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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 Jones, and Solorio)**

(Coauthor: Senator Alquist)

December 4, 2006

An act to amend ~~Sections 6254 and 11126 of, and to add Section 11126 of, and to add Sections 6254.28, 12803.1, and 12803.2~~ to, the Government Code, to amend Sections 1357, 1357.12, 1363, and 1378 of, ~~and to add Section 1347 to,~~ 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, ~~and to add Chapter 4 (commencing with Section 128850) to Part 5 of Division 107 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, 12693.57, 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 amend ~~Sections 131, 144, and 1095 of Section 144 of~~, to add Sections 131.1, 683.5, and 1095.1 to, 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~~ 14005.301, 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-care.~~

(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, 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 would generally require employers to elect prior to July 1, 2009, to make health 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 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 employers to provide the Employment Development Department with specified wage and health expenditures information and comply with other specified requirements. The bill would authorize the department to assess a penalty against an employer who failed to comply with those requirements or failed to remit the employer fees and employee premium payments. 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 *and would require certain health care service plans to submit a good faith bid to be a participating plan through Cal-CHIPP.* 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~~ 100 employees. The bill would require health care service plans and health insurers offering group plans *on and after January 1, 2010*, to offer ~~benchmark plans or policies~~ *a Cal-CHIPP Medi-Cal plan and Cal-CHIPP Healthy Families plan, as specified*, at a rate negotiated with and approved by the Managed Risk Medical Insurance Board that is available to group members and dependents, *if applicable*, eligible

for coverage through the Medi-Cal *program* or *the Healthy Families Programs Program*. 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 bill, effective July 1, 2008, would also create the California Health Care Cost and Quality Transparency Commission in the Health and Human Services Agency, with various powers and duties, including the development of a health care cost and quality transparency plan. The bill would authorize the commission to impose fees on data sources and data users, as specified, and to impose penalties on data sources that fail to file any report required by the commission. The bill would transfer certain data collection responsibilities from the Office of Statewide Health Planning and Development to the commission on July 1, 2009.*

(6) *The bill would create the California Health Benefits Service within the Health and Human Services Agency, with various powers and duties relative to creation of joint ventures between certain county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans.*

~~(5)~~

(7) 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.

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

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

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

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

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

1 SEC. 2.5. Section 12803.1 is added to the Government Code,
2 to read:

3 12803.1. (a) The California Health Benefits Service is hereby
4 created within the California Health and Human Services Agency.

5 (1) The California Health Benefits Service (CHBS) shall be
6 governed by a nine member board appointed by the Governor, the
7 Senate Committee on Rules, and the Speaker of the Assembly. The
8 Governor shall appoint a representative of local initiatives
9 authorized under the Welfare and Institutions Code, a
10 representative of county organized health systems, and a
11 representative of health care purchasers. The Senate Committee
12 on Rules shall appoint a representative of local initiatives
13 authorized under the Welfare and Institutions Code, a
14 representative of county organized health systems, and a
15 representative of health care consumers. The Speaker of the
16 Assembly shall appoint a representative of local initiatives
17 authorized under the Welfare and Institutions Code, a
18 representative of health care providers, and a representative of
19 organized labor. Terms of appointment shall be four years. The
20 members of the board shall elect a board chair from among the
21 nine appointed members.

22 (2) The board shall appoint an executive director for the board,
23 who shall serve at the pleasure of the board. The executive director
24 shall receive the salary established by the Department of Personnel
25 Administration for exempt officials. The executive director shall
26 administer the affairs of the board as directed by the board and
27 shall direct the staff of the board. The executive director may
28 appoint, with the approval of the board, staff necessary to carry
29 out the provisions of this section.

30 (b) The Health and Human Services Agency shall convene a
31 working group with the collaboration of the Department of
32 Managed Health Care, the State Department of Health Care
33 Services, and the Managed Risk Medical Insurance Board. This
34 working group shall assist CHBS in identifying statutory,
35 regulatory, or financial barriers or incentives that must be
36 addressed before CHBS can facilitate the establishment and
37 maintenance of one or more joint ventures between health plans
38 that contract with, or are governed, owned, or operated by, a
39 county board of supervisors, a county special commission, or
40 county health authority authorized by Section 14018.7, 14087.31,

1 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and
2 Institutions Code. The working group shall also assist CHBS in
3 identifying statutory, regulatory, or financial barriers or incentives
4 that must be addressed before CHBS can enter into contracts with
5 providers to provide health care services in counties in which there
6 is not a prepaid health plan that contracts with, or is governed,
7 owned, or operated by, a county board of supervisors, a county
8 special commission, or a county health authority authorized by
9 Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or
10 14087.96 of the Welfare and Institutions Code. The working group
11 shall, no later than April 1, 2008, report its findings to the
12 executive director, the CHBS governing board, and the committees
13 of jurisdiction in the Senate and Assembly.

14 (c) To the extent permitted under existing law, CHBS is
15 authorized to solicit and assist prepaid health plans that contract
16 with, or are governed, owned, or operated by, a county board of
17 supervisors, a county special commission or county health
18 authority authorized by Section 14018.7, 14087.31, 14087.35,
19 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions
20 Code in forming joint ventures to create integrated networks of
21 public health plans that pool risk and share networks. CHBS may,
22 upon agreement of participating health plans, administer those
23 joint ventures. Consistent with the recommendations pursuant to
24 subdivision (b), and existing law, CHBS is authorized to develop
25 networks to provide health care services in counties in which there
26 is not a prepaid health plan that contracts with, or is governed,
27 owned, or operated by, a county board of supervisors, a county
28 special commission, or a county health authority authorized by
29 Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or
30 14087.96 of the Welfare and Institutions Code.

31 (1) In forming joint ventures, CHBS and participating health
32 plans shall seek to contract with the 22 designated public hospitals,
33 county health clinics, and community clinics.

34 (2) All joint ventures established pursuant to this section shall
35 seek licensure as a health care service plan consistent with the
36 Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2
37 (commencing with Section 1340) of the Health and Safety Code).
38 Prior to commencement of enrollment, the joint venture shall be
39 licensed pursuant to that chapter.

1 *(d) By March 1, 2009, and annually thereafter, CHBS shall*
2 *submit a report to the committees of jurisdiction in the Senate and*
3 *Assembly on implementation of this section and make*
4 *recommendations on resources, regulatory, and legislative changes*
5 *necessary to implement this section. The report shall also include*
6 *recommendations on resources, policy, and legislative changes*
7 *necessary to build and implement a system of health coverage*
8 *throughout California.*

9 SEC. 3. Section 12803.2 is added to the Government Code, to
10 read:

11 12803.2. (a) The California Health and Human Services
12 Agency shall encourage fitness, wellness, and health promotion
13 programs that promote safe workplaces, healthy employer practices,
14 and individual efforts to improve health.

15 (b) (1) The Secretary of California Health and Human Services
16 shall establish and administer a program to track and assess the
17 effects of health care reform as set forth in the California Health
18 Care Reform and Cost Control Act. The secretary shall either
19 complete the assessment or contract for its preparation. If the
20 secretary determines to contract for the preparation of the
21 assessment, he or she shall seek a partnership and contract with
22 independent, nonprofit groups or foundations, academic
23 institutions, or governmental entities providing grants for
24 health-related activities. The secretary may seek other sources of
25 funding, including grants, to fund the assessment. The assessment
26 shall include, at minimum, the following components:

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

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

- 1 (C) An assessment of the health care coverage market in
- 2 California, including a review of the various insurers and health
- 3 care service plans, their offering and underwriting practices, their
- 4 efficiency in providing health care services, and their financial
- 5 conditions, including their medical loss ratios. This assessment
- 6 shall also include an assessment of risk selection by the plans and
- 7 insurers.
- 8 (D) An assessment of the effect on employers and employment,
- 9 including employer administrative costs, employee turnover rate,
- 10 and wages categorized by the type of employer and the size of the
- 11 business.
- 12 (E) An assessment of employer-based health care coverage,
- 13 including the number of employers providing coverage and the
- 14 number paying into Cal-CHIP categorized by employer
- 15 characteristic.
- 16 (F) An assessment of the change in access and availability of
- 17 health care throughout the state, including tracking the availability
- 18 of health care coverage products in rural and other underserved
- 19 areas of the state and assessing the adequacy of the health care
- 20 delivery infrastructure to meet the need for health care services.
- 21 This assessment shall include a more in-depth review of areas of
- 22 the state that were determined to be medically underserved in 2007.
- 23 (G) An assessment of the impact on the county health care safety
- 24 net system, including a review of the amount of uncompensated
- 25 care and emergency room use.
- 26 (H) An assessment of health care coverage as compiled in the
- 27 California Health Interview Survey or other applicable surveys.
- 28 (I) An assessment of the wellness and health status of
- 29 Californians as compiled in the California Health Interview Survey
- 30 or other applicable surveys.
- 31 (J) An assessment of the capacity of the various health care
- 32 professions to provide care to the population included in health
- 33 care reform, identifying the number of each profession and their
- 34 location in the state.
- 35 (K) An assessment of the quality of the health care services, as
- 36 determined by recognized measures, provided in California.
- 37 (L) An assessment of the availability and potential for increasing
- 38 federal funding for health care services and coverage in California.
- 39 (M) Any other assessments as determined necessary by the
- 40 advisory board established pursuant to paragraph (2).

1 (2) An advisory body of individuals with knowledge and
2 expertise in health care policy reflecting the broad range of interests
3 in health policy that is chaired by the Secretary of California Health
4 and Human Services shall guide the assessment of health care
5 reform. The Governor shall appoint five members to the advisory
6 body, the Senate Committee on Rules shall appoint two members,
7 and the Speaker of the Assembly shall appoint two members.

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

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

18 (5) The Secretary of California Health and Human Services and
19 the advisory body shall establish a timeline for reporting
20 information to the appropriate policy and fiscal committees of the
21 Legislature. At a minimum, the reporting timeline shall include
22 the release of annual data to serve as a benchmark for the
23 assessment of the health care reform. These annual benchmarks
24 shall include the employer compliance rate and the cost of health
25 care coverage in the state. In addition, the timeline shall include
26 more in-depth reports addressing the items listed under paragraph
27 (1).

28 (c) The California Health and Human Services Agency, in
29 consultation with the Board of Administration of the Public
30 Employees' Retirement System, and after consultation with
31 affected health care provider groups, shall develop health care
32 provider performance measurement benchmarks and incorporate
33 these benchmarks into a common pay for performance model to
34 be offered in every state-administered health care program,
35 including, but not limited to, the Public Employees' Medical and
36 Hospital Care Act, the Healthy Families Program, the Major Risk
37 Medical Insurance Program, the Medi-Cal program, and
38 Cal-CHIPP. These benchmarks shall be developed to advance a
39 common statewide framework for health care quality measurement
40 and reporting, including, but not limited to, measures that have

1 been approved by the National Quality Forum (NQF) such as the
2 Health Plan Employer Data and Information Set (HEDIS) and the
3 Joint Commission on Accreditation of Health Care Organizations
4 (JCAHO), and that have been adopted by the Hospitals Quality
5 Alliance and other national and statewide groups concerned with
6 quality.

7 (d) The California Health and Human Services Agency, in
8 consultation with the Board of Administration of the Public
9 Employees' Retirement System, shall assume lead agency
10 responsibility for professional review and development of best
11 practice standards in the care and treatment of patients with
12 high-cost chronic diseases, such as asthma, diabetes, and heart
13 disease. In developing the best practice standards, the agency shall
14 consider the use of an annual health assessment for patients. Upon
15 adoption of the standards, each state health care program, including,
16 but not limited to, programs offered under the Public Employees'
17 Medical and Hospital Care Act, the Medi-Cal program, the Healthy
18 Families Program, the Major Risk Medical Insurance Program,
19 and the California Cooperative Health Insurance Purchasing
20 Program, shall implement those standards.

21 *SEC. 3.5. Section 1347 is added to the Health and Safety Code,*
22 *to read:*

23 *1347. The director shall provide regulatory and program*
24 *flexibilities as may be necessary to facilitate new, modified, or*
25 *combined licenses of local initiatives, county organized health*
26 *systems, or the California Health Benefits Service, created pursuant*
27 *to Section 12803.1 of the Government Code, seeking licensure for*
28 *regional or statewide networks for the purposes of contracting*
29 *with the Managed Risk Medical Insurance Board as a participating*
30 *plan in the California Cooperative Health Insurance Purchasing*
31 *Program by January 1, 2010, or for the purposes of providing*
32 *coverage in the individual and group coverage markets. In*
33 *providing those flexibilities, the director shall ensure that the*
34 *health plans established pursuant to this section meet essential*
35 *financial, capacity, and consumer protection requirements of this*
36 *chapter.*

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

39 *1357. As used in this article:*

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

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

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

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

28 (B) The employer offers the employees health coverage under
29 a health benefit plan.

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

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

38 (2) Any member of a guaranteed association as defined in
39 subdivision (o).

1 (c) “In force business” means an existing health benefit plan
2 contract issued by the plan to a small employer.

3 (d) “Late enrollee” means an eligible employee or dependent
4 who has declined enrollment in a health benefit plan offered by a
5 small employer at the time of the initial enrollment period provided
6 under the terms of the health benefit plan and who subsequently
7 requests enrollment in a health benefit plan of that small employer,
8 provided that the initial enrollment period shall be a period of at
9 least 30 days. It also means any member of an association that is
10 a guaranteed association as well as any other person eligible to
11 purchase through the guaranteed association when that person has
12 failed to purchase coverage during the initial enrollment period
13 provided under the terms of the guaranteed association’s plan
14 contract and who subsequently requests enrollment in the plan,
15 provided that the initial enrollment period shall be a period of at
16 least 30 days. However, an eligible employee, any other person
17 eligible for coverage through a guaranteed association pursuant to
18 subdivision (o), or an eligible dependent shall not be considered
19 a late enrollee if any of the following is applicable:

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

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

24 (B) He or she certified at the time of the initial enrollment that
25 coverage under another employer health benefit plan, the Healthy
26 Families Program, or no share-of-cost Medi-Cal coverage was the
27 reason for declining enrollment, provided that, if the individual
28 was covered under another employer health plan, the individual
29 was given the opportunity to make the certification required by
30 this subdivision and was notified that failure to do so could result
31 in later treatment as a late enrollee.

32 (C) He or she has lost or will lose coverage under another
33 employer health benefit plan as a result of termination of
34 employment of the individual or of a person through whom the
35 individual was covered as a dependent, change in employment
36 status of the individual or of a person through whom the individual
37 was covered as a dependent, termination of the other plan’s
38 coverage, cessation of an employer’s contribution toward an
39 employee or dependent’s coverage, death of the person through
40 whom the individual was covered as a dependent, legal separation,

1 divorce, loss of coverage under the Healthy Families Program as
2 a result of exceeding the program's income or age limits, or loss
3 of no share-of-cost Medi-Cal coverage.

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

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

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

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

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

36 (C) In the case of an employer or person who is not a member
37 of an association, was eligible to purchase coverage through a
38 guaranteed association, and did not do so, and would not be eligible
39 to purchase guaranteed coverage unless purchased through a
40 guaranteed association, the employer or person can demonstrate

1 that he or she meets the requirements of subparagraphs (A), (C),
2 and (D) of paragraph (1), or meets the requirements of paragraph
3 (2) or (3), or that he or she recently had a change in status that
4 would make him or her eligible and that application for enrollment
5 was made within 30 days of the change.

6 (5) The individual is an employee or dependent who meets the
7 criteria described in paragraph (1) and was under a COBRA
8 continuation provision and the coverage under that provision has
9 been exhausted. For purposes of this section, the definition of
10 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
11 apply.

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

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

33 (8) The individual is an eligible employee who has declined
34 coverage for himself or herself or his or her dependents during a
35 previous enrollment period because his or her dependents were
36 covered by another employer health benefit plan at the time of the
37 previous enrollment period. That individual may enroll himself or
38 herself or his or her dependents for plan coverage during a special
39 open enrollment opportunity if his or her dependents have lost or
40 will lose coverage under that other employer health benefit plan.

1 The special open enrollment opportunity shall be requested by the
2 employee not more than 30 days after the date that the other health
3 coverage is exhausted or terminated. Upon enrollment, coverage
4 shall be effective not later than the first day of the first calendar
5 month beginning after the date the request for enrollment is
6 received. Notice of the special enrollment rights contained in this
7 paragraph shall be provided by the employer to an employee at or
8 before the time the employee is offered an opportunity to enroll
9 in plan coverage.

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

12 (f) “Preexisting condition provision” means a contract provision
13 that excludes coverage for charges or expenses incurred during a
14 specified period following the employee’s effective date of
15 coverage, as to a condition for which medical advice, diagnosis,
16 care, or treatment was recommended or received during a specified
17 period immediately preceding the effective date of coverage.

18 (g) “Creditable coverage” means:

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

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

36 (3) The Medicaid program pursuant to Title XIX of the Social
37 Security Act.

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

- 1 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
- 2 (Civilian Health and Medical Program of the Uniformed Services
- 3 (CHAMPUS)).
- 4 (6) A medical care program of the Indian Health Service or of
- 5 a tribal organization.
- 6 (7) A state health benefits risk pool.
- 7 (8) A health plan offered under 5 U.S.C. Chapter 89
- 8 (commencing with Section 8901) (Federal Employees Health
- 9 Benefits Program (FEHBP)).
- 10 (9) A public health plan as defined in federal regulations
- 11 authorized by Section 2701(c)(1)(I) of the Public Health Service
- 12 Act, as amended by Public Law 104-191, the Health Insurance
- 13 Portability and Accountability Act of 1996.
- 14 (10) A health benefit plan under Section 5(e) of the Peace Corps
- 15 Act (22 U.S.C. Sec. 2504(e)).
- 16 (11) Any other creditable coverage as defined by subdivision
- 17 (c) of Section 2701 of Title XXVII of the federal Public Health
- 18 Services Act (42 U.S.C. Sec. 300gg(c)).
- 19 (h) “Rating period” means the period for which premium rates
- 20 established by a plan are in effect and shall be no less than six
- 21 months.
- 22 (i) “Risk adjusted employee risk rate” means the rate determined
- 23 for an eligible employee of a small employer in a particular risk
- 24 category after applying the risk adjustment factor.
- 25 (j) “Risk adjustment factor” means the percentage adjustment
- 26 to be applied equally to each standard employee risk rate for a
- 27 particular small employer, based upon any expected deviations
- 28 from standard cost of services. This factor may not be more than
- 29 120 percent or less than 80 percent until July 1, 1996. Effective
- 30 July 1, 1996, this factor may not be more than 110 percent or less
- 31 than 90 percent. On and after January 1, 2010, no risk adjustment
- 32 factor shall be applied.
- 33 (k) “Risk category” means the following characteristics of an
- 34 eligible employee: age, geographic region, and family composition
- 35 of the employee, plus the health benefit plan selected by the small
- 36 employer.
- 37 (1) No more than the following age categories may be used in
- 38 determining premium rates:
- 39 Under 30
- 40 30–39

- 1 40–49
- 2 50–54
- 3 55–59
- 4 60–64
- 5 65 and over

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

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

- 14 (A) Single.
- 15 (B) Married couple.
- 16 (C) One adult and child or children.
- 17 (D) Married couple and child or children.

18 (3) (A) In determining rates for small employers, a plan that
19 operates statewide shall use no more than nine geographic regions
20 in the state, have no region smaller than an area in which the first
21 three digits of all its ZIP Codes are in common within a county,
22 and divide no county into more than two regions. Plans shall be
23 deemed to be operating statewide if their coverage area includes
24 90 percent or more of the state’s population. Geographic regions
25 established pursuant to this section shall, as a group, cover the
26 entire state, and the area encompassed in a geographic region shall
27 be separate and distinct from areas encompassed in other
28 geographic regions. Geographic regions may be noncontiguous.

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

1 encompassed in other geographic regions. Geographic regions
2 may be noncontiguous. No plan shall have less than one geographic
3 area.

4 (ii) If the formula in clause (i) results in a plan that operates in
5 more than one county having only one geographic region, then the
6 formula in clause (i) shall not apply and the plan may have two
7 geographic regions, provided that no county is divided into more
8 than one region.

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

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

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

1 purchasing coverage for employees through a guaranteed
2 association.

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

5 (m) “Standard employee risk rate” means the rate applicable to
6 an eligible employee in a particular risk category in a small
7 employer group.

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

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

38 For purposes of this subdivision, an association formed by a
39 merger of two or more associations after January 1, 1992, and
40 otherwise meeting the criteria of this subdivision shall be deemed

1 to have been in active existence on January 1, 1992, if its
2 predecessor organizations had been in active existence on January
3 1, 1992, and for at least five years prior to that date and otherwise
4 met the criteria of this subdivision.

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

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

20 SEC. 5. Section 1357.12 of the Health and Safety Code is
21 amended to read:

22 1357.12. Premiums for contracts offered or delivered by plans
23 on or after the effective date of this article shall be subject to the
24 following requirements:

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

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

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

38 (b) (1) The premium for in force business shall be determined
39 for an eligible employee in a particular risk category after applying
40 a risk adjustment factor to the plan’s standard employee risk rates.

1 The risk adjusted employee risk rates may not be more than 120
2 percent or less than 80 percent of the plan's applicable standard
3 employee risk rate until July 1, 1996. Effective July 1, 1996, this
4 factor may not be more than 110 percent or less than 90 percent.
5 The factor effective July 1, 1996, shall apply to in force business
6 at the earlier of either the time of renewal or July 1, 1997. The risk
7 adjustment factor applied to a small employer may not increase
8 by more than 10 percentage points from the risk adjustment factor
9 applied in the prior rating period. The risk adjustment factor for a
10 small employer may not be modified more frequently than every
11 12 months. On and after January 1, 2010, no risk adjustment factor
12 shall be applied.

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

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

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

1 (2) The composite rates shall be used for all employees and
2 dependents covered throughout a rating period of no less than six
3 months nor more than 12 months, except that a plan may reserve
4 the right to redetermine the composite rates if the enrollment under
5 the contract changes by more than a specified percentage during
6 the rating period. Any redetermination of the composite rates shall
7 be based on the same risk adjusted employee risk rates used to
8 determine the initial composite rates for the rating period. If a plan
9 reserves the right to redetermine the rates and the enrollment
10 changes more than the specified percentage, the plan shall
11 redetermine the composite rates if the redetermined rates would
12 result in a lower premium for the small employer. A plan reserving
13 the right to redetermine the composite rates based upon a change
14 in enrollment shall use the same specified percentage to measure
15 that change with respect to all small employers electing composite
16 rates.

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

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

28

29

Article 3.11. Insurance Market Reform

30

31 1357.20. Effective July 1, 2008, every full-service health care
32 service plan that offers, markets, and sells health plan contracts to
33 individuals and conducts medical underwriting to determine
34 whether to issue coverage to a specific individual shall use a
35 standardized health questionnaire developed by the Managed Risk
36 Medical Insurance Board in consultation with the Department of
37 Insurance and the Department of Managed Health Care. A health
38 care service plan subject to this section may not exclude a potential
39 enrollee from any individual coverage on the basis of an actual or
40 expected health condition, type of illness, treatment, medical

1 condition, or accident, or for a preexisting condition, except as
2 provided by the board pursuant to Section 12711.1 of the Insurance
3 Code.

4 ~~1357.21. (a) Every full-service health care service plan shall
5 offer, market, and sell all of the uniform benefit plan designs made
6 available through the California Cooperative Health Insurance
7 Purchasing Program (Cal-CHIPP) pursuant to Part 6.45
8 (commencing with Section 12699.201) of Division 2 of the
9 Insurance Code to purchasers in each region and in all individual
10 and group markets where the plan offers, markets, and sells health
11 care service plan contracts, consistent with statutory and regulatory
12 rating and underwriting requirements applicable to the respective
13 individual and group markets. A health care service plan that is
14 also a participating health plan in Cal-CHIPP may not charge a
15 standard rate, with reference to subscribers of any age, family size,
16 and geographical region, that is less than the plan's rate for the
17 same benefit plan design sold through Cal-CHIPP.~~

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

21 *1357.21. The department, in consultation with the Department
22 of Insurance, shall require each health care service plan with one
23 million or more enrollees in California, based on the plan's
24 enrollment in the prior year, to submit a good faith bid to the
25 Managed Risk Medical Insurance Board in order to be a
26 participating plan through the California Cooperative Health
27 Insurance Purchasing Program (Cal-CHIPP) pursuant to Part
28 6.45 (commencing with Section 12699.201) of Division 2 of the
29 Insurance Code.*

30 1357.22. It is the intent of the Legislature that all health care
31 providers shall participate in an Internet-based personal health
32 record system under which patients have access to their own health
33 care records. A patient's personal health care record shall only be
34 accessible to that patient or other individual as authorized by the
35 patient. It is the intent of the Legislature that all health care service
36 plans and providers shall adopt standard electronic medical records
37 by January 1, 2012.

38 1357.23. Effective July 1, 2008, all requirements in Article 3.1
39 (commencing with Section 1357) applicable to offering, marketing,
40 and selling health care service plan contracts to small employers

1 as defined in that article, including, but not limited to, the
 2 obligation to fairly and affirmatively offer, market, and sell all of
 3 the plan's contracts to all employers, guaranteed renewal of all
 4 health care service plan contracts, use of the risk adjustment factor,
 5 and the restriction of risk categories to age, geographic region, and
 6 family composition as described in that article, shall be applicable
 7 to all health care service plan contracts offered to all employers
 8 with ~~250~~ 100 or fewer eligible employees, except as follows:

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

11 (b) For employers with 51 to ~~250~~ 100, inclusive, eligible
 12 employees, all requirements in that article shall apply, except that
 13 the health care service plan may develop health care coverage
 14 benefit plan designs to fairly and affirmatively market only to
 15 employer groups of 51 to ~~250~~ 100, inclusive, eligible employees.

16 (c) On and after January 1, 2010, no risk adjustment factor shall
 17 be applied to a plan contract offered to an employer with 51 to ~~250~~
 18 100, inclusive, eligible employees.

19 1357.24. (a) Every group health care service plan shall obtain
 20 from each employer or group subscriber contracting with the health
 21 care service plan the premium contribution amounts the employer
 22 or group makes for each enrolled group member and dependent
 23 using the family size categories premium payments made to the
 24 group plan.

25 (b) (1) Every health care service plan offering group health
 26 plan contracts shall provide as one coverage option of each group
 27 contract a ~~Healthy Families benchmark~~ *Cal-CHIPP Healthy*
 28 *Families* plan established by the board so that group members and
 29 their dependents with family incomes at or below 300 percent of
 30 the federal poverty level that are determined eligible for coverage
 31 through the Healthy Families Program or who are eligible for
 32 Medi-Cal pursuant to Section ~~14005.33~~ *14005.301* of the Welfare
 33 and Institutions Code can enroll in the ~~Healthy Families benchmark~~
 34 *Cal-CHIPP Healthy Families* plan. The ~~Healthy Families~~
 35 ~~benchmark~~ *Cal-CHIPP Healthy Families* plan of a group health
 36 care service plan shall be provided at a rate negotiated with and
 37 approved by the board. The health care service plan shall collect
 38 the employer's applicable dollar premium contribution for
 39 employees and, if applicable, dependents in the ~~Healthy Families~~
 40 ~~benchmark~~ *Cal-CHIPP Healthy Families* plan and credit that

1 amount toward the cost of the ~~Healthy Families benchmark~~
2 *Cal-CHIPP Healthy Families 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 a Cal-CHIPP Healthy~~
7 *Families plan*, the health care service plan shall instead collect an
8 amount determined by the board but not to exceed the employer's
9 applicable dollar premium contribution as identified in subdivision
10 (a) and transmit that amount to the board towards the premium
11 cost of a ~~Healthy Families benchmark plan in Cal-CHIPP~~
12 *Cal-CHIPP Healthy Families plan*.

13 (c) (1) Every health care service plan offering group health
14 plan contracts shall provide as one coverage option of each group
15 contract a ~~Medi-Cal benchmark Cal-CHIPP Medi-Cal plan~~
16 established by the board so that group members and their
17 dependents that are determined eligible for coverage through the
18 Medi-Cal program, except for coverage pursuant to Section
19 ~~14005.33 14005.301~~ of the Welfare and Institutions Code, can
20 enroll in the ~~Medi-Cal benchmark Cal-CHIPP Medi-Cal plan~~. The
21 ~~Medi-Cal benchmark Cal-CHIPP Medi-Cal plan~~ of a group health
22 care service plan shall be provided at a rate negotiated with and
23 approved by the board. The health care service plan shall collect
24 the employer's applicable dollar premium contribution for
25 employees and, if applicable, dependents, in the ~~Medi-Cal~~
26 ~~benchmark Cal-CHIPP Medi-Cal plan~~ and credit that amount
27 toward the cost of the ~~Medi-Cal benchmark Cal-CHIPP Medi-Cal~~
28 *plan*.

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

38 (d) Every health care service plan shall include in the plan's
39 evidence of coverage notice of the ability of employees and
40 dependents with family incomes at or below 300 percent of the

1 federal poverty level to enroll in Medi-Cal or Healthy Families
2 coverage through a ~~Healthy Families benchmark~~ *Cal-CHIPP*
3 *Healthy Families* plan or a ~~Medi-Cal benchmark~~ *Cal-CHIPP*
4 *Medi-Cal* plan, with instructions on how to apply for coverage.

5 (e) The department, in consultation with the board, may issue
6 regulations, as necessary pursuant to the Administrative Procedure
7 Act, to implement the requirements of this section. Until January
8 1, 2012, the adoption and readoption of regulations pursuant to
9 this section shall be deemed to be an emergency and necessary for
10 the immediate preservation of public peace, health and safety, or
11 general welfare.

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

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

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

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

29 ~~(3) “Healthy Families benchmark plan” shall mean coverage~~
30 ~~equivalent to coverage provided through the Healthy Families~~
31 ~~Program established pursuant to Part 6.2 (commencing with Section~~
32 ~~12693) of Division 2 of the Insurance Code.~~

33 (3) “*Cal-CHIPP Healthy Families plan*” shall have the same
34 meaning as in Section 12699.201 of the Insurance Code.

35 ~~(4) “Medi-Cal benchmark plan” shall mean coverage equivalent~~
36 ~~to~~

37 (4) “*Cal-CHIPP Medi-Cal plan*” shall mean a plan providing
38 the same amount, duration, scope, and level of coverage provided
39 through the Medi-Cal program (Chapter 7 (commencing with

1 Section 14000) of Part 3 of Division 9 of the Welfare and
2 Institutions Code).

3 (h) This section shall apply to health care service plan contracts
4 issued, amended, or renewed on or after ~~July 1, 2008~~ *January 1,*
5 *2010.*

6 1357.25. The requirements of this article shall not apply to a
7 specialized health care service plan or a Medicare supplement
8 contract.

9 1357.26. This article shall become operative on July 1, 2008.

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

12 1363. (a) The director shall require the use by each plan of
13 disclosure forms or materials containing information regarding
14 the benefits, services, and terms of the plan contract as the director
15 may require, so as to afford the public, subscribers, and enrollees
16 with a full and fair disclosure of the provisions of the plan in
17 readily understood language and in a clearly organized manner.
18 The director may require that the materials be presented in a
19 reasonably uniform manner so as to facilitate comparisons between
20 plan contracts of the same or other types of plans. Nothing
21 contained in this chapter shall preclude the director from permitting
22 the disclosure form to be included with the evidence of coverage
23 or plan contract.

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

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

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

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

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

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

39 (6) A statement that the disclosure form is a summary only, and
40 that the plan contract itself should be consulted to determine

1 governing contractual provisions. The first page of the disclosure
2 form shall contain a notice that conforms with all of the following
3 conditions:

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (14) Conditions and procedures for disenrollment.

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

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

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

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

- 29 (A) Deductibles.
- 30 (B) Lifetime maximums.
- 31 (C) Professional services.
- 32 (D) Outpatient services.
- 33 (E) Hospitalization services.
- 34 (F) Emergency health coverage.
- 35 (G) Ambulance services.
- 36 (H) Prescription drug coverage.
- 37 (I) Durable medical equipment.
- 38 (J) Mental health services.
- 39 (K) Chemical dependency services.
- 40 (L) Home health services.

1 (M) Other.

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

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

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

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

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

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

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

36 (h) In addition to the other disclosures required by this section,
37 every health care service plan and any agent or employee of the
38 plan shall, when presenting a plan for examination or sale to any
39 individual purchaser or the representative of a group, disclose in
40 writing the ratio of premium costs to health services paid for plan

1 contracts with individuals and with groups of the same or similar
2 size for the plan's preceding fiscal year. A plan may report that
3 information by geographic area, provided the plan identifies the
4 geographic area and reports information applicable to that
5 geographic area.

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

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

12
13 Article 4.1. California Individual Coverage Guarantee Issue

14
15 1366.10. It is the intent of the Legislature to do both of the
16 following:

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

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

23 1366.104. (a) On or before September 1, 2008, the director
24 and the Insurance Commissioner shall jointly adopt regulations
25 governing five classes of individual health benefit plans that health
26 care service plans and health insurers shall make available.

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

1 and shall be enforced consistently between health care service
2 plans and health insurers in the same marketplace regardless of
3 licensure.

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

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

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

13 1366.105. On and after January 1, 2009, health care service
14 plans and health insurers participating in the individual market
15 shall, except as provided in Section 12711.1 of the Insurance Code,
16 guarantee issue the five classes of approved health benefit plans
17 and shall, at the same time, discontinue offering and selling health
18 benefit plans other than those within the five approved classes of
19 benefit plans in the individual market.

20 1366.106. (a) Individuals may purchase a health benefit plan
21 from one of the five classes of approved plans on a guaranteed
22 issue basis. After selecting and purchasing a health benefit plan
23 within a class of benefits, an individual may change plans only as
24 set forth in this section. For individuals enrolled as a family, the
25 subscriber may change classes for himself or herself, or for all
26 dependents:

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

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

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

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

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

39 (B) Upon divorce.

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

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

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

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

17 1366.107. At the time an individual applies for health coverage
18 from a health care service plan or health insurer participating in
19 the individual market, an individual shall provide information as
20 required by a standardized health status questionnaire to assist
21 plans and insurers in identifying persons in need of disease
22 management. Health care service plans and health insurers may
23 not use information provided on the questionnaire to decline
24 coverage or to limit an individual's choice of health care benefit
25 plan, except as provided in Section 12711.1 of the Insurance Code.

26 1366.108. Health benefit plans shall become effective within
27 31 days of receipt of the individual's application, standardized
28 health status questionnaire, and premium payment.

29 1366.109. Health care service plans and health insurers may
30 reject an application for health care benefits if the individual does
31 not reside or work in a plan's or insurer's approved service area.

32 1366.110. The director or the Insurance Commissioner, as
33 applicable, may require a health care service plan or health insurer
34 to discontinue the offering of health care benefits, or acceptance
35 of applications from individuals, upon a determination by the
36 director or commissioner that the plan or insurer does not have
37 sufficient financial viability, or organizational and administrative
38 capacity, to ensure the delivery of health care benefits to its
39 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, high
21 risk pool contracts with the Major Risk Medical Insurance Program,
22 Medicare supplement policies, long-term care policies, specialized
23 health plan contracts, or contracts issued to individuals who secure
24 coverage from Cal-CHIP.

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 *requiring that* at least 85 percent of aggregate dues, fees, and other
33 periodic payments received by a full-service plan ~~are~~ *be* spent on
34 health care services. *The regulations shall also define "health care*
35 *services."* This section shall not apply to Medicare supplement
36 contracts.

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

1 *SEC. 9.5. Chapter 4 (commencing with Section 128850) is*
 2 *added to Part 5 of Division 107 of the Health and Safety Code, to*
 3 *read:*

4
 5 *CHAPTER 4. HEALTH CARE COST AND QUALITY TRANSPARENCY*

6
 7 *Article 1. General Provisions*

8
 9 *128850. The Legislature hereby finds and declares that:*

10 *(a) The steady rise in health costs is eroding health access,*
 11 *undermining wages and pensions, straining public health and*
 12 *finance systems, and placing an undue burden on the state's*
 13 *economy. Health care that costs more is not necessarily health*
 14 *care that improves life expectancy, reduces death rates, improves*
 15 *health or minimizes illness and chronic conditions.*

16 *(b) Although there are existing voluntary efforts to report on*
 17 *health care quality at various levels of the health care system in*
 18 *California, the collection of performance data on a voluntary basis*
 19 *is inconsistent and incomplete and does not meet the needs of*
 20 *policymakers, purchasers, consumers, or the health industry for*
 21 *reliable comparisons of provider cost and quality.*

22 *(c) Data that is collected through existing state programs is not*
 23 *collected or analyzed with the goal of reducing health care costs*
 24 *in the system, monitoring performance, or ensuring quality patient*
 25 *outcomes.*

26 *(d) The present day overall lack of transparency of health*
 27 *outcomes and the factors affecting health care costs limits the*
 28 *ability of consumers, purchasers, and policymakers to seek out*
 29 *and reward high quality providers, or to make quality*
 30 *improvements where they are needed.*

31 *(e) The effective use and distribution of health care data and*
 32 *meaningful analysis of that data will lead to greater transparency*
 33 *in the health care system resulting in improved health care quality*
 34 *and outcomes, more cost-effective care and improvements in life*
 35 *expectancy, reduced death rates, and improved overall public*
 36 *health.*

37 *(f) Hospitals, physicians, health care providers, and health*
 38 *insurers who have access to systemwide performance data can*
 39 *use the information to improve patient safety, efficiency of health*

1 *care delivery, and quality of care, leading to quality improvement*
2 *and costs savings throughout the health care system.*

3 *(g) Without comprehensive, systemwide data that is adequately*
4 *analyzed and reported widely, the Legislature cannot effectively*
5 *evaluate the health care system, establish appropriate regulatory*
6 *standards, or identify the most effective use and value for state*
7 *health care dollars. Moreover, consumers and purchasers cannot*
8 *exercise informed choice in the market or identify the most*
9 *cost-effective quality providers and services.*

10 *(h) The State of California is uniquely positioned to collect,*
11 *analyze, and report all payer data on health care utilization,*
12 *quality, and costs in the state in order to facilitate value-based*
13 *purchasing of health care and to support and promote continuous*
14 *quality improvement among health care plans and providers.*

15 *(i) It is therefore the intent of the Legislature to assume a*
16 *leadership role in measuring performance and value in the health*
17 *care system. By establishing statewide data and common*
18 *measurement and analyses of health care costs, quality, and*
19 *outcomes, and by establishing a statewide leadership organization*
20 *with sufficient revenues to adequately analyze and report*
21 *meaningful performance measures related to health care costs*
22 *and quality, the Legislature intends to promote competition, identify*
23 *appropriate health care utilization, and ensure the highest quality*
24 *of health care services for all Californians.*

25 *(j) The Legislature further intends to reduce duplication and*
26 *inconsistency in the collection, analysis, and dissemination of*
27 *health care performance information within state government and*
28 *among both public and private entities by establishing one*
29 *state-level commission with primary responsibility for coordinating*
30 *health care data development, collection, analysis, evaluation,*
31 *and dissemination.*

32 *(k) The Legislature intends for the commission to ensure the*
33 *availability of reliable data to measure and compare performance*
34 *within the health care system along each of the domains identified*
35 *by the Institute of Medicine: safety, timeliness, effectiveness,*
36 *efficiency, equity and patient-centeredness.*

37 *(l) It is further the intent of the Legislature that the data*
38 *collected be used for the transparent public reporting of quality*
39 *and cost efficiency information regarding all levels of the health*
40 *care system, including health care service plans and health*

1 *insurers, hospitals and other health facilities, and medical groups*
2 *and physicians, so that health care plans and providers can*
3 *improve their performance and deliver safer, better health care*
4 *more affordably; so that purchasers can know which health care*
5 *services reduce morbidity, mortality, and other adverse health*
6 *outcomes; so that consumers can choose whether and where to*
7 *have health care provided; and so that the Legislature can*
8 *effectively regulate and monitor the health care delivery system*
9 *to ensure quality and value for all purchasers and consumers.*

10 *128851. As used in this chapter, the following terms have the*
11 *following meanings:*

12 *(a) “Administrative claims data” means data that is submitted*
13 *electronically or otherwise to, or collected by, health insurers,*
14 *health care service plans, administrators, or other payers of health*
15 *care services, and which are submitted to, or collected for, the*
16 *purposes of payment to any physician, physician group, laboratory,*
17 *pharmacy, hospital of any type, imaging center, or any other*
18 *facility or person that is requesting payment for the provision of*
19 *medical care.*

20 *(b) “Ambulatory surgery center” means a facility where*
21 *procedures are performed on an outpatient basis in general*
22 *operating rooms, ambulatory surgery rooms, endoscopy units, or*
23 *cardiac catheterization laboratories of a hospital or a freestanding*
24 *ambulatory surgery clinic.*

25 *(c) “Commission” means the California Health Care Cost and*
26 *Quality Transparency Commission.*

27 *(d) “Data source” means any physician, physician group, health*
28 *facility, health care service plan, health insurer, any state agency*
29 *providing or paying for health care or collecting health care data*
30 *or information, or any other payer for health care services in*
31 *California.*

32 *(e) “Encounter data” means data relating to treatment or*
33 *services rendered by providers to patients which may be*
34 *reimbursed on a fee-for-service or capitation basis.*

35 *(f) “Group” or “physician group” means an affiliation of*
36 *physicians and other health care professionals, whether a*
37 *partnership, corporation, or other legal form, with the primary*
38 *purpose of providing medical care.*

39 *(g) “Healthcare-associated infection” means a localized or*
40 *systemic condition that (1) results from adverse reaction to the*

1 *presence of an infectious agent or its toxin and (2) was not present*
2 *or incubating at the time of admission to the hospital.*

3 (h) *“Health care provider” means a physician, physician group,*
4 *or health facility.*

5 (i) *“Health facility” or “health facilities” means health facilities*
6 *required to be licensed pursuant to Chapter 2 (commencing with*
7 *Section 1250) of Division 2.*

8 (j) *“Office” means the Office of Statewide Health Planning and*
9 *Development.*

10 (k) *“Risk-adjusted outcomes” means the clinical outcomes of*
11 *patients grouped by diagnoses or procedures that have been*
12 *adjusted for demographic and clinical factors.*

13 128852. *Notwithstanding the provisions of Chapter 1*
14 *(commencing with Section 128675), commencing July 1, 2009, the*
15 *responsibilities of the office with respect to determining the data*
16 *to be collected and the analysis and reporting of the data collected*
17 *pursuant to Chapter 1 (commencing with Section 128675) shall*
18 *be transferred to the commission, as determined by the commission*
19 *and as reported to the Secretary of Health and Welfare and the*
20 *Legislature no later than January 1, 2009. Any limitations on the*
21 *collection, analysis, and use of data in that chapter shall be*
22 *inapplicable to the extent determined necessary by the commission*
23 *to implement its responsibilities under this chapter. All data*
24 *collected by the office shall be available to the commission for the*
25 *purposes of carrying out its responsibilities under this chapter.*
26 *During the initial development of the data plan pursuant to Section*
27 *128675, the office shall make available to the commission any and*
28 *all data files, information, and staff resources as may be necessary*
29 *to assist in and support the plan’s development.*

30 128853. *This chapter shall be operative on July 1, 2008.*

31

32 *Article 2. Health Care Cost and Quality Transparency*
33 *Commission*

34

35 128855. *There is hereby created in the Health and Human*
36 *Services Agency, the California Health Care Cost and Quality*
37 *Transparency Commission composed of 13 members, each of whom*
38 *shall have demonstrated knowledge and experience in the*
39 *measurement and analysis of health care quality or cost data, in*
40 *deploying that data on behalf of consumers and purchasers, or in*

1 *health care or other issues relevant to the commission's*
2 *responsibilities. The appointments shall be made as follows:*
3 *(a) The Governor shall appoint seven members as follows:*
4 *(1) One academic with experience in health care data and cost*
5 *efficiency research.*
6 *(2) One representative of hospitals.*
7 *(3) One representative of an integrated multispecialty medical*
8 *group.*
9 *(4) One representative of physician and surgeons.*
10 *(5) One representative of large employers that purchase group*
11 *health care coverage for employees and that is not also a supplier*
12 *or broker in health care coverage.*
13 *(6) One representative of a labor union.*
14 *(7) One representative of employers that purchase group health*
15 *care coverage for their employees or a representative of a nonprofit*
16 *organization that demonstrates experience working with employers*
17 *to enhance value and affordability of health care coverage.*
18 *(b) The Senate Committee on Rules shall appoint three members*
19 *as follows:*
20 *(1) One representative of a labor union.*
21 *(2) One representative of consumers with a demonstrated record*
22 *of advocating health care issues on behalf of consumers.*
23 *(3) One representative of health insurers or health care service*
24 *plans.*
25 *(c) The Assembly Speaker shall appoint three members as*
26 *follows:*
27 *(1) One representative of consumers with a demonstrated record*
28 *of advocating health care issues on behalf of consumers.*
29 *(2) One representative of small employers that purchase group*
30 *health care coverage for employees and that is not also a supplier*
31 *or broker in health care coverage.*
32 *(3) One representative of a nonprofit labor-management*
33 *purchaser coalition that has a demonstrated record of working*
34 *with employers and employee associations to enhance value and*
35 *affordability in health care.*
36 *(d) The following members shall serve in an ex officio, nonvoting*
37 *capacity:*
38 *(1) The Secretary of Health and Human Services or a designee.*
39 *(2) A designee of the California Public Employees' Retirement*
40 *System.*

1 (3) *The director of the Department of Managed Health Care or*
2 *a designee.*

3 (4) *The executive director of the Managed Risk Medical*
4 *Insurance Board or a designee.*

5 (5) *The Insurance Commissioner or a designee.*

6 (e) *The Governor shall designate a member to serve as*
7 *chairperson for a two-year term. No member may serve more than*
8 *two, two-year terms as chairperson. All appointments shall be for*
9 *four-year terms; provided, however, that the initial term shall be*
10 *two years for members initially filling the positions set forth in*
11 *paragraphs 1, 2, 4, and 6 of subdivision (a), paragraph 2 of*
12 *subdivision (b), and paragraph 2 of subdivision (c).*

13 128856. *The commission shall meet at least once every two*
14 *months, or more often if necessary to fulfill its duties.*

15 128857. *The members of the commission shall receive a per*
16 *diem of one hundred dollars (\$100) for each day actually spent in*
17 *the discharge of official duties and shall be reimbursed for any*
18 *actual and necessary expenses incurred in connection with their*
19 *duties as members of the commission.*

20 128858. *The commission shall appoint an executive director,*
21 *who shall serve at the pleasure of the commission. The executive*
22 *director shall receive the salary established by the Department of*
23 *Personnel Administration for exempt officials. The executive*
24 *director shall administer the affairs of the commission as directed*
25 *by the commission and shall direct the staff of the commission.*
26 *The executive director may appoint, with the approval of the*
27 *commission, staff necessary to carry out the functions and duties*
28 *of the commission.*

29 128859. *The commission shall be authorized to do the*
30 *following:*

31 (a) *Enter into contracts.*

32 (b) *Sue and be sued.*

33 (c) *Employ necessary staff.*

34 (d) *Authorize expenditures from the fund or from other moneys*
35 *appropriated in the annual budget act or other public or private*
36 *revenues as necessary to carry out its responsibilities under this*
37 *chapter.*

38 (e) *Adopt, amend, and rescind such regulations, forms, and*
39 *orders as are necessary to carry out its responsibilities under this*
40 *chapter.*

1 (f) Require any data source to submit data necessary to
2 implement the health care cost and quality transparency plan,
3 provided the health care cost and quality transparency plan is
4 adopted by regulation, pursuant to Chapter 3.5 (commencing with
5 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
6 Code.

7 (g) Determine the data elements to be collected, the reporting
8 formats for data submitted, and the use and reporting by the
9 commission of any data submitted.

10 (h) Audit the accuracy of all data submitted and require entities
11 submitting financial data for the purposes of this part to submit
12 proof that financial data submitted has been audited in accordance
13 with generally accepted auditing principles.

14 (i) Exercise all powers reasonably necessary to carry out the
15 powers and responsibilities expressly granted or imposed upon it
16 under this chapter.

17 128860. The commission shall have no authority to disclose
18 any confidential information concerning contracted rates between
19 health care providers and any data source, but nothing in this
20 section shall prevent the commission from publicly disclosing
21 information on the relative or comparative cost to payers or
22 purchasers of health care or the costs for a specific course of
23 treatment or episode, as applicable for the reporting.

24 128861. (a) No later than January 1, 2009, the commission
25 shall determine the functions currently performed by the office
26 that are necessary to the commission's activities and report to the
27 Secretary of Health and Welfare and the Legislature those
28 functions that shall be transferred to the commission effective July
29 1, 2009.

30 (b) All regulations adopted by the office that relate to functions
31 vested in the commission and that are in effect immediately
32 preceding July 1, 2009, shall remain in effect and shall be fully
33 enforceable unless and until readopted, amended, or repealed by
34 the commission.

35 (c) The commission may use the unexpended balance of funds
36 available for use in connection with the performance of the
37 functions of the office transferred to the commission.

38 (d) All officers and employees of the office who, on July 1, 2009,
39 are serving in the state civil service, other than as temporary
40 employees, and engaged in the performance of a function vested

1 *in the commission shall be transferred to the commission. The*
2 *status, positions, and rights of these persons shall not be affected*
3 *by the transfer except as to positions exempted from civil service.*

4 *(e) The commission shall have possession and control of all*
5 *records, papers, offices, equipment, supplies, moneys, funds,*
6 *appropriations, land or other property, real or personal, held for*
7 *the benefit or use of the office for the performance of functions*
8 *transferred to the commission.*

9 *128862. The functions and duties of the commission shall*
10 *include the following:*

11 *(a) Develop, implement, and periodically update a health care*
12 *quality and cost containment plan, including data collection,*
13 *performance measurement, and reporting methods, that provides*
14 *for effective measurement of the safety and quality of an array of*
15 *health care services provided to Californians.*

16 *(b) Determine the data to be collected, and method of collection,*
17 *to implement the data collection and reporting requirements set*
18 *forth in this chapter.*

19 *(c) Determine the measures necessary to implement the*
20 *reporting requirements in the plan developed pursuant to 128864*
21 *in a manner that is cost-effective and reasonable for data sources*
22 *and timely, relevant, and reliable for consumers and purchasers.*

23 *(d) Determine the reports and data to be made available to the*
24 *public in order to accomplish the purposes of this chapter,*
25 *including conducting studies and reporting the results of the*
26 *studies.*

27 *(e) Seek to establish agreements for voluntary reporting of*
28 *health care claims and data from any and all health care payors*
29 *who are not subject to mandatory reporting to the commission*
30 *pursuant to this chapter, and its subsequent regulations, in order*
31 *to ensure availability of the most comprehensive, systemwide data*
32 *on health care costs and quality.*

33 *(f) Collect, aggregate, and timely distribute performance data*
34 *on quality, health outcomes, cost, utilization, and pricing in a*
35 *manner accessible for purchasers, consumers, and policymakers.*

36 *(g) Fully protect patient privacy, in compliance with state and*
37 *federal medical privacy laws, while preserving the ability to*
38 *analyze data using date of birth, ethnicity, and sex where the*
39 *disclosure of this information will not identify an individual.*

1 (h) Create technical advisory committees and clinical advisory
2 committees, as necessary, to advise the commission on technical
3 or clinical issues.

4 (i) Annually report to the Governor and the Legislature, on or
5 before March 1, on the status of implementing this chapter, the
6 resources necessary to fully implement this chapter, and any
7 recommendations for statutory changes that would advance the
8 purposes of this chapter.

9 (j) Provide state leadership and coordination of public and
10 private health care quality and performance measurements to
11 ensure efficiency, cost-effectiveness, transparency, and informed
12 choice by purchasers and consumers.

13 128863. (a) The commission shall appoint at least one
14 technical advisory committee, and may appoint additional technical
15 advisory committees as the commission deems appropriate, and
16 shall include on each such committee academic and professional
17 experts with expertise related to the activities of the commission.

18 (b) The commission shall appoint at least one clinical advisory
19 committee and may appoint additional advisory committees specific
20 to issues that require additional or different clinical expertise.
21 Each clinical advisory committee shall include clinicians and
22 others with expertise related to the activities of the commission
23 and any issue under consideration.

24 (c) The commission shall, as appropriate, refer technical and
25 clinical issues, including issues related to risk adjustment
26 methodology, to an advisory committee for recommendation. The
27 advisory committee shall, within the time period specified by the
28 commission, issue to the commission a written recommendation
29 concerning the issue referred to the advisory committee. The
30 commission shall consider the recommendation of the advisory
31 committee. If the commission rejects the recommendation, it shall
32 issue a written finding and rationale for rejecting the
33 recommendation. If the advisory committee fails to issue a
34 recommendation within the time period prescribed by the
35 commission, the commission may appoint another advisory
36 committee or take such other action it deems necessary to obtain
37 the needed technical or clinical information required to carry out
38 its responsibilities.

39 (d) The members of the technical and clinical advisory
40 committees appointed by the commission shall receive no

1 compensation, but shall be reimbursed for any actual and
2 necessary expenses incurred in connection with their duties as
3 members of the advisory committee.

4 (e) The commission shall provide opportunities for participation
5 from consumers, purchasers, and providers at all advisory
6 committee meetings.

7 128864. The commission shall develop and implement a
8 conflict-of-interest policy applicable to all employees, contractors,
9 and advisory committee members that will ensure, at a minimum,
10 that persons advising the commission disclose any material
11 financial interest in the outcome of the work performed on behalf
12 of the commission.

13
14 Article 3. Health Care Cost and Quality Transparency Plan

15
16 128865. (a) The Commission shall, by December 1, 2009,
17 develop and, by regulation adopt, a health care cost and quality
18 transparency plan that will, when implemented, result in the
19 transparent public reporting of safety, quality, and cost efficiency
20 information at all levels of the health care system. The plan shall:

21 (1) Include specific strategies to measure and collect data
22 related to health care safety and quality, utilization, cost to payers,
23 and health outcomes and shall focus on data elements that foster
24 quality improvement and peer group comparisons.

25 (2) Facilitate value-based, cost-effective purchasing of health
26 care services by public and private purchasers.

27 (3) Result in useable information that allows health care
28 purchasers, consumers, and data sources to identify and compare
29 health plans and insurers as well as individual health facilities,
30 physicians, and other health care providers, on the extent to which
31 they provide safe, cost-effective, high quality health care services.

32 (4) Be designed to measure each of the performance domains
33 identified by the Institute of Medicine: safety, timeliness,
34 effectiveness, efficiency, equity and patient-centeredness.

35 (5) Use and build on existing data collection standards and
36 methods to the greatest extent possible to accomplish the goals of
37 the commission in a cost-effective manner, which may include, but
38 not be limited to, collecting and disseminating one or more
39 nationally recognized methodologies for measuring and quantifying
40 provider quality, cost and service effectiveness, and implementing

1 *systemwide mandatory collection of data elements otherwise being*
2 *collected in existing voluntary public and private reporting*
3 *programs in California.*

4 *(6) Incorporate and utilize administrative claims data to the*
5 *extent it is the most cost-efficient method of collecting data in order*
6 *to minimize the cost and administrative burden on data sources.*
7 *The commission may incorporate and utilize data other than*
8 *administrative claims data, provided it is necessary to measure*
9 *and analyze a significant health care quality, safety, or cost issue*
10 *that cannot be adequately measured with the use of administrative*
11 *claims data.*

12 *(b) The plan shall include all of the following:*

13 *(1) The reports, analyses, and data that will be made available*
14 *to data sources, purchasers, and consumers on the performance*
15 *of health plans and insurers, medical groups, health facilities, and*
16 *physicians, the format in which the reports and data will be made*
17 *available, and the planned implementation dates.*

18 *(2) The data elements necessary to produce the reports and*
19 *data to be made available. The plan shall address the extent to*
20 *which standardized electronic reporting of administrative claims*
21 *data can provide the information necessary for the purposes of*
22 *this chapter, and the most efficient, least burdensome method of*
23 *collecting other necessary data, including systemwide encounter*
24 *data.*

25 *(3) The data elements to be collected and how they will be*
26 *collected.*

27 *(4) A unique patient identifier to permit analysis of health care*
28 *utilization patterns that indicate inadequate quality of care, such*
29 *as hospital readmissions and repetitive service utilization.*

30 *(5) The manner in which patient confidentiality will be*
31 *maintained in compliance with state and federal medical and*
32 *patient privacy laws.*

33 *(6) The administration of data collection, quality assurance,*
34 *and reporting functions.*

35 *(7) The funding necessary to implement the plan and*
36 *recommendations for revenue sources to provide that funding.*

37 *(8) A review of existing public and private health performance*
38 *data collection and reporting standards and practices, at the state*
39 *and federal level, and strategies for incorporating or coordinating*
40 *with existing mandatory and voluntary measurement and reporting*

1 activities as the commission determines necessary to accomplish
2 the goal of this chapter in a cost-effective manner. The review of
3 state programs shall include, at a minimum, review of data
4 collection programs administered by the office and the Office of
5 the Patient Advocate.

6 (9) The timeline for implementation of the plan and a specific
7 timeline and process for updating the plan on a regular basis.

8 128866. The commission may contract with a qualified public
9 or private agency or academic institution to assist in the review
10 of existing data collection programs or to conduct other research
11 or analysis the commission deems necessary to complete and
12 implement the plan required pursuant to Section 128865 or to meet
13 any of its obligations under this chapter.

14 128867. The commission shall review and, where appropriate,
15 incorporate into the plan required by Section 128865 health care
16 data collection and reporting required under other state laws,
17 including, but not limited to, Chapter 1 (commencing with Section
18 128675), Article 3.5 (commencing with Section 1288.10) of Chapter
19 2 of Division 2, and Sections 1279.1, 1279.3, and 1368.02, and
20 shall recommend any modification of these statutes necessary to
21 be consistent with the plan developed pursuant to Section 128865.
22 Data collection and reporting required by these provisions shall
23 not be delayed pending the development and implementation of
24 the plan.

25 128868. (a) No later than December 1, 2008, and annually
26 thereafter, the commission shall publicly report the federal Agency
27 for Healthcare Research and Quality Patient Safety Indicators
28 and Inpatient Quality Indicators for each acute care hospital
29 licensed in California using administrative discharge data that
30 hospitals report pursuant to this part.

31 (b) No later than July 1, 2010, the commission shall publish an
32 initial report of health care associated infection rates in general
33 acute care hospitals. The types of infection to be included and the
34 methods to be used shall be determined by the commission, in
35 consultation with the state Department of Public Health and the
36 committee established pursuant to Section 1288.5. The report shall
37 be based on data collected for a period of 12 months, and
38 thereafter shall be updated quarterly.

39
40 Article 4. Fees

1 128870. (a) The commission shall, to the extent possible,
2 recover the cost of implementing this chapter from fees charged
3 to data sources and data users. As part of the plan adopted
4 pursuant to Article 3 (commencing with Section 128865), the
5 commission shall promulgate a schedule of fees that will, to the
6 extent possible, recover the cost of implementing centralized data
7 collection, effective analysis, and reporting activities under this
8 chapter. The schedule of fees shall be based on the relative need
9 to collect and analyze information from various data sources, and
10 the relative value to data sources and users, in order to correct
11 the adverse health effects that have resulted from the lack of
12 transparency of health care cost and quality information. The fee
13 schedule shall ensure appropriate access to data at a reasonable
14 cost for academic researchers. Notwithstanding this section, the
15 commission shall not fail to publish reports for the public consistent
16 with the plan and shall not otherwise charge members of the public
17 for access to the reports generated and published by the
18 commission.

19 (b) The commission may seek and accept contributions to
20 support the work of the commission from any foundation or other
21 public or private entity that does not have a financial interest in
22 the outcome of the work of the commission, as defined in the
23 conflict-of-interest policy adopted pursuant to Section 128864.

24 128871. There is hereby established in the State Treasury, the
25 Health Care Cost and Quality Transparency Fund to support the
26 work of the commission. All fees and contributions collected by
27 the commission pursuant to Section 128870 shall be deposited in
28 this fund and used to support the work of the commission.

29
30
31

Article 5. Penalties

32 128875. (a) Any data source that fails to file any report as
33 required by this chapter or by the health care cost and quality
34 transparency plan adopted pursuant to this chapter, shall be liable
35 for a civil penalty of one hundred dollars (\$100) to one thousand
36 dollars (\$1,000) per day. The commission shall, as part of the plan
37 developed pursuant to section 128865, promulgate a schedule of
38 civil penalties that will be assessed for reporting violations that
39 varies from one hundred dollars (\$100) per day for the least

1 *serious violation, up to one thousand dollars (\$1,000) for the most*
2 *serious violation.*

3 *(b) Civil penalties shall be assessed and recovered in a civil*
4 *action brought by the commission in the name of the people of the*
5 *State of California. Assessment of a civil penalty may, at the*
6 *request of a health care provider, be reviewed on appeal and the*
7 *penalty may be reduced or waived by the commission for good*
8 *cause.*

9 *(c) Any money received by the commission pursuant to this*
10 *section shall be paid into the General Fund.*

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

13
14 CHAPTER 1.6. CALIFORNIA INDIVIDUAL COVERAGE GUARANTEE
15 ISSUE
16

17 10199.10. It is the intent of the Legislature to do both of the
18 following:

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

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

25 10199.104. (a) On or before September 1, 2008, the
26 commissioner and the Director of the Department of Managed
27 Health Care shall jointly adopt regulations governing five classes
28 of individual health benefit plans that health care service plans and
29 health insurers shall make available.

30 (b) Within 90 days of the adoption of the regulations required
31 by subdivision (a), the commissioner and the Director of the
32 Department of Managed Health Care shall jointly approve five
33 classes of individual health benefit plans for each health care
34 service plan and health insurer participating in the individual
35 market, with each class having an increased level of benefits
36 beginning with the lowest class. Within each class, the
37 commissioner and the Director of the Department of Managed
38 Health Care shall jointly approve one baseline HMO and one
39 baseline PPO, to be issued by health care service plans and health
40 insurers in the individual market. The classes of benefits jointly

1 approved by the commissioner and the Director of the Department
2 of Managed Health Care shall reflect a reasonable continuum
3 between the class with the lowest level of benefits and the class
4 with the highest level of benefits, shall permit reasonable benefit
5 variation that will allow for a diverse market within each class,
6 and shall be enforced consistently between health care service
7 plans and health insurers in the same marketplace regardless of
8 licensure.

9 (c) In approving the five classes of plans filed by health care
10 service plans and health insurers, the commissioner and the
11 Director of the Department of Managed Health Care shall do both
12 of the following:

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

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

19 10199.105. On and after January 1, 2009, health care service
20 plans and health insurers participating in the individual market
21 shall, except as provided in Section 12711.1, guarantee issue the
22 five classes of approved health benefit plans and shall, at the same
23 time, discontinue offering and selling health benefit plans other
24 than those within the five approved classes of benefit plans in the
25 individual market.

26 10199.106. (a) Individuals may purchase a health benefit plan
27 from one of the five classes of approved plans on a guaranteed
28 issue basis. After selecting and purchasing a health benefit plan
29 within a class of benefits, an individual may change plans only as
30 set forth in this section. For individuals enrolled as a family, the
31 subscriber may change classes for himself or herself, or for all
32 dependents:

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

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

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

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

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

6 (B) Upon divorce.

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

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

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

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

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

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

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

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

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

1 individuals, upon a determination by the director or commissioner
2 that the plan or insurer does not have sufficient financial viability,
3 or organizational and administrative capacity, to ensure the delivery
4 of health care benefits to its enrollees or insureds.

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

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

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

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

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

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

1 care benefit plan it issues. Rates for health care benefits may vary
2 from applicant to applicant only by any of the following:

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

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

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

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

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

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

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

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

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

37 (c) The requirements of this chapter shall not apply to a
38 Medicare supplement, vision-only, dental-only, or
39 CHAMPUS-supplement insurance or to hospital indemnity,

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

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

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

12 SEC. 13. Section 10700 of the Insurance Code is amended to
13 read:

14 10700. As used in this chapter:

15 (a) “Agent or broker” means a person or entity licensed under
16 Chapter 5 (commencing with Section 1621) of Part 2 of Division
17 1.

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

29 (c) “Board” means the Major Risk Medical Insurance Board.

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

37 (e) “Dependent” means the spouse or child of an eligible
38 employee, subject to applicable terms of the health benefit plan
39 covering the employee, and includes dependents of guaranteed
40 association members if the association elects to include dependents

1 under its health coverage at the same time it determines its
2 membership composition pursuant to subdivision (z).

3 (f) “Eligible employee” means either of the following:

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

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

24 (B) The employer offers the employee health coverage under a
25 health benefit plan.

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

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

34 (2) Any member of a guaranteed association as defined in
35 subdivision (z).

36 (g) “Enrollee” means an eligible employee or dependent who
37 receives health coverage through the program from a participating
38 carrier.

1 (h) “Financially impaired” means, for the purposes of this
2 chapter, a carrier that, on or after the effective date of this chapter,
3 is not insolvent and is either:

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (4) (A) In the case of an eligible employee as defined in
34 paragraph (1) of subdivision (f), the carrier cannot produce a
35 written statement from the employer stating that the individual or
36 the person through whom an individual was eligible to be covered
37 as a dependent, prior to declining coverage, was provided with,
38 and signed acknowledgment of, an explicit written notice in
39 boldface type specifying that failure to elect coverage during the
40 initial enrollment period permits the carrier to impose, at the time

1 of the individual's later decision to elect coverage, an exclusion
2 from coverage for a period of 12 months as well as a six-month
3 preexisting condition exclusion unless the individual meets the
4 criteria specified in paragraph (1), (2), or (3).

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

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

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

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

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

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

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

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

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

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

2 (q) “Preexisting condition provision” means a policy provision
3 that excludes coverage for charges or expenses incurred during a
4 specified period following the insured’s effective date of coverage,
5 as to a condition for which medical advice, diagnosis, care, or
6 treatment was recommended or received during a specified period
7 immediately preceding the effective date of coverage.

8 (r) “Creditable coverage” means:

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

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

26 (3) The Medicaid program pursuant to Title XIX of the Social
27 Security Act.

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

30 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
31 (Civilian Health and Medical Program of the Uniformed Services
32 (CHAMPUS)).

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

35 (7) A state health benefits risk pool.

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

39 (9) A public health plan as defined in federal regulations
40 authorized by Section 2701(c)(1)(I) of the Public Health Service

1 Act, as amended by Public Law 104-191, the Health Insurance
2 Portability and Accountability Act of 1996.

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

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

8 (s) "Rating period" means the period for which premium rates
9 established by a carrier are in effect and shall be no less than six
10 months.

11 (t) "Risk adjusted employee risk rate" means the rate determined
12 for an eligible employee of a small employer in a particular risk
13 category after applying the risk adjustment factor.

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

22 (v) "Risk category" means the following characteristics of an
23 eligible employee: age, geographic region, and family size of the
24 employee, plus the benefit plan design selected by the small
25 employer.

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

- 28 Under 30
- 29 30–39
- 30 40–49
- 31 50–54
- 32 55–59
- 33 60–64
- 34 65 and over

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

1 (2) Small employer carriers shall base rates to small employers
 2 using no more than the following family size categories:
 3 (A) Single.
 4 (B) Married couple.
 5 (C) One adult and child or children.
 6 (D) Married couple and child or children.
 7 (3) (A) In determining rates for small employers, a carrier that
 8 operates statewide shall use no more than nine geographic regions
 9 in the state, have no region smaller than an area in which the first
 10 three digits of all its ZIP Codes are in common within a county
 11 and shall divide no county into more than two regions. Carriers
 12 shall be deemed to be operating statewide if their coverage area
 13 includes 90 percent or more of the state’s population. Geographic
 14 regions established pursuant to this section shall, as a group, cover
 15 the entire state, and the area encompassed in a geographic region
 16 shall be separate and distinct from areas encompassed in other
 17 geographic regions. Geographic regions may be noncontiguous.
 18 (B) In determining rates for small employers, a carrier that does
 19 not operate statewide shall use no more than the number of
 20 geographic regions in the state than is determined by the following
 21 formula: the population, as determined in the last federal census,
 22 of all counties which are included in their entirety in a carrier’s
 23 service area divided by the total population of the state, as
 24 determined in the last federal census, multiplied by nine. The
 25 resulting number shall be rounded to the nearest whole integer.
 26 No region may be smaller than an area in which the first three
 27 digits of all its ZIP Codes are in common within a county and no
 28 county may be divided into more than two regions. The area
 29 encompassed in a geographic region shall be separate and distinct
 30 from areas encompassed in other geographic regions. Geographic
 31 regions may be noncontiguous. No carrier shall have less than one
 32 geographic area.
 33 (w) “Small employer” means either of the following:
 34 (1) Any person, proprietary or nonprofit firm, corporation,
 35 partnership, public agency, or association that is actively engaged
 36 in business or service that, on at least 50 percent of its working
 37 days during the preceding calendar quarter, or preceding calendar
 38 year, employed at least two, but not more than 50, eligible
 39 employees, the majority of whom were employed within this state,
 40 that was not formed primarily for purposes of buying health

1 insurance and in which a bona fide employer-employee relationship
2 exists. In determining whether to apply the calendar quarter or
3 calendar year test, the insurer shall use the test that ensures
4 eligibility if only one test would establish eligibility. However,
5 for purposes of subdivisions (b) and (h) of Section 10705, the
6 definition shall include employers with at least three eligible
7 employees until July 1, 1997, and two eligible employees
8 thereafter. In determining the number of eligible employees,
9 companies that are affiliated companies and that are eligible to file
10 a combined income tax return for purposes of state taxation shall
11 be considered one employer. Subsequent to the issuance of a health
12 benefit plan to a small employer pursuant to this chapter, and for
13 the purpose of determining eligibility, the size of a small employer
14 shall be determined annually. Except as otherwise specifically
15 provided, provisions of this chapter that apply to a small employer
16 shall continue to apply until the health benefit plan anniversary
17 following the date the employer no longer meets the requirements
18 of this definition. It includes any small employer as defined in this
19 paragraph who purchases coverage through a guaranteed
20 association, and any employer purchasing coverage for employees
21 through a guaranteed association.

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

24 (x) "Standard employee risk rate" means the rate applicable to
25 an eligible employee in a particular risk category in a small
26 employer group.

27 (y) "Guaranteed association" means a nonprofit organization
28 comprised of a group of individuals or employers who associate
29 based solely on participation in a specified profession or industry,
30 accepting for membership any individual or employer meeting its
31 membership criteria which (1) includes one or more small
32 employers as defined in paragraph (1) of subdivision (w), (2) does
33 not condition membership directly or indirectly on the health or
34 claims history of any person, (3) uses membership dues solely for
35 and in consideration of the membership and membership benefits,
36 except that the amount of the dues shall not depend on whether
37 the member applies for or purchases insurance offered by the
38 association, (4) is organized and maintained in good faith for
39 purposes unrelated to insurance, (5) has been in active existence
40 on January 1, 1992, and for at least five years prior to that date,

1 (6) has been offering health insurance to its members for at least
2 five years prior to January 1, 1992, (7) has a constitution and
3 bylaws, or other analogous governing documents that provide for
4 election of the governing board of the association by its members,
5 (8) offers any benefit plan design that is purchased to all individual
6 members and employer members in this state, (9) includes any
7 member choosing to enroll in the benefit plan design offered to
8 the association provided that the member has agreed to make the
9 required premium payments, and (10) covers at least 1,000 persons
10 with the carrier with which it contracts. The requirement of 1,000
11 persons may be met if component chapters of a statewide
12 association contracting separately with the same carrier cover at
13 least 1,000 persons in the aggregate.

14 This subdivision applies regardless of whether a master policy
15 by an admitted insurer is delivered directly to the association or a
16 trust formed for or sponsored by an association to administer
17 benefits for association members.

18 For purposes of this subdivision, an association formed by a
19 merger of two or more associations after January 1, 1992, and
20 otherwise meeting the criteria of this subdivision shall be deemed
21 to have been in active existence on January 1, 1992, if its
22 predecessor organizations had been in active existence on January
23 1, 1992, and for at least five years prior to that date and otherwise
24 met the criteria of this subdivision.

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

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

1 SEC. 14. Section 10714 of the Insurance Code is amended to
2 read:

3 10714. Premiums for benefit plan designs written, issued, or
4 administered by carriers on or after the effective date of this act,
5 shall be subject to the following requirements:

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

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

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

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

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

38 (3) For a benefit plan design that a carrier has discontinued
39 offering, the risk adjustment factor applied to the standard
40 employee risk rates for the first rating period of the new benefit

1 plan design that the small employer elects to purchase shall be no
2 greater than the risk adjustment factor applied in the prior rating
3 period to the discontinued benefit plan design. However, the risk
4 adjusted employee rate may not be more than 120 percent or less
5 than 80 percent of the carrier's applicable standard employee risk
6 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted
7 employee risk rate may not be more than 110 percent or less than
8 90 percent. The factor effective July 1, 1996, shall apply to in force
9 business at the earlier of either the time of renewal or July 1, 1997.
10 The risk adjustment factor for a small employer may not be
11 modified more frequently than every 12 months. On and after
12 January 1, 2010, no risk adjustment factor shall be applied.

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

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

38 (d) Nothing in this section shall be construed to prevent an
39 insurer from changing the standard employee risk rates applied to
40 a small employer in order to ensure that the insurer's rates for a

1 standard benefit plan design sold pursuant to Section 10761 are
2 not less than the insurer's rates for the same benefit plan design
3 sold through the California Cooperative Health Insurance
4 Purchasing Program (Part 6.45 (commencing with Section
5 12699.201)).

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

8

9

CHAPTER 8.1. INSURANCE MARKET REFORM

10

11 10760. Effective July 1, 2008, every insurer that offers,
12 markets, and sells health insurance to individuals and conducts
13 medical underwriting to determine whether to issue coverage to a
14 specific individual shall use a standardized health questionnaire
15 developed by the Managed Risk Medical Insurance Board. A health
16 insurer subject to this section may not exclude a potential insured
17 from any individual coverage on the basis of an actual or expected
18 health condition, type of illness, treatment, medical condition, or
19 accident, or for a preexisting condition, except as provided by the
20 board pursuant to Section 12711.1.

21 ~~10761. (a) Every insurer that provides health insurance to~~
22 ~~residents of this state shall offer, market, and sell all of the uniform~~
23 ~~benefit plan designs made available through the California~~
24 ~~Cooperative Health Insurance Purchasing Program (Cal-CHIPP)~~
25 ~~pursuant to Part 6.45 (commencing with Section 12699.201) to~~
26 ~~purchasers in each region and all individual and group markets~~
27 ~~where the insurer offers, markets, and sells health insurance~~
28 ~~policies, consistent with statutory and regulatory rating and~~
29 ~~underwriting requirements applicable to the respective individual~~
30 ~~and group markets. A health insurer that is also a participating~~
31 ~~health plan in Cal-CHIPP may not charge a standard rate, with~~
32 ~~reference to insureds of any age, family size, and geographical~~
33 ~~region, that is less than the insurer's rate for the same benefit plan~~
34 ~~design sold through Cal-CHIPP.~~

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

38 *10761. The department, in consultation with the Department*
39 *of Managed Health Care, shall require each health insurer with*
40 *one million or more insureds in California, based on the insurer's*

1 *enrollment in the prior year, to submit a good faith bid to the*
2 *Managed Risk Medical Insurance Board in order to be a*
3 *participating plan through the California Cooperative Health*
4 *Insurance Purchasing Program (Cal-CHIPP) pursuant to Part*
5 *6.45 (commencing with Section 12699.201).*

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

14 10763. On and after July 1, 2008, all requirements in Chapter
15 8 (commencing with Section 10700) applicable to offering,
16 marketing, and selling health benefit plans to small employers as
17 defined in that chapter, including, but not limited to, the obligation
18 to fairly and affirmatively offer, market, and sell all of the carrier's
19 health benefit plan designs to all employers, guaranteed renewal
20 of all health benefit plan designs, use of the risk adjustment factor,
21 and the restriction of risk categories to age, geographic region, and
22 family composition as described in that chapter, shall be applicable
23 to all health benefit plan designs offered to all employers with ~~250~~
24 *100* or fewer eligible employees, except as follows:

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

27 (b) For employers with 51 to ~~250~~ *100*, inclusive, eligible
28 employees, all requirements in that chapter shall apply, except that
29 the carrier may develop health care coverage benefit plan designs
30 to fairly and affirmatively market only to employer groups of 51
31 to ~~250~~ *100* eligible employees.

32 (c) On and after January 1, 2010, no risk adjustment factor shall
33 be applied to a policy offered to an employer with 51 to ~~250~~ *100*,
34 inclusive, eligible employees.

35 10764. (a) Every group health insurer shall obtain from each
36 employer or group policyholder contracting with the health insurer
37 the premium contribution amounts the employer or group makes
38 for each enrolled group member and dependent using the family
39 size categories premium payments made to the group plan.

1 (b) (1) Every health insurer offering group health insurance
2 policies shall provide as one coverage option of each group policy
3 a ~~Healthy Families benchmark policy~~ *Cal-CHIPP Healthy Families*
4 *plan* established by the board so that group members and their
5 dependents with family incomes at or below 300 percent of the
6 federal poverty level that are determined eligible for coverage
7 through the Healthy Families Program or who are eligible for
8 Medi-Cal pursuant to Section ~~14005.33~~ *14005.301* of the Welfare
9 and Institutions Code can enroll in the ~~Healthy Families benchmark~~
10 ~~policy~~ *Cal-CHIPP Healthy Families plan*. The ~~Healthy Families~~
11 ~~benchmark policy~~ *Cal-CHIPP Healthy Families plan* of a group
12 health insurer shall be provided at a rate negotiated with and
13 approved by the board. The health insurer shall collect the
14 employer's applicable dollar premium contribution for employees
15 and, if applicable, dependents in the ~~Healthy Families benchmark~~
16 ~~policy~~ *Cal-CHIPP Healthy Families plan* and credit that amount
17 toward the cost of the ~~Healthy Families benchmark policy~~
18 *Cal-CHIPP Healthy Families plan*.

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

29 (c) (1) Every health insurer offering group health policies shall
30 provide as one coverage option of each group contract a ~~Medi-Cal~~
31 ~~benchmark policy~~ *Cal-CHIPP Medi-Cal plan* established by the
32 board so that group members and their dependents that are
33 determined eligible for coverage through the Medi-Cal program,
34 except for coverage pursuant to Section ~~14005.33~~ *14005.301* of
35 the Welfare and Institutions Code, can enroll in the ~~Medi-Cal~~
36 ~~benchmark policy~~. The ~~Medi-Cal benchmark policy~~ *Cal-CHIPP*
37 *Medi-Cal plan*. The *Cal-CHIPP Medi-Cal plan* of a group health
38 insurer shall be provided at a rate negotiated with and approved
39 by the board. The health insurer shall collect the employer's
40 applicable dollar premium contribution for employees and, if

1 applicable, dependents in the ~~Medi-Cal benchmark~~ *Cal-CHIPP*
2 *Medi-Cal* plan and credit that amount toward the cost of the
3 ~~Medi-Cal benchmark~~ *Cal-CHIPP Medi-Cal* plan.

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

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

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

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

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

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

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

4 ~~(3) “Healthy Families benchmark policy” shall mean coverage
5 equivalent to coverage provided through the Healthy Families
6 Program established pursuant to Part 6.2 (commencing with Section
7 12693).~~

8 (3) “*Cal-CHIPP Healthy Families plan*” shall have the same
9 meaning as in Section 12699.201.

10 ~~(4) “Medi-Cal benchmark policy” shall mean coverage
11 equivalent to~~

12 (4) “*Cal-CHIPP Medi-Cal plan*” shall mean a health insurance
13 policy providing the same amount, duration, scope, and level of
14 coverage provided through the Medi-Cal program (Chapter 7
15 (commencing with Section 14000) of Part 3 of Division 9 of the
16 Welfare and Institutions Code).

17 (h) This section shall apply to health insurance policies issued,
18 amended, or renewed on or after ~~July 1, 2008~~ *January 1, 2010*.

19 10765. (a) As used in this chapter, “health insurance” shall
20 have the same meaning as in subdivision (b) of Section 106.

21 (b) The requirements of this chapter shall not apply to a
22 Medicare supplement, vision-only, dental-only, or
23 CHAMPUS-supplement insurance or to hospital indemnity,
24 hospital-only, accident-only, or specified disease insurance that
25 does not pay benefits on a fixed benefit, cash payment only basis.

26 10766. This chapter shall become operative on July 1, 2008.

27 SEC. 16. Section 12693.43 of the Insurance Code is amended
28 to read:

29 12693.43. (a) Applicants applying to the purchasing pool shall
30 agree to pay family contributions, unless the applicant has a family
31 contribution sponsor. Family contribution amounts consist of the
32 following two components:

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

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

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

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

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

12 (3) On and after July 1, 2005, fifteen dollars (\$15) per child
13 with a maximum required contribution of forty-five dollars (\$45)
14 per month per family for applicants with annual household income
15 to which subparagraph (B) of paragraph (6) of subdivision (a) of
16 Section 12693.70 is applicable. Notwithstanding any other
17 provision of law, if an application with an effective date prior to
18 July 1, 2005, was based on annual household income to which
19 subparagraph (B) of paragraph (6) of subdivision (a) of Section
20 12693.70 is applicable, then this paragraph shall be applicable to
21 the applicant on July 1, 2005, unless subparagraph (B) of paragraph
22 (6) of subdivision (a) of Section 12693.70 is no longer applicable
23 to the relevant family income. The program shall provide prior
24 notice to any applicant for currently enrolled subscribers whose
25 premium will increase on July 1, 2005, pursuant to this paragraph
26 and, prior to the date the premium increase takes effect, shall
27 provide that applicant with an opportunity to demonstrate that
28 subparagraph (B) of paragraph (6) of subdivision (a) of Section
29 12693.70 is no longer applicable to the relevant family income.

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

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

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

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

10 (2) Six dollars (\$6) per child with a maximum required
11 contribution of eighteen dollars (\$18) per month per family for
12 applicants with annual household incomes greater than 150 percent
13 and up to and including 200 percent of the federal poverty level
14 and for applicants on behalf of children described in clause (ii) of
15 subparagraph (A) of paragraph (6) of subdivision (a) of Section
16 12693.70.

17 (3) On and after July 1, 2005, twelve dollars (\$12) per child
18 with a maximum required contribution of thirty-six dollars (\$36)
19 per month per family for applicants with annual household income
20 to which subparagraph (B) of paragraph (6) of subdivision (a) of
21 Section 12693.70 is applicable. Notwithstanding any other
22 provision of law, if an application with an effective date prior to
23 July 1, 2005, was based on annual household income to which
24 subparagraph (B) of paragraph (6) of subdivision (a) of Section
25 12693.70 is applicable, then this paragraph shall be applicable to
26 the applicant on July 1, 2005, unless subparagraph (B) of paragraph
27 (6) of subdivision (a) of Section 12693.70 is no longer applicable
28 to the relevant family income. The program shall provide prior
29 notice to any applicant for currently enrolled subscribers whose
30 premium will increase on July 1, 2005, pursuant to this paragraph
31 and, prior to the date the premium increase takes effect, shall
32 provide that applicant with an opportunity to demonstrate that
33 subparagraph (B) of paragraph (6) of subdivision (a) of Section
34 12693.70 is no longer applicable to the relevant family income.

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

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

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

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

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

29 SEC. 17. Section 12693.57 is added to the Insurance Code, to
30 read:

31 12693.57. Every person administering or providing benefits
32 under the program shall perform his or her duties in such a manner
33 as to secure for every subscriber the amount of assistance to which
34 the subscriber is entitled, without attempting to elicit any
35 information that is not required to carry out the provisions of law
36 applicable to the program.

37 SEC. 18. Section 12693.58 is added to the Insurance Code, to
38 read:

39 12693.58. (a) All types of information, whether written or
40 oral, concerning an applicant, subscriber, or household member,

1 made or kept by any public officer or agency in connection with
2 the administration of any provision of this part shall be confidential,
3 and shall not be open to examination other than for purposes
4 directly connected with the administration of the Healthy Families
5 Program or the Medi-Cal program.

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

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

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

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

27 SEC. 19. Section 12693.59 is added to the Insurance Code, to
28 read:

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

38 SEC. 20. Section 12693.621 is added to the Insurance Code,
39 to read:

1 12693.621. ~~The~~ *On and after January 1, 2010, the coverage*
2 *under this part for a child who is a dependent of an employee of*
3 *an employer electing to make a payment to the California Health*
4 *Trust Fund in lieu of making health expenditures pursuant to*
5 *Section 4802.1 of the Unemployment Insurance Code, shall be*
6 *provided through a ~~Healthy Families benchmark~~ Cal-CHIPP*
7 *Healthy Families plan under Part 6.45 (commencing with Section*
8 *12699.201). The requirement that an individual enroll in a*
9 *Cal-CHIPP Healthy Families plan shall apply to an individual*
10 *enrolled in the Healthy Families Program at the individual's next*
11 *annual redetermination of eligibility for the Healthy Families*
12 *Program, or earlier upon request.*

13 SEC. 21. Section 12693.70 of the Insurance Code is amended
14 to read:

15 12693.70. To be eligible to participate in the program, an
16 applicant shall meet all of the following requirements:

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

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

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

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

29 (4) [Reserved].

30 (5) A resident of the State of California pursuant to Section 244
31 of the Government Code; or, if not a resident pursuant to Section
32 244 of the Government Code, is physically present in California
33 and entered the state with a job commitment or to seek
34 employment, whether or not employed at the time of application
35 to or after acceptance in, the program.

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

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

39 (ii) When implemented by the board, subject to subdivision (b)
40 of Section 12693.765 and pursuant to this section, a child under

1 the age of two years who was delivered by a mother enrolled in
2 the Access for Infants and Mothers Program as described in Part
3 6.3 (commencing with Section 12695). Commencing July 1, 2007,
4 eligibility under this subparagraph shall not include infants during
5 any time they are enrolled in employer-sponsored health insurance
6 or are subject to an exclusion pursuant to Section 12693.71 or
7 12693.72, or are enrolled in the full scope of benefits under the
8 Medi-Cal program at no share of cost. For purposes of this clause,
9 any infant born to a woman whose enrollment in the Access for
10 Infants and Mothers Program begins after June 30, 2004, shall be
11 automatically enrolled in the Healthy Families Program, except
12 during any time on or after July 1, 2007, that the infant is enrolled
13 in employer-sponsored health insurance or is subject to an
14 exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled
15 in the full scope of benefits under the Medi-Cal program at no
16 share of cost. Except as otherwise specified in this section, this
17 enrollment shall cover the first 12 months of the infant's life. At
18 the end of the 12 months, as a condition of continued eligibility,
19 the applicant shall provide income information. The infant shall
20 be disenrolled if the gross annual household income exceeds the
21 income eligibility standard that was in effect in the Access for
22 Infants and Mothers Program at the time the infant's mother
23 became eligible, or following the two-month period established
24 in Section 12693.981 if the infant is eligible for Medi-Cal with no
25 share of cost. At the end of the second year, infants shall again be
26 screened for program eligibility pursuant to this section, with
27 income eligibility evaluated pursuant to clause (i), subparagraphs
28 (B) and (C), and paragraph (2) of subdivision (a).

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

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

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

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

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

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

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

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

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

38 SEC. 22. Section 12693.73 of the Insurance Code is amended
39 to read:

1 12693.73. Notwithstanding any other provision of law, children
2 excluded from coverage under Title XXI of the Social Security
3 Act are not eligible for coverage under the program, except as
4 specified in clause (ii) of subparagraph (A) of paragraph (6) of
5 subdivision (a) of Section 12693.70 and Section 12693.76, or
6 except children who otherwise meet eligibility requirements for
7 the program but for their immigration status.

8 SEC. 23. Section 12693.755 of the Insurance Code is amended
9 to read:

10 12693.755. (a) Subject to subdivision (b), but no later than
11 July 1, 2008, the board shall expand eligibility under this part to
12 uninsured parents of, and as defined by the board, adults
13 responsible for, children enrolled to receive coverage under this
14 part whose income does not exceed 300 percent of the federal
15 poverty level, before applying the income disregard provided for
16 in subparagraph (B) of paragraph (6) of subdivision (a) of Section
17 12693.70.

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

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

36 (c) The coverage under this section for a person who is an
37 employee or, if applicable, an adult dependent of an employee, of
38 an employer electing to make a payment to the California Health
39 Trust Fund in lieu of making health expenditures pursuant to
40 Section 4802.1 of the Unemployment Insurance Code, shall be

1 provided through a ~~Healthy Families benchmark~~ *Cal-CHIPP*
 2 *Healthy Families* plan under Part 6.45 (commencing with Section
 3 12699.201).

4 SEC. 24. Section 12693.76 of the Insurance Code is amended
 5 to read:

6 12693.76. (a) Notwithstanding any other provision of law, a
 7 child ~~who is a qualified alien as defined in Section 1641 of Title~~
 8 ~~8 of the United States Code~~ shall not be determined ineligible
 9 solely on the basis of his or her date of entry into the United States.

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

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

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

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

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

27
 28 PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH
 29 INSURANCE PURCHASING PROGRAM

30
 31 CHAPTER 1. GENERAL PROVISIONS

32
 33 12699.201. For the purposes of this part, the following terms
 34 have the following meanings:

35 (a) “Benefit plan design” means a specific health coverage
 36 product offered for sale and includes services covered and the
 37 levels of copayments, deductibles, and annual out-of-pocket
 38 expenses, and may include the professional providers who are to
 39 provide those services and the sites where those services are to be
 40 provided. A benefit plan design may also be an integrated system

1 for the financing and delivery of quality health care services that
2 has significant incentives for the covered individuals to use the
3 system.

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

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

8 (d) “*Dependent*” shall have the same meaning as in Section
9 4800.02 of the Unemployment Insurance Code.

10 ~~(d)~~

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

13 ~~(e)~~

14 (f) “Fund” means the California Health Trust Fund established
15 pursuant to Section 12699.212.

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

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

23 (g) “*Cal-CHIPP Healthy Families plan*” shall mean health
24 care coverage provided through a health care service plan or a
25 health insurer that provides either of the following:

26 (1) *For individuals less than 19 years of age, the same amount,
27 duration, scope, and level of coverage provided through the
28 Healthy Families Program established pursuant to Part 6.2
29 (commencing with Section 12693) of Division 2.*

30 (2) *For individuals eligible pursuant to Section 12693.755 or
31 Section 14005.301 of the Welfare and Institutions Code, coverage
32 that meets the requirements of federal law and that, at a minimum,
33 provides the same covered services and benefits required under
34 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
35 2.2 (commencing with Section 1340) of Division 2 of the Health
36 and Safety Code) plus prescription drugs.*

37 (h) “*Cal-CHIPP Medi-Cal plan*” shall mean health care
38 coverage provided through a health care service plan or health
39 insurer that provides the same amount, duration, scope, and level
40 of coverage provided through the Medi-Cal program (Chapter 7

1 (commencing with Section 14000) of Part 3 of Division 9 of the
 2 Welfare and Institutions Code).

3 ~~(h)~~

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

9 ~~(i)~~

10 (j) “Participating health plan” means either a private health
 11 insurer holding a valid outstanding certificate of authority from
 12 the commissioner or a health care service plan as defined under
 13 subdivision (f) of Section 1345 of the Health and Safety Code that
 14 contracts with the board to provide coverage in Cal-CHIPP and,
 15 pursuant to its contract with the board, provides, arranges, pays
 16 for, or reimburses the costs of health services for Cal-CHIPP
 17 enrollees.

18 ~~(j)~~

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

25

26 CHAPTER 2. ADMINISTRATION

27

28 12699.202. (a) The board shall be responsible for establishing
 29 Cal-CHIPP and administering this part.

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

32 (1) Determine eligibility and enrollment criteria and processes
 33 for Cal-CHIPP consistent with the eligibility standards in Chapter
 34 3 (commencing with Section 12699.211).

35 (2) Determine the participation requirements for enrollees.

36 (3) Determine the participation requirements and the standards
 37 and selection criteria for participating health, dental, and vision
 38 care plans, including reasonable limits on a plan’s administrative
 39 costs to ensure that a plan expends on patient care not less than 85

1 percent of aggregate dues, fees, and other periodic payments
2 received by the plan.

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

5 (5) Determine premium schedules, collect the premiums, and
6 administer subsidies to eligible enrollees.

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

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

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

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

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

17 (11) Enter into contracts.

18 (12) Sue and be sued.

19 (13) Employ necessary staff.

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

23 (15) Issue rules and regulations, as necessary.

24 (16) Maintain enrollment and expenditures to ensure that
25 expenditures do not exceed the amount of revenue available in the
26 fund, and if sufficient revenue is not available to pay the estimated
27 expenditures, the board shall institute appropriate measures to
28 ensure fiscal solvency. This paragraph shall not be construed to
29 allow the board to deny enrollment of a person who otherwise
30 meets the eligibility requirements of Chapter 3 (commencing with
31 Section 12699.211) in order to ensure the fiscal solvency of the
32 fund.

33 (17) Establish the criteria and procedures through which
34 employers direct employees' premium dollars, withheld under the
35 terms of cafeteria plans pursuant to Section 4809 of the
36 Unemployment Insurance Code, to Cal-CHIPP to be credited
37 against the employees' premium obligations.

38 (18) Share information obtained pursuant to this part with the
39 Employment Development Department solely for the purpose of
40 the administration and enforcement of this part.

1 (19) Exercise all powers reasonably necessary to carry out the
2 powers and responsibilities expressly granted or imposed by this
3 part.

4 12699.203. The board shall develop and offer ~~at least three~~
5 ~~uniform benefit plan designs to Cal-CHIPP enrollees~~ *a variety of*
6 *benefit plan designs, including low-cost plans for Cal-CHIPP*
7 *enrollees who are adults with family incomes below 300 percent*
8 *of the federal poverty level who are ineligible for coverage through*
9 *the Healthy Families Program or the Medi-Cal program.* In
10 addition to ~~the three uniform~~ *these* benefit plan designs, each
11 participating health plan *and health insurer* shall offer a ~~Healthy~~
12 ~~Families benchmark~~ *Cal-CHIPP Healthy Families* plan and a
13 ~~Medi-Cal benchmark~~ *plan Cal-CHIPP Medi-Cal* plan, and the
14 board shall limit enrollment in these plans only to eligible
15 individuals. For purposes of the ~~Medi-Cal benchmark plan offered~~
16 ~~in Cal-CHIPP~~ *Cal-CHIPP Medi-Cal* plan, the board shall enter
17 into an agreement with the State Department of Health Care
18 Services for the provision of the ~~Medi-Cal benchmark~~ *Cal-CHIPP*
19 *Medi-Cal* plan by the Medi-Cal program. The ~~three uniform~~ benefit
20 plan designs shall include varying benefit levels, deductibles,
21 coinsurance factors, or copayments, and annual limits on
22 out-of-pocket expenses. In developing the benefit plan designs,
23 the board shall comply with all of the following:

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

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

39 (c) In determining the enrollee and dependent deductibles,
40 coinsurance, and copayment requirements, the board shall consider

1 whether those costs would deter an enrollee or his or her
2 dependents from obtaining appropriate and timely care, including
3 those enrollees with a low- or moderate-family income. The board
4 shall also consider the impact of these costs on an enrollee's ability
5 to afford health care services.

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

9 12699.204. (a) The board may adjust premiums at a public
10 meeting of the board after providing, at minimum, 30 days' public
11 notice of the adjustment. In making the adjustment, the board shall
12 take into account the costs of health care typically paid for by
13 employers and employees in California.

14 (b) Notwithstanding subdivision (a), the amount of the premium
15 paid by an employee with a household income at or below 300
16 percent of the federal poverty level shall not exceed 0 to 5 percent
17 of the household income, depending on the income, after taking
18 into account the tax savings the employee is able to realize by
19 using the cafeteria plan made available by his or her employer
20 pursuant to Section 4809 of the Unemployment Insurance Code.

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

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

33 12699.205. The board, in its contract with a participating health
34 plan, shall require that the plan utilize efficient practices to improve
35 and control costs. These practices shall include, but are not limited
36 to, the following:

37 (a) Preventive care.

38 (b) Care management for chronic diseases.

39 (c) Promotion of health information technology.

40 (d) Standardized billing practices.

- 1 (e) Reduction of medical errors.
- 2 (f) Incentives for healthy lifestyles.
- 3 (g) Patient cost-sharing to encourage the use of preventive and
- 4 appropriate care.
- 5 (h) Rational use of new technology.

6 12699.206. (a) The board shall negotiate with Medi-Cal
 7 managed care plans to obtain affordable coverage for eligible
 8 enrollees.

9 (b) The board shall implement the requirements for a ~~benchmark~~
 10 ~~plan or policy~~ *Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy*
 11 *Families plan* as required pursuant to Section 1357.24 of the Health
 12 and Safety Code and Section 10764, and shall limit enrollment in
 13 these plans ~~or policies~~ only to eligible individuals.

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

18 12699.206.1. (a) To provide prescription drug coverage for
 19 Cal-CHIPP enrollees, the board may take any of the following
 20 actions:

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

24 (2) Contract with a pharmacy benefits manager (PBM) if the
 25 PBM meets transparency and disclosure requirements established
 26 by the board.

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

31 (b) The board may engage in any of the activities described in
 32 subdivision (a), or in any cost-effective combination of those
 33 activities.

34 (c) If the board enters into a prescription drug purchasing
 35 arrangement pursuant to paragraph (2) or (3) of subdivision (a),
 36 the board may allow any of the following entities to participate in
 37 that arrangement:

- 38 (1) ~~Employers.~~
- 39 (2)

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

3 ~~(3)~~

4 (2) A board or administrator responsible for providing or
5 delivering health care coverage pursuant to a collective bargaining
6 agreement, memorandum of understanding, or other similar
7 agreement with a labor organization.

8 12699.206.2. (a) All information, whether written or oral,
9 concerning an applicant to Cal-CHIPP, an enrollee in Cal-CHIPP,
10 or a household member of the applicant or enrollee, created or
11 maintained by a public officer or agency in connection with the
12 administration of this part shall be confidential and shall not be
13 open to examination other than for purposes directly connected
14 with the administration of this part. "Purposes directly connected
15 with the administration of this part" includes all activities and
16 responsibilities in which the board or the State Department of
17 Health Care Services and their agents, officers, trustees, employees,
18 consultants, and contractors engage to conduct program operations.

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

24 (c) Nothing in this section shall be construed to prohibit the
25 disclosure of information about applicants and enrollees, or their
26 household members, if express written authorization for the
27 disclosure has been provided by the person to whom the
28 information pertains or, if that person is a minor, authorization has
29 been provided by the minor's parent or other adult with legal
30 custody of the minor.

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

34 12699.207. (a) Notwithstanding any other provision of law,
35 the board shall not be subject to licensure or regulation by the
36 Department of Insurance or the Department of Managed Health
37 Care.

38 (b) Participating health, dental, and vision care plans that
39 contract with the board shall be regulated by either the Insurance
40 Commissioner or the Department of Managed Health Care and

1 shall be licensed and in good standing with their respective
 2 licensing agency. In their application to Cal-CHIPP and upon
 3 request by the board, the participating health, dental, and vision
 4 care plans shall provide assurance of their licensure and standing
 5 with the appropriate licensing agency.

6 12699.208. The board shall collect and disseminate, as
 7 appropriate and to the extent possible, information on the quality
 8 of participating health, dental, and vision care plans and each plan's
 9 cost-effectiveness to assist enrollees in selecting a plan.

10 12699.209. The board shall establish a working group for the
 11 purpose of developing recommendations to broaden access to
 12 Cal-CHIPP to all self-employed individuals and submit the
 13 recommendations to the Legislature on or before January 1, 2009.

14 12699.210. The provisions of Section 12693.54 shall apply to
 15 a contract entered into pursuant to this part.

16

17

CHAPTER 3. ELIGIBILITY

18

19 12699.211. (a) To be eligible to enroll in Cal-CHIPP, an
 20 individual shall meet all of the following requirements:

21 (1) Is a resident of the state pursuant to Section 244 of the
 22 Government Code or is physically present in the state, having
 23 entered the state with an employment commitment or to obtain
 24 employment, whether or not employed at the time of application
 25 to Cal-CHIPP or after enrollment in Cal-CHIPP.

26 (2) Is an employee or a dependent of an employee of an
 27 employer who elected to pay into the California Health Trust Fund
 28 in lieu of making health expenditures pursuant to Section 4802.1
 29 of the Unemployment Insurance Code. *To the extent an employer*
 30 *elects to pay into the California Health Trust Fund only for either*
 31 *the employer's part-time or full-time employees, only employees*
 32 *and dependents in the category of employees for which the*
 33 *employer has elected to pay shall be eligible to enroll in*
 34 *Cal-CHIPP.*

35 (b) Notwithstanding paragraph (2) of subdivision (a), eligible
 36 employees and, if applicable, dependents of eligible employees,
 37 eligible for coverage through a ~~Medi-Cal or Healthy Families~~
 38 ~~benchmark plan or policy~~ *Cal-CHIPP Medi-Cal plan or*
 39 *Cal-CHIPP Healthy Families plan* pursuant to paragraph (2) of
 40 subdivision (b) and paragraph (2) of subdivision (c) of Section

1 1357.24 of the Health and Safety Code or paragraph (2) of
2 subdivision (b) and paragraph (2) of subdivision (c) of Section
3 10764 are eligible for Cal-CHIPP. These employees and, if
4 applicable, their dependents shall be limited to the choice of a
5 ~~benchmark plan or policy under Cal-CHIPP~~ *Cal-CHIPP Medi-Cal*
6 *plan or a Cal-CHIPP Healthy Families plan* and shall not have
7 access to other benefit plan options available to Cal-CHIPP
8 enrollees pursuant to Section 12699.203.

9 12699.211.01. (a) The failure of an employer to continue to
10 pay the fee required by Section 4802.1 of the Unemployment
11 Insurance Code shall not make an enrollee employed by that
12 employer and the employee's dependents, if any, ineligible for
13 participation in Cal-CHIPP until the last day of the second month
14 following the month in which the employer failed to make the fee
15 payment.

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

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

23 (2) The coverage of the employee and his or her dependents, if
24 any, will terminate on the last day of the second month following
25 the month in which the employer failed to make the fee payment,
26 and the employee and his or her dependents, if any, shall be
27 ineligible for Cal-CHIPP.

28 (3) Their rights and remedies under law.

29 (c) The board may, through regulations adopted pursuant to
30 Chapter 3.5 (commencing with Section 11340) of Part 1 of Division
31 3 of Title 2 of the Government Code, allow an employee and his
32 or her dependents, if any, whose employer failed to pay the fee
33 required by Section 4802.1 of the Unemployment Insurance Code,
34 to continue coverage for up to 36 months from the date of
35 ineligibility described in subdivision (b) if the employee pays the
36 entire cost for the coverage. Subject to the availability of funds,
37 the board may, upon appropriation by the Legislature, use revenue
38 in the penalty account in the fund to subsidize the cost of coverage
39 under this subdivision.

CHAPTER 4. FISCAL

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

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

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

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

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

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

12699.216. The board, subject to federal approval pursuant to Section 14199.10 of the Welfare and Institutions Code, shall pay the nonfederal share of cost from the fund for employees and dependents eligible under that federal approval.

12699.217. This part shall become operative on January 1, 2009.

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

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

1 (b) The board shall develop a standardized health questionnaire
2 to be used by all health plans and insurers that offer and sell
3 individual coverage. The questionnaire shall provide for an
4 objective evaluation of a person's health status by assigning a
5 discrete measure, such as a system of point scoring, to each person.
6 The questionnaire shall be designed to identify the 3 to 5 percent
7 of persons who are the most expensive to treat if covered under
8 an individual health care service plan or an individual health
9 insurance policy, and the board shall obtain from an actuary a
10 certification that the standard health questionnaire meets this
11 requirement. The questionnaire shall be designed to collect only
12 that information necessary to identify if a person is eligible for
13 coverage in the program pursuant to subdivision (a). Consistent
14 with Section 1357.21 of the Health and Safety Code and Section
15 10761, health plans and insurers shall not deny coverage for any
16 individual except for those who qualify for automatic eligibility
17 for the program as determined by the board pursuant to this section.

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

19 ~~SEC. 27. Section 131 of the Unemployment Insurance Code~~
20 ~~is amended to read:~~

21 ~~131. "Contributions" means the money payments to the~~
22 ~~Unemployment Fund, Employment Training Fund, California~~
23 ~~Health Trust Fund, or Unemployment Compensation Disability~~
24 ~~Fund that are required by this code.~~

25 *SEC. 27. Section 131.1 is added to the Unemployment*
26 *Insurance Code, to read:*

27 *131.1. "Contributions" also means the money payments to the*
28 *California Health Trust Fund that are required by Division 1.2*
29 *(commencing with Section 4800).*

30 ~~SEC. 28. Section 144 of the Unemployment Insurance Code~~
31 ~~is amended to read:~~

32 ~~144. "Worker contributions," "contributions by workers,"~~
33 ~~"employee contributions," or "contributions by employees" mean~~
34 ~~contributions to the Disability Fund and or to the California Health~~
35 ~~Trust Fund.~~

36 ~~SEC. 29. Section 1095 of the Unemployment Insurance Code~~
37 ~~is amended to read:~~

38 ~~1095. The director shall permit the use of any information in~~
39 ~~his or her possession to the extent necessary for any of the~~
40 ~~following purposes and may require reimbursement for all direct~~

1 costs incurred in providing any and all information specified in
2 this section, except information specified in subdivisions (a) to
3 (e), inclusive:

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

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

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

9 (d) To furnish an employer or his or her authorized agent with
10 information to enable him or her to fully discharge his or her
11 obligations or safeguard his or her rights under this division or
12 Division 3 (commencing with Section 9000).

13 (e) To enable an employer to receive a reduction in contribution
14 rate.

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

23 (g) To enable county administrators of general relief or
24 assistance, or their representatives, to determine entitlement to
25 locally provided general relief or assistance, where the
26 determination is directly connected with, and limited to, the
27 administration of general relief or assistance.

28 (h) To enable state or local governmental departments or
29 agencies to seek criminal, civil, or administrative remedies in
30 connection with the unlawful application for, or receipt of, relief
31 provided under Division 9 (commencing with Section 10000) of
32 the Welfare and Institutions Code or to enable the collection of
33 expenditures for medical assistance services pursuant to Part 5
34 (commencing with Section 17000) of Division 9 of the Welfare
35 and Institutions Code.

36 (i) To provide any law enforcement agency with the name,
37 address, telephone number, birth date, social security number,
38 physical description, and names and addresses of present and past
39 employers, of any victim, suspect, missing person, potential
40 witness, or person for whom a felony arrest warrant has been

1 issued, when a request for this information is made by any
2 investigator or peace officer as defined by Sections 830.1 and
3 830.2 of the Penal Code, or by any federal law enforcement officer
4 to whom the Attorney General has delegated authority to enforce
5 federal search warrants, as defined under Sections 60.2 and 60.3
6 of Title 28 of the Code of Federal Regulations, as amended, and
7 when the requesting officer has been designated by the head of
8 the law enforcement agency and requests this information in the
9 course of and as a part of an investigation into the commission of
10 a crime when there is a reasonable suspicion that the crime is a
11 felony and that the information would lead to relevant evidence.
12 The information provided pursuant to this subdivision shall be
13 provided to the extent permitted by federal law and regulations,
14 and to the extent the information is available and accessible within
15 the constraints and configurations of existing department records.
16 Any person who receives any information under this subdivision
17 shall make a written report of the information to the law
18 enforcement agency that employs him or her, for filing under the
19 normal procedures of that agency.

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

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

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

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

34 (j) To provide public employee retirement systems in California
35 with information relating to the earnings of any person who has
36 applied for or is receiving a disability income, disability allowance,
37 or disability retirement allowance, from a public employee
38 retirement system. The earnings information shall be released only
39 upon written request from the governing board specifying that the
40 person has applied for or is receiving a disability allowance or

1 disability retirement allowance from its retirement system. The
2 request may be made by the chief executive officer of the system
3 or by an employee of the system so authorized and identified by
4 name and title by the chief executive officer in writing.

5 (k) ~~To enable the Division of Labor Standards Enforcement in
6 the Department of Industrial Relations to seek criminal, civil, or
7 administrative remedies in connection with the failure to pay, or
8 the unlawful payment of, wages pursuant to Chapter 1
9 (commencing with Section 200) of Part 1 of Division 2 of, and
10 Chapter 1 (commencing with Section 1720) of Part 7 of Division
11 2 of, the Labor Code.~~

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

16 (m) ~~To provide federal, state, or local governmental departments
17 or agencies with wage and claim information in its possession that
18 will assist those departments and agencies in the administration
19 of the Victims of Crime Program or in the location of victims of
20 crime who, by state mandate or court order, are entitled to
21 restitution that has been or can be recovered.~~

22 (n) ~~To provide federal, state, or local governmental departments
23 or agencies with information concerning any individuals who are
24 or have been:~~

25 (1) ~~Directed by state mandate or court order to pay restitution,
26 fines, penalties, assessments, or fees as a result of a violation of
27 law.~~

28 (2) ~~Delinquent or in default on guaranteed student loans or who
29 owe repayment of funds received through other financial assistance
30 programs administered by those agencies. The information released
31 by the director for the purposes of this paragraph shall not include
32 unemployment insurance benefit information.~~

33 (o) ~~To provide an authorized governmental agency with any or
34 all relevant information that relates to any specific workers'
35 compensation insurance fraud investigation. The information shall
36 be provided to the extent permitted by federal law and regulations.
37 For the purposes of this subdivision, "authorized governmental
38 agency" means the district attorney of any county, the office of
39 the Attorney General, the Department of Industrial Relations, and
40 the Department of Insurance. An authorized governmental agency~~

1 may disclose this information to the State Bar, the Medical Board
2 of California, or any other licensing board or department whose
3 licensee is the subject of a workers' compensation insurance fraud
4 investigation. This subdivision shall not prevent any authorized
5 governmental agency from reporting to any board or department
6 the suspected misconduct of any licensee of that body.

7 ~~(p) To enable the Director of the Bureau for Private
8 Postsecondary and Vocational Education, or his or her
9 representatives, to access unemployment insurance quarterly wage
10 data on a case-by-case basis to verify information on school
11 administrators, school staff, and students provided by those schools
12 who are being investigated for possible violations of Chapter 7
13 (commencing with Section 94700) of Part 59 of the Education
14 Code.~~

15 ~~(q) To provide employment tax information to the tax officials
16 of Mexico, if a reciprocal agreement exists. For purposes of this
17 subdivision, "reciprocal agreement" means a formal agreement to
18 exchange information between national taxing officials of Mexico
19 and taxing authorities of the State Board of Equalization, the
20 Franchise Tax Board, and the Employment Development
21 Department. Furthermore, the reciprocal agreement shall be limited
22 to the exchange of information that is essential for tax
23 administration purposes only. Taxing authorities of the State of
24 California shall be granted tax information only on California
25 residents. Taxing authorities of Mexico shall be granted tax
26 information only on Mexican nationals.~~

27 ~~(r) To enable city and county planning agencies to develop
28 economic forecasts for planning purposes. The information shall
29 be limited to businesses within the jurisdiction of the city or county
30 whose planning agency is requesting the information, and shall
31 not include information regarding individual employees.~~

32 ~~(s) To provide the State Department of Developmental Services
33 with wage and employer information that will assist in the
34 collection of moneys owed by the recipient, parent, or any other
35 legally liable individual for services and supports provided pursuant
36 to Chapter 9 (commencing with Section 4775) of Division 4.5 of,
37 and Chapter 2 (commencing with Section 7200) and Chapter 3
38 (commencing with Section 7500) of Division 7 of, the Welfare
39 and Institutions Code.~~

1 ~~(t) Nothing in this section shall be construed to authorize or~~
2 ~~permit the use of information obtained in the administration of this~~
3 ~~code by any private collection agency.~~

4 ~~(u) The disclosure of the name and address of an individual or~~
5 ~~business entity that was issued an assessment that included~~
6 ~~penalties under Section 1128 or 1128.1 shall not be in violation~~
7 ~~of Section 1094 if the assessment is final. The disclosure may also~~
8 ~~include any of the following:~~

9 ~~(1) The total amount of the assessment.~~

10 ~~(2) The amount of the penalty imposed under Section 1128 or~~
11 ~~1128.1 that is included in the assessment.~~

12 ~~(3) The facts that resulted in the charging of the penalty under~~
13 ~~Section 1128 or 1128.1.~~

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

17 ~~(w) To provide any peace officer with the Division of~~
18 ~~Investigation in the Department of Consumer Affairs information~~
19 ~~pursuant to subdivision (i) when the requesting peace officer has~~
20 ~~been designated by the Chief of the Division of Investigations and~~
21 ~~requests this information in the course of and in part of an~~
22 ~~investigation into the commission of a crime or other unlawful act~~
23 ~~when there is reasonable suspicion to believe that the crime or act~~
24 ~~may be connected to the information requested and would lead to~~
25 ~~relevant information regarding the crime or unlawful act.~~

26 ~~(x) To provide information obtained in the administration and~~
27 ~~enforcement of the California Health Insurance Purchasing Pool~~
28 ~~Program (Division 1.2 (commencing with Section 4800) to the~~
29 ~~Managed Risk Medical Insurance Board for the purpose of~~
30 ~~administering the California Health Care Reform and Cost Control~~
31 ~~Act.~~

32 *SEC. 28.5. Section 683.5 is added to the Unemployment*
33 *Insurance Code, to read:*

34 *683.5. (a) Commencing January 1, 2010, for the purposes of*
35 *Division 1.2 (commencing with Section 4800), "employer" means*
36 *the employer of record established by each county pursuant to*
37 *Section 12302.25 of the Welfare and Institutions Code.*

38 *(b) Notwithstanding any other provision of law, recipients of*
39 *in-home supportive services under Article 7 (commencing with*
40 *Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare*

1 *and Institutions Code shall not be the employer for the purposes*
2 *of Division 1.2 (commencing with Section 4800).*

3 *SEC. 29. Section 1095.1 is added to the Unemployment*
4 *Insurance Code, to read:*

5 *1095.1. The director shall permit the use of any information*
6 *in his or her possession to the extent necessary to provide*
7 *information obtained in the administration and enforcement of the*
8 *California Health Insurance Purchasing Pool Program (Division*
9 *1.2 (commencing with Section 4800)) to the Managed Risk Medical*
10 *Insurance Board for the purpose of administering the California*
11 *Health Care Reform and Cost Control Act, and may require*
12 *reimbursement for all direct costs incurred in providing any and*
13 *all information specified in this section.*

14 *SEC. 30. Division 1.2 (commencing with Section 4800) is*
15 *added to the Unemployment Insurance Code, to read:*

16
17 **DIVISION 1.2. CALIFORNIA HEALTH INSURANCE**
18 **PURCHASING POOL PROGRAM**

19
20 **CHAPTER 1. ADMINISTRATION AND GENERAL PROVISIONS**

21
22 4800. The Employment Development Department shall
23 administer and enforce this division. The department, in
24 conjunction with other state entities, shall establish a process to
25 resolve complaints regarding the administration of this division,
26 including a toll-free telephone hotline number and an Internet Web
27 site for employers, employees, and their dependents to access
28 information and file complaints.

29 4800.01. The following provisions of this code shall apply to
30 any amount required to be reported and paid under this division:

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

33 (b) Sections 403 to 413, inclusive, Section 1336, and Chapter
34 8 (commencing with Section 1951) of Part 1 of Division 1, relating
35 to appeals and hearing procedures.

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

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

- 1 (e) Article 9 (commencing with Section 1176), except Section
- 2 1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and
- 3 overpayments.
- 4 (f) Article 10 (commencing with Section 1206) of Chapter 4 of
- 5 Part 1 of Division 1, relating to notice.
- 6 (g) Article 11 (commencing with Section 1221) of Chapter 4
- 7 of Part 1 of Division 1, relating to administrative appellate review.
- 8 (h) Article 12 (commencing with Section 1241) of Chapter 4
- 9 of Part 1 of Division 1, relating to judicial review.
- 10 (i) Chapter 7 (commencing with Section 1701) of Part 1 of
- 11 Division 1, relating to collections.
- 12 (j) Chapter 10 (commencing with Section 2101) of Part 1 of
- 13 Division 1, relating to violations.
- 14 4800.02. For the purposes of this division, the following
- 15 definitions apply:
- 16 (a) “Board” means the Managed Risk Medical Insurance Board.
- 17 (b) “California Cooperative Health Insurance Purchasing
- 18 Program” or “Cal-CHIPP” shall have the same meaning as in
- 19 Section 12699.201 of the Insurance Code.
- 20 (c) “Department” means the Employment Development
- 21 Department.
- 22 (d) “Dependent” means any of the following persons:
- 23 (1) The spouse or registered domestic partner of an employee.
- 24 (2) (A) An unmarried child under ~~26~~ 23 years of age who is
- 25 the natural child of the employee or an adopted child or a stepchild
- 26 of the employee, as described in subparagraph (B), and who meets
- 27 either of the following criteria:
- 28 (i) Lives with the employee.
- 29 (ii) Is economically dependent upon the employee.
- 30 (B) (i) A child shall be considered to be adopted from the date
- 31 on which the adoptive child’s birth parents, or other appropriate
- 32 legal authority, sign a written document, including, but not limited
- 33 to, a health facility minor release report, a medical authorization
- 34 form, or a relinquishment form, granting the employee, or the
- 35 spouse of the employee, the right to control health care for the
- 36 adoptive child or, absent this written document, on the date
- 37 evidence exists of the right of the employee, or the spouse of the
- 38 employee, to control the health care of the child placed for
- 39 adoption.

- 1 (ii) A child shall be considered a stepchild upon the employee's
2 marriage to the natural or adopted stepchild's parent.
- 3 (3) An unmarried child ~~26~~ 23 years of age or older who is an
4 adopted child or stepchild, as described in subparagraph (B) of
5 paragraph (2), of the enrollee or a natural child of the enrollee and
6 who at the time of attaining ~~26~~ 23 years of age was incapable of
7 self-support because of a physical or mental disability that existed
8 continuously from a date prior to the child's attainment of ~~26~~ 23
9 years of age.
- 10 (e) "Director" means the Director of Employment Development.
- 11 (f) "Employee" has the same meaning as set forth in Article
12 1.5 (commencing with Section 621).
- 13 ~~(f) "Employer" has the same meaning as set forth in Article 3~~
14 ~~(commencing with Section 675) of Chapter 3 of Part 1 of Division~~
15 ~~4.~~
- 16 (g) "Employer" has the meaning set forth in Section 683.5.
- 17 ~~(g)~~
- 18 (h) (1) "Employer fee" means the payment required of an
19 employer electing to pay an equivalent amount into the fund
20 pursuant to subdivision (a) of Section 4802.1.
- 21 (2) For purposes of Part 1 (commencing with Section 100) of
22 Division 1 and Division 6, "employer fee" also means "employer
23 contributions" or "contributions."
- 24 ~~(h)~~
- 25 (i) "Employing unit" has the same meaning as set forth in
26 Section 135.
- 27 ~~(i)~~
- 28 (j) "Employment" has the same meaning as set forth in Article
29 1 (commencing with Section 601) of Chapter 3 of Part 1 of
30 Division 1. Employment does not include services provided
31 pursuant to Sections 629 to 657, inclusive.
- 32 ~~(j)~~
- 33 (k) "Fund" means the California Health Trust Fund established
34 pursuant to Section 12699.212 of the Insurance Code.
- 35 ~~(k)~~
- 36 (l) (1) "Health expenditures" means any amount paid by an
37 employer subject to this division to, or on behalf of, its employees
38 and their dependents, if applicable, to provide health care or
39 health-related services or to reimburse the costs of those services,
40 including, but not limited to, any of the following:

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

4 (B) Reimbursement by the employer to its employees, and their
5 dependents, if applicable, for incurred health care expenses, if
6 those recipients have no entitlement to that reimbursement under
7 any plan, fund, or program maintained by the employer. As used
8 in this subparagraph, “health care expenses” includes, but is not
9 limited to, an expense for which payment is deductible from
10 personal income under Section 213(d) of the Internal Revenue
11 Code.

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

17 (D) Disease management programs.

18 (E) Pharmacy benefit management programs.

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

22 (G) Contributions made pursuant to Section 302 (c)(5) of the
23 Labor Management Relations Act, under a collective bargaining
24 agreement.

25 (H) Purchasing health care coverage from a health care service
26 plan or a health insurer.

27 (2) “Health expenditures” does not include a payment made
28 directly or indirectly for workers’ compensation, Medicare benefits,
29 or any other health benefit cost or taxes, penalties, or assessment
30 that the employer is required to pay by state or federal law, other
31 than as required by Section 4802.1. “Health expenditures” does
32 not include penalties imposed pursuant to this division.

33 ~~(t)~~

34 (m) “Public program” means publicly funded health care
35 coverage that is defined as creditable coverage in paragraphs (2)
36 to (10), inclusive, of subdivision (g) of Section 1357 of the Health
37 and Safety Code.

38 ~~(m)~~

39 (n) “Wages” means all remuneration, as defined in Section
40 13009.5. Wages paid to an employee that are in excess of the

1 applicable contribution and benefit base, as determined under
2 Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for
3 the calendar year ~~subject to withholding by the Social Security~~
4 ~~Administration~~ shall be excluded for the purposes of Section
5 4802.1.

6 (n)

7 (o) The definitions set forth in Sections 126, 127, 129, 133, and
8 134 shall apply to this division.

9 4800.03. The board shall annually publish information
10 describing health plan choices in Cal-CHIPP for the department
11 to disseminate to all employers making employer fee payments to
12 the fund. The employer shall provide this information to all of its
13 employees.

14 4800.04. The director shall provide to each employer a notice
15 pursuant to Section 1089 and the employer shall post and distribute
16 it in accordance with Section 1089 to inform employees and their
17 dependents of the requirements of this division.

18 4800.05. The department shall provide information obtained
19 in the administration and enforcement of this division to the board
20 for the purpose of administering Cal-CHIPP.

21 4800.06. The department shall adopt rules and regulations to
22 implement the provisions of this division.

23 4800.07. An employer shall file all forms required by this
24 division by electronic means and shall remit all moneys owed
25 pursuant to this division by electronic funds transfer. If an employer
26 demonstrates to the director's satisfaction that undue hardship
27 would be imposed on it by this section, the director may authorize
28 an exemption from this requirement. The director may assess a
29 penalty of twenty-five dollars (\$25) for each remittance that is not
30 filed electronically.

31

32 CHAPTER 2. EMPLOYER ELECTION

33

34 4802.1. (a) (1) Each employer shall elect to take one of the
35 following actions:

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

39 (B) Pay an equivalent amount into the fund.

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

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

6 (B) Pay an equivalent amount into the fund.

7 (3) (A) An employer's cumulative amount of health
8 expenditures for the employer's full-time employees working 120
9 or more hours per month shall be equivalent, at a minimum, to 7.5
10 percent of wages paid by the employer to its full-time employees.
11 In computing this amount, wages paid to an employee that are in
12 excess of the applicable contribution and benefit base, as
13 determined under Section 230 of the Social Security Act (42 U.S.C.
14 Sec. 430), for the calendar year ~~subject to withholding by the Social~~
15 ~~Security Administration~~ shall be excluded.

16 (B) An employer's cumulative amount of health expenditures
17 for the employer's part-time employees working less than 120
18 hours per month shall be equivalent, at a minimum, to 7.5 percent
19 of wages paid by the employer to its part-time employees. In
20 computing this amount, wages paid to an employee that are in
21 excess of the applicable contribution and benefit base, as
22 determined under Section 230 of the Social Security Act (42 U.S.C.
23 Sec. 430), for the calendar year ~~subject to withholding by the Social~~
24 ~~Security Administration~~ shall be excluded.

25 (b) (1) The amount payable to the fund by an employer electing
26 to pay shall be deposited into the fund.

27 (2) The department, in consultation with the board, shall ensure
28 that the employer fees paid pursuant to this section are deposited
29 in the fund and are available to ensure the timely enrollment of
30 eligible employees and their dependents, if any, in Cal-CHIPP.

31 (c) Notwithstanding subparagraphs (A) and (B) of paragraph
32 (3) of subdivision (a), the board may adjust the health expenditure
33 amounts required by those subparagraphs. The adjustments shall
34 be made by the board at a public meeting of the board. On or before
35 October 31 of each year, the board shall prepare a statement, which
36 shall be a public record, setting forth the adjustments for the next
37 calendar year and shall promptly notify the department of those
38 adjustments.

39 4802.2. (a) If an employer is required by a collective
40 bargaining agreement to make health expenditures on behalf of

1 bargaining unit employees pursuant to Section 302 (c)(5) of the
2 Labor Management Relations Act that, in the aggregate, equal or
3 exceed the percentage of wages set forth in paragraph (3) of
4 subdivision (a) of Section 4802.1 for those bargaining unit
5 employees, the employer shall be deemed to have satisfied the
6 requirements of subdivision (a) of Section 4802.1 with respect to
7 those bargaining unit employees.

8 (b) For purposes of the health expenditures requirement in
9 subdivision (a) of Section 4802.1, the department shall not accept
10 any employer fees made to the fund by an employer on behalf of
11 bargaining unit employees represented by a labor organization for
12 purposes of collective bargaining if notified by the labor
13 organization that the expenditures were made without express
14 written mutual agreement of the employer and the applicable labor
15 organization.

16 (c) An employer with employees represented by a labor
17 organization for purposes of collective bargaining shall participate
18 in the elections required by subdivision (a) of Section 4802.1
19 separately for each bargaining unit unless otherwise provided for
20 in the collective bargaining agreement.

21 (d) For all non-bargaining unit employees, the employer shall
22 participate in the elections as set forth in subdivision (a) of Section
23 4802.1.

24 4802.3. (a) An employee of an employer that elects, pursuant
25 to Section 4802.1, to pay an employer fee in lieu of making health
26 expenditures shall be required to enroll in Cal-CHIPP to receive
27 coverage under Cal-CHIPP. *To the extent an employer elects,*
28 *pursuant to Section 4802.1, to pay an employer fee only for either*
29 *the employer's part-time or full-time employees, only employees*
30 *and dependents in the category of employees for which the*
31 *employer has elected to pay shall be required to enroll in*
32 *Cal-CHIPP.*

33 (b) Notwithstanding subdivision (a), an employee is exempt
34 from enrolling in Cal-CHIPP if the employee is able to demonstrate
35 that he or she is covered by individual coverage that is in force on
36 the effective date of this section, a public program, or other group
37 health care coverage. An employee who is exempt under this
38 subdivision from enrolling in Cal-CHIPP may choose to enroll in
39 that program, however.

1 (c) (1) An employee of an employer that elects, pursuant to
2 Section 4802.1, to make health expenditures shall accept the health
3 expenditures made by the employer. However, for any employee
4 with a household income of 300 percent of the federal poverty
5 level or less, if accepting an employer's health expenditures would
6 result in annual health expenditures by that employee in excess of
7 5 percent of his or her household income after taking into account
8 any tax savings the employee is able to realize, that employee shall
9 be exempt from the requirement to accept health expenditures
10 made by his or her employer.

11 (2) An employee that shows evidence of other group health care
12 coverage or is covered by individual coverage that is in force on
13 the effective date of this section shall not be required to accept
14 health expenditures made by his or her employer.

15 4803. (a) Each employer, prior to July 1, 2009, shall make an
16 election pursuant to subdivision (a) of Section 4802.1 for its
17 full-time employees and its part-time employees and notify the
18 department of its election. An employer that fails to make an
19 election by August 1, 2009, shall, within 30 days of that date be
20 deemed to be an employer electing to pay an employer fee into
21 the fund, unless the employer is able to demonstrate to the
22 satisfaction of the department good cause for failure to make the
23 election and that it is making health expenditures as described in
24 Section 4802.1.

25 (b) After January 1, 2010, each employer shall notify the
26 department on or before September 15 of each year of its election
27 pursuant to subdivision (a) of Section 4802.1 for the subsequent
28 calendar year, if different from the current year, on a form and in
29 a format required by the department.

30 (c) A new employer, on and after July 1, 2009, within 30 days
31 of paying total wages of one hundred dollars (\$100) or more, shall
32 make an election pursuant to subdivision (a) of Section 4802.1 for
33 its full-time employees and its part-time employees. For purposes
34 of this subdivision, "new employer" shall have the same meaning
35 as set forth in Section 675. A new employer that fails to make an
36 election shall, within 30 days of the date of paying total wages of
37 one hundred dollars (\$100) or more, be deemed to be an employer
38 electing to pay an employer fee into the fund, unless the new
39 employer is able to demonstrate to the satisfaction of the

1 department good cause for failure to make the election and that it
2 is making health expenditures as described in Section 4802.1.

3 4804. (a) On and after October 1, 2009, an employer electing
4 to pay an employer fee into the fund pursuant to subdivision (a)
5 of Section 4802.1 shall complete all of the following actions:

6 (1) File a monthly return with the department by the 15th day
7 of each month based on wages paid in the prior month. If an
8 employer paid no wages, the employer shall file a no payroll return
9 with the department.

10 (2) File with the department an annual return by January 31 of
11 each year on wages paid that month and in the prior calendar year.

12 (3) Remit the employer fee required by Section 4802.1 to the
13 department by the 15th day of each month based on wages paid
14 in the prior month.

15 (4) Notify all employees annually through a written notice to
16 each employee of the requirement in Section 4802.3 to enroll in
17 Cal-CHIPP and advise employees of the exemption from that
18 requirement under that section.

19 (5) Notify employees annually, through a written notice to each
20 employee, of the right to apply to the board to determine eligibility
21 for a subsidy under Cal-CHIPP.

22 (6) Comply with the requirements of Section 4807.

23 (b) An employer shall use the format developed by the
24 department for making the returns required by paragraphs (1) and
25 (2) of subdivision (a) and the remittance of the employer fee
26 required by paragraph (3) of subdivision (a).

27 4805. An employer that elects to pay an employer fee into the
28 fund pursuant to subdivision (a) of Section 4802.1 shall not change
29 that election for, at minimum, 24 months from the date of its first
30 payment into the fund.

31 4806. (a) On and after October 1, 2009, an employer electing
32 to make health expenditures pursuant to subdivision (a) of Section
33 4802.1 shall complete the following actions:

34 (1) File a quarterly return with the department on April 15, July
35 15, October 15, and January 15 of each year, reporting its wages
36 and health expenditures for the prior quarter.

37 (2) File an annual return with the department by January 31 of
38 each year reporting wages and health expenditures paid in the prior
39 calendar year.

1 (3) Notify all employees annually through a written notice to
2 each employee that employees with a family income at or below
3 300 percent of the federal poverty level are eligible to apply for
4 the Medi-Cal program or the Healthy Families Program, including
5 instructions on the application process for those programs.

6 (4) Comply with the requirements of subdivisions (a) and (b)
7 of Section 4807.

8 (b) An employer shall use the format developed by the
9 department to make the returns required by paragraphs (1) and (2)
10 of subdivision (a).

11 4807. (a) An employer shall notify its employees of its election
12 pursuant to subdivision (a) of Section 4802.1 to make health
13 expenditures or to pay an employer fee into the fund within five
14 business days of making the election and shall notify an employee
15 hired after the date of that notification within five days of the
16 employee's date of hire.

17 (b) The employer shall notify its employees within five business
18 days of the date it makes a change to its election decision.

19 (c) (1) An employer electing pursuant to subdivision (a) of
20 Section 4802.1 to pay an employer fee shall within five business
21 days of making that election notify its employees of the following:

22 (A) The employee's requirement to enroll in Cal-CHIPP
23 pursuant to Section 4802.3 and the exemption from enrollment in
24 that section.

25 (B) The employee's right to apply for a subsidy under
26 Cal-CHIPP.

27 (2) The employer shall provide the notice required by this
28 subdivision to an employee hired after the timeframe described in
29 paragraph (1), within five business days of the employee's date of
30 hire.

31
32 CHAPTER 3. CAFETERIA PLAN
33

34 4809. (a) Unless provided otherwise by state or federal law,
35 each employer in this state during a ~~taxable~~ *calendar* year shall
36 adopt and retain a cafeteria plan, within the meaning of Section
37 125 of the Internal Revenue Code, to allow employees to pay
38 premiums for health care coverage, to the extent those payments
39 are excludable from the gross income of the employee under
40 Section 106 of the Internal Revenue Code.

1 (b) An employer that fails to ~~establish~~ *adopt and retain* a
2 cafeteria plan is subject to a penalty of one hundred dollars (\$100)
3 for each of its employees during the ~~taxable~~ *calendar* year unless
4 the employer establishes, to the department's satisfaction, good
5 cause for the failure to ~~establish~~ *adopt and retain* the plan. An
6 employer who willfully fails to ~~establish~~ *adopt and retain* a
7 cafeteria plan is subject to a penalty of five hundred dollars (\$500)
8 for each of its employees during the ~~taxable~~ *calendar* year.

9
10 CHAPTER 4. ENFORCEMENT

11
12 4811. (a) An employer that without good cause, as determined
13 by the department, fails to complete any of the following actions
14 shall be subject to assessment of a penalty as described in
15 subdivision (b):

16 (1) Notify the department of its election pursuant to Section
17 4803.

18 (2) File returns required by Sections 4804 and 4806.

19 (3) Provide notices to its employees as required by Sections
20 4804, 4806, and 4807.

21 (b) The amount of the penalty for a first violation shall be
22 twenty-five dollars (\$25) for each of the employer's employees at
23 the time of the violation. The amount of the penalty for a second
24 violation shall be fifty dollars (\$50) for each of the employer's
25 employees at the time of the violation. The amount of the penalty
26 for all subsequent violations shall be one hundred dollars (\$100)
27 for each of the employer's employees at the time of the violation.

28 (c) The amount of the penalty described in subdivision (b) shall
29 be increased by 10 percent if the employer without good cause, as
30 determined by the department, fails to complete any of the actions
31 described in subdivision (a) within 60 days of the date it is required
32 to be completed.

33 (d) (1) An employer that, without good cause, as determined
34 by the department, fails to make any payments required of it or of
35 its employees within the time required by this division, shall be
36 assessed a penalty equaling 10 percent of the amount of the
37 payment it failed to make or equaling 10 percent of the unpaid
38 payment amount, if the employer failed to make the payment in
39 its entirety.

1 (2) The amount of the penalty described in paragraph (1) shall
2 be increased by 10 percent if the employer without good cause, as
3 determined by the department, fails to make the payment required
4 by this division within 60 days of the date the employer is required
5 to make the payment.

6 (e) An employer that fails to file the annual return required by
7 Sections 4804 and 4806 within 30 days of the date the employer
8 was notified of its failure to file the return shall, in addition to any
9 other penalties imposed by this code, be assessed an additional
10 penalty of up to one hundred dollars (\$100) for each of its
11 employees at the time the return was due, unless the employer
12 demonstrates, to the department's satisfaction, good cause for its
13 failure to file the return.

14 4812. If the director determines a return made by an employer
15 inaccurately reports the amount of health expenditures or the
16 amount of its employer fee payment required pursuant to Section
17 4802.1, he or she shall assess a penalty. The penalty amount shall
18 be determined by the director based on the facts contained in the
19 return or on his or her estimate of the correct amount of health
20 expenditures or employer fees based on any information in his or
21 her possession or that may come into his or her possession. If any
22 part of the deficiency in the health expenditures or employer fee
23 amount is due to negligence or intentional disregard of this division
24 or the regulations adopted pursuant to it, the penalty shall be
25 increased by an amount equaling 10 percent of the amount of the
26 deficiency in the amount of the health expenditures or employer
27 fees.

28 4813. If the employer's failure to file a return or to make a
29 payment within the time required by this division, and the
30 regulations adopted pursuant to it, is due to fraud or to an intent
31 to evade the provisions of this division, or of the regulations
32 adopted pursuant to it, a penalty equaling 50 percent of the amount
33 of the payment or of the health expenditures the employer was
34 required to make shall be assessed against the employer.

35 4814. (a) An employer that elects to pay the employer fee and
36 fails to withhold premium payment amounts authorized by an
37 employee pursuant to Section 12699.203 of the Insurance Code
38 and Section 4809 of this code is subject to a penalty equaling 200
39 percent of the amount the employer failed to withhold.

1 (b) An employer that fails to remit premium payment amounts
2 it withheld as authorized by an employee is subject to a penalty
3 equaling 200 percent of the amount the employer failed to remit.

4 (c) In addition to the penalties set forth in subdivisions (a) and
5 (b), the employer shall reimburse the employee for any health care
6 expenses incurred by the employee and his or her dependents
7 because of a lapse or cancellation of health care coverage resulting
8 from the employer's failure to withhold or remit the employee's
9 premium payment amounts.

10 4815. (a) An employer electing to make health expenditures
11 pursuant to Section 4802.1 that fails to make expenditures in the
12 amount required by that section shall be subject to a penalty in an
13 amount equaling 10 percent of the balance between the amount
14 required by Section 4802.1 and the amount of the health
15 expenditures made by the employer and shall be subject to a
16 penalty in an amount equaling 20 percent of that balance amount
17 if the amount of health expenditures made by the employer is less
18 than 80 percent of the amount required by Section 4802.1.

19 (b) If the employer fails to pay the penalty assessed pursuant to
20 subdivision (a) within 60 days of its assessment date, an additional
21 penalty shall be assessed against ~~the employer~~ the employer in an
22 amount equaling 10 percent of the penalty assessed under
23 subdivision (a).

24 (c) Notwithstanding subdivisions (a) and (b), an employer that
25 demonstrates good cause, as determined by the department, for its
26 failure to make the health expenditures amount required by Section
27 4802.1 is not subject to a penalty under this section.

28 (d) Penalties shall be assessed under this section pursuant to an
29 annual reconciliation and review process by the department.

30 4816. If the director is not satisfied with the accuracy or the
31 sufficiency of a return filed by an employer or of an employer fee
32 paid by an employer, he or she may assess a civil penalty in the
33 sum of ____ dollars (\$____).

34 4817. It shall be unlawful for an employer to take any of the
35 following actions if a purpose for the action is to avoid the
36 requirements of this division:

37 (a) Designate an employee as a temporary employee.

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

39 (c) Terminate and rehire an employee.

1 4818. It is unlawful for a person to take any of the following
2 actions.

3 (a) Willfully misclassify an employee as an independent
4 contractor which misclassification results in avoiding the
5 requirements of this division.

6 (b) Procure, counsel, advise, or coerce another to willfully make
7 a false statement or representation or to knowingly fail to disclose
8 a material fact in order to avoid the requirements of this division.

9 4819. An employer that takes any of the actions described in
10 Section 4818 shall, in addition to any other fees or penalties
11 imposed pursuant to this code, pay a penalty equaling 50 percent
12 of the amount of all employer fees that would be required by this
13 division if the employer elected to pay the employer fee or a
14 penalty equaling 50 percent of the amount of all health expenditures
15 that would be required by this division if the employer elected to
16 make health care expenditures.

17 4821. (a) The director shall provide to each service recipient,
18 as defined in paragraph (1) of subdivision (b) of Section 1088.8,
19 a notice informing each service provider, as defined in paragraph
20 (2) of subdivision (b) of Section 1088.8, of their rights,
21 responsibilities, and the differences in workplace benefit coverage
22 as an independent contractor, including their right to file for a
23 status determination with the department. This notice shall be given
24 by every service recipient required pursuant to Section 1088.8 to
25 report payments equal to, or in excess of, six hundred dollars
26 (\$600) in any year to a service provider when the first payment is
27 made.

28 (b) In order to ensure the proper implementation of this division,
29 the department shall adopt regulations for accelerating the appeal
30 process for issues relating to misclassification of an employee as
31 an independent contractor pursuant to this division.

32 4822. The penalties and remedies provided pursuant to this
33 division are cumulative and in addition to any other penalties or
34 remedies provided by law.

35
36
37

CHAPTER 5. FISCAL

38 4823. The department shall deposit all employer fees and
39 employee premium payments into the fund. The department shall
40 deposit all fines, penalties, and interest collected pursuant to this

1 division into a penalty account within the fund. Notwithstanding
2 the provisions of Section 12699.212 of the Insurance Code, the
3 revenue in the penalty account shall not be continuously
4 appropriated to the board and shall be available for expenditure
5 only upon appropriation by the Legislature.

6 4824. The department is authorized to obtain a loan from the
7 General Fund for all necessary and reasonable expenses incurred
8 prior to January 1, 2011, related to implementing this division and
9 administering its provisions. The proceeds of the loan are subject
10 to appropriation in the annual Budget Act. The department shall
11 repay principal and interest, using the pooled money investment
12 account rate of interest, to the General Fund no later than January
13 1, 2016.

14
15 CHAPTER 6. OPERATIVE PROVISIONS
16

17 4829. This division shall become operative on January 1, 2009.

18 SEC. 31. Section 14005.23 of the Welfare and Institutions
19 Code is amended to read:

20 14005.23. (a) To the extent federal financial participation is
21 available, the department shall, when determining eligibility for
22 children under Section 1396a(l)(1)(D) of Title 42 of the United
23 States Code, designate a birth date by which all children who have
24 not attained the age of 19 years will meet the age requirement of
25 Section 1396a(l)(1)(D) of Title 42 of the United States Code.

26 (b) Commencing July 1, 2008, to the extent federal financial
27 participation is available, the department shall apply a less
28 restrictive income deduction described in Section 1396a(r) of Title
29 42 of the United States Code when determining eligibility for the
30 children identified in subdivision (a). The amount of this deduction
31 shall be the difference between 133 percent and 100 percent of the
32 federal poverty level applicable to the size of the family.

33 (c) For children enrolled in the Healthy Families Program as of
34 July 1, 2008, the income limit in subdivision (b) shall be applied
35 in determining eligibility at the next annual redetermination for
36 that program, or earlier upon request of the beneficiary. The
37 coverage under this section for a child who is a dependent of an
38 employee of an employer electing to make a payment to the
39 California Health Trust Fund in lieu of making health expenditures
40 pursuant to Section 4802.1 of the Unemployment Insurance Code,

1 shall be provided through a ~~Medi-Cal benchmark~~ *Cal-CHIP*
2 *Medi-Cal* plan under Part 6.45 (commencing with Section
3 12699.201) of Division 2 of the Insurance Code.

4 SEC. 32. Section 14005.30 of the Welfare and Institutions
5 Code is amended to read:

6 14005.30. (a) (1) To the extent that federal financial
7 participation is available, Medi-Cal benefits under this chapter
8 shall be provided to individuals eligible for services under Section
9 1396u-1 of Title 42 of the United States Code, including any
10 options under Section 1396u-1(b)(2)(C) made available to and
11 exercised by the state.

12 (2) The department shall exercise its option under Section
13 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
14 less restrictive income and resource eligibility standards and
15 methodologies to the extent necessary to allow all recipients of
16 benefits under Chapter 2 (commencing with Section 11200) to be
17 eligible for Medi-Cal under paragraph (1).

18 (3) To the extent federal financial participation is available, the
19 department shall exercise its option under Section 1396u-1(b)(2)(C)
20 of Title 42 of the United States Code authorizing the state to
21 disregard all changes in income or assets of a beneficiary until the
22 next annual redetermination under Section 14012. The department
23 shall implement this paragraph only if, and to the extent that the
24 State Child Health Insurance Program waiver described in Section
25 12693.755 of the Insurance Code extending Healthy Families
26 Program eligibility to parents and certain other adults is approved
27 and implemented.

28 (b) To the extent that federal financial participation is available,
29 the department shall exercise its option under Section
30 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
31 to simplify eligibility for Medi-Cal under subdivision (a) by
32 exempting all resources for applicants and recipients.

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

1 than, and is substituted for, the earned income disregard available
2 to recipients.

3 (d) Commencing July 1, 2008, the department shall adopt an
4 income disregard for applicants equal to the difference between
5 the income standard under the program adopted pursuant to Section
6 1931(b) of the federal Social Security Act (42 U.S.C. Sec.
7 1396u-1(b)) and the amount equal to 133 percent of the federal
8 poverty level applicable to the size of the family. A recipient shall
9 be entitled to the same disregard, but only to the extent it is more
10 generous than, and is substituted for, the earned income disregard
11 available to recipients. Implementation of this subdivision is
12 contingent upon federal financial participation. Upon
13 implementation of this subdivision, the income disregard described
14 in subdivision (c) shall no longer apply.

15 (e) For purposes of calculating income under this section during
16 any calendar year, increases in social security benefit payments
17 under Title II of the federal Social Security Act (42 U.S.C. Sec.
18 401 and following) arising from cost-of-living adjustments shall
19 be disregarded commencing in the month that these social security
20 benefit payments are increased by the cost-of-living adjustment
21 through the month before the month in which a change in the
22 federal poverty level requires the department to modify the income
23 disregard pursuant to subdivision (c) and in which new income
24 limits for the program established by this section are adopted by
25 the department.

26 (f) Notwithstanding Chapter 3.5 (commencing with Section
27 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
28 the department shall implement, without taking regulatory action,
29 subdivisions (a) and (b) of this section by means of an all county
30 letter or similar instruction. Thereafter, the department shall adopt
31 regulations in accordance with the requirements of Chapter 3.5
32 (commencing with Section 11340) of Part 1 of Division 3 of Title
33 2 of the Government Code. Beginning six months after the effective
34 date of this section, the department shall provide a status report to
35 the Legislature on a semiannual basis until regulations have been
36 adopted.

37 SEC. 33. Section 14005.31 of the Welfare and Institutions
38 Code is amended to read:

39 14005.31. (a) (1) Subject to paragraph (2), for any person
40 whose eligibility for benefits under Section 14005.30 has been

1 determined with a concurrent determination of eligibility for cash
2 aid under Chapter 2 (commencing with Section 11200), loss of
3 eligibility or termination of cash aid under Chapter 2 (commencing
4 with Section 11200) shall not result in a loss of eligibility or
5 termination of benefits under Section 14005.30 absent the existence
6 of a factor that would result in loss of eligibility for benefits under
7 Section 14005.30 for a person whose eligibility under Section
8 14005.30 was determined without a concurrent determination of
9 eligibility for benefits under Chapter 2 (commencing with Section
10 11200).

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

17 (b) The department, in consultation with the counties and
18 representatives of consumers, managed care plans, and Medi-Cal
19 providers, shall prepare a simple, clear, consumer-friendly notice
20 to be used by the counties, to inform Medi-Cal beneficiaries whose
21 eligibility for cash aid under Chapter 2 (commencing with Section
22 11200) has ended, but whose eligibility for benefits under Section
23 14005.30 continues pursuant to subdivision (a), that their benefits
24 will continue. To the extent feasible, the notice shall be sent out
25 at the same time as the notice of discontinuation of cash aid, and
26 shall include all of the following:

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

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

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

1 if changes have occurred that should be reported to the Medi-Cal
2 eligibility worker.

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

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

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

11 (c) This section shall be implemented on or before July 1, 2001,
12 but only to the extent that federal financial participation under
13 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.
14 1396 and following) is available.

15 (d) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department shall, without taking any regulatory action,
18 implement this section by means of all county letters or similar
19 instructions. Thereafter, the department shall adopt regulations in
20 accordance with the requirements of Chapter 3.5 (commencing
21 with Section 11340) of Part 1 of Division 3 of Title 2 of the
22 Government Code. Comprehensive implementing instructions
23 shall be issued to the counties no later than March 1, 2001.

24 SEC. 34. Section 14005.32 of the Welfare and Institutions
25 Code is amended to read:

26 14005.32. (a) (1) If the county has evidence clearly
27 demonstrating that a beneficiary is not eligible for benefits under
28 this chapter pursuant to Section 14005.30, but is eligible for
29 benefits under this chapter pursuant to other provisions of law, the
30 county shall transfer the individual to the corresponding Medi-Cal
31 program. Eligibility under Section 14005.30 shall continue until
32 the transfer is complete.

33 (2) The department, in consultation with the counties and
34 representatives of consumers, managed care plans, and Medi-Cal
35 providers, shall prepare a simple, clear, consumer-friendly notice
36 to be used by the counties, to inform beneficiaries that their
37 Medi-Cal benefits have been transferred pursuant to paragraph (1)
38 and to inform them about the program to which they have been
39 transferred. To the extent feasible, the notice shall be issued with

1 the notice of discontinuance from cash aid, and shall include all
2 of the following:

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

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

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

11 (D) A statement that the Medi-Cal beneficiary does not need to
12 fill out monthly status reports in order to remain eligible for
13 Medi-Cal, but shall be required to submit a semiannual status report
14 and annual reaffirmation forms, except that the semiannual status
15 report shall no longer be required on and after July 1, 2008. In
16 addition, if the person or persons to whom the notice is directed
17 has been found eligible for transitional Medi-Cal as described in
18 Section 14005.8, 14005.81, or 14005.85, the statement shall explain
19 the reporting requirements and duration of benefits under those
20 programs, and shall further explain that, at the end of the duration
21 of these benefits, a redetermination, as provided for in Section
22 14005.37 shall be conducted to determine whether benefits are
23 available under any other provision of law.

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

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

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

32 (b) No later than September 1, 2001, the department shall submit
33 a federal waiver application seeking authority to eliminate the
34 reporting requirements imposed by transitional medicaid under
35 Section 1925 of the federal Social Security Act (Title 42 U.S.C.
36 Sec. 1396r-6).

37 (c) This section shall be implemented on or before July 1, 2001,
38 but only to the extent that federal financial participation under
39 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.
40 1396 and following) is available.

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

10 SEC. 35. Section ~~14005.33~~ *14005.301* is added to the Welfare
11 and Institutions Code, to read:

12 ~~14005.33.~~

13 *14005.301.* (a) Notwithstanding Section 14005.30, to the extent
14 that federal financial participation is available, Medi-Cal benefits
15 under a ~~Healthy Families benchmark~~ *Cal-CHIPP Healthy Families*
16 plan as permitted under Section 6044 of the federal Deficit
17 Reduction Act of 2005 (42 U.S.C. Sec. 1396u-7) shall be provided
18 to a population composed of parents and other caretaker relatives
19 with a household income at or below 300 percent of the federal
20 poverty level who are not otherwise eligible for full scope benefits
21 with no share of cost.

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

26 *(b) The Cal-CHIPP Healthy Families plan referenced in*
27 *subdivision (a) shall be health plan coverage provided through a*
28 *health care service plan or a health insurer that meets the*
29 *requirements of federal law and that provides the same covered*
30 *services and benefits required under the Knox-Keene Health Care*
31 *Service Plan Act of 1975 (Chapter 2.2 (commencing with Section*
32 *1340) of Division 2 of the Health and Safety Code) plus*
33 *prescription drugs.*

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

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

39 (e) The department shall implement this section by means of a
40 state plan amendment. If this section cannot be implemented by a

1 state plan amendment, the department shall seek a waiver or a
2 waiver and a state plan amendment necessary to accomplish the
3 intent of this section.

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

5 SEC. 36. Section 14005.331 is added to the Welfare and
6 Institutions Code, to read:

7 ~~14005.331. (a) Notwithstanding any other provision of law,
8 all individuals under 19 years of age with a countable family
9 income at or below 133 percent of the federal poverty level who
10 would be eligible for full-scope benefits under the Medi-Cal
11 program without a share of cost if not for their immigration status,
12 shall be eligible for full-scope benefits under the Medi-Cal program
13 if the individual meets the state residency requirements of the
14 Medi-Cal program.~~

15 ~~(b) Notwithstanding any other provision of law, all infants under
16 1 year of age with a countable family income at or below 200
17 percent of the federal poverty level who would be eligible for
18 full-scope benefits under the Medi-Cal program if not for their
19 immigration status, shall be eligible for full-scope benefits under
20 the Medi-Cal program if the infant meets the state residency
21 requirements of the Medi-Cal program.~~

22 *14005.331. (a) All children under 19 years of age who meet
23 the state residency requirements of the Medi-Cal program or the
24 Healthy Families Program shall be eligible for health care
25 coverage in accordance with subdivision (b) if they either (1) live
26 in families with countable household income at or below 300
27 percent of the federal poverty level, or (2) meet the income and
28 resource requirements of Section 14005.7 of the Welfare and
29 Institutions Code or the income requirements of Section 14005.30
30 of the Welfare and Institutions Code. The children described in
31 this section include all children for whom federal financial
32 participation under Title XIX of the federal Social Security Act
33 (42 U.S.C. Sec. 1396 et seq.) or Title XXI of the federal Social
34 Security Act (42 U.S.C. Sec. 1397 et seq.) is not available due to
35 their immigration status or date of entry into the United States,
36 but does not include children who are ineligible for Title XIX and
37 Title XXI funds based on other grounds. Nothing in this section
38 shall be construed to limit a child's right to Medi-Cal eligibility
39 under existing law.*

1 (b) Children described in subdivision (a) in families whose
2 household income would render them ineligible for no-cost
3 Medi-Cal, and who are in compliance with Sections 12693.71 and
4 12693.72 of the Insurance Code, shall be eligible for the Healthy
5 Families Program and shall also be eligible for Medi-Cal with a
6 share of cost in accordance with Section 14005.7 of the Welfare
7 and Institutions Code. Other children described in this section
8 shall be eligible for Medi-Cal with no share of cost.

9 (c) The coverage under this section for a child who is an
10 employee or, if applicable, a dependent of an employee of an
11 employer electing to make a payment to the California Health
12 Trust Fund in lieu of making health expenditures pursuant to
13 Section 4802.1 of the Unemployment Insurance Code, shall be
14 provided through a ~~Medi-Cal benchmark~~ *Cal-CHIPP Medi-Cal*
15 plan under Part 6.45 (commencing with Section 12699.201) of
16 Division 2 of the Insurance Code.

17 SEC. 37. Section 14005.82 is added to the Welfare and
18 Institutions Code, to read:

19 14005.82. (a) The department shall exercise its options under
20 Section 1906 of Title 19 of the federal Social Security Act (42
21 U.S.C. Sec. 1396e) to require, as a condition of an individual
22 becoming or remaining eligible for the Medi-Cal program, that
23 the individual, or if a child, the child's parent, offered the option
24 of enrolling in a ~~Medi-Cal benchmark~~ *Cal-CHIPP Medi-Cal* plan
25 pursuant to Section 1357.24 of the Health and Safety Code or
26 Section 10764 of the Insurance Code enroll in that ~~benchmark~~
27 *Cal-CHIPP Medi-Cal* plan. If the individual is eligible for the
28 Medi-Cal program under Section ~~14005.33~~ *14005.301* and the
29 individual is offered the option of enrolling in a ~~Healthy Families~~
30 ~~benchmark~~ *Cal-CHIPP Healthy Families* plan pursuant to Section
31 1357.24 of the Health and Safety Code or Section 10764 of the
32 Insurance Code, the individual shall, as a condition of the
33 individual becoming or remaining eligible for the Medi-Cal
34 program, enroll in the ~~Healthy Families Program benchmark~~
35 *Cal-CHIPP Healthy Families* plan.

36 (b) The requirement that an individual enroll in a ~~benchmark~~
37 *Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy Families*
38 plan, as described in subdivision (a), shall apply to an individual
39 enrolled in the Medi-Cal program or in the Healthy Families
40 Program at the individual's next annual redetermination of

1 eligibility for the Medi-Cal program or the Healthy Families
2 Program, or before that time if requested by the beneficiary or
3 subscriber.

4 SEC. 38. Section 14008.85 of the Welfare and Institutions
5 Code is amended to read:

6 14008.85. (a) To the extent federal financial participation is
7 available, a parent who is the principal wage earner shall be
8 considered an unemployed parent for purposes of establishing
9 eligibility based upon deprivation of a child where any of the
10 following applies:

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

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

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

24 (b) The department shall seek any federal approval required to
25 waive or to increase the income limit in paragraph (2) of
26 subdivision (a) to the extent necessary to implement Sections
27 14005.30 and ~~14005.33~~ 14005.301.

28 (c) Notwithstanding Chapter 3.5 (commencing with Section
29 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
30 the department shall implement this section by means of an all
31 county letter or similar instruction without taking regulatory action.
32 Thereafter, the department shall adopt regulations in accordance
33 with the requirements of Chapter 3.5 (commencing with Section
34 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

35 SEC. 39. Section 14011.16 of the Welfare and Institutions
36 Code is amended to read:

37 14011.16. (a) Commencing August 1, 2003, the department
38 shall implement a requirement for beneficiaries to file semiannual
39 status reports as part of the department's procedures to ensure that
40 beneficiaries make timely and accurate reports of any change in

1 circumstance that may affect their eligibility. The department shall
2 develop a simplified form to be used for this purpose. The
3 department shall explore the feasibility of using a form that allows
4 a beneficiary who has not had any changes to so indicate by
5 checking a box and signing and returning the form.

6 (b) Beneficiaries who have been granted continuous eligibility
7 under Section 14005.25 shall not be required to submit semiannual
8 status reports. To the extent federal financial participation is
9 available, all children under 19 years of age shall be exempt from
10 the requirement to submit semiannual status reports.

11 (c) Beneficiaries whose eligibility is based on a determination
12 of disability or on their status as aged or blind shall be exempt
13 from the semiannual status report requirement described in
14 subdivision (a). The department may exempt other groups from
15 the semiannual status report requirement as necessary for simplicity
16 of administration.

17 (d) When a beneficiary has completed, signed, and filed a
18 semiannual status report that indicated a change in circumstance,
19 eligibility shall be redetermined.

20 (e) Notwithstanding Chapter 3.5 (commencing with Section
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
22 the department shall implement this section by means of all county
23 letters or similar instructions without taking regulatory action.
24 Thereafter, the department shall adopt regulations in accordance
25 with the requirements of Chapter 3.5 (commencing with Section
26 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

27 (f) This section shall be implemented only if and to the extent
28 federal financial participation is available.

29 (g) This section shall become inoperative on July 1, 2008, and,
30 as of January 1, 2009, is repealed, unless a later enacted statute
31 that is enacted before January 1, 2009, deletes or extends the dates
32 on which it becomes inoperative and is repealed.

33 SEC. 40. Section 14131.01 is added to the Welfare and
34 Institutions Code, to read:

35 14131.01. ~~The~~ *On and after January 1, 2010, the coverage*
36 *under this chapter to a person who is an employee or, if applicable,*
37 *a dependent of an employee, of an employer electing to make a*
38 *payment to the California Health Trust Fund in lieu of making*
39 *health expenditures pursuant to Section 4802.1 of the*
40 *Unemployment Insurance Code, shall be provided through a*

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

3 SEC. 41. Article 7 (commencing with Section 14199.10) is
4 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
5 Institutions Code, to read:

6
7 Article 7. Coordination with the California Health Trust Fund
8

9 14199.10. The department shall seek any necessary federal
10 approval to enable the state to receive federal funds for coverage
11 provided through the California Cooperative Health Insurance
12 Purchasing Program (Cal-CHIPP) to persons who would be eligible
13 for the Medi-Cal program if the state expanded eligibility to a
14 population composed of parents and other caretaker relatives with
15 a household income at or below 300 percent of the federal poverty
16 level who are not otherwise eligible for full scope benefits with
17 no share of cost. Revenues in the California Health Trust Fund
18 created pursuant to Section 12699.212 of the Insurance Code shall
19 be used as state matching funds for receipt of federal funds
20 resulting from the implementation of this section. All federal funds
21 received pursuant to that federal approval shall be deposited in the
22 California Health Trust Fund.

23 ~~SEC. 42. Section 6254 of the Government Code is amended~~
24 ~~to read:~~

25 ~~6254. Except as provided in Sections 6254.7 and 6254.13,~~
26 ~~nothing in this chapter shall be construed to require disclosure of~~
27 ~~records that are any of the following:~~

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

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

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

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

39 (1) ~~Applications filed with any state agency responsible for the~~
40 ~~regulation or supervision of the issuance of securities or of financial~~

1 institutions, including, but not limited to, banks, savings and loan
2 associations, industrial loan companies, credit unions, and
3 insurance companies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 ~~(s) A final accreditation report of the Joint Commission on~~
38 ~~Accreditation of Hospitals that has been transmitted to the State~~
39 ~~Department of Public Health pursuant to subdivision (b) of Section~~
40 ~~1282 of the Health and Safety Code.~~

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

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

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

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

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

36 ~~(2) (A) Except for the portion of a contract that contains the~~
 37 ~~rates of payment, contracts for health coverage entered into~~
 38 ~~pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5~~
 39 ~~(commencing with Section 12700) of Division 2 of the Insurance~~

1 Code, on or after July 1, 1991, shall be open to inspection one year
2 after they have been fully executed.

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

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

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

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

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

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

38 (x) Financial data contained in applications for registration, or
39 registration renewal, as a service contractor filed with the Director
40 of Consumer Affairs pursuant to Chapter 20 (commencing with

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 *SEC. 42. Section 6254.28 is added to the Government Code,*
24 *to read:*

25 *6254.28. (a) Nothing in this chapter or any other provision of*
26 *law shall require the disclosure of records of the Managed Risk*
27 *Medical Insurance Board relating to activities governed by Part*
28 *6.45 (commencing with Section 12699.201) of Division 2 of the*
29 *Insurance Code, and that reveal the deliberative processes,*
30 *discussions, communications, or any other portion of the*
31 *negotiations with entities contracting or seeking to contract with*
32 *the board, or the impressions, opinions, recommendations, meeting*
33 *minutes, research, work product, theories, or strategy of the board*
34 *or its staff, or records that provide instructions, advice, or training*
35 *to employees.*

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

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

5 (c) *Three years after a contract or amendment is open to*
6 *inspection pursuant to this section, the portion of the contract or*
7 *amendment containing the rates of payment shall be open to*
8 *inspection.*

9 (d) *Notwithstanding any other provision of law, the entire*
10 *contract or amendments to a contract shall be open to inspection*
11 *by the Joint Legislative Audit Committee and the Legislative*
12 *Analyst's Office. The committee and the office shall maintain the*
13 *confidentiality of the contracts and amendments thereto until the*
14 *contract or amendments to a contract are open to inspection*
15 *pursuant to subdivision (b) or (c).*

16 SEC. 43. Section 11126 of the Government Code is amended
17 to read:

18 11126. (a) (1) Nothing in this article shall be construed to
19 prevent a state body from holding closed sessions during a regular
20 or special meeting to consider the appointment, employment,
21 evaluation of performance, or dismissal of a public employee or
22 to hear complaints or charges brought against that employee by
23 another person or employee unless the employee requests a public
24 hearing.

25 (2) As a condition to holding a closed session on the complaints
26 or charges to consider disciplinary action or to consider dismissal,
27 the employee shall be given written notice of his or her right to
28 have a public hearing, rather than a closed session, and that notice
29 shall be delivered to the employee personally or by mail at least
30 24 hours before the time for holding a regular or special meeting.
31 If notice is not given, any disciplinary or other action taken against
32 any employee at the closed session shall be null and void.

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

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

38 (b) For the purposes of this section, "employee" does not include
39 any person who is elected to, or appointed to a public office by,
40 any state body. However, officers of the California State University

1 who receive compensation for their services, other than per diem
2 and ordinary and necessary expenses, shall, when engaged in that
3 capacity, be considered employees. Furthermore, for purposes of
4 this section, the term employee includes a person exempt from
5 civil service pursuant to subdivision (e) of Section 4 of Article VII
6 of the California Constitution.

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

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

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

25 (3) Prohibit a state body from holding a closed session to
26 deliberate on a decision to be reached in a proceeding required to
27 be conducted pursuant to Chapter 5 (commencing with Section
28 11500) or similar provisions of law.

29 (4) Grant a right to enter any correctional institution or the
30 grounds of a correctional institution where that right is not
31 otherwise granted by law, nor shall anything in this article be
32 construed to prevent a state body from holding a closed session
33 when considering and acting upon the determination of a term,
34 parole, or release of any individual or other disposition of an
35 individual case, or if public disclosure of the subjects under
36 discussion or consideration is expressly prohibited by statute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (17) Prevent a state body, or boards, commissions,
35 administrative officers, or other representatives that may properly
36 be designated by law or by a state body, from holding closed
37 sessions with its representatives in discharging its responsibilities
38 under Chapter 10 (commencing with Section 3500), Chapter 10.3
39 (commencing with Section 3512), Chapter 10.5 (commencing with
40 Section 3525), or Chapter 10.7 (commencing ~~of~~ *with* Section 3540)

1 of Division 4 of Title 1 as the sessions relate to salaries, salary
2 schedules, or compensation paid in the form of fringe benefits.
3 For the purposes enumerated in the preceding sentence, a state
4 body may also meet with a state conciliator who has intervened
5 in the proceedings.

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

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

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

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

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

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

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

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

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

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

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

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

28 (ii) The legal counsel of the state body shall prepare and submit
29 to it a memorandum stating the specific reasons and legal authority
30 for the closed session. If the closed session is pursuant to paragraph
31 (1), the memorandum shall include the title of the litigation. If the
32 closed session is pursuant to subparagraph (A) or (B), the
33 memorandum shall include the existing facts and circumstances
34 on which it is based. The legal counsel shall submit the
35 memorandum to the state body prior to the closed session, if
36 feasible, and in any case no later than one week after the closed
37 session. The memorandum shall be exempt from disclosure
38 pursuant to Section 6254.25.

39 (iii) For purposes of this subdivision, “litigation” includes any
40 adjudicatory proceeding, including eminent domain, before a court,

1 administrative body exercising its adjudicatory authority, hearing
2 officer, or arbitrator.

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

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

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

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

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

31 (4) Prevent a state body, as defined in subdivision (b) of Section
32 11121, from conducting a closed session to consider any matter
33 that properly could be considered in closed session by the state
34 body whose authority it exercises.

35 (5) Prevent a state body, as defined in subdivision (d) of Section
36 11121, from conducting a closed session to consider any matter
37 that properly could be considered in a closed session by the body
38 defined as a state body pursuant to subdivision (a) or (b) of Section
39 11121.

1 (6) Prevent a state body, as defined in subdivision (c) of Section
2 11121, from conducting a closed session to consider any matter
3 that properly could be considered in a closed session by the state
4 body it advises.

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

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

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

12 (8) Require the State Board of Equalization to disclose any
13 action taken in closed session or documents executed in connection
14 with that action, the public disclosure of which is prohibited by
15 law pursuant to Sections 15619 and 15641 of this code and Sections
16 833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651,
17 45982, 46751, 50159, 55381, and 60609 of the Revenue and
18 Taxation Code.

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

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

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

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

36 (h) This article does not prevent the Board of Administration
37 of the Public Employees' Retirement System from holding closed
38 sessions when considering matters relating to the development of
39 rates and competitive strategy for plans offered pursuant to Chapter

1 15 (commencing with Section 21660) of Part 3 of Division 5 of
2 Title 2.

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

9 SEC. 44. The State Department of Health Care Services, in
10 consultation with the Managed Risk Medical Insurance Board,
11 shall take all reasonable steps that are required to obtain the
12 maximum amount of federal funds and to support federal claiming
13 procedures in the administration of this act.

14 SEC. 45. Notwithstanding Chapter 3.5 (commencing with
15 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
16 Code, during the period January 1, 2008, to December 31, 2011,
17 inclusive, the State Department of Health Care Services may
18 implement this act by means of all county letters or similar
19 instructions without taking regulatory action. ~~Prior to~~ *After*
20 December 31, 2011, the department shall adopt all necessary
21 regulations in accordance with the requirements of Chapter 3.5
22 (commencing with Section 11340) of Part 1 of Division 3 of Title
23 2 of the Government Code.

24 SEC. 46. The Legislature finds and declares that Section 42 of
25 this act, which ~~amends Section 6254 of~~ *adds Section 6254.28 to*
26 the Government Code, and Section 43, which amends Section
27 11126 of the Government Code, impose a limitation on the public's
28 right of access to the meetings of public bodies or the writings of
29 public officials and agencies within the meaning of Section 3 of
30 Article I of the California Constitution. Pursuant to that
31 constitutional provision, the Legislature makes the following
32 findings to demonstrate the interest protected by this limitation
33 and the need for protecting that interest:

34 In order to maximize the ability of the Managed Risk Medical
35 Insurance Board to implement agreements with health plans and
36 to provide a wide choice of plans at minimal cost under the
37 California Cooperative Health Insurance Purchasing Program
38 created pursuant to Part 6.45 (commencing with Section
39 12699.201) of Division 2 of the Insurance Code, it is necessary

1 and appropriate to provide limited confidentiality to certain writings
2 developed in that regard and meetings related thereto.

3 SEC. 47. Notwithstanding any other provision of law, the
4 Managed Risk Medical Insurance Board may implement the
5 provisions of this act expanding the Healthy Families Program
6 only to the extent that funds are appropriated for those purposes
7 in the annual Budget Act or in another statute.

8 SEC. 48. During the period from January 1, 2008 to December
9 31, 2011, inclusive, the adoption of regulations pursuant to this
10 act by the Managed Risk Medical Insurance Board shall be deemed
11 to be an emergency and necessary for the immediate preservation
12 of public peace, health, and safety, or the general welfare.

13 SEC. 49. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution for certain
15 costs that may be incurred by a local agency or school district
16 because, in that regard, this act creates a new crime or infraction,
17 eliminates a crime or infraction, or changes the penalty for a crime
18 or infraction, within the meaning of Section 17556 of the
19 Government Code, or changes the definition of a crime within the
20 meaning of Section 6 of Article XIII B of the California
21 Constitution.

22 However, if the Commission on State Mandates determines that
23 this act contains other costs mandated by the state, reimbursement
24 to local agencies and school districts for those costs shall be made
25 pursuant to Part 7 (commencing with Section 17500) of Division
26 4 of Title 2 of the Government Code.