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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 to amend Section 2069 of, to add Sections 4040.1, 4071.2, 4071.3, and 4071.4 to, and to add and repeal Section 2838 of, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.2, 12803.25, 22830.5, and 22830.6 to, and to add Chapter 15 (commencing with Section 8899.50) to Division 1 of Title 2 of, the Government Code, to amend Sections 1357.54, 1365, 124900, 124905, 124910, 124920, 128745, and 128748 of, to amend, repeal, and add Section 1399.56 of, to add Sections 1262.9, 1342.9, 1347, 1356.2, 1367.16, 1367.205, 1367.38, 1368.025, 1378.1, 1395.2, 1399.58, 104376, 124905.1, 124946, and 130545 to, to add Chapter 1.6 (commencing with Section 155) to Part 1 of Division 1 of, to add Article 11.6 (commencing with Section 1399.820) 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 12693.43, 12693.70, 12693.73, and 12693.76 of, to amend, repeal, and add Section 796.02 of, to add Sections 796.05, 10113.10, 10113.11, 10123.56, 10176.15,

10273.6, 12693.56, 12693.57, 12693.58, 12693.59, 12693.766, 12886, and 12887 to, to add Chapter 9.6 (commencing with Section 10919) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) and Part 6.7 (commencing with Section 12739.50) to Division 2 of, the Insurance Code, to add Section 96.8 to the Labor Code, to amend Sections 19167 and 19611 of, to add Sections 17052.31, 17052.32, 19528.5, and 19553.5 to, and to add and repeal Section 17052.30 of, the Revenue and Taxation Code, to add Sections 301.1 and 1120 to, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 12306.1, 14005.30, and 14011.16 of, to add Sections 14005.301, 14005.305, 14005.306, 14005.310, 14005.311, 14005.331, 14005.333, 14011.16.1, 14074.5, 14081.6, 14092.5, 14132.105, and 14137.10 to, and to add Article 5.215 (commencing with Section 14167.22) to, and to add and repeal Article 5.21 (commencing with Section 14167.1) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage.

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 care 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 Committee in the California Health and Human Services Agency, with various powers and duties, including the development and periodic review of a health care cost and quality transparency plan. The bill would require the Office of Statewide Health Planning and Development to assist the committee in that regard. The bill would require the Secretary of California Health and Human Services to track and assess the effects of health care reform and to

report to the Legislature by March 1, 2012, and biennially thereafter. The bill would also create the California Health Benefits Service within the State Department of Health Care Services, 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 and would create a stakeholder committee.

(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 enroll in and maintain at least minimum creditable health care coverage, as determined by the Managed Risk Medical Insurance Board, for themselves and their dependents, as defined. The bill would require the board to establish, by regulation, the definition and standards for minimum creditable coverage, including an affordability standard and hardship exemptions, by March 1, 2009, and would require the board to facilitate enrollment in public or private coverage and to establish an education and awareness program, by January 1, 2010, relating to the requirement to obtain minimum creditable coverage. The bill would enact related provisions, 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 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 in which 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 in the State Treasury for the purposes of this act. 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, on and after July 1, 2010, would also extend Medi-Cal benefits to parents and caretaker relatives and various other persons meeting certain eligibility requirements. The bill would require certain of these individuals to receive their benefits in the form of a benchmark package, which would be the Cal-CHIPP Healthy Families benefit package. 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 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 for low-income adults that would be the exclusive Medi-Cal coverage for a 4-year period beginning with the program's commencement, for county residents who, among other requirements, have a family income at or below 100% 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, subject to approval by the State Department of Health Care Services and contingent on

establishment of a county share of cost. 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, 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, 2009. The bill would, on and after July 1, 2009, 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 programs under federal law, thereby creating a state-only element of the programs. The bill would additionally, on and after July 1, 2009, 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 certain applicants and recipients, commencing July 1, 2010.

The bill would enact the Medi-Cal Physician Services Rate Increase Act, which would establish, with respect to services rendered to Medi-Cal beneficiaries on and after July 1, 2010, to the extent funds are appropriated in the annual Budget Act, increased reimbursements of up to 100% of the Medicare rate for physicians, physician groups, as defined, and others 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.

This bill would also enact the Medi-Cal Hospital Rate Stabilization Act, which would revise the methodology by which safety net care pool funds are paid to designated public hospitals for providing uncompensated care to the uninsured. The bill would require the State Department of Health Care Services to determine an outpatient base rate and an inpatient base rate, as defined, for various types of hospitals. The bill would also, commencing July 1, 2010, establish specified reimbursement rate methodologies under the Medi-Cal program for hospital services, as defined, that are rendered by designated public hospitals and for managed health care plans, as specified, and would require managed health care plans to expend 100% of moneys received under the increased rates for payments to hospitals for providing services to Medi-Cal patients. The bill would make implementation of certain of these provisions contingent on the establishment of certain requirements under which counties pay a share of cost for persons enrolled in the Medi-Cal program, and would make implementation of all of these provisions contingent on the imposition of a 4% fee on the net patient revenue of general acute care hospitals.

This bill would also require a portion of the nonfederal share of the reimbursement for designated public hospitals be transferred to the Workforce Development Program Fund, which the bill would create in the State Treasury. Moneys in the fund would, upon appropriation, be used exclusively for retraining county hospital and clinic systems' health care workers and be allocated by the Office of Statewide Health Planning and Development.

(3) Existing law provides for the county administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization.

Existing law permits services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium.

Existing law provides that when any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium, the county shall use county only funds for the state and county share of any increase in the program, unless otherwise provided in the Budget Act or appropriated by statute.

Existing law establishes a formula with regard to provider wages or benefits increases negotiated or agreed to by a public authority or nonprofit consortium, and specifies the percentages required to be paid by the state and counties, beginning with the 2000–01 fiscal year, with regard to the nonfederal share of any increases.

This bill would revise the formula for state participation in provider health benefit increases. The bill would also authorize a county employee representative to elect to provide health benefits through a trust fund, as specified.

(4) 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 and other requirements relating to individual coverage, modified disclosures, and other related changes. The bill, on and after July 1, 2010, would 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 benefits 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 to be subject solely to the filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program for designated subjects. The bill would require the department and the State Department of Health Care Services to develop a joint filing and review process for medical quality surveys.

The bill would also require group health care service plan contracts and group health insurance policies offered, amended, or renewed on or after January 1, 2009, to offer to include 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 Rewards 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.

(5) The Personal Income Tax Law authorizes various credits against the taxes imposed by that law.

This bill would, for taxable years beginning on or after January 1, 2010, and before January 1, 2015, allow to a qualified taxpayer, as defined, a refundable credit against those taxes in an amount equal to those qualified health care plan premium costs, as defined, that are in excess of 5.5% of a qualified taxpayer's adjusted gross income for the taxable year, except as provided. This bill would, upon appropriation by the Legislature, require that all amounts deposited into the California Health Trust Fund be transferred to the Managed Risk Medical Insurance Board for purposes of advancing the refundable credit and to the Franchise Tax Board for purposes of recovering amounts expended for the refunds, as provided.

(6) Existing law creates the Employment Development Department in the Labor and Workforce Development Agency and vests that department with the duties, purposes, responsibilities, and jurisdiction previously exercised by the State Department of Benefit Payments or the California Health and Human Services Agency with respect to job creation activities.

This bill would require the department to establish data collection and reporting methods and requirements, as specified, to collect and report information related to employer health expenditures on behalf of their employees. The bill would require the department to report on that data to the Managed Risk Medical Insurance Board and the Legislature on an annual basis commencing April 1, 2011, and would authorize the department to adopt regulations to implement these provisions.

(7) Under existing federal law, a cafeteria plan is a written plan through which employees choose among 2 or more benefits consisting of cash and qualified benefits. Existing federal law provides that, except as specified, no amount is included in the gross income of a participant

in a cafeteria plan solely because the participant may choose among the benefits of the plan.

This bill would, beginning January 1, 2010, require an employer to adopt and maintain a cafeteria plan to allow employees to pay premiums for health care coverage to the extent amounts for that coverage are excludable from the gross income of the employee, as specified. The bill would require an employer who fails to establish or maintain a cafeteria plan to pay a penalty of $100 or $500 per employee, as specified.

(8) 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, 2010, to provide or arrange for the provision of an electronic personal health record for enrollees receiving health care benefits.

(9) 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.

(10) Existing law requires the State Department of Health Care Services to select certain primary care clinics to be reimbursed for delivering medical services, including preventive health care and smoking prevention and cessation health education, to program beneficiaries, based upon specified criteria. Existing law requires that a clinic meet specified requirements in order to receive a reimbursement. Under existing law, a program beneficiary is a person whose income is at or below 200% of the federal poverty level. Existing law requires the department to utilize existing contractual claims processing services to promote efficiency and maximize the use of funds.

This bill would additionally require that, in order receive a reimbursement, a clinic serve as a designated primary care medical home for program beneficiaries, as specified. The bill would also revise the definition of program beneficiary to mean a person whose income is at or below 250% of the poverty level and who either does not have

private or employer-based health care coverage or is not enrolled in or is ineligible for public health care coverage programs. This bill would delete the provision requiring the department to utilize existing contractual claims processing services and instead authorize the department to contract with public and private entities or utilize existing health care service provider enrollment and payment mechanisms in order to perform its duties, as specified. The bill would additionally require that the department maximize the availability of federal funding for services provided pursuant to these provisions. The bill would make related changes.

(11) 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.

(12) 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.

(13) 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.

This bill would, until July 1, 2011, 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.

(14) 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.

(15) 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.

(16) 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.

(17) The bill would make its provisions operative upon the date that the Director of Finance files a finding with the Secretary of State that, among other circumstances, sufficient state resources will exist in the Health Care Trust Fund to implement those provisions. The bill would also require the director to transmit that finding to the Chief Clerk of the Assembly, the Secretary of the Senate, and the chairs of the

appropriate committees of the Legislature at least 90 days prior to implementation of its provisions.

(18) The bill would require that all of its provisions become inoperative, as specified, if any portion of the bill is held to be invalid, as determined by a final judgment of a court of competent jurisdiction.

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

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

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

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

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

SECTION 1. This act shall be known and may be cited as the Health Care Security and Cost Reduction Act.

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

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

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

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

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

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

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

2069. (a) (1) Notwithstanding any other provision of law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist.

(2) The licensed physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the licensed physician and surgeon is not onsite, so long as the following apply:

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

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

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

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical, nursing, or podiatry corporation, for a physician assistant, a nurse practitioner, or a nurse-midwife as provided in subdivision (a), or for a health care service plan,

who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the Division of Licensing. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist, authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

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

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or nurse-midwife.

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a nurse-midwife.

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

(d) Notwithstanding any other provision of law, a medical assistant may not be employed for inpatient care in a licensed

general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(e) Nothing in this section shall be construed as authorizing a medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200). Nothing in this section shall be construed as authorizing a nurse practitioner, nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (7) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

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

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

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

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

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

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

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

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

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

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

(f) This section shall become inoperative on July 1, 2011, and, as of January 1, 2012, is repealed, unless a later enacted statute, that is enacted before January 1, 2012, deletes or extends the dates on which it becomes inoperative and is repealed.

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

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

(b) Notwithstanding subdivision (c) of Section 4040, "electronic prescribing" or "e-prescribing" means a prescription or prescription-related information transmitted between the point of care and the pharmacy using electronic media.

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

4071.2. (a) On or before January 1, 2012, every licensed prescriber, prescriber's authorized agent, or pharmacy operating in California shall have the ability to transmit and receive prescriptions by electronic data transmission.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this section with respect to their respective licensees.

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

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

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

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

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

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

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

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

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

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

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

(1) A pupil enrolled in kindergarten.

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

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

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

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

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

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

(4) Contact information for county public health departments.

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

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

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

CHAPTER 15. MINIMUM HEALTH CARE COVERAGE

8899.50. (a) On and after July 1, 2010, every California resident shall be enrolled in and maintain at least minimum creditable coverage, as defined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code, unless otherwise exempt pursuant to subdivision (d).

(b) On and after July 1, 2010, a subscriber shall obtain and maintain at least minimum creditable coverage, as defined by the Managed Risk Medical Insurance Board, for any person who qualifies as his or her dependent. For purposes of this chapter, the term “dependent” means the spouse, registered domestic partner, minor child of the subscriber, or a child 18 years of age and over who is dependent on the subscriber, as defined by the Managed Risk Medical Insurance Board.

(c) Notwithstanding subdivisions (a) and (b), compliance with those subdivisions shall not be required until Sections 12739.50, 12739.51, and 12699.211.01 of the Insurance Code, Section 17052.30 of the Revenue and Taxation Code, and Sections 14005.301 and 14005.305 of the Welfare and Institutions Code are implemented, and only so long as these sections remain operative, and the Managed Risk Medical Insurance Board has defined by regulation the minimum creditable coverage that will satisfy the requirements of this section.

(d) An individual shall not be subject to the requirements of subdivisions (a) and (b) if the Managed Risk Medical Insurance Board, pursuant to Section 12739.501 of the Insurance Code, determines that health care coverage meeting the definition of minimum creditable coverage is not affordable for that individual or that the purchase of minimum creditable coverage would constitute an undue hardship for that individual, or if the person or family has an income at or below 250 percent of the federal poverty level and the person's or family's share of the premium for minimum creditable coverage exceeds 5 percent of his or her family's income.

(e) An individual shall not be subject to the requirements of subdivisions (a) and (b) if the individual has been in California for six months or less and is not eligible for guaranteed issue of health care coverage under Section 1399.829 of the Health and Safety Code or Section 10928 of the Insurance Code.

(f) "California resident" means an individual who is a resident of the state pursuant to Section 244 or is physically present in the state for at least six months, having entered the state with an employment commitment or to obtain employment, whether or not employed at the time of application for health care coverage or after acceptance.

(g) "Subscriber" means an individual with dependents, as determined by the Managed Risk Medical Insurance Board consistent with subdivision (b), who is generally eligible to enroll dependents for health care coverage purposes, including, but not limited to, an individual whose employment status, or status as head of household, parent, spouse, or other status, makes the individual eligible to enroll his or her dependents for health care coverage purposes.

8899.501. For purposes of subdivisions (e) and (f) of Section 8899.50, subdivision (d) of Section 1399.836 of the Health and Safety Code, and subdivision (g) of Section 10928 of the Insurance Code, the reference to an individual or person who has been a resident of California for six months or less and the definition of "California resident" as an individual who is a resident of the state for at least six months shall mean a six-month period or any lesser period required by federal and state law.

SEC. 13. Section 12803.2 is added to the Government Code, to read:

12803.2. The California Health and Human Services Agency, in consultation with the Board of Administration of the Public Employees' Retirement System, and after consultation with affected health care provider groups, shall develop health care provider performance measurement benchmarks and incorporate these benchmarks into a common pay-for-performance model to be offered in every state-administered health care program, including, but not limited to, the Public Employees' Medical and Hospital Care Act, the Healthy Families Program, the Major Risk Medical Insurance Program, the Medi-Cal program, and the California Cooperative Health Insurance Purchasing Program. These benchmarks shall be developed to advance a common statewide framework for health care quality measurement and reporting, including, but not limited to, measures that have been approved by the National Quality Forum (NQF) such as the Health Plan Employer Data and Information Set (HEDIS) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and that have been adopted by the Hospitals Quality Alliance and other national and statewide groups concerned with quality. The provisions of Section 14167.25 of the Welfare and Institutions Code shall be implemented in addition to the requirements of this section in such a manner that they are appropriately integrated with the pay-for-performance model required under this section.

SEC. 14. Section 12803.25 is added to the Government Code, to read:

12803.25. (a) The Secretary of California Health and Human Services, in collaboration with other relevant state agencies, shall track and assess the effects of health care reform as set forth in the act enacting this section. The secretary shall either complete the assessment or contract for its preparation. The secretary may seek other sources of funding, including grants, to fund the assessment. The assessment shall include, at minimum, the following components:

(1) An assessment of the sustainability and solvency of the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code. This assessment shall include data regarding persons purchasing health care coverage through that program.

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

(3) An assessment of the health care coverage market in California, including a review of the various insurers and health care service plans, their offerings, their efficiency in providing health care services, and their financial conditions, including their medical loss ratios.

(4) An assessment of the effect on employers and employment, including employer administrative costs, employee turnover rate, and wages categorized by the type of employer and the size of the business. The assessment shall also review if there have been significant changes to the labor market and increased underground economy activity.

(5) An assessment of the racial and ethnic disparities in access and availability of health care, including cultural competency and language access, and what effects the act adding this section has had in reducing these disparities.

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

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

(8) An overall assessment of health care coverage.

(9) An assessment of the capacity of the various health care professions and facilities to provide care to Californians.

(b) An advisory body of individuals with knowledge and expertise in health care policy and financing shall provide input on the assessment described in subdivision (a). The Governor shall appoint five members to the advisory body, the Senate Committee

on Rules shall appoint two members, and the Speaker of the Assembly shall appoint two members.

(c) To the extent possible, the assessment described in subdivision (a) shall maximize the use of current surveys and databases.

(d) To the extent feasible, in order to track the effect of health care reform on ongoing trends in the health care field, the assessment described in subdivision (a) shall include data from years prior to the enactment of the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

(e) All state agencies shall cooperate with the secretary in implementing the provisions of this section.

(f) The Secretary of California Health and Human Services shall submit the assessment described in subdivision (a) to the appropriate policy and fiscal committees of the Legislature on or before March 1, 2012. The secretary shall update the assessment biennially.

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

22830.5. (a) On or before January 1, 2010, the board shall provide or arrange for the provision of an electronic personal health record for enrollees receiving health care benefits. The record shall be provided for the purpose of providing enrollees with information to assist them in understanding their coverage benefits and managing their health care.

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

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

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

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

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

22830.6. On or before January 1, 2010, the board shall provide or arrange for the provision of a Healthy Action Incentives and Rewards Program, as described in subdivision (c) of Section 1367.38 of the Health and Safety Code, to all enrollees.

SEC. 17. Chapter 1.6 (commencing with Section 155) is added to Part 1 of Division 1 of the Health and Safety Code, to read:

Chapter 1.6. California Health Benefits Service

155. (a) The California Health Benefits Service Program is hereby created within the State Department of Health Care Services for the purposes of expanding cost-effective health coverage options to purchasers governed by the Health Care Security and Cost Reduction Act. The program shall do all of the following:

(1) Identify statutory, regulatory, or financial barriers or incentives that should be addressed to facilitate the establishment and maintenance of one or more joint ventures between health plans that contract with, or are governed, owned, or operated by, a county board of supervisors, a county special commission, a county-organized health system or a county health authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96 or Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Division 9 of Part 3 of the Welfare and Institutions Code, as well as the County Medical Services Program.

(2) Identify statutory, regulatory, or financial barriers or incentives that should be addressed before joint ventures among these health plans may be formed, or existing health plans or the County Medical Services Program may expand to serve other geographic areas, for the purposes of providing public health care services in counties where there is not a local initiative or county-organized health plan that contracts with the State Department of Health Care Services, or the County Medical Services Program, participating in these joint ventures.

(3) Report these initial findings to the committees of jurisdiction in the Senate and Assembly on or before January 15, 2009.

(4) Provide technical assistance to local health care delivery entities, including local initiatives, county-organized health systems, and the County Medical Services Program, to support joint ventures and efforts by these entities to expand to serve other geographic areas and specified populations, or to contract with providers to provide health care services in counties where there is not a local initiative or county-organized health plan that contracts with the State Department of Health Care Services that opts to participate in such joint ventures, or participation from the County Medical Services Program.

(5) Consistent with the report and recommendations provided pursuant to this section and consistent with existing law, the department is authorized to enter into contracts with joint ventures authorized pursuant to this section to provide medical services to specified populations, as determined by the program.

(b) Health plans that contract with or are governed, owned, or operated by, a county board of supervisors, a county special commission, a county-organized health system, or county health authority authorized by Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96 or Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Division 9 of Part 3 of the Welfare and Institutions Code, and the County Medical Services Program, are authorized to form joint ventures to create integrated networks of public health plans that pool risk and share networks.

(1) In forming joint ventures, participating health plans shall seek to contract with designated public hospitals, county health clinics, community health centers, and other traditional safety net providers.

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

(c) There is hereby created the California Health Benefits Service Program Stakeholder Committee. The committee shall be comprised of 10 members appointed by the Director of Health Care Services, the Senate Committee on Rules, and the Speaker of the Assembly. The director shall appoint six members including

two representatives of local initiatives authorized under the Welfare and Institutions Code, a representative of county-organized health systems, a representative of the County Medical Services Program, a representative of health care providers, and a representative of employers. The Senate Committee on Rules shall appoint two members including a labor representative and a representative of health care consumers. The Speaker of the Assembly shall appoint two members, including a representative of local initiatives authorized under the Welfare and Institutions Code, and a representative of organized labor. The committee shall meet at least quarterly to provide input to the program and assist the program in carrying out its responsibilities as outlined in this section.

(d) On or before November 1, 2009, and annually thereafter, the department, with input from the committee, shall update the committees of jurisdiction in the Senate and Assembly on implementation of this section and make recommendations, as applicable, on changes necessary to implement this section. The update shall also include progress on fulfilling the intent of the Health Care Security and Cost Reduction Act and recommendations on resources, policy, and legislative changes necessary to build and implement a system of public health coverage throughout California. The update shall describe the projects proposed or established pursuant to this section, including, but not limited to, the participating providers, the groups covered, the physicians and hospitals in the network, and the counties served.

(e) The program shall consult with relevant departments, including the Department of Managed Health Care, in the implementation of this section.

(f) Nothing in this section shall be construed to prohibit any other licensed health care service plan not mentioned in subdivisions (b) and (c) from entering in joint ventures or contracts with the State Department of Health Care Services to provide services in counties in which there is not a Medi-Cal managed care health plan that contracts with the department.

SEC. 18. Section 1262.9 is added to the Health and Safety Code, to read:

1262.9. (a) If a patient has coverage for emergency health care services and poststabilizing care, a noncontracting hospital shall not bill the patient for emergency health care services and

poststabilizing care, except for applicable copayments and cost shares.

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

(c) For the purposes of this section:

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

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

SEC. 19. Section 1342.9 is added to the Health and Safety Code, to read:

1342.9. (a) Notwithstanding any other provision of this chapter, a health care service plan that provides services to a beneficiary of the Medi-Cal program pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of Chapter 7 of, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8 of, Part 3 of Division 9 of the Welfare and Institutions Code shall, regarding coverage for participants in a Medi-Cal managed care program, be subject solely to the filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program as those requirements pertain to the following subjects: advertising and marketing; member materials, including member handbooks, evidences of coverage, and disclosure forms; and product design,

including its scope and limitations. A health care service plan that satisfies any of the foregoing filing, reporting, monitoring, or survey requirements shall be deemed in compliance with corresponding provisions, if any, of this chapter.

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

SEC. 20. Section 1347 is added to the Health and Safety Code, to read:

1347. The director is authorized to provide regulatory and program flexibilities to facilitate new, modified, or combined licenses of local initiatives and county-organized health systems, created pursuant to Section 155 or the California Health Benefits Service Program (Chapter 1.6 (commencing with Section 155) of Part 1 of Division 1), that seek licensure for regional or statewide networks for the purposes of contracting with the Managed Risk Medical Insurance Board as a participating plan in the California Cooperative Health Insurance Purchasing Program, or for the purposes of providing coverage in the individual and group coverage markets. In providing those flexibilities, the director shall ensure that the health plans established pursuant to this section meet essential financial, capacity, and consumer protection requirements of this chapter.

SEC. 20.5. Section 1356.2 is added to the Health and Safety Code, to read:

1356.2. (a) It is the intent of the Legislature to establish mechanisms by which the state may defray the costs of an enrollee's public program participation. The state's efforts may include, but shall not be limited to, creating mechanisms to take advantage of other opportunities for coverage available to that enrollee, to access nonstate resources available to fund care for that enrollee, or other mechanisms to minimize state costs.

(b) (1) The State Department of Health Care Services, in consultation with the Department of Insurance and the Department of Managed Health Care, shall evaluate and consider the options to effectuate the intent of this section and determine the process and procedures to implement subdivision (a). The departments shall assess the fiscal ramifications and administrative feasibility

of potential options, and determine the requirements that best effectuate and implement this section. The department shall report its findings to the Joint Legislative Budget Committee by July 1, 2009.

(2) Ninety days following the department's notification to the Joint Legislative Budget Committee pursuant to paragraph (1), the departments shall implement the policies, procedures, and requirements described in its report.

(c) To the extent necessary to achieve the purposes of subdivision (a), the State Department of Health Care Services may implement Section 1396e of Title 42 of the United States Code. To the extent necessary to achieve the purposes of this section, this option shall be exercised in conjunction with the benchmark authority provided in Section 1396u-7 of Title 42 of the United States Code.

(d) To the extent necessary to achieve the purposes of subdivision (a), the Department of Insurance and the Department of Managed Health Care shall establish appropriate licensing requirements for health insurers and health care service plans to permit the state to access funds and contributions available to enrollees to reduce the cost of subsidized coverage.

(e) For the purposes of implementing this section, the State Department of Health Care Services, the Department of Insurance, and the Department of Managed Health Care shall promulgate regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) For the purposes of this section, "subsidized coverage" means coverage provided under either of the following:

(1) Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code through a Cal-CHIPP Healthy Families plan.

(2) Section 14005.333 of the Welfare and Institutions Code.

(g) This section shall be implemented no later than one year from the date that the act enacting this section becomes operative.

SEC. 21. Section 1357.54 of the Health and Safety Code is amended to read:

1357.54. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with

respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.

(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.

(c) Movement of the individual contractholder outside the service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) If the plan ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in the state is provided to the director and to the individual at least 180 days prior to discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A plan that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the director.

(e) If the plan withdraws an individual health benefit plan from the market; provided, that the plan notifies all affected individuals and the director at least 90 days prior to the discontinuation of these plans, and that the plan makes available to the individual all health benefit plans that it makes available to new individual business without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

This section shall become inoperative on the date that Section 1399.829 becomes operative.

SEC. 22. Section 1365 of the Health and Safety Code is amended to read:

1365. (a) An enrollment or a subscription may not be canceled or not renewed except for the following:

(1) Failure to pay the charge for such coverage if the subscriber has been duly notified and billed for the charge and at least 15 days has elapsed since the date of notification.

(2) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting such fraud or deception by another.

(3) Such other good cause as is agreed upon in the contract between the plan and a group or the subscriber.

(b) An enrollee or subscriber who alleges that an enrollment or subscription has been canceled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review by the director. If the director determines that a proper complaint exists under the provisions of this section, the director shall notify the plan. Within 15 days after receipt of such notice, the plan shall either request a hearing or reinstate the enrollee or subscriber. If, after hearing, the director determines that the cancellation or failure to renew is contrary to subdivision (a), the director shall order the plan to reinstate the enrollee or subscriber. A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation or nonrenewal to and including the date of reinstatement.

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and a health care service plan or a specialized health care service plan including, but not limited to, the financial liability of that plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under any such preexisting contracts to conform them to the provisions of subdivision (a).

(d) On and after the date that Section 1399.829 becomes operative, this section shall not apply to individual health plan contracts.

SEC. 22.7. Section 1367.16 is added to the Health and Safety Code, to read:

1367.16. For purposes of subdivision (c) of Section 1367.15, "comparable benefits" means any health plan contract in the same coverage choice category, as determined by the department and the Department of Insurance pursuant to Section 1399.832, that a closed block of business would have been in, had that block of business not been closed. If the coverage benefits provided in the closed block of business do not meet or exceed the minimum health care coverage requirements of Section 1399.824, they shall be deemed comparable to the lowest coverage choice category.

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

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

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

1367.38. (a) On and after January 1, 2009, every health care service plan, except for a Medicare supplement plan, that covers hospital, medical, or surgical expenses on a group basis shall offer to include a Healthy Action Incentives and Rewards Program, as described in subdivision (b), to be implemented in connection with a health care service plan, under such terms and conditions as may be agreed upon between the subscriber group and the health care service plan. Every plan shall communicate the availability of that program to all prospective subscriber groups with whom it is negotiating and to existing subscriber groups upon renewal.

(b) For purposes of this section, benefits under a Healthy Action Incentives and Rewards Program shall provide for all of the following, where appropriate:

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

(2) Enrollee access to an appropriate health care provider, as medically necessary, to review and address the results of the health risk appraisal. In addition, where appropriate, the Healthy Action Incentives and Rewards Program may include followup through

a Web-based tool or a nurse hotline either in combination with a referral to a provider or separately.

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

(c) (1) A health care service plan subject to this section shall offer and price all Healthy Action Incentives and Rewards Programs approved by the director consistently across all groups, potential groups, and individuals and offer and price the programs without regard to the health status, prior claims experience, or risk profile of the members of a group. A health plan shall not condition the offer, delivery, or renewal of a contract that covers hospital, medical, or surgical expenses on the group's purchase, acceptance, or enrollment in a Healthy Action Incentives and Rewards Program. Rewards and incentives established in the program may not be designed, provided, or withheld based on the actual health service utilization or health care claims experience of the group, members of the group, or the individual.

(2) In order to demonstrate compliance with this section, a health care service plan shall file the program description and design as an amendment to its application for licensure pursuant to subdivision (a) of Section 1352. The director shall disapprove, suspend, or withdraw any product or program developed pursuant to this section if the director determines that the product or product design has the effect of allowing health care service plans to market, sell, or price health coverage for healthier lower risk profile

groups in a preferential manner that is inconsistent with the requirement to offer, market, and sell products pursuant to Article 3.1 (commencing with Section 1357) and Article 11.6 (commencing with Section 1399.820).

(d) This section shall supplement, and not supplant, any other section in this chapter concerning requirements for plans to provide health care services, childhood immunizations, adult immunizations, and preventive care services.

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

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

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

SEC. 26. Section 1378.1 is added to the Health and Safety Code, to read:

1378.1. (a) Except as provided in subdivision (f), a full-service health care service plan shall, on and after July 1, 2010, expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, premiums, or other periodic payments received by the plan. For purposes of this section, the plan may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the plan the amount of income taxes or other taxes that the plan expensed. For purposes of this section, "health care benefits" shall mean health care services that are either provided by or reimbursed by the plan or its contracted providers as plan benefits.

(b) (1) In addition to the health care benefits defined in subdivision (a), health care benefits shall include:

(A) The costs of programs or activities, including training and the provision of informational materials that are determined as

part of the regulations under subdivision (d) to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(B) Disease management expenses using cost-effective evidence-based guidelines.

(C) Plan medical advice by telephone.

(D) Payments to providers as risk pool payments of pay-for-performance initiatives.

(2) Health care benefits shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2007.

(c) To assess compliance with this section, a plan licensed to operate in California may average its total costs across all health care service plan contracts issued, amended, or renewed in California, and all health insurance policies issued, amended, or renewed by its affiliated disability insurers with valid California certificates of authority, except for those policies listed in subdivision (f) of Section 10113.10 of the Insurance Code.

(d) The department and the Department of Insurance shall jointly adopt and amend regulations to implement this section and Section 10113.10 of the Insurance Code to establish uniform reporting by plans and insurers of the information necessary to determine compliance with this section. These regulations may include additional elements in the definition of health care benefits not identified in paragraph (1) of subdivision (b) in order to consistently operationalize the requirements of this section among health plans and health insurers, but such regulatory additions shall be consistent with the legislative intent that health plans expend at least 85 percent of aggregate payments as provided in subdivision (a) on health care benefits.

(e) The department may exclude from the determination of compliance with the requirement of subdivision (a) any new health care service plan contracts for up to the first two years that these contracts are offered for sale in California, provided that the director determines that the new contracts are substantially different from the existing contracts being issued, amended, or renewed by the health plan seeking the exclusion.

(f) This section shall not apply to Medicare supplement plans or to coverage offered by specialized health care service plans,

including, but not limited to, ambulance, dental, vision, behavioral health, chiropractic, and naturopathic.

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

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

(1) Obtains authorization from the applicant, enrollee, or subscriber to provide notices by electronic transmission and to cease providing notices by United States mail. "Authorization" means the agreement by the applicant, enrollee, or subscriber through interactive voice response, the Internet or other similar medium, or in writing, to receive notices by electronic transmission.

(2) Uses an authorization process, approved by the department, in which the applicant, enrollee, or subscriber confirms understanding of and agreement with the specific notices or materials that will be provided by electronic transmission.

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

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

(5) Allows the applicant, enrollee, or subscriber at any time to terminate the authorization to provide notices by electronic transmission and receive the notices through the United States mail, if specific statutory or regulatory requirements require notice by mail.

(6) Sends the electronic transmission of a notice to the last known electronic address of the applicant, enrollee, or subscriber. If the electronic transmission fails to reach its intended recipient twice, the health care service plan shall resume sending all notices to the last known United States mail address of the applicant, enrollee, or subscriber.

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

(8) Informs the applicant, enrollee, or subscriber how to terminate the authorization to provide notices sent by electronic transmission.

(b) A health care service plan shall not use the electronic mail address of an applicant, enrollee, or subscriber that it obtained for the purposes of providing notice pursuant to subdivision (a) for any purpose other than communicating with the enrollee, applicant, or subscriber about his or her policy, plan, or benefits.

(c) No person other than the applicant, enrollee, or subscriber to whom the medical information in the notice pertains or a representative lawfully authorized to act on behalf of the applicant, enrollee, or subscriber, may authorize the transmission of medical information by electronic transmission. "Medical information" for these purposes shall have the meaning set forth in subdivision (g) of Section 56.05 of the Civil Code. The transmission of any medical information, as that term is used in subdivision (g) of Section 56.05 of the Civil Code, shall comply with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

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

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

(f) Notices that may be made by electronic transmission include an explanation of benefits; responses to inquiries from an applicant, enrollee, or subscriber; underwriting decisions; distribution of plan contracts, including evidence of coverage and disclosure forms

pursuant to Sections 1300.63.1 and 1300.63.2 of Title 28 of the California Code of Regulations; a list of contracting providers pursuant to Section 1367.26; and changes in rates or coverage pursuant to Sections 1374.21, 1374.22, and 1374.23. A plan may not transmit through electronic means any notice that may affect the eligibility for, or continued enrollment in, coverage.

SEC. 27.3. Section 1399.56 of the Health and Safety Code is amended to read:

1399.56. (a) Compensation of a person retained by a health care service plan to review claims for health care services shall not be based on either of the following:

(1) A percentage of the amount by which a claim is reduced for payment.

(2) The number of claims or the cost of services for which the person has denied authorization or payment.

(b) This section shall become inoperative on December 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 27.5. Section 1399.56 is added to the Health and Safety Code, to read:

1399.56. (a) Compensation of a person employed by or contracted with a health care service plan to review claims or eligibility for health care services shall not be based on either of the following:

(1) A percentage of the amount by which a claim is reduced for payment.

(2) The number of claims or the cost of services for which the person has denied authorization or payment.

(b) This section shall become operative on December 1, 2008.

SEC. 28. Section 1399.58 is added to the Health and Safety Code, to read:

1399.58. (a) No health care service plan shall set performance goals or quotas or provide additional compensation to any person employed by or contracted with the health care service plan based on the number of persons for which coverage is rescinded or the financial savings to the health care service plan associated with the rescission of coverage.

(b) This section shall become operative on December 1, 2008.

SEC. 28.5. Article 11.6 (commencing with Section 1399.820) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.6. Individual Market Reform and Guarantee Issue

1399.820. It is the intent of the Legislature to do both of the following:

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

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

1399.821. For purposes of this article, the following terms shall have the following meanings:

(a) "Anniversary date" means the calendar date one year from, and each subsequent year thereafter, the date an individual enrolls in a health plan contract.

(b) "Coverage choice category" means the category of health plan contracts and health insurance policies established by the department and the Department of Insurance pursuant to Section 1399.832.

(c) "Dependent" means the spouse, registered domestic partner, or child of an individual, subject to applicable terms of the health plan contract covering the individual.

(d) "Health insurance policy" means an individual disability insurance policy offered, sold, amended, or renewed to individuals and their dependents and that provides coverage for hospital, medical, or surgical benefits. The term shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident-only, and specified disease insurance that pays benefits on a fixed benefit, cash-payment-only basis.

(3) Credit disability, as defined in Section 779.2 of the Insurance Code.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01 of the Insurance Code.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care coverage.

(9) Dental coverage.

(10) Vision coverage.

(11) Medicare supplement, CHAMPUS-supplement or Tricare-supplement, behavioral health-only, pharmacy-only, hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash-payment-only basis.

(e) "Health insurer" means a disability insurer that offers and sells health insurance.

(f) "Health plan" means a health care service plan, as defined in subdivision (f) of Section 1345, that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of health care services and is offering or selling health care service plan contracts in the individual market. A health plan shall not include a specialized health care service plan.

(g) "Health plan contract" means an individual health care service plan contract offered, sold, amended, or renewed to individuals and their dependents. The term shall not include long-term care insurance, dental, or vision coverage. In addition, the term shall not include a specialized health care service plan contract, as defined in subdivision (o) of Section 1345.

(h) "Purchasing pool" means the program established under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

(i) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months beginning on the effective date of the subscriber's health plan contract.

(j) "Risk adjustment factor" means the percentage adjustment to be applied to the standard risk rate for a particular individual, based upon any expected deviations from standard claims due to the health status of the individual.

(k) "Risk category" means the following characteristics of an individual: age, geographic region, and family composition of the individual, plus the health plan contract selected by the individual.

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

Under 1.

1–18.

19–24.

25–29.

30–34.

35–39.

40–44.

45–49.

50–54.

55–59.

60–64.

65 and over.

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

(2) Health plans shall determine rates using no more than the following family size categories:

(A) Single.

(B) More than one child 18 years of age or under and no adults.

(C) Married couple or registered domestic partners.

(D) One adult and child.

(E) One adult and children.

(F) Married couple and child or children, or registered domestic partners and child or children.

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

shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

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

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

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

(4) A health plan may rate its entire portfolio of health plan contracts in accordance with expected costs or other market considerations, but the rate for each health plan contract shall be set in relation to the balance of the portfolio, as certified by an actuary.

(5) Each health plan contract shall be priced as determined by each health plan to reflect the difference in benefit variation, or the effectiveness of a provider network, and each health plan may adjust the rate for a specific plan contract for risk selection only to the extent permitted by subdivision (d) of Section 1399.840.

(*l*) "Standard risk rate" means the rate applicable to an individual in a particular risk category.

(m) "Subscriber" means the individual who is enrolled in a health plan contract, is the basis for eligibility for enrollment in the contract, and is responsible for payment to the health plan.

1399.823. On and after March 31, 2009, a health plan shall not offer to an individual a health plan contract that provides less than minimum creditable coverage as defined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code.

1399.826. (a) Notwithstanding Chapter 15 (commencing with Section 8899.50) of Division 1 of Title 2 of the Government Code and Section 1399.823, a health plan may renew an individual health care benefit plan for anyone enrolled on March 1, 2009, indefinitely without increasing benefits to meet the required minimum creditable coverage established by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code. Those individual health care benefit plans, however, may not be offered to new enrollment, unless they are amended to meet the minimum creditable coverage established by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code. In offering those plans for renewal, rates determined by health plans shall meet the requirements of Sections 1399.821 and 1399.840. An individual who maintains coverage in a health plan contract pursuant to this section shall be deemed to be in compliance with Section 8899.50 of the Government Code.

(b) A health plan shall not cease to renew coverage in an individual health plan contract described in subdivision (a) except as permitted pursuant to Section 1367.15.

(c) On and after March 1, 2009, the director shall not approve for offer and sale in this state any new individual health plan contract that does not meet or exceed the requirements for minimum creditable coverage established by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code.

(d) Effective July 1, 2010, all individual health plan contracts approved, offered, and sold prior to March 1, 2009, which do not comply with minimum creditable coverage standards adopted by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code, exclusively because the contract includes a lifetime benefit maximum inconsistent with minimum creditable coverage requirements, shall be modified to comply with the minimum creditable coverage standard.

(e) This section shall become operative on January 1, 2009.

1399.827. A health plan shall, in addition to complying with this chapter and the rules of the director, comply with this article.

1399.828. This article shall not apply to health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Care Services, Healthy Families Program contracts with the Managed Risk Medical Insurance Board, long-term care coverage, specialized health care service plan contracts, as defined in subdivision (o) of Section 1345, or the purchasing pool established under Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

1399.829. (a) Except for the health plan contracts described in subdivision (a) of Section 1399.826, a health plan shall fairly and affirmatively offer, market, and sell all of the plan's contracts that are sold to individuals to all individuals in each service area in which the health plan provides or arranges for the provision of health care services.

(b) A health plan may not reject an application from an individual, or his or her dependents, for a health plan contract, or refuse to renew an individual health plan contract, if all of the following requirements are met:

(1) The individual agrees to make the required premium payments.

(2) The individual and his or her dependents who are to be covered by the health plan contract work or reside in the service area in which the health plan provides or otherwise arranges for the provision of health care services.

(3) The individual provides the information requested on the application to determine the appropriate rate.

(c) Notwithstanding subdivision (b), if an individual, or his or her dependents, applies for a health plan contract in a coverage choice category for which he or she is not eligible pursuant to Section 1399.837, the health plan may reject that application provided that the plan also offers the individual and his or her dependents coverage in the appropriate coverage choice category.

(d) Notwithstanding subdivision (b), a health plan is not required to renew an individual health plan contract if any of the conditions listed in subdivision (a) of Section 1399.839 are met.

(e) Notwithstanding any other provision of this chapter or of a health plan contract, every health plan shall comply with the requirements of Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

(f) A health plan may require an individual to provide information on his or her health status or health history, or that of his or her dependents, in the application for enrollment to the extent required to apply the risk adjustment factor permitted pursuant to subdivision (d) of Section 1399.840. The health plan shall use the standardized form and process developed by the department pursuant to Section 1399.840. After the health plan contract's effective date of coverage, a health plan may request that the subscriber provide information voluntarily on his or her health history or health status, or that of his or her dependents, for purposes of providing care management services, including disease management services.

(g) Notwithstanding subdivision (b), a health plan may reject an application for any person who has been a resident of California for six months or less unless one of the following applies: (1) the person is a federally eligible defined individual as defined in Section 1399.801 or Section 10785 of the Insurance Code; or (2) the individual can demonstrate a minimum of two years of prior creditable coverage at least equivalent to the minimum creditable coverage developed by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code and provided the person applies for coverage in California within 62 days of termination or cancellation of the prior creditable coverage.

(h) Notwithstanding subdivision (b), a health plan may reject an application for coverage from either of the following:

(1) A person who is exempt from the requirements of Section 8899.50 of the Government Code because the person or family has an income at or below 250 percent of the federal poverty level and the person's or family's share of premium for minimum creditable coverage exceeds 5 percent of his or her family income, except for those individuals meeting the criteria in paragraph (1) or (2) of subdivision (g).

(2) A person exempted from the requirements of Section 8899.50 of the Government Code pursuant to any exemption authorized or granted by the Managed Risk Medical Insurance Board pursuant

to Section 12739.501 of the Insurance Code, for the time period of the exemption, as determined by the board.

(i) Notwithstanding Section 1399.846, this section shall not become operative until Section 12739.51 of the Insurance Code is implemented.

1399.831. (a) A health plan shall not impose any preexisting condition exclusions, waivered conditions, or postenrollment waiting or affiliation periods on any health plan contract issued, amended, or renewed pursuant to this article, except as provided under subdivision (b) of this section.

(b) After the requirement to guarantee issue of coverage under Section 1399.826 has been in effect for nine months, a health plan may impose a preexisting condition exclusion of up to 12 months for any person who fails to comply for more than 62 days with the requirement to maintain coverage under Section 8899.50 of the Government Code, providing, however, that the exclusion may not exceed the length of time that the person failed to comply with the requirements of that section. "Preexisting condition exclusion" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the individual's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. For purposes of this section, preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

1399.832. (a) On or before April 1, 2009, the department and the Department of Insurance shall jointly, by regulation, develop a system to categorize all health plan contracts and health insurance polices offered and sold to individuals pursuant to this article and Chapter 9.6 (commencing with Section 10920) of Part 2 of Division 2 of the Insurance Code into five coverage choice categories. These coverage choice categories shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits.

(2) Permit reasonable benefit variation that will allow for a diverse market within each coverage choice category.

(3) Be enforced consistently between health plans and health insurers in the same marketplace regardless of licensure.

(4) Within each coverage choice category, include one standard health maintenance organization (HMO) and one standard preferred provider organization (PPO), each of which is the health plan contract with the lowest benefit level in that category and for that type of contract.

(b) All health plans shall submit filings required pursuant to Section 1399.842 no later than October 1, 2009, for all individual health plan contracts to be offered or sold on or after July 1, 2010, to comply with this article, and thereafter any additional health plan contracts shall be filed pursuant to Section 1399.842. The director shall categorize each health plan contract offered by a health plan into the appropriate coverage choice category on or before March 31, 2010.

(c) To facilitate consumer comparison shopping, all health plans that offer coverage on an individual basis shall offer at least one health plan contract in each coverage choice category, including offering at least one of the standard contracts developed pursuant to paragraph (4) of subdivision (a), but a health plan may offer multiple products in each category.

(d) If a health plan offers a specific type of health plan contract in one coverage choice category, it must offer that specific type of health plan contract in each coverage choice category. A "type of health plan contract" includes a preferred provider organization, an exclusive provider organization model plan, a point of service model plan, and a health maintenance organization model plan.

(e) Health plans shall have flexibility in establishing provider networks, provided that access to care standards pursuant to this chapter are met, and provided that the provider network offered for one health plan contract in one coverage choice category is offered for at least one health plan contract in each coverage choice category.

(f) A health plan shall establish prices for its products that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. A health plan shall not establish a standard risk

rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category.

(g) The coverage choice category with the lowest level of benefits shall include the benefits which meet the requirement of minimum creditable coverage as determined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code.

1399.833. A health plan shall offer coverage for a Healthy Action Incentives and Rewards Program that complies with the requirements of Section 1367.38 in at least one health plan contract in every coverage choice category.

1399.834. The Office of the Patient Advocate shall develop and maintain on its Internet Web site a uniform benefits matrix of all available individual health plan contracts and individual health insurance policies arranged by coverage choice category. This uniform benefit matrix shall include all of the following:

(a) Benefit information submitted by health plans pursuant to Section 1399.843 and by health insurers pursuant to Section 10940 of the Insurance Code, including, but not limited to, the following category descriptions:

(1) Deductibles.

(2) Copayments or coinsurance, as applicable.

(3) Annual out-of-pocket maximums.

(4) Professional services.

(5) Outpatient services.

(6) Preventive services.

(7) Hospitalization services.

(8) Emergency health services.

(9) Ambulance services.

(10) Prescription drug coverage.

(11) Durable medical equipment.

(12) Mental health and substance abuse services.

(13) Home health services.

(14) Other.

(b) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for additional assistance.

1399.835. When an individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first

15 days of the month, coverage under the health plan contract shall become effective no later than the first day of the following month. When that payment is either delivered or postmarked after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

1399.836. Except as provided in Section 1399.829, a health plan is not required to offer an individual health plan contract and may reject an application for an individual health plan contract in the case of any of the following:

(a) The individual and dependents who are to be covered by the health plan contract do not work or reside in a health plan's approved service area.

(b) (1) Within a specific service area or portion of a service area, if a health plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to assure that health care services will be available and accessible to the eligible individual and dependents of the individual because of its obligations to existing enrollees.

(2) A health plan that cannot offer a health plan contract to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a health plan contract in the area in which the health plan is not offering coverage to individuals until the health plan notifies the director that it has the ability to deliver services to new enrollees, and certifies to the director that from the date of the notice it will enroll all individuals and groups requesting coverage in that area from the health plan.

(c) The plan is licensed in California and meets all of the following criteria: (1) does not offer coverage to individuals in the commercial market; (2) requires that its members qualify through the Medicare Program or Medi-Cal program or their successors; and (3) 75 percent or more of the organization's total enrollment premiums are paid by the Medi-Cal program or Medicare Program, or by a combination of Medi-Cal and Medicare payments. In no event shall this exemption be based upon enrollment in Medicare supplement contracts, as described in Article 3.5 (commencing with Section 1358).

(d) Any person who has been a resident of California for six months or less unless one of the following applies: (1) the person

is a federally eligible defined individual as defined in Section 1399.801 or Section 10785 of the Insurance Code, or (2) the person can demonstrate a minimum of two years of prior creditable coverage at least equivalent to the minimum creditable coverage developed by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code and providing the person applies for coverage in California within 62 days of termination or cancellation of the prior creditable coverage.

(e) Any person who has been granted a temporary or permanent hardship exemption from the requirement to maintain minimum creditable coverage by the Managed Risk Medical Insurance Board pursuant to Section 12739.501 of the Insurance Code during the time period of the exemption as determined by the board.

1399.837. (a) If an individual disenrolls from a health plan contract or health insurance policy or if the individual's health plan contract or health insurance policy is canceled pursuant to Section 1399.839 or Section 10936 of the Insurance Code prior to the anniversary date of the health plan contract or health insurance policy, subsequent enrollment in an individual health plan contract or an individual health insurance policy shall be limited to the same coverage choice category the individual was enrolled in prior to disenrollment or cancellation.

(b) (1) An individual may change to a health plan contract in a different coverage choice category only on the anniversary date of the subscriber or upon a qualifying event.

(2) In no case, however, may an individual move up more than one coverage choice category on the anniversary date of the subscriber unless there is also a qualifying event.

(c) An individual health plan contract described in subdivision (a) of Section 1399.826 that does not meet or exceed the requirements for minimum creditable coverage established by the Managed Risk Medical Insurance Board shall be deemed to be the lowest coverage choice category for purposes of this section.

(d) On and after January 1, 2011, an individual who fails to comply with the provisions of Chapter 15 (commencing with Section 8899.50) of Division 1 of Title 2 of the Government Code for more than 62 days may only enroll in a health plan contract or health insurance policy in the lowest coverage choice category. Upon the individual's anniversary date, the individual may move to a higher coverage choice category pursuant to subdivision (b).

(e) For purposes of this section, a qualifying event occurs upon any of the following:

(1) Upon the death of the subscriber, on whose qualifying coverage an individual was a dependent.

(2) Upon marriage of the subscriber or entrance by the subscriber into a domestic partnership pursuant to Section 298.5 of the Family Code.

(3) Upon divorce or legal separation of an individual from the subscriber.

(4) Upon loss of dependent status by a dependent enrolled in group health care coverage through a health care service plan or a health insurer.

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

(6) Upon the loss of minimum creditable coverage as defined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 of the Insurance Code.

1399.838. The director may require a health plan to discontinue the offering of contracts or acceptance of applications from any individual upon a determination by the director that the health plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees.

1399.839. (a) All health plan contracts offered pursuant to this article shall be renewable with respect to all individuals and dependents at the option of the subscriber and shall not be canceled except for the following reasons:

(1) Failure to pay any charges for coverage provided pursuant to the contract if the subscriber has been duly notified and billed for those charges and at least 15 days has elapsed since the date of notification.

(2) Fraud or intentional misrepresentation of material fact under the terms of the health plan contract by the individual.

(3) Fraud or deception in the use of the services or facilities of the plan or knowingly permitting that fraud or deception by another.

(4) Movement of the subscriber outside the health plan's service area.

(5) If the health plan ceases to provide or arrange for the provision of health care services for new or existing individual

health plan contracts in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing individual health plan contracts in the state is provided to the director and to the individual at least 180 days prior to discontinuation of that coverage.

(B) Individual health plan contracts shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and for that business of a health plan that remains in force, any health plan that ceases to offer for sale new individual health plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(C) A health plan that ceases to write new individual health plan contracts in this state after the effective date of this section shall be prohibited from offering for sale individual health plan contracts in this state for a period of five years from the date of notice to the director. The director may permit a health plan to offer and sell individual health plan contracts in this state before the five-year time period has expired if the director determines that it is in the best interest of the state and necessary to preserve the integrity of the health care market.

(6) If the health plan withdraws an individual health plan contract from the market, provided that the health plan notifies all affected individuals and the director at least 90 days prior to the discontinuation of these health plan contracts, and that the health plan makes available to the individual all health plan contracts with comparable benefits that it makes available to new individual business.

(b) On or after July 1, 2010, a health plan shall not rescind the health plan contract of any individual.

(c) Nothing in this article shall limit any other remedies available at law to a health plan.

1399.840. Premiums for health plan contracts offered, renewed, or delivered by health plans on or after the effective date of this article shall be subject to the following requirements:

(a) The premium for new or existing business shall be the standard risk rate for an individual in a particular risk category.

(b) The premium rates shall be in effect for no less than 12 months from the date of the health plan contract.

(c) When determining the premium rate for more than one covered individual, the health plan shall determine the rate based on the standard risk rate for the subscriber. If more than one individual is a subscriber, the premium rate shall be based on the age of the youngest spouse or registered domestic partner.

(d) (1) Notwithstanding subdivision (a), for the first two years following the implementation of this section, a health plan may apply a risk adjustment factor to the standard risk rate that may not be more than 120 percent or less than 80 percent of the applicable standard risk rate. In determining the risk adjustment factor, a health plan shall use the standardized form and uniform process developed by the director pursuant to subdivision (f).

(2) After the first two years following the implementation of this section, the adjustments applicable under paragraph (1) shall not be more than 110 percent or less than 90 percent of the standard risk rate.

(3) Upon the renewal of any contract, the risk adjustment factor applied to the individual's rate may not be more than 5 percentage points different than the factor applied to that rate prior to renewal. The same limitation shall be applied to individuals with respect to the risk adjustment factor applicable for the purchase of a new product where the individual's prior health plan has discontinued that product.

(4) After the first four years following the implementation of this section, a health plan shall base rates on the standard risk rate with no risk adjustment factor.

(e) The director and the Insurance Commissioner shall jointly establish a maximum limit on the ratio between the standard risk rates for contracts for individuals in the 60 to 64 years of age, inclusive, category and contracts for individuals in the 30 to 34 years of age, inclusive, category.

(f) On or before March 1, 2009, the director shall, in consultation with the Insurance Commissioner and the Managed Risk Medical Insurance Board and using a qualified independent actuary, develop a standardized form and uniform evaluation process to be used by all health care service plans and all disability insurers exclusively for the purpose of determining any risk adjustment rating factor to be applied to an individual's premium rate based on actual or expected health care use. Health plans shall base the risk adjustment factors as authorized in this section solely on the results

of the standardized form and uniform evaluation process developed by the director.

1399.841. (a) In connection with the offering for sale of any health plan contract to an individual, each health plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions concerning the health plan's right to change premium rates on an annual basis and the factors other than provision of services experience that affect changes in premium rates.

(2) Provisions relating to the guaranteed issue and renewal of health plan contracts.

(3) Provisions relating to the individual's right to obtain any health plan contract the individual is eligible to enroll in pursuant to Sections 1399.829 and 1399.837.

(4) The availability, upon request, of a listing of all the health plan's contracts, including the rates for each health plan contract.

(b) Every solicitor or solicitor firm contracting with one or more health plans to solicit enrollments or subscriptions from individuals shall, when providing information on health plan contracts to an individual but making no specific recommendations on particular health plan contracts, do both of the following:

(1) Advise the individual of the health plan's obligation to sell to any individual any health plan contract it offers to individuals and provide him or her, upon request, with the actual rates that would be charged to that individual for a given health plan contract.

(2) Notify the individual that the solicitor or solicitor firm will procure rate and benefit information for the individual on any health plan contract offered by a health plan whose contract the solicitor sells.

(c) Prior to filing an application for a particular individual health plan contract, the health plan shall obtain a signed statement from the individual acknowledging that the individual has received the disclosures required by this section.

1399.842. (a) At least 20 business days prior to offering a health plan contract subject to this article, all health plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the health plan is in compliance with Sections 1399.821 and 1399.840.

The certified statement shall set forth the standard risk rate for each risk category that will be used in setting the rates at which the contract will be offered. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the health plan's use of a health plan contract shall be in writing, specifying the reasons that the health plan contract does not comply with the requirements of this article.

(b) Prior to making any changes in the standard risk rates filed with the director pursuant to subdivision (a), the health plan shall file as an amendment a statement setting forth the changes and certifying that the health plan is in compliance with Sections 1399.821 and 1399.840. If the standard risk rate is being changed, a health plan may commence offering health plan contracts utilizing the changed standard risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(c) Periodic changes to the standard risk rate that a health plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a) or (b).

(d) Each health plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this article.

(e) This section shall become operative on July 1, 2009.

1399.843. (a) A health plan shall include all of the following in the material modification notice filed pursuant to subdivision (a) of Section 1399.842:

(1) A summary explanation of the following for each health plan contract offered to individuals:

(A) Eligibility requirements.

(B) The full premium cost of each health plan contract in each risk category, as defined in subdivision (k) of Section 1399.821.

(C) When and under what circumstances benefits cease.

(D) Other coverage that may be available if benefits under the described health plan contract cease.

(E) The circumstances under which choice in the selection of physicians and providers is permitted.

(F) Deductibles.

(G) Annual out-of-pocket maximums.

(2) A summary explanation of coverage for the following, together with the corresponding copayments, coinsurance, and

applicable limitations for each health plan contract offered to individuals:

(A) Professional services.

(B) Outpatient services.

(C) Preventive services.

(D) Hospitalization services.

(E) Emergency health coverage.

(F) Ambulance services.

(G) Prescription drug coverage.

(H) Durable medical equipment.

(I) Mental health and substance abuse services.

(J) Home health services.

(3) The telephone number or numbers that may be used by an applicant to access a health plan customer service representative to request additional information about the health plan contract.

(b) The department shall share the information provided by health plans pursuant to this article with the Office of the Patient Advocate for purposes of the development, creation, and maintenance of the comparative benefits matrix.

1399.844. (a) The Director of the Department of Managed Health Care shall, in consultation with the Insurance Commissioner, an outside actuarial firm, and health plans and insurers participating in the individual market, no later than July 1, 2010, develop and implement mechanisms to assist health plans and health insurers in managing the risk of providing health coverage in the individual market on a guarantee issue basis to the extent that these mechanisms can improve access to individual coverage.

(b) The mechanisms required under subdivision (a) shall include methods for collecting information regarding the enrollment, prices, rate variance, and any other information that may be required to monitor the condition of the individual market, the risk exposure of individual health plans and insurers, and to implement subdivisions (c) and (d).

(c) (1) The mechanisms developed pursuant to subdivision (a) shall include a method by which an assessment is made of the health status risk mix of a plan's guarantee issue products. To the extent any plan's risk mix is disproportionately high compared to the overall risk mix of all enrollees in guarantee issue products in the individual market, the mechanisms developed pursuant to

subdivision (a) shall include provisions designed to make adjustments among plans and insurers based on the relative health risk of individuals enrolled in different health plans and health insurers. Methods to compensate for the relative health risk assumed by health plans and insurers shall include the ability to spread the costs to all health plan contracts and health insurance policies in the individual market.

(2) The director and the commissioner shall jointly adopt regulations identifying health plans and insurers that are required to participate in the mechanisms established pursuant to this subdivision.

(d) (1) The director and the commissioner shall also develop as part of the mechanisms under subdivision (a) a method for the provision of reinsurance for health plans or insurers offering guarantee issue products in the individual market if the age adjusted marketwide incidence of high-cost cases or high-risk categories significantly exceed the incidence of those cases or categories among enrollees of the California Cooperative Health Insurance Purchasing Pool (Cal-CHIPP) who are ineligible for the Cal-CHIPP Healthy Families plan. This reinsurance mechanism shall be based on a uniform standard set of service payment levels based on a methodology to be determined by the director and the commissioner.

(2) This subdivision shall be implemented on July 1, 2010, or the operative date of this section, whichever is later, and shall continue to be implemented until one year after the implementation of paragraph (4) of subdivision (d) of Section 1399.840.

(e) The director and the commissioner may contract with a qualified actuarial firm or other entities to accomplish the requirements of this section.

(f) No later than two years following implementation of guarantee issue pursuant to Section 1399.829 and Section 10928 of the Insurance Code, the director and the commissioner shall make a finding whether and to what extent the relative risk profile of persons enrolled in individual coverage is higher than the risk profile of those of specified Cal-CHIPP enrollees, based on data following the first nine months of guarantee issue. If the risk profile of those enrolled in individual coverage is more than 5 percent higher than that of the specified Cal-CHIPP enrollees, the director and the commissioner shall establish a reinsurance program for

individual market health plans and insurers to compensate for the adverse risk selection. ~~The costs of reinsurance pursuant to this section in order to compensate for risk profile differentials of up to 10 percent shall be funded by a broad-based assessment across health care service plans and health insurers.~~ Funding to compensate for risk profile differentials exceeding 10 percent shall be paid by funds appropriated from the California Health Trust Fund.

1399.845. (a) The director may issue regulations that are necessary to carry out the purposes of this article.

(b) Nothing in this article shall be construed as providing the director with rate regulation authority.

1399.846. Sections 1399.823, 1399.826, and 1399.832 shall become operative on January 1, 2009, and Section 1399.842 shall become operative on July 1, 2009. The remaining sections in this article shall become operative on July 1, 2010.

SEC. 29. Article 1 (commencing with Section 104250) is added to Chapter 4 of Part 1 of Division 103 of the Health and Safety Code, to read:

Article 1. California Diabetes Program

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

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

(b) Provide technical assistance to the Medi-Cal program, including participating providers and Medi-Cal managed care plans, regarding the proper scope of benefits to be provided to eligible individuals under Section 14137.10 of the Welfare and Institutions Code. The assistance may include, but shall not be limited to, all of the following:

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

(2) Develop, with assistance from the State Department of Health Care Services, the Comprehensive Diabetes Services Program operational screening guidelines and protocols, utilizing

the most current American Diabetes Association screening criteria for diabetes testing in adults.

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

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

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

(c) Provide technical assistance to the State Department of Health Care Services, including assistance on data collection and evaluation of the Medi-Cal program's Comprehensive Diabetes Services Program, established pursuant to Section 14137.10 of the Welfare and Institutions Code.

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

SEC. 30. Section 104376 is added to the Health and Safety Code, to read:

104376. (a) (1) 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, shall annually identify, on the basis of the number of persons insured, the 10 largest providers of health care coverage, including both public and private entities, and ascertain the smoking cessation benefits provided by each of these coverage providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 31. Article 3 (commencing with Section 104705) is added to Chapter 2 of Part 3 of Division 103 of the Health and Safety Code, to read:

Article 3. Community Makeover Grants

104705. (a) The Community Makeover Grant program is hereby created and shall be administered by the department. The

department shall award grants to local health departments to serve as local lead agencies in accordance with this article.

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

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

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

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

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

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

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

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

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

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

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

(g) For purposes of this article, "department" means the State Department of Public Health.

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

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

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

104715. (a) The department shall track and evaluate obesity-related measures, including, but not limited to, active living, healthy eating, and community environment indicators. These tracking and evaluation activities shall utilize scientifically appropriate methods, and may include, but need not be limited to, the following:

(1) Track statewide health indicators.

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

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

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

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

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

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

104720. The department shall develop a campaign to educate the public about the importance of obesity prevention that frames

active living and healthy eating as "California living." The campaign-centered efforts shall be closely linked with community-level program change efforts and shall be available in accessible and culturally and linguistically appropriate formats.

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

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

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

SEC. 31.1. Section 124900 of the Health and Safety Code is amended to read:

124900. (a) (1) The State Department of Health Care Services shall select primary care clinics that are licensed under paragraph (1) or (2) of subdivision (a) of Section 1204, or are exempt from licensure under subdivision (c) of Section 1206, to be reimbursed for delivering medical services, including preventive health care, and smoking prevention and cessation health education, to program beneficiaries.

(2) In order to be eligible to receive funds under this article a clinic shall meet all of the following conditions, at a minimum:

(A) Provide medical diagnosis and treatment.

(B) Provide medical support services of patients in all stages of illness.

(C) Provide communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provide maintenance of patients with chronic illness.

(E) Provide prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meet one or both of the following conditions:

(i) Are located in an area or a facility federally designated as a health professional shortage area, medically underserved area, or medically underserved population.

(ii) Are clinics that are able to demonstrate that at least 50 percent of the patients served are persons with incomes at or below 250 percent of the federal poverty level.

(G) Serve as a designated primary care medical home for program beneficiaries, as described in subdivision (c) of Section 124905.

(3) Notwithstanding the requirements of paragraph (2), all clinics that received funds under this article in the 1997–98 fiscal year shall continue to be eligible to receive funds under this article.

(b) As a part of the award process for funding pursuant to this article, the department shall take into account the availability of primary care services in the various geographic areas of the state. The department shall determine which areas within the state have populations which have clear and compelling difficulty in obtaining access to primary care. The department shall consider proposals from new and existing eligible providers to extend clinic services to these populations.

(c) Each primary care clinic applying for funds pursuant to this article shall demonstrate that the funds shall be used to expand medical services, including preventive health care, and smoking prevention and cessation health education, for program beneficiaries above the level of services provided in the 1988 calendar year or in the year prior to the first year a clinic receives funds under this article if the clinic did not receive funds in the 1989 calendar year.

(d) (1) The department, in consultation with clinics funded under this article, shall develop a formula for allocation of funds available. It is the intent of the Legislature that the funds allocated pursuant to this article promote stability for those clinics participating in programs under this article as part of the state's health care safety net and at the same time be distributed in a manner that best promotes access to health care to uninsured populations.

(2) The formula shall be based on both of the following:

(A) A hold harmless for clinics funded in the 1997–98 fiscal year to continue to reimburse them for some portion of their uncompensated care.

(B) Demonstrated unmet need by both new and existing clinics, as reflected in their levels of uncompensated care reported to the department. For purposes of this article, "uncompensated care" means clinic patient visits for persons with incomes at or below 250 percent of the federal poverty level for which there is no

encounter-based third-party reimbursement which includes, but is not limited to, unpaid expanded access to primary care claims.

(3) The department shall allocate available funds, for a three-year period, as follows:

(A) Clinics that received funding in the prior fiscal year shall receive 90 percent of their prior fiscal year allocation, subject to available funds, provided that the funding award is substantiated by the clinics' reported levels of uncompensated care.

(B) The remaining funds beyond 90 percent shall be awarded to new and existing applicants based on the clinics' reported levels of uncompensated care as verified by the department according to subparagraph (B) of paragraph (4). The department shall seek input from stakeholders to discuss any adjustments to award levels that the department deems reasonable, such as including base amounts for new applicant clinics.

(C) New applicants shall be awarded funds pursuant to this subdivision if they meet the minimum requirements for funding under this article based on the clinics' reported levels of uncompensated care as verified by the department according to subparagraph (A) of paragraph (4). New applicants include applicants for any new site expansions by existing applicants.

(4) In assessing reported levels of uncompensated care, the department shall utilize the data available from the Office of Statewide Health Planning and Development's (OSHPD) completed analysis of the "Annual Report of Primary Care Clinics" for the prior fiscal year, or if more recent data is available, then the most recent data. If this data is unavailable for an existing applicant to assess reported levels of uncompensated care, the existing applicant shall receive an allocation pursuant to subparagraph (A) of paragraph (3).

(A) The department shall utilize the most recent data available from OSHPD's completed analysis of the "Annual Report of Primary Care Clinics" for the prior fiscal year, or if more recent data is available, then the most recent data.

(B) If the funds allocated to the program are less than the prior year, the department shall allocate available funds to existing program providers only.

(5) The department shall establish a base funding level, subject to available funds, of no less than thirty-five thousand dollars ($35,000) for frontier clinics and Native American

reservation-based clinics. For purposes of this article, "frontier clinics" means clinics located in a medical services study area with a population of fewer than 11 persons per square mile.

(6) The department shall develop, in consultation with clinics funded pursuant to this article, a formula for reallocation of unused funds to other participating clinics to reimburse for uncompensated care. The department shall allocate the unused funds remaining on October 30, for the prior fiscal year to other participating clinics to reimburse for uncompensated care.

(e) In applying for funds, eligible clinics shall submit a single application per clinic corporation. Applicants with multiple sites shall apply for all eligible clinics, and shall report to the department the allocation of funds among their corporate sites in the prior year. A corporation may only claim reimbursement for services provided at a program-eligible clinic site identified in the corporate entity's application for funds, and approved for funding by the department. A corporation may increase or decrease the number of its program-eligible clinic sites on an annual basis, at the time of the annual application update for the subsequent fiscal years of any multiple-year application period.

(f) Grant allocations pursuant to this article shall be based on the formula developed by the department, notwithstanding a merger of one of more licensed primary care clinics participating in the program.

(g) A clinic that is eligible for the program in every other respect, but that provides dental services only, rather than the full range of primary care medical services, shall only be eligible to receive funds under this article on an exception basis. A dental-only provider's application shall include a memorandum of understanding (MOU) with a primary care clinic funded under this article. The MOU shall include medical protocols for making referrals by the primary care clinic to the dental clinic and from the dental clinic to the primary care clinic, and ensure that case management services are provided and that the patient is being provided comprehensive primary care as defined in subdivision (a).

(h) (1) For purposes of this article, an outpatient visit shall include diagnosis and medical treatment services, including the associated pharmacy, X-ray, and laboratory services, and prevention health and case management services that are needed

as a result of the outpatient visit. For a new patient, an outpatient visit shall also include a health assessment encompassing an assessment of smoking behavior and the patient's need for appropriate health education specific to related tobacco use and exposure.

(2) "Case management" includes, for this purpose, the management of all physician services, both primary and specialty, and arrangements for hospitalization, postdischarge care, and followup care.

(i) (1) Payment shall be on a per-visit basis at a rate that is determined by the department to be appropriate for an outpatient visit as defined in this section, and shall be not less than seventy-one dollars and fifty cents ($71.50).

(2) In developing a statewide uniform rate for an outpatient visit as defined in this article, the department shall consider existing rates of payments for comparable outpatient visits. The department shall review the outpatient visit rate on an annual basis.

(j) Not later than June 1 of each year, the department shall adopt and provide each licensed primary care clinic with a schedule for programs under this article, including the date for notification of availability of funds, the deadline for the submission of a completed application, and an anticipated contract award date for successful applicants.

(k) In administering the program created pursuant to this article, the department shall utilize the Medi-Cal program statutes and regulations pertaining to program participation standards, medical and administrative recordkeeping, the ability of the department to monitor and audit clinic records pertaining to program services rendered to program beneficiaries and take recoupments or recovery actions consistent with monitoring and audit findings, and the provider's appeal rights. Each primary care clinic applying for program participation shall certify that it will abide by these statutes and regulations and other program requirements set forth in this article.

SEC. 31.2. Section 124905 of the Health and Safety Code is amended to read:

124905. (a) For purposes of this article, a "program beneficiary" is a person whose income level is at or below 250 percent of the federal poverty level, as adjusted annually, and who meets one of the following requirements:

(1) Does not currently have private or employer-based health care coverage.

(2) Is not currently enrolled in or does not qualify for public health care coverage programs, including, but not limited to, full scope Medi-Cal, the Healthy Families Program, the benefits package made available under Section 14005.333 of the Welfare and Institutions Code, subsidized coverage provided by the Managed Risk Medical Insurance Board pursuant to Part 6.45 (commencing with section 12699.201) of Division 2 of the Insurance Code, or coverage made available through the Major Risk Medical Insurance Program pursuant to Part 6.5 (commencing with section 12700) of Division 2 of the Insurance Code.

(b) Program beneficiaries shall not be required to provide any copayment for services that are funded pursuant to this article, except that clinics may charge beneficiaries on a sliding fee scale for services, but no beneficiary shall be denied services because of an inability to pay. The department shall annually adjust this income standard to reflect any changes in the federal poverty level. Payment pursuant to this article shall be made only for services for which payment will not be made through any private or public third-party reimbursement.

(c) In order to ensure that a program beneficiary has access to appropriate preventive and primary care, the beneficiary shall choose a designated primary care medical home with a primary care provider that shall maintain all of that beneficiary's medical information.

(d) In order to readily access program benefits, a program beneficiary shall be issued a primary care card pursuant to Section 124905.1 upon the determination of eligibility.

(e) The period of eligibility under this section shall extend for a one-year period from the date that eligibility is established. If the program beneficiary experiences a change in circumstances which would impact his or her eligibility, the beneficiary shall report that change within 10 days of its occurrence.

SEC. 31.3. Section 124905.1 is added to the Health and Safety Code, to read:

124905.1. On or before July 1, 2010, the department shall develop an electronic system to perform all of the following functions:

(a) Provide an eligibility application for primary clinic services made available to program beneficiaries under this article. That application shall request all information necessary to determine eligibility for those services.

(b) Verify annual income of applicants.

(c) Issue a primary care clinic card to an applicant who is determined eligible for services under this article.

SEC. 31.4. Section 124910 of the Health and Safety Code is amended to read:

124910. (a) (1) Each licensed primary care clinic, as specified in subdivision (a) of Section 124900, applying for funds under this article, shall demonstrate in its application that it meets all of the following conditions, at a minimum:

(A) Provides medical diagnosis and treatment.

(B) Provides medical support services of patients in all stages of illness.

(C) Provides communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provides maintenance of patients with chronic illness.

(E) Provides prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meets one or both of the following conditions:

(i) Is located in an area or a facility federally designated as a health professional shortage area, medically underserved area, or medically underserved population.

(ii) Is a clinic in which at least 50 percent of the patients served are persons with incomes at or below 250 percent of the federal poverty level.

(2) Any applicant who has applied for and received a federal or state designation for serving a health professional shortage area, medically underserved area, or population shall be deemed to meet the requirements of subdivision (a) of Section 124900.

(b) Each applicant shall also demonstrate to the satisfaction of the department that the proposed services supplement, and do not supplant, those primary care services to program beneficiaries that are funded by any county, state, or federal program.

(c) Each applicant shall demonstrate that it is an active Medi-Cal provider by being enrolled in Medi-Cal and diligently billing the Medi-Cal program for services rendered to Medi-Cal eligible patients during the past three months prior to the application due

date. This subdivision shall not apply to clinics that are not currently Medi-Cal providers, and were funded participants pursuant to this article during the 1993–94 fiscal year.

(d) Each application shall be evaluated by the state department prior to funding to determine all of the following:

(1) The applicant shall provide its most recently audited financial statement to verify budget information.

(2) The applicant's ability to deliver basic primary care to program beneficiaries.

(3) A description of the applicant's operational quality assurance program.

(4) The applicant's use of protocols for the most common diseases in the population served under this article.

SEC. 31.5. Section 124920 of the Health and Safety Code is amended to read:

124920. (a) In order to implement this section, the department may contract with public or private entities or utilize existing health care service provider enrollment and payment mechanisms, including the fiscal intermediary of the Medi-Cal program.

(b) The department shall certify which primary care clinics are selected to participate in the program for each specific fiscal year, and how much in program funds each selected primary care clinic will be allocated each fiscal year.

(c) The department shall pay claims from selected primary care clinics up to each clinic's annual allocation. Once a clinic has exhausted its annual allocation, the state shall stop paying its program claims.

(d) The department may adjust any selected primary care clinic's allocation to take into account:

(1) An increase in program funds appropriated for the fiscal year.

(2) A decrease in program funds appropriated for the fiscal year.

(3) A clinic's projected inability to fully spend its allocation within the fiscal year.

(4) Surplus funds reallocated from other selected primary care clinics.

(e) The department shall notify all affected primary care clinics in writing prior to adjusting selected primary care clinics' allocations.

(f) Cessation of program payments under subdivision (e) or adjustment of selected primary care clinic's allocations under subdivision (d) shall not be subject to the Medi-Cal appeals process referenced in subdivision (g) of Section 124900.

(g) A clinic's allocation under this article shall not be reduced solely because the clinic has engaged in supplemental fundraising drives and activities, the proceeds of which have been used to defray the costs of services to the uninsured.

SEC. 31.6. Section 124946 is added to the Health and Safety Code, to read:

124946. The department shall seek to maximize the availability of federal funding for services provided pursuant to this article under the terms of any existing waiver, through amendment of any existing waiver, or by means of a new waiver, or any combination thereof.

SEC. 32. Section 128745 of the Health and Safety Code is amended to read:

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988–90	3
July 1994	1989–91	6
July 1995	1990–92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical, and obstetric conditions or procedures and shall be selected by the office, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with the technical advisory committee and medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon.

The office, in consultation with the technical advisory committee and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the technical advisory committee based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' data base. Prior to any additions from the Society of Thoracic Surgeons' data base, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the office may add, delete or revise clinical data elements, but shall add no more than a net of six elements not included in the Society of Thoracic Surgeons' data base, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.

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

(2) The office shall establish a clinical data collection program to collect data on percutaneous coronary interventions, including, but not limited to, the use of angioplasty or stents, performed in hospitals. Based upon the recommendation of the clinical advisory panel established pursuant to Section 128748, the office shall establish by regulation the data to be reported by each hospital at which percutaneous coronary interventions are performed.

(3) When establishing the clinical data collection program to collect data on percutaneous coronary interventions, the office shall consider all of the following factors:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(4) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the percutaneous coronary intervention report.

(e) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(f) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.

(g) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(h) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99 percent confidence level (0.01 p-value), 95 percent confidence level (0.05 p-value), and 90 percent confidence level (0.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.

SEC. 32.5. Section 128748 of the Health and Safety Code is amended to read:

128748. (a) This section shall apply to any risk-adjusted outcome report that includes reporting of data by an individual physician.

(b) (1) The office shall obtain data necessary to complete a risk-adjusted outcome report from hospitals. If necessary data for an outcome report is available only from the office of a physician and not the hospital where the patient received treatment, then the hospital shall make a reasonable effort to obtain the data from the physician's office and provide the data to the office. In the event that the office finds any errors, omissions, discrepancies, or other problems with submitted data, the office shall contact either the hospital or physician's office that maintains the data to resolve the problems.

(2) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model. Except for data collected for purposes of testing or validating a risk-adjusted model, the office shall not collect data for an outcome report nor issue an outcome report until the clinical panel established pursuant to this section has approved the risk-adjusted model.

(c) For each risk-adjusted outcome report on a medical, surgical, or obstetric condition or procedure that includes reporting of data by an individual physician, the office director shall appoint a clinical panel, which shall have nine members. Three members shall be appointed from a list of three or more names submitted by the physician specialty society that most represents physicians performing the medical, surgical, and obstetric procedure for which data is collected. Three members shall be appointed from a list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the physician specialty society and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(d) For the clinical panels authorized by subdivision (c) for coronary artery bypass graft surgery and percutaneous coronary

intervention, three members shall be appointed from a list of three or more names submitted by the California Chapter of the American College of Cardiology. Three members shall be appointed from list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the California Chapter of the American College of Cardiology, and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians and surgeons or hospitals. The panels may include physicians from another state. The panels shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(e) Any report that includes reporting by an individual physician shall include, at a minimum, the risk-adjusted outcome data for each physician. The office may also include in the report, after consultation with the clinical panel, any explanatory material, comparisons, groupings, and other information to facilitate consumer comprehension of the data.

(f) Members of a clinical panel shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the clinical panel.

SEC. 33. Chapter 4 (commencing with Section 128850) is added to Part 5 of Division 107 of the Health and Safety Code, to read:

Chapter 4. Health Care Cost and Quality Transparency

Article 1. General Provisions

128850. The Legislature hereby finds and declares all of the following:

(a) The steady rise in health costs is eroding health access, straining public health and finance systems, and placing an undue burden on the state's economy.

(b) The effective use and distribution of health care data and meaningful analysis of that data will lead to greater transparency

in the health care system resulting in improved health care quality and outcomes, more cost-effective care, improvements in life expectancy, reduced preventable deaths, and improved overall public health.

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

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

(e) Establishing statewide data and common measurement and analysis of health care costs, quality, and outcomes will identify appropriate health care utilization and ensure the highest quality of health care services for all Californians.

(f) Comprehensive statewide data and common measurement will allow analysis on the provision of care so that efforts can be undertaken to improve health outcomes for all Californians, including those groups with demonstrated health disparities.

(g) It is therefore the intent of the Legislature that the State of California assume a leadership role in measuring performance and value in the health care system. By establishing the primary statewide data and common measurement and analyses of health care costs, quality, and outcomes, and by providing sufficient revenues to adequately analyze and report meaningful performance measures related to health care costs, safety, and quality, the Legislature intends to promote competition, identify appropriate health care utilization, and ensure the highest quality of health care services for all Californians.

(h) The Legislature further intends to reduce duplication and inconsistency in the collection, analysis, and dissemination of health care performance information within state government and among both public and private entities by coordinating health care data development, collection, analysis, evaluation, and dissemination.

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

(j) The Legislature further intends that all existing duties, powers, and authority relating to health care cost, quality, and safety data collection and reporting under current state law continue in full effect.

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

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

(b) "Committee" means the Health Care Cost and Quality Transparency Committee.

(c) "Licensed health professional in independent practice" means those licensed health professionals who can order or direct health services or expenditures for patients who are in a category eligible to bill Medi-Cal for services. This includes, but is not limited to, nurse practitioners, physician assistants, dentists, chiropractors, and pharmacists.

(d) "Data source" may include any of the following: a licensed physician, other licensed health professional in independent practice, medical provider group, health facility, health care service plan licensed by the Department of Managed Health Care, insurer certificated by the Insurance Commissioner to sell health insurance,

any state agency providing or paying for health care or collecting health care data or information, or any other payer for health care services in California.

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

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

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

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

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

(j) "Secretary" is the Secretary of California Health and Human Services.

128852. Any limitations on the addition of data elements pursuant to Chapter 1 (commencing with Section 128675) shall be inapplicable to the extent determined necessary to implement the responsibilities under this chapter. All data collected by the office shall be available to the committee and secretary for the purposes of carrying out their responsibilities under this chapter. The office shall make available to the committee any and all data files, information, and staff resources as may be necessary to assist in and support the responsibilities of the committee.

Article 2. Health Care Cost and Quality Transparency Committee

12855. There is hereby created in the California Health and Human Services Agency the California Health Care Cost and Quality Transparency Committee composed of sixteen members. The appointments shall be made as follows:

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

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

(2) One representative of private hospitals.
(3) One representative of public hospitals.
(4) One representative of a multi-specialty medical group.
(5) One representative of health insurers or health care service plans.
(6) One representative of licensed health professionals in independent practice.
(7) One representative of large employers that purchase group health care coverage for employees and that is not also a supplier or broker of health care coverage.
(8) One representative of a labor union.
(9) One representative of employers that purchase group health care coverage for their employees or a representative of a nonprofit organization that demonstrates experience working with employers to enhance value and affordability of health care coverage.
(10) One representative of pharmacists.
(b) The Senate Committee on Rules shall appoint three members as follows:
(1) One representative of a labor union.
(2) One representative of consumers with a demonstrated record of advocating health care issues on behalf of consumers.
(3) One representative of physicians and surgeons who is a practicing patient-care physician licensed in the state of California.
(c) The Assembly Speaker shall appoint three members as follows:
(1) One representative of consumers with a demonstrated record of advocating health care issues on behalf of consumers.
(2) One representative of small employers that purchase group health care coverage for employees and that is not also a supplier or broker in health care coverage.
(3) One representative of a nonprofit labor-management purchaser coalition that has a demonstrated record of working with employers and employee associations to enhance value and affordability in health care.
(d) The following members shall serve in an ex officio, nonvoting capacity:
(1) The Executive Officer of the California Public Employees Retirement System or a designee.
(2) The Director of the Department of Managed Health Care or a designee.

(3) The Insurance Commissioner or a designee.

(4) The Director of the Department of Public Health or a designee.

(5) The Director of the State Department of Health Care Services or a designee.

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

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

128857. The members of the committee shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the committee.

128858. The secretary shall provide or contract for administrative support for the committee.

128859. The committee shall do all of the following:

(a) Develop and recommend to the secretary the Health Care Cost and Quality Transparency Plan, as provided in Article 3 (commencing with Section 128865).

(b) Monitor the implementation of the Health Care Cost and Quality Transparency Plan.

(c) Issue an annual public report, on or before March 1, on the status of implementing this chapter, the resources necessary to fully implement this chapter, and any recommendations for changes to the statutes, regulations, or the transparency plans that would advance the purposes of this chapter.

128860. (a) The committee shall appoint at least one technical committee, and may appoint additional technical committees as the committee deems appropriate, and shall include on each such committee academic and professional experts with expertise related to the activities of the committee.

(b) (1) The committee shall appoint at least one clinical panel and may appoint additional panels specific to issues that require additional or different clinical expertise. Each clinical panel shall contain a majority of clinicians with expertise related to the activities of the committee and any issue under consideration and

shall also include experts in collecting and reporting data. Each clinical panel shall also include two members of the committee, one of whom shall be a representative of hospitals or health professionals and the other of whom shall be a representative of consumers, purchasers or labor unions.

(2) For the initial plan, the committee shall appoint at least one clinical panel that shall do all of the following:

(i) Issue a written report of recommendations to implement the goals set forth by the committee, including how to measure quality improvement, necessary data elements, and appropriate risk-adjustment methodology. The report shall be submitted to the committee within the time period specified by the committee. The committee shall either adopt the recommendations of the clinical panel or by a two-thirds vote of the committee reject the recommendations. If the committee rejects the recommendations, it shall issue a written finding and rationale for rejecting the recommendations. If the committee rejects the recommendations, it shall refer the issue back to the clinical panel and request additional or modified recommendations in specific areas in which the committee found the recommendations deficient.

(ii) Make recommendations to the committee concerning the specific data to be collected and the methods of collection to implement this chapter, assure that the results are statistically valid and accurate, and state any limitations on the conclusions that can be drawn from the data.

(iii) Make recommendations concerning the measures necessary to implement the reporting requirements in a manner that is cost-effective and reasonable for data sources and is reliable, timely, and relevant to consumers, purchasers, and health providers.

(c) The members of the technical committees and clinical advisory panels shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical committee or clinical advisory panel.

(d) The committee shall provide opportunities for participation from consumers and patients as well as purchasers and providers at all committee meetings.

128861. The committee, technical committee, and clinical panel members, and any contractors, shall be subject to the conflict-of-interest policy of the California Health and Human Services Agency.

Article 3. Health Care Cost and Quality Transparency Plan

128865. (a) (1) The committee shall, within one year after its first meeting, develop and recommend to the secretary an initial Health Care Cost and Quality Transparency Plan.

(2) The committee shall periodically review and recommend updates to the Health Care Cost and Quality Transparency Plan. The committee shall conduct a full review every three years, and any recommendations resulting from the review shall be subject to Section 128866.

(3) The initial plan and updates to the plan shall result in public reporting of safety, quality and cost efficiency information on the health care system. The purpose of the plan shall be to improve health care cost efficiency, improve health system performance, and promote quality patient outcomes.

(4) In developing the initial plan and updates to the plan, the committee shall review existing data gathering and reporting, including existing voluntary efforts.

(5) In developing the initial plan and updates to the plan, the committee shall obtain the recommendation of the relevant clinical panel or panels, if any, on the measures to be reported.

(b) The plan shall include, but not be limited to, strategies to:

(1) Measure, and collect data related to, health care safety and quality, utilization, health outcomes, and cost of health care services from health plans and insurers, medical groups, health facilities, licensed physicians and other licensed health professionals in independent practice.

(2) Measure each of the performance domains, including, but not limited to, safety, timeliness, effectiveness, efficiency, quality, equity, and other domains as appropriate.

(3) Develop a valid and reliable methodology for collecting and reporting cost and quality information to ensure the integrity of the data and reflect the intensity, cost, and scope of services provided and that the data is collected from the most appropriate data source.

(4) Measure and collect data related to disparities in health outcomes among various populations and communities, including racial and ethnic groups.

(5) Use and build on existing data collection standards, methods, and definitions to the greatest extent possible to accomplish the

goals of this chapter in an efficient and effective manner, including those data collected by the state and federal governments.

(6) Incorporate and utilize administrative claims data to the extent that it is the most efficient method of collecting valid and reliable data.

(7) Improve coordination, alignment, and timeliness of data collection, state and federal reporting practices and standards, and existing mandatory and voluntary measurement and reporting activities by existing public and private entities, taking into account the reporting burden on providers.

(8) Provide public reports, analyses, and data on the health care quality, safety, and performance measures of health plans and insurers, medical groups, health facilities, licensed physicians, and other licensed health professionals in independent practice, that are accurate, statistically valid, and descriptive of how the data were derived.

(9) Maintain patient confidentiality consistent with state and federal medical and patient privacy laws.

(10) Coordinate and streamline existing related data collection and reporting activities within state government.

(11) Participate in the monitoring of implementation of the plan, including a timeline and prioritization of the planned data collection, analyses and reports.

(12) Participate in the monitoring of data collection, continuous quality improvement, and reporting functions.

(13) Assess compliance with data collection requirements needed to implement this chapter.

(14) Recommend a fee schedule sufficient to fund the implementation of this chapter.

(c) The secretary may contract with a qualified public or private agency or academic institution to assist in the review of existing data collection programs or to conduct other research or analysis deemed necessary for the committee or secretary to complete and implement the Health Care Cost and Quality Transparency Plan or to meet the obligations of this chapter.

128866. (a) Within 60 days of receipt of the Health Care Cost and Quality Transparency Plan recommended by the committee, the secretary shall do one of the following:

(1) Advise the committee that the recommended plan is accepted and implementing regulations shall be drafted and submitted to

the Office of Administrative Law pursuant to the Administrative Procedures Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Refer the plan back to the committee and request additional or modified recommendations in specific areas in which the secretary finds the plan is deficient. If referred back to the committee, the secretary shall respond to any modified recommendation in the manner provided in this section.

(b) Every six years after implementation, commencing with 2014, the secretary shall report to the Legislature on the work of the committee and whether the committee should be continued in the manner described in this article or whether changes should be made to the law.

Article 4. Implementation of Health Care Cost and Quality Transparency Plan

128867. (a) After acceptance of the plan pursuant to Section 128866, the secretary shall be responsible for timely implementation of the approved plan. The secretary shall assure timely implementation by the office, which shall include, but not be limited to, the following:

(1) Provide data, information, and reports as may be required by the committee to assist in its responsibilities under this chapter

(2) Determine the specific data to be collected and the methods of collection to implement this chapter, consistent with the approved plan, and assure that the results are statistically valid and accurate as well as risk-adjusted where appropriate.

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

(4) Collect the data consistent with the data reporting requirements of the approved plan including, but not limited to, data on quality, health outcomes, cost, and utilization.

(5) Audit, as necessary, the accuracy of any and all data submitted pursuant to this chapter.

(6) Seek to establish agreements for voluntary reporting of health care claims and data from any and all health care data sources that are not subject to mandatory reporting pursuant to this chapter in

order to assure the most comprehensive systemwide data on health care costs and quality.

(7) Fully protect patient privacy and confidentiality, in compliance with state and federal privacy laws, while preserving the ability to analyze the data. Any individual patient information obtained pursuant to this chapter shall be exempt from the disclosure requirements of the Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code.

(9) Adopt the same procedures for health care providers as those specified in Section 128750 and adopt substantially similar procedures for other data sources to ensure that all data sources identified in any outcome report have a reasonable opportunity to review, comment on, and appeal any outcome report in which the data source is identified before it is released to the public.

(b) The secretary and office shall consult with the committee in implementing this chapter, and shall cooperate with the committee in fulfilling the committee's responsibility to monitor implementation activities.

(c) All state agencies shall cooperate with the secretary and the office to implement the Health Care Cost and Quality Transparency Plan approved by the secretary.

(d) The secretary or the office shall adopt regulations necessary to carry out the intent of this chapter.

128868. Nothing in this chapter shall be construed to authorize the disclosure of any confidential information concerning contracted rates between health care providers and payers or any other data source, but nothing in this section shall prevent the disclosure of information on the relative or comparative cost to payers or purchasers of health care services, consistent with the requirements of this chapter.

128869. (a) Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(b) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise

transmitted to the office pursuant to the requirements of this chapter.

(c) No communication of data or information by a data source to the committee, the secretary or the office shall constitute a waiver of privileges preserved by Sections 1156, 1156.1, or 1157 of the Evidence Code or of Section 1370 of the Health and Safety Code.

(d) Information, documents or records from original sources otherwise subject to discovery or introduction into evidence shall not be immune from discovery or introduction into evidence merely because they were also provided to the committee or office pursuant to this chapter.

128870. The office shall solicit input from interested stakeholders and convene meetings to receive input on the creation of a fee schedule to implement the provisions of this section. This stakeholder process shall occur in a manner that allows for meaningful review of the information and fiscal projections by the interested stakeholders. After the stakeholder process has been convened and used in the development of a proposal, the office shall provide the secretary with a proposal that will, to the extent possible, identify a fee schedule and other financial resources for the implementation of this chapter and allow for the recovery of costs of implementing centralized data collection, and effective analysis and reporting activities under this chapter.

(b) The schedule of fees, including specific fees charged to each data source and user, shall be approved by the Legislature and Governor in the annual Budget Act. The annual budget of the committee shall be presented and justified to the Legislature with an annual work plan including a description of the data sources, data, elements, use of the data and the number and frequency of reports to be made available.

(c) The total amount of fees charged by the office to a hospital to recover the costs of implementing this chapter, and the fees charged to that hospital pursuant to Section 127280 of the Health and Safety Code shall not exceed 0.06 percent of the gross operating cost of the hospital for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

128871. There is hereby established in the State Treasury the Health Care Cost and Quality Transparency Fund to support the

implementation of this chapter. All fees and contributions collected by the office pursuant to Section 128870 shall be deposited in this fund and used to support the implementation of this chapter. Expenditures shall be subject to appropriation in the annual Budget Act.

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

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

(b) The State Department of Health Care Services shall develop a pilot program to foster the adoption and use of electronic prescribing by health care providers that contract with Medi-Cal. The implementation of this Medi-Cal pilot is contingent upon the availability of FFP or federal grant funds. The department may provide electronic prescribing technology, including equipment and software, to participating Medi-Cal prescribers.

SEC. 34.3. Section 796.02 of the Insurance Code is amended to read:

796.02. (a) Compensation of a person retained by a disability insurer to review claims for health care services shall not be based on either of the following:

(1) A percentage of the amount by which a claim is reduced for payment.

(2) The number of claims or the cost of services for which the person has denied authorization or payment.

(b) This section shall become inoperative on December 1, 2008, and, as of January 1, 2009, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 34.5. Section 796.02 is added to the Insurance Code, to read:

796.02. (a) Compensation of a person employed by or contracted with a disability insurer to review claims or eligibility for health care services shall not be based on either of the following:

(1) A percentage of the amount by which a claim is reduced for payment.

(2) The number of claims or the cost of services for which the person has denied authorization or payment.

(b) This section shall become operative on December 1, 2008.

SEC. 34.7. Section 796.05 is added to the Insurance Code, to read:

796.05. (a) No disability insurer shall set performance goals or quotas or provide additional compensation to any person employed by or contracted with the disability insurer based on the number of persons for which coverage is rescinded or the financial savings to the disability insurer associated with the rescission of coverage.

(b) This section shall become operative on December 1, 2008.

SEC. 35. Section 10113.10 is added to the Insurance Code, to read:

10113.10. (a) Notwithstanding Section 10270.95 and except as provided in subdivision (f), a health insurer selling health insurance shall, on and after July 1, 2010, expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, premiums, or other periodic payments received by the insurer. For purposes of this section, the insurer may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the insurer the amount of income taxes or other taxes that the insurer expensed. For purposes of this section, "health care benefits" shall mean health care services that are either provided or reimbursed by the insurer or its contracted providers as benefits to its policyholders and insurers.

(b) (1) In addition to the health care benefits defined in subdivision (a), health care benefits shall include:

(A) The costs of programs or activities, including training and the provision of informational materials that are determined as part of the regulation under subdivision (d) to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(B) Disease management expenses using cost-effective evidence-based guidelines.

(C) Plan medical advice by telephone.

(D) Payments to providers as risk pool payments of pay-for-performance initiatives.

(2) Health care benefits shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2007.

(c) To assess compliance with this section, an insurer with a valid certificate of authority may average its total costs across all health insurance policies issued, amended, or renewed in California, and all health care service plan contracts issued, amended, or renewed by its affiliated health care service plans which are licensed to operate in California, except for those contracts listed in subdivision (f) of Section 1378.1 of the Health and Safety Code.

(d) The department and the Department of Managed Health Care shall jointly adopt and amend regulations to implement this section and Section 1378.1 of the Health and Safety Code to establish uniform reporting by health care service plans and insurers of the information necessary to determine compliance with this section. These regulations may include additional elements in the definition of health care benefits not identified in paragraph (1) of subdivision (b) in order to consistently operationalize the requirements of this section among health insurers and health plans, but such regulatory additions shall be consistent with the legislative intent that health insurers expend at least 85 percent of aggregate payments as provided in subdivision (a) on health care benefits.

(e) The department may exclude from the determination of compliance with the requirement of subdivision (a) any new health insurance policies for up to the first two years that these policies are offered for sale in California, provided that the commissioner determines that the new policies are substantially different from the existing policies being issued, amended, or renewed by the insurer seeking the exclusion.

(f) This section shall not apply to Medicare supplement policies, short-term limited duration health insurance policies, vision-only, dental-only, behavioral health-only, pharmacy-only policies, CHAMPUS-supplement or TRICARE-supplement insurance policies, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance policies that do not pay benefits on a fixed benefit, cash payment only basis.

SEC. 36. Section 10113.11 is added to the Insurance Code, to read:

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

(1) Obtains authorization from the applicant or insured to provide notices by electronic transmission and to cease providing notices by United States mail. "Authorization" means the agreement by the applicant, enrollee, or subscriber through interactive voice response, the Internet or other similar medium, or in writing, to receive notices by electronic transmission.

(2) Uses an authorization process, approved by the department, in which the applicant or insured confirms understanding of and agreement with the specific notices or materials that will be provided by electronic transmission.

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

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

(5) Allows the applicant or insured at any time to terminate the authorization to provide notices by electronic transmission and receive the notices through the United States mail, if specific statutory or regulatory requirements require notice by mail.

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

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

(8) Informs the applicant, enrollee, or subscriber how to terminate the authorization to provide notices sent by electronic transmission.

(b) A health insurer shall not use the electronic mail address of an applicant or insured that it obtained for the purposes of providing notice pursuant to subdivision (a) for any purpose other than communicating with the enrollee, applicant, or subscriber about his or her policy, plan, or benefits.

(c) No person other than the applicant or insured to whom the medical information in the notice pertains or a representative lawfully authorized to act on behalf of the applicant or insured, may authorize the transmission of medical information by electronic transmission. "Medical information" for these purposes shall have the meaning set forth in subdivision (g) of Section 56.05 of the Civil Code. The transmission of any medical information, as that term is used in subdivision (g) of Section 56.05 of the Civil Code, shall comply with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

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

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

(f) Notices that may be made by electronic transmission include explanation of benefits; distribution of the insurer's policies and certificates of coverage; a list of contracting providers; responses to inquiries from insureds; changes in rates pursuant to Sections 10113.7 and 10901.3; and notices related to underwriting decisions pursuant to Section 791.10. A health insurer may not transmit through electronic means any notice that may affect the eligibility for, or continued enrollment in, coverage.

SEC. 37. Section 10123.56 is added to the Insurance Code, to read:

10123.56. (a) On and after January 1, 2009, every policy of health insurance, except for a Medicare supplement policy, that covers hospital, medical, or surgical expenses on a group basis shall offer to include a Healthy Action Incentives and Rewards

Program, as described in subdivision (b), to be implemented in connection with a health insurance policy, under such terms and conditions as may be agreed upon between the group policyholder and the health insurer. Every insurer shall communicate the availability of that program to all prospective group policyholders with whom it is negotiating and to existing group policyholders upon renewal.

(b) For purposes of this section, benefits under a Healthy Action Incentives and Rewards Program shall provide for all of the following where appropriate:

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

(2) Enrollee access to an appropriate health care provider, as medically necessary, to review and address the results of the health risk appraisal. In addition, where appropriate, the Healthy Action Incentives and Rewards Program may include follow-up through a Web-based tool or a nurse hotline either in combination with a referral to a provider or separately.

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

(c) (1) An insurer subject to this section shall offer and price all Healthy Action Incentives and Rewards Programs approved by

the commissioner consistently across all groups, potential groups, and individuals and offer and price the programs without regard to the health status, prior claims experience, or risk profile of the members of a group. An insurer shall not condition the offer, delivery, or renewal of a policy that covers hospital, medical or surgical expenses on the group's purchase, acceptance or enrollment in a Healthy Action Incentives and Rewards Program. Rewards and incentives established in the program may not be designed, provided, or withheld based on the actual health service utilization or health care claims experience of the group, members of the group, or the individual.

(2) In order to demonstrate compliance with this section, a health insurer shall file the program description and design with the commissioner. The commissioner shall disapprove, suspend, or withdraw any product or program developed pursuant to this section if the commissioner determines that the product or product design has the effect of allowing insurers to market, sell, or price health coverage for healthier lower risk profile groups in a preferential manner that is inconsistent with the requirement to offer, market and sell products pursuant to Chapter 8 (commencing with Section 10700) and Chapter 9.6 (commencing with Section 10919).

(d) This section shall supplement, and not supplant, any other section in this chapter concerning requirements for insurers to provide health care services, childhood immunizations, adult immunizations, and preventive care services.

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

SEC. 38. Section 10176.15 is added to the Insurance Code, to read:

10176.15. For purposes of subdivision (d) of Section 10176.10, "comparable benefits" means any health insurance policy in the same coverage choice category, as determined by the department and the Department of Managed Health Care pursuant to Section 10930, that a closed block of business would have been in had that block of business not been closed. If the coverage benefits provided in the closed block of business do not meet or exceed the minimum

health care coverage requirements of Section 10923, they shall be deemed comparable to the lowest coverage choice category.

SEC. 39. Section 10273.6 of the Insurance Code is amended to read:

10273.6. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.

(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.

(c) Movement of the individual contractholder outside the service area but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days prior to discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, any disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market; provided, that the disability insurer notifies all affected individuals and the commissioner at least 90 days prior to the discontinuation of these plans, and that the disability insurer makes available to the individual all health benefit plans that it

makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

This section shall become inoperative on the date that Section 10937 becomes operative.

SEC. 42. Chapter 9.6 (commencing with Section 10919) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.6. INDIVIDUAL MARKET REFORM AND GUARANTEE ISSUE

10919. It is the intent of the Legislature to do both of the following:

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

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

10920. For purposes of this chapter, the following terms shall have the following meanings:

(a) "Anniversary date" means the calendar date one year from, and each subsequent year thereafter, the date an individual enrolls in a health insurance policy.

(b) "Coverage choice category" means the category of health insurance policies and health plan contracts established by the department and the Department of Managed Health Care pursuant to Section 10930.

(c) "Dependent" means the spouse, registered domestic partner, or child of an individual, subject to applicable terms of the health insurance policy covering the individual.

(d) "Health insurance policy" means an individual disability insurance policy offered, sold, amended, or renewed to individuals and their dependents that provides coverage for hospital, medical, or surgical benefits. The term shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident-only, and specified disease insurance that pays benefits on a fixed benefit, cash-payment-only basis.

(3) Credit disability, as defined in Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care coverage.

(9) Dental coverage.

(10) Vision coverage.

(11) Medicare supplement, CHAMPUS-supplement or Tricare-supplement, behavioral health-only, pharmacy-only, hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash-payment-only basis.

(e) "Health insurer" means a disability insurer that offers and sells health insurance.

(f) "Health plan" means a health care service plan, as defined in subdivision (f) of Section 1345 of the Health and Safety Code, that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of health care services and is offering or selling health care service plan contracts in the individual market. A health plan shall not include a specialized health care service plan.

(g) "Health plan contract" means an individual health care service plan contract offered, sold, amended, or renewed to individuals and their dependents and shall not include long-term care insurance, dental, or vision coverage. In addition, the term shall not include a specialized health care service plan contract, as defined in subdivision (o) of Section 1345 of the Health and Safety Code.

(h) "Purchasing pool" means the program established under Part 6.45 (commencing with Section 12699.201).

(i) "Rating period" means the period for which premium rates established by an insurer are in effect and shall be no less than 12 months beginning on the effective date of the subscriber's health insurance policy.

(j) "Risk adjustment factor" means the percentage adjustment to be applied to the standard risk rate for a particular individual,

based upon any expected deviations from standard claims due to the health status of the individual.

(k) "Risk category" means the following characteristics of an individual: age, geographic region, and family composition of the individual, plus the health insurance policy selected by the individual.

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

Under 1.

1–18.

19–24.

25–29.

30–34.

35–39.

40–44.

45–49.

50–54.

55–59.

60–64.

65 and over.

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

(2) Health insurers shall determine rates using no more than the following family size categories:

(A) Single.

(B) More than one child 18 years of age or under and no adults.

(C) Married couple or registered domestic partners.

(D) One adult and child.

(E) One adult and children.

(F) Married couple and child or children, or registered domestic partners and child or children.

(3) (A) In determining rates for individuals, a health insurer that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Health insurers shall be deemed to be operating statewide if their coverage

area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

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

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

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

(4) A health insurer may rate its entire portfolio of health insurance policies in accordance with expected costs or other market considerations, but the rate for each health insurance policy shall be set in relation to the balance of the portfolio, as certified by an actuary.

(5) Each health insurance policy shall be priced as determined by each health insurer to reflect the difference in benefit variation, or the effectiveness of a provider network, and each insurer may adjust the rate for a specific policy for risk selection only to the extent permitted by subdivision (d) of Section 10937.

(*l*) "Standard risk rate" means the rate applicable to an individual in a particular risk category.

(m) "Subscriber" means the individual who is enrolled in a health insurance policy, is the basis for eligibility for enrollment in the policy, and is responsible for payment to the health insurer.

10922. On and after March 31, 2009, a health insurer shall not offer to an individual a health insurance policy that provides less than minimum creditable coverage, as defined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50.

10925. (a) Notwithstanding Chapter 15 (commencing with Section 8899.50) of Division 1 of Title 2 of the Government Code and Section 10922, a health insurer may renew an individual health insurance policy for anyone enrolled on March 1, 2009, indefinitely without increasing benefits to meet the required minimum creditable coverage established by the Managed Risk Medical Insurance Board pursuant to Section 12739.50. Those individual health insurance policies, however, may not be offered to new enrollment, unless they are amended to meet the minimum creditable coverage established by the Managed Risk Medical Insurance Board pursuant to Section 12739.50. In offering those policies for renewal, rates determined by health insurers shall meet the requirements of Sections 10920 and 10937. An individual who maintains coverage in a health insurance policy pursuant to this section shall be deemed to be in compliance with Section 8899.50 of the Government Code.

(b) A health insurer shall not cease to renew coverage in an individual health insurance policy described in subdivision (a) except as permitted pursuant to Section 10176.10.

(c) On and after March 1, 2009, the director shall not approve for offer and sale in this state any new individual health insurance policy that does not meet or exceed the minimum creditable coverage requirements established by the Managed Risk Medical Insurance Board pursuant to Section 12739.50.

(d) Effective July 1, 2010, all individual health insurance policies approved, offered, and sold prior to March 1, 2009, that do not comply with minimum creditable coverage standards adopted by the Managed Risk Medical Insurance Board pursuant to Section 12739.50, exclusively because the policy includes a lifetime benefit maximum inconsistent with the standard minimum

creditable coverage shall be modified to comply with the standards for minimum creditable coverage.

(e) This section shall become operative on January 1, 2009.

10926. A health insurer shall, in addition to complying with the applicable provisions of this code and the applicable rules of the commissioner, comply with this chapter.

10927. This chapter shall not apply to health insurance policies for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Care Services, Healthy Families Program contracts with the Managed Risk Medical Insurance Board, long-term care coverage, specialized health care service plan contracts, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, or the purchasing pool established under Part 6.45 (commencing with Section 12699.201).

10928. (a) Except for the health insurance policies described in subdivision (a) of Section 10925, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's policies that are sold to individuals to all individuals in each service area in which the health insurer provides or arranges for the provision of health care services.

(b) A health insurer may not reject an application from an individual, or his or her dependents, for an individual health insurance policy, or refuse to renew an individual health insurance policy, if all of the following requirements are met:

(1) The individual agrees to make the required premium payments.

(2) The individual and his or her dependents who are to be covered by the health insurance policy work or reside in the service area in which the health insurer provides or otherwise arranges for the provision of health care services.

(3) The individual provides the information requested on the application to determine the appropriate rate.

(c) Notwithstanding subdivision (b), if an individual, or his or her dependents, applies for a health insurance policy in a coverage choice category for which he or she is not eligible pursuant to Section 10934, the health insurer may reject that application provided that the insurer also offers the individual and his or her dependents coverage in the appropriate coverage choice category.

(d) Notwithstanding subdivision (b), a health insurer is not required to renew an individual health insurance policy if any of the conditions listed in subdivision (a) of Section 10936 are met.

(e) Notwithstanding any other provision of this chapter or of a health insurance policy, every health insurer shall comply with the requirements of Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

(f) A health insurer may require an individual to provide information on his or her health status or health history, or that of his or her dependents, in the application for enrollment to the extent required to apply the risk adjustment factor permitted pursuant to subdivision (d) of Section 10937. The health insurer shall use the standardized form and uniform evaluation process developed for this purpose by the Director of the Department of Managed Health Care pursuant to Section 1399.840 of the Health and Safety Code. After the individual health insurance policy's effective date of coverage, a health insurer may request that the enrollee provide information voluntarily on his or her health history or health status, or that of his or her dependents, for purposes of providing care management services, including disease management services.

(g) Notwithstanding subdivision (b), a health insurer may reject an application for any person who has been a resident of California for six months or less unless one of the following applies: (1) the person is a federally eligible defined individual pursuant to Section 10785 or Section 1399.801 of the Health and Safety Code; or (2) the person can demonstrate a minimum of two years of prior creditable coverage at least equivalent to the minimum creditable coverage developed by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 and providing the person applies for coverage in California within 62 days of termination or cancellation of the prior creditable coverage.

(h) Notwithstanding subdivision (b), a health plan may reject an application for coverage from either of the following:

(1) A person who is exempt from the requirements of Section 8899.50 of the Government Code because the person or family has an income at or below 250 percent of the federal poverty level and the person's or family's share of premium for minimum creditable coverage exceeds 5 percent of his or her family income,

except for those individuals meeting the criteria in paragraph (1) or (2) of subdivision (g).

(2) A person exempted from the requirements of Section 8899.50 of the Government Code pursuant to any exemption authorized or granted by the Managed Risk Medical Insurance Board pursuant to Section 12739.501, for the time period of the exemption, as determined by the board.

(i) Notwithstanding Section 10944, this section shall not become operative until the authority under Section 12739.51 is implemented.

10929. (a) A health insurer shall not impose any preexisting condition exclusions, waivered conditions, or postenrollment waiting or affiliation periods on any health insurance policy issued, amended, or renewed pursuant to this chapter, except as provided under subdivision (b) of this section.

(b) After the requirement to guarantee issue of coverage under Section 10928 has been in effect for nine months, a health insurer may impose a preexisting condition exclusion of up to 12 months for any person who fails to comply for more than 62 days with the requirement to maintain coverage under Section 8899.50 of the Government Code, providing, however, that the exclusion may not exceed the length of time that the person failed to comply with the requirements of that section. "Preexisting condition exclusion" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the individual's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. For purposes of this section, preexisting condition provisions contained in individual health insurance policies may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

10930. (a) On or before April 1, 2009, the department and the Department of Managed Health Care shall jointly, by regulation, develop a system to categorize all health insurance polices and health plan contracts offered and sold to individuals pursuant to this chapter and Article 11.6 (commencing with Section 1399.820)

of Chapter 2.2 of Division 2 of the Health and Safety Code into five coverage choice categories. These coverage choice categories shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits.

(2) Permit reasonable benefit variation that will allow for a diverse market within each coverage choice category.

(3) Be enforced consistently between health insurers and health plans in the same marketplace regardless of licensure.

(4) Within each coverage choice category, include one standard preferred provider organization (PPO), which is the health insurance policy with the lowest benefit level in that category and for that type of contract.

(b) All health insurers shall submit the filings required pursuant to Section 10939 no later than October 1, 2009, for all individual health insurance policies to be sold on or after July 1, 2010, to comply with this chapter, and thereafter any additional health insurance policies shall be filed pursuant to Section 10939. The commissioner shall categorize each health insurance policy offered by a health insurer into the appropriate coverage choice category on or before March 31, 2010.

(c) To facilitate consumer comparison shopping, all health insurers that offer coverage on an individual basis shall offer at least one health insurance policy in each coverage choice category, including offering at least one of the standard contracts developed pursuant to paragraph (4) of subdivision (a), but a health insurer may offer multiple products in each category.

(d) If a health insurer offers a specific type of health insurance policy in one coverage choice category, it must offer that specific type of health insurance policy in each coverage choice category. A “type of health insurance policy” includes a health maintenance organization model, a preferred provider organization model, an exclusive provider organization model, a traditional indemnity model, and a point of service model.

(e) Health insurers shall have flexibility in establishing provider networks, provided that access to care standards pursuant to Section 10133.5 are met, and provided that the provider network offered for one health insurance policy in one coverage choice category

is offered for at least one health insurance policy in each coverage choice category.

(f) A health insurer shall establish prices for its products that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. A health plan shall not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category.

(g) The coverage choice category with the lowest level of benefits shall include the benefits that meet the requirements of minimum creditable coverage as determined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50.

10931. A health insurer shall offer coverage for a Healthy Action Incentives and Rewards Program that complies with the requirements of Section 10123.56 in at least one health insurance policy in every coverage choice category.

10932. When an individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the health insurance policy shall become effective no later than the first day of the following month. When that payment is either delivered or postmarked after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

10933. Except as provided in Section 10928, a health insurer is not required to offer an individual health insurance policy and may reject an application for an individual health insurance policy in the case of either of the following:

(a) The individual and dependents who are to be covered by the health insurance policy do not work or reside in a health insurer's approved service area.

(b) (1) Within a specific service area or portion of a service area, if a health insurer reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to assure that health care services will be available and accessible to the eligible individual and dependents of the individual because of its obligations to existing enrollees.

(2) A health insurer that cannot offer a health insurance policy to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a health insurance policy in the area in which the health insurer is not offering coverage to individuals until the health insurer notifies the commissioner that it has the ability to deliver services to new enrollees, and certifies to the commissioner that from the date of the notice it will enroll all individuals and groups requesting coverage in that area from the health insurer.

(c) A person who has been a resident of California for six months or less unless one of the following applies: (1) the person is a federally eligible defined individual as defined in Section 10785 or Section 1399.801 of the Health and Safety Code; or (2) the person can demonstrate a minimum of two years of prior creditable coverage at least equivalent to the minimum creditable coverage developed by the Managed Risk Medical Insurance Board pursuant to Section 12739.50 and providing the person applies for coverage in California within 62 days of termination or cancellation of the prior creditable coverage.

(d) Any person who has been granted a temporary or permanent hardship exemption from the requirement to maintain minimum creditable coverage by the Managed Risk Medical Insurance Board pursuant to subdivision (e) of Section 12739.50, during the time period of the exemption, as determined by the board.

10934. (a) If an individual disenrolls from a health insurance policy or health plan contract or if the individual's health insurance policy or health plan contract is canceled pursuant to Section 10936 or Section 1399.839 of the Health and Safety Code prior to the anniversary date of the health insurance policy or health plan contract, subsequent enrollment in an individual health insurance policy or individual health plan contract shall be limited to the same coverage choice category the individual was enrolled in prior to disenrollment or cancellation.

(b) (1) An individual may change to a health insurance policy in a different coverage choice category only on the anniversary date of the subscriber or upon a qualifying event.

(2) In no case, however, may an individual move up more than one coverage choice category on the anniversary date of the subscriber unless there is also a qualifying event.

(c) An individual health insurance policy described in subdivision (a) of Section 10925 that does not meet or exceed the minimum health care coverage requirements of Section 12739.50 shall be deemed to be the lowest coverage choice category for purposes of this section.

(d) On and after January 1, 2011, an individual who fails to comply with the provisions of Chapter 15 (commencing with Section 8899.50) of Division 1 of Title 2 of the Government Code for more than 62 days may only enroll in a health insurance policy or health plan contract in the lowest coverage choice category. Upon the individual's anniversary date, the individual may move to a higher coverage choice category pursuant to subdivision (b).

(e) For purposes of this section, a qualifying event occurs upon any of the following:

(1) Upon the death of the subscriber, on whose qualifying coverage an individual was a dependent.

(2) Upon marriage of the subscriber or entrance by the subscriber into a domestic partnership pursuant to Section 298.5 of the Family Code.

(3) Upon divorce or legal separation of an individual from the subscriber.

(4) Upon loss of dependent status by a dependent enrolled in group health care coverage through a health care service plan or a health insurer.

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

(6) Upon loss of minimum creditable coverage as defined by the Managed Risk Medical Insurance Board pursuant to Section 12739.50.

10935. The commissioner may require a health insurer to discontinue the offering of policies or acceptance of applications from any individual upon a determination by the commissioner that the health insurer does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees.

10936. All health insurance policies offered pursuant to this chapter shall be renewable with respect to all individuals and dependents at the option of the subscriber and shall not be canceled except for the following reasons:

(a) Failure to pay any charges for coverage provided pursuant to the contract if the subscriber has been duly notified and billed

for those charges and at least 15 days has elapsed since the date of notification.

(b) Fraud or intentional misrepresentation of material fact under the terms of the health insurance policy by the individual.

(c) Fraud or deception in the use of the services or facilities of the health insurer or knowingly permitting that fraud or deception by another.

(d) Movement of the subscriber outside the health insurer's service area.

(e) If the health insurer ceases to provide or arrange for the provision of health care services for new or existing individual health insurance policies in this state, provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health insurance policies in the state is provided to the commissioner and to the individual at least 180 days prior to discontinuation of that coverage.

(2) Individual health insurance policies shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a health insurer that remains in force, any health insurer that ceases to offer for sale new individual health insurance policies shall continue to be governed by this chapter with respect to business conducted under this chapter.

(3) A health insurer that ceases to write new individual health insurance policies in this state after the effective date of this section shall be prohibited from offering for sale individual health insurance policies in this state for a period of five years from the date of notice to the commissioner. The commissioner may permit a health insurer to offer and sell individual health insurance policies in this state before the five-year time period has expired if the commissioner determines that it is in the best interest of the state and necessary to preserve the integrity of the health care market.

(f) If the health insurer withdraws an individual health insurance policy from the market, provided that the health insurer notifies all affected individuals and the commissioner at least 90 days prior to the discontinuation of these health insurance policies, and that the health insurer makes available to the individual all health insurance policies with comparable benefits that it makes available to new individual business.

(g) On or after July 1, 2010, a health insurer shall not rescind the health insurance policy of any individual.

(h) Nothing in this article shall limit any other remedies available at law to a health insurer.

10937. Premiums for health insurance policies offered or delivered by health insurers on or after the effective date of this chapter shall be subject to the following requirements:

(a) The premium for new or existing business shall be the standard risk rate for an individual in a particular risk category.

(b) The premium rates shall be in effect for no less than 12 months from the date of the health insurance policy.

(c) When determining the premium rate for more than one covered individual, the health insurer shall determine the rate based on the standard risk rate for the subscriber. If more than one individual is a subscriber, the premium rate shall be based on the age of the youngest spouse or registered domestic partner.

(d) (1) Notwithstanding subdivision (a), for the first two years following the implementation of this section, a health insurer may apply a risk adjustment factor to the standard risk rate that may not be more than 120 percent or less than 80 percent of the applicable standard risk rate. In determining the risk adjustment factor, a health insurer shall use the standardized form and process developed by the Director of the Department of Managed Health Care pursuant to subdivision (f) of Section 1399.840 of the Health and Safety Code.

(2) After the first two years following the implementation of this section, the adjustments applicable under paragraph (1) shall not be more than 110 percent or less than 90 percent of the standard risk rate.

(3) Upon the renewal of any contract, the risk adjustment factor applied to the individual's rate may not be more than 5 percentage points different than the factor applied to that rate prior to renewal. The same limitation shall be applied to individuals with respect to the risk adjustment factor applicable for the purchase of a new product where the individual's prior health insurer has discontinued that product.

(4) After the first four years following the implementation of this section, a health insurer shall base rates on the standard risk rate with no risk adjustment factor.

(e) The commissioner and the Director of the Department of Managed Health Care shall jointly establish a maximum limit on the ratio between the standard risk rates for contracts for individuals in the 60 to 64 years of age, inclusive, category and contracts for individuals in the 30 to 34 years of age, inclusive, category.

10938. (a) In connection with the offering for sale of any health insurance policy to an individual, each health insurer shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The provisions concerning the health insurer's right to change premium rates on an annual basis and the factors other than provision of services experience that affect changes in premium rates.

(2) Provisions relating to the guaranteed issue and renewal of individual health insurance policies.

(3) Provisions relating to the individual's right to obtain any health insurance policy the individual is eligible to enroll in pursuant to Sections 10928 and 10934.

(4) The availability, upon request, of a listing of all the individual health insurance policies offered by the health insurer, including the rates for each health insurance policy.

(b) Every solicitor or solicitor firm contracting with one or more health insurers to solicit enrollments or subscriptions from individuals shall, when providing information on health insurance policies to an individual but making no specific recommendations on particular health insurance policies, do both of the following:

(1) Advise the individual of the health insurer's obligation to sell to any individual any health insurance policy it offers to individuals and provide him or her, upon request, with the actual rates that would be charged to that individual for a given health insurance policy.

(2) Notify the individual that the solicitor or solicitor firm will procure rate and benefit information for the individual on any health insurance policy offered by a health insurer whose policy the solicitor sells.

(c) Prior to filing an application for a particular individual health insurance policy, the health insurer shall obtain a signed statement from the individual acknowledging that the individual has received the disclosures required by this section.

10939. (a) At least 20 business days prior to offering a health insurance policy subject to this chapter, all health insurers shall file with the commissioner a statement certifying that the health insurer is in compliance with Sections 10920 and 10937. The certified statement shall set forth the standard risk rate for each risk category that will be used in setting the rates at which the contract will be offered. Any action by the commissioner to disapprove, suspend, or postpone the health insurer's use of a health insurance policy shall be in writing, specifying the reasons that the health insurance policy does not comply with the requirements of this chapter.

(b) Prior to making any changes in the standard risk rates filed with the commissioner pursuant to subdivision (a), the health insurer shall file as an amendment a statement setting forth the changes and certifying that the health insurer is in compliance with Sections 10920 and 10937. If the standard risk rate is being changed, a health insurer may commence offering health insurance policies utilizing the changed standard risk rate upon filing the certified statement unless the commissioner disapproves the amendment by written notice.

(c) Periodic changes to the standard risk rate that a health insurer proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a) or (b).

(d) Each health insurer shall maintain at its principal place of business all of the information required to be filed with the commissioner pursuant to this chapter.

(e) This section shall become operative on July 1, 2009.

10940. (a) A health insurer shall include all of the following in the statement filed pursuant to subdivision (a) of Section 10939:

(1) A summary explanation of the following for each health insurance policy offered to individuals:

(A) Eligibility requirements.

(B) The full premium cost of each health insurance policy in each risk category, as defined in subdivision (k) of Section 10920.

(C) When and under what circumstances benefits cease.

(D) Other coverage that may be available if benefits under the described health insurance policy cease.

(E) The circumstances under which choice in the selection of physicians and providers is permitted.

(F) Deductibles.
(G) Annual out-of-pocket maximums.
(2) A summary explanation of coverage for the following, together with the corresponding copayments, coinsurance, and applicable limitations for each health insurance policy offered to individuals:
(A) Professional services.
(B) Outpatient services.
(C) Preventive services.
(D) Hospitalization services.
(E) Emergency health coverage.
(F) Ambulance services.
(G) Prescription drug coverage.
(H) Durable medical equipment.
(I) Mental health and substance abuse services.
(J) Home health services.
(3) The telephone number or numbers that may be used by an applicant to access a health insurer customer service representative to request additional information about the health insurance policy.
(b) If any information provided pursuant to subdivision (a) changes, the health insurer shall provide to the commissioner, on an annual basis, an update of that information.
10941. The commissioner shall share the information provided by health insurers pursuant to this article with the Office of the Patient Advocate for purposes of the development, creation, and maintenance of the comparative benefits matrix described in Section 1399.834 of the Health and Safety Code.
10943. (a) The commissioner may issue regulations that are necessary to carry out the purposes of this chapter.
(b) Nothing in this chapter shall be construed as providing the commissioner with rate regulation authority.
10944. Sections 10922, 10925, and 10930 shall become operative on January 1, 2009, and Section 10939 shall become operative on July 1, 2009. All remaining sections of this chapter shall become operative on July 1, 2010.
SEC. 43. Section 12693.43 of the Insurance Code is amended to read:
12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family

contribution sponsor. Family contribution amounts consist of the following two components:

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

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

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

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

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

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. On and after July 1, 2009, this paragraph shall only apply to

individuals to which clause (i), but not clause (ii), of subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable.

(4) On and after July 1, 2009, twenty-five dollars ($25) per child with a maximum required contribution of seventy-five dollars ($75) per month per family for applicants with annual household income to which clause (ii) of subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable.

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

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

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

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

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph

(6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. On and after July 1, 2009, this paragraph shall only apply to individuals to which clause (i) but not clause (ii) of subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable.

(4) On and after July 1, 2009, twenty-two dollars ($22) with a maximum required contribution of sixty-six dollars ($66) per month per family for applicants with annual household income to which clause (ii) of subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable.

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

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

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

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative

Law. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative law, is hereby extended to 180 days.

SEC. 44. Section 12693.56 is added to the Insurance Code, to read:

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

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

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

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

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

SEC. 45. Section 12693.57 is added to the Insurance Code, to read:

12693.57. Every person administering or providing benefits under the program shall not elicit any information from the applicant or subscriber that is not required to carry out the provisions of law applicable to the program.

SEC. 46. Section 12693.58 is added to the Insurance Code, to read:

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

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

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

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

(e) Nothing in this part shall prohibit the disclosure of protected health information as provided in Section 164.512 of Title 45 of the Code of Federal Regulations.

(f) In the event of a conflict between this section and Section 14100.2 of the Welfare and Institutions Code, the latter section shall control.

SEC. 47. Section 12693.59 is added to the Insurance Code, to read:

12693.59. Nothing in this part shall preclude the board from soliciting voluntary participation by applicants and subscribers in

communicating with the board, or with any other party, concerning their needs as well as the needs of others who are not adequately covered by existing private and public health care delivery systems or concerning means of ensuring the availability of adequate health care services. The board shall inform applicants and subscribers that their participation is voluntary and shall inform them of the uses for which the information is intended.

SEC. 48. Section 12693.70 of the Insurance Code is amended to read:

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

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

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

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

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act, except as specified in Section 12693.76.

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

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

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

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part

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

(B) (i) All income over 200 percent of the federal poverty level but less than or equal to 250 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(ii) On and after July 1, 2009, all income over 250 percent of the federal poverty level but less than or equal to 300 percent of the federal poverty level shall also be disregarded in calculating annual or monthly household income.

(C) Prior to July 1, 2009, in a family with an annual or monthly household income greater than 250 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or

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

(D) On and after July 1, 2009, in a family with an annual or monthly household income greater than 300 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 300 percent or less of the federal poverty level, subparagraph (B) shall be applied.

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

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

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

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

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

SEC. 49. Section 12693.73 of the Insurance Code is amended to read:

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

(b) On and after July 1, 2009, children who otherwise meet eligibility requirements for the program but for their immigration status are eligible for the program.

SEC. 50. Section 12693.76 of the Insurance Code is amended to read:

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

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

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

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

(e) Notwithstanding any other provision of law, on and after July 1, 2009, a child who is otherwise eligible to participate in the program shall not be determined ineligible solely on the basis of his or her immigration status.

SEC. 51. Section 12693.766 is added to the Insurance Code, to read:

12693.766. (a) To establish that the individual meets the requirements under subdivision (b) of Section 12693.73 and subdivision (e) of Section 12693.76, the parent or caretaker relative shall sign under penalty of perjury an attestation that the individual is not described in any of the categories enumerated on the attestation for which federal financial participation for full-scope services is available.

(b) In implementing this section, the board shall consult with stakeholders, including, but not limited to, consumer advocates and counties.

(c) Nothing in this section shall be construed to limit a child's access to Medi-Cal or Healthy Families eligibility under existing law.

(d) This section shall become operative July 1, 2009.

SEC. 53. Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE CALIFORNIA COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM

Chapter 1. General Provisions

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

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

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

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

(d) "Dependent" means the spouse, child, or registered domestic partner of an individual, subject to applicable terms of the health plan contract covering the individual.

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

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

(g) "Cal-CHIPP Healthy Families plan" shall mean health care coverage provided through a health care service plan or a health insurer that provides for individuals eligible pursuant to Section

12699.211.01 of the Insurance Code, or Section 14005.301 or 14005.305 of the Welfare and Institutions Code, coverage that, at a minimum, provides the same covered services and benefits required under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) plus prescription drug benefits. Prescription drug benefits shall, at minimum, provide coverage for outpatient generic prescription drugs and brand name drugs when a prescription drug that is prescribed has no generic equivalent or when an individual is unable to achieve the desired therapeutic result with a generic drug. Prescription drug coverage may be subject to utilization controls.

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

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

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

Chapter 2. Administration

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

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

(1) Determine eligibility, enrollment, and disenrollment criteria and processes for Cal-CHIPP consistent with the eligibility

standards in Chapter 3 (commencing with Section 12699.211) and, for Cal-CHIPP Healthy Families plan enrollees, the enrollment process developed pursuant to Section 12699.211.04.

(2) Determine the participation requirements for enrollees.

(3) Determine the participation requirements and the standards and selection criteria for participating health, dental, and vision care plans, including reasonable limits on a plan's administrative costs.

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

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

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

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

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

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

(10) Determine and approve the benefit designs and cost-sharing provisions for participating health, dental, and vision care plans.

(11) Enter into contracts.

(12) Sue and be sued.

(13) Employ necessary staff.

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

(15) Issue rules and regulations, as necessary.

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

(17) Establish the criteria and procedures through which employers direct employees' premium dollars, withheld under the

terms of a cafeteria plan pursuant to Section 4801 of the Unemployment Insurance Code, to Cal-CHIPP to be credited against the employees' premium obligations.

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

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

12699.203. In developing the benefit plan designs, the board shall comply with all of the following:

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

(b) The Cal-CHIPP Healthy Families plan shall meet the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and shall include prescription drug benefits, combined with enrollee cost-sharing levels that promote prevention and health maintenance, including appropriate cost-sharing for physician office visits, diagnostic laboratory services, and maintenance medications to manage chronic diseases. Prescription drug benefits shall, at minimum, provide coverage for outpatient generic prescription drugs and brand name drugs when a prescription drug that is prescribed has no generic equivalent or when an individual is unable to achieve the desired therapeutic result with a generic drug. Prescription drug coverage may be subject to utilization controls.

(c) For individuals ineligible for a Cal-CHIPP Healthy Families plan, the board shall make available, at a minimum, one product that offers the same benefits as the minimum health care coverage defined in Section 12739.50 and one product each from coverage choice categories 3 and 5, established pursuant to Section 10930 and Section 1399.832 of the Health and Safety Code. Notwithstanding Section 1399.828 of the Health and Safety Code and Section 10927, this coverage shall be subject to the same rules as set forth in Article 11.6 (commencing with Section 1399.820) of Chapters 2.2 of Division 2 of the Health and Safety Code or as set forth in Chapter 9.6 (commencing with Section 10919) of Part 2.

(d) The board may make available, through the program, dental and vision coverage for individuals eligible for and enrolled in other health benefit coverage through the pool under this part, if the board makes all of the following determinations:

(1) Making that coverage available will provide a significant benefit for the health coverage marketplace in the state.

(2) Making that coverage available will be cost effective.

(3) The board can make that coverage available on a guarantee issue basis without undue risk of adverse selection.

(e) In determining enrollee and dependent cost-sharing for the Cal-CHIPP Healthy Families plan, the board shall consider whether those costs would deter an enrollee or his or her dependents from obtaining appropriate and timely care, including those enrollees with a low-or-moderate family income. The board shall also consider the impact of these costs on an enrollee's ability to afford health care services.

(f) The board shall consult with the Insurance Commissioner, the Director of the Department of Managed Health Care, and the Director of Health Care Services. As a condition of eligibility for the Cal-CHIPP Healthy Families plan, enrollees shall provide all necessary information and documentation to meet the minimum federal requirements necessary for federal claiming.

12699.204. (a) The board may adjust premiums at a public meeting of the board after providing, at minimum, 60 days' public notice of the adjustment. In making the adjustment, the board shall take into account the costs of health care typically paid for by employers and employees in California.

(b) The following premiums shall apply to coverage under this part for the population eligible for coverage pursuant to Section 12699.211.01 of the Insurance Code and Sections 14005.301 and 14005.305 of the Welfare and Institutions Code.

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

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

(c) For health care coverage made available pursuant to this part for enrollees ineligible for a Cal-CHIPP Healthy Families

plan, the applicable premiums shall be commensurate with the full premium cost of the coverage choice made by the enrollee. However, enrollees eligible for the state health care tax credit established pursuant to Section 17052.30 of the Revenue and Taxation Code may reduce their premiums by the value of the credit. The board shall provide an additional contribution equal to 20 percent of the premium of a tier 1 product in the pool, at a minimum, to employees with incomes at or above 250 percent of the federal poverty level whose employers pay into the fund *and where the individual is not enrolled in or eligible for health expenditures that may be credited against any required employer health care contribution*. The amount of this contribution may be applied to any product offered by the California Cooperative Health Insurance Purchasing Program except the Cal-CHIPP Healthy Families plan.

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

12699.204.1. The board shall limit enrollment in the Cal-CHIPP Heathy Families plan to individuals who are eligible under Sections 14005.301 and 14005.305 of the Welfare and Institutions Code and to individuals eligible under Section 12699.211.01 with a family income greater than 100 percent of the federal poverty level.

12699.206. (a) The board shall negotiate with Medi-Cal managed care plans to obtain affordable coverage for eligible enrollees. Nothing in this subdivision shall limit the ability of the board to contract with other licensed health care service plans or health insurers holding a valid certificate of authority.

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

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

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

(2) Procure products directly through the prescription drug purchasing program established pursuant to Chapter 12

(commencing with Section 14977) of Part 5.5 of Division 3 of Title 2 of the Government Code.

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

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

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

(2) A board of trustees or plan administrator responsible for providing or delivering health care coverage pursuant to a collective bargaining agreement, memorandum of understanding, or other similar agreement with a labor organization. Nothing in this section shall modify, alter or amend the fiduciary duties of these entities under applicable federal and state laws.

(d) Notwithstanding this section, any licensed health care service plan shall be subject to all statutory and regulatory requirements applicable to coverage for prescription drugs under the Knox-Keene Health Care Service Plan Act of 1975.

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

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

(c) Nothing in this section shall be construed to prohibit the disclosure of information about applicants and enrollees, or their household members, if express written authorization for the

disclosure has been provided by the person to whom the information pertains or, if that person is a minor, authorization has been provided by the minor's parent or other adult with legal custody of the minor.

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

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

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

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

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

12699.208.01. Participating carriers may contract with agents or brokers to provide marketing and servicing of health benefits coverage offered through the program. Any commissions set and paid pursuant to this section shall be determined by the participating carrier and the agent or broker.

12699.208.02. (a) In addition to the duties specified in Section 12699.202, the board shall coordinate with the Franchise Tax Board in the administration of the tax credit established by Section 17052.30 of the Revenue and Taxation Code.

(b) The board shall, on behalf of an enrollee who is a qualified taxpayer as defined in Section 17052.30 of the Revenue and

Taxation Code, pay any premium credit advance that may be authorized to that qualified taxpayer or to the participating health plan in which the enrollee receives coverage for himself or herself or for his or her dependents.

(c) A participating health plan providing coverage pursuant to this part shall credit payments under this section against the enrollee's premium.

(d) In administering this section the board shall:

(1) Exchange information, including the total amount of qualified premiums paid by each taxpayer during the calendar year, total amount of any premium credit advances paid to or on behalf of each taxpayer during the calendar year, the specific average premium amounts by age category for a plan from coverage choice category 3 offered pursuant to subdivision (c) of Section 12699.203, and other necessary or appropriate information, with the Franchise Tax Board solely for the purpose of the administration and enforcement of Section 17052.30 of the Revenue and Taxation Code and any premium credit advance that may be authorized.

(2) Administer any premium credit advance that may be authorized.

(3) Establish the form and manner by which a qualified taxpayer applies for any premium credit advance that may be authorized, which shall include the provision of the applicant's social security number or other taxpayer identification number.

(4) Provide each qualified taxpayer an annual statement regarding premiums paid and any premium credit advances that may be authorized to be paid to the qualified taxpayer or to a participating plan on behalf of the qualified taxpayer.

(e) For purposes of this section, "premium credit advance" means any premium credit advance that may be authorized in accordance with the intent reflected in Section 17052.31 of the Revenue and Taxation Code.

12699.209. The board shall consult and coordinate with the State Department of Health Care Services in seeking federal financial support for Cal-CHIPP Healthy Families coverage provided pursuant to this part. To the extent that the state obtains federal financial support for that subsidized coverage, the coverage shall be subject to the terms, conditions, and duration of any applicable state plan amendment or waiver. To the extent required

to obtain federal financial support, the board shall apply citizenship, immigration, and identity documentation standards required in Title XIX of the federal Social Security Act.

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

Chapter 3. Eligibility

12699.211. To be eligible to enroll in Cal-CHIPP, an individual must be a resident of the state pursuant to Section 244 of the Government Code or physically present in the state, having entered the state with an employment commitment or to obtain employment, whether or not employed at the time of application to Cal-CHIPP or after enrollment in Cal-CHIPP. In addition, to be eligible to enroll in Cal-CHIPP, an individual must meet one of the following requirements:

(a) Be an employee or a dependent of an employee of an employer who elected to pay *the full contribution* into the California Health Trust Fund.

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

(c) Be an individual described in Section 12699.211.01.

(d) Be an employee or his or her dependent paying the full cost of health care coverage through an employee tax savings plan established pursuant to Section 4801 of the Unemployment Insurance Code, where the employer designates Cal-CHIPP in the cafeteria plan.

(e) Be eligible for a state tax credit made available pursuant to Section 17052.30 of the Revenue and Taxation Code.

12699.211.01. (a) Eligibility for coverage under this part shall be available through enrollment in the Cal-CHIPP Healthy Families plan to a population composed of individuals who meet all of the following requirements:

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

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

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

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

(5) Is ineligible for the Medi-Cal program.

(6) Is not offered employer-sponsored health care coverage or where ~~there is no financial contribution toward the premium by the employer on behalf of the employee~~ *the individual is enrolled in or eligible for health expenditures that may be credited against any required employer health care contribution*.

(b) Implementation of this section is contingent on the establishment of a county share of cost.

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

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

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

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

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

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

12699.211.03. The board may, through regulations adopted pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, allow individuals who enrolled in coverage under this chapter and who would be otherwise ineligible to continue that coverage, to be eligible for extended coverage for a period of time established by the board, not to exceed 18 months from the date of ineligibility, if the individual pays the entire cost for the coverage. Coverage extension policies under this section may not increase coverage costs for other pool participants. The board may differentiate or delimit eligibility or conditions for such continuation coverage, as well as the rating factors used, depending on the basis of initial eligibility and the coverage options available to that person.

12699.211.04. The State Department of Health Care Services, in consultation with the board, shall convene a stakeholders group to develop an outreach and enrollment process for the purchasing pool program that is cost effective and coordinated with the Medi-Cal and Healthy Families programs, in order to ensure seamless access to coverage through these programs for eligible Californians. The process and procedures shall be subject to implementation through future legislative action. The involved stakeholders shall include, but not be limited to, legislative staff, counties, consumer organizations, labor organizations, and others as appropriate. In developing the procedures, items to be considered shall include, but not be limited to, simplicity and ease of enrollment, current enrollment practices, quality, accuracy, competence, customer service, cost-effectiveness, need for automation, problem resolution, timeliness, and ensuring that federal requirements regarding screening and enrollment processes and procedures are met. Implementation of the process shall be contingent on funding being appropriated for this purpose.

Chapter 4. Fiscal

12699.212. (a) The California Health Trust Fund is hereby created in the State Treasury for the purpose of the Health Care Security and Cost Reduction Act. 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.

12699.216. The board, subject to federal approval and an appropriation therefor, shall pay the nonfederal share of cost from the fund for individuals eligible under that federal approval. Revenues in the fund shall be used, upon appropriation, to the extent allowable under federal law, as state matching funds for receipt of federal funds.

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. 54. Part 6.7 (commencing with Section 12739.50) is added to Division 2 of the Insurance Code, to read:

PART 6.7. MINIMUM CREDITABLE COVERAGE

12739.50. (a) On or before March 1, 2009, the Managed Risk Medical Insurance Board shall establish, by regulation, the definition of minimum creditable coverage for purposes of compliance with the requirement in Section 8899.50 of the Government Code. On or before March 1, 2009, the board shall also establish, by regulation, the standards for minimum creditable coverage that at a minimum apply to the individual health insurance market. The standards set by the board pursuant to this section shall ensure that minimum creditable coverage at least includes coverage for physician, hospital, and preventive services and is at a minimum inclusive of existing coverage requirements under law.

(b) The board shall consult with the Director of the Department of Managed Health Care and the Insurance Commissioner in developing the standards for minimum creditable coverage.

(c) In establishing the standards for minimum creditable coverage, including the scope of services, enrollee and dependent deductible, copayment requirements, and coverage of services outside the deductible, the board shall consider all of the following:

(1) The degree to which minimum creditable coverage protects individuals subject to the requirement of Section 8899.50 of the Government Code and health purchasers from catastrophic medical costs.

(2) The extent to which cost sharing, including any deductible, coinsurance, or copayment requirements, would deter an enrollee or his or her dependents from obtaining appropriate and timely care, including consideration of coverage for prevention services that would not be subject to any deductible. The board shall consider the importance of encouraging periodic health evaluations and the use of services that have been shown to be effective in detecting ~~or preventing serious illness~~*, preventing, or managing serious illness and chronic conditions*.

(3) The affordability of the minimum policy for individuals who are subject to the requirements of Section 8899.50 of the Government Code, taking into account deductibles, coinsurance, copayments, and total out-of-pocket costs, and the extent to which

the resulting premium cost would prevent an individual from obtaining coverage at a reasonable price.

(4) The extent to which and under what circumstances benefits offered or provided by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means may be included in or qualify as meeting the requirement to maintain minimum creditable coverage under Section 8899.50 of the Government Code.

12739.501. (a) A person or family who has an income at or below 250 percent of the federal poverty level shall be exempt from the requirements established in Section 8899.50 of the Government Code if the person's or family's share of the premium for 8899.50 minimum creditable coverage exceeds 5 percent of his or her family's income.

(b) In addition to the exemption pursuant to subdivision (a), the board shall adopt regulations by January 1, 2010, to establish *and review* affordability and hardship standards for purposes of the requirements in Section 8899.50 of the Government Code. In developing these standards, the board shall consider all of the following:

(1) The availability of public coverage, subsidies, and tax credits for low-income individuals and families.

(2) Total out-of-pocket costs associated with minimum creditable coverage, including premiums, copays, coinsurance, and deductibles.

(3) The percentage or amount of a taxpayer's adjusted gross income that the individual would be required to contribute toward premiums for health care.

(4) The percentage of family income that persons insured across all health care markets currently spend on their health care premiums, copays, coinsurance, and deductibles.

(5) The percentage of insured persons who meet or exceed their deductibles.

(6) The impact of the premium amount on the ability of an individual or family to afford other necessities of life, including, but not limited to, expenses for housing, utilities, food, clothing, child care, transportation, education, and taxes. It is the intent of the Legislature that an individual's contributions toward health care coverage premiums not interfere with his or her ability to pay for basic necessities of life.

(7) The effect of the exemption criteria on premium levels for all health care coverage purchasers.

(8) Specific circumstances and conditions that could make it a temporary hardship for an individual to be required to purchase minimum creditable coverage, such as significant increases in basic living expenses because of unexpected changes in family circumstances, expenses or living arrangements or hardship that results from a fire, flood, natural disaster or other unexpected natural or human-caused event causing substantial household or personal damage.

(c) The board shall develop a process for considering requests for exemptions for affordability and hardship and for granting those exemptions if the board determines that the purchase or continuation of minimum creditable coverage would create an undue hardship on an individual or family. The board shall consider the offering of both temporary and continuing hardship exemptions and shall establish the timelines and the process whereby an individual and family must obtain coverage after the expiration of a temporary exemption and the board shall establish an individual's rights and responsibilities related to obtaining that coverage. Individuals who are granted an exemption by the board shall not be subject to the requirements of Section 8899.50 of the Government Code for the period prescribed by the board.

(d) The board shall track and identify, to the extent feasible, the number of individuals who are exempted from the mandate to maintain minimum creditable coverage in Section 8899.50 of the Government Code as a result of the exemptions developed by the board, including the specific types and categories of those exemptions, and report the information to the Legislature and to the Director of the Department of Managed Health Care to be used in establishing the reinsurance mechanisms in Section 1399.844 of the Health and Safety Code.

12739.51. (a) On or before January 1, 2010, the Managed Risk Medical Insurance Board shall establish and maintain an active statewide education and awareness program to inform all California residents of their obligation under Section 8899.50 of the Government Code, including informing them of the options available to obtain affordable coverage through public programs, the state purchasing pool, and commercial coverage.

(b) The board, in consultation with the State Department of Health Care Services, shall identify and implement methods and strategies to establish multiple entry points and opportunities for enrollment in public or private coverage, as appropriate, for individuals subject to Section 8899.50 of the Government Code. The board shall work with state and local agencies, health care providers, health plans, employers, consumer groups, community organizations, and other appropriate stakeholders to establish point-of-service methods to facilitate enrollment of individuals who do not have or maintain minimum creditable coverage as required under Section 8899.50 of the Government Code. The board shall identify and implement in state-administered health care programs, to the greatest extent practicable and permissible under federal law, best practices for streamlined eligibility and enrollment.

(c) The board shall establish methods by which individuals who have not obtained health care coverage shall be informed of the method available to obtain affordable coverage through public programs, the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, and commercial coverage. The board shall also establish methods to ensure that uninsured individuals obtain the minimum creditable coverage. The board shall pay the cost of health care coverage on behalf of a previously uninsured individual who is enrolled in minimum creditable coverage by the board after being uninsured for at least 62 days, and the board shall establish methods by which funds advanced for coverage may be recouped by the state from individuals for whom coverage is purchased. The board may enter into an agreement with the Franchise Tax Board to use the Franchise Tax Board's civil authority and procedures in compliance with notice and other due process requirements imposed by law to collect funds owed to the state that were advanced to individuals pursuant to this subdivision.

(d) To the extent possible, activities undertaken pursuant to subdivision (c) shall be based on existing reporting processes employed throughout the state to report on the employment and tax status of individuals and other existing mechanisms. Relevant state agencies shall cooperate with the board and other responsible entities in undertaking these activities and implementing this section.

(e) The board may enter into agreements with other agencies or departments to perform the activities required under this section. Prior to entering into any agreements, the board shall report to the Legislature on the activities to be undertaken pursuant to subdivision (c). The report shall include the method by which individuals with and without coverage are identified, the method by which persons are to be given notice of the availability of coverage and the timeframe to enroll, the actions that will be taken to enroll uninsured persons, and the actions that will be taken if persons do not enroll in minimum creditable coverage. The board shall submit the required report by March 15, 2010.

(f) The board shall adopt regulations, as appropriate, to implement this section.

(g) Implementation of *any of the provisions of* this section shall be contingent on the appropriation of funds for the purposes of this section in the annual Budget Act or another statute.

SEC. 55. 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 program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment. An employer who pays the premium for the employee in the program established pursuant to Part 6.45 (commencing with Section 12699.201) shall not, on the basis of that action, be deemed to be in violation of this section.

SEC. 56. Section 12887 is added to the Insurance Code, to read:

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

SEC. 57. Section 96.8 is added to the Labor Code, to read:

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

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

SEC. 57.1. Section 17052.30 is added to the Revenue and Taxation Code, to read:

17052.30. (a) (1) For each taxable year beginning on or after January 1, 2010, and before January 1, 2015, there shall be allowed as a credit against the "net tax," as defined in Section 17039, an amount equal to those qualified health care plan premium costs that are in excess of 5.5 percent of a qualified taxpayer's adjusted gross income for the taxable year.

(2) The amount of credit otherwise allowed under paragraph (1) shall be reduced by 1 percent for every 2 percent by which the qualified taxpayer's adjusted gross income exceeds 300 percent of the applicable federal poverty level.

(3) No credit shall be allowed under this section to a qualified taxpayer with adjusted gross income in excess of 400 percent of the applicable federal poverty level.

(4) (A) In the case of any taxpayer who is not a qualified taxpayer for the entire taxable year, the allowable credit under paragraph (1) shall be computed by first dividing the total adjusted gross income of the qualified taxpayer by 12, and then multiplying that amount by the number of months during the taxable year that the taxpayer is a qualified taxpayer.

(B) Paragraphs (2) and (3) shall apply to any taxpayer described in subparagraph (A), without the adjustment required under subparagraph (A).

(C) The maximum amount of credit for any month computed pursuant to this paragraph shall not exceed the maximum monthly credit amount prescribed in paragraph (5).

(5) (A) The maximum annual and monthly allowable credit amounts for health care premiums shall be as follows:

Maximum Annual Credit Amount

Age	Single	Subscriber & Spouse	Subscriber & Child	Subscriber & Children	Family
19–29	$0	$665	$629	$816	$1,500
30–34	$135	$1,457	$962	$1,410	$2,634
35–39	$441	$2,069	$1,034	$1,608	$3,093
40–44	$909	$2,600	$1,088	$1,725	$3,687
45–49	$1,071	$3,338	$1,268	$1,914	$4,263
50–54	$1,755	$4,679	$1,988	$2,607	$5,370
55–59	$2,646	$6,335	$3,104	$3,444	$6,954
60–64	$3,762	$8,090	$4,112	$4,740	$8,772

Children only	1 child	2 children	3+ children
<1	$0	$0	$264
1-18	$0	$0	$0

Maximum Monthly Credit Amount

Age	Single	Subscriber & Spouse	Subscriber & Child	Subscriber & Children	Family
19–29	$0	$55	$52	$68	$125
30–34	$11	$121	$80	$118	$220
35–39	$37	$172	$86	$134	$258
40–44	$76	$217	$91	$144	$307
45–49	$89	$278	$106	$160	$355
50–54	$146	$390	$166	$217	$448
55–59	$221	$528	$259	$287	$580
60–64	$314	$674	$343	$395	$731

Children only	1 child	2 children	3+ children
<1	$0	$0	$22
1-18	$0	$0	$0

(B) For each taxable year beginning on or after January 1, 2010, the Franchise Tax Board shall recompute the maximum annual and monthly credit amounts reflected in subparagraph (A) to reflect the change in the California Consumer Price Index, U Medical Care, from July 1, 2007, to June 30 of the calendar year

immediately preceding the beginning of the taxable year for which the recomputation is to be made.

(C) The Department of Industrial Relations shall transmit annually to the Franchise Tax Board, no later than August 1 of the current calendar year, the percentage change in the California Consumer Price Index, U Medical Care, from July 1 of the prior calendar year to June 30 of the current calendar year.

(D) Notwithstanding any other provision of this section or any premium credit advance that may be authorized in accordance with the intent reflected in Section 17052.31, the maximum allowable amount of either of those credits shall not exceed the applicable maximum credit amounts identified in subparagraph (A), as recomputed in accordance with subparagraph (B).

(b) For purposes of this section:

(1) "Adjusted gross income" means adjusted gross income as computed for purposes of Section 17072.

(2) (A) "Federal poverty level" has the same meaning as poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services pursuant to Section 9902(2) of Title 42 of the United States Code.

(B) For purposes of determining the applicable federal poverty level, family size equals the sum of the number of individuals, including a taxpayer, spouse, and each dependent reported on the return for the taxable year.

(3) "MRMIB" means the Managed Risk Medical Insurance Board in its capacity in administering the program established pursuant to Article 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

(4) "Premium for a plan from coverage choice category 3" means the monthly average cost, as determined and updated annually by the MRMIB, of a health care service plan contract or health insurance policy from coverage choice category 3 of the products offered by MRMIB pursuant to subdivision (c) of Section 12699.203 of the Insurance Code for the applicable age category. *This health care service plan contract or health insurance policy shall be one that covers prescription drugs, physician visits, and preventive services, including the services to manage chronic conditions, outside of any deductible.* The MRMIB shall provide to the Franchise Tax Board the specific premium amounts for this

plan for purposes of determining the qualified health care plan premium cost, as described in paragraph (6) of this subdivision.

(5) "Qualified health care plan" means any health plan, other than a Cal-CHIPP Healthy Families Plan, purchased through the MRMIB pursuant to subdivision (c) of Section 12699.203 of the Insurance Code that provides health care coverage to satisfy the requirements established pursuant to Section 8899.50 of the Government Code for a qualified taxpayer, his or her spouse, or their dependents, including any health insurance policy or health care service plan contract.

(6) "Qualified health care plan premium costs" means amounts paid by the qualified taxpayer during the taxable year for a qualified health care plan that are equal to 75 percent of the lesser of either of the following:

(A) The qualified premiums paid during the taxable year by the qualified taxpayer.

(B) The monthly premium for a plan from coverage choice category 3 multiplied by the number of months during the taxable year that the taxpayer is a qualified taxpayer.

(7) "Qualified premiums" means the amounts paid by a qualified taxpayer to purchase a qualified health care plan through the MRMIB for coverage for the period during which the taxpayer is a qualified taxpayer. Any premium credit advance, as may be authorized in accordance with the intent reflected in Section 17052.31, used by the MRMIB to pay all or a portion of premiums payable of a qualified taxpayer, shall be considered "qualified premiums."

(8) (A) "Qualified taxpayer" means any taxpayer whose adjusted gross income for the taxable year is at least 250 percent, but not in excess of 400 percent, of the applicable federal poverty level for the calendar year that begins in the taxable year for which the credit is claimed.

(B) (i) Except as provided in clause (ii), any taxpayer who is eligible to receive coverage under a group health plan that is offered through the taxpayer's employment or through the employment of the taxpayer's spouse for which the employer pays any portion of the cost *or where the individual is enrolled in or eligible for health expenditures that may be credited against any required employer health care contribution* is not a qualified taxpayer under

subparagraph (A) during any period that the taxpayer is eligible to receive coverage as described in this subparagraph.

(ii) A taxpayer shall be considered a qualified taxpayer if the group health plan described in clause (i) does not provide coverage with respect to one or more dependents of the taxpayer, but only to the extent of the qualified health care plan premium costs paid by the taxpayer with respect to those dependents.

(C) Any taxpayer who is eligible to receive coverage under the Cal-CHIPP Healthy Families Plan pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code or the Medi-Cal program established pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code is not a qualified taxpayer under subparagraph (A) during any period that the taxpayer is eligible to receive coverage as described in this subparagraph.

(9) "Dependent" means dependent as defined in Section 8899.50 of the Government Code.

(c) In the case of a married couple, the credit allowed by this section shall be claimed on a joint return.

(d) In the case where the credit allowed under this section exceeds the "net tax," the excess shall be credited against other amounts due, if any, by the qualified taxpayer and the balance, if any, shall, upon appropriation by the Legislature, be refunded to the qualified taxpayer.

(e) The Franchise Tax Board, in consultation with the MRMIB, may prescribe those regulations as may be necessary or appropriate to carry out the purposes of this section.

(f) (1) ~~All amounts deposited into~~ *Appropriate amounts in* the California Health Trust Fund established pursuant to Section 12699.212 of the Insurance Code shall, upon appropriation by the Legislature, be transferred as follows:

(A) To the MRMIB for purposes of advancing the refundable credit for the purchase of health care plan premiums.

(B) To the Franchise Tax Board for the purpose of recovering the amounts expended from the Tax Relief and Refund Account for amounts claimed as credits against tax liability and amounts in excess of tax liability as authorized under subdivision (d).

(2) The Franchise Tax Board shall notify the MRMIB of the aggregate amount of tax credits allowed pursuant to subdivision (a) in each fiscal quarter.

(g) (1) No credit shall be allowed under this section for any taxable year in the disallowance period.

(2) For purposes of this section, the "disallowance period" is either of the following:

(A) The period of two taxable years after the most recent taxable year for which there was a final determination that the taxpayer's claim of credit under this section was due to fraud.

(B) The period of two taxable years after the most recent taxable year for which there was a final determination that the taxpayer's claim of credit under this section was due to reckless or intentional disregard of rules and regulations, but not due to fraud.

(h) This section shall remain in effect only until December 31, 2015, and as of that date is repealed.

SEC. 57.2. Section 17052.31 is added to the Revenue and Taxation Code, to read:

17052.31. It is the intent of the Legislature to enact legislation to authorize the credit under Section 17052.30 to be advanceable.

SEC. 57.3. Section 17052.32 is added to the Revenue and Taxation Code, to read:

17052.32. It is the intent of the Legislature to enact legislation to authorize a health care coverage credit for persons who are between the ages of 50 and 64, inclusive, and are not qualified taxpayers as defined in paragraph (8) of subdivision (b) of Section 17052.30, to the extent fiscal resources are available, not to exceed fifty million dollars ($50,000,000) annually, subject to an appropriation.

SEC. 57.4. Section 19167 of the Revenue and Taxation Code is amended to read:

19167. A penalty shall be imposed under this section for any of the following:

(a) In accordance with Section 6695(a) of the Internal Revenue Code, for failure to furnish a copy of the return to the taxpayer, as required by Section 18625.

(b) In accordance with Section 6695(c) of the Internal Revenue Code, for failure to furnish an identifying number, as required by Section 18624.

(c) In accordance with Section 6695(d) of the Internal Revenue Code, for failure to retain a copy or list, as required by Section 18625 or for failure to retain an electronic filing declaration, as required by Section 18621.5.

(d) Failure to register as a tax preparer with the California Tax Education Council, as required by Section 22253 of the Business and Professions Code, unless it is shown that the failure was due to reasonable cause and not due to willful neglect.

(1) The amount of the penalty under this subdivision for the first failure to register is two thousand five hundred dollars ($2,500). This penalty shall be waived if proof of registration is provided to the Franchise Tax Board within 90 days from the date notice of the penalty is mailed to the tax preparer.

(2) The amount of the penalty under this subdivision for a failure to register, other than the first failure to register, is five thousand dollars ($5,000).

(e) The Franchise Tax Board shall not impose the penalties authorized by subdivision (d) until either one of the following has occurred:

(1) Commencing January 1, 2006, and continuing each year thereafter, there is an appropriation in the Franchise Tax Board's annual budget to fund the costs associated with the penalty authorized by subdivision (d).

(2) (A) An agreement has been executed between the California Tax Education Council and the Franchise Tax Board that provides that an amount equal to all first year costs associated with the penalty authorized by subdivision (d) shall be received by the Franchise Tax Board. For purposes of this subparagraph, first year costs include, but are not limited to, costs associated with the development of processes or systems changes, if necessary, and labor.

(B) An agreement has been executed between the California Tax Education Council and the Franchise Tax Board that provides that the annual costs incurred by the Franchise Tax Board associated with the penalty authorized by subdivision (d) shall be reimbursed by the California Tax Education Council to the Franchise Tax Board.

(C) Pursuant to the agreement described in subparagraph (A), the Franchise Tax Board has received an amount equal to the first year costs described in that subparagraph.

(f) (1) In accordance with Section 6695(g) of the Internal Revenue Code, as modified by paragraphs (2) and (3), for failure to be diligent in determining eligibility for the refundable credit authorized under Section 17052.30.

(2) The amount of the penalty imposed under this subdivision shall be one thousand dollars ($1,000) for each failure.

(3) For purposes of the penalty imposed under this subdivision, the due diligence requirements imposed by the Secretary of the Treasury under Section 6695(g) of the Internal Revenue Code, and any regulations promulgated thereunder, shall be modified by the Franchise Tax Board through instructions or notices.

SEC. 57.5. Section 19528.5 is added to the Revenue and Taxation Code, to read:

19528.5. (a) Notwithstanding any other law, the Franchise Tax Board may establish an agreement with the Managed Risk Medical Insurance Board under which the MRMIB provides a report to the Franchise Tax Board, at a time and in the manner prescribed by the Franchise Tax Board, the following information with respect to every individual that purchased a health care plan through the MRMIB in the calendar year:

(1) Name.

(2) Address or addresses of record.

(3) Social security number or other taxpayer identification number.

(4) Total amount of health care plan premiums paid in the calendar year.

(5) Total amount of premium credit advances, as may be authorized in accordance with the intent reflected in Section 17052.31, for purchase of premiums in the calendar year.

(b) The reports required under this section shall be transmitted through a secure electronic process in a form and manner as shall be jointly determined by the MRMIB and the Franchise Tax Board.

(c) Information provided to the Franchise Tax Board by the MRMIB shall be used only for tax administration purposes and shall be deemed to be return information within the meaning of Section 19549.

SEC. 57.6. Section 19553.5 is added to the Revenue and Taxation Code, to read:

19553.5. (a) Subject to the limitations of this section and federal law, including Section 6103 of the Internal Revenue Code, the Franchise Tax Board may provide the Managed Risk Medical Insurance Board with information obtained from a state income tax return for purposes of verifying income, filing status, and number of dependents of an applicant for health care plan coverage

obtained through the MRMIB. Use of the information provided under this section shall be limited to determining eligibility for premium credit advances, as may be authorized in accordance with the intent reflected in Section 17052.31.

(b) Neither the MRMIB nor any officer, employee, or agent, or former officer, employee, or agent, of the MRMIB may disclose or use any information obtained from the Franchise Tax Board pursuant to this section except for the purposes of administering health care plan coverage for taxpayers.

SEC. 57.7. Section 19611 of the Revenue and Taxation Code is amended to read:

19611. (a) The Tax Relief and Refund Account is hereby created in the General Fund. Notwithstanding Section 13340 of the Government Code, all moneys in the Tax Relief and Refund Account are hereby continuously appropriated, without regard to fiscal year, to the Franchise Tax Board for purposes of making all payments as provided in this section.

(b) Notwithstanding any other law, all payments required to be made to taxpayers or other persons from the Personal Income Tax Fund shall be paid from the Tax Relief and Refund Account.

(c) The Controller shall transfer, as needed, to the Tax Relief and Refund Account:

(1) From the unexpended balance of the annual Budget Act appropriation for Item 9100-101-001, Schedule 80-Renter's Tax Relief, an amount determined by the Franchise Tax Board to be equivalent to the total amount of renters' assistance credits and refunds allowed under Section 17053.5.

(A) If there is no unexpended balance of the appropriation, as provided for in paragraph (1), the Controller shall transfer sufficient moneys from the Personal Income Tax Fund to make the renters' assistance credits and refunds until there is an unexpended balance.

(B) Subsequent to there being no unexpended balance of the appropriation, as provided for in paragraph (1), and there being a transfer of moneys from the Personal Income Tax Fund to make the renters' assistance credits and refunds, reimbursement shall be made from the unexpended balance of the appropriation as provided for in paragraph (1) to the Personal Income Tax Fund. However, if no such appropriation is subsequently made, reimbursement shall be made from the General Fund.

(2) From the disability fund, the amount transferable to the General Fund pursuant to subdivision (a) of Section 1176.5 of the Unemployment Insurance Code.

(3) From the Personal Income Tax Fund, such additional amounts as determined by the Franchise Tax Board to be necessary to make the payments required under this section.

(4) Upon appropriation by the Legislature, the following transfers shall be made:

(A) From the unexpended balance of the California Health Trust Fund established pursuant to Section 12699.215 of the Insurance Code, an amount determined by the Franchise Tax Board to be equivalent to the total amount of health care premium credits allowed under Section 17052.30.

(B) If there is no unexpended balance of the California Health Trust Fund, as provided for in this paragraph, the Controller shall, upon appropriation by the Legislature, transfer sufficient moneys from the Personal Income Tax Fund for credits allowed under Section 17052.30.

(C) Subsequent to there being no unexpended balance of the California Health Trust Fund, as provided for in this paragraph, and there being a transfer of moneys from the Personal Income Tax Fund to allow the health care premium credits, reimbursement shall, upon appropriation by the Legislature, be made from the unexpended balance of the California Health Trust Fund, as provided for in this paragraph, to the Personal Income Tax Fund. However, if no such appropriation is subsequently made, reimbursement shall, upon appropriation by the Legislature, be made from the General Fund.

SEC. 58. Section 301.1 is added to the Unemployment Insurance Code, to read:

301.1. (a) The Employment Development Department shall establish data collection and reporting methods and requirements, compatible with existing forms and filings that employers submit to the department, to collect and report information related to employer health expenditures on behalf of their employees.

(b) The Employment Development Department shall report on the data collected pursuant to subdivision (a) to the Managed Risk Medical Insurance Board and to the Legislature on an annual basis commencing April 1, 2011.

(c) The Employment Development Department may adopt regulations to implement this section as needed.

SEC. 58.5. Section 1120 is added to the Unemployment Insurance Code, to read:

1120. Any employer who fails to establish or maintain a cafeteria plan as required by Section 4801 shall pay a penalty of one hundred dollars ($100) per employee for the failure to establish or maintain a cafeteria plan without good cause, or five hundred dollars ($500) per employee if the failure to establish or maintain a cafeteria plan is willful.

SEC. 59. Division 1.2 (commencing with Section 4800) is added to the Unemployment Insurance Code, to read:

DIVISION 1.2. HEALTH CARE TAX SAVINGS PLAN

4800. This division shall be known and may be cited as the Health Care Tax Savings Plan.

4801. (a) Each employer of one or more employees in this state shall, beginning January 1, 2010, adopt and maintain a cafeteria plan, within the meaning of Section 125 of the Internal Revenue Code, to allow all employees to pay premiums for health care coverage to the extent amounts for that coverage are excludable from the gross income of the employee under Section 106 of the Internal Revenue Code.

(b) The establishment or maintenance of a cafeteria plan shall neither be inconsistent with Section 125 of Title 26 of the United States Code, nor require any employer to take any action that would violate Section 125 of Title 26 of the United States Code.

(c) For the purposes of this division, the following definitions apply:

(1) “Employee” means an employee as defined in Article 1.5 (commencing with Section 621) of Chapter 3 of Part 1 of Division 1.

(2) “Employer” means an employer as defined in Article 3 (commencing with Section 675) of Chapter 3 of Part 1 of Division 1, except as described in subdivision (a) of Section 683 and in subdivision (a) of Section 685.

(3) “Employing unit” means an “employing unit” as defined in Section 135.

(4) "Employment" means employment as defined in Article 1 (commencing with Section 601) of Chapter 3 of Part 1 of Division 1. "Employment" does not include services excluded under Section 632, subdivision (c) of Section 634.5, and Sections 640, 641, 643, 644, and 644.5.

(d) The department shall promulgate rules and regulations to implement the provisions of this division.

SEC. 60. Section 12306.1 of the Welfare and Institutions Code is amended to read:

12306.1. (a) When any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium under Section 12301.6, then the county shall use county-only funds to fund both the county share and the state share, including employment taxes, of any increase in the cost of the program, unless otherwise provided for in the annual Budget Act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect unless and until, prior to its implementation, the department has obtained the approval of the State Department of Health Services for the increase pursuant to a determination that it is consistent with federal law and to ensure federal financial participation for the services under Title XIX of the federal Social Security Act, and unless and until all of the following conditions have been met:

(1) Each county has provided the department with documentation of the approval of the county board of supervisors of the proposed public authority of nonprofit consortium rate, including wages and related expenditures. The documentation shall be received by the department before the department and the State Department of Health Services may approve the increase.

(2) Each county has met department guidelines and regulatory requirements as a condition of receiving state participation in the rate.

(b) Any rate approved pursuant to subdivision (a) shall take effect commencing on the first day of the month subsequent to the month in which final approval is received from the department. The department may grant approval on a conditional basis, subject to the availability of funding.

(c) The state shall pay 65 percent, and each county shall pay 35 percent, of the nonfederal share of wage and benefit increases negotiated by a public authority or nonprofit consortium pursuant

to Section 12301.6 and associated employment taxes, only in accordance with subdivisions (d) to (f), inclusive.

(d) (1) The state shall participate as provided in subdivision (c) in wages up to seven dollars and fifty cents ($7.50) per hour and individual health benefits up to sixty cents ($0.60) per hour for all public authority or nonprofit consortium providers. This paragraph shall be operative for the 2000–01 fiscal year and each year thereafter unless otherwise provided in paragraphs (2), (3), (4), and (5), and without regard to when the wage and benefit increase becomes effective.

(2) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to nine dollars and ten cents ($9.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the nine dollars and ten cents ($9.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative for the 2001–02 fiscal year and each fiscal year thereafter, unless otherwise provided in paragraphs (3), (4), and (5).

(3) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to ten dollars and ten cents ($10.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the ten dollars and ten cents ($10.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which paragraph (2) became operative.

(4) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to eleven dollars and ten cents ($11.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided

for in subdivision (c) of Section 12301.6, what portion of the eleven dollars and ten cents ($11.10) per hour shall be used to fund wage increases or individual health benefits, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (3) became operative.

(5) (A) The state shall participate as provided in subdivision (c) in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the twelve dollars and ten cents ($12.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both.

(B) In addition to participating in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour as provided for in subparagraph (A), and in addition to the amount up to sixty cents ($0.60) per hour provided for in paragraph (1), the state shall participate in an additional twenty-five cents ($0.25) per hour so long as the additional funds under this subparagraph are used to increase funding for individual health benefits. This subparagraph shall become inoperative when subparagraph (C) goes into effect.

(C) In addition to participating in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour as provided for in subparagraph (A), and in addition to the amount up to sixty cents ($0.60) per hour provided for in paragraph (1), the state shall participate in an additional fifty cents ($0.50) per hour so long as the additional funds under this subparagraph are used to increase funding for individual health benefits. This subparagraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which subparagraph (B) became operative. This subparagraph shall become inoperative when subparagraph (D) goes into effect.

(D) In addition to participating in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour as provided for in subparagraph (A), and in addition to the amount up to sixty cents ($0.60) per hour provided for in paragraph (1), the state shall participate in an additional seventy-five cents ($0.75) per hour so long as the additional funds under this subparagraph are used to increase funding for individual health benefits. This subparagraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which subparagraph (C) became operative.

(e) (1) On or before May 14 immediately prior to the fiscal year for which state participation is provided under paragraphs (2) to (5), inclusive, of subdivision (d), the Director of Finance shall certify to the Governor, the appropriate committees of the Legislature, and the department that the condition for each subdivision to become operative has been met.

(2) For purposes of certifications under paragraph (1), the General Fund revenue forecast, excluding transfers, that is used for the relevant fiscal year shall be calculated in a manner that is consistent with the definition of General Fund revenues, excluding transfers, that was used by the Department of Finance in the 2000–01 Governor's Budget revenue forecast as reflected on Schedule 8 of the Governor's Budget.

(f) Any increase in overall state participation in wage and benefit increases under paragraphs (2) to (5), inclusive, of subdivision (d), shall be limited to a wage and benefit increase of one dollar ($1) per hour with respect to any fiscal year. With respect to actual changes in specific wages and health benefits negotiated through the collective bargaining process, the state shall participate in the costs, as approved in subdivision (c), up to the maximum levels as provided under paragraphs (2) to (5), inclusive, of subdivision (d).

(g) In any county with employee representation, the employee representative may elect to provide health benefits through a trust fund and the public authority or nonprofit consortium shall agree to ~~those terms~~ *that term*.

(h) The recipient of in-home supportive services shall not be deemed the employer for purposes of any employer fee that may

be established to finance the expansion of health care coverage to provide coverage to all Californians. *Any such employer fee requirement shall be met in the same manner as provided in Section 12302.2.*

SEC. 61. Section 14005.30 of the Welfare and Institutions Code is amended to read:

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

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

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

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

(2) To the extent that federal financial participation is available, the department shall exercise its option under Section

1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to simplify eligibility for Medi-Cal under subdivision (a) by exempting all resources for applicants and recipients, commencing July 1, 2010.

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

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

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

SEC. 62. Section 14005.301 is added to the Welfare and Institutions Code, to read:

14005.301. (a) The department shall provide benefits pursuant to Section 14005.306 to a population composed of parents and

other caretaker relatives who meet all of the following requirements:

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

(2) The individual is not otherwise eligible for full-scope benefits under Section 14005.30 but would be eligible for these benefits if family income were at or below 100 percent of the federal poverty level.

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

(b) The eligibility determination under this section shall not include an asset test.

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

(d) The department shall seek federal approval to utilize the same premiums and copayments for the population described in this section as are applied to the population eligible for the Cal-CHIPP Healthy Families plan established pursuant to Section 12699.204 of the Insurance Code.

(e) To the extent necessary to implement this section and Section 14005.305, the department shall seek federal approval to waive the deprivation requirement or to modify the definition of unemployed parent provided in Section 14008.85.

(f) This section shall be implemented only if and to the extent that federal approval to provide benchmark benefits in a manner consistent with Section 14005.306 has been obtained.

(g) The income test for eligibility determinations under this section shall be the same test used for the federal poverty level programs, but shall not include any income disregards available under those programs.

(h) This section shall become operative on July 1, 2010, or on the date that the authority under Section 12739.51 is implemented, whichever is later.

SEC. 63. Section 14005.305 is added to the Welfare and Institutions Code, to read:

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

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

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

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

(b) The eligibility determination under this section shall not include an asset test.

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

(d) The department shall seek federal approval to utilize the same premiums and copayments for the population to whom this section applies as are applied to the population established pursuant to Section 12699.211.01 of the Insurance Code.

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

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

(g) This section shall become operative on July 1, 2010, or on the date that Section 12739.51 of the Insurance Code is implemented, whichever is later, but only to the extent federal financial participation is available.

SEC. 64. Section 14005.306 is added to the Welfare and Institutions Code, to read:

14005.306. (a) Subject to the limitations provided in subdivisions (b) and (c), a Medi-Cal beneficiary with a net family income above 100 percent of the federal poverty level whose eligibility is based on Section 14005.301 or Section 14005.305 and who is otherwise eligible for full-scope benefits, shall receive his or her benefits by means of a benchmark package pursuant to Section 1937 of the federal Social Security Act. This package shall be the Cal-CHIPP Healthy Families benefit package established for the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

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

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

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

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

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

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

SEC. 65. Section 14005.310 is added to the Welfare and Institutions Code, to read:

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

SEC. 66. Section 14005.311 is added to the Welfare and Institutions Code, to read:

14005.311. (a) The department and the Managed Risk Medical Insurance Board shall enter into an interagency agreement under which the board shall have authority and responsibility for administering benchmark benefits under Sections 14005.301 and 14005.305 and for prescribing all rules and procedures necessary for administering these benefits subject to the single state agency oversight responsibilities of the department and consistent with the process developed pursuant to Section 12699.211.04 of the Insurance Code.

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

SEC. 67. Section 14005.331 is added to the Welfare and Institutions Code, to read:

14005.331. (a) An individual under the age of 19 years who would be eligible for full-scope Medi-Cal benefits without a share of cost, if not for his or her immigration status, shall be eligible for full-scope Medi-Cal services under this section.

(b) To establish that the individual meets the immigration requirements under this section, the parent or caretaker relative shall sign under penalty of perjury an attestation that the individual is not described in any of the categories enumerated on the attestation for which federal financial participation for full-scope services is available.

(c) In implementing this section, the department shall consult with stakeholders, including, but not limited to, consumer advocates and counties.

(d) Nothing in this section shall be construed to limit a child's access to Medi-Cal or Healthy Families eligibility under existing law.

(e) Implementation of this section is contingent upon an appropriation for the purposes of this section in the annual Budget Act or another statute.

(f) This section shall become operative on July 1, 2009.

SEC. 68. Section 14005.333 is added to the Welfare and Institutions Code, to read:

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

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

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

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

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

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

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

(5) They are not offered employer-sponsored health care coverage or ~~where there is no financial contribution toward the premium by the employer on behalf of the employee~~ *the individual is enrolled in or eligible for health expenditures that may be credited against any required employer health care contribution*.

(d) Benefits available under this section shall consist of a benefit package that is designed by the department and is equivalent to the Cal-CHIPP Healthy Families plan coverage defined in subdivision (g) of Section 12699.201 that is made available in the purchasing pool established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code. To the extent that specific services are excluded from the subsidized package, these services are not required to be provided under this section to the population described under subdivision (c). These excluded services shall include, but are not limited to, long-term care services, nursing home care, personal care services, in-home supportive services, and home- and community-based or other waiver services.

(e) In determining eligibility for benefits under this section, the department shall use the application requirements and the income methodology of the federal poverty level programs for pregnant

women and children, including the income deductions and exemptions applicable under those programs, but shall not include any income disregards available under those programs.

(f) Notwithstanding Section 14007.2 or any other provision of law, this section creates no right or entitlement for any individual to receive any service including any emergency service, unless that individual has been determined to meet all of the eligibility requirements in subdivision (c) and the documentation and verification requirements in subdivision (g).

(g) In order for an otherwise eligible individual to be eligible for, or to receive, any service, including, but not limited to, any emergency service under this section, the individual shall be required to meet all of the minimum federal requirements necessary for federal claiming by furnishing all necessary information and providing all necessary documentation.

(h) Except to the extent required by the terms of any applicable federal waiver, federal Medicaid rights, including the right to retroactive eligibility, do not apply to persons or services under this section.

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

(j) Implementation of this section is contingent on the establishment of a county share of cost.

(k) This section shall become operative on July 1, 2010, or on the date that the authority under Section 12739.51 of the Insurance Code is implemented, whichever is later.

SEC. 69. Section 14011.16 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

(g) This section shall become inoperative upon implementation of Section 14011.16.1 and shall remain inoperative for as long as that section continues to be implemented.

SEC. 70. Section 14011.16.1 is added to the Welfare and Institutions Code, to read:

14011.16.1. (a) Commencing July 1, 2010, the department shall implement a requirement for any beneficiary who is not required to make premium payments to file a semiannual address verification report. The department shall develop a simplified form to be used for this purpose so that a beneficiary who has not had a change of address can so indicate by checking a box and returning the form.

(b) When a beneficiary who is required to complete and return the form described in subdivision (a) fails to do so, the county shall follow up by attempting to contact the individual using the last known phone number or numbers. If the attempted phone contact fails to resolve the issue by providing confirmation of the

current address, the county shall search available files to determine if an alternate or new address has been used by the beneficiary and shall send a form to that address that is required to be returned. In the absence of a new or alternate address, a form shall be sent to the last known address. If the form is not returned, or if it is returned under circumstances indicating that the individual no longer resides at the address last provided by the individual and no forwarding address is provided, eligibility shall be terminated for loss of contact.

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

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

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

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

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

SEC. 71. Section 14074.5 is added to the Welfare and Institutions Code, to read:

14074.5. The department shall seek to maximize the availability of federal funding for the costs of providing Cal-CHIPP Healthy Families coverage to non-Medi-Cal beneficiaries through the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

SEC. 72. Section 14081.6 is added to the Welfare and Institutions Code, to read:

14081.6. If Article 5.21 (commencing with Section 14167.1) or Article 5.22 (commencing with Section 14167.31), or both, become inoperative, hospitals shall be paid for services rendered to Medi-Cal beneficiaries at the rates that were in effect on June

30, 2010, including the rates paid pursuant to the provisions of this article.

SEC. 73. Section 14092.5 is added to the Welfare and Institutions Code, to read:

14092.5. (a) (1) The director shall establish a local coverage option program to provide Medi-Cal coverage for low-income adults eligible pursuant to Section 14005.333. The program shall meet the requirements of this section.

(2) For a four-year period beginning with the first month of operation of a local coverage option program in a county under this section, the local coverage option program shall be the exclusive Medi-Cal coverage available for the individuals who reside in the county and who are eligible Medi-Cal beneficiaries under Section 14005.333.

(b) Local coverage option programs shall only be implemented in counties that operate designated public hospitals where the county elects to operate a local coverage option program and the department approves the county's application. Counties operating a local coverage option shall provide coverage for those eligible individuals described in Section 14005.333 who reside in the county.

(1) All covered services shall be provided by designated public hospitals, their affiliated public providers, and primary care clinics licensed under subdivision (a) of Section 1204 of the Health and Safety Code, except with respect to those medically necessary services that are not available or accessible through these providers. Local coverage option programs shall contract with primary care clinics licensed under subdivision (a) of Section 1204 of the Health and Safety Code in the county and provide reimbursement for covered services to the extent and as required by federal law. Each enrollee shall be assigned a medical home at a public provider affiliated with a public hospital or at a primary care clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code. Local coverage option programs shall contract with additional providers, including safety net providers such as disproportionate share hospitals, for services to enrollees as necessary to comply with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or other provisions of law.

(2) Counties may only provide coverage in a local coverage option through a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975. The local coverage option may include any one of the following:

(A) Direct operation through a county-operated licensed health care service plan.

(B) Operation through a local initiative, created pursuant to Section 14087.31, 14087.35, or 14087.38 that is licensed as a health care service plan.

(C) Operation through a county organized health system described in Section 14087.51 or 14087.54 that is licensed as a health care service plan.

(3) The department shall issue a request for applications from applicable counties and shall approve applications based on the criteria set forth in subdivisions (g) and (h).

(4) The department shall enter into contracts with those counties that have had their applications approved by the department.

(5) In implementing this section, the department may enter into contracts for the provision of essential administrative and other services.

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

(B) An entity receiving payment under subparagraph (A), including a unit or subunit of county government, shall not transfer any portion of the payments received to the county or to any other unit of government; provided, however, that retention of those funds by the entity receiving payments under subparagraph (A) for use in either the current or subsequent fiscal year is allowable. Retained funds may be commingled with county funds for cash management or related purposes, provided that those funds are appropriately tracked and only the depositing entity is authorized to expend them.

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

(d) In consultation with participating counties, the director shall design a common identification card to be provided by the county to each enrollee in a local coverage option program.

(e) Each county, local initiative, or county organized health system that operates a local coverage option program shall be entitled to periodic payments per individual who resides in the county who is an eligible Medi-Cal beneficiary under Section 14005.333 and is enrolled in the local coverage option program. Rates for those payments shall be determined by the department and shall meet the requirements of Section 14301.1. During the first three years of operation, the department shall offer the local coverage option program the option of a contract provision that sets a specified dollar threshold that, if exceeded, allows the local coverage option program to share with the state the risk and gains of providing coverage through a risk corridor agreement that sets boundaries on profits or losses by the local coverage option program above and below the specified dollar thresholds as set forth in the contract between the department and the local coverage option program. The risk corridor agreement shall provide that if the profits or losses incurred by the local coverage option program exceed an initial specified dollar threshold, the local coverage option program and the state shall share in the profits or losses, and that if the profits or losses incurred by the local coverage option program exceed a final specified dollar threshold such profits or losses shall be allocated entirely to the state. The dollar thresholds and corridors for profits and losses shall be the same amount.

(f) All providers that provide out of network emergency services to local coverage option program enrollees shall accept as payment in full payments they receive from the local coverage option program that comply with Section 1396u-2(b)(2)(D) of Title 42 of the United States Code regarding maximum payments for those services.

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

(1) Enrolled patient population.

(2) The use of medical services.

(3) Access and barriers to health care.

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

(5) Patient satisfaction.

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

(1) Designation of a medical home and assignment of eligible individuals to a primary care provider within 60 days of enrollment. For purposes of this paragraph, "medical home" means a single provider or facility that maintains all of an individual's medical information. The primary care provider shall be a provider from which the enrollee can access primary and preventive care, or specialty care as determined appropriate by a medical professional.

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

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

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

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

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

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

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

(i) After three years of operation of a local coverage option program in a county, the department shall conduct a review using the local coverage option program assessment tool to evaluate each county's performance against the benchmarks established under subdivisions (g) and (h). If the department determines that the local

coverage option program in a particular county has substantially met the benchmarks, the director shall extend the local coverage option program in that county for an additional two years. If the department concludes that a county failed to substantially meet the benchmarks, the county's local coverage option program shall cease to be the exclusive coverage option as provided in paragraph (2) of subdivision (a). The county shall have the opportunity for an administrative hearing pursuant to Section 100171 of the Health and Safety Code, and for judicial review of the department's determination.

(j) (1) After four years of operation of a local coverage option program in a county, if the local coverage option program in a county substantially met the benchmarks pursuant to subdivision (i), Medi-Cal beneficiaries enrolled in the local coverage option program shall have the ability to disenroll from the local coverage option program and enroll in either the county organized health system or one of the two-plan contractors in the county.

(2) After five years of operation of a local coverage option program in a county, newly enrolled Medi-Cal beneficiaries described in Section 14005.333 shall have the ability to enroll in either the local coverage option program or the county organized health system or one of the two-plan contractors in the county, if available in the county. If the newly eligible Medi-Cal beneficiary fails to select a health plan within the time specified by the director, the beneficiary shall be enrolled in the local coverage program, if available in the county.

(k) (1) Notwithstanding the Medi-Cal managed care program requirements of Chapters 4 and 4.1 of Title 22 of the California Code of Regulations, the director may authorize local coverage option programs to offer a limited network of providers pursuant to this section.

(2) Notwithstanding the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and if consistent with the authority and requirements of subdivision (a) of Section 1344 of the Health and Safety Code, the Director of Managed Health Care may authorize local coverage option programs to offer a limited network of providers pursuant to this section.

(3) In implementing this subdivision, the directors shall find the action to be in the public interest and not detrimental to the protection of patients.

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

(m) The department shall seek any federal waivers or obtain approval from the Centers for Medicare and Medicaid Services of a state plan amendment as necessary to allow for federal financial participation under this section. This section shall only be implemented if and to the extent that federal financial participation is available.

(n) Implementation of this section is contingent on establishment of a county share of cost.

SEC. 74. Section 14132.105 is added to the Welfare and Institutions Code, to read:

14132.105. (a) (1) The department shall establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under the Medi-Cal program.

(2) The benefits described in this section shall only be provided under the terms and conditions determined by the department, and shall meet all the requirements described in subdivision (b).

(b) For purposes of this section, the Healthy Action Incentives and Rewards Program shall include, but need not be limited to, all of the following:

(1) Health risk appraisals that collect information from eligible beneficiaries to assess overall health status and identify risk factors, including, but not limited to, smoking and smokeless tobacco use, alcohol abuse, drug use, nutrition, and physical activity practices.

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

(3) Incentives or rewards or both for eligible beneficiaries to become more engaged in their health care and to make appropriate choices that support good health, including obtaining health risk appraisals, screening services, immunizations, or participating in health lifestyle programs or practices. These programs or practices may include, but need not be limited to, smoking cessation, physical activity, or nutrition. Incentives may include, but need not be limited to, nonmedical pharmacy products or services not

otherwise covered under this chapter, gym memberships, and weight management programs.

(c) The department shall seek and obtain federal financial participation and secure all federal approvals, including all required state plan amendments or waivers, necessary to implement and fund the services authorized under this section.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and has been obtained.

SEC. 75. Section 14137.10 is added to the Welfare and Institutions Code, to read:

14137.10. (a) (1) There is hereby established in the department the Comprehensive Diabetes Services Program to provide comprehensive diabetes prevention and management services to any individual who meets the requirements set forth in paragraph (2). For purposes of this subdivision, "comprehensive diabetes prevention and management services" shall be defined by the department based on consultation pursuant to subdivision (b). Services may include, but need not be limited to, all of the following:

(A) Screening for diabetes and prediabetes in accordance with the operational screening guidelines and protocols developed for the Comprehensive Diabetes Services Program utilizing the most current American Diabetes Association criteria for diabetes in adults.

(B) Providing visits by certified practitioners in accordance with the operational protocols developed for the Comprehensive Diabetes Service Program for eligible beneficiaries who have been diagnosed with prediabetes.

(C) Providing culturally and linguistically appropriate lifestyle coaching and self-management training for eligible adult beneficiaries with prediabetes and diabetes, in accordance with evidence-based interventions, to avoid unhealthy blood sugar levels that contribute to the progression of diabetes and its complications.

(D) Conducting regular and timely laboratory evaluations, by the primary care physician of the eligible beneficiary, in conjunction with a program of blood sugar level self-management education and training for eligible adult beneficiaries who have been diagnosed with prediabetes and diabetes.

(2) A beneficiary is eligible for services pursuant to this section if he or she is all of the following:

(A) Between 18 and 64 years of age.

(B) Not dually enrolled in the Medi-Cal program and the federal Medicare program.

(C) Diagnosed with prediabetes or diabetes.

(D) Otherwise eligible for full scope of benefits under this chapter but not enrolled in a Medi-Cal managed care plan.

(b) The department shall seek and obtain federal financial participation and secure all federal approvals, including all required state plan amendments or waivers, necessary to implement and fund the services authorized under this section.

(c) For the purposes of implementation of this section, the director may enter into contracts for the purposes of providing the benefits offered under the Comprehensive Diabetes Services Program.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and has been obtained.

(e) The Comprehensive Diabetes Services Program shall be developed and implemented only to the extent that state funds are appropriated annually for the services provided under this section.

(f) The department shall develop and implement incentives for Medi-Cal fee-for-service eligible beneficiaries who participate in the Comprehensive Diabetes Services Program and are compliant with program requirements for screening and self-management activities.

(g) The department shall develop and implement financial incentives for Medi-Cal fee-for-service providers who participate in the Comprehensive Diabetes Services Program and are compliant with program requirements in the screening and management of eligible beneficiaries who have been diagnosed with prediabetes and diabetes.

(h) The department shall collect data including, but not be limited to, laboratory values from screening and diagnostic tests for the individual beneficiaries participating in the Comprehensive Diabetes Services Program and monitor the health outcomes of the participating individual beneficiaries.

(i) The department shall, in consultation with the California Diabetes Program in the State Department of Public Health, contract with an independent organization to:

(1) Evaluate and report the health outcomes and cost savings of the Comprehensive Diabetes Services program.

(2) Estimate the short- and long-term cost savings of expanding the strategies of the Comprehensive Diabetes Services Program statewide through the private or commercial insurance markets.

SEC. 76. Article 5.21 (commencing with Section 14167.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.21. Medi-Cal Hospital Rate Stabilization Act

14167.1. For purposes of this article, the following definitions shall apply:

(a) "Acute inpatient day" means a fee-for-service day, as defined for purposes of the Office of Statewide Health Planning and Development reporting by hospitals, for which the hospital has been paid by the Medi-Cal program where the Medi-Cal program is the primary payer.

(b) "Base period" means the 12-month period ending on the base period ending date. However, in the case of a hospital that terminates a contract for the provision of hospital inpatient services negotiated with the California Medical Assistance Commission after the date this article is enacted and prior to the base period ending date, the base period shall be the 12-calendar months prior to the contract termination date.

(c) "Base period ending date" means the last day of the sixth month immediately preceding the implementation date.

(d) "Contract hospital" means a hospital that has a written contract with a managed health care plan to provide hospital services to the plan's subscribers or enrollees.

(e) "Designated public hospital" means any one of the following hospitals:

(1) UC Davis Medical Center.

(2) UC Irvine Medical Center.

(3) UC San Diego Medical Center.

(4) UC San Francisco Medical Center.

(5) UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center.
(6) LA County Harbor/UCLA Medical Center.
(7) LA County Olive View UCLA Medical Center.
(8) LA County Rancho Los Amigos National Rehabilitation Center.
(9) LA County University of Southern California Medical Center.
(10) Alameda County Medical Center.
(11) Arrowhead Regional Medical Center.
(12) Contra Costa Regional Medical Center.
(13) Kern Medical Center.
(14) Natividad Medical Center.
(15) Riverside County Regional Medical Center.
(16) San Francisco General Hospital.
(17) San Joaquin General Hospital.
(18) San Mateo Medical Center.
(19) Santa Clara Valley Medical Center.
(20) Ventura County Medical Center.

(f) "Hospital community" means the California Hospital Association and any other hospital industry organization or system that represents children's hospitals, nondesignated public hospitals, designated public hospitals, private safety net hospitals, and other public or private hospitals.

(g) "Hospital inpatient services" means all services covered under the Medi-Cal program and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services include physician services only if the service is furnished to a hospital inpatient, the physician is compensated by the hospital for the service, and the service is billed to the Medi-Cal program by the hospital under a provider number assigned to the hospital. Hospital inpatient services do not include inpatient mental health services for which a county is financially responsible or services furnished under a managed health care plan.

(h) "Hospital outpatient services" means all services covered under the Medi-Cal program furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services include physician services only if the service is furnished to a hospital outpatient, the physician is compensated by the hospital for the service, and the service is billed to the Medi-Cal program by the hospital under a provider number assigned to the hospital. Hospital outpatient services do not include outpatient mental health services for which a county is financially responsible or services furnished under a managed health care plan.

(i) "Implementation date" means the first day on which hospitals provide health care services to Medi-Cal beneficiaries that are reimbursed under this article.

(j) "Inpatient base rate" means the per diem rate, or per discharge rate if used by the department, established pursuant to Section 14167.4.

(k) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries. Managed health care plans include, but are not limited to, county organized health systems and entities contracting with the department to provide services pursuant to two-plan models, geographic managed care, and prepaid plans. Entities providing these services contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8.

(*l*) "Market basket index" means the percentage increase used by the Medicare Program for the purpose of determining payment rates for acute care inpatient hospital services as described in Section 1886(b)(3)(B)(ii) of the federal Social Security Act.

(m) "Medi-Cal fee-for-service payments" means all payments made by the Medi-Cal program to hospitals as reimbursement for hospital inpatient services furnished with respect to acute inpatient days, including payments for both routine and ancillary services, and payments described in subdivision (e) of Section 14167.4, but

excluding payments described in subdivision (f) of Section 14167.4.

(n) "New hospital" means a hospital that did not provide hospital inpatient services to Medi-Cal beneficiaries under current or prior ownership and has no history of Medi-Cal reimbursement.

(o) "Nondesignated public hospital" means a public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(p) "Outpatient base rates" means the Medi-Cal payment rates for hospital outpatient services in effect on the date immediately preceding the implementation date.

(q) "Private hospital" means a hospital licensed under subdivision (a) of Section 1250 of the Health and Safety Code that is a nonpublic hospital, nonpublic-converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(r) "Safety net care pool" means the federal funds available to ensure continued government support for the provision of health care services to uninsured populations, as described in subdivision (k) of Section 14166.1.

14167.2. (a) The department shall determine outpatient base rates for hospital outpatient services furnished by nondesignated public hospitals based on the payment methodology in effect on the day immediately preceding the implementation date until the department has developed new methods and standards for payment of hospital outpatient services under subdivision (b). The department shall increase the outpatient base rates by the percentage the department determines is necessary to comply with subdivision (c) so that each outpatient base rate is increased by the same percentage, except as may be necessary to comply with federal Medicaid law.

(b) The department, in consultation with the hospital community, and with input from others as deemed necessary and appropriate, shall develop new methods and standards of payment for hospital outpatient services. These new methods and standards shall implement subdivision (c) and take into consideration factors such as acuity and the cost incurred by hospitals in providing services.

(c) Medi-Cal rates for hospital outpatient services furnished by nondesignated public hospitals during a fiscal year shall be set to

result in aggregate payments equal to the maximum permitted by federal Medicaid law.

(d) The department shall establish rates of payment pursuant to this section prior to the implementation date and prior to the beginning of each state fiscal year commencing on or after the implementation date. The department shall monitor payments during the fiscal year and may make adjustments as may be necessary to comply with subdivision (c).

14167.3. (a) The department shall determine outpatient base rates for hospital outpatient services furnished by private hospitals based on the payment methodology in effect on the day immediately preceding the implementation date until the department has developed new methods and standards for payment of hospital outpatient services under subdivision (b). The department shall increase the outpatient base rates by the percentage the department determines is necessary to comply with subdivision (c) so that each outpatient base rate is increased by the same percentage, except as may be necessary to comply with federal Medicaid law.

(b) The department, in consultation with the hospital community, and with input from others as deemed necessary and appropriate, shall develop new methods and standards of payments for hospital outpatient services. These new methods and standards shall implement subdivision (c) and take into consideration factors such as acuity and the cost incurred by hospitals in providing services.

(c) Medi-Cal rates for hospital outpatient services furnished by private hospitals during a fiscal year shall be set to result in aggregate payments equal to the maximum permitted by federal Medicaid law.

(d) The department shall establish rates of payment pursuant to this section prior to the implementation date and prior to the beginning of each state fiscal year commencing on or after the implementation date. The department shall monitor payments during the fiscal year and may make adjustments as may be necessary to comply with subdivision (c).

14167.4. (a) The department shall determine an inpatient base rate for each private hospital and nondesignated public hospital.

(b) The inpatient base rate shall be an estimate of the hospital's Medi-Cal fee-for-service payments per acute inpatient day, or per

acute inpatient discharge if used by the department, as of the day immediately preceding the implementation date.

(c) Each hospital's inpatient base rate shall be determined as follows:

(1) The department shall determine the hospital's total Medi-Cal fee-for-service payments for services furnished during the base period.

(2) The department shall determine the hospital's total Medi-Cal acute inpatient days, or the number of acute inpatient discharges if used by the department, for the base period.

(3) The department shall divide the result of paragraph (1) by the result of paragraph (2).

(4) The department shall adjust the result of paragraph (3) by the rate of increase in the market basket index from the midpoint of the base period to the implementation date. The result shall be the hospital's inpatient base rate.

(d) The department shall make available a paid claims summary for each hospital that sets forth all of the Medi-Cal fee-for-service payments made for services furnished during the hospital's base period and the hospital's fee-for-service Medi-Cal acute inpatient days for the base period, and any other data the department may require to determine each hospital's base rate. The Medi-Cal fee-for-service payments for hospitals reimbursed on a cost basis shall be the hospital's interim payments. The department shall use this data to compute the inpatient base rate.

(e) The department shall add to each hospital's Medi-Cal fee-for-service payments set forth in the paid claims summary prepared pursuant to subdivision (d) the supplemental payments under Section 14166.12 or Section 14166.17 made by the department to the hospital with respect to the state fiscal year ending during the base period.

(f) In determining each hospital's inpatient base rate, the department shall exclude payments made pursuant to Sections 14085.5, 14166.11, 14166.16, 14166.21, and 14166.23, payments by a managed health care plan or one of its contractors, payments resulting from an intergovernmental transfer, or payments made where the Medi-Cal program is not the primary payer, such as services covered under Medicare Part A and Part B where the individual receiving the services is a Medi-Cal beneficiary.

(g) The department shall make available a preliminary list of each hospital's inpatient base rate and provide each hospital with the data used to compute its base rate no later than 90 days before the implementation date. The department shall make available a final list of each hospital's inpatient base rate 30 days prior to the implementation date.

(h) A hospital's base rate shall be corrected if the hospital demonstrates any of the following:

(1) The department made a mathematical error.

(2) The data used by the department is inaccurate based on the data in the possession of the department or its fiscal intermediary at the time the paid claims summary under subdivision (d) was prepared. Payments made after the date of the preparation of the paid claims summary under subdivision (d) shall not be a ground for correction.

(3) The department failed to include payments described in subdivision (e).

(4) The department included payments described in subdivision (f).

(i) The impatient base rate for a new hospital shall be the median base rate of hospitals in the peer group to which the new hospital is assigned by the department. The peer groups are those groupings of hospitals described in Section 51553 of Title 22 of the California Code of Regulations.

(j) The department shall review and issue a determination concerning a hospital's request for a correction under subdivision (h) within 30 days of receipt of the request. Any correction that is made shall be applied prospectively, beginning the first day of the first calendar quarter beginning after the date of the department's determination. However, if the department receives a hospital's request for a correction no later than 30 days after the department publishes the preliminary list under subdivision (g), any correction shall be effective as of the implementation date.

(k) The department shall develop an informal process for reviewing and making decisions promptly concerning disputes by hospitals of the department's action or proposed action under this section or Section 14167.5, consistent with the provisions of this section and Section 14167.5. The process shall be exempt from the provisions of the Administrative Procedure Act.

(*l*) Notwithstanding any other provision of law, no change to a hospital's base rate shall be applied to payments for services rendered prior to the effective date of the change to the base rate.

14167.5. To the extent feasible, the department shall develop a case mix adjustment factor to apply to inpatient base rates for private and nondesignated public hospitals. If developed, the department shall take all of the following steps:

(a) Each private and nondesignated public hospital's inpatient base rate shall be adjusted to reflect changes in the hospital's Medi-Cal case mix for fee-for-service Medi-Cal inpatients as compared to the base period.

(b) Case mix adjustments shall be applied prospectively at the beginning of each state fiscal year beginning with the first state fiscal year that begins no less than 12 months after the implementation date.

(c) The department shall compute a case mix adjustment factor for each hospital for each state fiscal year. The case mix adjustment factor shall be the hospital's case mix index for the most recent calendar year divided by the case mix index for the base period.

(d) The department, in consultation with the hospital community, and with input from others as deemed necessary and appropriate, shall develop the methodology for computing the case mix index, including the data to be used and the sources of the data. In developing the case mix index methodology, the department shall consider, at minimum, the following factors:

(1) The development of a methodology that reasonably measures the relative cost that would be expected to be incurred in treating different types of cases.

(2) The use of an approach using diagnosis-related groups and relative weights for those groups used by the Medicare Program under the Medicare inpatient prospective payment system.

(3) The accuracy of applying weights used by the Medicare Program for the purpose of measuring the Medi-Cal case mix.

(4) The available data.

(5) The comparability of the data available for the base period and the data available for later years.

(6) The development of accurate measures of relative case mix for pediatric patients.

(e) No later than 90 days prior to the beginning of the fiscal period to which a case mix adjustment factor is applied, the

department shall determine each hospital's case mix adjustment factor, advise each hospital of its case mix adjustment factor and the case mix index factors used to compute the case mix adjustment factor, and provide each hospital with the data used to compute the case mix adjustment factor.

(f) A hospital's case mix adjustment factor shall be corrected if the hospital demonstrates any of the following:

(1) The department made a mathematical error.

(2) The data used by the department is inaccurate.

(3) More accurate data is available.

(g) The department shall review and issue a determination concerning a hospital's request for a correction under subdivision (f) within 30 days of receipt of the request. Any correction that is made shall be applied prospectively, beginning the first day of the first calendar quarter beginning after the date of the department's determination.

(h) (1) The department may make adjustments to a hospital's base rate to take into account an event or series of events that may significantly affect a hospital's costs of furnishing hospital inpatient services that is not reflected in the case mix adjustment, such as a merger or consolidation of hospitals, a substantial change in the types of services furnished by a hospital, or a substantial change in the acuity of the hospital's patients. An event or series of events shall be deemed to significantly affect a hospital's costs only if the department determines that the hospital's cost per day has increased or decreased by 10 percent or more as a result of the event or series of events. Events that are generally applicable to multiple hospitals, such as a market basket increase in the costs of goods or services purchased by hospitals, shall not be a basis for an adjustment under this subdivision.

(2) The department shall notify the hospital in writing of any adjustment it proposes to make under this subdivision. The notice shall include an explanation of the department's reasons for making the adjustment, the computation of the adjustment, and the data relied on by the department in making the adjustment. The hospital may dispute an adjustment within 30 days after receipt of the notice described in this paragraph by providing written notice to the person identified by the department in the notice. The hospital shall include in the written notice of dispute the reasons the hospital believes the adjustment should not be made as proposed by the

department, including all data supporting the hospital's position. The department may not implement any adjustment under this subdivision until it makes a final determination concerning a notice of dispute.

(3) Any adjustment under this subdivision shall be made prospectively beginning the first day of the calendar quarter beginning no sooner than 60 days after the department issues a notice to the hospital of the proposed adjustment. However, if the hospital timely disputes the proposed adjustment, as specified in paragraph (2), the proposed adjustment shall not be implemented until the first day of the first calendar quarter beginning after the department issues its decision concerning the dispute.

14167.6. (a) The department shall determine inpatient base rates pursuant to Section 14167.4 for hospital inpatient services provided by nondesignated public hospitals based on the payment methodologies in effect on the day immediately preceding the implementation date until the department has developed new methods and standards under subdivision (b). The department shall increase each hospital's inpatient base rate by the percentage the department determines is necessary to comply with subdivision (c), taking into account the additional payments made pursuant to subdivision (e), so that each hospital's inpatient base rate is increased by the same percentage, except as may be necessary to comply with federal Medicaid law. The department shall pay each nondesignated public hospital for hospital inpatient services provided prior to the implementation of new methods and standards of payment developed pursuant to subdivision (b) based on its inpatient base rate as increased pursuant to this subdivision.

(b) The department, in consultation with the hospital community, and with input from others as deemed necessary and appropriate, shall develop new methods and standards of payments for hospital inpatient services provided by nondesignated public hospitals. These new methods and standards shall implement subdivision (c) and take into consideration factors such as patient acuity, the cost incurred by hospitals in providing services, and equitable payment for outlier patients.

(c) Medi-Cal rates for hospital inpatient services furnished by nondesignated public hospitals during a state fiscal year shall be set at an amount that results in aggregate payments equal to the maximum permitted by federal Medicaid law.

(d) The department shall establish rates of payment pursuant to this section prior to the implementation date and prior to the beginning of each state fiscal year beginning on or after the implementation date. The department shall monitor payments during the fiscal year, and may make adjustments that may be necessary to comply with subdivision (c).

(e) The department shall develop a reimbursement methodology to equitably compensate nondesignated public hospitals for the delivery of Medi-Cal acute inpatient psychiatric services.

14167.7. (a) The department shall determine inpatient base rates pursuant to Section 14167.4 for hospital inpatient services provided by private hospitals based on the payment methodologies in effect on the day immediately preceding the implementation date until the department has developed new methods and standards under subdivision (b). The department shall increase each hospital's inpatient base rate by the percentage the department determines is necessary to comply with subdivision (c), taking into account the additional payments made under subdivision (f), so that each hospital's inpatient base rate is increased by the same percentage, except as may be necessary to comply with federal Medicaid law. The department shall pay each private hospital for hospital inpatient services provided prior to the implementation of new methods and standards of payment developed pursuant to subdivision (b) based on its inpatient base rate as increased pursuant to this subdivision.

(b) The department, in consultation with the hospital community, and with input from others as deemed necessary and appropriate, shall develop new methods and standards of payments for hospital inpatient services provided by private hospitals. These new methods and standards shall implement subdivision (c) and take into consideration factors such as patient acuity, the cost incurred by hospitals in providing services, and equitable payment for outlier patients.

(c) Medi-Cal rates for hospital inpatient services furnished by private hospitals during a state fiscal year shall be set to result in aggregate payments equal to the maximum permitted by federal Medicaid law.

(d) The department shall establish rates of payment pursuant to this section prior to the implementation date and prior to the beginning of each state fiscal year beginning on or after the

implementation date. The department shall monitor payments during the fiscal year and may make such adjustments as may be necessary to comply with subdivision (c).

(e) Subject to subdivision (c) of Section 14167.12, the department shall establish rates of payment to major teaching institutions that have a formal academic affiliation with a designated public hospital or a private or public California medical school that take into consideration the cost of medical education programs.

(f) The department shall develop a reimbursement methodology to equitably compensate private hospitals for the delivery of Medi-Cal acute inpatient psychiatric services.

14167.8. (a) The amount of any increased payments made under this article to private hospitals in excess of the payments that would have been made under the payment rates in effect on the day immediately prior to the implementation date, including the amount of increased payments to hospitals by managed health care plans pursuant to Section 14167.9, shall not be included in the calculation of the numerator or denominator of the low-income percent of the OBRA limit for purposes of the disproportionate share hospital replacement fund payments pursuant to Section 14166.11.

(b) The department shall continue to make payments to private and nondesignated public hospitals pursuant to Sections 14085.5, 14105.17, 14105.97, 14166.11, and 14166.16, in addition to other payments made under this article. The department shall take all of these payments into account in determining whether an applicable federal limitation is satisfied only if, and to the extent, required by federal Medicaid law.

(c) Each private and nondesignated public hospital, as a condition of receiving reimbursement under this section, shall keep, maintain, and have readily retrievable, any records specified by the department to fully support reimbursement amounts to which the hospital is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

14167.9. (a) The director shall increase reimbursement rates to managed health care plans by the actuarial equivalent amount necessary to ensure that managed health care plans increase rates of payments to hospitals under their contracts by the same percentage that Medi-Cal fee-for-service rates to hospitals are

increased pursuant to this article, subject to the limitations of federal Medicaid law, if any.

(b) Subject to subdivision (c), as applicable, the department shall further increase payments to managed health care plans, in addition to any increased payments made under subdivision (a), as may be necessary to ensure that the full amount of the revenue arising from payments of a fee from all hospitals subject to the fee for patient days in a fiscal year is expended after making the expenditures for the payments under Sections 14167.2, 14167.3, 14167.6, 14167.7, and 14167.10.

(c) (1) The amount of increased payments under this section shall not exceed either of the following limits:

(A) The maximum amount, if any, for which federal financial participation may be claimed.

(B) The sum of available revenue derived from a fee, as described in subdivision (*l*) of Section 14167.12, plus interest, penalties, and federal financial participation.

(2) The revenue derived from a fee, as described in subdivision (*l*) of Section 14167.12, that is made available for purposes of this section shall be 23.29 percent of the total fees that are assessed on nondesignated public and private hospitals with respect to any fiscal year.

(d) A Medi-Cal managed care plan shall equitably expend, in the form of increased rates to all private hospitals, nondesignated public hospitals, and designated public hospitals, for providing services to Medi-Cal patients, 100 percent of any rate increase it receives under this section. Managed health care plans shall submit documentation as the department may require to demonstrate compliance with the provisions of this subdivision.

14167.10. (a) (1) Commencing July 1, 2010, designated public hospitals shall receive Medi-Cal reimbursement as specified in this section.

(2) For purposes of this section, "hospital services" means inpatient services and services rendered in the outpatient department of the hospital, excluding services rendered by a hospital-based federally qualified health center for which reimbursement is received pursuant to Section 14132.100.

(b) Notwithstanding Article 2.6 (commencing with Section 14081), Sections 14166.35 to 14166.9, inclusive, and any other provision of law, each of the designated public hospitals shall be

paid for those hospital services provided to Medi-Cal beneficiaries on a fee-for-service basis during any fiscal year as follows:

(1) Except as provided in paragraph (5), each of the designated public hospitals shall receive, as payment for inpatient hospital services provided to Medi-Cal beneficiaries during any fiscal year, amounts based on the hospital's allowable costs incurred in providing those services. These costs shall be determined annually by the department making use of the data provided pursuant to subdivision (c).

(2) Except as provided in paragraph (5), for the 2010–11 fiscal year, and each fiscal year thereafter, each of the designated public hospitals shall receive a reimbursement rate, limited to the payments funded using state funds as provided in paragraph (3), for the estimated cost of inpatient and outpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claims process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. Estimated costs shall be derived pursuant to the process set forth in subdivision (b) of Section 14166.4. Costs not reimbursed pursuant to this paragraph shall be reimbursed pursuant to paragraph (7). Inpatient hospital rates may be on a per diem or per discharge basis as determined by the department.

(3) (A) (i) The nonfederal share of the reimbursement specified in paragraph (2) shall consist of state funds, which shall be established for fiscal year 2010–11 through and including fiscal year 2012–13 at the nonfederal share of the full cost incurred by the particular hospital in the 2009–10 fiscal year, adjusted annually by the percentage increase in the medical component of the Consumer Price Index-Urban for the United States, but not to exceed the nonfederal share of allowable, actual costs. For purposes of this paragraph, the 2009–10 fiscal year shall be the hospital's initial base year.

(ii) Notwithstanding clause (i), the nonfederal share of reimbursement available for the purposes of paragraph (2) shall be reduced annually by the amount of twenty-five million dollars ($25,000,000), which amount of state funds shall be made available for purposes of subdivision (g).

(B) For purposes of this paragraph, the nonfederal share shall be calculated by subtracting the federal medical assistance percentage in effect for the particular fiscal year from 100 percent.

(C) (i) For fiscal year 2013–14 and each fiscal year thereafter, the nonfederal share of the reimbursement specified in paragraph (2), as reduced pursuant to clause (ii) of subparagraph (A), shall consist of state funds, which shall be established at the nonfederal share of the full cost incurred by the particular hospital in the hospital's base year, adjusted annually by the percentage increase in the medical component of the Consumer Price Index-Urban for the United States, but not to exceed the nonfederal share of allowable, actual costs.

(ii) At the beginning of each three-year period beginning with the three-year period commencing on July 1, 2013, each hospital's costs incurred, for purposes of clause (i), shall be determined to be the full cost incurred by the particular hospital in the fiscal year beginning two years prior to the beginning of the new three-year period, which fiscal year shall be the hospital's new base year.

(4) For the 2010–11 fiscal year, and each fiscal year thereafter, each designated public hospital shall receive supplemental federal reimbursement pursuant to Section 14105.96, in addition to the reimbursement received by each hospital for outpatient services pursuant to paragraph (2).

(5) Reimbursement paid to Federally Qualified Health Centers shall continue pursuant to Section 14132.100 for those hospitals that were designated by the state as Federally Qualified Health Centers as of July 1, 2007.

(6) The cost data and the resulting estimated costs submitted pursuant to this section shall be certified as accurate by the unit of government that owns or operates the hospital submitting the estimated costs. Certifications required by this paragraph shall comply with the requirements of subdivision (e) of Section 14166.8.

(7) (A) To the extent that the amount of the estimated allowable costs for each designated public hospital determined pursuant to paragraph (1) exceeds the amounts actually paid pursuant to paragraph (2), the hospital shall receive a quarterly supplemental payment equal to the federal reimbursement received as a result of the amounts claimed by the department to the federal government based on the total amounts certified pursuant to paragraph (6).

(B) Services provided by clinics and hospital outpatient departments for which reimbursement is made under a cost-based

methodology pursuant to Section 14105.24 shall continue to be reimbursed under that methodology.

(C) The supplemental Medi-Cal reimbursement provided by this paragraph shall be distributed quarterly under a payment methodology based on inpatient services provided to Medi-Cal patients at the eligible facility, either on a per-visit basis, per-procedure basis, or any other federally permissible basis.

(D) Payments made pursuant to this paragraph shall be subject to reconciliation pursuant to subdivision (f), and pursuant to any other applicable requirement of state or federal law.

(c) (1) Within five months after the end of each fiscal year, each designated public hospital shall submit to the department both of the following reports:

(A) The hospital's Medi-Cal cost report for the fiscal year.

(B) Other cost reporting and statistical data necessary for the determination of amounts due the hospital, as requested by the department.

(2) For each fiscal year, the reports shall identify the costs incurred in providing inpatient hospital services to Medi-Cal beneficiaries on a fee-for-service basis.

(3) Reports submitted under this subdivision shall include all allowable costs.

(d) Designated public hospitals shall receive disproportionate share hospital payments pursuant to Section 14166.6.

(e) In the event of a conflict between the provisions of this section and any provision of Article 5.2 (commencing with Section 14166), the provisions of this section shall govern. In addition to direct conflicts, if continuing the implementation or application of any of the provisions of Article 5.2 (commencing with Section 14166) leads to results that are inconsistent with the payment methodology established in this section, after consultation with representatives of the designated public hospitals, the director shall not implement or apply any provision of Article 5.2 (commencing with Section 14166) that the director determines has those results.

(f) No later than April 1 following the end of the fiscal year, the department shall undertake an interim reconciliation of payments made pursuant to this section based on the hospitals' Medi-Cal cost reports and other cost and statistical data submitted by the hospitals for the fiscal year and shall adjust payments to each hospital accordingly.

(g) (1) (A) The amount of twenty-five million dollars ($25,000,000), made available pursuant to subparagraph (A) of paragraph (3) of subdivision (b), shall be transferred to the Workforce Development Program Fund established pursuant to subparagraph (B).

(B) The Workforce Development Program Fund is hereby established in the State Treasury. For purposes of this subdivision, "fund" means the Workforce Development Program Fund.

(1) Moneys in the fund shall, upon appropriation, be used exclusively for retraining county hospital and clinic systems' health care workers.

(2) Any moneys remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(3) Moneys in the fund shall, upon appropriation, be allocated from the fund by the Office of Statewide Health Planning and Development.

(4) By May 1, 2010, counties shall develop and submit work plans to the Office of Statewide Health Planning and Development for the implementation of programs and needed investments for workforce training that are consistent with the implementation of health care reform at the county level. The Office of Statewide Health Planning and Development shall provide comments on the work plan within 45 days from the date of submission of the work plan and allocate funds from the fund within 90 days.

(5) Allocations from the fund shall recognize successful training programs, either through existing labor-management training partnerships, or emerging intracounty labor management-initiatives.

(6) Federal financial participation shall be claimed for expenditures under this subdivision only as authorized by federal law and regulations.

(h) This section shall be implemented only to the extent that counties with designated public hospitals seeking reimbursement under this section contribute toward the cost of care through a county share of cost.

14167.11. (a) Notwithstanding Article 5.2 (commencing with Section 14166), for the period of time during which this article is operative, safety net care pool funds, as defined in subdivision (r) of Section 14167.1, shall be paid to the designated public hospitals, as defined in subdivision (e) of Section 14167.1, in accordance with this section, to the extent that those funds are available.

(b) (1) Each designated public hospital, or the governmental entity with which it is affiliated, that operates nonhospital clinics or provides other health care services that are not identified as hospital services, may report and certify, in accordance with Section 14166.8, all or a portion of its uncompensated costs of the services furnished to the uninsured. Each designated public hospital, or the governmental entity with which it is affiliated, shall receive from the safety net care pool for each fiscal year an amount equal to the federal funds derived from the certification of uncompensated care costs pursuant to the preceding sentence. The maximum amount payable pursuant to this paragraph shall be one hundred million dollars ($100,000,000).

(2) If, for any fiscal year, the amount payable from the safety net care pool is insufficient for purposes of the payments described in paragraph (1), each designated public hospital, or governmental entity with which it is affiliated, shall receive a pro rata share of the amount specified in paragraph (1). The pro rata amount determined for purposes of this paragraph shall be based on the percentage that each designated public hospital's certified uncompensated medical care costs of medical services provided to uninsured individuals bears to the total amount of the costs certified by all of the participating designated public hospitals or governmental entity with which it is affiliated.

(3) Safety net care pool funds above one hundred million dollars ($100,000,000) in any state fiscal year shall be claimed by the director for the state's expenditures under Section 14005.333 and under Part 6.45 (commencing with Section 12699. 201) of Division 2 of the Insurance Code.

(4) If the expenditures specified in paragraph (3) are insufficient to claim the full amount of safety net care pool funds available in any state fiscal year, and the designated public hospitals, or governmental entities with which they are affiliated, have certified expenditures in the aggregate in excess of the amount necessary to make the payments required by this subdivision, the department shall seek Medicaid federal financial participation from the safety net care pool to the maximum extent possible based on the remaining certified public expenditures of the designated public hospitals and governmental entities with which they are affiliated, and shall distribute the funds to the designated public hospitals, or governmental entities with which they are affiliated, based on

the amount of each entity's certified expenditures. If the designated public hospitals' remaining certified public expenditures exceed the amount of available safety net care pool funds, the amounts remaining in the safety net care pool, when claimed, shall be distributed on a pro rata basis.

(5) Subdivision (a) of Section 14166.21 shall remain operative for the period of time during which this article is operative, but subdivision (b) of Section 14166.21 shall be inoperative for the period of time during which this article is operative.

(c) Except as provided in subdivision (b), subdivision (g) of Section 14166.8 shall be inoperative for the period of time during which this article is operative. The department shall seek Medicaid federal financial participation from the safety net care pool based on qualifying expenditures from the designated public hospitals or governmental entity with which it is affiliated.

(d) Payments and funding described in this section shall be subject to the availability of federal funds through a demonstration project approved by the federal government pursuant to Section 1115 of the federal Social Security Act.

(e) The director may suspend, modify, or adjust any methodology or computation required by Article 5.2 (commencing with Section 14166) that is necessary to implement this section.

14167.12. (a) The department shall consult with the hospital community, and shall receive input from others as deemed necessary and appropriate, in developing and implementing any and all payment methodologies developed or implemented for purposes of this article. The consultation, with input from others as deemed necessary and appropriate, shall occur sufficiently in advance of the publication of any proposed regulation pertaining to any such payment methodology so as to allow the hospital community, and others as deemed necessary and appropriate, to have meaningful participation and offer comments as well as to allow the department an opportunity to consider additional information and engage in follow-up discussions.

(b) The director shall seek federal approval of each payment methodology set forth in this article. The director, in consultation with the hospital community, and with input from others as deemed necessary and appropriate, may alter any methodology specified in this article to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. If, after

seeking federal approval, federal approval is not obtained, that methodology shall not be implemented.

(c) Payments made pursuant to this article are contingent on the receipt of federal reimbursement.

(d) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into with any Medicare fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(e) Except as otherwise provided in this article, Sections 14166.11 to 14166.14, inclusive, Sections 14166.17 to 14166.20, inclusive, and Sections 14166.22 and 14166.23, shall be inoperative for the period of time during which this article is operative.

(f) This article shall become inoperative five years after the implementation date of this article and as of January 1, 2016, is repealed, unless a later enacted statute that is enacted on or before January 1, 2016, extends or deletes the dates on which it becomes inoperative and is repealed.

(g) This article shall be applicable to services rendered to Medi-Cal beneficiaries on and after July 1, 2010. For services that are paid under this article, any other provider rate methodology, including those established by the California Medical Assistance Commission pursuant to Article 2.6 (commencing with Section 14081), shall become inoperative for those services on and after that date.

(h) This article shall not apply to any service furnished prior to the effective date of any federal approvals that may be required to ensure the availability of federal financial participation for expenditures made pursuant to this article.

(i) This article shall become inoperative in the event, and on the effective date, of a final judicial determination by any court of appellate jurisdiction or a final determination by the federal Department of Health and Human Services or the Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

(j) The department shall implement this article only to the extent that state funds are appropriated for the nonfederal share of the rate increases provided in this article.

(k) If this article becomes inoperative, hospitals shall be paid the rates that were in effect on June 30, 2010, including the rates paid pursuant to the provision of Article 2.6 (commencing with Section 14081).

(*l*) This article shall be implemented only during those fiscal years in which a 4 percent fee is imposed on the net patient revenue of general acute care hospitals.

SEC. 77. Article 5.215 (commencing with Section 14167.22) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.215. Medi-Cal Physician Services Rate Increase Act

14167.22. (a) The director shall seek federal approval of the rate methodology set forth in this article. The director may alter any methodology specified in this article, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. If, after seeking federal approval, federal approval is not obtained, that methodology shall not be implemented.

(b) Payments made pursuant to this article are contingent on the receipt of federal reimbursement. Unless otherwise expressly provided in this article, nothing in this article shall create an obligation on the part of the department to fund any payment from state funds in the absence of, or on account of a shortfall in, federal funding.

(c) The director shall increase reimbursement rates to managed health care plans by the actuarially equivalent amount necessary to ensure that managed health care plans increase rates of payment to the classes of providers whose rates are governed by this article at the same percentage increase that Medi-Cal fee-for-service rates are increased to the same classes of providers pursuant to this article, subject to the limitations of federal law, if any.

14167.23. For purposes of this article, the following definitions shall apply:

(a) "Nonphysician medical practitioner" means a physician's assistant, a certified nurse midwife, or a nurse practitioner, who provides primary care services, as defined in Section 51170.5 of Title 22 of the California Code of Regulations, who is an enrolled Medi-Cal provider eligible to receive Medi-Cal payments, and who provides physician services to Medi-Cal beneficiaries. Primary

care physician services rendered by nonphysician medical practitioners are covered as physician services to the extent permitted by applicable licensing statutes and regulations. The terms "physician's assistant," "nurse midwife," and "nurse practitioner" are defined for purposes of this article in Sections 51170.1, 51170.2, and 51170.3 of Title 22 of the California Code of Regulations, respectively.

(b) "Physician" means a practitioner meeting the requirements of Section 51228 of Title 22 of the California Code of Regulations who is an enrolled Medi-Cal provider eligible to receive Medi-Cal payments and who provides physician services to Medi-Cal beneficiaries.

(c) "Physician group" means two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, or similar association that meets the requirements of Section 51000.16 of Title 22 of the California Code of Regulations and that is an enrolled Medi-Cal provider eligible to receive Medi-Cal payments and provides physician services to Medi-Cal beneficiaries.

(d) "Physician services" means those services as described in Section 51305 of Title 22 of the California Code of Regulations.

(e) "Podiatrist" means a person as defined in Section 51075 of Title 22 of the California Code of Regulations who is an enrolled Medi-Cal provider eligible to receive Medi-Cal payments and who provides physician services to Medi-Cal beneficiaries.

(f) "Clinic" means an organized outpatient health facility as defined in Section 1200 of the Health and Safety Code.

14167.24. (a) A physician, physician group, clinic, podiatrist, or nonphysician medical practitioner shall receive Medi-Cal reimbursement to the extent provided in this section.

(b) Physician services, including those rendered by physicians, physician groups, podiatrists, and nonphysician medical practitioners, shall be calculated and paid as follows:

(1) Except as provided under Section 14167.25, and only to the extent that state funds are appropriated in the annual Budget Act, commencing on July 1, 2010, reimbursement shall be established at a percentage of the amount that the federal Medicare Program would pay for the same physician service rendered on the same date; provided, however, that such increased reimbursement shall not exceed 100 percent of the amount that Medicare would pay.

This paragraph shall not reduce physician service rates currently reimbursed at or above 100 percent of the Medicare reimbursement rate or the rate that the department determines to be equivalent to the Medicare rate pursuant to paragraph (3). In determining the amounts to be paid pursuant to this paragraph, the department shall ensure that the equivalent Medicare rate to be used takes into account all of the factors, supplemental payments, and other variables that are used to determine the Medicare rate.

(2) The supplemental rate augmentation paid for physician services in California Children Services, as established in the annual Budget Act, shall continue and be paid in addition to the rate established in this section.

(3) Subject to the funding limitation set forth in paragraph (1), the department shall establish a rate for physician services for which Medicare does not provide a comparable physician service, or for which the Medicare payment for the physician service cannot be separately determined, which shall be the department's best estimate of what Medicare would pay for that physician service, to be set at the percentage established in paragraph (1).

(4) Physician services that are reimbursable under this section may be provided in any service location, including in clinics, except for hospitals when the hospital bills for the services, federally qualified health centers, and rural health centers. Notwithstanding the provisions of Section 14167.23, physicians, physician groups, podiatrists, and nonphysician medical practitioners that provide physician services in clinics shall not be required to be enrolled as Medi-Cal providers in order for a clinic to receive reimbursement for those services pursuant to this section.

(5) Claims for payment of services rendered by a nonphysician medical practitioner, where the rate is established pursuant to this section, shall comply with the provisions of subdivision (d) of Section 51503.1 of Title 22 of the California Code of Regulations.

(c) As a condition of receiving reimbursement under this section, a physician, physician group, clinic, podiatrist, or nonphysician medical practitioner shall keep, maintain, and have readily retrievable, any records specified by the department to fully disclose reimbursement amounts to which the physician, physician group, clinic, podiatrist, or nonphysician medical practitioner is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(d) This section shall apply to all services specified in this section that are rendered to Medi-Cal beneficiaries on and after July 1, 2010. With respect to all services that are paid under this section, any other provider rate methodology that is inconsistent or duplicative of the rates paid pursuant to this section shall become inoperative for those services to the extent that the rates are inconsistent or duplicative.

14167.25. (a) (1) Notwithstanding Section 14105 or any other provision of law, on or after July 1, 2010, the director may designate up to 25 percent of the rate increase paid to Medi-Cal fee-for-service providers pursuant to subdivision (b) of Section 14167.24, to be directly linked to performance measures developed pursuant to subdivisions (c) and (d), including a demonstrated showing of continued performance improvement.

(2) For purposes of paragraph (1), the percentage of the rate that is linked to performance measures shall be established by the director such that physicians, physician groups, clinics, podiatrists, and nonphysician medical practitioners will be sufficiently reimbursed for implementing performance measures, including continued performance improvement.

(b) The performance measures shall be developed by the department in consultation with stakeholders, including, but not limited to, representatives of patients, physicians, podiatrists, nonphysician medical practitioners, managed care plans, payers, and other appropriate stakeholders.

(c) The department, in consultation with the stakeholders identified in subdivision (b), shall develop a comprehensive list of performance measures relying, in part, on existing quality and performance measures endorsed by national organizations, such as the Ambulatory Quality Alliance, the Hospital Quality Alliance, and the National Quality Forum.

(d) In developing the performance measures pursuant to subdivision (c), the following performance measures may be taken into consideration in determining the appropriate percentage rate increases:

(1) Reporting of health care outcomes, including the cost of that health care.

(2) Improvements in health care efficiency.

(3) Improvements in health care safety.

(4) The efficient exchange of health information data through technology.

(5) The quality assurance requirements set forth in Section 1300.70 of Title 28 of the California Code of Regulations.

(6) Efforts to promote healthy behaviors among Medi-Cal beneficiaries pursuant to the Healthy Incentives and Rewards Program described in Section 14132.105.

(7) The extent to which purchasers, payers, providers, and consumers are able to monitor the quality and cost of health care utilizing public reporting information published by the Office of the Patient Advocate.

(8) The extent to which physicians, physician groups, clinics, podiatrists, and nonphysician medical practitioners that provide services to Medi-Cal beneficiaries on a fee-for-service basis implement activities, such as telemedicine, electronic prescribing and the electronic exchange of health information among various payers and providers for the purpose of attaining health care safety and quality improvements, informed clinical care decisions, the increased use of interoperable platforms for the exchange of relevant health care data, and more accurate and timely diagnosis and treatment.

(9) Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Sec. 300gg).

(e) The department shall consult with stakeholders, including, but not limited to, representatives of patients, physicians, managed care plans, payers, and other appropriate stakeholders, to determine the means to measure and document implementation by each physician, physician group, clinic, podiatrist, and nonphysician medical practitioner of the performance measures developed pursuant to subdivisions (c) and (d).

(f) The department may exempt classes of physicians, physician groups, clinics, podiatrists, and nonphysician medical practitioners and specific services from this section, if necessary to comply with the requirements of federal law or regulations.

(g) The department may file one or more state plan amendments to implement this section.

(h) The department shall seek necessary federal approvals for implementation of this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations. This section shall be implemented

only to the extent that federal approval is obtained and federal financial participation is available.

(i) The department shall implement this section only to the extent that state funds are appropriated for the nonfederal share of the rate increases provided under this section.

(j) The provisions of this section shall be implemented in such a manner that they are appropriately integrated with the pay-for-performance model described in subdivision (a) of Section 12803.2 of the Government Code.

SEC. 78. The State Department of Health Care Services, in consultation with the Managed Risk Medical Insurance Board, shall take all reasonable steps that are required to obtain the maximum amount of federal funds and to support federal claiming procedures in the administration of this act.

SEC. 80. Notwithstanding any other provision of law, the Managed Risk Medical Insurance Board may implement the provisions of this act expanding the Healthy Families Program only to the extent that funds are appropriated for those purposes in the annual Budget Act or in another statute.

SEC. 81. (a) In order to achieve the purposes of this act, the State Department of Health Care Services, after consultation with the Department of Finance, may utilize either state plan amendments or waivers, or combination thereof, as necessary to implement this act, to maximize the availability of federal financial participation, and to maximize the number of persons for whom that federal financial participation is available to cover the cost of health care services.

(b) The flexibility authorized by this act shall include modification of the requirements, standards, and methodologies for expansion categories or populations created by this act in order to maximize the availability of federal financial participation. When exercising this flexibility, the State Department of Health Care Services shall not make changes that would do any of the following:

(1) Make otherwise eligible individuals ineligible for health coverage under the Medi-Cal program and the Healthy Families Program.

(2) Increase cost-sharing amounts beyond levels established in this act.

(3) Reduce benefits below those provided for in this act.

(4) Otherwise disadvantage applicants or recipients in a way not contemplated by this act.

(c) The department shall take all reasonable steps necessary to maximize federal financial participation and to support federal claiming in the implementation of this act.

(d) It is the intent of the Legislature that the provisions of this act shall be implemented simultaneously to the extent possible in order to harmonize and best effectuate the purposes and intent of this act.

(e) The Director of Health Care Services shall notify the Chair of the Joint Legislative Budget Committee in any case when it is necessary to exercise the flexibility provided under this section. This notification shall be provided 30 days prior to exercising that flexibility.

SEC. 82. It is the intent of the Legislature that provisions of this act shall be financed by contributions from employers; individuals; federal, state, and local governments; and health care providers. Specifically financial support shall include:

(a) Federal financial participation through the federal Medicaid and S-CHIP programs.

(b) Revenue from counties to support the cost of enrolling persons who would otherwise be entitled to county-funded care if not for this act.

(c) Fees paid by acute care hospitals at a rate of 4 percent of patient revenues.

(d) Fees paid by employers.

(e) Premium contributions from currently offering employers when employees, eligible for employer-based coverage, choose to enroll in public programs.

(f) Premium payments for individuals enrolled in publicly subsidized coverage and coverage purchased in the individual market.

(g) Additional public funds obtained through increasing the tax on the sale of each package of cigarettes.

(h) Other state funds made available through savings generated through reduced demand for existing health care programs.

SEC. 83. (a) Notwithstanding any other provision of this act, the implementation of the provisions of this act other than this section, including, but not limited to, the expansion of eligibility for publicly funded or subsidized health care coverage, the increase

in the Medi-Cal program's provider rates, the requirements imposed on the offering and sale of health plan contracts or health insurance policies in the state, and the requirement that individuals enroll in and maintain health care coverage, shall be contingent on a finding by the Director of Finance under subdivision (b) that the financial resources necessary to implement those provisions are available.

(b) Except as otherwise provided in subdivision (d), this act shall become operative upon the date that the Director of Finance files a finding with the Secretary of State that all of the following circumstances exist:

(1) Based on reasonable financial projections, sufficient state resources will exist in the Health Care Trust Fund to implement the act. This determination shall be based on the projected amounts of revenue that will be available to support the act and the projected costs required by the act. These projections shall consider *and include* the sufficiency of resources that will be available during the first three years of operation under the act.

(2) The required federal approvals for program changes under the act have been obtained or can reasonably be expected to be obtained by the time those programs are implemented.

(3) Required federal resources will be available to implement the act based on the anticipated schedule of review and approval of state plan amendments and waivers applicable to the act.

(c) At least 90 days prior to filing the finding with the Secretary of State, the Director of Finance shall transmit the finding described in subdivision (b) to the Chief Clerk of the Assembly, the Secretary of the Senate, and the chairs of the appropriate committees of the Legislature.

(d) If any operative date specified in this act is later than the date of the filing of the finding described in subdivision (b), that later date shall apply.

(e) Nothing in this section shall be construed to prevent the appropriation of funds for the support of the activities necessary to prepare for the implementation of this act prior to the filing of the finding described in subdivision (b).

SEC. 83.5. It is the intent of the Legislature that credits against employer contributions to finance Cal-CHIPP be for health expenditures that do not discriminate on the basis of wage level and that allow employees eligible for Cal-CHIPP or Medi-Cal to

choose to enroll in those programs by bringing the employer contribution to the Cal-CHIPP or the Medi-Cal program.

SEC. 84. It is the intent of the Legislature that the state shall develop and effectively implement a transition plan, by July 1, 2010, that will allow for payment of the premium and cost-sharing burdens associated with insurance coverage with funding under the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (42 U.S.C. Sec. 201) and other funding.

SEC. 84.5. The Legislature finds and declares that each provision of this act is an integral part of a comprehensive health care reform effort and that no provision of this act is intended to be severable from the remaining provisions. If any provision of this act is held to be invalid, as determined by a final judgment of a court of competent jurisdiction, the entire act shall become inoperative, and those provisions of law amended by this act that were in effect and operative immediately prior to the operative date of this act shall again be operative.

SEC. 85. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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