pursuant to subdivision (a) or (b) of Section
9 11121.

10 (6) Prevent a state body, as defined in subdivision (c) of Section
11 11121, from conducting a closed session to consider any matter
12 that properly could be considered in a closed session by the state
13 body it advises.

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

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

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

21 (8) Require the State Board of Equalization to disclose any
22 action taken in closed session or documents executed in connection
23 with that action, the public disclosure of which is prohibited by
24 law pursuant to Sections 15619 and 15641 of this code and Sections
25 833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651,
26 45982, 46751, 50159, 55381, and 60609 of the Revenue and
27 Taxation Code.

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

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

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

1 Teachers' Retirement System or the Public Employees' Retirement
 2 System.

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

6 (h) This article does not prevent the Board of Administration
 7 of the Public Employees' Retirement System from holding closed
 8 sessions when considering matters relating to the development of
 9 rates and competitive strategy for plans offered pursuant to Chapter
 10 15 (commencing with Section 21660) of Part 3 of Division 5 of
 11 Title 2.

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

18 ~~SEC. 37.~~

19 *SEC. 44.* The State Department of Health Care Services, in
 20 consultation with the Managed Risk Medical Insurance Board,
 21 shall take all reasonable steps that are required to obtain the
 22 maximum amount of federal funds and to support federal claiming
 23 procedures in the administration of this act.

24 *SEC. 45.* *Notwithstanding Chapter 3.5 (commencing with*
 25 *section 11340) of Part 1 of Division 3 of Title 2 of the Government*
 26 *Code, during the period January 1, 2008, to December 31, 2011,*
 27 *inclusive, the State Department of Health Care Services may*
 28 *implement this act by means of all county letters or similar*
 29 *instructions without taking regulatory action. Prior to December*
 30 *31, 2011, the department shall adopt all necessary regulations in*
 31 *accordance with the requirements of Chapter 3.5 (commencing*
 32 *with Section 11340) of Part 1 of Division 3 of Title 2 of the*
 33 *Government Code.*

34 ~~SEC. 38.~~ ~~Sections 22 and 32 of this act shall become operative~~
 35 ~~on July 1, 2008.~~

36 ~~SEC. 39.~~

37 *SEC. 46.* The Legislature finds and declares that ~~Section 3~~ 42
 38 of this act, which amends Section 6254 of the Government Code,
 39 and ~~Section 4~~ 43, which amends Section 11126 of the Government
 40 Code, impose a limitation on the public's right of access to the

1 meetings of public bodies or the writings of public officials and
2 agencies within the meaning of Section 3 of Article I of the
3 California Constitution. Pursuant to that constitutional provision,
4 the Legislature makes the following findings to demonstrate the
5 interest protected by this limitation and the need for protecting
6 that interest:

7 In order to maximize the ability of the Managed Risk Medical
8 Insurance Board to implement agreements with health plans and
9 to provide a wide choice of plans at minimal cost under the
10 California Cooperative Health Insurance Purchasing Program
11 created pursuant to Part 6.45 (commencing with Section
12 12699.201) of Division 2 of the Insurance Code, it is necessary
13 and appropriate to provide limited confidentiality to certain writings
14 developed in that regard *and meetings related thereto*.

15 ~~SEC. 40.~~

16 *SEC. 47.* Notwithstanding any other provision of law, the
17 Managed Risk Medical Insurance Board may implement the
18 provisions of this act expanding the Healthy Families Program
19 only to the extent that funds are appropriated for those purposes
20 in the annual Budget Act or in another statute.

21 *SEC. 48.* *During the period from January 1, 2008 to December*
22 *31, 2011, inclusive, the adoption of regulations pursuant to this*
23 *act by the Managed Risk Medical Insurance Board shall be deemed*
24 *to be an emergency and necessary for the immediate preservation*
25 *of public peace, health, and safety, or the general welfare.*

26 ~~SEC. 41.~~

27 *SEC. 49.* No reimbursement is required by this act pursuant to
28 Section 6 of Article XIII B of the California Constitution for certain
29 costs that may be incurred by a local agency or school district
30 because, in that regard, this act creates a new crime or infraction,
31 eliminates a crime or infraction, or changes the penalty for a crime
32 or infraction, within the meaning of Section 17556 of the
33 Government Code, or changes the definition of a crime within the
34 meaning of Section 6 of Article XIII B of the California
35 Constitution.

36 However, if the Commission on State Mandates determines that
37 this act contains other costs mandated by the state, reimbursement
38 to local agencies and school districts for those costs shall be made

- 1 pursuant to Part 7 (commencing with Section 17500) of Division
- 2 4 of Title 2 of the Government Code.

O