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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, Jones, and Solorio)
(Coauthor: Senator Alquist)

December 4, 2006

An act to amend 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, 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 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 14005.301, 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.

(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. 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 allow employees to decline employer-provided health expenditures or health care coverage under Cal-CHIPP if the employee premium cost exceeds specified amounts.* 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 100 employees. The bill would require health care service plans and health insurers offering group plans on and after January 1, 2010, ~~to offer 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 Program~~ *with respect to employees electing to obtain employer-provided coverage through a Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy Families plan, as specified, to collect premiums from employers and transmit them to the Managed Risk Medical Insurance Board*. 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 andz 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.

(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:

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

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

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

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

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

(d) Engage in early and systematic evaluation at each step of the implementation process to identify the impacts on state costs, the costs of coverage, employment and insurance markets, health

delivery systems, quality of care, and overall progress in moving toward universal coverage.

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

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

(1) The California Health Benefits Service (CHBS) shall be governed by a nine member board appointed by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly. The Governor shall appoint a representative of local initiatives authorized under the Welfare and Institutions Code, a representative of county organized health systems, and a representative of health care purchasers. The Senate Committee on Rules shall appoint a representative of local initiatives authorized under the Welfare and Institutions Code, a representative of county organized health systems, and a representative of health care consumers. The Speaker of the Assembly shall appoint a representative of local initiatives authorized under the Welfare and Institutions Code, a representative of health care providers, and a representative of organized labor. Terms of appointment shall be four years. The members of the board shall elect a board chair from among the nine appointed members.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1357. As used in this article:

(a) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health care plan

contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) "Eligible employee" means either of the following:

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

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

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

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

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

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

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

(d) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program as

a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

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

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

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

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

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

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C),

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

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

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

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

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

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

(e) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

Under 30

30–39

40–49
50–54
55–59
60–64
65 and over

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

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

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

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

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

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

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

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

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

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

purchasing coverage for employees through a guaranteed association.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 3.11. Insurance Market Reform

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

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

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

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

1357.23. Effective July 1, 2008, all requirements in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan's contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health care service plan contracts offered to all employers with 100 or fewer eligible employees, except as follows:

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

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

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

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

~~(b) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a Cal-CHIPP Healthy Families plan established by the board so that group members and their dependents with family incomes at or below 300 percent of the federal poverty level that are determined eligible for coverage through the Healthy Families Program or who are eligible for Medi-Cal pursuant to Section 14005.301 of the Welfare and Institutions Code can enroll in the Cal-CHIPP Healthy Families plan. The Cal-CHIPP Healthy Families plan of a group health care service plan shall be provided at a rate negotiated with and approved by the board. The health care service plan shall collect the employer's applicable dollar premium contribution for employees and, if applicable, dependents in the Cal-CHIPP Healthy Families plan and credit that amount toward the cost of the Cal-CHIPP Healthy Families plan.~~

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

~~(c) (1) Every health care service plan offering group health plan contracts shall provide as one coverage option of each group contract a Cal-CHIPP Medi-Cal plan established by the board so that group members and their dependents that are determined eligible for coverage through the Medi-Cal program, except for coverage pursuant to Section 14005.301 of the Welfare and Institutions Code, can enroll in the Cal-CHIPP Medi-Cal plan. The~~

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

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

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

1357.24. (a) For employees and, if applicable, dependents who are currently enrolled in or determined eligible for coverage through the Healthy Families Program or the Medi-Cal program and who are offered group coverage, the group health care service plan shall collect the employer's applicable dollar premium contribution for those employees and, if applicable, dependents and transmit that amount to the board towards the cost of the applicable Cal-CHIPP plan.

~~(e)~~

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

~~(f) Employees and dependents receiving coverage through the Medi-Cal program or Healthy Families Program pursuant to this section shall make premium payments, if any, as determined by~~

~~the board and shall pay other cost sharing amounts. The amount of the premium payments and cost sharing shall not exceed premium payments or cost sharing levels for enrollment in those programs required under the applicable state laws governing those programs. The board shall consider using the process in effect on January 1, 2008, for determining eligibility for the Medi-Cal program, including the eligibility determination made by the counties.~~

~~(g)~~

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

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

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

(3) "Cal-CHIPP Healthy Families plan" shall have the same meaning as in Section 12699.201 of the Insurance Code.

(4) "Cal-CHIPP Medi-Cal plan" shall mean a plan providing the same amount, duration, scope, and level of coverage provided through the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

~~(h)~~

(d) This section shall apply to health care service plan contracts issued, amended, or renewed on or after January 1, 2010.

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

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

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

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

contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

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

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

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

(3) The full premium cost of the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) Conditions and procedures for disenrollment.

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

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

(17) A notice as required by Section 1364.5.

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

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

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

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

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

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

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

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

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

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

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

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

Article 4.1. California Individual Coverage Guarantee Issue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Upon divorce.

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

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

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

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

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

1366.107. At the time an individual applies for health coverage from a health care service plan or health insurer participating in the individual market, an individual shall provide information as required by a standardized health status questionnaire to assist

plans and insurers in identifying persons in need of disease management. Health care service plans and health insurers may not use information provided on the questionnaire to decline coverage or to limit an individual's choice of health care benefit plan, except as provided in Section 12711.1 of the Insurance Code.

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

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

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

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

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

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

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

1366.113. This article shall not apply to individual health plan contracts for coverage of Medicare services pursuant to contracts with the United States Government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Family contracts with the Managed Risk Medical Insurance Board, high risk pool contracts with the Major Risk Medical Insurance Program,

Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure coverage from Cal-CHIPP.

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

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

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

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

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

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

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

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

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

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

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

Chapter 4. Health Care Cost and Quality Transparency

Article 1. General Provisions

128850. The Legislature hereby finds and declares that:

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

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

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

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

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

(f) Hospitals, physicians, health care providers, and health insurers who have access to systemwide performance data can use the information to improve patient safety, efficiency of health care delivery, and quality of care, leading to quality improvement and costs savings throughout the health care system.

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

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

(i) It is therefore the intent of the Legislature to assume a leadership role in measuring performance and value in the health care system. By establishing statewide data and common measurement and analyses of health care costs, quality, and outcomes, and by establishing a statewide leadership organization with sufficient revenues to adequately analyze and report meaningful performance measures related to health care costs and quality, the Legislature intends to promote competition, identify

appropriate health care utilization, and ensure the highest quality of health care services for all Californians.

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

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

(*l*) It is further the intent of the Legislature that the data collected be used for the transparent public reporting of quality and cost efficiency information regarding all levels of the health care system, including health care service plans and health insurers, hospitals and other health facilities, and medical groups and physicians, so that health care plans and providers can improve their performance and deliver safer, better health care more affordably; so that purchasers can know which health care services reduce morbidity, mortality, and other adverse health outcomes; so that consumers can choose whether and where to have health care provided; and so that the Legislature can effectively regulate and monitor the health care delivery system to ensure quality and value for all purchasers and consumers.

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

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

(b) "Ambulatory surgery center" means a facility where procedures are performed on an outpatient basis in general operating rooms, ambulatory surgery rooms, endoscopy units, or

cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

(c) "Commission" means the California Health Care Cost and Quality Transparency Commission.

(d) "Data source" means any physician, physician group, health facility, health care service plan, health insurer, any state agency providing or paying for health care or collecting health care data or information, or any other payer for health care services in California.

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

(f) "Group" or "physician group" means an affiliation of physicians and other health care professionals, whether a partnership, corporation, or other legal form, with the primary purpose of providing medical care.

(g) "Healthcare-associated infection" means a localized or systemic condition that (1) results from adverse reaction to the presence of an infectious agent or its toxin and (2) was not present or incubating at the time of admission to the hospital.

(h) "Health care provider" means a physician, physician group, or health facility.

(i) "Health facility" or "health facilities" means health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(j) "Office" means the Office of Statewide Health Planning and Development.

(k) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

128852. Notwithstanding the provisions of Chapter 1 (commencing with Section 128675), commencing July 1, 2009, the responsibilities of the office with respect to determining the data to be collected and the analysis and reporting of the data collected pursuant to Chapter 1 (commencing with Section 128675) shall be transferred to the commission, as determined by the commission and as reported to the Secretary of Health and Welfare and the Legislature no later than January 1, 2009. Any limitations on the collection, analysis, and use of data in that chapter shall be inapplicable to the extent determined necessary by the commission

to implement its responsibilities under this chapter. All data collected by the office shall be available to the commission for the purposes of carrying out its responsibilities under this chapter. During the initial development of the data plan pursuant to Section 128675, the office shall make available to the commission any and all data files, information, and staff resources as may be necessary to assist in and support the plan's development.

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

Article 2. Health Care Cost and Quality Transparency Commission

128855. There is hereby created in the Health and Human Services Agency, the California Health Care Cost and Quality Transparency Commission composed of 13 members, each of whom shall have demonstrated knowledge and experience in the measurement and analysis of health care quality or cost data, in deploying that data on behalf of consumers and purchasers, or in health care or other issues relevant to the commission's responsibilities. The appointments shall be made as follows:

(a) The Governor shall appoint seven members as follows:

(1) One academic with experience in health care data and cost efficiency research.

(2) One representative of hospitals.

(3) One representative of an integrated multispecialty medical group.

(4) One representative of physician and surgeons.

(5) One representative of large employers that purchase group health care coverage for employees and that is not also a supplier or broker in health care coverage.

(6) One representative of a labor union.

(7) One representative of employers that purchase group health care coverage for their employees or a representative of a nonprofit organization that demonstrates experience working with employers to enhance value and affordability of health care coverage.

(b) The Senate Committee on Rules shall appoint three members as follows:

(1) One representative of a labor union.

(2) One representative of consumers with a demonstrated record of advocating health care issues on behalf of consumers.

(3) One representative of health insurers or health care service plans.

(c) The Assembly Speaker shall appoint three members as follows:

(1) One representative of consumers with a demonstrated record of advocating health care issues on behalf of consumers.

(2) One representative of small employers that purchase group health care coverage for employees and that is not also a supplier or broker in health care coverage.

(3) One representative of a nonprofit labor-management purchaser coalition that has a demonstrated record of working with employers and employee associations to enhance value and affordability in health care.

(d) The following members shall serve in an ex officio, nonvoting capacity:

(1) The Secretary of Health and Human Services or a designee.

(2) A designee of the California Public Employees' Retirement System.

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

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

(5) The Insurance Commissioner or a designee.

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

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

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

128858. The commission shall appoint an executive director, who shall serve at the pleasure of the commission. The executive director shall receive the salary established by the Department of

Personnel Administration for exempt officials. The executive director shall administer the affairs of the commission as directed by the commission and shall direct the staff of the commission. The executive director may appoint, with the approval of the commission, staff necessary to carry out the functions and duties of the commission.

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

(a) Enter into contracts.

(b) Sue and be sued.

(c) Employ necessary staff.

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

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

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

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

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

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

128860. The commission shall have no authority to disclose any confidential information concerning contracted rates between health care providers and any data source, but nothing in this section shall prevent the commission from publicly disclosing information on the relative or comparative cost to payers or

purchasers of health care or the costs for a specific course of treatment or episode, as applicable for the reporting.

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

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

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

(d) All officers and employees of the office who, on July 1, 2009, are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the commission shall be transferred to the commission. The status, positions, and rights of these persons shall not be affected by the transfer except as to positions exempted from civil service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The members of the technical and clinical advisory committees appointed by the commission shall receive no compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the advisory committee.

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

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

Article 3. Health Care Cost and Quality Transparency Plan

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

(1) Include specific strategies to measure and collect data related to health care safety and quality, utilization, cost to payers, and

health outcomes and shall focus on data elements that foster quality improvement and peer group comparisons.

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

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

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

(5) Use and build on existing data collection standards and methods to the greatest extent possible to accomplish the goals of the commission in a cost-effective manner, which may include, but not be limited to, collecting and disseminating one or more nationally recognized methodologies for measuring and quantifying provider quality, cost and service effectiveness, and implementing systemwide mandatory collection of data elements otherwise being collected in existing voluntary public and private reporting programs in California.

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

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

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

(2) The data elements necessary to produce the reports and data to be made available. The plan shall address the extent to which standardized electronic reporting of administrative claims data can provide the information necessary for the purposes of this chapter,

and the most efficient, least burdensome method of collecting other necessary data, including systemwide encounter data.

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

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

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

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

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

(8) A review of existing public and private health performance data collection and reporting standards and practices, at the state and federal level, and strategies for incorporating or coordinating with existing mandatory and voluntary measurement and reporting activities as the commission determines necessary to accomplish the goal of this chapter in a cost-effective manner. The review of state programs shall include, at a minimum, review of data collection programs administered by the office and the Office of the Patient Advocate.

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

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

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

shall not be delayed pending the development and implementation of the plan.

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

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

Article 4. Fees

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

(b) The commission may seek and accept contributions to support the work of the commission from any foundation or other public or private entity that does not have a financial interest in

the outcome of the work of the commission, as defined in the conflict-of-interest policy adopted pursuant to Section 128864.

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

Article 5. Penalties

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

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

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

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

Chapter 1.6. California Individual Coverage Guarantee Issue

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

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

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

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

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

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

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

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

10199.105. On and after January 1, 2009, health care service plans and health insurers participating in the individual market shall, except as provided in Section 12711.1, guarantee issue the

five classes of approved health benefit plans and shall, at the same time, discontinue offering and selling health benefit plans other than those within the five approved classes of benefit plans in the individual market.

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

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

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

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

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

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

(B) Upon divorce.

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

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

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

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

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

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

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

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

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

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

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

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

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

10199.113. This chapter shall not apply to individual health plan contracts for coverage of Medicare services pursuant to

contracts with the United States Government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Family contracts with the Managed Risk Medical Insurance Board, high-risk pool contracts with the Major Risk Medical Insurance Program, Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure coverage from Cal-CHIPP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10700. As used in this chapter:

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

(b) "Benefit plan design" means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) "Fund" means the California Small Group Reinsurance Fund.

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

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

(*l*) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment

period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (z), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

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

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

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

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

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

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph

(2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for coverage was made within 30 days of the change.

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

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

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

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health

coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(m) "New business" means a health benefit plan issued to a small employer that is not the carrier's in force business.

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

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

(p) "Program" means the Health Insurance Plan of California.

(q) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(r) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

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

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

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

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

(B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties which are included in their entirety in a carrier's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three

digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No carrier shall have less than one geographic area.

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

(1) Any person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar year, employed at least two, but not more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (b) and (h) of Section 10705, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply until the health benefit plan anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

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

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

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

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

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

(z) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that

person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it may also include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include those persons as members of the guaranteed association, the association must so elect in advance of purchasing coverage from a plan. Health plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

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

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

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

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

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

(b) (1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the carrier's standard employee risk rates. The risk adjusted employee risk rates may not be more than 120 percent or less than 80 percent of the carrier's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, the risk adjusted employee risk rate may not be more than 110 percent or less than 90 percent. The factor effective July 1, 1996, shall apply to in force business at the earlier of either the

time of renewal or July 1, 1997. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months. On and after January 1, 2010, no risk adjustment factor shall be applied.

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

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

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

(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of no less than six months, nor more than 12 months, except that a carrier may reserve the right to redetermine the composite rates if the enrollment under the health benefit plan changes by more than a specified percentage during the rating period. Any redetermination of the composite

rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period. If a carrier reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the carrier shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A carrier reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

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

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

Chapter 8.1. Insurance Market Reform

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

10761. The department, in consultation with the Department of Managed Health Care, shall require each health insurer with one million or more insureds in California, based on the insurer's enrollment in the prior year, to submit a good faith bid to the Managed Risk Medical Insurance Board in order to be a participating plan through the California Cooperative Health

Insurance Purchasing Program (Cal-CHIPP) pursuant to Part 6.45 (commencing with Section 12699.201).

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

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

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

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

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

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

~~(b) (1) Every health insurer offering group health insurance policies shall provide as one coverage option of each group policy a Cal-CHIPP Healthy Families plan established by the board so that group members and their dependents with family incomes at~~

~~or below 300 percent of the federal poverty level that are determined eligible for coverage through the Healthy Families Program or who are eligible for Medi-Cal pursuant to Section 14005.301 of the Welfare and Institutions Code can enroll in the Cal-CHIPP Healthy Families plan. The Cal-CHIPP Healthy Families plan of a group health insurer shall be provided at a rate negotiated with and approved by the board. The health insurer shall collect the employer's applicable dollar premium contribution for employees and, if applicable, dependents in the Cal-CHIPP Healthy Families plan and credit that amount toward the cost of the Cal-CHIPP Healthy Families plan.~~

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

~~(c) (1) Every health insurer offering group health policies shall provide as one coverage option of each group contract a Cal-CHIPP Medi-Cal plan established by the board so that group members and their dependents that are determined eligible for coverage through the Medi-Cal program, except for coverage pursuant to Section 14005.301 of the Welfare and Institutions Code, can enroll in the Cal-CHIPP Medi-Cal plan. The Cal-CHIPP Medi-Cal plan of a group health insurer shall be provided at a rate negotiated with and approved by the board. The health insurer shall collect the employer's applicable dollar premium contribution for employees and, if applicable, dependents in the Cal-CHIPP Medi-Cal plan and credit that amount toward the cost of the Cal-CHIPP Medi-Cal plan.~~

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

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

10764. (a) For employees and, if applicable, dependents who are currently enrolled in or determined eligible for coverage through the Healthy Families Program or the Medi-Cal program and who are offered group coverage, the group health insurer shall collect the employer's applicable dollar premium contribution for those employees and, if applicable, dependents and transmit that amount to the board toward the premium cost of the applicable Cal-CHIPP plan.

~~(e)~~

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

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

~~(g)~~

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

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

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

(3) "Cal-CHIPP Healthy Families plan" shall have the same meaning as in Section 12699.201.

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

~~(h)~~

(d) This section shall apply to health insurance policies issued, amended, or renewed on or after January 1, 2010.

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

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

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

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

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

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

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

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

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

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty

level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Except as provided in this section and to the extent permitted by federal law or regulation, all information about applicants, subscribers, and household members to be safeguarded as provided

for in subdivision (a) includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, agency evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.

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

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

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

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

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

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

12693.621. On and after January 1, 2010, the coverage under this part for a child who is a dependent of an employee of an employer electing to make a payment to the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code, shall be provided through a Cal-CHIPP Healthy Families plan under Part 6.45 (commencing with Section 12699.201). The requirement that an individual enroll in a Cal-CHIPP Healthy Families plan shall apply to an individual enrolled in the Healthy Families Program

at the individual's next annual redetermination of eligibility for the Healthy Families Program, or earlier upon request.

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

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

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

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

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

(3) In compliance with Sections 12693.71 and 12693.72.

(4) [Reserved].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The coverage under this section for a person who is an employee or, if applicable, an adult dependent of an employee, of an employer electing to make a payment to the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code, shall be provided through a Cal-CHIPP Healthy Families plan under Part 6.45 (commencing with Section 12699.201).

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

12693.76. (a) Notwithstanding any other provision of law, a child shall not be determined ineligible solely on the basis of his or her date of entry into the United States.

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

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

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

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

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

PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM

Chapter 1. General Provisions

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

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

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

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

(d) "Dependent" shall have the same meaning as in Section 4800.02 of the Unemployment Insurance Code.

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

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

(g) "Cal-CHIPP Healthy Families plan" shall mean health care coverage provided through a health care service plan or a health insurer that provides either of the following:

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

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

(h) "Cal-CHIPP Medi-Cal plan" shall mean health care coverage provided through a health care service plan or health insurer that provides the same amount, duration, scope, and level of coverage provided through the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

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

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

(k) "Participating vision care plan" means either an insurer holding a valid certificate of authority from the commissioner that issues vision-only coverage or a specialized health care service

plan, as defined by subdivision (o) of Section 1345 of the Health and Safety Code, that contracts with the board to provide vision coverage to enrollees.

Chapter 2. Administration

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

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

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

(2) Determine the participation requirements for enrollees.

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

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

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

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

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

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

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

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

(11) Enter into contracts.

(12) Sue and be sued.

(13) Employ necessary staff.

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

(15) Issue rules and regulations, as necessary.

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

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

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

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

12699.203. The board shall develop and offer a variety of benefit plan designs, including low-cost plans for Cal-CHIPP enrollees who are adults with family incomes below 300 percent of the federal poverty level who are ineligible for coverage through the Healthy Families Program or the Medi-Cal program. In addition to these benefit plan designs, each participating health plan and health insurer shall offer a Cal-CHIPP Healthy Families plan and a Cal-CHIPP Medi-Cal plan, and the board shall limit enrollment in these plans only to eligible individuals. For purposes of the Cal-CHIPP Medi-Cal plan, the board shall enter into an agreement with the State Department of Health Care Services for the provision of the Cal-CHIPP Medi-Cal plan by the Medi-Cal program. The benefit plan designs shall include varying benefit levels, deductibles, coinsurance factors, or copayments, and annual limits on out-of-pocket expenses. In developing the benefit plan designs, the board shall comply with all of the following:

(a) The board shall take into consideration the levels of health care coverage provided in the state and medical economic factors as may be deemed appropriate. The board shall include coverage

and design elements that are reflective of and commensurate with health insurance coverage provided through a representative number of large insured employers in the state.

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

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

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

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

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

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

(d) Employees and dependents receiving coverage through the Medi-Cal program or the Healthy Families Program pursuant to this part shall make premium payments, if any, as determined by the board, and pay other cost sharing amounts that do not exceed

premium payments and cost sharing levels for enrollment in those programs required under the applicable state laws governing those programs. The board shall consider using the process in effect on January 1, 2008, for determining eligibility for the Medi-Cal program including the eligibility determination made by the counties.

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

(a) Preventive care.

(b) Care management for chronic diseases.

(c) Promotion of health information technology.

(d) Standardized billing practices.

(e) Reduction of medical errors.

(f) Incentives for healthy lifestyles.

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

(h) Rational use of new technology.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3. Eligibility

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

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

(2) Is an employee or a dependent of an employee of an employer who elected to pay into the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code. To the extent an employer elects to pay into the California Health Trust Fund only for either

the employer's part-time or full-time employees, only employees and dependents in the category of employees for which the employer has elected to pay shall be eligible to enroll in Cal-CHIPP.

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

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

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

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

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

(3) Their rights and remedies under law.

(c) The board may, through regulations adopted pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, allow an employee and his or her dependents, if any, whose employer failed to pay the fee

required by Section 4802.1 of the Unemployment Insurance Code, to continue coverage for up to 36 months from the date of ineligibility described in subdivision (b) if the employee pays the entire cost for the coverage. Subject to the availability of funds, the board may, upon appropriation by the Legislature, use revenue in the penalty account in the fund to subsidize the cost of coverage under this subdivision.

Chapter 4. Fiscal

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. *The board shall provide health coverage pursuant to this part on and after January 1, 2010.*

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.

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

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

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

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

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

144. "Worker contributions," "contributions by workers," "employee contributions," or "contributions by employees" mean contributions to the Disability Fund or to the California Health Trust Fund.

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

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

(b) Notwithstanding any other provision of law, recipients of in-home supportive services under Article 7 (commencing with Section 12300) of Chapter 3 of Part 3 of Division 9 of the Welfare and Institutions Code shall not be the employer for the purposes of Division 1.2 (commencing with Section 4800).

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

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

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

DIVISION 1.2. CALIFORNIA HEALTH INSURANCE PURCHASING POOL PROGRAM

Chapter 1. Administration and General Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) "Department" means the Employment Development Department.

(d) "Dependent" means any of the following persons:

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

(2) (A) An unmarried child under 23 years of age who is the natural child of the employee or an adopted child or a stepchild of the employee, as described in subparagraph (B), and who meets either of the following criteria:

(i) Lives with the employee.

(ii) Is economically dependent upon the employee.

(B) (i) A child shall be considered to be adopted from the date on which the adoptive child's birth parents, or other appropriate legal authority, sign a written document, including, but not limited

to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting the employee, or the spouse of the employee, the right to control health care for the adoptive child or, absent this written document, on the date evidence exists of the right of the employee, or the spouse of the employee, to control the health care of the child placed for adoption.

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

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

(e) "Director" means the Director of Employment Development.

(f) "Employee" has the same meaning as set forth in Article 1.5 (commencing with Section 621).

~~(g) "Employer" has the meaning set forth in Section 683.5.~~

(g) "Employer" has the same meaning as set forth in Article 3 (commencing with Section 675) of Chapter 3 of Part 1 of Division 1.

(h) (1) "Employer fee" means the payment required of an employer electing to pay an equivalent amount into the fund pursuant to subdivision (a) of Section 4802.1.

(2) For purposes of Part 1 (commencing with Section 100) of Division 1 and Division 6, "employer fee" also means "employer contributions" or "contributions."

(i) "Employing unit" has the same meaning as set forth in Section 135.

(j) "Employment" has the same meaning as set forth in Article 1 (commencing with Section 601) of Chapter 3 of Part 1 of Division 1. Employment does not include services provided pursuant to Sections 629 to 657, inclusive.

(k) "Fund" means the California Health Trust Fund established pursuant to Section 12699.212 of the Insurance Code.

(*l*) (1) "Health expenditures" means any amount paid by an employer subject to this division to, or on behalf of, its employees and their dependents, if applicable, to provide health care or

health-related services or to reimburse the costs of those services, including, but not limited to, any of the following:

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

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

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

(D) Disease management programs.

(E) Pharmacy benefit management programs.

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

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

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

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

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

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

applicable contribution and benefit base, as determined under Section 230 of the Social Security Act (42 U.S.C. Sec. 430), for the calendar year shall be excluded for the purposes of Section 4802.1.

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

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

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

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

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

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

Chapter 2. Employer Election

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

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

(B) Pay an equivalent amount into the fund.

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

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

(B) Pay an equivalent amount into the fund.

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

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

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

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

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

4802.2. (a) If an employer is required by a collective bargaining agreement to make health expenditures on behalf of bargaining unit employees pursuant to Section 302 (c)(5) of the Labor Management Relations Act that, in the aggregate, equal or exceed the percentage of wages set forth in paragraph (3) of subdivision (a) of Section 4802.1 for those bargaining unit

employees, the employer shall be deemed to have satisfied the requirements of subdivision (a) of Section 4802.1 with respect to those bargaining unit employees.

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

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

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

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

(b) *(1)* Notwithstanding subdivision (a), an employee is exempt from enrolling in Cal-CHIPP if the employee is able to demonstrate that he or she is covered by individual coverage that is in force on the effective date of this section, a public program, or other group health care coverage. An employee who is exempt under this subdivision from enrolling in Cal-CHIPP may choose to enroll in that program, however.

(2) Notwithstanding subdivision (a), an employee is exempt from enrolling in Cal-CHIPP if the cost of coverage through Cal-CHIPP exceeds 5 percent of wages paid by the electing employer for coverage with a maximum out-of-pocket cost of one thousand five hundred dollars ($1,500).

(c) (1) An employee of an employer that elects, pursuant to Section 4802.1, to make health expenditures shall accept the health expenditures made by the employer. However, for any employee ~~with a household income of~~ *earning wages equivalent to* 300 percent of the federal poverty level or less, if accepting an employer's health expenditures would result in annual health expenditures by that employee in excess of 5 percent of his or her ~~household income after taking into account any tax savings the employee is able to realize~~ *wages paid by the electing employer*, that employee shall be exempt from the requirement to accept health expenditures made by his or her employer. *For an employee earning wages equivalent to more than 300 percent of the federal poverty level, if accepting an employer's health expenditures would result in annual health expenditures by that employee in excess of 5 percent of his or her wages paid by the electing employer, the employee shall be exempt from the requirement to accept health expenditures made by his or her employer.*

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

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

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

(c) A new employer, on and after July 1, 2009, within 30 days of paying total wages of one hundred dollars ($100) or more, shall make an election pursuant to subdivision (a) of Section 4802.1 for its full-time employees and its part-time employees. For purposes

of this subdivision, "new employer" shall have the same meaning as set forth in Section 675. A new employer that fails to make an election shall, within 30 days of the date of paying total wages of one hundred dollars ($100) or more, be deemed to be an employer electing to pay an employer fee into the fund, unless the new employer is able to demonstrate to the satisfaction of the department good cause for failure to make the election and that it is making health expenditures as described in Section 4802.1.

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

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

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

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

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

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

(6) Comply with the requirements of Section 4807.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3. Cafeteria Plan

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

(b) An employer that fails to adopt and retain a cafeteria plan is subject to a penalty of one hundred dollars ($100) for each of its employees during the calendar year unless the employer establishes, to the department's satisfaction, good cause for the failure to adopt and retain the plan. An employer who willfully fails to adopt and retain a cafeteria plan is subject to a penalty of five hundred dollars ($500) for each of its employees during the calendar year.

Chapter 4. Enforcement

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

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

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

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

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

(c) The amount of the penalty described in subdivision (b) shall be increased by 10 percent if the employer without good cause, as determined by the department, fails to complete any of the actions

described in subdivision (a) within 60 days of the date it is required to be completed.

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

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

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

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

4813. If the employer's failure to file a return or to make a payment within the time required by this division, and the regulations adopted pursuant to it, is due to fraud or to an intent to evade the provisions of this division, or of the regulations

adopted pursuant to it, a penalty equaling 50 percent of the amount of the payment or of the health expenditures the employer was required to make shall be assessed against the employer.

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

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

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

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

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

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

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

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

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

(a) Designate an employee as a temporary employee.

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

(c) Terminate and rehire an employee.

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

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

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

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

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

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

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

CHAPTER 5. FISCAL

4823. The department shall deposit all employer fees and employee premium payments into the fund. The department shall deposit all fines, penalties, and interest collected pursuant to this division into a penalty account within the fund. Notwithstanding the provisions of Section 12699.212 of the Insurance Code, the revenue in the penalty account shall not be continuously appropriated to the board and shall be available for expenditure only upon appropriation by the Legislature.

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

CHAPTER 6. OPERATIVE PROVISIONS

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

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

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

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

(c) For children enrolled in the Healthy Families Program as of July 1, 2008, the income limit in subdivision (b) shall be applied in determining eligibility at the next annual redetermination for

that program, or earlier upon request of the beneficiary. The coverage under this section for a child who is a dependent of an employee of an employer electing to make a payment to the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code, shall be provided through a Cal-CHIPP Medi-Cal plan under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

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

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

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

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

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

(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income

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

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

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

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

the Legislature on a semiannual basis until regulations have been adopted.

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

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

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

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

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

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

(3) A statement that the Medi-Cal beneficiary does not need to fill out monthly status reports in order to remain eligible for Medi-Cal, but shall be required to submit a semiannual status report

and annual reaffirmation forms, except that the semiannual status report shall no longer be required on and after July 1, 2008. The notice shall remind individuals whose cash aid ended under the CalWORKs program as a result of not submitting a status report that he or she should review his or her circumstances to determine if changes have occurred that should be reported to the Medi-Cal eligibility worker.

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

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

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

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

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

SEC. 34. Section 14005.32 of the Welfare and Institutions Code is amended to read:

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

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice

to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. To the extent feasible, the notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

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

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

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

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

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

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

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

(b) No later than September 1, 2001, the department shall submit a federal waiver application seeking authority to eliminate the reporting requirements imposed by transitional medicaid under Section 1925 of the federal Social Security Act (Title 42 U.S.C. Sec. 1396r-6).

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

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

SEC. 35. Section14005.301 is added to the Welfare and Institutions Code, to read:

14005.301. (a) Notwithstanding Section 14005.30, to the extent that federal financial participation is available, Medi-Cal benefits under a Cal-CHIPP Healthy Families plan as permitted under Section 6044 of the federal Deficit Reduction Act of 2005 (42 U.S.C. Sec. 1396u-7) shall be provided to a population composed of parents and other caretaker relatives with a household income at or below 300 percent of the federal poverty level who are not otherwise eligible for full scope benefits with no share of cost.

(b) The Cal-CHIPP Healthy Families plan referenced in subdivision (a) shall be health plan coverage provided through a health care service plan or a health insurer that meets the requirements of federal law and that provides the same covered services and benefits required under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) plus prescription drugs.

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

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

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

waiver and a state plan amendment necessary to accomplish the intent of this section.

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

SEC. 36. Section 14005.331 is added to the Welfare and Institutions Code, to read:

14005.331. (a) All children under 19 years of age who meet the state residency requirements of the Medi-Cal program or the Healthy Families Program shall be eligible for health care coverage in accordance with subdivision (b) if they either (1) live in families with countable household income at or below 300 percent of the federal poverty level, or (2) meet the income and resource requirements of Section 14005.7 of the Welfare and Institutions Code or the income requirements of Section 14005.30 of the Welfare and Institutions Code. The children described in this section include all children for whom federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) or Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.) is not available due to their immigration status or date of entry into the United States, but does not include children who are ineligible for Title XIX and Title XXI funds based on other grounds. Nothing in this section shall be construed to limit a child's right to Medi-Cal eligibility under existing law.

(b) Children described in subdivision (a) in families whose household income would render them ineligible for no-cost Medi-Cal, and who are in compliance with Sections 12693.71 and 12693.72 of the Insurance Code, shall be eligible for the Healthy Families Program and shall also be eligible for Medi-Cal with a share of cost in accordance with Section 14005.7 of the Welfare and Institutions Code. Other children described in this section shall be eligible for Medi-Cal with no share of cost.

(c) ~~The~~ *On and after January 1, 2010, the* coverage under this section for a child who is an employee or, if applicable, a dependent of an employee of an employer electing to make a payment to the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code, shall be provided through a Cal-CHIPP Medi-Cal plan under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

SEC. 37. Section 14005.82 is added to the Welfare and Institutions Code, to read:

14005.82. (a) The department shall exercise its options under Section 1906 of Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396e) to require, as a condition of an individual becoming or remaining eligible for the Medi-Cal program, that the individual, or if a child, the child's parent, offered the option of enrolling in a Cal-CHIPP Medi-Cal plan pursuant to Section 1357.24 of the Health and Safety Code or Section 10764 of the Insurance Code enroll in that Cal-CHIPP Medi-Cal plan. If the individual is eligible for the Medi-Cal program under Section 14005.301 and the individual is offered the option of enrolling in a Cal-CHIPP Healthy Families plan pursuant to Section 1357.24 of the Health and Safety Code or Section 10764 of the Insurance Code, the individual shall, as a condition of the individual becoming or remaining eligible for the Medi-Cal program, enroll in the Cal-CHIPP Healthy Families plan.

(b) The requirement that an individual enroll in a Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy Families plan, as described in subdivision (a), shall apply to an individual enrolled in the Medi-Cal program or in the Healthy Families Program at the individual's next annual redetermination of eligibility for the Medi-Cal program or the Healthy Families Program, or before that time if requested by the beneficiary or subscriber.

SEC. 38. Section 14008.85 of the Welfare and Institutions Code is amended to read:

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

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

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

(3) The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under

the program established by Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).

(b) The department shall seek any federal approval required to waive or to increase the income limit in paragraph (2) of subdivision (a) to the extent necessary to implement Sections 14005.30 and 14005.301.

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

SEC. 39. Section 14011.16 of the Welfare and Institutions Code is amended to read:

14011.16. (a) Commencing August 1, 2003, the department shall implement a requirement for beneficiaries to file semiannual status reports as part of the department's procedures to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility. The department shall develop a simplified form to be used for this purpose. The department shall explore the feasibility of using a form that allows a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.

(b) Beneficiaries who have been granted continuous eligibility under Section 14005.25 shall not be required to submit semiannual status reports. To the extent federal financial participation is available, all children under 19 years of age shall be exempt from the requirement to submit semiannual status reports.

(c) Beneficiaries whose eligibility is based on a determination of disability or on their status as aged or blind shall be exempt from the semiannual status report requirement described in subdivision (a). The department may exempt other groups from the semiannual status report requirement as necessary for simplicity of administration.

(d) When a beneficiary has completed, signed, and filed a semiannual status report that indicated a change in circumstance, eligibility shall be redetermined.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

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

(f) This section shall be implemented only if and to the extent federal financial participation is available.

(g) This section shall become inoperative on July 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute that is enacted before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 40. Section 14131.01 is added to the Welfare and Institutions Code, to read:

14131.01. On and after January 1, 2010, the coverage under this chapter to a person who is an employee or, if applicable, a dependent of an employee, of an employer electing to make a payment to the California Health Trust Fund in lieu of making health expenditures pursuant to Section 4802.1 of the Unemployment Insurance Code, shall be provided through a Cal-CHIPP Medi-Cal plan under Part 6.45 (commencing with Section 12699.201) of the Insurance Code.

SEC. 41. Article 7 (commencing with Section 14199.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 7. Coordination with the California Health Trust Fund

14199.10. The department shall seek any necessary federal approval to enable the state to receive federal funds for coverage provided through the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) to persons who would be eligible for the Medi-Cal program if the state expanded eligibility to a population composed of parents and other caretaker relatives with a household income at or below 300 percent of the federal poverty level who are not otherwise eligible for full scope benefits with no share of cost. Revenues in the California Health Trust Fund created pursuant to Section 12699.212 of the Insurance Code shall be used as state matching funds for receipt of federal funds resulting from the implementation of this section. All federal funds

received pursuant to that federal approval shall be deposited in the California Health Trust Fund.

SEC. 42. Section 6254.28 is added to the Government Code, to read:

6254.28. (a) Nothing in this chapter or any other provision of law shall require the disclosure of records of the Managed Risk Medical Insurance Board relating to activities governed by Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

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

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

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

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

SEC. 43. Section 11126 of the Government Code is amended to read:

11126. (a) (1) Nothing in this article shall be construed to prevent a state body from holding closed sessions during a regular or special meeting to consider the appointment, employment,

evaluation of performance, or dismissal of a public employee or to hear complaints or charges brought against that employee by another person or employee unless the employee requests a public hearing.

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

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

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

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

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

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

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

program concerning an individual licensee or applicant where the inquiry occurs prior to the filing of a civil, criminal, or administrative disciplinary action against the licensee or applicant by the state body.

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

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

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

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

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

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

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

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

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

(8) Prevent the California Postsecondary Education Commission from holding closed sessions to consider matters pertaining to the

appointment or termination of the Director of the California Postsecondary Education Commission.

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

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

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

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

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

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

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

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

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

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

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

(C) After meeting in closed session pursuant to subparagraph (A), the state body shall reconvene in open session prior to adjournment and report that a closed session was held pursuant to

subparagraph (A), the general nature of the matters considered, and whether any action was taken in closed session.

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

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

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

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

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

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

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

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

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

(ii) The legal counsel of the state body shall prepare and submit to it a memorandum stating the specific reasons and legal authority for the closed session. If the closed session is pursuant to paragraph (1), the memorandum shall include the title of the litigation. If the closed session is pursuant to subparagraph (A) or (B), the memorandum shall include the existing facts and circumstances on which it is based. The legal counsel shall submit the memorandum to the state body prior to the closed session, if feasible, and in any case no later than one week after the closed session. The memorandum shall be exempt from disclosure pursuant to Section 6254.25.

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

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

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

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

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

(3) Prevent an administrative committee established by the California Board of Accountancy pursuant to Section 5020 of the

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

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

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

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

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

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

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

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

(9) Prevent the California Earthquake Prediction Evaluation Council, or other body appointed to advise the Director of the Office of Emergency Services or the Governor concerning matters

relating to volcanic or earthquake predictions, from holding closed sessions when considering the evaluation of possible predictions.

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

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

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

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

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

SEC. 44. The State Department of Health Care Services, in consultation with the Managed Risk Medical Insurance Board, shall take all reasonable steps that are required to obtain the maximum amount of federal funds and to support federal claiming procedures in the administration of this act.

SEC. 45. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, during the period January 1, 2008, to December 31, 2011, inclusive, the State Department of Health Care Services may implement this act by means of all county letters or similar instructions without taking regulatory action. After December 31, 2011, the department shall adopt all necessary regulations in accordance with the requirements of Chapter 3.5 (commencing

with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 46. The Legislature finds and declares that Section 42 of this act, which adds Section 6254.28 to the Government Code, and Section 43, which amends Section 11126 of the Government Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

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

SEC. 47. Notwithstanding any other provision of law, the Managed Risk Medical Insurance Board may implement the provisions of this act expanding the Healthy Families Program only to the extent that funds are appropriated for those purposes in the annual Budget Act or in another statute.

SEC. 48. During the period from January 1, 2008 to December 31, 2011, inclusive, the adoption of regulations pursuant to this act by the Managed Risk Medical Insurance Board shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or the general welfare.

SEC. 49. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement

to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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