

AMENDED IN ASSEMBLY NOVEMBER 8, 2007

CALIFORNIA LEGISLATURE—2007—08 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL

No. 1

Introduced by Assembly Member Nunez
(Principal coauthor: Senator Perata)

September 11, 2007

~~An act relating to health care.~~ *An act to amend Sections 2069, 2836.1, and 3516 of, and to add Sections 2838, 4040.1, 4071.2, 4071.3, and 4071.4 to, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.1, 12803.2, 22830.5, and 22830.6 to, and to add Chapter 15 (commencing with Section 8899.50) to Division 1 of Title of, the Government Code, to amend Sections 1363 and 1378 of, to add Sections 1262.9, 1342.9, 1347, 1367.205, 1367.38, 1368.025, 1395.2, 104376, 128745.1, and 130545 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, to add Article 1 (commencing with Section 104250) to Chapter 4 of Part 1 of Division 103 of, to add Article 3 (commencing with Section 104705) to Chapter 2 of Part 3 of Division 103 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, 12693.43, 12693.70, 12693.73, and 12693.76 of, to add Sections 10113.11, 10123.56, 10293.5, 12693.56, 12693.57, 12693.58, 12693.59, 12886, and 12887 to, to add Chapter 1.6 (commencing with Section 10199.10) and Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to add Sections 96.8 and 96.81 to the Labor Code, and to amend Sections 14005.30, 14005.31, 14005.32, and 14008.85 of, to amend and repeal Section 14011.16 of, to add Sections 14005.301, 14005.305, 14005.306, 14005.307, 14005.310, 14005.311, 14005.331, 14005.333,*

14005.334, 14011.16.1, 14132.105, and 14137.10 to, and to add Article 5.22 (commencing with Section 14167.22) and 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 1, as amended, Nunez. Health care reform.

(1) *Existing law creates the California Health and Human Services Agency.*

This bill would 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.

The bill, effective July 1, 2008, would 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. The bill would also create the California Health Benefits Service within the California 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.

(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.

This bill would require California residents, subject to certain exceptions, to maintain a minimum policy of health care coverage for themselves and their dependents, as defined. The bill would require the Managed Risk Medical Insurance Board to determine the minimum policy of health care coverage and would require the board to facilitate enrollment in public or private coverage and to establish an education and awareness program, on or before January 1, 2010, relating to the requirement to obtain a minimum policy of health care coverage. The bill would make implementation of these requirements subject to an appropriation of funds therefor in the annual Budget Act or other statute. The bill would make related changes, including authorizing a school district, on and after January 1, 2010, to provide parents and guardians information explaining these health care coverage requirements.

The 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 and be administered by the Managed Risk Medical Insurance Board. The bill would require, on and after January 1, 2010, certain health care service plans and health insurers to submit a good faith bid to the board to be a participating plan in Cal-CHIPP. The bill would specify eligibility for Cal-CHIPP and would require the board to develop and offer a variety of benefit plan designs, including the Cal-CHIPP Healthy Families plan where enrollment would be restricted to specified low-income persons. The bill would authorize an employer to pay all or a part of the premium payment required of its employees enrolled in Cal-CHIPP. The bill would make it an unfair labor practice for an employer to refer an employee, or his or her dependent, to Cal-CHIPP or to arrange for their application to that program to separate them from group coverage provided through the employment relationship, and for an employer to change the share-of-cost ratio or modify coverage in order for an employee or his or her dependents to enroll in that program. Because an unfair labor practice may be punishable as a crime, the bill would impose a state-mandated local program. The bill would create the California Health Trust Fund as part of

Cal-CHIPP, and moneys in the fund would be continuously appropriated to the board for the purposes of Cal-CHIPP. 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 expand eligibility under the Medi-Cal program, commencing July 1, 2010, to certain populations subject to federal financial participation and would additionally expand eligibility under the Medi-Cal program to a population 19 years of age or older with a family income greater than 100% of the federal poverty level but less than or equal to 250% of the federal poverty level, subject to establishment of a county share of cost. The bill would require certain of these individuals to receive their benefits in the form of a benchmark package, which would be the subsidized benefit package or packages established under Cal-CHIPP. The bill would provide for the benchmark benefits to be administered by the Managed Risk Medical Insurance Board, pursuant to an interagency agreement with the department. The bill would make these provisions subject to federal financial participation and approval, as specified.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program on and after July 1, 2010. The bill would, on and after July 1, 2010, delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child satisfy 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, 2010, 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 authorize the board to provide, or arrange for the provision of, an electronic personal health record under the Healthy Families Program, to the extent funds are appropriated for that purpose, and would provide for the confidentiality of information obtained pursuant to the program.

The bill would require the department to exercise its federal option as necessary to simplify Medi-Cal eligibility by exempting all resources for applicants and recipients, commencing July 1, 2010, and it would

revise the semiannual status reports required of Medi-Cal beneficiaries on and after July 1, 2010.

The bill would require the State Department of Health Care Services to establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval. The bill would also require the Director of Health Care Services to establish a local coverage option program that would be the exclusive Medi-Cal coverage for a 5-year period beginning with the program's commencement, for county residents 21 years of age or older who, among other requirements, have a family income at or below 100 percent of the federal poverty level and are not otherwise eligible for the Medi-Cal program. The bill would specify that the program would become operational for services rendered on or after July 1, 2010. The bill would specify that coverage under the program would be provided at a county's option and only by a county that operates a designated public hospital. The bill would require the State Department of Health Care Services, by January 1, 2010, to contract with an independent 3rd party to develop an assessment tool to measure the care provided under the program. The bill would require the department after 3 years of the program's operation, to evaluate the program using the assessment tool and would extend the program for an additional 2 years if the program substantially met certain criteria and would terminate the program if it did not. The bill would enact other related provisions.

The bill would provide for the Medi-Cal Physician Rate Increase Act, which would establish, with respect to services rendered to Medi-Cal beneficiaries on and after July 1, 2010, increased reimbursements for physicians and physician groups, as defined, that are enrolled Medi-Cal providers eligible to receive payments for Medi-Cal services. The bill would permit some of these rate increases to be linked to specified performance measures and would provide that these rate increases would be implemented only to the extent that state funds are appropriated for the nonfederal share of these increases. The bill would require the Director of Health Care Services to seek federal approval of the rate methodology set forth in the act and would prohibit the methodology from being implemented if federal approval is not obtained.

Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

(3) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This 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, modified small employer coverage, modified disclosures, and other related changes. 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. The bill would allow a health care service plan and a health insurer to provide notices by electronic transmission using specified procedures.

The bill would require a health care service plan providing prescription drug benefits and maintaining a drug formulary to, commencing on or before January 1, 2010, make the most current formularies available electronically to prescribers and pharmacies and would require health care service plans that provide services to certain beneficiaries under a Medi-Cal managed care program comply to filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program.

The bill would also require specified group health care service plan contracts and group health insurance policies offered, amended, or renewed on or after January 1, 2009, to offer at least one benefit design that includes a Healthy Action Incentives and Rewards Program, as specified. The bill would also authorize an employer to provide health coverage that includes a Healthy Action Incentives and Reward program to his or her employees.

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.

(4) Existing law authorizes the Board of Administration of the Public Employees' Retirement System to contract with carriers offering health benefit plans for coverage for eligible employees and annuitants.

This bill would require the board, on or before January 1, 2009, to provide or arrange for the provision of an electronic personal health record for enrollees receiving health care benefits.

(5) Existing law establishes the State Department of Public Health, which licenses and regulates health facilities and also administers funds for programs relating to smoking cessation. Under existing law, a noncontracting hospital is required to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee for inpatient poststabilization care, as defined, or prior to transferring the enrollee, if certain conditions apply. Existing law prohibits the hospital from billing the enrollee for poststabilization care if it is required to, and fails to, contact the enrollee's health care service plan. Under existing law, a violation of any of these provisions is punishable as a misdemeanor.

This bill would prohibit a noncontracting hospital, as defined, from billing a covered patient for emergency health care services and poststabilizing care except for applicable copayments and cost shares. By changing the definition of an existing crime, this bill would impose a state-mandated local program.

The bill would also require the department to maintain the California Diabetes Program to provide information and assistance pertaining to the prevention and treatment of diabetes. The bill would also establish the Comprehensive Diabetes Services Program in the State Department of Health Care Services to provide diabetes prevention and management services to certain beneficiaries in the Medi-Cal program, to the extent funding is available for this purpose. The bill would also require the department, in consultation with the Department of Managed Health Care, the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and the Department of Insurance, to annually identify the 10 largest providers of health care coverage in the state, to ascertain and summarize the smoking cessation benefits provided by those coverage providers, to publish the benefit summary on the department's Internet Web site, to include the benefit summary as part of its preventive health education against tobacco use campaign, and to evaluate any changes in connection with the smoking cessation benefits provided by the coverage providers, as provided. The bill would also require the department, to the extent that funds are available and appropriated for this purpose, to increase the capacity of effective smoking cessation services available from, and expand the awareness

of, services available through, the California Smokers' Helpline, as prescribed.

The bill would also create the Community Makeover Grant program that would be administered by the department and would require it to award grants to local health departments in cities and counties, which would serve as the local lead agencies in administering the program, for the purpose of developing new programs or improving existing programs that promote active living and healthy eating. The bill would require the department to issue guidelines and to specify data reporting requirements for local lead agencies to comply with various requirements relating to the administration of the program. The bill would also require the department to develop a sustained media campaign to educate the public about the importance of obesity prevention.

(6) Existing law provides for the Office of Statewide Health Planning and Development, which has specified powers and duties. Existing law requires the office to publish specified reports.

This bill would require the office to publish risk-adjusted outcome reports for percutaneous coronary interventions, commencing January 1, 2010, and would require the office to establish a clinical data collection program to collect data on percutaneous coronary interventions and establish by regulation the data to be reported by each hospital.

(7) Existing law provides for the certification and regulation of nurses, including nurse practitioners and nurse-midwives, by the Board of Registered Nursing and for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law provides that a medical assistant may administer medication upon the specific authorization and supervision of a licensed physician and surgeon or licensed podiatrist or, in specified clinic settings, upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant.

This bill would remove the requirement that a medical assistant's administration of medication upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant occur in specified clinic settings, and would make related changes.

(8) Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing which is within the Department of Consumer Affairs. Under existing

law, a physician and surgeon is prohibited from supervising more than 4 nurse practitioners at one time.

This bill would instead prohibit a physician and surgeon from supervising more than 6 nurse practitioners at one time. The bill would create the Task Force on Nurse Practitioner Scope of Practice that would consist of specified members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. The bill would make the task force responsible for developing a recommended scope of practice for nurse practitioners and would require the task force to report the recommended scope of practice to the Governor and the Legislature on or before June 30, 2009. The bill would require the Director of Consumer Affairs, on or before July 1, 2010, to promulgate regulations that adopt the recommended scope of practice. The bill would require the aforementioned boards to pay the state administrative costs of implementing these provisions.

(9) Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California and limits the number of physician assistants supervised by a physician.

This bill would prohibit a physician and surgeon from supervising more than 6 physician assistants at one time.

(10) Existing law, the Pharmacy Law, defines an electronic transmission prescription and sets forth the requirements for those types of prescriptions.

This bill would require electronic prescribing systems to meet specified standards and requirements and would require a prescriber or prescriber's authorized agent to offer patients a written receipt of information transmitted electronically, including the patient's name and the drug prescribed, and would require the State Department of Health Care Services to develop a pilot program to foster the adoption and use of electronic prescribing by health care providers that contract with the Medi-Cal program, as specified. The bill would require every licensed prescriber, or prescriber's authorized agent, or pharmacy operating in California, on or before January 1, 2010, to have the ability to transmit and receive prescriptions by electronic data transmission.

(11) This bill would give the State Department of Health Care Services, in consultation with the Department of Finance, authority to take various actions as necessary to implement the bill, including promoting flexibility of implementation and maximizing federal financial participation. The bill would require the Director of Health Care

Services to notify the Chair of the Joint Legislative Budget Committee prior to exercising this flexibility. The bill would declare the intent of the Legislature to implement the bill to harmonize and best effectuate the purposes and intent of the bill.

(12) This bill would declare the Legislature’s intent that the act’s provisions be financed by contributions from various sources, including payments by acute care hospitals and employers, and by increasing the taxes on cigarettes and other tobacco products. The bill would also declare the Legislature’s intent to increase the rates paid under the Medi-Cal program for inpatient and outpatient hospital services.

(13) 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.

~~Existing law does not provide for a health care system for all California residents. Existing law provides for the creation of various programs to provide health care services 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. 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 state that it is the intent of the Legislature to enact comprehensive health care reform:~~

~~Vote: majority. Appropriation: no-yes. Fiscal committee: no-yes. State-mandated local program: no-yes.~~

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

- 1 ~~SECTION 1. It is the intent of the Legislature to enact~~
- 2 ~~comprehensive health care reform.~~

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 for all California residents. To*
5 *accomplish this goal, the Legislature proposes to take all of the*
6 *following steps:*

7 *(a) Ensure that all Californians have access to affordable,*
8 *comprehensive health care.*

9 *(b) Leverage available federal funds to the greatest extent*
10 *possible through existing federal programs.*

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

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

23 *SEC. 3. Section 2069 of the Business and Professions Code is*
24 *amended to read:*

25 2069. (a) (1) Notwithstanding any other provision of law, a
26 medical assistant may administer medication only by intradermal,
27 subcutaneous, or intramuscular injections and perform skin tests
28 and additional technical supportive services upon the specific
29 authorization and supervision of a licensed physician and surgeon,
30 *nurse practitioner, nurse-midwife, physician assistant, or a licensed*
31 *podiatrist. A medical assistant may also perform all these tasks*
32 *and services in a clinic licensed pursuant to subdivision (a) of*
33 *Section 1204 of the Health and Safety Code upon the specific*
34 *authorization of a physician assistant, a nurse practitioner, or a*
35 *nurse-midwife.*

36 (2) ~~The supervising physician and surgeon at a clinic described~~
37 ~~in paragraph (1) licensed physician and surgeon, nurse practitioner,~~
38 ~~nurse-midwife, physician assistant, or licensed podiatrist may, at~~
39 ~~his or her discretion, in consultation with the nurse practitioner,~~
40 ~~nurse-midwife, or physician assistant provide written instructions~~

1 to be followed by a medical assistant in the performance of tasks
 2 or supportive services. These written instructions may provide that
 3 ~~the supervisory function for the medical assistant for these tasks~~
 4 ~~or supportive services may be delegated to the nurse practitioner,~~
 5 ~~nurse-midwife, or physician assistant within the standardized~~
 6 ~~procedures or protocol, and that tasks may be performed when the~~
 7 ~~supervising physician and surgeon~~ *licensed physician and surgeon,*
 8 *nurse practitioner, nurse-midwife, physician assistant, or licensed*
 9 *podiatrist* is not onsite, so long as the following apply:

10 (A) The nurse practitioner or nurse-midwife is functioning
 11 pursuant to standardized procedures, as defined by Section 2725,
 12 or protocol. The standardized procedures or protocol shall be
 13 developed and approved by the supervising physician and surgeon,
 14 the nurse practitioner or nurse-midwife, and the facility
 15 administrator or his or her designee.

16 (B) The physician assistant is functioning pursuant to regulated
 17 services defined in Section 3502 and is approved to do so by the
 18 supervising physician or surgeon.

19 (b) As used in this section and Sections 2070 and 2071, the
 20 following definitions shall apply:

21 (1) “Medical assistant” means a person who may be unlicensed,
 22 who performs basic administrative, clerical, and technical
 23 supportive services in compliance with this section and Section
 24 2070 for a licensed physician and surgeon or a licensed podiatrist,
 25 or group thereof, for a medical, *nursing*, or podiatry corporation,
 26 for a physician assistant, a nurse practitioner, or a nurse-midwife
 27 as provided in subdivision (a), or for a health care service plan,
 28 who is at least 18 years of age, and who has had at least the
 29 minimum amount of hours of appropriate training pursuant to
 30 standards established by the Division of Licensing. The medical
 31 assistant shall be issued a certificate by the training institution or
 32 instructor indicating satisfactory completion of the required
 33 training. A copy of the certificate shall be retained as a record by
 34 each employer of the medical assistant.

35 (2) “Specific authorization” means a specific written order
 36 prepared by the ~~supervising physician and surgeon or the~~
 37 ~~supervising podiatrist, or the physician assistant, the nurse~~
 38 ~~practitioner, or the nurse-midwife as provided in subdivision (a);~~
 39 *licensed physician and surgeon, nurse practitioner, nurse-midwife,*
 40 *physician assistant, or licensed podiatrist* authorizing the

1 procedures to be performed on a patient, which shall be placed in
2 the patient’s medical record, or a standing order prepared by the
3 ~~supervising physician and surgeon or the supervising podiatrist,~~
4 ~~or the physician assistant, the nurse practitioner, or the~~
5 ~~nurse-midwife as provided in subdivision (a),~~ *licensed physician*
6 *and surgeon, nurse practitioner, nurse-midwife, physician assistant,*
7 *or licensed podiatrist,* authorizing the procedures to be performed,
8 the duration of which shall be consistent with accepted medical
9 practice. A notation of the standing order shall be placed on the
10 patient’s medical record.

11 (3) “Supervision” means the supervision of procedures
12 authorized by this section by the following practitioners, within
13 the scope of their respective practices, who shall be physically
14 present in the treatment facility during the performance of those
15 procedures:

16 (A) A licensed physician and surgeon.

17 (B) A licensed podiatrist.

18 (C) A physician assistant, nurse practitioner, or nurse-midwife
19 ~~as provided in subdivision (a).~~

20 (4) “Technical supportive services” means simple routine
21 medical tasks and procedures that may be safely performed by a
22 medical assistant who has limited training and who functions under
23 the supervision of a licensed physician and surgeon ~~or~~, a licensed
24 podiatrist, ~~or~~ a physician assistant, a nurse practitioner, or a
25 nurse-midwife ~~as provided in subdivision (a).~~

26 (c) Nothing in this section shall be construed as authorizing the
27 licensure of medical assistants. Nothing in this section shall be
28 construed as authorizing the administration of local anesthetic
29 agents by a medical assistant. Nothing in this section shall be
30 construed as authorizing the division to adopt any regulations that
31 violate the prohibitions on diagnosis or treatment in Section 2052.

32 (d) Notwithstanding any other provision of law, a medical
33 assistant may not be employed for inpatient care in a licensed
34 general acute care hospital as defined in subdivision (a) of Section
35 1250 of the Health and Safety Code.

36 (e) Nothing in this section shall be construed as authorizing a
37 medical assistant to perform any clinical laboratory test or
38 examination for which he or she is not authorized by Chapter 3
39 (commencing with Section 1200). Nothing in this section shall be
40 construed as authorizing a nurse practitioner, nurse-midwife, or

1 physician assistant to be a laboratory director of a clinical
2 laboratory, as those terms are defined in paragraph (7) of
3 subdivision (a) of Section 1206 and subdivision (a) of Section
4 1209.

5 *SEC. 4. Section 2836.1 of the Business and Professions Code*
6 *is amended to read:*

7 2836.1. Neither this chapter nor any other provision of law
8 shall be construed to prohibit a nurse practitioner from furnishing
9 or ordering drugs or devices when all of the following apply:

10 (a) The drugs or devices are furnished or ordered by a nurse
11 practitioner in accordance with standardized procedures or
12 protocols developed by the nurse practitioner and the supervising
13 physician and surgeon when the drugs or devices furnished or
14 ordered are consistent with the practitioner’s educational
15 preparation or for which clinical competency has been established
16 and maintained.

17 (b) The nurse practitioner is functioning pursuant to standardized
18 procedure, as defined by Section 2725, or protocol. The
19 standardized procedure or protocol shall be developed and
20 approved by the supervising physician and surgeon, the nurse
21 practitioner, and the facility administrator or the designee.

22 (c) (1) The standardized procedure or protocol covering the
23 furnishing of drugs or devices shall specify which nurse
24 practitioners may furnish or order drugs or devices, which drugs
25 or devices may be furnished or ordered, under what circumstances,
26 the extent of physician and surgeon supervision, the method of
27 periodic review of the nurse practitioner’s competence, including
28 peer review, and review of the provisions of the standardized
29 procedure.

30 (2) In addition to the requirements in paragraph (1), for Schedule
31 II controlled substance protocols, the provision for furnishing
32 Schedule II controlled substances shall address the diagnosis of
33 the illness, injury, or condition for which the Schedule II controlled
34 substance is to be furnished.

35 (d) The furnishing or ordering of drugs or devices by a nurse
36 practitioner occurs under physician and surgeon supervision.
37 Physician and surgeon supervision shall not be construed to require
38 the physical presence of the physician, but does include (1)
39 collaboration on the development of the standardized procedure,
40 (2) approval of the standardized procedure, and (3) availability by

1 telephonic contact at the time of patient examination by the nurse
2 practitioner.

3 (e) For purposes of this section, no physician and surgeon shall
4 supervise more than ~~four~~ six nurse practitioners at one time.

5 (f) (1) Drugs or devices furnished or ordered by a nurse
6 practitioner may include Schedule II through Schedule V controlled
7 substances under the California Uniform Controlled Substances
8 Act (Division 10 (commencing with Section 11000) of the Health
9 and Safety Code) and shall be further limited to those drugs agreed
10 upon by the nurse practitioner and physician and surgeon and
11 specified in the standardized procedure.

12 (2) When Schedule II or III controlled substances, as defined
13 in Sections 11055 and 11056, respectively, of the Health and Safety
14 Code, are furnished or ordered by a nurse practitioner, the
15 controlled substances shall be furnished or ordered in accordance
16 with a patient-specific protocol approved by the treating or
17 supervising physician. A copy of the section of the nurse
18 practitioner's standardized procedure relating to controlled
19 substances shall be provided, upon request, to any licensed
20 pharmacist who dispenses drugs or devices, when there is
21 uncertainty about the nurse practitioner furnishing the order.

22 (g) (1) The board has certified in accordance with Section
23 2836.3 that the nurse practitioner has satisfactorily completed (1)
24 at least six month's physician and surgeon-supervised experience
25 in the furnishing or ordering of drugs or devices and (2) a course
26 in pharmacology covering the drugs or devices to be furnished or
27 ordered under this section.

28 (2) Nurse practitioners who are certified by the board and hold
29 an active furnishing number, who are authorized through
30 standardized procedures or protocols to furnish Schedule II
31 controlled substances, and who are registered with the United
32 States Drug Enforcement Administration, shall complete, as part
33 of their continuing education requirements, a course including
34 Schedule II controlled substances based on the standards developed
35 by the board. The board shall establish the requirements for
36 satisfactory completion of this subdivision.

37 (h) Use of the term "furnishing" in this section, in health
38 facilities defined in Section 1250 of the Health and Safety Code,
39 shall include (1) the ordering of a drug or device in accordance

1 with the standardized procedure and (2) transmitting an order of
2 a supervising physician and surgeon.

3 (i) “Drug order” or “order” for purposes of this section means
4 an order for medication which is dispensed to or for an ultimate
5 user, issued by a nurse practitioner as an individual practitioner,
6 within the meaning of Section 1306.02 of Title 21 of the Code of
7 Federal Regulations. Notwithstanding any other provision of law,
8 (1) a drug order issued pursuant to this section shall be treated in
9 the same manner as a prescription of the supervising physician;
10 (2) all references to “prescription” in this code and the Health and
11 Safety Code shall include drug orders issued by nurse practitioners;
12 and (3) the signature of a nurse practitioner on a drug order issued
13 in accordance with this section shall be deemed to be the signature
14 of a prescriber for purposes of this code and the Health and Safety
15 Code.

16 *SEC. 5. Section 2838 is added to the Business and Professions*
17 *Code, to read:*

18 *2838. (a) The Task Force on Nurse Practitioner Scope of*
19 *Practice is hereby created and shall consist of the following*
20 *members:*

21 *(1) The Director of Consumer Affairs, who shall serve as an ex*
22 *officio member of the task force and shall cast the deciding vote*
23 *in any matter voted upon by the task force that results in a tie vote.*

24 *(2) Three members of the Medical Board of California, two of*
25 *whom shall be appointed to the task force by the Governor, and*
26 *one of whom shall be appointed to the task force by the Speaker*
27 *of the Assembly.*

28 *(3) Three members of the Board of Registered Nursing, two of*
29 *whom shall be appointed to the task force by the Governor, and*
30 *one of whom shall be appointed to the task force by the Senate*
31 *Committee on Rules.*

32 *(4) Two representatives of an institution of higher education,*
33 *who shall be appointed to the task force by the Governor as*
34 *nonvoting members.*

35 *(b) The duty of the task force shall be to develop a recommended*
36 *scope of practice for nurse practitioners.*

37 *(c) The task force shall report its recommended scope of practice*
38 *for nurse practitioners to the Governor and the Legislature on or*
39 *before June 30, 2009.*

1 (d) On or before July 1, 2010, the Director of Consumer Affairs
2 shall promulgate regulations that adopt the task force's
3 recommended scope of practice.

4 (e) The Medical Board of California and the Board of Registered
5 Nursing shall pay the state administrative costs of implementing
6 this section.

7 SEC. 6. Section 3516 of the Business and Professions Code,
8 as amended by Section 4 of Chapter 376 of the Statutes of 2007,
9 is amended to read:

10 3516. (a) Notwithstanding any other provision of law, a
11 physician assistant licensed by the committee shall be eligible for
12 employment or supervision by any physician and surgeon who is
13 not subject to a disciplinary condition imposed by the board
14 prohibiting that employment or supervision.

15 (b) No physician and surgeon shall supervise more than ~~four~~
16 six physician assistants at any one time, except as provided in
17 Section 3502.5.

18 (c) The board may restrict a physician and surgeon to
19 supervising specific types of physician assistants including, but
20 not limited to, restricting a physician and surgeon from supervising
21 physician assistants outside of the field of specialty of the physician
22 and surgeon.

23 SEC. 7. Section 4040.1 is added to the Business and Professions
24 Code, to read:

25 4040.1. Electronic prescribing shall not interfere with a
26 patient's existing freedom to choose a pharmacy, and shall not
27 interfere with the prescribing decision at the point of care.

28 SEC. 8. Section 4071.2 is added to the Business and Professions
29 Code, to read:

30 4071.2. (a) On or before January 1, 2010, every licensed
31 prescriber, prescriber's authorized agent, or pharmacy operating
32 in California shall have the ability to transmit and receive
33 prescriptions by electronic data transmission.

34 (b) The Medical Board of California, the State Board of
35 Optometry, the Bureau of Naturopathic Medicine, the Dental Board
36 of California, the Osteopathic Medical Board of California, the
37 Board of Registered Nursing, and the Physician Assistant
38 Committee shall have authority with the California State Board
39 of Pharmacy to ensure compliance with this section, and those

1 boards are specifically charged with the enforcement of this section
2 with respect to their respective licensees.

3 (c) Nothing in this section shall be construed to diminish or
4 modify any requirements or protections provided for in the
5 prescription of controlled substances as otherwise established by
6 this chapter or by the California Uniform Controlled Substances
7 Act (Division 10 (commencing with Section 11000) of the Health
8 and Safety Code).

9 SEC. 9. Section 4071.3 is added to the Business and Professions
10 Code, to read:

11 4071.3. Every electronic prescription system shall meet all of
12 the following requirements:

13 (a) Comply with nationally recognized or certified standards
14 for data exchange or be accredited by a recognized accreditation
15 organization.

16 (b) Allow real-time verification of an individual's eligibility for
17 benefits and whether the prescribed medication is a covered
18 benefit.

19 (c) Comply with applicable state and federal confidentiality and
20 data security requirements.

21 (d) Comply with applicable state record retention and reporting
22 requirements.

23 SEC. 10. Section 4071.4 is added to the Business and
24 Professions Code, to read:

25 4071.4. A prescriber or prescriber's authorized agent using
26 an electronic prescription system shall offer patients a written
27 receipt of the information that has been transmitted electronically
28 to the pharmacy. The receipt shall include the patient's name, the
29 dosage and drug prescribed, the name of the pharmacy where the
30 electronic prescription was sent, and shall indicate that the receipt
31 cannot be used as a duplicate order for the same medicine.

32 SEC. 11. Section 49452.9 is added to the Education Code, to
33 read:

34 49452.9. (a) On and after January 1, 2010, the school district
35 may provide an information sheet regarding health insurance
36 requirements to the parent or guardian of all of the following:

37 (1) A pupil enrolled in kindergarten.

38 (2) A pupil enrolled in first grade if the pupil was not previously
39 enrolled in kindergarten.

1 (3) A pupil enrolled during the course of the year in the case of
2 children who have recently arrived, and intend to remain, in
3 California.

4 (b) The information sheet described in subdivision (a) shall
5 include all of the following:

6 (1) An explanation of the health insurance requirements under
7 Section 8899.50 of the Government Code.

8 (2) Information on the important relationship between health
9 and learning.

10 (3) A toll-free telephone number to request an application for
11 Healthy Families, Medi-Cal, or other government-subsidized health
12 insurance programs.

13 (4) Contact information for county public health departments.

14 (5) A statement of privacy applicable under state and federal
15 laws and regulations.

16 (c) By January 1, 2010, the State Department of Education
17 shall, in consultation with the State Department of Health Care
18 Services and the Managed Risk Medical Insurance Board, develop
19 a standardized template for the information sheet required by this
20 section. To the extent possible, the information provided pursuant
21 to this section shall be consolidated with the information listed in
22 subdivision (c) of Section 49452.8 into one document. The State
23 Department of Education shall make the template available on its
24 Internet Web site and shall, upon request, provide written copies
25 of the template to a school district.

26 SEC. 12. Chapter 15 (commencing with Section 8899.50) is
27 added to Division 1 of Title 2 of the Government Code, to read:

28

29

CHAPTER 15. MINIMUM HEALTH CARE COVERAGE

30

31 8899.50. (a) Every individual in this state shall be required
32 to maintain a minimum policy of health care coverage, as
33 determined by the Managed Risk Medical Insurance Board, for
34 himself or herself and his or her dependents.

35 (b) An individual is not subject to the requirements of
36 subdivision (a) if either of the following apply:

37 (1) The total cost for a minimum policy, including all
38 out-of-pocket costs, exceeds 6.5 percent of the individual's family
39 income.

1 (2) *The individual has a significant financial hardship, as*
2 *determined by the Managed Risk Medical Insurance Board.*

3 (c) *For purposes of this chapter, the term “dependents” means*
4 *the spouse, domestic partner, minor child of the individual, or a*
5 *child 18 years of age and over who is dependent on the individual,*
6 *as defined by the Managed Risk Medical Insurance Board.*

7 (d) *In establishing the minimum policy of health care coverage,*
8 *the board shall consider all of the following:*

9 (1) *The affordability of the minimum policy for individuals who*
10 *are subject to the requirements of subdivision (a), taking into*
11 *account premiums, deductibles, coinsurance, copayments, and*
12 *total out-of-pocket costs.*

13 (2) *The degree to which the minimum policy protects individuals*
14 *subject to the requirement of subdivision (a) from catastrophic*
15 *medical costs.*

16 (3) *The importance of encouraging periodic health evaluations*
17 *and the use of services that have been shown to be effective in*
18 *detecting or preventing serious illness.*

19 (e) *It is the intent of the Legislature that the Managed Risk*
20 *Medical Insurance Board pay the cost of health care coverage on*
21 *behalf of an individual who has been without health care coverage*
22 *for a period greater than 63 days after the date of leaving*
23 *employment where the individual had health care coverage, by*
24 *enrolling him or her in minimum health coverage through the*
25 *California Cooperative Health Insurance Purchasing Program*
26 *established pursuant to Part 6.45 (commencing with Section*
27 *12699.201) of Division 2 of the Insurance Code and then recouping*
28 *from the individual the cost of that coverage.*

29 (f) *The Managed Risk Medical Insurance Board shall identify*
30 *and implement methods and strategies to establish multiple entry*
31 *points and opportunities for enrollment in public or private*
32 *coverage, as appropriate, for individuals subject to subdivision*
33 *(a). The board shall work with state and local agencies, health*
34 *care providers, health plans, employers, consumer groups,*
35 *community organizations, and other appropriate stakeholders to*
36 *establish point-of-service methods to facilitate enrollment of*
37 *individuals who do not have or maintain a minimum policy of*
38 *health care coverage as required under this section. The board*
39 *shall identify and implement in state-administered health care*
40 *programs, to the greatest extent practicable and permissible under*

1 federal law, best practices for streamlined eligibility and
2 enrollment.

3 (g) On or before January 1, 2010, the board shall establish and
4 maintain an active statewide education and awareness program
5 to inform all California residents of their obligation under this
6 section, including informing them of the options available to obtain
7 affordable coverage through public programs, the state purchasing
8 pool, and commercial coverage.

9 (h) The board may enter into, or authorize entities within the
10 agency to enter into, agreements with other state agencies or
11 departments, or local agencies or organizations, to develop,
12 implement, or participate in the educational program established
13 pursuant to this section.

14 (i) Implementation of this section shall be contingent upon an
15 appropriation of funds for the purpose of this section in the annual
16 Budget Act or another statute.

17 SEC. 13. Section 12803.1 is added to the Government Code,
18 to read:

19 12803.1. (a) The California Health Benefits Service is hereby
20 created within the California Health and Human Services Agency.

21 (1) The California Health Benefits Service (CHBS) shall be
22 governed by a nine member board appointed by the Governor, the
23 Senate Committee on Rules, and the Speaker of the Assembly. The
24 Governor shall appoint a representative of local initiatives
25 authorized under the Welfare and Institutions Code, a
26 representative of county organized health systems, and a
27 representative of health care purchasers. The Senate Committee
28 on Rules shall appoint a representative of local initiatives
29 authorized under the Welfare and Institutions Code, a
30 representative of county organized health systems, and a
31 representative of health care consumers. The Speaker of the
32 Assembly shall appoint a representative of local initiatives
33 authorized under the Welfare and Institutions Code, a
34 representative of health care providers, and a representative of
35 organized labor. Terms of appointment shall be four years. The
36 members of the board shall elect a board chair from among the
37 nine appointed members.

38 (2) The board shall appoint an executive director for the board,
39 who shall serve at the pleasure of the board. The executive director
40 shall receive the salary established by the Department of Personnel

1 Administration for exempt officials. The executive director shall
2 administer the affairs of the board as directed by the board and
3 shall direct the staff of the board. The executive director may
4 appoint, with the approval of the board, staff necessary to carry
5 out the provisions of this section.

6 (b) The Health and Human Services Agency shall convene a
7 working group with the collaboration of the Department of
8 Managed Health Care, the State Department of Health Care
9 Services, and the Managed Risk Medical Insurance Board. This
10 working group shall assist CHBS in identifying statutory,
11 regulatory, or financial barriers or incentives that must be
12 addressed before CHBS can facilitate the establishment and
13 maintenance of one or more joint ventures between health plans
14 that contract with, or are governed, owned, or operated by, a
15 county board of supervisors, a county special commission, or
16 county health authority authorized by Section 14018.7, 14087.31,
17 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and
18 Institutions Code. The working group shall also assist CHBS in
19 identifying statutory, regulatory, or financial barriers or incentives
20 that must be addressed before CHBS can enter into contracts with
21 providers to provide health care services in counties in which there
22 is not a prepaid health plan that contracts with, or is governed,
23 owned, or operated by, a county board of supervisors, a county
24 special commission, or a county health authority authorized by
25 Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or
26 14087.96 of the Welfare and Institutions Code. The working group
27 shall, no later than April 1, 2008, report its findings to the
28 executive director, the CHBS governing board, and the committees
29 of jurisdiction in the Senate and Assembly.

30 (c) To the extent permitted under existing law, CHBS is
31 authorized to solicit and assist prepaid health plans that contract
32 with, or are governed, owned, or operated by, a county board of
33 supervisors, a county special commission or county health
34 authority authorized by Section 14018.7, 14087.31, 14087.35,
35 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions
36 Code in forming joint ventures to create integrated networks of
37 public health plans that pool risk and share networks. CHBS may,
38 upon agreement of participating health plans, administer those
39 joint ventures. Consistent with the recommendations pursuant to
40 subdivision (b), and existing law, CHBS is authorized to develop

1 networks to provide health care services in counties in which there
2 is not a prepaid health plan that contracts with, or is governed,
3 owned, or operated by, a county board of supervisors, a county
4 special commission, or a county health authority authorized by
5 Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or
6 14087.96 of the Welfare and Institutions Code.

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

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

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

24 SEC. 14. Section 12803.2 is added to the Government Code,
25 to read:

26 12803.2. (a) The California Health and Human Services
27 Agency, in consultation with the Board of Administration of the
28 Public Employees' Retirement System, and after consultation with
29 affected health care provider groups, shall develop health care
30 provider performance measurement benchmarks and incorporate
31 these benchmarks into a common pay-for-performance model to
32 be offered in every state-administered health care program,
33 including, but not limited to, the Public Employees' Medical and
34 Hospital Care Act, the Healthy Families Program, the Major Risk
35 Medical Insurance Program, the Medi-Cal program, and the
36 California Cooperative Health Insurance Purchasing Program.
37 These benchmarks shall be developed to advance a common
38 statewide framework for health care quality measurement and
39 reporting, including, but not limited to, measures that have been
40 approved by the National Quality Forum (NQF) such as the Health

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

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

20 *SEC. 15. Section 22830.5 is added to the Government Code,*
21 *to read:*

22 *22830.5. (a) On or before January 1, 2009, the board shall*
23 *provide or arrange for the provision of an electronic personal*
24 *health record for enrollees receiving health care benefits. The*
25 *record shall be provided for the purpose of providing enrollees*
26 *with information to assist them in understanding their coverage*
27 *benefits and managing their health care.*

28 *(b) At a minimum, the personal health record shall provide*
29 *access to real-time, patient-specific information regarding*
30 *eligibility for covered benefits and cost sharing requirements. Such*
31 *access can be provided through the use of an Internet-based*
32 *system.*

33 *(c) In addition to the data required pursuant to subdivision (b),*
34 *the board may determine that the personal health record shall also*
35 *incorporate additional data, such as laboratory results,*
36 *prescription history, claims history, and personal health*
37 *information authorized or provided by the enrollee. Inclusion of*
38 *this additional data shall be at the option of the enrollee.*

39 *(d) Systems or software that pertain to the personal health*
40 *record shall adhere to accepted national standards for*

1 interoperability, privacy, and data exchange, or shall be certified
2 by a nationally recognized certification body.

3 (e) The personal health record shall comply with applicable
4 state and federal confidentiality and data security requirements.

5 SEC. 16. Section 22830.6 is added to the Government Code,
6 to read:

7 22830.6. On or before January 1, 2009, the board shall provide
8 or arrange for the provision of a Healthy Action Incentives and
9 Rewards Program, as described in subdivision (c) of Section
10 1367.38 of the Health and Safety Code, to all enrollees.

11 SEC. 17. Section 1262.9 is added to the Health and Safety
12 Code, to read:

13 1262.9. (a) If a patient has coverage for emergency health
14 care services and poststabilizing care, a noncontracting hospital
15 shall not bill the patient for emergency health care services and
16 poststabilizing care, except for applicable copayments and cost
17 shares.

18 (b) The noncontracting hospital and the health care service
19 plan or health insurer shall each retain their right to pursue all
20 currently available legal remedies they may have against each
21 other, including the right to determine the final payment due.

22 (c) For the purposes of this section:

23 (1) "Noncontracting hospital" means a general acute care
24 hospital as defined in subdivision (a) of Section 1250 that has a
25 special permit to operate an emergency medical service and does
26 not have a contract with a health care service plan or a health
27 insurer for the provision of emergency health care services and
28 poststabilizing care to the patient, who is one of that health care
29 service plan's or health insurer's enrollees, members, or insureds.

30 (2) "Emergency health care services and poststabilizing care"
31 means emergency services and out-of-area urgent services provided
32 in an emergency department and a hospital through discharge in
33 compliance with Sections 1262.8 and 1317 and, in the case of
34 health care service plans, the services required to be covered
35 pursuant to paragraph (6) of subdivision (b) of Section 1345,
36 subdivision (i) of Section 1367, Sections 1371.4, and 1371.5, of
37 this code, and Sections 1300.67(g) and 1300.71.4 of Title 28 of
38 the California Code of Regulations.

39 SEC. 18. Section 1342.9 is added to the Health and Safety
40 Code, to read:

1 1342.9. (a) Notwithstanding any other provision of this
2 chapter, a health care service plan that provides services to a
3 beneficiary of the Medi-Cal program pursuant to Article 2.7
4 (commencing with Section 14087.3), Article 2.8 (commencing with
5 Section 14087.5), or Article 2.91 (commencing with Section 14089)
6 of Chapter 7 of, or Article 1 (commencing with Section 14200) or
7 Article 7 (commencing with Section 14490) of Chapter 8 of, Part
8 3 of Division 9 of the Welfare and Institutions Code shall,
9 regarding coverage for participants in a Medi-Cal managed care
10 program, be subject solely to the filing, reporting, monitoring, and
11 survey requirements established by the State Department of Health
12 Care Services for the Medi-Cal managed care program as those
13 requirements pertain to the following subjects: advertising and
14 marketing; member materials, including member handbooks,
15 evidences of coverage, and disclosure forms; and product design,
16 including its scope and limitations. A health care service plan that
17 satisfies any of the foregoing filing, reporting, monitoring, or
18 survey requirements shall be deemed in compliance with
19 corresponding provisions, if any, of this chapter.

20 (b) The department and the State Department of Health Care
21 Services shall develop a joint filing and review process for medical
22 quality surveys required pursuant to Section 1380 and pursuant
23 to Chapter 8 (commencing with Section 14200) of Part 3 of
24 Division 9 of the Welfare and Institutions Code.

25 SEC. 19. Section 1347 is added to the Health and Safety Code,
26 to read:

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

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

4
5 Article 3.11. Insurance Market Reform
6

7 1357.20. On and after January 1, 2010, the department, in
8 consultation with the Department of Insurance, shall require each
9 health care service plan with one million or more enrollees in
10 California, based on the plan's enrollment in the prior year, to
11 submit a good faith bid to the Managed Risk Medical Insurance
12 Board in order to be a participating plan through the California
13 Cooperative Health Insurance Purchasing Program (Cal-CHIPP)
14 pursuant to Part 6.45 (commencing with Section 12699.201) of
15 Division 2 of the Insurance Code.

16 1357.23. Effective July 1, 2010, all requirements in Article 3.1
17 (commencing with Section 1357) applicable to offering, marketing,
18 and selling health care service plan contracts to small employers
19 as defined in that article, including, but not limited to, the
20 obligation to fairly and affirmatively offer, market, and sell all of
21 the plan's contracts to all employers, guaranteed renewal of all
22 health care service plan contracts, use of the risk adjustment factor,
23 and the restriction of risk categories to age, geographic region,
24 and family composition as described in that article, shall be
25 applicable to all health care service plan contracts offered to all
26 employers with 100 or fewer eligible employees, except as follows:

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

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

34 1357.24. It is the intent of the Legislature to establish a
35 mechanism by which the state may defray the costs of an enrollee's
36 public program participation by taking advantage of other
37 opportunities for coverage available to that enrollee.

38 1357.25. The requirements of this article shall not apply to a
39 specialized health care service plan or a Medicare supplement
40 contract.

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

2 SEC. 21. *Section 1363 of the Health and Safety Code is*
3 *amended to read:*

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

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

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

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

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

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

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

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

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

38 (ii) States, with respect to individual plan contracts, small group
39 plan contracts, and any other group plan contracts for which health
40 care services are not negotiated, that the applicant has a right to

1 view the evidence of coverage prior to enrollment, and, if the
2 evidence of coverage is not combined with the disclosure form,
3 the notice shall specify where the evidence of coverage can be
4 obtained prior to enrollment.

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

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

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

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

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

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

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

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

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

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

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

4 (14) Conditions and procedures for disenrollment.

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

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

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

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

20 (A) Deductibles.

21 (B) Lifetime maximums.

22 (C) Professional services.

23 (D) Outpatient services.

24 (E) Hospitalization services.

25 (F) Emergency health coverage.

26 (G) Ambulance services.

27 (H) Prescription drug coverage.

28 (I) Durable medical equipment.

29 (J) Mental health services.

30 (K) Chemical dependency services.

31 (L) Home health services.

32 (M) Other.

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

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

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

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

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

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

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

27 (h) In addition to the other disclosures required by this section,
28 every health care service plan and any agent or employee of the
29 plan shall, when presenting a plan for examination or sale to any
30 individual purchaser or the representative of a group consisting of
31 ~~25~~ 100 or fewer individuals, disclose in writing the ratio of
32 premium costs to health services paid for plan contracts with
33 individuals and with groups of the same or similar size for the
34 plan's preceding fiscal year. A plan may report that information
35 by geographic area, provided the plan identifies the geographic
36 area and reports information applicable to that geographic area.

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

1 SEC. 22. Article 4.1 (commencing with Section 1366.10) is
2 added to Chapter 2.2 of Division 2 of the Health and Safety Code,
3 to read:

4

5 Article 4.1. California Individual Coverage Guarantee Issue

6

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

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

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

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

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

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

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

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

5 1366.105. On and after July 1, 2010, health care service plans
6 and health insurers participating in the individual market shall
7 guarantee issue the five classes of approved health benefit plans
8 and shall, at the same time, discontinue offering and selling health
9 benefit plans other than those within the five approved classes of
10 benefit plans in the individual market.

11 1366.106. Individuals may purchase a health benefit plan from
12 one of the five classes of approved plans on a guaranteed issue
13 basis. After selecting and purchasing a health benefit plan within
14 a class of benefits, an individual may change plans only as set
15 forth in this section. For individuals enrolled as a family, the
16 subscriber may change classes for himself or herself, or for all
17 dependents:

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

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

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

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

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

30 (2) Upon divorce.

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

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

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

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

1 *domestic partner enrolled in the plan, the oldest child may become*
2 *the subscriber.*

3 *1366.107. At the time an individual applies for health coverage*
4 *from a health care service plan or health insurer participating in*
5 *the individual market, an individual shall provide information as*
6 *required by a standardized health status questionnaire to assist*
7 *plans and insurers in identifying persons in need of disease*
8 *management. Health care service plans and health insurers may*
9 *not use information provided on the questionnaire to decline*
10 *coverage or to limit an individual's choice of health care benefit*
11 *plan.*

12 *1366.108. Health benefit plans shall become effective within*
13 *31 days of receipt of the individual's application, standardized*
14 *health status questionnaire, and premium payment.*

15 *1366.109. Health care service plans and health insurers may*
16 *reject an application for health care benefits if the individual does*
17 *not reside or work in a plan's or insurer's approved service area.*

18 *1366.110. The director or the Insurance Commissioner, as*
19 *applicable, may require a health care service plan or health insurer*
20 *to discontinue the offering of health care benefits, or acceptance*
21 *of applications from individuals, upon a determination by the*
22 *director or commissioner that the plan or insurer does not have*
23 *sufficient financial viability, or organizational and administrative*
24 *capacity, to ensure the delivery of health care benefits to its*
25 *enrollees or insureds.*

26 *1366.111. All health care benefits offered to individuals shall*
27 *be renewable with respect to all individuals and dependents at the*
28 *option of the subscriber, except:*

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

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

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

1 1366.113. *This article shall not apply to individual health plan*
2 *contracts for coverage of Medicare services pursuant to contracts*
3 *with the United States Government, Medi-Cal contracts with the*
4 *State Department of Health Care Services, Healthy Families*
5 *Program contracts with the Managed Risk Medical Insurance*
6 *Board, high risk pool contracts with the Major Risk Medical*
7 *Insurance Program, Medicare supplement policies, long-term care*
8 *policies, specialized health plan contracts, or contracts issued to*
9 *individuals who secure coverage from Cal-CHIPP.*

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

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

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

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

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

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

1 1366.115. *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 article.*

6 1366.116. *This article, other than Section 1366.104, shall not*
7 *become operative until the date that the provisions of Section*
8 *8899.50 of the Government Code are implemented.*

9 SEC. 23. *Section 1367.205 is added to the Health and Safety*
10 *Code, to read:*

11 1367.205. *Commencing on or before January 1, 2010, a health*
12 *care service plan that provides prescription drug benefits and*
13 *maintains one or more drug formularies shall make the most*
14 *current formularies available electronically to prescribers and*
15 *pharmacies.*

16 SEC. 24. *Section 1367.38 is added to the Health and Safety*
17 *Code, to read:*

18 1367.38. (a) *A full-service health care service plan, except*
19 *for a Medicare supplement plan, that offers, delivers, amends, or*
20 *renews a contract on or after January 1, 2009, that covers hospital,*
21 *medical, or surgical expenses on a group basis shall offer at least*
22 *one benefit design that includes a Healthy Action Incentives and*
23 *Rewards Program as described in subdivision (c). Any plan subject*
24 *to this section shall communicate the availability of the Healthy*
25 *Action Incentives and Rewards Program coverage to all group*
26 *subscribers and to all prospective group subscribers with whom*
27 *they are negotiating.*

28 (b) *In addition to benefit designs offered pursuant to subdivision*
29 *(a), every health care service plan contract offered, delivered,*
30 *amended, or renewed on or after January 1, 2009, that offers*
31 *coverage on a group basis shall offer a Healthy Action Incentives*
32 *and Rewards Program, as described in subdivision (c), as a*
33 *supplement to every contract that covers hospital, medical, or*
34 *surgical expenses and that does not include a Healthy Action*
35 *Incentives and Rewards Program as part of the overall benefit*
36 *design.*

37 (c) *For purposes of this section, benefits for a Healthy Action*
38 *Incentives and Rewards Program shall provide for all of the*
39 *following:*

1 (1) Health risk appraisals to be used to assess an individual's
2 overall health status and to identify risk factors, including, but not
3 limited to, smoking and smokeless tobacco use, alcohol abuse,
4 drug use, and nutrition and physical activity practices.

5 (2) A followup appointment with a licensed health care
6 professional acting within his or her scope of practice to review
7 the results of the health risk appraisal and discuss any
8 recommended actions.

9 (3) Incentives or rewards for enrollees to become more engaged
10 in their health care and to make appropriate choices that support
11 good health, including obtaining health risk appraisals, screening
12 services, immunizations, or participating in healthy lifestyle
13 programs and practices. These programs and practices may
14 include, but need not be limited to, smoking cessation, physical
15 activity, or nutrition. Incentives may include, but need not be
16 limited to, health premium reductions, differential copayment or
17 coinsurance amounts, and cash payments. Rewards may include,
18 but need not be limited to, nonprescription pharmacy products or
19 services not otherwise covered under an enrollee's health plan
20 contract, exercise classes, gym memberships, and weight
21 management programs. If a health care service plan elects to offer
22 an incentive in the form of a reduction in the premium amount,
23 the premium reduction shall be standardized and uniform for all
24 groups and subscribers and shall be offered only after the
25 successful completion of the specified program or practice by the
26 enrollee or subscriber.

27 (d) In order to demonstrate compliance with this section, a
28 health care service plan may file an amendment to its application
29 for licensure pursuant to subdivision (a) of Section 1352.

30 (e) This section is in addition to, and does not replace, any other
31 section in this chapter concerning requirements for plans to
32 provide health care screening services, childhood immunizations,
33 adult immunizations, and preventive care services.

34 (f) (1) Notwithstanding any other provision of law, the provision
35 of healthy incentives and rewards pursuant to this section by a
36 health care provider, or his or her agent, that meets the
37 requirement of this section, shall not be considered or construed
38 as an unlawful practice, act, kickback, bribe, rebate, remuneration,
39 offer, coupon, product, payment, or any other form of compensation
40 by a provider or his or her agent, directly or indirectly, overtly or

1 *covertly, in exchange for another to obtain, participate, or*
2 *otherwise undergo or receive health care services.*

3 *(2) Notwithstanding any other provision of law, incentives*
4 *authorized pursuant to this section are not subject to the penalties,*
5 *discipline, limitations, or sanctions imposed under law to preclude*
6 *or prohibit, as an unlawful practice, bribe, kickback, or other act,*
7 *the offering or delivery of a rebate, remuneration, offer, coupon,*
8 *product, rebate, payment, or any other form of compensation by*
9 *the provider, or his or her agent, directly or indirectly, overtly or*
10 *covertly, in exchange for another to obtain, participate, or*
11 *otherwise undergo or receive health care services.*

12 *(3) Notwithstanding any other provision of law, the provision*
13 *of healthy incentives and rewards pursuant to this section by a*
14 *health care provider, or his or her agent, that meets the*
15 *requirements of this section shall not be considered or construed*
16 *as an inducement to enroll.*

17 *(g) This section shall only be implemented if and to the extent*
18 *allowed under federal law. If any portion of this section is held to*
19 *be invalid, as determined by a final judgment of a court of*
20 *competent jurisdiction, this section shall become inoperative.*

21 *SEC. 25. Section 1368.025 is added to the Health and Safety*
22 *Code, to read:*

23 *1368.025. In addition to the duties listed in paragraph (3) of*
24 *subdivision (c) of Section 1368.02, the duties of the Office of*
25 *Patient Advocate shall include providing access to the public to*
26 *reports and data obtained by the lead agency in a format and*
27 *through mechanisms, including, but not limited to, the Internet,*
28 *that allow the public to use the information to assist them in making*
29 *informed selections of health plans, hospitals, medical groups,*
30 *nursing homes, and other providers about whom the office has*
31 *collected information.*

32 *SEC. 26. Section 1378 of the Health and Safety Code is*
33 *amended to read:*

34 *1378. No plan shall expend for administrative costs in any*
35 *fiscal year an excessive amount of the aggregate dues, fees and*
36 *other periodic payments received by the plan for providing health*
37 *care services to its subscribers or enrollees. The term*
38 *“administrative costs,” as used herein, includes costs incurred in*
39 *connection with the solicitation of subscribers or enrollees for the*
40 *plan. The director shall adopt regulations no later than July 1,*

1 2008, requiring that at least 85 percent of aggregate dues, fees,
2 and other periodic payments received by a full-service plan be
3 spent on health care services. The regulations shall also define
4 “health care services.” This section shall not apply to Medicare
5 supplement contracts.

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

10 SEC. 27. Section 1395.2 is added to the Health and Safety
11 Code, to read:

12 1395.2. (a) A health care service plan may provide notice by
13 electronic transmission and shall be deemed to have fully complied
14 with the specific statutory or regulatory requirements to provide
15 notice by United States mail to an applicant, enrollee, or
16 subscriber, if it complies with all of the following requirements:

17 (1) Obtains written authorization from the applicant, enrollee,
18 or subscriber to provide notices by electronic transmission and to
19 cease providing notices by United States mail. The authorization
20 shall be renewed by the enrollee or subscriber on an annual basis.
21 If the health care service plan obtains an application for coverage
22 by electronic transmission, it may obtain authorization by
23 electronic transmission from the applicant, enrollee, or subscriber
24 to provide notices by electronic transmission.

25 (2) Uses an authorization form, approved by the department,
26 in which the applicant, enrollee, or subscriber confirms
27 understanding of the type of notice that will be provided by
28 electronic transmission.

29 (3) Complies with the specific statutory or regulatory
30 requirements as to the content of the notices it sends by electronic
31 transmission.

32 (4) Provides for the privacy of the notice as required by state
33 and federal laws and regulations.

34 (5) Allows the applicant, enrollee, or subscriber at any time to
35 terminate the authorization to provide notices by electronic
36 transmission and receive the notices through the United States
37 mail.

38 (6) Sends the electronic transmission of a notice to the last
39 known electronic address of the applicant, enrollee, or subscriber.
40 If the electronic transmission fails to reach its intended recipient

1 twice, the health care service plan shall resume sending all notices
2 to the last known United States mail address of the applicant,
3 enrollee, or subscriber.

4 (7) Maintains an Internet Web site where the applicant, enrollee,
5 or subscriber may access the notices sent by electronic
6 transmission.

7 (b) A health care service plan shall not use the electronic mail
8 address of an applicant, enrollee, or subscriber that it obtained
9 for the purposes of providing notice pursuant to subdivision (a)
10 for any purpose other than sending a notice as described in
11 subdivision (a).

12 (c) No person other than the applicant, enrollee, or subscriber
13 to whom the medical information in the notice pertains or a
14 representative lawfully authorized to act on behalf of the applicant,
15 enrollee, or subscriber, may authorize the transmission of medical
16 information by electronic transmission. "Medical information"
17 for these purposes shall have the meaning set forth in subdivision
18 (g) of Section 56.05 of the Civil Code.

19 (d) A notice transmitted electronically pursuant to this section
20 is a private and confidential communication, and it shall constitute
21 a violation of this chapter for a person, other than the applicant,
22 enrollee, or subscriber to whom the notice is addressed, to read
23 or otherwise gain access to the notice without the express, specific
24 permission of the notice's addressee. This subdivision shall not
25 apply to a provider of an applicant, enrollee, or subscriber if the
26 provider is authorized to have access to the medical information
27 pursuant to the Confidentiality of Medical Information Act (Part
28 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

29 (e) A health care service plan shall not impose additional fees
30 or a differential if an applicant, enrollee, or subscriber elects not
31 to receive notices by electronic transmission.

32 (f) "Notice" for purposes of this section includes an explanation
33 of benefits; responses to inquiries from an applicant, enrollee, or
34 subscriber; underwriting decisions; distribution of plan contracts,
35 including evidence of coverage and disclosure forms pursuant to
36 Sections 1300.63.1 and 1300.63.2 of Title 28 of the California
37 Code of Regulations; a list of contracting providers pursuant to
38 Section 1367.26; and changes in rates or coverage pursuant to
39 Sections 1374.21, 1374.22, and 1374.23.

1 SEC. 28. Article 1 (commencing with Section 104250) is added
2 to Chapter 4 of Part 1 of Division 103 of the Health and Safety
3 Code, to read:

4
5 Article 1. California Diabetes Program
6

7 104250. The State Department of Public Health shall maintain
8 the California Diabetes Program, including, but not limited to,
9 the following:

10 (a) Provide information on diabetes prevention and management
11 to the public, including health care providers.

12 (b) Provide technical assistance to the Medi-Cal program,
13 including participating providers and Medi-Cal managed care
14 plans, regarding the proper scope of benefits to be provided to
15 eligible individuals under Section 14132.23 of the Welfare and
16 Institutions Code. The assistance may include, but shall not be
17 limited to, all of the following:

18 (1) Provide information on evidence-based screening guidelines,
19 tools, and protocols, including the distribution of these guidelines,
20 tools, and protocols.

21 (2) Develop, with assistance from the State Department of
22 Health Care Services, the Comprehensive Diabetes Services
23 Program operational screening guidelines and protocols, utilizing
24 the most current American Diabetes Association screening criteria
25 for diabetes testing in adults.

26 (3) Provide the Comprehensive Diabetes Services Program
27 operational screening guidelines, tools, and protocols, including
28 the distribution of those guidelines, tools, and protocols.

29 (4) Provide screening service criteria for diabetes and
30 prediabetes in accordance with the guidelines developed for the
31 Comprehensive Diabetes Services Program.

32 (5) Provide information regarding culturally and linguistically
33 appropriate lifestyle coaching and self-management training for
34 eligible adults with prediabetes and diabetes, in accordance with
35 evidence-based interventions to avoid unhealthy blood sugar levels
36 that contribute to the progression of diabetes and its complications.

37 (c) Provide technical assistance to the State Department of
38 Health Care Services, including assistance on data collection and
39 evaluation of the Medi-Cal program's Comprehensive Diabetes

1 *Services Program, established pursuant to Section 14132.23 of*
2 *the Welfare and Institutions Code.*

3 *(d) This section shall be implemented only to the extent funds*
4 *are appropriated for purposes of this section in the annual Budget*
5 *Act or in another statute.*

6 *SEC. 29. Section 104376 is added to the Health and Safety*
7 *Code, to read:*

8 *104376. (a) (1) The department, in consultation with the*
9 *Department of Managed Health Care, the State Department of*
10 *Health Care Services, the Managed Risk Medical Insurance Board,*
11 *and the Department of Insurance, shall annually identify, on the*
12 *basis of the number of persons insured, the 10 largest providers*
13 *of health care coverage, including both public and private entities,*
14 *and ascertain the smoking cessation benefits provided by each of*
15 *these coverage providers.*

16 *(2) The department shall summarize the smoking cessation*
17 *benefit information gathered under this subdivision and make the*
18 *benefit summary available on the Internet, including the*
19 *department's Web site.*

20 *(b) The department shall, where appropriate, include the*
21 *smoking cessation benefit information as part of its educational*
22 *efforts to prevent tobacco use that it renders to the public and to*
23 *health care providers.*

24 *(c) The department shall conduct an evaluation, commencing*
25 *one year following the publication of the smoking cessation benefit*
26 *information on the department's Web site as provided in this*
27 *section, to assess all of the following:*

28 *(1) Any changes in the awareness of the beneficiaries of the 10*
29 *largest providers of health care coverage as to the availability of*
30 *smoking cessation benefits.*

31 *(2) Any changes in the awareness of health care providers as*
32 *to the availability of smoking cessation benefits.*

33 *(3) The extent to which smoking cessation benefits are utilized*
34 *by beneficiaries of the 10 largest providers of health care coverage,*
35 *and any changes in the utilization rate of these benefits as*
36 *determined by a comparison with any available preexisting*
37 *information.*

38 *(4) Smoking-related indicators available through the Health*
39 *Plan Employer Data and Information Set.*

1 (5) Any changes to the smoking cessation benefit coverage of
2 the 10 largest providers of health care coverage.

3 (6) The impact on smoking rates based on the expansion of
4 counseling services and the direct provision of tobacco cessation
5 pharmacotherapy by the California Smokers' Helpline.

6 (d) To the extent funds are appropriated for these purposes, the
7 department shall increase its efforts to do all of the following:

8 (1) Reduce smoking by increasing the capacity of effective
9 cessation services available from the California Smokers' Helpline,
10 including tobacco cessation pharmacotherapy.

11 (2) Expand public awareness about the services that are
12 available through the California Smokers' Helpline.

13 (3) Expand public awareness and use of existing cessation
14 benefits that are available to California smokers through their
15 public and private providers of health care coverage.

16 SEC. 30. Article 3 (commencing with Section 104705) is added
17 to Chapter 2 of Part 3 of Division 103 of the Health and Safety
18 Code, to read:

19
20 Article 3. Community Makeover Grants

21
22 104705. (a) The Community Makeover Grant program is
23 hereby created and shall be administered by the department. The
24 department shall award grants to local health departments to serve
25 as local lead agencies in accordance with this article.

26 (b) For purposes of determining the amount of each grant
27 awarded under this article, local health departments shall be
28 allocated, at a minimum, base funding in proportion to total
29 available funding.

30 (c) Except as provided in subdivision (b), local health
31 departments shall receive an allocation based on each county's
32 or city's proportion of the statewide population, to be expended
33 for purposes that include, but need not be limited to:

34 (1) Creating a community infrastructure that promotes active
35 living and healthy eating.

36 (2) Coordinating with, at minimum, city, county, and school
37 partners to facilitate community level, multisector collaboration
38 for the development and implementation of strategies to facilitate
39 active living and healthy eating.

1 (3) Conducting competitive grant application processes to
2 support local grants. These local grants may be used to develop
3 new programs and improve existing programs to promote physical
4 activity for children, improve access to healthy foods, and better
5 utilize community recreation facilities.

6 (4) Preparing program interventions and materials that will be
7 available in accessible, and culturally and linguistically
8 appropriate, formats.

9 (d) The department shall issue guidelines for local lead agencies
10 on how to prepare a local plan for a comprehensive community
11 intervention program that includes changes to promote active
12 living and healthy eating, and to prevent obesity and other related
13 chronic diseases.

14 (e) The department shall specify data reporting requirements
15 for local lead agencies and their subcontractors.

16 (f) (1) The department shall conduct a fiscal and program
17 review on a regular basis.

18 (2) If the department determines that any local lead agency is
19 not in compliance with any provision of this article, the local lead
20 agency shall submit to the department, within 60 days, a plan for
21 complying with this article.

22 (3) The department may withhold funds allocated under this
23 section from local lead agencies that are not in compliance with
24 this article.

25 (g) For purposes of this article, “department” means the State
26 Department of Public Health.

27 104710. (a) The department may provide a variety of training,
28 consultation, and technical assistance to support local programs.

29 (b) Notwithstanding any other provision of law, the department
30 may use a request for proposal process or may directly award
31 contracts to provide the assistance described in subdivision (a) to
32 another state, federal, or auxiliary organization.

33 (c) Any organization awarded a contract under this section
34 shall demonstrate the ability to provide statewide assistance to
35 accelerate progress, and to ensure the long-term impact of local
36 obesity prevention programs.

37 104715. (a) The department shall track and evaluate obesity
38 related measures, including, but not limited to, active living,
39 healthy eating, and community environment indicators. These
40 tracking and evaluation activities shall utilize scientifically

1 appropriate methods, and may include, but need not be limited to,
2 the following:

3 (1) Track statewide health indicators.

4 (2) Evaluate funded projects, determining baseline measures
5 and progress toward goals, as well as capturing successes and
6 emerging models.

7 (3) Compare the effectiveness of individual programs to inform
8 funding decisions and program modifications.

9 (4) Incorporate other aspects into the evaluation that have been
10 identified by the department in consultation with state and local
11 advisory groups, local health departments, and other interested
12 parties.

13 (5) Forecast health and economic cost consequences associated
14 with obesity.

15 (6) Funds permitting, utilize a sample size that is adequate to
16 produce county-, ethnic-, and disability-specific estimates.

17 (b) The purpose of the evaluation shall be to direct the most
18 efficient allocation of resources appropriated under this article
19 to accomplish the maximum reduction of obesity rates. The
20 comprehensive evaluation shall be designed to measure the extent
21 to which programs funded pursuant to this article promote the
22 goals identified in the California Obesity Prevention Plan.

23 104720. The department shall develop a campaign to educate
24 the public about the importance of obesity prevention that frames
25 active living and healthy eating as “California living.” The
26 campaign-centered efforts shall be closely linked with
27 community-level program change efforts and shall be available
28 in accessible and culturally and linguistically appropriate formats.

29 104721. The department shall provide assistance and other
30 support for schools to promote the availability and consumption
31 of fresh fruits and vegetables and foods with whole grains.

32 104725. The department shall provide technical assistance to
33 help employers integrate wellness policies and programs into
34 employee benefit plans and worksites.

35 104726. Notwithstanding any other provision of law, this article
36 shall be implemented only to the extent funds are appropriated for
37 purposes of this article in the annual Budget Act or in another
38 statute.

39 SEC. 31. Section 128745.1 is added to the Health and Safety
40 Code, to read:

1 128745.1. (a) In addition to any other established and pending
 2 reports, commencing January 1, 2010, and every year thereafter,
 3 the office shall publish risk-adjusted outcome reports for
 4 percutaneous coronary interventions, including, but not limited
 5 to, the use of angioplasty or stents. In each year, the reports shall
 6 compare risk-adjusted outcomes by hospital, and in at least every
 7 other year, by hospital and physician. Upon the recommendation
 8 of the technical advisory committee based on statistical and
 9 technical considerations, information on individual hospitals and
 10 surgeons may be excluded from the reports.

11 (b) The office shall establish a clinical data collection program
 12 to collect data on percutaneous coronary interventions, including,
 13 but not limited to, the use of angioplasty or stents, performed in
 14 hospitals. The office shall establish by regulation the data to be
 15 reported by each hospital at which percutaneous coronary
 16 interventions are performed. In establishing the data to be
 17 reported, the office shall consult with the clinical panel established
 18 pursuant to Section 128748.

19 SEC. 32. 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
 32 care that improves life expectancy, reduces death rates, improves
 33 health 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
18 use the information to improve patient safety, efficiency of health
19 care delivery, and quality of care, leading to quality improvement
20 and 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,
30 quality, and costs in the state in order to facilitate value-based
31 purchasing of health care and to support and promote continuous
32 quality 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
40 and 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,
9 and 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
16 collected be used for the transparent public reporting of quality
17 and cost efficiency information regarding all levels of the health
18 care system, including health care service plans and health
19 insurers, hospitals and other health facilities, and medical groups
20 and physicians, so that health care plans and providers can
21 improve their performance and deliver safer, better health care
22 more affordably; so that purchasers can know which health care
23 services reduce morbidity, mortality, and other adverse health
24 outcomes; so that consumers can choose whether and where to
25 have health care provided; and so that the Legislature can
26 effectively regulate and monitor the health care delivery system
27 to ensure quality and 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
36 facility or person that is requesting payment for the provision of
37 medical 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
11 services rendered by providers to patients which may be
12 reimbursed on a 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, the
33 responsibilities of the office with respect to determining the data
34 to be collected and the analysis and reporting of the data collected
35 pursuant to Chapter 1 (commencing with Section 128675) shall
36 be transferred to the commission, as determined by the commission
37 and as reported to the Secretary of Health and Welfare and the
38 Legislature no later than January 1, 2009. Any limitations on the
39 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 California Health and
 14 Human Services Agency, the California Health Care Cost and
 15 Quality Transparency Commission composed of 13 members, each
 16 of whom shall have demonstrated knowledge and experience in
 17 the measurement and analysis of health care quality or cost data,
 18 in deploying that data on behalf of consumers and purchasers, or
 19 in 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 that is not also a supplier or*
9 *broker in health care coverage.*

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

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

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

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

20 (3) *The Director of the Department of Managed Health Care*
21 *or a designee.*

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

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

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

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

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

39 128858. *The commission shall appoint an executive director,*
40 *who shall serve at the pleasure of the commission. The executive*

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

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

10 *(a) Enter into contracts.*

11 *(b) Sue and be sued.*

12 *(c) Employ necessary staff.*

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

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

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

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

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

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

36 *128860. The commission shall have no authority to disclose*
37 *any confidential information concerning contracted rates between*
38 *health care providers and any data source, but nothing in this*
39 *section shall prevent the commission from publicly disclosing*
40 *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
7 functions that shall be transferred to the commission effective July
8 1, 2009.

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

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

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

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

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

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

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

38 (c) Determine the measures necessary to implement the
39 reporting requirements in the plan developed pursuant to 128864

1 *in a manner that is cost-effective and reasonable for data sources*
2 *and timely, relevant, and reliable for consumers and purchasers.*

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

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

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

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

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

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

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

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

37 *(b) The commission shall appoint at least one clinical advisory*
38 *committee and may appoint additional advisory committees specific*
39 *to issues that require additional or different clinical expertise.*
40 *Each clinical advisory committee shall include clinicians and*

1 *others with expertise related to the activities of the commission*
2 *and any issue under consideration.*

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

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

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

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

32

33 *Article 3. Health Care Cost and Quality Transparency Plan*

34

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

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

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

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

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

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

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

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

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

38 (2) The data elements necessary to produce the reports and
39 data to be made available. The plan shall address the extent to
40 which standardized electronic reporting of administrative claims

1 data can provide the information necessary for the purposes of
2 this chapter, and the most efficient, least burdensome method of
3 collecting other necessary data, including systemwide encounter
4 data.

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

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

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

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

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

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

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

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

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

1 *be consistent with the plan developed pursuant to Section 128865.*
2 *Data collection and reporting required by these provisions shall*
3 *not be delayed pending the development and implementation of*
4 *the plan.*

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

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

19
20
21

Article 4. Fees

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

1 (b) *The commission may seek and accept contributions to*
2 *support the work of the commission from any foundation or other*
3 *public or private entity that does not have a financial interest in*
4 *the outcome of the work of the commission, as defined in the*
5 *conflict-of-interest policy adopted pursuant to Section 128864.*

6 128871. *There is hereby established in the State Treasury, the*
7 *Health Care Cost and Quality Transparency Fund to support the*
8 *work of the commission. All fees and contributions collected by*
9 *the commission pursuant to Section 128870 shall be deposited in*
10 *this fund and, upon appropriation by the Legislature, used to*
11 *support the work of the commission.*

12
13 *Article 5. Penalties*
14

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

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

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

33 SEC. 33. *Section 130545 is added to the Health and Safety*
34 *Code, to read:*

35 130545. (a) *The State Department of Health Care Services*
36 *shall identify best practices related to e-prescribing modalities*
37 *and standards and shall make recommendations for statewide*
38 *adoption of e-prescribing on or before January 1, 2009.*

39 (b) *The State Department of Health Care Services shall develop*
40 *a pilot program to foster the adoption and use of electronic*

1 *prescribing by health care providers that contract with Medi-Cal.*
2 *The implementation of this Medi-Cal pilot is contingent upon the*
3 *availability of FFP or federal grant funds. The department may*
4 *provide electronic prescribing technology, including equipment*
5 *and software, to participating Medi-Cal prescribers.*

6 *SEC. 34. Section 10113.11 is added to the Insurance Code, to*
7 *read:*

8 *10113.11. (a) A health insurer may provide notice by electronic*
9 *transmission and shall be deemed to have fully complied with the*
10 *specific statutory or regulatory requirements to provide notice by*
11 *United States mail to an applicant or insured if it complies with*
12 *all of the following requirements:*

13 *(1) Obtains written authorization from the applicant or insured*
14 *to provide notices by electronic transmission and to cease*
15 *providing notices by United States mail. The authorization shall*
16 *be renewed by the insured on an annual basis. If the health insurer*
17 *obtains an application for coverage by electronic transmission, it*
18 *may obtain authorization by electronic transmission from the*
19 *applicant or insured to provide notices by electronic transmission.*

20 *(2) Uses an authorization form, approved by the department,*
21 *in which the applicant or insured confirms understanding of the*
22 *type of notice that will be provided by electronic transmission.*

23 *(3) Complies with the specific statutory or regulatory*
24 *requirements as to the content of the notices it sends by electronic*
25 *transmission.*

26 *(4) Provides for the privacy of the notice as required by state*
27 *and federal laws and regulations.*

28 *(5) Allows the applicant or insured at any time to terminate the*
29 *authorization to provide notices by electronic transmission and*
30 *receive the notices through the United States mail.*

31 *(6) Sends the electronic transmission of a notice to the last*
32 *known electronic address of the applicant or insured. If the*
33 *electronic transmission of the notice fails to reach its intended*
34 *recipient twice, the health insurer shall resume sending all notices*
35 *to the last known United States mail address of the applicant or*
36 *insured.*

37 *(7) Maintains an Internet Web site where the applicant or*
38 *insured may access the notices sent by electronic transmission.*

39 *(b) A health insurer shall not use the electronic mail address*
40 *of an applicant or insured that it obtained for the purposes of*

1 providing notice pursuant to subdivision (a) for any purpose other
2 than sending a notice as described in subdivision (a).

3 (c) No person other than the applicant or insured to whom the
4 medical information in the notice pertains or a representative
5 lawfully authorized to act on behalf of the applicant or insured,
6 may authorize the transmission of medical information by
7 electronic transmission. “Medical information” for these purposes
8 shall have the meaning set forth in subdivision (g) of Section 56.05
9 of the Civil Code.

10 (d) A notice transmitted electronically pursuant to this section
11 is a private and confidential communication, and it shall be
12 unlawful for a person, other than the applicant or insured to whom
13 the notice is addressed, to read or otherwise gain access to the
14 notice without the express, specific permission of the notice’s
15 addressee. This subdivision shall not apply to a provider of an
16 applicant or insured if the provider is authorized to have access
17 to the medical information pursuant to the Confidentiality of
18 Medical Information Act (Part 2.6 (commencing with Section 56)
19 of Division 1 of the Civil Code).

20 (e) A health insurer may not impose additional fees or a
21 differential if an applicant or insured elects not to receive notices
22 by electronic transmissions.

23 (f) “Notice” for purposes of this section includes explanation
24 of benefits; distribution of the insurer’s policies and certificates
25 of coverage; a list of contracting providers; responses to inquiries
26 from insureds; changes in rates pursuant to Sections 10113.7 and
27 10901.3; and notices related to underwriting decisions pursuant
28 to Section 791.10.

29 SEC. 35. Section 10123.56 is added to the Insurance Code, to
30 read:

31 10123.56. (a) Every policy of group health insurance that is
32 offered, delivered, amended, or renewed on or after January 1,
33 2009, that covers hospital, medical, or surgical expenses shall
34 offer coverage that includes a Healthy Action Incentives and
35 Rewards Program as described in subdivision (c). Every insurer
36 shall communicate the availability of this coverage to all group
37 policyholders and to all prospective group policyholders with
38 whom they are negotiating.

39 (b) Every policy of insurance that is offered, delivered, amended,
40 or renewed on or after January 1, 2009, that covers hospital,

1 *medical, or surgical expenses on an individual basis shall offer*
2 *individuals at least one coverage choice that includes a Healthy*
3 *Action Incentives and Rewards Program that meets the*
4 *requirements described in subdivision (c).*

5 *(c) For purposes of this section, benefits for a Healthy Action*
6 *Incentives and Rewards Program shall provide for all of the*
7 *following:*

8 *(1) Health risk appraisals that collect information from*
9 *individuals to assess overall health status and to identify risk*
10 *factors, including, but not limited to, smoking and smokeless*
11 *tobacco use, alcohol abuse, drug use, and nutrition and physical*
12 *activity practices.*

13 *(2) A followup appointment with a licensed health care*
14 *professional acting within his or her scope of practice to review*
15 *the results of the health risk appraisal and discuss any*
16 *recommended actions.*

17 *(3) Incentives or rewards for policyholders to become more*
18 *engaged in their health care and to make appropriate choices that*
19 *support good health, including obtaining health risk appraisals,*
20 *screening services, immunizations, or participating in healthy*
21 *lifestyle programs or practices. These programs or practices may*
22 *include, but need not be limited to, smoking cessation, physical*
23 *activity, or nutrition. Incentives may include, but need not be*
24 *limited to, health premium reductions, differential copayment or*
25 *coinsurance amounts, and cash payments. Rewards may include,*
26 *but need not be limited to, nonmedical pharmacy products or*
27 *services not otherwise covered under a policyholder's health*
28 *insurance contract, gym memberships, and weight management*
29 *programs. If an insurer elects to offer an incentive in the form of*
30 *a reduction in the premium amount, the premium reduction shall*
31 *be standardized and uniform for all groups and policyholders and*
32 *shall be offered only after the successful completion of the specified*
33 *program or practice by the insured or policyholder.*

34 *(d) This section is in addition to, and does not replace, any other*
35 *section in this code concerning requirements for insurers to provide*
36 *health care screening services, childhood immunizations, adult*
37 *immunizations, and preventive care services.*

38 *(e) (1) Notwithstanding any other provision of law, the*
39 *provision of healthy incentives and rewards pursuant to this section*
40 *by a health care provider, or his or her agent, that meets the*

1 requirements of this section, Section 1367.38 of the Health and
2 Safety Code, or Section 14132.105 of the Welfare and Institutions
3 Code shall not be considered or construed as an unlawful practice,
4 act, kickback, bribe, rebate, remuneration, offer, coupon, product,
5 payment, or any other form of compensation by a provider or his
6 or her agent, directly or indirectly, overtly or covertly, in exchange
7 for another to obtain, participate, or otherwise undergo or receive
8 health care services.

9 (2) Notwithstanding any other provision of law, incentives
10 authorized pursuant to this section are not subject to the penalties,
11 discipline, limitations, or sanctions imposed under law to preclude
12 or prohibit, as an unlawful practice, bribe, kickback or other act,
13 the offering or delivery of a rebate, remuneration, offer, coupon,
14 product, rebate, payment, or any other form of compensation by
15 the provider, or his or her agent, directly or indirectly, overtly or
16 covertly, in exchange for another to obtain, participate, or
17 otherwise undergo or receive health care services.

18 (3) Notwithstanding any other provision of law, the provision
19 of healthy incentives and rewards pursuant to this section by a
20 health care provider, or his or her agent, that meets the
21 requirements of this section shall not be considered or construed
22 as an inducement to enroll.

23 (f) This section shall only be implemented if and to the extent
24 allowed under federal law. If any portion of this section is held to
25 be invalid, as determined by a final judgment of a court of
26 competent jurisdiction, this section shall become inoperative.

27 SEC. 36. Chapter 1.6 (commencing with Section 10199.10) is
28 added to Part 2 of Division 2 of the Insurance Code, to read:

29

30 CHAPTER 1.6. CALIFORNIA INDIVIDUAL COVERAGE GUARANTEE
31 ISSUE

32

33 10199.10. It is the intent of the Legislature to do both of the
34 following:

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

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

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

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

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

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

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

35 10199.105. On and after July 1, 2010, health care service plans
36 and health insurers participating in the individual market shall
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 10199.106. *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 (a) *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 level of benefits.*

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

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

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

20 (2) *Upon divorce.*

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

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

24 (e) *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 (f) *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 10199.107. *At the time an individual applies for health*
34 *coverage from a health care service plan or health insurer*
35 *participating in the individual market, an individual shall provide*
36 *information as required by a standardized health status*
37 *questionnaire to assist plans and insurers in identifying persons*
38 *in need of disease management. Health care service plans and*
39 *health insurers may not use information provided on the*

1 questionnaire to decline coverage, or to limit an individual's choice
2 of health care benefit plan.

3 10199.108. Health benefit plans shall become effective within
4 31 days of receipt of the individual's application, standardized
5 health status questionnaire, and premium payment.

6 10199.109. Health care service plans and health insurers may
7 reject an application for health care benefits if the individual does
8 not reside or work in a plan's or insurer's approved service area.

9 10199.110. The commissioner or the Director of the
10 Department of Managed Health Care, as applicable, may require
11 a health care service plan or health insurer to discontinue the
12 offering of health care benefits, or acceptance of applications from
13 individuals, upon a determination by the director or commissioner
14 that the plan or insurer does not have sufficient financial viability,
15 or organizational and administrative capacity, to ensure the
16 delivery of health care benefits to its enrollees or insureds.

17 10199.111. All health care benefits offered to individuals shall
18 be renewable with respect to all individuals and dependents at the
19 option of the subscriber, except:

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

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

24 10199.112. No health care service plan or health insurer shall,
25 directly or indirectly, enter into any contract, agreement, or
26 arrangement with a solicitor that provides for or results in the
27 compensation paid to a solicitor for the sale of a health care
28 service plan contract or health insurance policy to be varied
29 because of the health status, claims experience, occupation, or
30 geographic location of the individual, provided the geographic
31 location is within the plan's or insurer's approved service area.

32 10199.113. This chapter shall not apply to individual health
33 plan contracts for coverage of Medicare services pursuant to
34 contracts with the United States Government, Medi-Cal contracts
35 with the State Department of Health Care Services, Healthy
36 Families Program contracts with the Managed Risk Medical
37 Insurance Board, high-risk pool contracts with the Major Risk
38 Medical Insurance Program, Medicare supplement policies,
39 long-term care policies, specialized health plan contracts, or

1 *contracts issued to individuals who secure coverage from*
2 *Cal-CHIPP.*

3 *10199.114. (a) A health care service plan or health insurer*
4 *may rate its entire portfolio of health benefit plans in accordance*
5 *with expected costs or other market considerations, but the rate*
6 *for each plan or insurer shall be set in relation to the balance of*
7 *the portfolio as certified by an actuary. Each benefit plan shall be*
8 *priced as determined by each health care service plan or health*
9 *insurer to reflect the difference in benefit variation, or the*
10 *effectiveness of a provider network, but may not adjust the rate*
11 *for a specific plan for risk selection. A health care service plan's*
12 *or health insurer's rates shall use the same rating factors for age,*
13 *family size, and geographic location for each individual health*
14 *care benefit plan it issues. Rates for health care benefits may vary*
15 *from applicant to applicant only by any of the following:*

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

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

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

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

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

35 *10199.115. 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 chapter.*

1 10199.116 This chapter, other than Section 10199.104, shall
2 not become operative until the date that the provisions of Section
3 8899.50 of the Government Code are implemented.

4 SEC. 37. Section 10293.5 is added to the Insurance Code, to
5 read:

6 10293.5. (a) The commissioner shall adopt regulations no
7 later than July 1, 2008, requiring that at least 85 percent of health
8 insurance premium revenue received by a health insurer be spent
9 on health care services. The regulations shall also define "health
10 care services."

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

13 (c) 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 SEC. 38. Section 10607 of the Insurance Code is amended to
19 read:

20 10607. In addition to the other disclosures required by this
21 chapter, every insurer and their employees or agents shall, when
22 presenting a plan for examination or sale to any individual or the
23 representative of a group consisting of ~~25~~ 100 or fewer individuals,
24 disclose in writing the ratio of incurred claims to earned premiums
25 (loss-ratio) for the insurer's preceding calendar-year. ~~This section~~
26 ~~shall become operative on March 1, 1991, in order to allow insurers~~
27 ~~time to comply year for policies with its provisions. individuals~~
28 ~~and with groups of the same or similar size for the insurer's~~
29 ~~preceding fiscal year.~~

30 SEC. 39. Chapter 8.1 (commencing with Section 10760) is
31 added to Part 2 of Division 2 of the Insurance Code, to read:

32

33

CHAPTER 8.1. INSURANCE MARKET REFORM

34

35 10760. On and after January 1, 2010, the department, in
36 consultation with the Department of Managed Health Care, shall
37 require each health insurer with one million or more insureds in
38 California, based on the insurer's enrollment in the prior year, to
39 submit a good faith bid to the Managed Risk Medical Insurance
40 Board in order to be a participating plan through the California

1 *Cooperative Health Insurance Purchasing Program (Cal-CHIP)*
2 *pursuant to Part 6.45 (commencing with Section 12699.201).*

3 *10763. On and after July 1, 2010, all requirements in Chapter*
4 *8 (commencing with Section 10700) applicable to offering,*
5 *marketing, and selling health benefit plans to small employers as*
6 *defined in that chapter, including, but not limited to, the obligation*
7 *to fairly and affirmatively offer, market, and sell all of the carrier's*
8 *health benefit plan designs to all employers, guaranteed renewal*
9 *of all health benefit plan designs, use of the risk adjustment factor,*
10 *and the restriction of risk categories to age, geographic region,*
11 *and family composition as described in that chapter, shall be*
12 *applicable to all health benefit plan designs offered to all*
13 *employers with 100 or fewer eligible employees, except as follows:*

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

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

21 *10764. It is the intent of the Legislature to establish a*
22 *mechanism by which the state may defray the costs of an insured's*
23 *public program participation by taking advantage of other*
24 *opportunities for coverage available to that insured.*

25 *10765. (a) As used in this chapter, "health insurance" shall*
26 *have the same meaning as in subdivision (b) of Section 106.*

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

32 *10766. This chapter shall become operative on July 1, 2008.*

33 *SEC. 40. Section 12693.43 of the Insurance Code is amended*
34 *to read:*

35 *12693.43. (a) Applicants applying to the purchasing pool shall*
36 *agree to pay family contributions, unless the applicant has a family*
37 *contribution sponsor. Family contribution amounts consist of the*
38 *following two components:*

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

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

5 (b) In each geographic area, the board shall designate one or
6 more ~~Family Value Packages~~ *family value packages* for which the
7 required total family contribution is:

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

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

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

38 (4) *On and after July 1, 2010, twenty-five dollars (\$25) per child*
39 *with a maximum required contribution of seventy-five dollars (\$75)*
40 *per month per family for applicants with annual household incomes*

1 *greater than 250 percent and up to and including 300 percent of*
2 *the federal poverty level.*

3 (c) Combinations of health, dental, and vision plans that are
4 more expensive to the program than the highest cost ~~Family Value~~
5 ~~Package~~ *family value package* may be offered to and selected by
6 applicants. However, the cost to the program of those combinations
7 that exceeds the price to the program of the highest cost ~~Family~~
8 ~~Value Package~~ *family value package* shall be paid by the applicant
9 as part of the family contribution.

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

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

19 (2) Six dollars (\$6) per child with a maximum required
20 contribution of eighteen dollars (\$18) per month per family for
21 applicants with annual household incomes greater than 150 percent
22 and up to and including 200 percent of the federal poverty level
23 and for applicants on behalf of children described in clause (ii) of
24 subparagraph (A) of paragraph (6) of subdivision (a) of Section
25 12693.70.

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

1 increase takes effect, shall provide that applicant with an
2 opportunity to demonstrate that subparagraph (B) of paragraph (6)
3 of subdivision (a) of Section 12693.70 is no longer applicable to
4 the relevant family income.

5 (4) *On and after July 1, 2010, twenty-two dollars (\$22) per child*
6 *with a maximum required contribution of sixty-six dollars (\$66)*
7 *per month per family for applicants with annual household incomes*
8 *greater than 250 percent and up to and including 300 percent of*
9 *the federal poverty level.*

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

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

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

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

38 *SEC. 41. Section 12693.56 is added to the Insurance Code, to*
39 *read:*

1 12693.56. (a) *The board may provide or arrange for the*
2 *provision of an electronic personal health record for enrollees*
3 *receiving health care benefits, to the extent funds are appropriated*
4 *for this purpose. The record shall be provided for the purpose of*
5 *providing enrollees with information to assist them in*
6 *understanding their coverage benefits and managing their health*
7 *care.*

8 (b) *At a minimum, the personal health record shall provide*
9 *access to real-time, patient-specific information regarding*
10 *eligibility for covered benefits and cost sharing requirements. The*
11 *access may be provided through the use of an Internet-based*
12 *system.*

13 (c) *In addition to the data required pursuant to subdivision (b),*
14 *the board may determine that the personal health record shall also*
15 *incorporate additional data, including, but not limited to,*
16 *laboratory results, prescription history, claims history, and*
17 *personal health information authorized or provided by the enrollee.*
18 *Inclusion of this additional data shall be at the option of the*
19 *enrollee.*

20 (d) *Systems or software that pertain to the personal health*
21 *record shall adhere to accepted national standards for*
22 *interoperability, privacy, and data exchange, or shall be certified*
23 *by a nationally recognized certification body.*

24 (e) *The personal health record shall comply with applicable*
25 *state and federal confidentiality and data security requirements.*

26 SEC. 42. *Section 12693.57 is added to the Insurance Code, to*
27 *read:*

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

34 SEC. 43. *Section 12693.58 is added to the Insurance Code, to*
35 *read:*

36 12693.58. (a) *All types of information, whether written or oral,*
37 *concerning an applicant, subscriber, or household member, made*
38 *or kept by any public officer or agency in connection with the*
39 *administration of any provision of this part shall be confidential,*
40 *and shall not be open to examination other than for purposes*

1 *directly connected with the administration of the Healthy Families*
2 *Program or the Medi-Cal program.*

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

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

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

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

24 SEC. 44. *Section 12693.59 is added to the Insurance Code, to*
25 *read:*

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

35 SEC. 45. *Section 12693.70 of the Insurance Code is amended*
36 *to read:*

37 12693.70. *To be eligible to participate in the program, an*
38 *applicant shall meet all of the following requirements:*

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

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

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

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

11 (4) A child who meets citizenship and immigration status
12 requirements that are applicable to persons participating in the
13 program established by Title XXI of the Social Security Act, except
14 as specified in Section 12693.76. *This paragraph shall become*
15 *inoperative on July 1, 2010.*

16 (5) A resident of the State of California pursuant to Section 244
17 of the Government Code; or, if not a resident pursuant to Section
18 244 of the Government Code, is physically present in California
19 and entered the state with a job commitment or to seek
20 employment, whether or not employed at the time of application
21 to or after acceptance in, the program.

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

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

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

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

15 (B) All income over 200 percent of the federal poverty level
16 but less than or equal to 250 percent of the federal poverty level
17 shall be disregarded in calculating annual or monthly household
18 income. *On and after July 1, 2010, all income over 250 percent*
19 *of the federal poverty level but less than or equal to 300 percent*
20 *of the federal poverty level shall be disregarded in calculating*
21 *annual or monthly household income.*

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

29 (D) *On and after July 1, 2010, in a family with an annual or*
30 *monthly household income greater than 300 percent of the federal*
31 *poverty level, any income deduction that is applicable to a child*
32 *under the Medi-Cal program shall be applied in determining the*
33 *annual or monthly household income. If the income deductions*
34 *reduce the annual or monthly household income to 300 percent*
35 *or less of the federal poverty level, subparagraph (B) shall apply.*

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

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

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

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

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

24 *SEC. 46. Section 12693.73 of the Insurance Code is amended*
25 *to read:*

26 12693.73. Notwithstanding any other provision of law, children
27 excluded from coverage under Title XXI of the Social Security
28 Act are not eligible for coverage under the program, except as
29 specified in clause (ii) of subparagraph (A) of paragraph (6) of
30 subdivision (a) of Section 12693.70 and Section 12693.76. *On and*
31 *after July 1, 2010, children who otherwise meet eligibility*
32 *requirements for the program but for their immigration status are*
33 *eligible for the program.*

34 *SEC. 47. 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 who is a qualified alien as defined in Section 1641 of Title
38 8 of the United States Code Annotated shall not be determined
39 ineligible solely on the basis of his or her date of entry into the
40 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, on and after*
13 *July 1, 2010, a child who is otherwise eligible to participate in the*
14 *program shall not be determined ineligible solely on the basis of*
15 *his or her immigration status.*

16 SEC. 48. *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.*

1 (d) “Dependent” means the spouse, domestic partner, minor
2 child of an enrollee, and a child 18 years of age or older of the
3 enrollee who is dependent on the enrollee, as defined by the board.

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

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

8 (g) “Cal-CHIPP Healthy Families plan” shall mean health
9 care coverage provided through a health care service plan or a
10 health insurer that provides for individuals eligible pursuant to
11 Section 14005.301 or 14005.307 of the Welfare and Institutions
12 Code, coverage that meets the requirements of federal law and
13 that, at a minimum, provides the same covered services and benefits
14 required under the Knox-Keene Health Care Service Plan Act of
15 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2
16 of the Health and Safety Code) plus prescription drug benefits.

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

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

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

36
37 CHAPTER 2. ADMINISTRATION

38
39 12699.202. (a) The board shall be responsible for establishing
40 Cal-CHIPP and administering this part.

- 1 (b) The board may do all of the following consistent with the
2 standards of this part:
- 3 (1) Determine eligibility and enrollment criteria and processes
4 for Cal-CHIPP consistent with the eligibility standards in Chapter
5 3 (commencing with Section 12699.211).
- 6 (2) Determine the participation requirements for enrollees.
- 7 (3) Determine the participation requirements and the standards
8 and selection criteria for participating health, dental, and vision
9 care plans, including reasonable limits on a plan's administrative
10 costs.
- 11 (4) Determine when an enrollee's coverage commences and the
12 extent and scope of coverage.
- 13 (5) Determine premium schedules, collect the premiums, and
14 administer subsidies to eligible enrollees.
- 15 (6) Determine rates paid to participating health, dental, and
16 vision care plans.
- 17 (7) Provide, or make available, coverage through participating
18 health plans in Cal-CHIPP.
- 19 (8) Provide, or make available, coverage through participating
20 dental and vision care plans in Cal-CHIPP.
- 21 (9) Provide for the processing of applications and the enrollment
22 of enrollees.
- 23 (10) Determine and approve the benefit designs and cost-sharing
24 provisions for participating health, dental, and vision care plans.
- 25 (11) Enter into contracts.
- 26 (12) Sue and be sued.
- 27 (13) Employ necessary staff.
- 28 (14) Authorize expenditures, as necessary, from the fund to pay
29 program expenses that exceed enrollee contributions and to
30 administer Cal-CHIPP.
- 31 (15) Issue rules and regulations, as necessary.
- 32 (16) Maintain enrollment and expenditures to ensure that
33 expenditures do not exceed the amount of revenue available in the
34 fund, and if sufficient revenue is not available to pay the estimated
35 expenditures, the board shall institute appropriate measures to
36 ensure fiscal solvency. This paragraph shall not be construed to
37 allow the board to deny enrollment of a person who otherwise
38 meets the eligibility requirements of Chapter 3 (commencing with
39 Section 12699.211) in order to ensure the fiscal solvency of the
40 fund.

1 (17) Establish the criteria and procedures through which
2 employers direct employees' premium dollars, withheld under the
3 terms of a cafeteria plan, to Cal-CHIPP to be credited against the
4 employees' premium obligations.

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

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

11 12699.203. The board shall develop and offer a variety of
12 benefit plan designs, including, but not limited to the following:

13 (a) A Cal-CHIPP Healthy Families plan for parents and
14 caretaker relatives pursuant to Section 14005.301 of the Welfare
15 and Institutions Code and for adults eligible for coverage pursuant
16 to Section 14005.307 of the Welfare and Institutions Code with
17 incomes greater than 100 percent of the federal poverty level.

18 (b) A low-cost plan for Cal-CHIPP enrollees who are adults
19 with a family income at or below 300 percent of the federal poverty
20 level who are ineligible for coverage through Section 14005.301
21 or 14005.307 of the Welfare and Institutions Code or the Medi-Cal
22 program.

23 (c) A high value plan for all Cal-CHIPP enrollees with a family
24 income above 300 percent of the federal poverty level.

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

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

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

4 12699.204. (a) The board may adjust premiums at a public
5 meeting of the board after providing, at minimum, 30 days' public
6 notice of the adjustment. In making the adjustment, the board shall
7 take into account the costs of health care typically paid for by
8 employers and employees in California.

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

15 (c) The following premiums shall apply to coverage under this
16 part for the population eligible for coverage pursuant to Section
17 14005.301 of the Welfare and Institutions Code.

18 (1) For individuals with a family income less than or equal to
19 150 percent of the federal poverty level, no premiums or
20 out-of-pocket costs shall be allowed.

21 (2) For individuals with a family income above 150 percent but
22 less than or equal to 300 percent of the federal poverty level
23 premiums shall not exceed 5 percent of the family income net of
24 applicable deductions.

25 (d) The following premiums shall apply to coverage under this
26 part for the population eligible for coverage pursuant to Sections
27 14005.305 and 14005.307 of the Welfare and Institutions Code:

28 (1) For individuals with a family income less than or equal to
29 150 percent of the federal poverty level, no premiums or
30 out-of-pocket costs shall be allowed.

31 (2) For individuals with a family income above 150 percent but
32 less than or equal to 250 percent of the federal poverty level,
33 premiums shall not exceed 5 percent of the family income net of
34 applicable deductions.

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

37 12699.204.1. The board shall limit enrollment in the
38 Cal-CHIPP Healthy Families plan to individuals who are eligible
39 under Sections 14005.301 and 14005.305 of the Welfare and
40 Institutions Code and to individuals eligible under Section

1 14005.307 of the Welfare and Institutions Code with a family
2 income greater than 100 percent of the federal poverty level.

3 12699.205. The board, in its contract with a participating
4 health plan, shall require that the plan utilize efficient practices
5 to improve and control costs. These practices may include, but are
6 not limited to, the following:

7 (a) Preventive care.

8 (b) Care management for chronic diseases.

9 (c) Promotion of health information technology.

10 (d) Standardized billing practices.

11 (e) Reduction of medical errors.

12 (f) Incentives for healthy lifestyles.

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

15 (h) Evidence-based use of new technology.

16 12699.206. (a) The board shall negotiate with Medi-Cal
17 managed care plans to obtain affordable coverage for eligible
18 enrollees.

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

24 12699.206.1. (a) To provide prescription drug coverage for
25 Cal-CHIPP enrollees, the board may take any of the following
26 actions:

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

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

33 (3) Procure products directly through the prescription drug
34 purchasing program established pursuant to Chapter 12
35 (commencing with Section 14977) of Part 5.5 of Division 3 of Title
36 2 of the Government Code.

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

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

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

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

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

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

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

35 (d) The use and disclosure of information concerning an
36 applicant or enrollee in the program who is a beneficiary in the
37 Medi-Cal program or an applicant to the Medi-Cal program shall
38 be strictly limited to the circumstances described in Section
39 14100.2 of the Welfare and Institutions Code.

1 (e) Except as provided in subdivision (d), nothing in this part
2 shall prohibit the disclosure of protected health information as
3 provided in Section 164.152 of Title 45 of the Code of Federal
4 Regulations.

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

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

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

21 12699.209. The board, in consultation with the State
22 Department of Health Care Services, shall take all reasonable
23 steps necessary to maximize federal funding and support federal
24 claiming in the administration of the purchasing pool created
25 pursuant to this part. In addition, the board shall consult and
26 coordinate with the State Department of Health Care Services in
27 seeking federal financial support pursuant to Article 7
28 (commencing with Section 14199.10) of Chapter 7 of Part 3 of
29 Division 9 of the Welfare and Institutions Code. To the extent the
30 state obtains federal financial support for the populations described
31 in Section 14199.10 of the Welfare and Institutions Code, the
32 coverage shall be subject to the terms, conditions, and duration
33 of any applicable state plan amendment or waiver. To the extent
34 required to obtain federal financial support, the board shall apply
35 citizenship, immigration, and identity documentation standards
36 required in Title XIX of the federal Social Security Act.

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

CHAPTER 3. ELIGIBILITY

1
2
3 12699.211. To be eligible to enroll in Cal-CHIP, an individual
4 must be a resident of the state pursuant to Section 244 of the
5 Government Code or physically present in the state, having entered
6 the state with an employment commitment or to obtain employment,
7 whether or not employed at the time of application to Cal-CHIP
8 or after enrollment in Cal-CHIP. In addition, to be eligible to
9 enroll in Cal-CHIP, an individual must meet any of the following
10 requirements:

11 (a) Be an employee or a dependent of an employee of an
12 employer who elected to pay into the California Health Trust Fund.
13 To the extent an employer elects to pay into the California Health
14 Trust Fund, only employees and dependents in the category of
15 employees for which the employer has elected to pay shall be
16 eligible to enroll in Cal-CHIP.

17 (b) Be an individual eligible for coverage pursuant to Section
18 14005.301, 14005.305, or 14005.307 of the Welfare and
19 Institutions Code.

20 (c) Be an individual eligible for a state tax credit for purposes
21 of purchasing affordable health care coverage.

22 12699.211.01. Notwithstanding any other provision of law, an
23 adult otherwise eligible for coverage under Section 14005.307 of
24 the Welfare and Institutions Code is not eligible to enroll in
25 Cal-CHIP if he or she is offered health care coverage through
26 his or her employment.

27 12699.211.02. (a) The following program decisions may be
28 appealed to the board:

29 (1) A decision that an individual is not qualified to participate
30 or continue to participate in the program.

31 (2) A decision that an individual is not eligible for enrollment
32 or continuing enrollment in the program.

33 (3) A decision as to the effective date of coverage.

34 (b) An applicant or subscriber who appeals one of the decisions
35 listed in subdivision (a) shall be accorded an opportunity for an
36 administrative hearing. The hearing shall be conducted, insofar
37 as practicable, pursuant to Chapter 5 (commencing with Section
38 11500) of Part 1 of Division 3 of the Government Code.

39 (c) To the extent required by law, the board shall implement
40 this section consistent with applicable federal law.

CHAPTER 4. FISCAL

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

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

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

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

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

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

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

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

SEC. 49. *Section 12886 is added to the Insurance Code, to read:*

12886. *It shall constitute an unfair labor practice contrary to public policy, and enforceable under Section 95 of the Labor Code, for an employer to refer an individual employee or employee's dependent to the program established pursuant to Part 6.45 (commencing with Section 12699.201), or to arrange for an individual employee or employee's dependent to apply to that*

1 program, for the purpose of separating that employee or
2 employee's dependent from group health coverage provided in
3 connection with the employee's employment. An employer who
4 pays the premium for the employee in the program established
5 pursuant to Part 6.45 (commencing with Section 12699.201) shall
6 not, on the basis of that action, be deemed to be in violation of this
7 section.

8 SEC. 50. Section 12887 is added to the Insurance Code, to
9 read:

10 12887. It shall constitute an unfair labor practice contrary to
11 public policy and enforceable under Section 95 of the Labor Code
12 for an employer to change the employee-employer share-of-cost
13 ratio based upon the employee's wage base or job classification
14 or to make any modification of coverage for employees and
15 employees' dependents in order that the employees or employees'
16 dependents enroll in the program established pursuant to Part
17 6.45 (commencing with Section 12699.201).

18 SEC. 51. Section 96.8 is added to the Labor Code, to read:

19 96.8. (a) Notwithstanding any other provision in this chapter,
20 an employer may provide health coverage that includes a Healthy
21 Action Incentives and Rewards Program that meets the
22 requirements of Section 1367.38 of the Health and Safety Code,
23 or Section 10123.56 of the Insurance Code, to the employer's
24 employees.

25 (b) A Healthy Action Incentives and Rewards Program offered
26 pursuant to this section may include, but need not be limited to,
27 monetary incentives and health coverage premium cost reductions
28 for employees for nonsmokers and smoking cessation.

29 SEC. 52. Section 96.81 is added to the Labor Code, to read:

30 96.81. (a) (1) Notwithstanding any other provision of law,
31 the delivery or provision of Healthy Action Incentives and Rewards
32 Program benefits or coverage by the employer or the employer's
33 agents to employees for the purposes of and in accordance with
34 the criteria and requirements established under Section 96.8 shall
35 not be considered or construed as an unlawful practice, act,
36 kickback, bribe, rebate, remuneration, offer, payment, or any other
37 form of compensation made directly or indirectly, overtly or
38 covertly, in exchange for another to obtain, participate, or
39 otherwise undergo or receive health care services.

1 (2) Notwithstanding any other provision of law, the delivery or
2 provision of Healthy Action Incentives and Rewards Program
3 benefits or coverage by the employer or the employer's agents to
4 employees for the purposes of and in accordance with the criteria
5 and requirements established under Section 96.8 is not subject to
6 the penalties, discipline, limitations, or sanctions imposed under
7 state law to preclude or prohibit, as an unlawful practice, bribe,
8 kickback, or other act, the offering or delivery of a rebate,
9 remuneration, offer, coupon, product, rebate, payment, or any
10 other form of compensation made directly or indirectly, overtly or
11 covertly, in exchange for another to obtain, participate, or
12 otherwise undergo or receive health care services.

13 (b) This section shall only be implemented if and to the extent
14 allowed under federal law. If any portion of this section is held to
15 be invalid, as determined by a final judgment of a court of
16 competent jurisdiction, this section shall become inoperative.

17 SEC. 53. Section 14005.30 of the Welfare and Institutions Code
18 is amended to read:

19 14005.30. (a) (1) To the extent that federal financial
20 participation is available, Medi-Cal benefits under this chapter
21 shall be provided to individuals eligible for services under Section
22 1396u-1 of Title 42 of the United States Code, including any
23 options under Section 1396u-1(b)(2)(C) made available to and
24 exercised by the state.

25 (2) The department shall exercise its option under Section
26 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
27 less restrictive income and resource eligibility standards and
28 methodologies to the extent necessary to allow all recipients of
29 benefits under Chapter 2 (commencing with Section 11200) to be
30 eligible for Medi-Cal under paragraph (1).

31 (3) To the extent federal financial participation is available, the
32 department shall exercise its option under Section 1396u-1(b)(2)(C)
33 of Title 42 of the United States Code authorizing the state to
34 disregard all changes in income or assets of a beneficiary until the
35 next annual redetermination under Section 14012. The department
36 shall implement this paragraph only if, and to the extent that the
37 State Child Health Insurance Program waiver described in Section
38 12693.755 of the Insurance Code extending Healthy Families
39 Program eligibility to parents and certain other adults is approved
40 and implemented.

1 (b) (1) To the extent that federal financial participation is
2 available, the department shall exercise its option under Section
3 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
4 to expand eligibility for Medi-Cal under subdivision (a) by
5 establishing the amount of countable resources individuals or
6 families are allowed to retain at the same amount medically needy
7 individuals and families are allowed to retain, except that a family
8 of one shall be allowed to retain countable resources in the amount
9 of three thousand dollars (\$3,000). *This paragraph shall not be*
10 *operative during implementation of paragraph (2).*

11 (2) *To the extent that federal financial participation is available,*
12 *the department shall exercise its option under Section*
13 *1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary*
14 *to simplify eligibility for Medi-Cal under subdivision (a) by*
15 *exempting all resources for applicants and recipients, commencing*
16 *July 1, 2010.*

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

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

38 ~~(e) Subdivision (b) shall be applied retroactively to January 1,~~
39 ~~1998.~~

40 (f)

1 (e) Notwithstanding Chapter 3.5 (commencing with Section
2 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
3 the department shall implement, without taking regulatory action,
4 subdivisions (a) and (b) of this section by means of an all county
5 letter or similar instruction. Thereafter, the department shall adopt
6 regulations in accordance with the requirements of Chapter 3.5
7 (commencing with Section 11340) of Part 1 of Division 3 of Title
8 2 of the Government Code. Beginning six months after the effective
9 date of this section, the department shall provide a status report to
10 the Legislature on a semiannual basis until regulations have been
11 adopted.

12 *SEC. 54. Section 14005.301 is added to the Welfare and*
13 *Institutions Code, to read:*

14 *14005.301. (a) Notwithstanding Section 14005.30, to the extent*
15 *that federal financial participation is available, and as permitted*
16 *under Section 6044 of the federal Deficit Reduction Act of 2005*
17 *(42 U.S.C. Sec. 1396u-7) the department shall provide benefits*
18 *under a Cal-CHIPP Healthy Families plan to a population*
19 *composed of parents and other caretaker relatives with a household*
20 *income at or below 300 percent of the federal poverty level who*
21 *are not otherwise eligible for full scope benefits with no share of*
22 *cost.*

23 *(b) The eligibility determination under this section shall not*
24 *include an asset test. A redetermination for eligibility under this*
25 *section shall be completed annually.*

26 *(c) To the extent necessary to implement this section, the*
27 *department shall seek federal approval to modify the definition of*
28 *“unemployed parent” in Section 14008.85.*

29 *(d) The department shall implement this section by means of a*
30 *state plan amendment. If this section cannot be implemented by a*
31 *state plan amendment, the department shall seek a waiver or a*
32 *waiver and a state plan amendment necessary to accomplish the*
33 *intent of this section.*

34 *(e) This section shall become operative on July 1, 2010.*

35 *SEC. 55. Section 14005.305 is added to the Welfare and*
36 *Institutions Code, to read:*

37 *14005.305. (a) The department shall provide benefits to a*
38 *population composed of individuals who are either 19 or 20 years*
39 *of age and who meet all of the following requirements:*

1 (1) Net family income is at or below 250 percent of the federal
2 poverty level.

3 (2) The individual is not otherwise eligible for full-scope benefits
4 in one of the federal poverty level programs for children, but would
5 be eligible for those benefits if he or she were under 19 years of
6 age with income at or below 100 percent of the federal poverty
7 level.

8 (3) The individual is a citizen, national, or qualified alien
9 without regard to date of entry.

10 (b) The eligibility determination under this section shall not
11 include an asset test. A redetermination for eligibility under this
12 section shall be completed annually.

13 (c) The department shall implement this section by means of a
14 state plan amendment under Section 1902(a)(10)(A)(ii)(I) of the
15 federal Social Security Act (Title 42 U.S.C. Sec.
16 1396a(a)(10)(A)(ii)(I)), or by any other state plan amendment or
17 waiver, or combination thereof, as is necessary to accomplish the
18 intent of this section.

19 (d) The department shall seek federal approval to utilize the
20 same premiums and copayments for the population to whom this
21 section applies as are applied to the population established
22 pursuant to Section 14005.307.

23 (e) This section shall be implemented only if, and to the extent
24 that federal approval has been obtained to provide benchmark
25 benefits for individuals made eligible under this section with net
26 income over 100 percent of the federal poverty level in a manner
27 consistent with Section 14005.306.

28 (f) The income methodology for eligibility determinations under
29 this section shall be the methodology used for the federal poverty
30 level programs, but shall not include any income disregards
31 available under those programs.

32 (g) This section shall become operative on July 1, 2010, but
33 only to the extent federal financial participation is available.

34 SEC. 56. Section 14005.306 is added to the Welfare and
35 Institutions Code, to read:

36 14005.306. (a) Subject to the limitations provided in
37 subdivisions (b) and (c), a Medi-Cal beneficiary with a net family
38 income above 100 percent of the federal poverty level whose
39 eligibility is based on Section 14005.301 or Section 14005.305
40 and who is otherwise eligible for full-scope benefits, shall receive

1 *his or her benefits by means of a benchmark package pursuant to*
2 *Section 1937 of the federal Social Security Act. This package shall*
3 *be the Cal-CHIPP Healthy Families benefit package established*
4 *for the program established pursuant to Part 6.45 (commencing*
5 *with Section 12699.201) of Division 2 of the Insurance Code.*

6 *(b) To the extent required by federal law, the categories of*
7 *beneficiaries listed in Section 1937(a)(2)(B) of the federal Social*
8 *Security Act (Title 42 U.S.C. Sec. 1396u-7(a)(2)(B)), are exempt*
9 *from mandatory enrollment in the benchmark package described*
10 *in subdivision (a).*

11 *(c) The department, with the concurrence of the Managed Risk*
12 *Medical Insurance Board, may identify groups of otherwise exempt*
13 *individuals that will be allowed a choice, at the beneficiary's*
14 *option, to participate in a benchmark package.*

15 *(d) The department, with concurrence of the Managed Risk*
16 *Medical Insurance Board, may exempt other groups or categories*
17 *of beneficiaries from the requirements provided in subdivision (a).*

18 *(e) To the extent federal approval is obtained, the appeals*
19 *process for issues relating to receipt of benefits through the*
20 *benchmark package shall be the process prescribed by the*
21 *Managed Risk Medical Insurance Board for the program*
22 *established pursuant to Part 6.45 (commencing with Section*
23 *12699.201) of Division 2 of the Insurance Code.*

24 *(f) This section shall be implemented only if and to the extent*
25 *that federal financial participation is available and all necessary*
26 *federal approvals have been obtained.*

27 *(g) The department shall accomplish the intent of this section*
28 *by means of a state plan amendment or by a waiver. If this section*
29 *is implemented in whole or in part by means of a state plan*
30 *amendment, all applicable federal requirements not otherwise*
31 *waived, including, but not limited to, requirements related to cost*
32 *sharing, shall apply.*

33 *SEC. 57. Section 14005.307 is added to the Welfare and*
34 *Institutions Code, to read:*

35 *14005.307. (a) The department shall provide benefits under*
36 *a Cal-CHIPP Healthy Families plan to a population composed of*
37 *individuals who meet all of the following requirements:*

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

1 *employment, whether or not employed at the time of application*
 2 *to the program.*

3 (2) *Is a citizen or national of the United States or a qualified*
 4 *alien without regard to date of entry.*

5 (3) *Is 19 years of age or older and is ineligible for Medicare*
 6 *Parts A and B.*

7 (4) *Has family income, less applicable deductions, greater than*
 8 *100 percent of the federal poverty level but less than or equal to*
 9 *250 percent of the federal poverty level.*

10 (5) *Is either ineligible for the Medi-Cal program or eligible to*
 11 *participate in benchmark package pursuant to Section 14005.306.*

12 (6) *Does not have access to employer-sponsored health care*
 13 *coverage. However, this provision does not apply to a person with*
 14 *coverage under Section 14005.301 or 14005.305.*

15 (b) *Implementation of this section with respect to individuals*
 16 *with coverage under Section 14005.332 is contingent on*
 17 *establishment of a county share of cost.*

18 SEC. 58. *Section 14005.31 of the Welfare and Institutions Code*
 19 *is amended to read:*

20 14005.31. (a) (1) Subject to paragraph (2), for any person
 21 whose eligibility for benefits under Section 14005.30 has been
 22 determined with a concurrent determination of eligibility for cash
 23 aid under Chapter 2 (commencing with Section 11200), loss of
 24 eligibility or termination of cash aid under Chapter 2 (commencing
 25 with Section 11200) shall not result in a loss of eligibility or
 26 termination of benefits under Section 14005.30 absent the existence
 27 of a factor that would result in loss of eligibility for benefits under
 28 Section 14005.30 for a person whose eligibility under Section
 29 14005.30 was determined without a concurrent determination of
 30 eligibility for benefits under Chapter 2 (commencing with Section
 31 11200).

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

38 (b) 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 Medi-Cal beneficiaries whose
2 eligibility for cash aid under Chapter 2 (commencing with Section
3 11200) has ended, but whose eligibility for benefits under Section
4 14005.30 continues pursuant to subdivision (a), that their benefits
5 will continue. To the extent feasible, the notice shall be sent out
6 at the same time as the notice of discontinuation of cash aid, and
7 shall include all of the following:

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

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

13 (3) A statement that the Medi-Cal beneficiary does not need to
14 fill out monthly status reports in order to remain eligible for
15 Medi-Cal, but shall be required to submit a semiannual status report
16 and annual reaffirmation ~~forms~~. *forms, except that the semiannual*
17 *status report shall no longer be required on and after July 1, 2010.*
18 The notice shall remind individuals whose cash aid ended under
19 the CalWORKs program as a result of not submitting a status report
20 that he or she should review his or her circumstances to determine
21 if changes have occurred that should be reported to the Medi-Cal
22 eligibility worker.

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

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

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

31 (c) This section shall be implemented on or before July 1, 2001,
32 but only to the extent that federal financial participation under
33 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.
34 1396 and following) is available.

35 (d) Notwithstanding Chapter 3.5 (commencing with Section
36 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
37 the department shall, without taking any regulatory action,
38 implement this section by means of all county letters or similar
39 instructions. Thereafter, the department shall adopt regulations in
40 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. Comprehensive implementing instructions
3 shall be issued to the counties no later than March 1, 2001.

4 *SEC. 59. Section 14005.310 is added to the Welfare and*
5 *Institutions Code, to read:*

6 *14005.310. The department shall seek federal approval to*
7 *utilize an interval of one year in determining the cost amounts*
8 *specified in Section 12699.204 of the Insurance Code for persons*
9 *receiving benchmark benefits pursuant to Sections 14005.301 and*
10 *14005.305.*

11 *SEC. 60. Section 14005.311 is added to the Welfare and*
12 *Institutions Code, to read:*

13 *14005.311. (a) The department and the Managed Risk Medical*
14 *Insurance Board shall enter into an interagency agreement under*
15 *which the board shall have authority and responsibility for*
16 *administering benchmark benefits under Sections 14005.301,*
17 *14005.305, and 14005.307 and for prescribing all rules and*
18 *procedures necessary for administering these benefits subject to*
19 *the single state agency oversight responsibilities of the department.*

20 *(b) This section shall be implemented only to the extent that*
21 *federal financial participation is not jeopardized.*

22 *SEC. 61. Section 14005.32 of the Welfare and Institutions Code*
23 *is amended to read:*

24 *14005.32. (a) (1) If the county has evidence clearly*
25 *demonstrating that a beneficiary is not eligible for benefits under*
26 *this chapter pursuant to Section 14005.30, but is eligible for*
27 *benefits under this chapter pursuant to other provisions of law, the*
28 *county shall transfer the individual to the corresponding Medi-Cal*
29 *program. Eligibility under Section 14005.30 shall continue until*
30 *the transfer is complete.*

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

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

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

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

9 (D) A statement that the Medi-Cal beneficiary does not need to
10 fill out monthly status reports in order to remain eligible for
11 Medi-Cal, but shall be required to submit a semiannual status report
12 and annual reaffirmation ~~forms~~. *forms, except that the semiannual*
13 *status report shall no longer be required on and after July 1, 2010.*
14 In addition, if the person or persons to whom the notice is directed
15 has been found eligible for transitional Medi-Cal as described in
16 Section 14005.8, 14005.81, or 14005.85, the statement shall explain
17 the reporting requirements and duration of benefits under those
18 programs, and shall further explain that, at the end of the duration
19 of these benefits, a redetermination, as provided for in Section
20 14005.37 shall be conducted to determine whether benefits are
21 available under any other provision of law.

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

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

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

30 (b) No later than September 1, 2001, the department shall submit
31 a federal waiver application seeking authority to eliminate the
32 reporting requirements imposed by transitional medicaid under
33 Section 1925 of the federal Social Security Act (Title 42 U.S.C.
34 Sec. 1396r-6).

35 (c) This section shall be implemented on or before July 1, 2001,
36 but only to the extent that federal financial participation under
37 Title XIX of the federal Social Security Act (Title 42 U.S.C. Sec.
38 1396 and following) is available.

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

8 *SEC. 62. Section 14005.331 is added to the Welfare and*
9 *Institutions Code, to read:*

10 *14005.331. (a) All children under 19 years of age who meet*
11 *the state residency requirements of the Medi-Cal program or the*
12 *Healthy Families Program shall be eligible for health care*
13 *coverage in accordance with subdivision (b) if they either (1) live*
14 *in a family with countable household income at or below 300*
15 *percent of the federal poverty level, or (2) meet the income and*
16 *resource requirements of Section 14005.7 or the income*
17 *requirements of Section 14005.30. The children described in this*
18 *section include all children for whom federal financial*
19 *participation under Title XIX of the federal Social Security Act*
20 *(42 U.S.C. Sec. 1396 et seq.) or Title XXI of the federal Social*
21 *Security Act (42 U.S.C. Sec. 1397 et seq.) is not available due to*
22 *their immigration status or date of entry into the United States,*
23 *but does not include children who are ineligible for Title XIX and*
24 *Title XXI funds based on other grounds. Nothing in this section*
25 *shall be construed to limit a child's right to Medi-Cal eligibility*
26 *under existing law.*

27 *(b) Children described in subdivision (a) in families whose*
28 *household income would render them ineligible for no-cost*
29 *Medi-Cal, and who are in compliance with Sections 12693.71 and*
30 *12693.72 of the Insurance Code, shall be eligible for the Healthy*
31 *Families Program and shall also be eligible for Medi-Cal with a*
32 *share of cost in accordance with Section 14005.7. Other children*
33 *described in this section shall be eligible for Medi-Cal with no*
34 *share of cost.*

35 *(c) This section shall become operative on July 1, 2010.*

36 *SEC. 63. Section 14005.333 is added to the Welfare and*
37 *Institutions Code, to read:*

38 *14005.333. (a) The department shall design and implement a*
39 *program to provide the benefits described in subdivision (d) to the*
40 *population described in subdivision (c).*

1 (b) The department shall seek to maximize the availability of
2 federal funding for this section under the terms of any existing
3 waiver, through amendment of any existing waiver, or by means
4 of a new waiver, or any combination thereof.

5 (c) The population eligible to receive benefits under this section
6 shall consist of all residents 21 years of age or older who meet all
7 of the following requirements.

8 (1) Their family income is at or below 100 percent of the federal
9 poverty level.

10 (2) They are not otherwise eligible for the Medi-Cal program.

11 (3) They would be eligible for full-scope Medi-Cal without a
12 share of cost if they had a categorical linkage.

13 (4) They are citizens, nationals, or qualified aliens without
14 regard to date of entry.

15 (5) They do not have access to employer-sponsored health care
16 coverage.

17 (d) (1) Benefits available under this section shall consist of a
18 benefit package that is designed by the department and is
19 equivalent to the subsidized coverage made available in the
20 purchasing pool established pursuant to Part 6.45 (commencing
21 with Section 12699.201) of Division 2 of the Insurance Code,
22 except as provided in subdivision (k) of Section 14005.334. To the
23 extent that specific services are excluded from the subsidized
24 package, these services are not required to be provided under this
25 section to the population described under subdivision (c). These
26 excluded services shall include, but are not limited to, long-term
27 care services, nursing home care, personal care services, in-home
28 supportive services, and home- and community-based or other
29 waiver services.

30 (2) For a five year period beginning with the first month of
31 operation of a local coverage option program in a county under
32 Section 14005.334, the local coverage option program shall be
33 the exclusive Medi-Cal coverage available for the individuals who
34 reside in the county and who are eligible Medi-Cal beneficiaries
35 under this section. This paragraph shall apply only if local
36 coverage option program services are provided by or through a
37 health care service plan licensed under the Knox-Keene Health
38 Care Service Plan Act of 1975 (Chapter 2.2 (commencing with
39 Section 1340) of Division 2 of the Health and Safety Code).

1 (e) In determining eligibility for benefits under this section, the
 2 department shall use the application requirements and the income
 3 methodology of the federal poverty level programs for pregnant
 4 women and children, including the income deductions and
 5 exemptions applicable under those programs, but shall not include
 6 any income disregards available under those programs.

7 (f) Nothing in this section is intended to affect or modify the
 8 availability of the eligibility category described in Section 14052
 9 or the application process, documentation requirements,
 10 methodology, or benefits available pursuant to that section.

11 SEC. 64. Section 14005.334 is added to the Welfare and
 12 Institutions Code, to read:

13 14005.334. (a) The director shall establish a local coverage
 14 option program to provide Medi-Cal coverage for low income
 15 adults. The program shall meet the requirements of this section.

16 (b) Coverage shall be provided, at the option of the county, only
 17 by counties that operate designated public hospitals. Each county
 18 shall provide coverage only for those eligible individuals who
 19 reside in the county.

20 (1) All covered services shall be provided by designated public
 21 hospitals, their affiliated public providers, and community clinics,
 22 except with respect to those medically necessary services that are
 23 not available or accessible through these providers. Each enrollee
 24 shall be assigned a medical home at a public provider affiliated
 25 with a public hospital or at a community clinic. Counties may elect
 26 to contract with additional providers for services to enrollees, if
 27 the county, the department, or the Department of Managed Health
 28 Care determines that the services of a particular provider are
 29 necessary to serve a specific need of enrollees.

30 (2) Counties may provide coverage directly through a county
 31 operated health care service plan licensed under the Knox-Keene
 32 Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing
 33 with Section 1340) of Division 2 of the Health and Safety Code),
 34 or through a local initiative created pursuant to Section 14087.31,
 35 14087.35, 14087.36 or 14087.38 or a county organized health
 36 system described in Section 14087.51 or 14087.54.

37 (3) A county may elect to provide coverage through the local
 38 initiative or county organized health system only if the
 39 administrative costs of the local initiative or county organized
 40 health system do not exceed 15 percent, such that at least 85

1 percent of aggregate dues, fees, and other periodic payments
2 received by the local initiative or county organized health system
3 is spent on health care services.

4 (4) If a county elects to provide coverage through a local
5 initiative or county organized health system, the director shall
6 contract with, and make the payments required under this section
7 to, the designated local initiative or county organized health
8 system.

9 (c) A county may offer enrollment in its local coverage option
10 program to employers and individuals.

11 (d) In consultation with participating counties, the director shall
12 complete the following actions:

13 (1) Establish a uniform benefit package consistent with
14 subdivision (d) of Section 14005.333.

15 (2) Design a common identification card to be provided by the
16 county to each enrollee in a local coverage option program.

17 (e) Each county, local initiative, or county organized health
18 system that operates a local coverage option program shall be
19 entitled to periodic payments per individual who resides in the
20 county who is an eligible Medi-Cal beneficiary under Section
21 141005.333 that are actuarially determined to be adequate to meet
22 the full cost of services, including administrative costs and the cost
23 incurred in paying for out of network emergency services required
24 in the benefit package established under subdivision (d) of Section
25 14005.333 for these individuals.

26 (f) In consultation with participating counties, the director shall
27 establish payment rates that shall be accepted by Medi-Cal
28 participating providers that provide out of network emergency
29 services to local coverage option program enrollees as payment
30 in full for those services. The payment rates shall not exceed the
31 amount the provider would have received had the services been
32 provided on a fee for service basis to a Medi-Cal beneficiary.

33 (g) In consultation with the participating counties, by January
34 1, 2010, the department shall contract with an independent third
35 party to develop a local coverage option program assessment tool
36 to measure the extent to which the counties are providing quality,
37 coordinated care to eligible individuals. The local coverage option
38 program assessment tool shall be designed to evaluate the
39 following for each local coverage option program:

40 (1) Enrolled patient population.

1 (2) *The use of medical services.*

2 (3) *Access and barriers to health care.*

3 (4) *Processes and quality of care for selected medical*
4 *conditions, as appropriate for the population enrolled in the*
5 *program.*

6 (5) *Patient satisfaction.*

7 (h) *The following elements shall be evaluated using the local*
8 *coverage option program assessment tool developed under*
9 *subdivision (g):*

10 (1) *Designation of a medical home and assignment of eligible*
11 *individuals to a primary care provider within 60 days of*
12 *enrollment. For purposes of this paragraph, “medical home”*
13 *means a single provider or facility that maintains all of an*
14 *individual’s medical information. The primary care provider shall*
15 *be a provider from which the enrollee can access primary and*
16 *preventive care, or specialty care as determined appropriate by*
17 *a medical professional.*

18 (2) *An enrollment process that includes a patient identification*
19 *system to demonstrate enrollment into the program.*

20 (3) *A screening process for individuals who may qualify for*
21 *enrollment into the Healthy Families Program and the Access for*
22 *Infants and Mothers Program prior to enrollment into the local*
23 *coverage option program.*

24 (4) *Use of a medical record system, which may include*
25 *electronic medical records.*

26 (5) *Demonstrated progress in meeting industry-accepted quality*
27 *monitoring processes to assess the health care outcomes of*
28 *individuals with chronic conditions who are enrolled in the local*
29 *coverage option program, including HEDIS and NCQA standards.*

30 (6) *Promotion of the use of preventive services and early*
31 *intervention.*

32 (7) *The ability to demonstrate how the local coverage option*
33 *program will promote the viability of the existing safety net health*
34 *care system.*

35 (8) *Demonstration of how the program will provide consumer*
36 *assistance to individuals applying to, participating in, or accessing*
37 *services in the local coverage option program. For purposes of*
38 *this paragraph, “consumer assistance” includes specific processes*
39 *to address consumer grievances and patient advocacy.*

1 (i) After three years of operation of a local coverage option
2 program in a county, the department shall conduct a review using
3 the local coverage option program assessment tool to evaluate
4 each county's performance against the benchmarks established
5 under subdivisions (g) and (h). If the department determines that
6 the local coverage option program in a particular county has
7 substantially met the benchmarks, the director shall extend the
8 period of exclusive coverage in that county for an additional two
9 years. If the department concludes that a county failed to
10 substantially meet the benchmarks, the county's local coverage
11 option program shall cease to be the exclusive coverage option as
12 provided in paragraph (2) of subdivision (d) of Section
13 14005.332.01. The county shall have the opportunity for
14 administrative and judicial review of the department's
15 determination.

16 (j) After five years of operation of a local coverage option
17 program in a county, newly enrolled Medi-Cal beneficiaries
18 described in Section 14005.333 shall have the ability to enroll in
19 either the local coverage option program or the county organized
20 health system (COHS) or the two-plan contractor in the county.

21 (k) To the extent necessary to implement the local coverage
22 option program, the director may waive, or exempt local coverage
23 option programs from, the Medi-Cal managed care program
24 requirements of Chapters 4 and 4.1 of Title 22 of the California
25 Code of Regulations, and the director of the Department of
26 Managed Health Care may waive, or exempt local coverage option
27 programs from, the requirements of Chapter 2.2 (commencing
28 with Section 1340) of Division 2 of the Health and Safety Code if
29 the director of Health Care Services and the director of the
30 Department of Managed Health Care find the action to be in the
31 public interest and not detrimental to the protection of patients.
32 The director shall comply with the following provisions in
33 implementing this subdivision:

34 (1) Waivers or exemptions may be granted to a program as
35 necessary to implement the limited network of providers authorized
36 under this section.

37 (2) Financial responsibility requirements may be waived or
38 adjusted to recognize the financial viability of the public entity
39 operating the program.

1 (3) Section 1342.9 of the Health and Safety Code shall apply
 2 to local coverage option programs.

3 (l) The local coverage option program shall become operational
 4 for services rendered on and after July 1, 2010.

5 SEC. 65. Section 14008.85 of the Welfare and Institutions Code
 6 is amended to read:

7 14008.85. (a) To the extent federal financial participation is
 8 available, a parent who is the principal wage earner shall be
 9 considered an unemployed parent for purposes of establishing
 10 eligibility based upon deprivation of a child where any of the
 11 following applies:

12 (1) The parent works less than 100 hours per month as
 13 determined pursuant to the rules of the Aid to Families with
 14 Dependent Children program as it existed on July 16, 1996,
 15 including the rule allowing a temporary excess of hours due to
 16 intermittent work.

17 (2) The total net nonexempt earned income for the family is not
 18 more than 100 percent of the federal poverty level as most recently
 19 calculated by the federal government. The department may adopt
 20 additional deductions to be taken from a family's income.

21 (3) The parent is considered unemployed under the terms of an
 22 existing federal waiver of the 100-hour rule for recipients under
 23 the program established by Section 1931(b) of the federal Social
 24 Security Act (42 U.S.C. Sec. 1396u-1).

25 (b) The department shall seek any federal approval required to
 26 waive or to increase the income limit in paragraph (2) of
 27 subdivision (a) to the extent necessary to implement Sections
 28 14005.30 and 14005.301.

29 ~~(b)~~

30 (c) Notwithstanding Chapter 3.5 (commencing with Section
 31 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
 32 the department shall implement this section by means of an all
 33 county letter or similar instruction without taking regulatory action.
 34 Thereafter, the department shall adopt regulations in accordance
 35 with the requirements of Chapter 3.5 (commencing with Section
 36 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

37 ~~(e) This section shall become operative March 1, 2000.~~

38 SEC. 66. Section 14011.16 of the Welfare and Institutions Code
 39 is amended to read:

1 14011.16. (a) Commencing August 1, 2003, the department
2 shall implement a requirement for beneficiaries to file semiannual
3 status reports as part of the department's procedures to ensure that
4 beneficiaries make timely and accurate reports of any change in
5 circumstance that may affect their eligibility. The department shall
6 develop a simplified form to be used for this purpose. The
7 department shall explore the feasibility of using a form that allows
8 a beneficiary who has not had any changes to so indicate by
9 checking a box and signing and returning the form.

10 (b) Beneficiaries who have been granted continuous eligibility
11 under Section 14005.25 shall not be required to submit semiannual
12 status reports. To the extent federal financial participation is
13 available, all children under 19 years of age shall be exempt from
14 the requirement to submit semiannual status reports.

15 (c) Beneficiaries whose eligibility is based on a determination
16 of disability or on their status as aged or blind shall be exempt
17 from the semiannual status report requirement described in
18 subdivision (a). The department may exempt other groups from
19 the semiannual status report requirement as necessary for simplicity
20 of administration.

21 (d) When a beneficiary has completed, signed, and filed a
22 semiannual status report that indicated a change in circumstance,
23 eligibility shall be redetermined.

24 (e) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department shall implement this section by means of all county
27 letters or similar instructions without taking regulatory action.
28 Thereafter, the department shall adopt regulations in accordance
29 with the requirements of Chapter 3.5 (commencing with Section
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

31 (f) This section shall be implemented only if and to the extent
32 federal financial participation is available.

33 (g) *This section shall become inoperative on July 1, 2010, and,*
34 *as of January 1, 2011, is repealed, unless a later enacted statute*
35 *that is enacted before January 1, 2011, deletes or extends the dates*
36 *on which it becomes inoperative and is repealed.*

37 *SEC. 67. Section 14011.16.1 is added to the Welfare and*
38 *Institutions Code, to read:*

39 *14011.16.1. (a) Commencing July 1, 2010, the department*
40 *shall implement a requirement for any beneficiary who is not*

1 required to make premium payments to file a semiannual address
2 verification report. The department shall develop a simplified form
3 to be used for this purpose so that a beneficiary who has not had
4 a change of address can so indicate by checking a box and
5 returning the form.

6 (b) When a beneficiary who is required to complete and return
7 the form described in subdivision (a) fails to do so, the county shall
8 follow up by attempting to contact the individual using the last
9 known phone number or numbers. If the attempted phone contact
10 fails to resolve the issue by providing confirmation of the current
11 address, the county shall search available files to determine if an
12 alternate or new address has been used by the beneficiary and
13 shall send a form to that address that is required to be returned.
14 In the absence of a new or alternate address, a form shall be sent
15 to the last known address. If the form is not returned, or if it is
16 returned under circumstances indicating that the individual no
17 longer resides at the address last provided by the individual and
18 no forwarding address is provided, eligibility shall be terminated
19 for loss of contact.

20 (c) Whenever Medi-Cal eligibility is terminated based on a loss
21 of contact as described in this section, the entity responsible for
22 redeterminations of eligibility for the affected beneficiary shall
23 document the facts causing the eligibility termination in the
24 beneficiary's file. Following this written certification, a notice of
25 action specifying that Medi-Cal eligibility was terminated based
26 on loss of contact shall be sent to the beneficiary.

27 (d) A beneficiary whose eligibility is based on a determination
28 of disability or on his or her status as aged or blind shall be exempt
29 from the requirements of subdivision (a).

30 (e) Children under 19 years of age and pregnant women shall
31 be exempt from the requirements of this section.

32 (f) The department may exempt categories or groups of
33 individuals from the requirement to file an address verification as
34 necessary for simplicity of administration.

35 (g) This section shall be implemented only if and to the extent
36 that its implementation does not jeopardize federal financial
37 participation.

38 SEC. 68. Section 14132.105 is added to the Welfare and
39 Institutions Code, to read:

1 14132.105. (a) (1) *The department shall establish a Healthy*
2 *Action Incentives and Rewards Program to be provided as a*
3 *covered benefit under the Medi-Cal program.*

4 (2) *The benefits described in this section shall only be provided*
5 *under the terms and conditions determined by the department, and*
6 *shall meet all the requirements described in subdivision (b).*

7 (b) *For purposes of this section, the Healthy Action Incentives*
8 *and Rewards Program shall include, but need not be limited to,*
9 *all of the following:*

10 (1) *Health risk appraisals that collect information from eligible*
11 *beneficiaries to assess overall health status and identify risk*
12 *factors, including, but not limited to, smoking and smokeless*
13 *tobacco use, alcohol abuse, drug use, nutrition, and physical*
14 *activity practices.*

15 (2) *A followup appointment with a licensed health care*
16 *professional acting within his or her scope of practice to review*
17 *the results of the health risk appraisal and discuss any*
18 *recommended actions.*

19 (3) *Incentives or rewards or both for eligible beneficiaries to*
20 *become more engaged in their health care and to make appropriate*
21 *choices that support good health, including obtaining health risk*
22 *appraisals, screening services, immunizations, or participating in*
23 *health lifestyle programs or practices. These programs or practices*
24 *may include, but need not be limited to, smoking cessation, physical*
25 *activity, or nutrition. Incentives may include, but need not be*
26 *limited to, nonmedical pharmacy products or services not otherwise*
27 *covered under this chapter, gym memberships, and weight*
28 *management programs.*

29 (c) *The department shall seek and obtain federal financial*
30 *participation and secure all federal approvals, including all*
31 *required state plan amendments or waivers, necessary to implement*
32 *and fund the services authorized under this section.*

33 (d) *This section shall be implemented only if and to the extent*
34 *that federal financial participation is available and has been*
35 *obtained.*

36 (e) (1) *Notwithstanding any other provision of law, the*
37 *provision of healthy incentives and rewards pursuant to this section*
38 *by a health care provider, or his or her agent, that meets the*
39 *requirements of this section, Section 1367.38 of the Health and*
40 *Safety Code, or Section 10123.56 of the Insurance Code shall not*

1 *be considered or construed as an unlawful practice, act, kickback,*
2 *bribe, rebate, remuneration, offer, coupon, product, payment, or*
3 *any other form of compensation by a provider or his or her agent,*
4 *directly or indirectly, overtly or covertly, in exchange for another*
5 *to obtain, participate, or otherwise undergo or receive health care*
6 *services.*

7 (2) *Notwithstanding any other provision of law, incentives*
8 *authorized pursuant to this section are not subject to the penalties,*
9 *discipline, limitations, or sanctions imposed under law to preclude*
10 *or prohibit, as an unlawful practice, bribe, kickback or other act,*
11 *the offering or delivery of a rebate, remuneration, offer, coupon,*
12 *product, rebate, payment, or any other form of compensation by*
13 *the provider, or his or her agent, directly or indirectly, overtly or*
14 *covertly, in exchange for another to obtain, participate, or*
15 *otherwise undergo or receive health care services.*

16 (3) *Notwithstanding any other provision of law, the provision*
17 *of healthy incentives and rewards pursuant to this section by a*
18 *health care provider, or his or her agent, that meets the*
19 *requirements of this section shall not be considered or construed*
20 *as an inducement to enroll.*

21 (f) *This section shall only be implemented if, and to the extent,*
22 *allowed under federal law. If any portion of this section is found*
23 *to be invalid, as determined by a final judgment of a court of*
24 *complaint jurisdiction, this section shall become inoperative.*

25 SEC. 69. *Section 14137.10 is added to the Welfare and*
26 *Institutions Code, to read:*

27 14137.10. (a) (1) *There is hereby established in the*
28 *department the Comprehensive Diabetes Services Program to*
29 *provide comprehensive diabetes prevention and management*
30 *services to any individual who meets the requirements set forth in*
31 *paragraph (2). For purposes of this subdivision, “comprehensive*
32 *diabetes prevention and management services” shall be defined*
33 *by the department based on consultation pursuant to subdivision*
34 *(b). Services may include, but need not be limited to, all of the*
35 *following:*

36 (A) *Screening for diabetes and prediabetes in accordance with*
37 *the operational screening guidelines and protocols developed for*
38 *the Comprehensive Diabetes Services Program utilizing the most*
39 *current American Diabetes Association criteria for diabetes in*
40 *adults.*

1 (B) Providing visits by certified practitioners in accordance
2 with the operational protocols developed for the Comprehensive
3 Diabetes Service Program for eligible beneficiaries who have been
4 diagnosed with prediabetes.

5 (C) Providing culturally and linguistically appropriate life-style
6 coaching and self-management training for eligible adult
7 beneficiaries with prediabetes and diabetes, in accordance with
8 evidence-based interventions, to avoid unhealthy blood sugar
9 levels that contribute to the progression of diabetes and its
10 complications.

11 (D) Conducting regular and timely laboratory evaluations, by
12 the primary care physician of the eligible beneficiary, in
13 conjunction with a program of blood sugar level self-management
14 education and training for eligible adult beneficiaries who have
15 been diagnosed with prediabetes and diabetes.

16 (2) A beneficiary is eligible for services pursuant to this section
17 if he or she is all of the following:

18 (A) Between 18 and 64 years of age.

19 (B) Not dually enrolled in the Medi-Cal program and the federal
20 Medicare program.

21 (C) Diagnosed with prediabetes or diabetes.

22 (D) Otherwise eligible for full scope of benefits under this
23 chapter but not enrolled in a Medi-Cal managed care plan.

24 (b) The department shall seek and obtain federal financial
25 participation and secure all federal approvals, including all
26 required state plan amendments or waivers, necessary to implement
27 and fund the services authorized under this section.

28 (c) For the purposes of implementation of this section, the
29 director may enter into contracts for the purposes of providing the
30 benefits offered under the Comprehensive Diabetes Services
31 Program.

32 (d) This section shall be implemented only if and to the extent
33 that federal financial participation is available and has been
34 obtained.

35 (e) The Comprehensive Diabetes Services Program shall be
36 developed and implemented only to the extent that state funds are
37 appropriated annually for the services provided under this section.

38 (f) The department shall develop and implement incentives for
39 Medi-Cal fee-for-service eligible beneficiaries who participate in
40 the Comprehensive Diabetes Services Program and are compliant

1 with program requirements for screening and self-management
2 activities.

3 (g) The department shall develop and implement financial
4 incentives for Medi-Cal fee-for-service providers who participate
5 in the Comprehensive Diabetes Services Program and are
6 compliant with program requirements in the screening and
7 management of eligible beneficiaries who have been diagnosed
8 with prediabetes and diabetes.

9 (h) The department shall collect data including, but not be
10 limited to, laboratory values from screening and diagnostic tests
11 for the individual beneficiaries participating in the Comprehensive
12 Diabetes Services Program and monitor the health outcomes of
13 the participating individual beneficiaries.

14 (i) The department shall, in consultation with the California
15 Diabetes Program in the State Department of Public Health,
16 contract with an independent organization to:

17 (1) Evaluate and report the health outcomes and cost savings
18 of the Comprehensive Diabetes Services program.

19 (2) Estimate the short- and long-term cost savings of expanding
20 the strategies of the Comprehensive Diabetes Services Program
21 statewide through the private or commercial insurance markets.

22 SEC. 70. Article 5.22 (commencing with Section 14167.22) is
23 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
24 Institutions Code, to read:

25
26 *Article 5.22. Medi-Cal Physician Rate Increase Act*

27
28 14167.22. (a) The director shall seek federal approval of the
29 rate methodology set forth in this article. The director may alter
30 any methodology specified in this article, to the extent necessary
31 to meet the requirements of federal law or regulations or to obtain
32 federal approval. If, after seeking federal approval, federal
33 approval is not obtained, that methodology shall not be
34 implemented.

35 (b) Payments made pursuant to this article are contingent on
36 the receipt of federal reimbursement. Unless otherwise expressly
37 provided in this article, nothing in this article shall create an
38 obligation on the part of the department to fund any payment from
39 state funds in the absence of, or on account of a shortfall in, federal
40 funding.

1 (c) *It is the intent of the Legislature that, to the extent*
2 *practicable, the director increase reimbursement rates to managed*
3 *health care plans by the actuarial equivalent amount necessary*
4 *to ensure that managed health care plans make payments to the*
5 *classes of providers whose rates are governed by this article at*
6 *the same level as are made pursuant to this article.*

7 14167.23. *For purposes of this article, the following definitions*
8 *shall apply:*

9 (a) *“Physician” means a practitioner meeting the requirements*
10 *of Section 51228 of Title 22 of the California Code of Regulations.*

11 (b) *“Physician group” means two or more physicians legally*
12 *organized as a partnership, professional corporation, foundation,*
13 *not-for-profit corporation, or similar association, and that meets*
14 *the requirements of Section 51000.16 of Title 22 of the California*
15 *Code of Regulations.*

16 14167.24. (a) *A physician or physician group, as described*
17 *in subdivision (b), shall receive Medi-Cal reimbursement to the*
18 *extent provided in this section.*

19 (b) *A physician or physician group shall be eligible for*
20 *reimbursement if the particular physician or physician group has*
21 *all of the following characteristics:*

22 (1) *Is an enrolled Medi-Cal provider eligible to receive*
23 *Medi-Cal payments and provides services to Medi-Cal*
24 *beneficiaries.*

25 (2) *Is a physician or physician group as defined in Section*
26 *14167.23.*

27 (c) *An eligible physician’s reimbursement pursuant to this*
28 *section shall be calculated and paid as follows:*

29 (1) *Except as provided under Section 14167.25, commencing*
30 *on July 1, 2010, reimbursement to an eligible physician or*
31 *physician group, as described in subdivisions (a) and (b), shall*
32 *not be less than ____ percent of the amount that the federal*
33 *Medicare program would pay the physician or physician group*
34 *for the same service, rendered on the same date. In determining*
35 *the amounts to be paid pursuant to this paragraph, the department*
36 *shall ensure that the equivalent Medicare rate to be used takes*
37 *into account all of the factors, supplemental payments, and other*
38 *variables that are used to determine the Medicare rate. The*
39 *supplemental rate augmentation paid for physician services in*

1 *California Children Services, as established in the annual Budget*
2 *Act, shall continue.*

3 (2) *The department shall establish a rate for services for which*
4 *Medicare does not provide a comparable service, or for which the*
5 *Medicare payment for the service cannot be separately determined,*
6 *which shall be the department's best estimate of a rate that is not*
7 *less than ____ percent of what Medicare would pay for that service.*

8 (d) *As a condition of receiving reimbursement under this section,*
9 *a physician or physician group shall keep, maintain, and have*
10 *readily retrievable, any records specified by the department to*
11 *fully disclose reimbursement amounts to which the physician or*
12 *physician group is entitled, and any other records required by the*
13 *federal Centers for Medicare and Medicaid Services.*

14 (e) *This section shall apply to services rendered to Medi-Cal*
15 *beneficiaries on and after July 1, 2010. With respect to services*
16 *that are paid under this section, any other provider rate*
17 *methodology that is inconsistent or duplicative of the rates paid*
18 *pursuant to this section shall become inoperative for those services*
19 *to the extent that the rates are inconsistent or duplicative.*

20 14167.25. (a) (1) *Notwithstanding Section 14105 or any other*
21 *provision of law, on or after July 1, 2010, the director may*
22 *designate a percentage of the rate increase paid to Medi-Cal*
23 *fee-for-service providers pursuant to paragraph (1) of subdivision*
24 *(c) of Section 14167.24, to be directly linked to performance*
25 *measures developed pursuant to subdivisions (c) and (d), including*
26 *a demonstrated showing of continued performance improvement.*

27 (2) *For purposes of paragraph (1), the percentage of the rate*
28 *that is linked to performance measures shall be established by the*
29 *director such that physicians and physician groups will be*
30 *sufficiently reimbursed for implementing performance measures,*
31 *including continued performance improvement.*

32 (b) *The performance measures shall be developed by the*
33 *department in consultation with stakeholders, including, but not*
34 *limited to, representatives of patients, physicians, managed care*
35 *plans, payers, and other appropriate stakeholders.*

36 (c) *The department, in consultation with the stakeholders*
37 *identified in subdivision (b), shall develop a comprehensive list of*
38 *performance measures relying, in part, on existing quality and*
39 *performance measures endorsed by national organizations, such*

1 *as the Ambulatory Quality Alliance, the Hospital Quality Alliance,*
2 *and the National Quality Forum (NQF).*

3 *(d) At a minimum, all of the following performance measures*
4 *shall be used in determining the appropriate percentage rate*
5 *increases:*

6 *(1) Reporting of health care outcomes, including the cost of that*
7 *health care.*

8 *(2) Improvements in health care efficiency.*

9 *(3) Improvements in health care safety.*

10 *(4) The efficient exchange of health information data through*
11 *technology.*

12 *(5) The quality assurance requirements set forth in Section*
13 *1300.70 of Title 28 of the California Code of Regulations.*

14 *(6) Efforts to promote healthy behaviors among Medi-Cal*
15 *beneficiaries pursuant to the Healthy Incentives and Rewards*
16 *Program described in Section 14132.105.*

17 *(7) The extent to which purchasers, payers, providers, and*
18 *consumers are able to monitor the quality and cost of health care*
19 *utilizing public reporting information published by the Office of*
20 *the Patient Advocate.*

21 *(8) The extent to which physicians and physician groups that*
22 *provide services to Medi-Cal beneficiaries on a fee-for-service*
23 *basis implement activities, such as telemedicine, electronic*
24 *prescribing and the electronic exchange of health information*
25 *among various payers and providers for the purpose of attaining*
26 *health care safety and quality improvements, informed clinical*
27 *care decisions, the increased use of interoperable platforms for*
28 *the exchange of relevant health care data, and more accurate and*
29 *timely diagnosis and treatment.*

30 *(9) Compliance with the federal Health Insurance Portability*
31 *and Accountability Act (HIPAA) (42 U.S.C. Sec. 300gg).*

32 *(e) The department shall consult with stakeholders, including,*
33 *but not limited to, representatives of patients, managed care plans,*
34 *and payers, to determine the means to measure and document*
35 *implementation by each physician and physician group of the*
36 *performance measures developed pursuant to subdivisions (c) and*
37 *(d).*

38 *(f) The department may exempt classes of physician and*
39 *physician groups and services from this section, if necessary to*
40 *comply with the requirements of federal law or regulations.*

1 (g) The department may file one or more state plan amendments
2 to implement this section.

3 (h) The department shall seek necessary federal approvals for
4 implementation of this section. The department shall implement
5 this section only in a manner that is consistent with federal
6 Medicaid law and regulations. This section shall be implemented
7 only to the extent that federal approval is obtained and federal
8 financial participation is available.

9 (i) The department shall implement this section only to the extent
10 that state funds are appropriated for the nonfederal share of the
11 rate increases provided under this section.

12 SEC. 71. Article 7 (commencing with Section 14199.10) is
13 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
14 Institutions Code, to read:

15
16 Article 7. Coordination with the California Health Trust Fund
17

18 14199.10. The department shall seek any necessary federal
19 approval to enable the state to receive federal funds for coverage
20 provided through the California Cooperative Health Insurance
21 Purchasing Program (Cal-CHIPP) to persons who would be
22 eligible for the Medi-Cal program if the state expanded eligibility
23 to a population composed of parents and other caretaker relatives
24 with a household income at or below 300 percent of the federal
25 poverty level who are not otherwise eligible for full scope benefits
26 with no share of cost. Revenues in the California Health Trust
27 Fund created pursuant to Section 12699.212 of the Insurance Code
28 shall be used as state matching funds for receipt of federal funds
29 resulting from the implementation of this section. All federal funds
30 received pursuant to that federal approval shall be deposited in
31 the California Health Trust Fund.

32 SEC. 72. The State Department of Health Care Services, in
33 consultation with the Managed Risk Medical Insurance Board,
34 shall take all reasonable steps that are required to obtain the
35 maximum amount of federal funds and to support federal claiming
36 procedures in the administration of this act.

37 SEC. 73. Notwithstanding Chapter 3.5 (commencing with
38 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
39 Code, during the period January 1, 2008, to December 31, 2011,
40 inclusive, the State Department of Health Care Services may

1 *implement this act by means of all county letters or similar*
2 *instructions without taking regulatory action. After December 31,*
3 *2011, the department shall adopt all necessary regulations in*
4 *accordance with the requirements of Chapter 3.5 (commencing*
5 *with Section 11340) of Part 1 of Division 3 of Title 2 of the*
6 *Government Code.*

7 *SEC. 74. Notwithstanding any other provision of law, the*
8 *Managed Risk Medical Insurance Board may implement the*
9 *provisions of this act expanding the Healthy Families Program*
10 *only to the extent that funds are appropriated for those purposes*
11 *in the annual Budget Act or in another statute.*

12 *SEC. 75. During the period from January 1, 2008 to December*
13 *31, 2011, inclusive, the adoption of regulations pursuant to this*
14 *act by the Managed Risk Medical Insurance Board shall be deemed*
15 *to be an emergency and necessary for the immediate preservation*
16 *of public peace, health, and safety, or the general welfare.*

17 *SEC. 76. (a) In order to achieve the purposes of this act, the*
18 *State Department of Health Care Services, after consultation with*
19 *the Department of Finance, may utilize either state plan*
20 *amendments or waivers, or combination thereof, as necessary to*
21 *implement this act, to maximize the availability of federal financial*
22 *participation, and to maximize the number of persons for whom*
23 *that federal financial participation is available to cover the cost*
24 *of health care services.*

25 *(b) The flexibility authorized by this act shall include*
26 *modification of the requirements, standards, and methodologies*
27 *for expansion categories or populations created by this act in order*
28 *to maximize the availability of federal financial participation.*
29 *When exercising this flexibility, the State Department of Health*
30 *Care Services shall not make changes that would do any of the*
31 *following:*

32 *(1) Make otherwise eligible individuals ineligible for health*
33 *coverage under the Medi-Cal program and the Healthy Families*
34 *Program.*

35 *(2) Increase cost-sharing amounts beyond levels established in*
36 *this act.*

37 *(3) Reduce benefits below those provided for in this act.*

38 *(4) Otherwise disadvantage applicants or recipients in a way*
39 *not contemplated by this act.*

1 (c) *The department shall take all reasonable steps necessary to*
2 *maximize federal financial participation and to support federal*
3 *claiming in the implementation of this act.*

4 (d) *It is the intent of the Legislature that the provisions of this*
5 *act shall be implemented simultaneously to the extent possible in*
6 *order to harmonize and best effectuate the purposes and intent of*
7 *this act.*

8 (e) *The Director of Health Care Services shall notify the Chair*
9 *of the Joint Legislative Budget Committee in any case when it is*
10 *necessary to exercise the flexibility provided under this section.*
11 *This notification shall be provided 30 days prior to exercising that*
12 *flexibility.*

13 *SEC. 77. It is the intent of the Legislature that provisions of*
14 *this act shall be financed by contributions from employers;*
15 *individuals; federal, state, and local governments; and health care*
16 *providers. Specifically financial support shall include:*

17 (a) *Federal financial participation through the federal Medicaid*
18 *and S-CHIP programs.*

19 (b) *Revenue from counties to support the cost of enrolling*
20 *persons otherwise entitled to county-funded care.*

21 (c) *Fees paid by acute care hospitals at a rate of 4 percent of*
22 *patient revenues.*

23 (d) *Fees paid by employers not expending an equivalent amount*
24 *for health care expenditures at a rate ranging from 2 to 6.5 percent*
25 *of total payroll, based on social security wages.*

26 (e) *Premium contributions from currently offering employers*
27 *when employees, eligible for employer-based coverage, choose to*
28 *enroll in public programs.*

29 (f) *Premium payments for individuals enrolled in publicly*
30 *subsidized coverage and coverage purchased in the individual*
31 *market.*

32 (g) *Additional public funds obtained through increasing the*
33 *taxes by two dollars (\$2) on the sale of each package of cigarettes*
34 *and by an equivalent amount on other tobacco products.*

35 (h) *Other state funds made available through savings generated*
36 *through reduced demand for existing health care programs.*

37 *SEC. 78. It is the intent of the Legislature that the rates paid*
38 *pursuant to the Medi-Cal program for inpatient and outpatient*
39 *hospital services be increased.*

1 *SEC. 79. No reimbursement is required by this act pursuant*
 2 *to Section 6 of Article XIII B of the California Constitution for*
 3 *certain costs that may be incurred by a local agency or school*
 4 *district because, in that regard, this act creates a new crime or*
 5 *infraction, eliminates a crime or infraction, or changes the penalty*
 6 *for a crime or infraction, within the meaning of Section 17556 of*
 7 *the Government Code, or changes the definition of a crime within*
 8 *the meaning of Section 6 of Article XIII B of the California*
 9 *Constitution.*

10 *However, if the Commission on State Mandates determines that*
 11 *this act contains other costs mandated by the state, reimbursement*
 12 *to local agencies and school districts for those costs shall be made*
 13 *pursuant to Part 7 (commencing with Section 17500) of Division*
 14 *4 of Title 2 of the Government Code.*

15

16

17 **CORRECTIONS:**

18 **Digest—Page 10.**

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