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AMENDED IN ASSEMBLY MARCH 29, 2007

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

**ASSEMBLY BILL**

**No. 8**

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**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

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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 and to develop a standardized questionnaire for carriers in the individual market to identify persons eligible for the program. The bill would prohibit a health insurer and a health care service plan from denying coverage to an individual, except for those who are automatically eligible for the program.

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

(6) The bill would create the California Health Benefits Service within the Health and Human Services Agency, with various powers and duties relative to creation of joint ventures between certain

county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans.

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

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

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: yes. Fiscal committee: yes.

State-mandated local program: yes.

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

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

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

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

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

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

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

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

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

5 12803.1. (a) The California Health Benefits Service is hereby  
6 created within the California Health and Human Services Agency.

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

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

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

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

15 (c) To the extent permitted under existing law, CHBS is  
16 authorized to solicit and assist prepaid health plans that contract  
17 with, or are governed, owned, or operated by, a county board of  
18 supervisors, a county special commission or county health authority  
19 authorized by Section 14018.7, 14087.31, 14087.35, 14087.36,  
20 14087.38, or 14087.96 of the Welfare and Institutions Code in  
21 forming joint ventures to create integrated networks of public  
22 health plans that pool risk and share networks. CHBS may, upon  
23 agreement of participating health plans, administer those joint  
24 ventures. Consistent with the recommendations pursuant to  
25 subdivision (b), and existing law, CHBS is authorized to develop  
26 networks to provide health care services in counties in which there  
27 is not a prepaid health plan that contracts with, or is governed,  
28 owned, or operated by, a county board of supervisors, a county  
29 special commission, or a county health authority authorized by  
30 Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or  
31 14087.96 of the Welfare and Institutions Code.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 1357. As used in this article:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

17 (g) “Creditable coverage” means:

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

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

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

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

1 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
2 (Civilian Health and Medical Program of the Uniformed Services  
3 (CHAMPUS)).

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

6 (7) A state health benefits risk pool.

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

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

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

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

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

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

25 (j) "Risk adjustment factor" means the percentage adjustment  
26 to be applied equally to each standard employee risk rate for a  
27 particular small employer, based upon any expected deviations  
28 from standard cost of services. This factor may not be more than  
29 120 percent or less than 80 percent until July 1, 1996. Effective  
30 July 1, 1996, this factor may not be more than 110 percent or less  
31 than 90 percent. On and after January 1, 2010, no risk adjustment  
32 factor shall be applied.

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

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

39 Under 30

40 30-39

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

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

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

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

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

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

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

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

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

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

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

1 purchasing coverage for employees through a guaranteed  
2 association.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28

29

#### Article 3.11. Insurance Market Reform

30

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



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

4 1357.21. The department, in consultation with the Department  
5 of Insurance, shall require each health care service plan with one  
6 million or more enrollees in California, based on the plan's  
7 enrollment in the prior year, to submit a good faith bid to the  
8 Managed Risk Medical Insurance Board in order to be a  
9 participating plan through the California Cooperative Health  
10 Insurance Purchasing Program (Cal-CHIP) pursuant to Part 6.45  
11 (commencing with Section 12699.201) of Division 2 of the  
12 Insurance Code.

13 1357.22. It is the intent of the Legislature that all health care  
14 providers shall participate in an Internet-based personal health  
15 record system under which patients have access to their own health  
16 care records. A patient's personal health care record shall only be  
17 accessible to that patient or other individual as authorized by the  
18 patient. It is the intent of the Legislature that all health care service  
19 plans and providers shall adopt standard electronic medical records  
20 by January 1, 2012.

21 1357.23. Effective July 1, 2008, all requirements in Article 3.1  
22 (commencing with Section 1357) applicable to offering, marketing,  
23 and selling health care service plan contracts to small employers  
24 as defined in that article, including, but not limited to, the  
25 obligation to fairly and affirmatively offer, market, and sell all of  
26 the plan's contracts to all employers, guaranteed renewal of all  
27 health care service plan contracts, use of the risk adjustment factor,  
28 and the restriction of risk categories to age, geographic region, and  
29 family composition as described in that article, shall be applicable  
30 to all health care service plan contracts offered to all employers  
31 with 100 or fewer eligible employees, except as follows:

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

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

1 (c) On and after January 1, 2010, no risk adjustment factor shall  
2 be applied to a plan contract offered to an employer with 51 to  
3 100, inclusive, eligible employees.

4 ~~1357.24. (a) Every group health care service plan shall obtain~~  
5 ~~from each employer or group subscriber contracting with the health~~  
6 ~~care service plan the premium contribution amounts the employer~~  
7 ~~or group makes for each enrolled group member and dependent~~  
8 ~~using the family size categories premium payments made to the~~  
9 ~~group plan.~~

10 ~~(b) (1) Every health care service plan offering group health~~  
11 ~~plan contracts shall provide as one coverage option of each group~~  
12 ~~contract a Cal-CHIPP Healthy Families plan established by the~~  
13 ~~board so that group members and their dependents with family~~  
14 ~~incomes at or below 300 percent of the federal poverty level that~~  
15 ~~are determined eligible for coverage through the Healthy Families~~  
16 ~~Program or who are eligible for Medi-Cal pursuant to Section~~  
17 ~~14005.301 of the Welfare and Institutions Code can enroll in the~~  
18 ~~Cal-CHIPP Healthy Families plan. The Cal-CHIPP Healthy~~  
19 ~~Families plan of a group health care service plan shall be provided~~  
20 ~~at a rate negotiated with and approved by the board. The health~~  
21 ~~care service plan shall collect the employer's applicable dollar~~  
22 ~~premium contribution for employees and, if applicable, dependents~~  
23 ~~in the Cal-CHIPP Healthy Families plan and credit that amount~~  
24 ~~toward the cost of the Cal-CHIPP Healthy Families plan.~~

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

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

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

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

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

22 *1357.24. (a) For employees and, if applicable, dependents*  
23 *who are currently enrolled in or determined eligible for coverage*  
24 *through the Healthy Families Program or the Medi-Cal program*  
25 *and who are offered group coverage, the group health care service*  
26 *plan shall collect the employer's applicable dollar premium*  
27 *contribution for those employees and, if applicable, dependents*  
28 *and transmit that amount to the board towards the cost of the*  
29 *applicable Cal-CHIPP plan.*

30 (e)

31 (b) The department, in consultation with the board, may issue  
32 regulations, as necessary pursuant to the Administrative Procedure  
33 Act, to implement the requirements of this section. Until January  
34 1, 2012, the adoption and readoption of regulations pursuant to  
35 this section shall be deemed to be an emergency and necessary for  
36 the immediate preservation of public peace, health and safety, or  
37 general welfare.

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

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

9 ~~(g)~~

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

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

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

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

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

23 ~~(h)~~

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

26 1357.25. The requirements of this article shall not apply to a  
 27 specialized health care service plan or a Medicare supplement  
 28 contract.

29 1357.26. This article shall become operative on July 1, 2008.

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

32 1363. (a) The director shall require the use by each plan of  
 33 disclosure forms or materials containing information regarding  
 34 the benefits, services, and terms of the plan contract as the director  
 35 may require, so as to afford the public, subscribers, and enrollees  
 36 with a full and fair disclosure of the provisions of the plan in  
 37 readily understood language and in a clearly organized manner.  
 38 The director may require that the materials be presented in a  
 39 reasonably uniform manner so as to facilitate comparisons between  
 40 plan contracts of the same or other types of plans. Nothing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (14) Conditions and procedures for disenrollment.

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

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

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

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

- 9 (A) Deductibles.
- 10 (B) Lifetime maximums.
- 11 (C) Professional services.
- 12 (D) Outpatient services.
- 13 (E) Hospitalization services.
- 14 (F) Emergency health coverage.
- 15 (G) Ambulance services.
- 16 (H) Prescription drug coverage.
- 17 (I) Durable medical equipment.
- 18 (J) Mental health services.
- 19 (K) Chemical dependency services.
- 20 (L) Home health services.
- 21 (M) Other.

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

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

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

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

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

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

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

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

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

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

34  
 35 Article 4.1. California Individual Coverage Guarantee Issue  
 36

37 1366.10. It is the intent of the Legislature to do both of the  
 38 following:

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



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

4 1366.104. (a) On or before September 1, 2008, the director  
5 and the Insurance Commissioner shall jointly adopt regulations  
6 governing five classes of individual health benefit plans that health  
7 care service plans and health insurers shall make available.

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

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

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

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

34 1366.105. On and after January 1, 2009, health care service  
35 plans and health insurers participating in the individual market  
36 shall, except as provided in Section 12711.1 of the Insurance Code,  
37 guarantee issue the five classes of approved health benefit plans  
38 and shall, at the same time, discontinue offering and selling health  
39 benefit plans other than those within the five approved classes of  
40 benefit plans in the individual market.

1 1366.106. (a) Individuals may purchase a health benefit plan  
2 from one of the five classes of approved plans on a guaranteed  
3 issue basis. After selecting and purchasing a health benefit plan  
4 within a class of benefits, an individual may change plans only as  
5 set forth in this section. For individuals enrolled as a family, the  
6 subscriber may change classes for himself or herself, or for all  
7 dependents:

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

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

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

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

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

20 (B) Upon divorce.

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

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

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

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

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

37 1366.107. At the time an individual applies for health coverage  
38 from a health care service plan or health insurer participating in  
39 the individual market, an individual shall provide information as  
40 required by a standardized health status questionnaire to assist

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

6 1366.108. Health benefit plans shall become effective within  
7 31 days of receipt of the individual's application, standardized  
8 health status questionnaire, and premium payment.

9 1366.109. Health care service plans and health insurers may  
10 reject an application for health care benefits if the individual does  
11 not reside or work in a plan's or insurer's approved service area.

12 1366.110. The director or the Insurance Commissioner, as  
13 applicable, may require a health care service plan or health insurer  
14 to discontinue the offering of health care benefits, or acceptance  
15 of applications from individuals, upon a determination by the  
16 director or commissioner that the plan or insurer does not have  
17 sufficient financial viability, or organizational and administrative  
18 capacity, to ensure the delivery of health care benefits to its  
19 enrollees or insureds.

20 1366.111. All health care benefits offered to individuals shall  
21 be renewable with respect to all individuals and dependents at the  
22 option of the subscriber, except:

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

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

27 1366.112. No health care service plan or health insurer shall,  
28 directly or indirectly, enter into any contract, agreement, or  
29 arrangement with a solicitor that provides for or results in the  
30 compensation paid to a solicitor for the sale of a health care service  
31 plan contract or health insurance policy to be varied because of  
32 the health status, claims experience, occupation, or geographic  
33 location of the individual, provided the geographic location is  
34 within the plan's or insurer's approved service area.

35 1366.113. This article shall not apply to individual health plan  
36 contracts for coverage of Medicare services pursuant to contracts  
37 with the United States Government, Medi-Cal contracts with the  
38 State Department of Health Care Services, Healthy Family  
39 contracts with the Managed Risk Medical Insurance Board, high  
40 risk pool contracts with the Major Risk Medical Insurance Program,

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

4 1366.114. (a) A health care service plan or health insurer may  
5 rate its entire portfolio of health benefit plans in accordance with  
6 expected costs or other market considerations, but the rate for each  
7 plan or insurer shall be set in relation to the balance of the portfolio  
8 as certified by an actuary. Each benefit plan shall be priced as  
9 determined by each health care service plan or health insurer to  
10 reflect the difference in benefit variation, or the effectiveness of  
11 a provider network, but may not adjust the rate for a specific plan  
12 for risk selection. A health care service plan's or health insurer's  
13 rates shall use the same rating factors for age, family size, and  
14 geographic location for each individual health care benefit plan it  
15 issues. Rates for health care benefits may vary from applicant to  
16 applicant only by any of the following:

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

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

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

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

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

35 1366.115. The first term of each health benefit plan contract  
36 or policy issued shall be from the effective date through the last  
37 day of the month immediately preceding the subscriber's next  
38 birthday. Contracts or policies may be renewed by the subscriber  
39 as set forth in this article.

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

3 1378. No plan shall expend for administrative costs in any  
4 fiscal year an excessive amount of the aggregate dues, fees and  
5 other periodic payments received by the plan for providing health  
6 care services to its subscribers or enrollees. The term  
7 “administrative costs,” as used herein, includes costs incurred in  
8 connection with the solicitation of subscribers or enrollees for the  
9 plan. The director shall adopt regulations no later than July 1, 2008,  
10 requiring that at least 85 percent of aggregate dues, fees, and other  
11 periodic payments received by a full-service plan be spent on health  
12 care services. The regulations shall also define “health care  
13 services.” This section shall not apply to Medicare supplement  
14 contracts.

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

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

22  
23 CHAPTER 4. HEALTH CARE COST AND QUALITY TRANSPARENCY

24  
25 Article 1. General Provisions

26  
27 128850. The Legislature hereby finds and declares that:

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

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

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

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

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

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

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

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

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

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

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

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

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

28 128851. As used in this chapter, the following terms have the  
29 following meanings:

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

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

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

3 (c) “Commission” means the California Health Care Cost and  
4 Quality Transparency Commission.

5 (d) “Data source” means any physician, physician group, health  
6 facility, health care service plan, health insurer, any state agency  
7 providing or paying for health care or collecting health care data  
8 or information, or any other payer for health care services in  
9 California.

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

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

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

21 (h) “Health care provider” means a physician, physician group,  
22 or health facility.

23 (i) “Health facility” or “health facilities” means health facilities  
24 required to be licensed pursuant to Chapter 2 (commencing with  
25 Section 1250) of Division 2.

26 (j) “Office” means the Office of Statewide Health Planning and  
27 Development.

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

31 128852. Notwithstanding the provisions of Chapter 1  
32 (commencing with Section 128675), commencing July 1, 2009,  
33 the responsibilities of the office with respect to determining the  
34 data to be collected and the analysis and reporting of the data  
35 collected pursuant to Chapter 1 (commencing with Section 128675)  
36 shall be transferred to the commission, as determined by the  
37 commission and as reported to the Secretary of Health and Welfare  
38 and the Legislature no later than January 1, 2009. Any limitations  
39 on the collection, analysis, and use of data in that chapter shall be  
40 inapplicable to the extent determined necessary by the commission



1 to implement its responsibilities under this chapter. All data  
2 collected by the office shall be available to the commission for the  
3 purposes of carrying out its responsibilities under this chapter.  
4 During the initial development of the data plan pursuant to Section  
5 128675, the office shall make available to the commission any and  
6 all data files, information, and staff resources as may be necessary  
7 to assist in and support the plan's development.

8 128853. This chapter shall be operative on July 1, 2008.

9  
10 Article 2. Health Care Cost and Quality Transparency  
11 Commission  
12

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

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

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

24 (2) One representative of hospitals.

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

27 (4) One representative of physician and surgeons.

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

31 (6) One representative of a labor union.

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

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

38 (1) One representative of a labor union.

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

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

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

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

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

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

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

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

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

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

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

23 (5) The Insurance Commissioner or a designee.

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

31 128856. The commission shall meet at least once every two  
32 months, or more often if necessary to fulfill its duties.

33 128857. The members of the commission shall receive a per  
34 diem of one hundred dollars (\$100) for each day actually spent in  
35 the discharge of official duties and shall be reimbursed for any  
36 actual and necessary expenses incurred in connection with their  
37 duties as members of the commission.

38 128858. The commission shall appoint an executive director,  
39 who shall serve at the pleasure of the commission. The executive  
40 director shall receive the salary established by the Department of

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

7 128859. The commission shall be authorized to do the  
8 following:

9 (a) Enter into contracts.

10 (b) Sue and be sued.

11 (c) Employ necessary staff.

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

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

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

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

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

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

35 128860. The commission shall have no authority to disclose  
36 any confidential information concerning contracted rates between  
37 health care providers and any data source, but nothing in this  
38 section shall prevent the commission from publicly disclosing  
39 information on the relative or comparative cost to payers or

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

3 128861. (a) No later than January 1, 2009, the commission  
4 shall determine the functions currently performed by the office  
5 that are necessary to the commission's activities and report to the  
6 Secretary of Health and Welfare and the Legislature those functions  
7 that shall be transferred to the commission effective July 1, 2009.

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

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

16 (d) All officers and employees of the office who, on July 1,  
17 2009, are serving in the state civil service, other than as temporary  
18 employees, and engaged in the performance of a function vested  
19 in the commission shall be transferred to the commission. The  
20 status, positions, and rights of these persons shall not be affected  
21 by the transfer except as to positions exempted from civil service.

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

27 128862. The functions and duties of the commission shall  
28 include the following:

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

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

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

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

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

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

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

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

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

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

29 128863. (a) The commission shall appoint at least one technical  
30 advisory committee, and may appoint additional technical advisory  
31 committees as the commission deems appropriate, and shall include  
32 on each such committee academic and professional experts with  
33 expertise related to the activities of the commission.

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

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

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

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

24 128864. The commission shall develop and implement a  
 25 conflict-of-interest policy applicable to all employees, contractors,  
 26 and advisory committee members that will ensure, at a minimum,  
 27 that persons advising the commission disclose any material  
 28 financial interest in the outcome of the work performed on behalf  
 29 of the commission.

30

31 Article 3. Health Care Cost and Quality Transparency Plan

32

33 128865. (a) The Commission shall, by December 1, 2009,  
 34 develop and, by regulation adopt, a health care cost and quality  
 35 transparency plan that will, when implemented, result in the  
 36 transparent public reporting of safety, quality, and cost efficiency  
 37 information at all levels of the health care system. The plan shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 128866. The commission may contract with a qualified public  
27 or private agency or academic institution to assist in the review of  
28 existing data collection programs or to conduct other research or  
29 analysis the commission deems necessary to complete and  
30 implement the plan required pursuant to Section 128865 or to meet  
31 any of its obligations under this chapter.

32 128867. The commission shall review and, where appropriate,  
33 incorporate into the plan required by Section 128865 health care  
34 data collection and reporting required under other state laws,  
35 including, but not limited to, Chapter 1 (commencing with Section  
36 128675), Article 3.5 (commencing with Section 1288.10) of  
37 Chapter 2 of Division 2, and Sections 1279.1, 1279.3, and 1368.02,  
38 and shall recommend any modification of these statutes necessary  
39 to be consistent with the plan developed pursuant to Section  
40 128865. Data collection and reporting required by these provisions



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

3 128868. (a) No later than December 1, 2008, and annually  
4 thereafter, the commission shall publicly report the federal Agency  
5 for Healthcare Research and Quality Patient Safety Indicators and  
6 Inpatient Quality Indicators for each acute care hospital licensed  
7 in California using administrative discharge data that hospitals  
8 report pursuant to this part.

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

17  
18 Article 4. Fees

19  
20 128870. (a) The commission shall, to the extent possible,  
21 recover the cost of implementing this chapter from fees charged  
22 to data sources and data users. As part of the plan adopted pursuant  
23 to Article 3 (commencing with Section 128865), the commission  
24 shall promulgate a schedule of fees that will, to the extent possible,  
25 recover the cost of implementing centralized data collection,  
26 effective analysis, and reporting activities under this chapter. The  
27 schedule of fees shall be based on the relative need to collect and  
28 analyze information from various data sources, and the relative  
29 value to data sources and users, in order to correct the adverse  
30 health effects that have resulted from the lack of transparency of  
31 health care cost and quality information. The fee schedule shall  
32 ensure appropriate access to data at a reasonable cost for academic  
33 researchers. Notwithstanding this section, the commission shall  
34 not fail to publish reports for the public consistent with the plan  
35 and shall not otherwise charge members of the public for access  
36 to the reports generated and published by the commission.

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

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

3 128871. There is hereby established in the State Treasury, the  
4 Health Care Cost and Quality Transparency Fund to support the  
5 work of the commission. All fees and contributions collected by  
6 the commission pursuant to Section 128870 shall be deposited in  
7 this fund and used to support the work of the commission.

8

9

Article 5. Penalties

10

11 128875. (a) Any data source that fails to file any report as  
12 required by this chapter or by the health care cost and quality  
13 transparency plan adopted pursuant to this chapter, shall be liable  
14 for a civil penalty of one hundred dollars (\$100) to one thousand  
15 dollars (\$1,000) per day. The commission shall, as part of the plan  
16 developed pursuant to section 128865, promulgate a schedule of  
17 civil penalties that will be assessed for reporting violations that  
18 varies from one hundred dollars (\$100) per day for the least serious  
19 violation, up to one thousand dollars (\$1,000) for the most serious  
20 violation.

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

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

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

31

32 CHAPTER 1.6. CALIFORNIA INDIVIDUAL COVERAGE GUARANTEE  
33 ISSUE

34

35 10199.10. It is the intent of the Legislature to do both of the  
36 following:

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

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

4 10199.104. (a) On or before September 1, 2008, the  
5 commissioner and the Director of the Department of Managed  
6 Health Care shall jointly adopt regulations governing five classes  
7 of individual health benefit plans that health care service plans and  
8 health insurers shall make available.

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

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

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

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

38 10199.105. On and after January 1, 2009, health care service  
39 plans and health insurers participating in the individual market  
40 shall, except as provided in Section 12711.1, guarantee issue the

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

5 10199.106. (a) Individuals may purchase a health benefit plan  
6 from one of the five classes of approved plans on a guaranteed  
7 issue basis. After selecting and purchasing a health benefit plan  
8 within a class of benefits, an individual may change plans only as  
9 set forth in this section. For individuals enrolled as a family, the  
10 subscriber may change classes for himself or herself, or for all  
11 dependents:

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

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

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

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

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

24 (B) Upon divorce.

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

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

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

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

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

1 10199.107. At the time an individual applies for health  
2 coverage from a health care service plan or health insurer  
3 participating in the individual market, an individual shall provide  
4 information as required by a standardized health status  
5 questionnaire to assist plans and insurers in identifying persons in  
6 need of disease management. Health care service plans and health  
7 insurers may not use information provided on the questionnaire  
8 to decline coverage, or to limit an individual's choice of health  
9 care benefit plan, except as provided in Section 12711.1.

10 10199.108. Health benefit plans shall become effective within  
11 31 days of receipt of the individual's application, standardized  
12 health status questionnaire, and premium payment.

13 10199.109. Health care service plans and health insurers may  
14 reject an application for health care benefits if the individual does  
15 not reside or work in a plan's or insurer's approved service area.

16 10199.110. The commissioner or the Director of the  
17 Department of Managed Health Care, as applicable, may require  
18 a health care service plan or health insurer to discontinue the  
19 offering of health care benefits, or acceptance of applications from  
20 individuals, upon a determination by the director or commissioner  
21 that the plan or insurer does not have sufficient financial viability,  
22 or organizational and administrative capacity, to ensure the delivery  
23 of health care benefits to its enrollees or insureds.

24 10199.111. All health care benefits offered to individuals shall  
25 be renewable with respect to all individuals and dependents at the  
26 option of the subscriber, except:

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

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

31 10199.112. No health care service plan or health insurer shall,  
32 directly or indirectly, enter into any contract, agreement, or  
33 arrangement with a solicitor that provides for or results in the  
34 compensation paid to a solicitor for the sale of a health care service  
35 plan contract or health insurance policy to be varied because of  
36 the health status, claims experience, occupation, or geographic  
37 location of the individual, provided the geographic location is  
38 within the plan's or insurer's approved service area.

39 10199.113. This chapter shall not apply to individual health  
40 plan contracts for coverage of Medicare services pursuant to

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

8 10199.114. (a) A health care service plan or health insurer  
9 may rate its entire portfolio of health benefit plans in accordance  
10 with expected costs or other market considerations, but the rate  
11 for each plan or insurer shall be set in relation to the balance of  
12 the portfolio as certified by an actuary. Each benefit plan shall be  
13 priced as determined by each health care service plan or health  
14 insurer to reflect the difference in benefit variation, or the  
15 effectiveness of a provider network, but may not adjust the rate  
16 for a specific plan for risk selection. A health care service plan's  
17 or health insurer's rates shall use the same rating factors for age,  
18 family size, and geographic location for each individual health  
19 care benefit plan it issues. Rates for health care benefits may vary  
20 from applicant to applicant only by any of the following:

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

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

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

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

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

1 10199.115. The first term of each health benefit plan contract  
2 or policy issued shall be from the effective date through the last  
3 day of the month immediately preceding the subscriber's next  
4 birthday. Contracts or policies may be renewed by the subscriber  
5 as set forth in this chapter.

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

8 10293.5. (a) The commissioner shall adopt regulations no later  
9 than July 1, 2008, requiring that at least 85 percent of health  
10 insurance premium revenue received by a health insurer be spent  
11 on health care services. The regulations shall also define "health  
12 care services."

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

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

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

22 10607. In addition to the other disclosures required by this  
23 chapter, every insurer and their employees or agents shall, when  
24 presenting a plan for examination or sale to any individual or the  
25 representative of a group, disclose in writing the ratio of incurred  
26 claims to earned premiums (loss-ratio) for the insurer's preceding  
27 calendar year for policies with individuals and with groups of the  
28 same or similar size for the insurer's preceding fiscal year.

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

31 10700. As used in this chapter:

32 (a) "Agent or broker" means a person or entity licensed under  
33 Chapter 5 (commencing with Section 1621) of Part 2 of Division  
34 1.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (q) “Preexisting condition provision” means a policy provision  
18 that excludes coverage for charges or expenses incurred during a  
19 specified period following the insured’s effective date of coverage,  
20 as to a condition for which medical advice, diagnosis, care, or  
21 treatment was recommended or received during a specified period  
22 immediately preceding the effective date of coverage.

23 (r) “Creditable coverage” means:

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

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

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

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

- 3 Under 30
- 4 30–39
- 5 40–49
- 6 50–54
- 7 55–59
- 8 60–64
- 9 65 and over

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

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

- 17 (A) Single.
- 18 (B) Married couple.
- 19 (C) One adult and child or children.
- 20 (D) Married couple and child or children.

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

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

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

7 (w) “Small employer” means either of the following:

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

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

38 (x) “Standard employee risk rate” means the rate applicable to  
39 an eligible employee in a particular risk category in a small  
40 employer group.



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

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

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

39 (z) “Members of a guaranteed association” means any individual  
40 or employer meeting the association’s membership criteria if that

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

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

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

16 10714. Premiums for benefit plan designs written, issued, or  
17 administered by carriers on or after the effective date of this act,  
18 shall be subject to the following requirements:

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

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

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

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

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

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

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

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

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

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

11 (d) Nothing in this section shall be construed to prevent an  
12 insurer from changing the standard employee risk rates applied to  
13 a small employer in order to ensure that the insurer's rates for a  
14 standard benefit plan design sold pursuant to Section 10761 are  
15 not less than the insurer's rates for the same benefit plan design  
16 sold through the California Cooperative Health Insurance  
17 Purchasing Program (Part 6.45 (commencing with Section  
18 12699.201)).

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

21

22 CHAPTER 8.1. INSURANCE MARKET REFORM

23

24 10760. Effective July 1, 2008, every insurer that offers,  
25 markets, and sells health insurance to individuals and conducts  
26 medical underwriting to determine whether to issue coverage to a  
27 specific individual shall use a standardized health questionnaire  
28 developed by the Managed Risk Medical Insurance Board. A health  
29 insurer subject to this section may not exclude a potential insured  
30 from any individual coverage on the basis of an actual or expected  
31 health condition, type of illness, treatment, medical condition, or  
32 accident, or for a preexisting condition, except as provided by the  
33 board pursuant to Section 12711.1.

34 10761. The department, in consultation with the Department  
35 of Managed Health Care, shall require each health insurer with  
36 one million or more insureds in California, based on the insurer's  
37 enrollment in the prior year, to submit a good faith bid to the  
38 Managed Risk Medical Insurance Board in order to be a  
39 participating plan through the California Cooperative Health

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

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

11 10763. On and after July 1, 2008, all requirements in Chapter  
12 8 (commencing with Section 10700) applicable to offering,  
13 marketing, and selling health benefit plans to small employers as  
14 defined in that chapter, including, but not limited to, the obligation  
15 to fairly and affirmatively offer, market, and sell all of the carrier's  
16 health benefit plan designs to all employers, guaranteed renewal  
17 of all health benefit plan designs, use of the risk adjustment factor,  
18 and the restriction of risk categories to age, geographic region, and  
19 family composition as described in that chapter, shall be applicable  
20 to all health benefit plan designs offered to all employers with 100  
21 or fewer eligible employees, except as follows:

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

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

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

32 ~~10764. (a) Every group health insurer shall obtain from each~~  
33 ~~employer or group policyholder contracting with the health insurer~~  
34 ~~the premium contribution amounts the employer or group makes~~  
35 ~~for each enrolled group member and dependent using the family~~  
36 ~~size categories premium payments made to the group plan.~~

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

1 or below 300 percent of the federal poverty level that are  
2 determined eligible for coverage through the Healthy Families  
3 Program or who are eligible for Medi-Cal pursuant to Section  
4 14005.301 of the Welfare and Institutions Code can enroll in the  
5 Cal-CHIPP Healthy Families plan. The Cal-CHIPP Healthy  
6 Families plan of a group health insurer shall be provided at a rate  
7 negotiated with and approved by the board. The health insurer  
8 shall collect the employer's applicable dollar premium contribution  
9 for employees and, if applicable, dependents in the Cal-CHIPP  
10 Healthy Families plan and credit that amount toward the cost of  
11 the Cal-CHIPP Healthy Families plan.

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

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

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

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

7 *10764. (a) For employees and, if applicable, dependents who*  
8 *are currently enrolled in or determined eligible for coverage*  
9 *through the Healthy Families Program or the Medi-Cal program*  
10 *and who are offered group coverage, the group health insurer*  
11 *shall collect the employer's applicable dollar premium contribution*  
12 *for those employees and, if applicable, dependents and transmit*  
13 *that amount to the board toward the premium cost of the applicable*  
14 *Cal-CHIPP plan.*

15 (e)

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

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

34 (g)

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

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

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

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

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

8 ~~(h)~~

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

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

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

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

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

21 12693.43. (a) Applicants applying to the purchasing pool shall  
 22 agree to pay family contributions, unless the applicant has a family  
 23 contribution sponsor. Family contribution amounts consist of the  
 24 following two components:

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 12693.58. (a) All types of information, whether written or  
32 oral, concerning an applicant, subscriber, or household member,  
33 made or kept by any public officer or agency in connection with  
34 the administration of any provision of this part shall be confidential,  
35 and shall not be open to examination other than for purposes  
36 directly connected with the administration of the Healthy Families  
37 Program or the Medi-Cal program.

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

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

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

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

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

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

21 12693.59. Nothing in this part shall preclude the board from  
22 soliciting voluntary participation by applicants and subscribers in  
23 communicating with the board, or with any other party, concerning  
24 their needs as well as the needs of others who are not adequately  
25 covered by existing private and public health care delivery systems  
26 or concerning means of ensuring the availability of adequate health  
27 care services. The board shall inform applicants and subscribers  
28 that their participation is voluntary and shall inform them of the  
29 uses for which the information is intended.

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

32 12693.621. On and after January 1, 2010, the coverage under  
33 this part for a child who is a dependent of an employee of an  
34 employer electing to make a payment to the California Health  
35 Trust Fund in lieu of making health expenditures pursuant to  
36 Section 4802.1 of the Unemployment Insurance Code, shall be  
37 provided through a Cal-CHIPP Healthy Families plan under Part  
38 6.45 (commencing with Section 12699.201). The requirement that  
39 an individual enroll in a Cal-CHIPP Healthy Families plan shall  
40 apply to an individual enrolled in the Healthy Families Program

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

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

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

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

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

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

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

19 (4) [Reserved].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 12693.73. Notwithstanding any other provision of law, children  
32 excluded from coverage under Title XXI of the Social Security  
33 Act are not eligible for coverage under the program, except as  
34 specified in clause (ii) of subparagraph (A) of paragraph (6) of  
35 subdivision (a) of Section 12693.70 and Section 12693.76, or  
36 except children who otherwise meet eligibility requirements for  
37 the program but for their immigration status.

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

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

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

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

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

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

36 12693.76. (a) Notwithstanding any other provision of law, a  
37 child shall not be determined ineligible solely on the basis of his  
38 or her date of entry into the United States.



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

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

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

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

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

18

19 PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH  
20 INSURANCE PURCHASING PROGRAM

21

22 CHAPTER 1. GENERAL PROVISIONS

23

24 12699.201. For the purposes of this part, the following terms  
25 have the following meanings:

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

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

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

39 (d) “Dependent” shall have the same meaning as in Section  
40 4800.02 of the Unemployment Insurance Code.

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

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

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

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

12 (2) For individuals eligible pursuant to Section 12693.755 or  
13 Section 14005.301 of the Welfare and Institutions Code, coverage  
14 that meets the requirements of federal law and that, at a minimum,  
15 provides the same covered services and benefits required under  
16 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter  
17 2.2 (commencing with Section 1340) of Division 2 of the Health  
18 and Safety Code) plus prescription drugs.

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

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

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

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

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

4  
5 CHAPTER 2. ADMINISTRATION  
6

7 12699.202. (a) The board shall be responsible for establishing  
8 Cal-CHIPP and administering this part.

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

11 (1) Determine eligibility and enrollment criteria and processes  
12 for Cal-CHIPP consistent with the eligibility standards in Chapter  
13 3 (commencing with Section 12699.211).

14 (2) Determine the participation requirements for enrollees.

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

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

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

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

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

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

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

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

35 (11) Enter into contracts.

36 (12) Sue and be sued.

37 (13) Employ necessary staff.

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

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

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

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

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

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

22 12699.203. The board shall develop and offer a variety of  
23 benefit plan designs, including low-cost plans for Cal-CHIPP  
24 enrollees who are adults with family incomes below 300 percent  
25 of the federal poverty level who are ineligible for coverage through  
26 the Healthy Families Program or the Medi-Cal program. In addition  
27 to these benefit plan designs, each participating health plan and  
28 health insurer shall offer a Cal-CHIPP Healthy Families plan and  
29 a Cal-CHIPP Medi-Cal plan, and the board shall limit enrollment  
30 in these plans only to eligible individuals. For purposes of the  
31 Cal-CHIPP Medi-Cal plan, the board shall enter into an agreement  
32 with the State Department of Health Care Services for the provision  
33 of the Cal-CHIPP Medi-Cal plan by the Medi-Cal program. The  
34 benefit plan designs shall include varying benefit levels,  
35 deductibles, coinsurance factors, or copayments, and annual limits  
36 on out-of-pocket expenses. In developing the benefit plan designs,  
37 the board shall comply with all of the following:

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

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

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

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

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

23 12699.204. (a) The board may adjust premiums at a public  
24 meeting of the board after providing, at minimum, 30 days' public  
25 notice of the adjustment. In making the adjustment, the board shall  
26 take into account the costs of health care typically paid for by  
27 employers and employees in California.

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

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

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

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

7 12699.205. The board, in its contract with a participating health  
8 plan, shall require that the plan utilize efficient practices to improve  
9 and control costs. These practices shall include, but are not limited  
10 to, the following:

- 11 (a) Preventive care.
- 12 (b) Care management for chronic diseases.
- 13 (c) Promotion of health information technology.
- 14 (d) Standardized billing practices.
- 15 (e) Reduction of medical errors.
- 16 (f) Incentives for healthy lifestyles.
- 17 (g) Patient cost-sharing to encourage the use of preventive and  
18 appropriate care.
- 19 (h) Rational use of new technology.

20 12699.206. (a) The board shall negotiate with Medi-Cal  
21 managed care plans to obtain affordable coverage for eligible  
22 enrollees.

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

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

32 12699.206.1. (a) To provide prescription drug coverage for  
33 Cal-CHIPP enrollees, the board may take any of the following  
34 actions:

- 35 (1) Contract directly with health care service plans or health  
36 insurers for prescription drug coverage as a component of a health  
37 care service plan contract or a health insurance policy.
- 38 (2) Contract with a pharmacy benefits manager (PBM) if the  
39 PBM meets transparency and disclosure requirements established  
40 by the board.

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

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

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

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

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

18 12699.206.2. (a) All information, whether written or oral,  
19 concerning an applicant to Cal-CHIPP, an enrollee in Cal-CHIPP,  
20 or a household member of the applicant or enrollee, created or  
21 maintained by a public officer or agency in connection with the  
22 administration of this part shall be confidential and shall not be  
23 open to examination other than for purposes directly connected  
24 with the administration of this part. "Purposes directly connected  
25 with the administration of this part" includes all activities and  
26 responsibilities in which the board or the State Department of  
27 Health Care Services and their agents, officers, trustees, employees,  
28 consultants, and contractors engage to conduct program operations.

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

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

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

4 12699.207. (a) Notwithstanding any other provision of law,  
5 the board shall not be subject to licensure or regulation by the  
6 Department of Insurance or the Department of Managed Health  
7 Care.

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

16 12699.208. The board shall collect and disseminate, as  
17 appropriate and to the extent possible, information on the quality  
18 of participating health, dental, and vision care plans and each plan's  
19 cost-effectiveness to assist enrollees in selecting a plan.

20 12699.209. The board shall establish a working group for the  
21 purpose of developing recommendations to broaden access to  
22 Cal-CHIPP to all self-employed individuals and submit the  
23 recommendations to the Legislature on or before January 1, 2009.

24 12699.210. The provisions of Section 12693.54 shall apply to  
25 a contract entered into pursuant to this part.

26  
27 CHAPTER 3. ELIGIBILITY  
28

29 12699.211. (a) To be eligible to enroll in Cal-CHIPP, an  
30 individual shall meet all of the following requirements:

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

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



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

5 (b) Notwithstanding paragraph (2) of subdivision (a), eligible  
6 employees and, if applicable, dependents of eligible employees,  
7 eligible for coverage through a Cal-CHIPP Medi-Cal plan or  
8 Cal-CHIPP Healthy Families plan pursuant to paragraph (2) of  
9 subdivision (b) and paragraph (2) of subdivision (c) of Section  
10 1357.24 of the Health and Safety Code or paragraph (2) of  
11 subdivision (b) and paragraph (2) of subdivision (c) of Section  
12 10764 are eligible for Cal-CHIPP. These employees and, if  
13 applicable, their dependents shall be limited to the choice of a  
14 Cal-CHIPP Medi-Cal plan or a Cal-CHIPP Healthy Families plan  
15 and shall not have access to other benefit plan options available  
16 to Cal-CHIPP enrollees pursuant to Section 12699.203.

17 12699.211.01. (a) The failure of an employer to continue to  
18 pay the fee required by Section 4802.1 of the Unemployment  
19 Insurance Code shall not make an enrollee employed by that  
20 employer and the employee's dependents, if any, ineligible for  
21 participation in Cal-CHIPP until the last day of the second month  
22 following the month in which the employer failed to make the fee  
23 payment.

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

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

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

36 (3) Their rights and remedies under law.

37 (c) The board may, through regulations adopted pursuant to  
38 Chapter 3.5 (commencing with Section 11340) of Part 1 of Division  
39 3 of Title 2 of the Government Code, allow an employee and his  
40 or her dependents, if any, whose employer failed to pay the fee

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

8

9

## CHAPTER 4. FISCAL

10

11 12699.212. (a) The California Health Trust Fund is hereby  
12 created in the State Treasury. Notwithstanding Section 13340 of  
13 the Government Code, the moneys in the fund shall be continuously  
14 appropriated to the board, without regard to fiscal year, for the  
15 purposes of providing health care coverage pursuant to this part.  
16 Any moneys in the fund that are unexpended or unencumbered at  
17 the end of a fiscal year, may be carried forward to the next  
18 succeeding fiscal year.

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

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

23 12699.213. The board, subject to the approval of the  
24 Department of Finance, may obtain loans from the General Fund  
25 for all necessary and reasonable expenses related to the  
26 administration of the fund.

27 12699.214. The board shall authorize, for the purposes of this  
28 part, the expenditure from the fund of any state or federal revenue  
29 or other revenue received from any source.

30 12699.215. The board may solicit and accept gifts,  
31 contributions, and grants from any source, public or private, to  
32 administer the program and shall deposit all revenue from those  
33 sources into the fund.

34 12699.216. The board, subject to federal approval pursuant to  
35 Section 14199.10 of the Welfare and Institutions Code, shall pay  
36 the nonfederal share of cost from the fund for employees and  
37 dependents eligible under that federal approval.

38 12699.217. This part shall become operative on January 1,  
39 2009. *The board shall provide health coverage pursuant to this*  
40 *part on and after January 1, 2010.*

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

3 12711.1. (a) The board shall establish a list of serious health  
4 conditions or diagnoses making an applicant automatically eligible  
5 for the program based on the standardized health questionnaire  
6 developed pursuant to subdivision (b). In developing the list of  
7 conditions, the board shall consult with the Director of the  
8 Department of Managed Health Care and the commissioner to  
9 identify common health plan and insurer underwriting criteria.

10 (b) The board shall develop a standardized health questionnaire  
11 to be used by all health plans and insurers that offer and sell  
12 individual coverage. The questionnaire shall provide for an  
13 objective evaluation of a person's health status by assigning a  
14 discrete measure, such as a system of point scoring, to each person.  
15 The questionnaire shall be designed to identify the 3 to 5 percent  
16 of persons who are the most expensive to treat if covered under  
17 an individual health care service plan or an individual health  
18 insurance policy, and the board shall obtain from an actuary a  
19 certification that the standard health questionnaire meets this  
20 requirement. The questionnaire shall be designed to collect only  
21 that information necessary to identify if a person is eligible for  
22 coverage in the program pursuant to subdivision (a). Consistent  
23 with Section 1357.21 of the Health and Safety Code and Section  
24 10761, health plans and insurers shall not deny coverage for any  
25 individual except for those who qualify for automatic eligibility  
26 for the program as determined by the board pursuant to this section.

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

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

30 131.1. "Contributions" also means the money payments to the  
31 California Health Trust Fund that are required by Division 1.2  
32 (commencing with Section 4800).

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

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

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

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

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

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

12 1095.1. The director shall permit the use of any information  
13 in his or her possession to the extent necessary to provide  
14 information obtained in the administration and enforcement of the  
15 California Health Insurance Purchasing Pool Program (Division  
16 1.2 (commencing with Section 4800)) to the Managed Risk Medical  
17 Insurance Board for the purpose of administering the California  
18 Health Care Reform and Cost Control Act, and may require  
19 reimbursement for all direct costs incurred in providing any and  
20 all information specified in this section.

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

23  
24  
25  
26  
27  
28

DIVISION 1.2. CALIFORNIA HEALTH INSURANCE  
PURCHASING POOL PROGRAM

CHAPTER 1. ADMINISTRATION AND GENERAL PROVISIONS

29 4800. The Employment Development Department shall  
30 administer and enforce this division. The department, in  
31 conjunction with other state entities, shall establish a process to  
32 resolve complaints regarding the administration of this division,  
33 including a toll-free telephone hotline number and an Internet Web  
34 site for employers, employees, and their dependents to access  
35 information and file complaints.

36 4800.01. The following provisions of this code shall apply to  
37 any amount required to be reported and paid under this division:

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

1 (b) Sections 403 to 413, inclusive, Section 1336, and Chapter  
2 8 (commencing with Section 1951) of Part 1 of Division 1, relating  
3 to appeals and hearing procedures.

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

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

9 (e) Article 9 (commencing with Section 1176), except Section  
10 1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and  
11 overpayments.

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

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

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

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

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

22 4800.02. For the purposes of this division, the following  
23 definitions apply:

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

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

28 (c) “Department” means the Employment Development  
29 Department.

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

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

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

36 (i) Lives with the employee.

37 (ii) Is economically dependent upon the employee.

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

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

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

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

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

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

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

21 *(g) "Employer" has the same meaning as set forth in Article 3*  
22 *(commencing with Section 675) of Chapter 3 of Part 1 of Division*  
23 *1.*

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

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

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

32 (j) "Employment" has the same meaning as set forth in Article  
33 1 (commencing with Section 601) of Chapter 3 of Part 1 of  
34 Division 1. Employment does not include services provided  
35 pursuant to Sections 629 to 657, inclusive.

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

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

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

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

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

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

19 (D) Disease management programs.

20 (E) Pharmacy benefit management programs.

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

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

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

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

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

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

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

5 (o) The definitions set forth in Sections 126, 127, 129, 133, and  
6 134 shall apply to this division.

7 4800.03. The board shall annually publish information  
8 describing health plan choices in Cal-CHIPP for the department  
9 to disseminate to all employers making employer fee payments to  
10 the fund. The employer shall provide this information to all of its  
11 employees.

12 4800.04. The director shall provide to each employer a notice  
13 pursuant to Section 1089 and the employer shall post and distribute  
14 it in accordance with Section 1089 to inform employees and their  
15 dependents of the requirements of this division.

16 4800.05. The department shall provide information obtained  
17 in the administration and enforcement of this division to the board  
18 for the purpose of administering Cal-CHIPP.

19 4800.06. The department shall adopt rules and regulations to  
20 implement the provisions of this division.

21 4800.07. An employer shall file all forms required by this  
22 division by electronic means and shall remit all moneys owed  
23 pursuant to this division by electronic funds transfer. If an employer  
24 demonstrates to the director's satisfaction that undue hardship  
25 would be imposed on it by this section, the director may authorize  
26 an exemption from this requirement. The director may assess a  
27 penalty of twenty-five dollars (\$25) for each remittance that is not  
28 filed electronically.

29  
30 CHAPTER 2. EMPLOYER ELECTION

31  
32 4802.1. (a) (1) Each employer shall elect to take one of the  
33 following actions:

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

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

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



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

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

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

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

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

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

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

35 4802.2. (a) If an employer is required by a collective  
36 bargaining agreement to make health expenditures on behalf of  
37 bargaining unit employees pursuant to Section 302 (c)(5) of the  
38 Labor Management Relations Act that, in the aggregate, equal or  
39 exceed the percentage of wages set forth in paragraph (3) of  
40 subdivision (a) of Section 4802.1 for those bargaining unit

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

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

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

17 (d) For all non-bargaining unit employees, the employer shall  
18 participate in the elections as set forth in subdivision (a) of Section  
19 4802.1.

20 4802.3. (a) An employee of an employer that elects, pursuant  
21 to Section 4802.1, to pay an employer fee in lieu of making health  
22 expenditures shall be required to enroll in Cal-CHIPP to receive  
23 coverage under Cal-CHIPP. To the extent an employer elects,  
24 pursuant to Section 4802.1, to pay an employer fee only for either  
25 the employer's part-time or full-time employees, only employees  
26 and dependents in the category of employees for which the  
27 employer has elected to pay shall be required to enroll in  
28 Cal-CHIPP.

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

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

1 (c) (1) An employee of an employer that elects, pursuant to  
2 Section 4802.1, to make health expenditures shall accept the health  
3 expenditures made by the employer. However, for any employee  
4 ~~with a household income of~~ *earning wages equivalent to* 300  
5 percent of the federal poverty level or less, if accepting an  
6 employer's health expenditures would result in annual health  
7 expenditures by that employee in excess of 5 percent of his or her  
8 ~~household income after taking into account any tax savings the~~  
9 ~~employee is able to realize~~ *wages paid by the electing employer,*  
10 that employee shall be exempt from the requirement to accept  
11 health expenditures made by his or her employer. *For an employee*  
12 *earning wages equivalent to more than 300 percent of the federal*  
13 *poverty level, if accepting an employer's health expenditures would*  
14 *result in annual health expenditures by that employee in excess of*  
15 *5 percent of his or her wages paid by the electing employer, the*  
16 *employee shall be exempt from the requirement to accept health*  
17 *expenditures made by his or her employer.*

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

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

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

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

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

9 4804. (a) On and after October 1, 2009, an employer electing  
10 to pay an employer fee into the fund pursuant to subdivision (a)  
11 of Section 4802.1 shall complete all of the following actions:

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

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

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

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

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

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

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

33 4805. An employer that elects to pay an employer fee into the  
34 fund pursuant to subdivision (a) of Section 4802.1 shall not change  
35 that election for, at minimum, 24 months from the date of its first  
36 payment into the fund.

37 4806. (a) On and after October 1, 2009, an employer electing  
38 to make health expenditures pursuant to subdivision (a) of Section  
39 4802.1 shall complete the following actions:

1 (1) File a quarterly return with the department on April 15, July  
2 15, October 15, and January 15 of each year, reporting its wages  
3 and health expenditures for the prior quarter.

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

7 (3) Notify all employees annually through a written notice to  
8 each employee that employees with a family income at or below  
9 300 percent of the federal poverty level are eligible to apply for  
10 the Medi-Cal program or the Healthy Families Program, including  
11 instructions on the application process for those programs.

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

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

17 4807. (a) An employer shall notify its employees of its election  
18 pursuant to subdivision (a) of Section 4802.1 to make health  
19 expenditures or to pay an employer fee into the fund within five  
20 business days of making the election and shall notify an employee  
21 hired after the date of that notification within five days of the  
22 employee's date of hire.

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

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

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

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

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

CHAPTER 3. CAFETERIA PLAN

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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

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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.

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(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

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

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

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

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

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

37 4813. If the employer's failure to file a return or to make a  
38 payment within the time required by this division, and the  
39 regulations adopted pursuant to it, is due to fraud or to an intent  
40 to evade the provisions of this division, or of the regulations

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

4 4814. (a) An employer that elects to pay the employer fee and  
5 fails to withhold premium payment amounts authorized by an  
6 employee pursuant to Section 12699.203 of the Insurance Code  
7 and Section 4809 of this code is subject to a penalty equaling 200  
8 percent of the amount the employer failed to withhold.

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

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

18 4815. (a) An employer electing to make health expenditures  
19 pursuant to Section 4802.1 that fails to make expenditures in the  
20 amount required by that section shall be subject to a penalty in an  
21 amount equaling 10 percent of the balance between the amount  
22 required by Section 4802.1 and the amount of the health  
23 expenditures made by the employer and shall be subject to a  
24 penalty in an amount equaling 20 percent of that balance amount  
25 if the amount of health expenditures made by the employer is less  
26 than 80 percent of the amount required by Section 4802.1.

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

31 (c) Notwithstanding subdivisions (a) and (b), an employer that  
32 demonstrates good cause, as determined by the department, for its  
33 failure to make the health expenditures amount required by Section  
34 4802.1 is not subject to a penalty under this section.

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

37 ~~4816. If the director is not satisfied with the accuracy or the~~  
38 ~~sufficiency of a return filed by an employer or of an employer fee~~  
39 ~~paid by an employer, he or she may assess a civil penalty in the~~  
40 ~~sum of \_\_\_\_\_ dollars (\$\_\_\_\_\_).~~



1 4817. It shall be unlawful for an employer to take any of the  
2 following actions if a purpose for the action is to avoid the  
3 requirements of this division:

- 4 (a) Designate an employee as a temporary employee.
- 5 (b) Reduce the number of hours of work of an employee.
- 6 (c) Terminate and rehire an employee.

7 4818. It is unlawful for a person to take any of the following  
8 actions.

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

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

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

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

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

38 4822. The penalties and remedies provided pursuant to this  
39 division are cumulative and in addition to any other penalties or  
40 remedies provided by law.

## CHAPTER 5. FISCAL

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3 4823. The department shall deposit all employer fees and  
4 employee premium payments into the fund. The department shall  
5 deposit all fines, penalties, and interest collected pursuant to this  
6 division into a penalty account within the fund. Notwithstanding  
7 the provisions of Section 12699.212 of the Insurance Code, the  
8 revenue in the penalty account shall not be continuously  
9 appropriated to the board and shall be available for expenditure  
10 only upon appropriation by the Legislature.

11 4824. The department is authorized to obtain a loan from the  
12 General Fund for all necessary and reasonable expenses incurred  
13 prior to January 1, 2011, related to implementing this division and  
14 administering its provisions. The proceeds of the loan are subject  
15 to appropriation in the annual Budget Act. The department shall  
16 repay principal and interest, using the pooled money investment  
17 account rate of interest, to the General Fund no later than January  
18 1, 2016.

## CHAPTER 6. OPERATIVE PROVISIONS

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22 4829. This division shall become operative on January 1, 2009.

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

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

31 (b) Commencing July 1, 2008, to the extent federal financial  
32 participation is available, the department shall apply a less  
33 restrictive income deduction described in Section 1396a(r) of Title  
34 42 of the United States Code when determining eligibility for the  
35 children identified in subdivision (a). The amount of this deduction  
36 shall be the difference between 133 percent and 100 percent of the  
37 federal poverty level applicable to the size of the family.

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

1 that program, or earlier upon request of the beneficiary. The  
2 coverage under this section for a child who is a dependent of an  
3 employee of an employer electing to make a payment to the  
4 California Health Trust Fund in lieu of making health expenditures  
5 pursuant to Section 4802.1 of the Unemployment Insurance Code,  
6 shall be provided through a Cal-CHIPP Medi-Cal plan under Part  
7 6.45 (commencing with Section 12699.201) of Division 2 of the  
8 Insurance Code.

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

11 14005.30. (a) (1) To the extent that federal financial  
12 participation is available, Medi-Cal benefits under this chapter  
13 shall be provided to individuals eligible for services under Section  
14 1396u-1 of Title 42 of the United States Code, including any  
15 options under Section 1396u-1(b)(2)(C) made available to and  
16 exercised by the state.

17 (2) The department shall exercise its option under Section  
18 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt  
19 less restrictive income and resource eligibility standards and  
20 methodologies to the extent necessary to allow all recipients of  
21 benefits under Chapter 2 (commencing with Section 11200) to be  
22 eligible for Medi-Cal under paragraph (1).

23 (3) To the extent federal financial participation is available, the  
24 department shall exercise its option under Section 1396u-1(b)(2)(C)  
25 of Title 42 of the United States Code authorizing the state to  
26 disregard all changes in income or assets of a beneficiary until the  
27 next annual redetermination under Section 14012. The department  
28 shall implement this paragraph only if, and to the extent that the  
29 State Child Health Insurance Program waiver described in Section  
30 12693.755 of the Insurance Code extending Healthy Families  
31 Program eligibility to parents and certain other adults is approved  
32 and implemented.

33 (b) To the extent that federal financial participation is available,  
34 the department shall exercise its option under Section  
35 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary  
36 to simplify eligibility for Medi-Cal under subdivision (a) by  
37 exempting all resources for applicants and recipients.

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

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

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

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

31 (f) Notwithstanding Chapter 3.5 (commencing with Section  
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
33 the department shall implement, without taking regulatory action,  
34 subdivisions (a) and (b) of this section by means of an all county  
35 letter or similar instruction. Thereafter, the department shall adopt  
36 regulations in accordance with the requirements of Chapter 3.5  
37 (commencing with Section 11340) of Part 1 of Division 3 of Title  
38 2 of the Government Code. Beginning six months after the effective  
39 date of this section, the department shall provide a status report to

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

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

5 14005.31. (a) (1) Subject to paragraph (2), for any person  
6 whose eligibility for benefits under Section 14005.30 has been  
7 determined with a concurrent determination of eligibility for cash  
8 aid under Chapter 2 (commencing with Section 11200), loss of  
9 eligibility or termination of cash aid under Chapter 2 (commencing  
10 with Section 11200) shall not result in a loss of eligibility or  
11 termination of benefits under Section 14005.30 absent the existence  
12 of a factor that would result in loss of eligibility for benefits under  
13 Section 14005.30 for a person whose eligibility under Section  
14 14005.30 was determined without a concurrent determination of  
15 eligibility for benefits under Chapter 2 (commencing with Section  
16 11200).

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

23 (b) The department, in consultation with the counties and  
24 representatives of consumers, managed care plans, and Medi-Cal  
25 providers, shall prepare a simple, clear, consumer-friendly notice  
26 to be used by the counties, to inform Medi-Cal beneficiaries whose  
27 eligibility for cash aid under Chapter 2 (commencing with Section  
28 11200) has ended, but whose eligibility for benefits under Section  
29 14005.30 continues pursuant to subdivision (a), that their benefits  
30 will continue. To the extent feasible, the notice shall be sent out  
31 at the same time as the notice of discontinuation of cash aid, and  
32 shall include all of the following:

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

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

38 (3) A statement that the Medi-Cal beneficiary does not need to  
39 fill out monthly status reports in order to remain eligible for  
40 Medi-Cal, but shall be required to submit a semiannual status report

1 and annual reaffirmation forms, except that the semiannual status  
2 report shall no longer be required on and after July 1, 2008. The  
3 notice shall remind individuals whose cash aid ended under the  
4 CalWORKs program as a result of not submitting a status report  
5 that he or she should review his or her circumstances to determine  
6 if changes have occurred that should be reported to the Medi-Cal  
7 eligibility worker.

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

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

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

16 (c) This section shall be implemented on or before July 1, 2001,  
17 but only to the extent that federal financial participation under  
18 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.  
19 1396 and following) is available.

20 (d) Notwithstanding Chapter 3.5 (commencing with Section  
21 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
22 the department shall, without taking any regulatory action,  
23 implement this section by means of all county letters or similar  
24 instructions. Thereafter, the department shall adopt regulations in  
25 accordance with the requirements of Chapter 3.5 (commencing  
26 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
27 Government Code. Comprehensive implementing instructions  
28 shall be issued to the counties no later than March 1, 2001.

29 SEC. 34. Section 14005.32 of the Welfare and Institutions  
30 Code is amended to read:

31 14005.32. (a) (1) If the county has evidence clearly  
32 demonstrating that a beneficiary is not eligible for benefits under  
33 this chapter pursuant to Section 14005.30, but is eligible for  
34 benefits under this chapter pursuant to other provisions of law, the  
35 county shall transfer the individual to the corresponding Medi-Cal  
36 program. Eligibility under Section 14005.30 shall continue until  
37 the transfer is complete.

38 (2) The department, in consultation with the counties and  
39 representatives of consumers, managed care plans, and Medi-Cal  
40 providers, shall prepare a simple, clear, consumer-friendly notice

1 to be used by the counties, to inform beneficiaries that their  
2 Medi-Cal benefits have been transferred pursuant to paragraph (1)  
3 and to inform them about the program to which they have been  
4 transferred. To the extent feasible, the notice shall be issued with  
5 the notice of discontinuance from cash aid, and shall include all  
6 of the following:

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

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

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

15 (D) A statement that the Medi-Cal beneficiary does not need to  
16 fill out monthly status reports in order to remain eligible for  
17 Medi-Cal, but shall be required to submit a semiannual status report  
18 and annual reaffirmation forms, except that the semiannual status  
19 report shall no longer be required on and after July 1, 2008. In  
20 addition, if the person or persons to whom the notice is directed  
21 has been found eligible for transitional Medi-Cal as described in  
22 Section 14005.8, 14005.81, or 14005.85, the statement shall explain  
23 the reporting requirements and duration of benefits under those  
24 programs, and shall further explain that, at the end of the duration  
25 of these benefits, a redetermination, as provided for in Section  
26 14005.37 shall be conducted to determine whether benefits are  
27 available under any other provision of law.

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

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

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

36 (b) No later than September 1, 2001, the department shall submit  
37 a federal waiver application seeking authority to eliminate the  
38 reporting requirements imposed by transitional medicaid under  
39 Section 1925 of the federal Social Security Act (Title 42 U.S.C.  
40 Sec. 1396r-6).

1 (c) This section shall be implemented on or before July 1, 2001,  
2 but only to the extent that federal financial participation under  
3 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.  
4 1396 and following) is available.

5 (d) Notwithstanding Chapter 3.5 (commencing with Section  
6 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
7 the department shall, without taking any regulatory action,  
8 implement this section by means of all county letters or similar  
9 instructions. Thereafter, the department shall adopt regulations in  
10 accordance with the requirements of Chapter 3.5 (commencing  
11 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
12 Government Code. Comprehensive implementing instructions  
13 shall be issued to the counties no later than March 1, 2001.

14 SEC. 35. Section 14005.301 is added to the Welfare and  
15 Institutions Code, to read:

16 14005.301. (a) Notwithstanding Section 14005.30, to the extent  
17 that federal financial participation is available, Medi-Cal benefits  
18 under a Cal-CHIPP Healthy Families plan as permitted under  
19 Section 6044 of the federal Deficit Reduction Act of 2005 (42  
20 U.S.C. Sec. 1396u-7) shall be provided to a population composed  
21 of parents and other caretaker relatives with a household income  
22 at or below 300 percent of the federal poverty level who are not  
23 otherwise eligible for full scope benefits with no share of cost.

24 (b) The Cal-CHIPP Healthy Families plan referenced in  
25 subdivision (a) shall be health plan coverage provided through a  
26 health care service plan or a health insurer that meets the  
27 requirements of federal law and that provides the same covered  
28 services and benefits required under the Knox-Keene Health Care  
29 Service Plan Act of 1975 (Chapter 2.2 (commencing with Section  
30 1340) of Division 2 of the Health and Safety Code) plus  
31 prescription drugs.

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

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

37 (e) The department shall implement this section by means of a  
38 state plan amendment. If this section cannot be implemented by a  
39 state plan amendment, the department shall seek a waiver or a



1 waiver and a state plan amendment necessary to accomplish the  
2 intent of this section.

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

4 SEC. 36. Section 14005.331 is added to the Welfare and  
5 Institutions Code, to read:

6 14005.331. (a) All children under 19 years of age who meet  
7 the state residency requirements of the Medi-Cal program or the  
8 Healthy Families Program shall be eligible for health care coverage  
9 in accordance with subdivision (b) if they either (1) live in families  
10 with countable household income at or below 300 percent of the  
11 federal poverty level, or (2) meet the income and resource  
12 requirements of Section 14005.7 of the Welfare and Institutions  
13 Code or the income requirements of Section 14005.30 of the  
14 Welfare and Institutions Code. The children described in this  
15 section include all children for whom federal financial participation  
16 under Title XIX of the federal Social Security Act (42 U.S.C. Sec.  
17 1396 et seq.) or Title XXI of the federal Social Security Act (42  
18 U.S.C. Sec. 1397 et seq.) is not available due to their immigration  
19 status or date of entry into the United States, but does not include  
20 children who are ineligible for Title XIX and Title XXI funds  
21 based on other grounds. Nothing in this section shall be construed  
22 to limit a child's right to Medi-Cal eligibility under existing law.

23 (b) Children described in subdivision (a) in families whose  
24 household income would render them ineligible for no-cost  
25 Medi-Cal, and who are in compliance with Sections 12693.71 and  
26 12693.72 of the Insurance Code, shall be eligible for the Healthy  
27 Families Program and shall also be eligible for Medi-Cal with a  
28 share of cost in accordance with Section 14005.7 of the Welfare  
29 and Institutions Code. Other children described in this section shall  
30 be eligible for Medi-Cal with no share of cost.

31 (c) ~~The~~ *On and after January 1, 2010, the* coverage under this  
32 section for a child who is an employee or, if applicable, a dependent  
33 of an employee of an employer electing to make a payment to the  
34 California Health Trust Fund in lieu of making health expenditures  
35 pursuant to Section 4802.1 of the Unemployment Insurance Code,  
36 shall be provided through a Cal-CHIPP Medi-Cal plan under Part  
37 6.45 (commencing with Section 12699.201) of Division 2 of the  
38 Insurance Code.

39 SEC. 37. Section 14005.82 is added to the Welfare and  
40 Institutions Code, to read:

1 14005.82. (a) The department shall exercise its options under  
2 Section 1906 of Title 19 of the federal Social Security Act (42  
3 U.S.C. Sec. 1396e) to require, as a condition of an individual  
4 becoming or remaining eligible for the Medi-Cal program, that  
5 the individual, or if a child, the child's parent, offered the option  
6 of enrolling in a Cal-CHIPP Medi-Cal plan pursuant to Section  
7 1357.24 of the Health and Safety Code or Section 10764 of the  
8 Insurance Code enroll in that Cal-CHIPP Medi-Cal plan. If the  
9 individual is eligible for the Medi-Cal program under Section  
10 14005.301 and the individual is offered the option of enrolling in  
11 a Cal-CHIPP Healthy Families plan pursuant to Section 1357.24  
12 of the Health and Safety Code or Section 10764 of the Insurance  
13 Code, the individual shall, as a condition of the individual  
14 becoming or remaining eligible for the Medi-Cal program, enroll  
15 in the Cal-CHIPP Healthy Families plan.

16 (b) The requirement that an individual enroll in a Cal-CHIPP  
17 Medi-Cal plan or a Cal-CHIPP Healthy Families plan, as described  
18 in subdivision (a), shall apply to an individual enrolled in the  
19 Medi-Cal program or in the Healthy Families Program at the  
20 individual's next annual redetermination of eligibility for the  
21 Medi-Cal program or the Healthy Families Program, or before that  
22 time if requested by the beneficiary or subscriber.

23 SEC. 38. Section 14008.85 of the Welfare and Institutions  
24 Code is amended to read:

25 14008.85. (a) To the extent federal financial participation is  
26 available, a parent who is the principal wage earner shall be  
27 considered an unemployed parent for purposes of establishing  
28 eligibility based upon deprivation of a child where any of the  
29 following applies:

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

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

39 (3) The parent is considered unemployed under the terms of an  
40 existing federal waiver of the 100-hour rule for recipients under

1 the program established by Section 1931(b) of the federal Social  
2 Security Act (42 U.S.C. Sec. 1396u-1).

3 (b) The department shall seek any federal approval required to  
4 waive or to increase the income limit in paragraph (2) of  
5 subdivision (a) to the extent necessary to implement Sections  
6 14005.30 and 14005.301.

7 (c) Notwithstanding Chapter 3.5 (commencing with Section  
8 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
9 the department shall implement this section by means of an all  
10 county letter or similar instruction without taking regulatory action.  
11 Thereafter, the department shall adopt regulations in accordance  
12 with the requirements of Chapter 3.5 (commencing with Section  
13 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

14 SEC. 39. Section 14011.16 of the Welfare and Institutions  
15 Code is amended to read:

16 14011.16. (a) Commencing August 1, 2003, the department  
17 shall implement a requirement for beneficiaries to file semiannual  
18 status reports as part of the department's procedures to ensure that  
19 beneficiaries make timely and accurate reports of any change in  
20 circumstance that may affect their eligibility. The department shall  
21 develop a simplified form to be used for this purpose. The  
22 department shall explore the feasibility of using a form that allows  
23 a beneficiary who has not had any changes to so indicate by  
24 checking a box and signing and returning the form.

25 (b) Beneficiaries who have been granted continuous eligibility  
26 under Section 14005.25 shall not be required to submit semiannual  
27 status reports. To the extent federal financial participation is  
28 available, all children under 19 years of age shall be exempt from  
29 the requirement to submit semiannual status reports.

30 (c) Beneficiaries whose eligibility is based on a determination  
31 of disability or on their status as aged or blind shall be exempt  
32 from the semiannual status report requirement described in  
33 subdivision (a). The department may exempt other groups from  
34 the semiannual status report requirement as necessary for simplicity  
35 of administration.

36 (d) When a beneficiary has completed, signed, and filed a  
37 semiannual status report that indicated a change in circumstance,  
38 eligibility shall be redetermined.

39 (e) Notwithstanding Chapter 3.5 (commencing with Section  
40 11340) of Part 1 of Division 3 of Title 2 of the Government Code,

1 the department shall implement this section by means of all county  
 2 letters or similar instructions without taking regulatory action.  
 3 Thereafter, the department shall adopt regulations in accordance  
 4 with the requirements of Chapter 3.5 (commencing with Section  
 5 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

6 (f) This section shall be implemented only if and to the extent  
 7 federal financial participation is available.

8 (g) This section shall become inoperative on July 1, 2008, and,  
 9 as of January 1, 2009, is repealed, unless a later enacted statute  
 10 that is enacted before January 1, 2009, deletes or extends the dates  
 11 on which it becomes inoperative and is repealed.

12 SEC. 40. Section 14131.01 is added to the Welfare and  
 13 Institutions Code, to read:

14 14131.01. On and after January 1, 2010, the coverage under  
 15 this chapter to a person who is an employee or, if applicable, a  
 16 dependent of an employee, of an employer electing to make a  
 17 payment to the California Health Trust Fund in lieu of making  
 18 health expenditures pursuant to Section 4802.1 of the  
 19 Unemployment Insurance Code, shall be provided through a  
 20 Cal-CHIPP Medi-Cal plan under Part 6.45 (commencing with  
 21 Section 12699.201) of the Insurance Code.

22 SEC. 41. Article 7 (commencing with Section 14199.10) is  
 23 added to Chapter 7 of Part 3 of Division 9 of the Welfare and  
 24 Institutions Code, to read:

25  
 26 Article 7. Coordination with the California Health Trust Fund  
 27

28 14199.10. The department shall seek any necessary federal  
 29 approval to enable the state to receive federal funds for coverage  
 30 provided through the California Cooperative Health Insurance  
 31 Purchasing Program (Cal-CHIPP) to persons who would be eligible  
 32 for the Medi-Cal program if the state expanded eligibility to a  
 33 population composed of parents and other caretaker relatives with  
 34 a household income at or below 300 percent of the federal poverty  
 35 level who are not otherwise eligible for full scope benefits with  
 36 no share of cost. Revenues in the California Health Trust Fund  
 37 created pursuant to Section 12699.212 of the Insurance Code shall  
 38 be used as state matching funds for receipt of federal funds  
 39 resulting from the implementation of this section. All federal funds

1 received pursuant to that federal approval shall be deposited in the  
2 California Health Trust Fund.

3 SEC. 42. Section 6254.28 is added to the Government Code,  
4 to read:

5 6254.28. (a) Nothing in this chapter or any other provision of  
6 law shall require the disclosure of records of the Managed Risk  
7 Medical Insurance Board relating to activities governed by Part  
8 6.45 (commencing with Section 12699.201) of Division 2 of the  
9 Insurance Code, and that reveal the deliberative processes,  
10 discussions, communications, or any other portion of the  
11 negotiations with entities contracting or seeking to contract with  
12 the board, or the impressions, opinions, recommendations, meeting  
13 minutes, research, work product, theories, or strategy of the board  
14 or its staff, or records that provide instructions, advice, or training  
15 to employees.

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

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

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

29 (d) Notwithstanding any other provision of law, the entire  
30 contract or amendments to a contract shall be open to inspection  
31 by the Joint Legislative Audit Committee and the Legislative  
32 Analyst's Office. The committee and the office shall maintain the  
33 confidentiality of the contracts and amendments thereto until the  
34 contract or amendments to a contract are open to inspection  
35 pursuant to subdivision (b) or (c).

36 SEC. 43. Section 11126 of the Government Code is amended  
37 to read:

38 11126. (a) (1) Nothing in this article shall be construed to  
39 prevent a state body from holding closed sessions during a regular  
40 or special meeting to consider the appointment, employment,

1 evaluation of performance, or dismissal of a public employee or  
2 to hear complaints or charges brought against that employee by  
3 another person or employee unless the employee requests a public  
4 hearing.

5 (2) As a condition to holding a closed session on the complaints  
6 or charges to consider disciplinary action or to consider dismissal,  
7 the employee shall be given written notice of his or her right to  
8 have a public hearing, rather than a closed session, and that notice  
9 shall be delivered to the employee personally or by mail at least  
10 24 hours before the time for holding a regular or special meeting.  
11 If notice is not given, any disciplinary or other action taken against  
12 any employee at the closed session shall be null and void.

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

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

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

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

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

32 (2) Prevent an advisory body of a state body that administers  
33 the licensing of persons engaged in businesses or professions from  
34 conducting a closed session to discuss matters that the advisory  
35 body has found would constitute an unwarranted invasion of the  
36 privacy of an individual licensee or applicant if discussed in an  
37 open meeting, provided the advisory body does not include a  
38 quorum of the members of the state body it advises. Those matters  
39 may include review of an applicant’s qualifications for licensure  
40 and an inquiry specifically related to the state body’s enforcement

1 program concerning an individual licensee or applicant where the  
2 inquiry occurs prior to the filing of a civil, criminal, or  
3 administrative disciplinary action against the licensee or applicant  
4 by the state body.

5 (3) Prohibit a state body from holding a closed session to  
6 deliberate on a decision to be reached in a proceeding required to  
7 be conducted pursuant to Chapter 5 (commencing with Section  
8 11500) or similar provisions of law.

9 (4) Grant a right to enter any correctional institution or the  
10 grounds of a correctional institution where that right is not  
11 otherwise granted by law, nor shall anything in this article be  
12 construed to prevent a state body from holding a closed session  
13 when considering and acting upon the determination of a term,  
14 parole, or release of any individual or other disposition of an  
15 individual case, or if public disclosure of the subjects under  
16 discussion or consideration is expressly prohibited by statute.

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

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

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

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

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

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

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

39 (8) Prevent the California Postsecondary Education Commission  
40 from holding closed sessions to consider matters pertaining to the

1 appointment or termination of the Director of the California  
2 Postsecondary Education Commission.

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

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

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

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

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

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

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



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

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

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

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

38 (C) After meeting in closed session pursuant to subparagraph  
39 (A), the state body shall reconvene in open session prior to  
40 adjournment and report that a closed session was held pursuant to

1 subparagraph (A), the general nature of the matters considered,  
2 and whether any action was taken in closed session.

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

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

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

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

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

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

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

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

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

7 (ii) The legal counsel of the state body shall prepare and submit  
8 to it a memorandum stating the specific reasons and legal authority  
9 for the closed session. If the closed session is pursuant to paragraph  
10 (1), the memorandum shall include the title of the litigation. If the  
11 closed session is pursuant to subparagraph (A) or (B), the  
12 memorandum shall include the existing facts and circumstances  
13 on which it is based. The legal counsel shall submit the  
14 memorandum to the state body prior to the closed session, if  
15 feasible, and in any case no later than one week after the closed  
16 session. The memorandum shall be exempt from disclosure  
17 pursuant to Section 6254.25.

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

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

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

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

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

39 (3) Prevent an administrative committee established by the  
40 California Board of Accountancy pursuant to Section 5020 of the

1 Business and Professions Code from conducting a closed session  
2 to consider disciplinary action against an individual accountant  
3 prior to the filing of an accusation against the accountant pursuant  
4 to Section 11503. Nothing in this article shall be construed to  
5 prevent an examining committee established by the California  
6 Board of Accountancy pursuant to Section 5023 of the Business  
7 and Professions Code from conducting a closed hearing to  
8 interview an individual applicant or accountant regarding the  
9 applicant's qualifications.

10 (4) Prevent a state body, as defined in subdivision (b) of Section  
11 11121, from conducting a closed session to consider any matter  
12 that properly could be considered in closed session by the state  
13 body whose authority it exercises.

14 (5) Prevent a state body, as defined in subdivision (d) of Section  
15 11121, from conducting a closed session to consider any matter  
16 that properly could be considered in a closed session by the body  
17 defined as a state body pursuant to subdivision (a) or (b) of Section  
18 11121.

19 (6) Prevent a state body, as defined in subdivision (c) of Section  
20 11121, from conducting a closed session to consider any matter  
21 that properly could be considered in a closed session by the state  
22 body it advises.

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

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

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

30 (8) Require the State Board of Equalization to disclose any  
31 action taken in closed session or documents executed in connection  
32 with that action, the public disclosure of which is prohibited by  
33 law pursuant to Sections 15619 and 15641 of this code and Sections  
34 833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651,  
35 45982, 46751, 50159, 55381, and 60609 of the Revenue and  
36 Taxation Code.

37 (9) Prevent the California Earthquake Prediction Evaluation  
38 Council, or other body appointed to advise the Director of the  
39 Office of Emergency Services or the Governor concerning matters

1 relating to volcanic or earthquake predictions, from holding closed  
2 sessions when considering the evaluation of possible predictions.

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

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

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

15 (h) This article does not prevent the Board of Administration  
16 of the Public Employees' Retirement System from holding closed  
17 sessions when considering matters relating to the development of  
18 rates and competitive strategy for plans offered pursuant to Chapter  
19 15 (commencing with Section 21660) of Part 3 of Division 5 of  
20 Title 2.

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

27 SEC. 44. The State Department of Health Care Services, in  
28 consultation with the Managed Risk Medical Insurance Board,  
29 shall take all reasonable steps that are required to obtain the  
30 maximum amount of federal funds and to support federal claiming  
31 procedures in the administration of this act.

32 SEC. 45. Notwithstanding Chapter 3.5 (commencing with  
33 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
34 Code, during the period January 1, 2008, to December 31, 2011,  
35 inclusive, the State Department of Health Care Services may  
36 implement this act by means of all county letters or similar  
37 instructions without taking regulatory action. After December 31,  
38 2011, the department shall adopt all necessary regulations in  
39 accordance with the requirements of Chapter 3.5 (commencing

1 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
2 Government Code.

3 SEC. 46. The Legislature finds and declares that Section 42 of  
4 this act, which adds Section 6254.28 to the Government Code, and  
5 Section 43, which amends Section 11126 of the Government Code,  
6 impose a limitation on the public's right of access to the meetings  
7 of public bodies or the writings of public officials and agencies  
8 within the meaning of Section 3 of Article I of the California  
9 Constitution. Pursuant to that constitutional provision, the  
10 Legislature makes the following findings to demonstrate the interest  
11 protected by this limitation and the need for protecting that interest:

12 In order to maximize the ability of the Managed Risk Medical  
13 Insurance Board to implement agreements with health plans and  
14 to provide a wide choice of plans at minimal cost under the  
15 California Cooperative Health Insurance Purchasing Program  
16 created pursuant to Part 6.45 (commencing with Section  
17 12699.201) of Division 2 of the Insurance Code, it is necessary  
18 and appropriate to provide limited confidentiality to certain writings  
19 developed in that regard and meetings related thereto.

20 SEC. 47. Notwithstanding any other provision of law, the  
21 Managed Risk Medical Insurance Board may implement the  
22 provisions of this act expanding the Healthy Families Program  
23 only to the extent that funds are appropriated for those purposes  
24 in the annual Budget Act or in another statute.

25 SEC. 48. During the period from January 1, 2008 to December  
26 31, 2011, inclusive, the adoption of regulations pursuant to this  
27 act by the Managed Risk Medical Insurance Board shall be deemed  
28 to be an emergency and necessary for the immediate preservation  
29 of public peace, health, and safety, or the general welfare.

30 SEC. 49. No reimbursement is required by this act pursuant to  
31 Section 6 of Article XIII B of the California Constitution for certain  
32 costs that may be incurred by a local agency or school district  
33 because, in that regard, this act creates a new crime or infraction,  
34 eliminates a crime or infraction, or changes the penalty for a crime  
35 or infraction, within the meaning of Section 17556 of the  
36 Government Code, or changes the definition of a crime within the  
37 meaning of Section 6 of Article XIII B of the California  
38 Constitution.

39 However, if the Commission on State Mandates determines that  
40 this act contains other costs mandated by the state, reimbursement

1 to local agencies and school districts for those costs shall be made  
2 pursuant to Part 7 (commencing with Section 17500) of Division  
3 4 of Title 2 of the Government Code.

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