AMENDED IN ASSEMBLY NOVEMBER 8, 2007

CALIFORNIA LEGISLATURE—2007–08 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL No. 2

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

September 11, 2007

~~An act relating to health care.~~ *An act to amend Sections 650, 2069, 2836.1, and 3516 of, to add Sections 650.5, 2838, 4040.1, 4071.2, 4071.3, and 4071.4 to, and to repeal Section 3516.1 of, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.2, 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 and 1365 of, to add Sections 1262.9, 1342.9, 1356.2, 1367.16, 1367.205, 1367.38, 1368.025, 1378.1, 1395.2, 104376, 128745.1, and 130545 to, to add Article 11.6 (commencing with Section 1399.821) 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 10273.6, 12693.43, 12693.70, and 12693.76 of, to add Sections 10113.10, 10113.11, 10123.56, 10176.15, 12693.56, 12693.58, 12693.766, 12694.5, 12885, 12886, and 12887 to, to add Chapter 9.6 (commencing with Section 10920) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to add Sections 96.8 and 96.81 to the Labor Code, to amend Sections 17072, 17131.4, 17131.5, 17215, 17215.1, 17215.4, and 19184 of, and to add Sections 17052, 17138.5, 17138.6, and 17216 to, the Revenue and Taxation Code, to add Section 1120 to, and to add Division 1.2*

(commencing with Section 4800) to, the Unemployment Insurance Code, to amend Sections 14005.30, 14008.85, and 14011.16 of, to add Sections 14005.01, 14005.301, 14005.305, 14005.306, 14005.310, 14005.311, 14005.331, 14005.332, 14011.16.1, 14074.5, 14100.3, 14132.105, 14132.23, and 14155 to, to add Article 2.96 (commencing with Section 14092.5), Article 5.22 (commencing with Section 14167.22), and Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, 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, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as amended, ~~Nunez~~ ______. Health care reform.

(1) 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 individuals who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services and county welfare departments. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care, under the Knox-Keene Health Care Service Plan Act of 1975, and health insurers by the Department of Insurance. Existing law sets forth various provisions governing individual contracts for health care coverage.

This bill would, on and after July 1, 2010, require all California residents, as defined, to obtain minimum health care coverage, as defined, and would require the Secretary of California Health and Human Services, subject to an appropriation of funds therefor, to establish methods to inform individuals of that requirement and to enforce the requirement by entering into an agreement with the Franchise Tax Board and through other specified means. However, compliance with the requirement to obtain minimum health care

coverage would not be required until the provisions relating to enforcement are implemented. The bill would also require the Secretary of California Health and Human Services to, among other things, track and assess the effects of this act, as specified.

The bill would require health care service plans and health insurers offering individual contracts and policies to offer individual contracts and policies that provide minimum health care coverage, as established by the Secretary of California Health and Human Services, and would require the Department of Managed Health Care and the Department of Insurance to jointly develop a system to categorize those contracts into 5 coverage choice categories. The bill would enact various health insurance market reforms, to be operative on specified dates, including requirements for guarantee issue and guarantee renewability of individual health care service plan contracts and individual health insurance policies. However, these requirements would only become operative when the provisions relating to enforcement of the requirement for individuals to obtain minimum health care coverage are implemented. The bill would require, on and after July 1, 2010, a health care service plan and a health insurer, as specified, to expend for health care benefits, as defined, 85% of certain payments they receive. The bill would require the Department of Insurance and the Department of Managed Health Care to jointly adopt regulations to establish uniform reporting by plans and insurers to determine compliance with this requirement, as specified.

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

The bill would also, as of January 1, 2009, require the Managed Risk Medical Insurance Board to establish and administer the Health Care Security and Cost Reduction Program to make subsidized and unsubsidized health care coverage meeting or exceeding the requirements for minimum health care coverage available effective July 1, 2010. The bill would also authorize the board, upon making certain determinations, to make available unsubsidized dental and vision coverage. The bill would establish the premiums applicable to and the eligibility criteria needed to purchase that coverage. The bill would

provide for the appeal of certain decisions and enact related provisions. The bill would also create the California Health Trust Fund in the State Treasury and continuously appropriate moneys in that fund to the board to provide health care coverage and for the program's expenses, as specified.

In addition, the bill would make it an unfair labor practice for an employer to refer an employee, or his or her dependent, to the Health Care Security and Cost Reduction Program 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.

(2) Existing law requires health care service plans to collect and report to the Department of Managed Health Care specified information from providers and requires the department to conduct periodic onsite medical surveys of the health delivery system of each plan.

The bill would make a plan that provides services to a beneficiary of the Medi-Cal program, as specified, subject only to the filing, reporting, monitoring, and survey requirements 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.

(3) Existing law requires health care service plans that provide prescription drug benefits and maintain one or more drug formularies to provide members of the public, upon request, with a copy of the most current list of prescription drugs on the plan formulary, as specified.

This 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.

(4) Under existing law, a willful violation of the Knox-Keene Health Care Service Plan Act of 1975 is a crime.

Because a willful violation of the requirements described above relative to health care services plans would be a crime, this bill would impose a state-mandated local program.

(5) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires a noncontracting hospital 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 services 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 nonemergency 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.

(6) Existing law imposes various responsibilities and duties on the State Department of Public Health relating to tobacco use and prevention programs, including administering funding for programs relating to smoking cessation, such as the California Smokers' Helpline.

This bill would 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 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 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 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.

(7) Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision services to eligible children. Existing law provides for the Healthy Families Fund, which is continuously appropriated to the board for the purposes of funding the Healthy Families Program. Eligibility requirements for the program include being a child in a family with a household income equal to or less than 200% of the federal poverty level. Existing law also requires applicants applying to the purchasing pool to agree to pay family contributions, unless the applicant has a family contribution sponsor. Existing law further requires the board to determine eligibility for the Healthy Families Program, and prohibits a child who is a qualified alien, as defined under federal law, from being determined ineligible for the Healthy Families Program solely on the basis of his or her date of entry into the United States.

This bill would, on July 1, 2010, revise the contribution amounts required to be paid under the Healthy Families Program. To the extent the bill would increase amounts deposited in a continuously appropriated fund, it would make an appropriation. Commencing on July 1, 2010, this bill would also expand coverage under the Healthy Families Program to include a child in a family with a household income that is equal to or less than 300% of the federal poverty level. This bill would, on July 1, 2010, notwithstanding any other provision of law, prohibit a child who is otherwise eligible for services under the Healthy Families Program from being determined ineligible solely on the basis of his or her immigration status.

This bill would also, upon implementation of a specified provision, authorize each county department that is required to make eligibility determinations for the Medi-Cal program to also make the eligibility determinations for the Healthy Families Program and for the subsidized coverage made available in the Health Care Security and Cost Reduction Program.

In addition, this bill would establish confidentiality procedures applicable to information concerning applicants, subscribers, and household members made or kept in connection with the administration of the Healthy Families Program and would require the Managed Risk

Medical Insurance Board to develop documentation procedures for certain program applicants.

(8) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income persons receive health care benefits. Existing law requires the State Department of Health Care Services to exercise its option under federal law to expand Medi-Cal eligibility by establishing the amount of countable resources individuals and families are allowed to retain at the same amount medically needy individuals and families, as defined, are allowed to retain, as specified.

This bill would require the department to exercise its federal option as necessary to simplify Medi-Cal eligibility by exempting all resources for applicants and recipients, commencing July 1, 2010. The bill would provide Medi-Cal benefits to, among others, individuals under 19 years of age who would be eligible for full-scope benefits without a share of cost, but for their immigration status, as specified. The bill would also expand eligibility under the Medi-Cal program, commencing July 1, 2010, by, among other things, requiring the department to provide Medi-Cal benefits to specified populations, including parents and caretaker relatives, and individuals 19 and 20 years of age who meet designated 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 subsidized benefit package or packages established under the Health Care Security and Cost Reduction Program. The bill would provide for the benchmark benefits to be administered by the Managed Risk Medical Insurance Board, pursuant to a cooperative agreement with the department. The bill would exempt designated categories of beneficiaries from mandatory enrollment in the benchmark package. The bill would make these provisions subject to federal financial participation and approval, as specified.

Because each county is required to determine eligibility for the Medi-Cal program, this bill would, by expanding program eligibility, impose a state-mandated local program.

In addition, the bill would create the Local Coverage Options program and authorize the Director of Health Care Services to contract with specified counties to provide the benchmark package benefits discussed above to county residents who, among other requirements, have a family income at or below 100% of the federal poverty level and are not eligible for Medi-Cal. The bill would require the department to request for applications from those counties, would specify the information required

to be included in the applications, and would enact other related provisions. The bill would make implementation 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 or the Health Care Security and Cost Reduction Program, as specified.

(9) Existing law requires the State Department of Health Care Services to implement a requirement for beneficiaries of the Medi-Cal program to file semiannual status reports, as specified.

This bill would instead require the department, commencing July 1, 2010, to implement a requirement for any beneficiary who is not required to make premium payments to file a semiannual address verification report. The bill would exempt certain beneficiaries from this requirement, and would suspend operation of the semiannual status report requirement during the implementation of the address verification report requirement. The bill would also make various conforming changes.

(10) Existing law requires that funds for the administration of the Medi-Cal program be advanced to the counties for the costs of administering the program, and provides that such advances may be made to counties for the costs of care under the program.

This bill would declare the Legislature's findings that counties would benefit from the bill's provisions and should contribute to the cost of providing health care coverage to persons who were without private coverage and ineligible for state coverage. The bill would declare the intent of the Legislature to establish a mechanism through which counties are required to contribute to the cost of providing health care coverage to individuals currently relying on counties for medical services.

(11) Existing law authorizes the California Medical Assistance Commission to negotiate selective provider contracts with eligible hospitals to provide inpatient hospital services to Medi-Cal beneficiaries. Under existing law, the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, specified hospital reimbursement methodologies are applied in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. Funding for the demonstration project comes from, in part, the Health Care Support Fund, which is a continuously appropriated fund in the State Treasury consisting of federal safety net

care pool funds, as defined, that are claimed and received by the department.

This bill would 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. The bill would require the State Department of Health Care Services to determine new methods and standards for payments for outpatient services, as defined, and to determine an inpatient base rate, as defined. The bill would authorize a designated public hospital, or governmental entity with which it is affiliated, that operates a nonhospital clinic or that provides other health care services other than hospital services, to receive from the Health Care Support Fund, to the extent funds are available, an amount equal to the federal funds derived from the certification of all or a portion of the hospital's or entity's uncompensated costs for providing services to the uninsured. If, for any fiscal year, the amount payable from the Health Care Support Fund pursuant to the act's provisions is insufficient, this bill would require each designated public hospital or governmental entity to receive a pro rata share of these funds, as determined in accordance with a specified formula. 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, as specified. The bill would specify, for the 2010–11 fiscal year, that the nonfederal share of payments for inpatient hospital services be made from appropriations in the annual Budget Act and would also specify, for the 2011–12 fiscal year and thereafter, the computation methodology for those payments. The bill would make implementation 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 or the Health Care Security and Cost Reduction Program, as specified, and the imposition of a 4% fee on the net patient revenue of acute care hospitals.

This bill would also 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, increased reimbursements for physicians, physician groups, podiatrists, and nonphysician medical practitioners, as defined, that are enrolled Medi-Cal providers eligible to receive payments for Medi-Cal services. The bill would permit some of these rate increases to be linked to specified performance measures, and would provide that these rate

increases would only be implemented 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.

(12) Existing law specifies certain covered benefits under the Medi-Cal program.

This bill would require the State Department of Health Care Services to establish a Healthy Action Incentives and Rewards Program, as specified, to be provided as a covered benefit under the Medi-Cal program to the extent allowed under federal law and to the extent that federal financial participation is provided for that purpose.

The bill would also establish, as a Medi-Cal benefit, the Comprehensive Diabetes Services Program to provide, to the extent allowed under federal law and to the extent federal participation is available and obtained for this purpose, comprehensive diabetes prevention and management services to individuals that meet specified eligibility criteria. The bill would require the State Department of Health Care Services to develop and implement incentives for fee-for-service eligible beneficiaries and providers who participate in the program, as provided.

The bill would require the department, in consultation with the California Diabetes Program, which this bill would also create within the State Department of Public Health, to contract with an independent organization to evaluate and report health outcomes and cost savings in connection to the Comprehensive Diabetes Services Program. The bill would require the California Diabetes Program to provide information on diabetes prevention to the public and technical assistance to the Medi-Cal program and the State Department of Health Care Services provided that funds are appropriated for those purposes, as specified.

(13) 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, as defined, of 2 or more full-time equivalent employees in the state 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.

(14) Existing law, the Personal Income Tax Law, authorizes various deductions in computing income that is subject to tax under that law and also authorizes various credits against the taxes imposed by that law.

This bill would, for taxable years beginning on or after January 1, 2010, allow a deduction in connection with health savings accounts in conformity with federal law. In general, the deduction would be an amount equal to the aggregate amount paid in cash during the taxable year by or on behalf of an eligible individual, as defined, to a health savings account of that individual, as provided. This bill would provide related conformity to federal law with respect to treatment of the account as a tax-exempt trust, the allowance of rollovers from the Archer Medical Savings Accounts to a health savings account, and penalties in connection therewith. The bill would also declare the intent of the Legislature to establish a tax credit to enhance the affordability of health care coverage for persons and families not eligible for enrollment in publicly subsidized coverage, as specified, and would set forth the intended structure of that tax credit.

(15) 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.

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

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

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

(17) Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law prohibits a physician from supervising more than 2 physician assistants at one time, except as specified.

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

(18) Existing law relative to insurance fraud makes it a crime for healing arts practitioners to receive money or other consideration for, or to engage in various related activities with respect to, the referral of patients, clients, or customers to any person. Existing law exempts from this provision specified entities that receive nonmonetary remuneration necessary and used solely to receive and transmit electronic prescription information, with regard to specified drugs.

This bill would include all drugs covered by the Medi-Cal program as drugs eligible for the exemptions, and would exempt from the prohibition pharmacists or pharmacies participating in the network of a Medi-Cal managed care organization and health care professionals receiving such remuneration from Medi-Cal managed care organizations.

The bill would also define electronic prescribing, and would require electronic prescribing and electronic prescribing systems to meet specified standards and requirements, including the sharing of specified information. The bill would require a prescriber or prescriber's authorized agent to give patients a written receipt containing specified

information, 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 Medi-Cal, as specified. The bill would require every licensed prescriber, or prescriber's authorized agent, or pharmacy operating in California to, on or before January 1, 2010, have the ability to transmit and receive prescriptions by electronic data transmission.

(19) Existing law, the Public Employees' Medical and Hospital Care Act, authorizes the Board of Administration of the Public Employees' Retirement System to contract with carriers of health benefit plans and major medical plans for employees and annuitants, as defined, and approve other specified plans.

This bill would require the board to provide or arrange for the provision of a Healthy Action Incentives and Rewards Program, as specified, to all enrollees. The bill would also authorize the Public Employees' Retirement System, the Medi-Cal program, and the Healthy Families Program to provide or arrange for the provision of an electronic personal health record meeting specified requirements for enrollees receiving health care benefits, to the extent that funds are appropriated for that purpose. The bill would require that system or software that pertains to the personal health record to adhere to accepted national standards for interoperability, privacy, and data exchange, or be certified by a nationally recognized certifying body, and comply with applicable state and federal confidentiality and data security requirements.

(20) 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.

This bill would also create the Health Care Cost and Quality Transparency Committee to be composed of 7 members to be appointed by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly, as specified. The bill would require the committee to meet at least monthly and to, within one year of its first meeting, develop

and present to the Secretary of California Health and Human Services a health care cost quality and transparency plan consisting of specified strategies in order to, among other things, assist in efforts to reduce health care costs in the health care system. The bill would provide for the abolition of the committee on January 1, 2011.

The bill would also require that a lead agency, as defined, provide administrative support to the committee. The bill would specify the authority and responsibilities of the lead agency, including, but not limited to, the responsibility to determine the data to be collected and the authority to appoint advisory committees and to contract with a qualified agency or public academic institution, as specified. The bill would require the lead agency to provide the Secretary of California Health and Human Services with a proposal that would identify possible financial resources to implement these provisions.

(21) Existing law requires the governing board of any school district to make rules for the physical examination of pupils that will ensure proper care of the pupils and proper secrecy with regard to any defects noted.

This bill would authorize each school district, on and after January 1, 2010, to provide an information sheet developed by the State Department of Education, in consultation with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the parent or legal guardian of specified pupils. The information sheet would be required to include, among other information, an explanation of the minimum health care coverage requirements imposed by this act, as specified.

(22) This bill would give the Director 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 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.

(23) 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 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. The bill would express the Legislature's intent that the act's provisions be financed by contributions from public and private sources, including fees paid by acute care hospitals and by employers.

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

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

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

~~Existing law does not provide for a health care system for all California residents. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board and the Medi-Cal program administered by the State Department of Health Care Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.~~

~~This bill would state that it is the intent of the Legislature to enact comprehensive health care reform.~~

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

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

1 *SECTION 1. This act shall be known and may be cited as the*
2 *Health Care Security and Cost Reduction Act.*
3 *SEC. 2. Section 650 of the Business and Professions Code, as*
4 *amended by Chapter 483 of the Statutes of 2007, is amended to*
5 *read:*
6 650. (a) Except as provided in Chapter 2.3 (commencing with
7 Section 1400) of Division 2 of the Health and Safety Code, the
8 offer, delivery, receipt, or acceptance by any person licensed under

this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a ~~federally- qualified~~ *federally qualified* health center, as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility; provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) (1) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, necessary and used solely to receive and transmit electronic prescription information in accordance with the standards set forth in Section 1860D-4(e) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. Sec. 1395w-104) in the following situations:

(A) In the case of a hospital, by the hospital to members of its medical staff.

(B) In the case of a group medical practice, by the practice to prescribing health care professionals that are members of the practice.

(C) In the case of Medicare prescription drug plan sponsors or Medicare Advantage organizations, by the sponsor or organization to pharmacists and pharmacies participating in the network of the sponsor or organization and to prescribing health care professionals.

(D) In the case of a Medi-Cal managed care organization, by the organization to pharmacists and pharmacies participating in the network of the organization and to prescribing health care professionals.

(2) The exceptions set forth in this subdivision are adopted to conform state law with the provisions of Section 1860D-4(e)(6) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. Sec. 1395w-104) and are limited to drugs covered under Part D of the federal Medicare Program that are prescribed to Part D eligible individuals (42 U.S.C. Sec. 1395w-101) *and drugs covered by the Medi-Cal program*.

(3) The exceptions set forth in this subdivision shall not be operative until the regulations required to be adopted by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1860D-4(e) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. Sec. 1395W-104) are effective. If the California Health and Human Services Agency determines that regulations are necessary to ensure that implementation of the provisions of

paragraph (1) is consistent with the regulations adopted by the Secretary of the United States Department of Health and Human Services, it shall adopt emergency regulations to that effect.

(f) 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. Pharmacies and prescribers shall share, when available, patient eligibility information, drug formularies, drug costs including generic alternatives, the patient's medical history including other prescribed medications and allergies, and medication reference information between a prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an electronic prescribing network.

~~(f)~~

(g) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

~~(g)~~

(h) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not exceeding fifty thousand dollars ($50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison or by imprisonment in the state prison and a fine of fifty thousand dollars ($50,000).

SEC. 3. Section 650.5 is added to the Business and Professions Code, to read:

650.5. (a) Notwithstanding Section 650 or any other provision of law, the provision by a health care provider, or his or her agent, of legally recognized incentives and rewards delivered for the purposes of and in accordance with the criteria and requirements established under Section 1367.38 of the Health and Safety Code, Section 10123.56 of the Insurance Code, Section 96.8 of the Labor Code, or Sections 14132.23 and 14132.105 of the Welfare and Institutions Code shall not be considered or construed as an unlawful practice, act, kickback, bribe, rebate, remuneration, offer,

payment, or any other form of compensation made directly or indirectly, overtly or covertly, in exchange for another to obtain, participate, or otherwise undergo or receive health care services.

(b) 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. 4. 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 ~~a~~ licensed podiatrist. ~~A medical assistant may also perform all these tasks and services in a clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code upon the specific authorization of a physician assistant, a nurse practitioner, or a nurse-midwife.~~

(2) The ~~supervising physician and surgeon at a clinic described in paragraph (1)~~ *licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist* 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 ~~supervising physician and surgeon~~ *licensed physician and surgeon, nurse practitioner, nurse-midwife, physician assistant, or licensed podiatrist* 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 ~~supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a),~~ *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 ~~supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the nurse-midwife as provided in subdivision (a),~~ *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 ~~as provided in subdivision (a)~~.
(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 ~~or~~*,* a licensed podiatrist, ~~or~~ a physician assistant, a nurse practitioner, or a nurse-midwife ~~as provided in subdivision (a)~~.
(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 2836.1 of the Business and Professions Code is amended to read:

2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:
(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner’s educational

preparation or for which clinical competency has been established and maintained.

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

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

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

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

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

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

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the

controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

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

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

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

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

SEC. 6. 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 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.

SEC. 7. Section 3516 of the Business and Professions Code is amended to read:

3516. Notwithstanding any other provision of law, ~~any~~ *a* physician assistant licensed by the committee shall be eligible for employment or supervision by any physician approved by the board to supervise physician assistants, except that:

(a) No physician *and surgeon* shall supervise more than ~~two~~ *six* physician assistants at any one time, except as provided in ~~Sections~~ *Section* 3502.5~~, 3516.1, and 3516.5~~.

(b) The board may restrict ~~physicians~~ *a physician and surgeon* to supervising specific types of physician assistants, including, but not limited to, restricting ~~physicians~~ *a physician and surgeon* from supervising physician assistants outside of the ~~physician's~~ field of specialty *of the physician and surgeon*.

SEC. 8. Section 3516.1 of the Business and Professions Code is repealed.

~~3516.1. (a) (1) Notwithstanding any other provision of law, a physician who provides services in a medically underserved area may supervise not more than four physician assistants at any one time.~~

~~(2) As used in this section, "medically underserved area" means a "health professional(s) shortage area" (HPSA) as defined in Part 5 (commencing with Section 5.1) of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225 of the Health and Safety Code.~~

~~(b) 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. 9. Section 4040.1 is added to the Business and Professions Code, to read:

4040.1. 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.

SEC. 10. Section 4071.2 is added to the Business and Professions Code, to read:

4071.2. (a) On or before January 1, 2010, 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. 11. 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. 12. 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. 13. 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.

1 *(3) A pupil enrolled during the course of the year in the case of*
2 *children who have recently arrived, and intend to remain, in*
3 *California.*
4 *(b) The information sheet described in subdivision (a) shall*
5 *include all of the following:*
6 *(1) An explanation of the health insurance requirements under*
7 *Section 8899.50 of the Government Code.*
8 *(2) Information on the important relationship between health*
9 *and learning.*
10 *(3) A toll-free telephone number to request an application for*
11 *Healthy Families, Medi-Cal, or other government-subsidized health*
12 *insurance programs.*
13 *(4) Contact information for county public health departments.*
14 *(5) A statement of privacy applicable under state and federal*
15 *laws and regulations.*
16 *(c) By January 1, 2010, the State Department of Education*
17 *shall, in consultation with the State Department of Health Care*
18 *Services and the Managed Risk Medical Insurance Board, develop*
19 *a standardized template for the information sheet required by this*
20 *section. To the extent possible, the information provided pursuant*
21 *to this section shall be consolidated with the information listed in*
22 *subdivision (c) of Section 49452.8 into one document. The State*
23 *Department of Education shall make the template available on its*
24 *Internet Web site and shall, upon request, provide written copies*
25 *of the template to a school district.*
26 *SEC. 14. Chapter 15 (commencing with Section 8899.50) is*
27 *added to Division 1 of Title 2 of the Government Code, to read:*
28
29 *Chapter 15. Minimum Health Care Coverage*
30
31 *8899.50. (a) On and after July 1, 2010, every California*
32 *resident shall be enrolled in and maintain at least minimum health*
33 *care coverage.*
34 *(b) On and after July 1, 2010, a subscriber shall obtain at least*
35 *minimum health care coverage for any individual who qualifies*
36 *as his or her dependent, as defined by Section 152 of the United*
37 *States Internal Revenue Code, as applicable for purposes of Part*
38 *10 of the Revenue and Taxation Code (commencing with Section*
39 *17001).*

1 *(c) Notwithstanding subdivisions (a) and (b), compliance with*
2 *those subdivisions shall not be required until Section 8899.52 is*
3 *implemented.*
4 *8899.51. For purposes of this chapter, the following definitions*
5 *shall apply:*
6 *(a) "Minimum health care coverage" means enrollment in any*
7 *of the following:*
8 *(1) A health plan contract that provides at least the minimum*
9 *health care coverage pursuant to Section 1399.824 of the Health*
10 *and Safety Code.*
11 *(2) A health insurance policy that provides at least the minimum*
12 *health care coverage pursuant to Section 10923 of the Insurance*
13 *Code.*
14 *(3) The federal Medicare Program pursuant to Title XVIII of*
15 *the federal Social Security Act if the scope of services covered is*
16 *equivalent to that covered by Medicare Parts A and B.*
17 *(4) The Medicaid Program pursuant to Title XIX of the Social*
18 *Security Act, but only if the individual has full scope coverage with*
19 *either (A) no share of cost or (B) a share of cost but eligibility was*
20 *established on the basis of his or her status as aged, blind, or*
21 *disabled.*
22 *(5) The Healthy Families Program pursuant to Part 6.2*
23 *(commencing with Section 12693) of Division 2 of the Insurance*
24 *Code.*
25 *(6) A medical care program of the Indian Health Service or of*
26 *a tribal organization.*
27 *(7) A health plan offered under Chapter 9 (commencing with*
28 *Section 8901) of Title 5 of the United States Code (Federal*
29 *Employees Health Benefits Program (FEHBP)).*
30 *(8) A public health plan as defined in federal regulations*
31 *authorized by Section 2701(c)(1)(I) of the Public Health Service*
32 *Act, as amended by Public Law 104-191, the Health Insurance*
33 *Portability and Accountability Act of 1996.*
34 *(9) A health benefit plan under Section 5(e) of the Peace Corps*
35 *Act (22 U.S.C. Sec. 2504(e)).*
36 *(10) Subsidized or unsubsidized health care coverage made*
37 *available in the program established pursuant to Part 6.45*
38 *(commencing with Section 12699.201) of Division 2 of the*
39 *Insurance Code.*

(11) County-sponsored health care coverage that includes both inpatient and outpatient care for low-income persons not otherwise eligible for subsidized coverage.

(12) Employer-sponsored health care coverage.

(13) Group health care coverage that is provided pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and that provides at least minimum health care coverage as defined in Section 1399.824 of the Health and Safety Code.

(14) Group health insurance, as defined by subdivision (b) of Section 106 of the Insurance Code, that covers hospital, surgical, and medical care expenses and that provides at least minimum health care coverage as defined in Section 10923 of the Insurance Code. For the purposes of this section, group health insurance shall not include Medicare supplement, vision-only, dental-only, behavioral health-only, pharmacy-only, CHAMPUS-supplement or Tricare supplement, hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash-payment-only basis.

(15) A Taft-Hartley health and welfare fund or any other lawful collective bargaining agreement that provides for health and welfare coverage for collective bargaining unit employees or other employees thereby covered.

(16) An employer-sponsored group health plan meeting the requirements of the federal Employee Retirement Income Security Act of 1974.

(17) A multiple employer welfare arrangement that holds a valid certificate of compliance under Section 742.20 of the Insurance Code.

(18) Health coverage provided under the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22850) of Division 5 of Title 2).

(19) Health coverage provided under the Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code).

(20) Health care coverage through CHAMPUS or Tricare or health care coverage for veterans.

(21) Health care coverage for students through a group or blanket health plan or health insurance policy issued to an

institution of higher education that is accredited by an accreditation agency.

(b) "California resident" means an individual who is a resident of the state pursuant to Section 244 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 for health care coverage or after acceptance.

(c) "Subscriber" means the individual who is responsible for payment to a health care service plan or to a health insurer or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

8899.52. (a) The Secretary of California Health and Human Services shall establish methods by which individuals who have not obtained health care coverage will 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 secretary may also establish methods to ensure that uninsured individuals obtain the minimum required coverage. The secretary may pay the cost of health care coverage on behalf of an uninsured individual enrolled in minimum health care coverage and may establish methods by which funds advanced for coverage may be recouped by the state from individuals for whom coverage is purchased. The recoupment may include interest. The secretary may enter into an agreement with the Franchise Tax Board to use the 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.

(b) To the extent possible, activities undertaken pursuant to this section 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. The Franchise Tax Board, the Employment Development Department, the Department of Motor Vehicles, and other appropriate state agencies shall cooperate with the secretary and other responsible entities in undertaking these activities and implementing this section.

(c) The secretary may enter into, or authorize entities within the agency to enter into, agreements with other agencies or departments to perform the activities required under this section.

1 *In addition, the secretary may contract with private vendors to*
2 *accomplish the purposes of this section.*
3 *(d) The Secretary shall adopt regulations, as appropriate, to*
4 *implement this section.*
5 *(e) Implementation of this section shall be contingent on the*
6 *appropriation of funds for the purposes of this section in the annual*
7 *Budget Act or another statute.*
8 *SEC. 15. Section 12803.2 is added to the Government Code,*
9 *to read:*
10 *12803.2. (a) (1) The Secretary of California Health and*
11 *Human Services, in collaboration with other relevant state*
12 *agencies, shall track and assess the effects of health care reform*
13 *as set forth in the act enacting this section. The secretary shall*
14 *either complete the assessment or contract for its preparation. The*
15 *secretary may seek other sources of funding, including grants, to*
16 *fund the assessment. The assessment shall include, at minimum,*
17 *the following components:*
18 *(A) An assessment of the sustainability and solvency of the*
19 *program established pursuant to Part 6.45 (commencing with*
20 *Section 12699.201) of Division 2 of the Insurance Code. This*
21 *assessment shall include data regarding persons purchasing health*
22 *care coverage through that program.*
23 *(B) An assessment of the cost and affordability of health care*
24 *in California. This assessment shall include the cost of health care*
25 *coverage products for individuals and families obtained through*
26 *employers, city and county governments, the Medi-Cal program,*
27 *the Healthy Families Program, the Public Employees' Medical*
28 *and Hospital Care Act, Medicare Advantage plans, and the*
29 *individual market.*
30 *(C) An assessment of the health care coverage market in*
31 *California, including a review of the various insurers and health*
32 *care service plans, their offerings, their efficiency in providing*
33 *health care services, and their financial conditions, including their*
34 *medical loss ratios.*
35 *(D) An assessment of the effect on employers and employment,*
36 *including employer administrative costs, employee turnover rate,*
37 *and wages categorized by the type of employer and the size of the*
38 *business.*
39 *(E) An assessment of the change in access and availability of*
40 *health care coverage throughout the state, including tracking the*

1 *availability of health care coverage products in rural and other*
2 *underserved areas of the state and assessing the adequacy of the*
3 *health care delivery infrastructure to meet the need for health care*
4 *services. This assessment shall include a more in-depth review of*
5 *areas of the state that were determined to be medically underserved*
6 *in 2007.*
7 *(F) An assessment of the impact on the county health care safety*
8 *net system, including a review of the amount of uncompensated*
9 *care and emergency room use.*
10 *(G) An overall assessment of health care coverage.*
11 *(H) An assessment of the capacity of the various health care*
12 *professions and facilities to provide care to Californians.*
13 *(2) An advisory body of individuals with knowledge and*
14 *expertise in health care policy and financing shall provide input*
15 *on the assessment described in paragraph (1). The Governor shall*
16 *appoint five members to the advisory body, the Senate Committee*
17 *on Rules shall appoint two members, and the Speaker of the*
18 *Assembly shall appoint two members.*
19 *(3) To the extent possible, the assessment described in*
20 *paragraph (1) shall maximize the use of current surveys and*
21 *databases.*
22 *(4) To the extent feasible, in order to track the effect of health*
23 *care reform on ongoing trends in the health care field, the*
24 *assessment described in paragraph (1) shall include data from*
25 *years prior to the enactment of the program established pursuant*
26 *to Part 6.45 (commencing with Section 12699.201) of Division 2*
27 *of the Insurance Code.*
28 *(5) The Secretary of California Health and Human Services*
29 *shall submit the assessment described in paragraph (1) to the*
30 *appropriate policy and fiscal committees of the Legislature on or*
31 *before March 1, 2012. The secretary shall update the assessment*
32 *biennially.*
33 *(b) The California Health and Human Services Agency, in*
34 *consultation with the Board of Administration of the Public*
35 *Employees' Retirement System, and after consultation with affected*
36 *health care provider groups, shall develop health care provider*
37 *performance measurement benchmarks and may incorporate these*
38 *benchmarks into a common pay for performance model to be*
39 *offered in every state-administered health care program, including,*
40 *but not limited to, programs pursuant to the Public Employees'*

1 *Medical and Hospital Care Act, the Healthy Families Program,*
2 *the Major Risk Medical Insurance Program, the Medi-Cal*
3 *program, and the Health Care Security and Cost Reduction*
4 *Program. These benchmarks shall be developed to advance a*
5 *common statewide framework for health care quality measurement*
6 *and reporting, including, but not limited to, measures that have*
7 *been approved by the National Quality Forum (NQF) such as the*
8 *Health Plan Employer Data and Information Set (HEDIS) and the*
9 *Joint Commission on Accreditation of Health Care Organizations*
10 *(JCAHO), and that have been adopted by the Hospitals Quality*
11 *Alliance and other national and statewide groups concerned with*
12 *quality.*
13 *SEC. 16. Section 22830.5 is added to the Government Code,*
14 *to read:*
15 *22830.5. (a) On or before January 1, 2009, the board shall*
16 *provide or arrange for the provision of an electronic personal*
17 *health record for enrollees receiving health care benefits. The*
18 *record shall be provided for the purpose of providing enrollees*
19 *with information to assist them in understanding their coverage*
20 *benefits and managing their health care.*
21 *(b) At a minimum, the personal health record shall provide*
22 *access to real-time, patient-specific information regarding*
23 *eligibility for covered benefits and cost sharing requirements. Such*
24 *access can be provided through the use of an Internet-based*
25 *system.*
26 *(c) In addition to the data required pursuant to subdivision (b),*
27 *the board may determine that the personal health record shall also*
28 *incorporate additional data, such as laboratory results,*
29 *prescription history, claims history, and personal health*
30 *information authorized or provided by the enrollee. Inclusion of*
31 *this additional data shall be at the option of the enrollee.*
32 *(d) Systems or software that pertain to the personal health*
33 *record shall adhere to accepted national standards for*
34 *interoperability, privacy, and data exchange, or shall be certified*
35 *by a nationally recognized certification body.*
36 *(e) The personal health record shall comply with applicable*
37 *state and federal confidentiality and data security requirements.*
38 *SEC. 17. Section 22830.6 is added to the Government Code,*
39 *to read:*

1 *22830.6. On or before January 1, 2009, the board shall provide*
2 *or arrange for the provision of a Healthy Action Incentives and*
3 *Rewards Program, as described in subdivision (c) of Section*
4 *1367.38 of the Health and Safety Code, to all enrollees.*
5 *SEC. 18. Section 1262.9 is added to the Health and Safety*
6 *Code, to read:*
7 *1262.9. (a) If a patient has coverage for emergency health*
8 *care services and poststabilizing care, a noncontracting hospital*
9 *shall not bill the patient for emergency health care services and*
10 *poststabilizing care, except for applicable copayments and cost*
11 *shares.*
12 *(b) The noncontracting hospital and the health care service*
13 *plan or health insurer shall each retain their right to pursue all*
14 *currently available legal remedies they may have against each*
15 *other, including the right to determine the final payment due.*
16 *(c) For the purposes of this section:*
17 *(1) "Noncontracting hospital" means a general acute care*
18 *hospital as defined in subdivision (a) of Section 1250 that has a*
19 *special permit to operate an emergency medical service and does*
20 *not have a contract with a health care service plan or a health*
21 *insurer for the provision of emergency health care services and*
22 *poststabilizing care to the patient, who is one of that health care*
23 *service plan's or health insurer's enrollees, members, or insureds.*
24 *(2) "Emergency health care services and poststabilizing care"*
25 *means emergency services and out-of-area urgent services provided*
26 *in an emergency department and a hospital through discharge in*
27 *compliance with Sections 1262.8 and 1317 and, in the case of*
28 *health care service plans, the services required to be covered*
29 *pursuant to paragraph (6) of subdivision (b) of Section 1345,*
30 *subdivision (i) of Section 1367, Sections 1371.4, and 1371.5, of*
31 *this code, and Sections 1300.67(g) and 1300.71.4 of Title 28 of*
32 *the California Code of Regulations.*
33 *SEC. 19. Section 1342.9 is added to the Health and Safety*
34 *Code, to read:*
35 *1342.9. (a) Notwithstanding any other provision of this*
36 *chapter, a health care service plan that provides services to a*
37 *beneficiary of the Medi-Cal program pursuant to Article 2.7*
38 *(commencing with Section 14087.3) of, Article 2.8 (commencing*
39 *with Section 14087.5) of, or Article 2.91 (commencing with Section*
40 *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 1356.2 is added to the Health and Safety Code, to read:

1356.2. It is the intent of the Legislature to establish a mechanism by which the state may defray the costs of an enrollee's public program participation by taking advantage of other opportunities for coverage available to that enrollee.

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 ~~such~~ *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. 23. 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. 24. Section 1367.205 is added to the Health and Safety Code, to read:

1 *1367.205. Commencing on or before January 1, 2010, a health*
2 *care service plan that provides prescription drug benefits and*
3 *maintains one or more drug formularies shall make the most*
4 *current formularies available electronically to prescribers and*
5 *pharmacies.*
6 *SEC. 25. Section 1367.38 is added to the Health and Safety*
7 *Code, to read:*
8 *1367.38. (a) A full-service health care service plan, except*
9 *for a Medicare supplement plan, that offers, delivers, amends, or*
10 *renews a contract on or after January 1, 2009, that covers hospital,*
11 *medical, or surgical expenses on a group basis shall offer at least*
12 *one benefit design that includes a Healthy Action Incentives and*
13 *Rewards Program as described in subdivision (c). Any plan subject*
14 *to this section shall communicate the availability of the Healthy*
15 *Action Incentives and Rewards Program coverage to all group*
16 *subscribers and to all prospective group subscribers with whom*
17 *they are negotiating.*
18 *(b) In addition to benefit designs offered pursuant to subdivision*
19 *(a), every health care service plan contract offered, delivered,*
20 *amended, or renewed on or after January 1, 2009, that offers*
21 *coverage on a group basis shall offer a Healthy Action Incentives*
22 *and Rewards Program, as described in subdivision (c), as a*
23 *supplement to every contract that covers hospital, medical, or*
24 *surgical expenses and that does not include a Healthy Action*
25 *Incentives and Rewards Program as part of the overall benefit*
26 *design.*
27 *(c) For purposes of this section, benefits for a Healthy Action*
28 *Incentives and Rewards Program shall provide for all of the*
29 *following:*
30 *(1) Health risk appraisals to be used to assess an individual's*
31 *overall health status and to identify risk factors, including, but not*
32 *limited to, smoking and smokeless tobacco use, alcohol abuse,*
33 *drug use, and nutrition and physical activity practices.*
34 *(2) A followup appointment with a licensed health care*
35 *professional acting within his or her scope of practice to review*
36 *the results of the health risk appraisal and discuss any*
37 *recommended actions.*
38 *(3) Incentives or rewards for enrollees to become more engaged*
39 *in their health care and to make appropriate choices that support*
40 *good health, including obtaining health risk appraisals, screening*

1 *services, immunizations, or participating in healthy lifestyle*
2 *programs and practices. These programs and practices may*
3 *include, but need not be limited to, smoking cessation, physical*
4 *activity, or nutrition. Incentives may include, but need not be*
5 *limited to, health premium reductions, differential copayment or*
6 *coinsurance amounts, and cash payments. Rewards may include,*
7 *but need not be limited to, nonprescription pharmacy products or*
8 *services not otherwise covered under an enrollee's health plan*
9 *contract, exercise classes, gym memberships, and weight*
10 *management programs. If a health care service plan elects to offer*
11 *an incentive in the form of a reduction in the premium amount,*
12 *the premium reduction shall be standardized and uniform for all*
13 *groups and subscribers and shall be offered only after the*
14 *successful completion of the specified program or practice by the*
15 *enrollee or subscriber.*
16 *(d) In order to demonstrate compliance with this section, a*
17 *health care service plan may file an amendment to its application*
18 *for licensure pursuant to subdivision (a) of Section 1352.*
19 *(e) This section is in addition to, and does not replace, any other*
20 *section in this chapter concerning requirements for plans to*
21 *provide health care screening services, childhood immunizations,*
22 *adult immunizations, and preventive care services.*
23 *(f) (1) Notwithstanding any other provision of law, the provision*
24 *of healthy incentives and rewards pursuant to this section by a*
25 *health care provider, or his or her agent, that meets the*
26 *requirement of this section, shall not be considered or construed*
27 *as an unlawful practice, act, kickback, bribe, rebate, remuneration,*
28 *offer, coupon, product, payment, or any other form of compensation*
29 *by a provider or his or her agent, directly or indirectly, overtly or*
30 *covertly, in exchange for another to obtain, participate, or*
31 *otherwise undergo or receive health care services.*
32 *(2) Notwithstanding any other provision of law, incentives*
33 *authorized pursuant to this section are not subject to the penalties,*
34 *discipline, limitations, or sanctions imposed under law to preclude*
35 *or prohibit, as an unlawful practice, bribe, kickback, or other act,*
36 *the offering or delivery of a rebate, remuneration, offer, coupon,*
37 *product, rebate, payment, or any other form of compensation by*
38 *the provider, or his or her agent, directly or indirectly, overtly or*
39 *covertly, in exchange for another to obtain, participate, or*
40 *otherwise undergo or receive health care services.*

1 *(3) Notwithstanding any other provision of law, the provision*
2 *of healthy incentives and rewards pursuant to this section by a*
3 *health care provider, or his or her agent, that meets the*
4 *requirements of this section shall not be considered or construed*
5 *as an inducement to enroll.*
6 *(g) This section shall only be implemented if and to the extent*
7 *allowed under federal law. If any portion of this section is held to*
8 *be invalid, as determined by a final judgment of a court of*
9 *competent jurisdiction, this section shall become inoperative.*
10 *SEC. 26. Section 1368.025 is added to the Health and Safety*
11 *Code, to read:*
12 *1368.025. In addition to the duties listed in paragraph (3) of*
13 *subdivision (c) of Section 1368.02, the duties of the Office of*
14 *Patient Advocate shall include providing access to the public to*
15 *reports and data obtained by the lead agency pursuant to Section*
16 *128862 in a format and through mechanisms, including, but not*
17 *limited to, the Internet, that allow the public to use the information*
18 *to assist them in making informed selections of health plans,*
19 *hospitals, medical groups, nursing homes, and other providers*
20 *about whom the office has collected information.*
21 *SEC. 27. Section 1378.1 is added to the Health and Safety*
22 *Code, to read:*
23 *1378.1. (a) Except as provided in subdivision (f), a full-service*
24 *health care service plan shall, on and after July 1, 2010, expend*
25 *in the form of health care benefits no less than 85 percent of the*
26 *aggregate dues, fees, premiums, or other periodic payments*
27 *received by the plan during the plan fiscal year. For purposes of*
28 *this section, the plan may deduct from the aggregate dues, fees,*
29 *premiums, or other periodic payments received by the plan during*
30 *the plan fiscal year the amount of income taxes or other taxes that*
31 *the plan expensed for the same fiscal year. For purposes of this*
32 *section, "health care benefits" shall mean health care services*
33 *that are either provided by or reimbursed by the plan or its*
34 *contracted providers as plan benefits.*
35 *(b) (1) Health care benefits shall include:*
36 *(A) The costs of programs or activities, including training and*
37 *the provision of informational materials which improve the*
38 *provision of quality care, improve health care outcomes, and*
39 *encourage the use of evidence-based medicine.*

(B) Disease management expenses based 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 may average its total costs across all health care service plan contracts approved for sale in California by the department, and all health insurance policies of its affiliated disability insurers approved for sale in California, 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).

(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.

(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. 28. 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 written authorization from the applicant, enrollee, or subscriber to provide notices by electronic transmission and to cease providing notices by United States mail. The authorization shall be renewed by the enrollee or subscriber on an annual basis.

If the health care service plan obtains an application for coverage by electronic transmission, it may obtain authorization by electronic transmission from the applicant, enrollee, or subscriber to provide notices by electronic transmission.

(2) Uses an authorization form, approved by the department, in which the applicant, enrollee, or subscriber confirms understanding of the type of notice 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.

(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.

(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 sending a notice as described in subdivision (a).

(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.

(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 provider of an applicant, enrollee, or subscriber if the provider 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) "Notice" for purposes of this section includes 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.

SEC. 29. Article 11.6 (commencing with Section 1399.821) 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

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

(a) "Anniversary date" means the calendar date an individual has enrolled 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, child, or registered domestic partner 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 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 a health care service plan contract offered, sold, amended, or renewed to individuals and their dependents. The term shall not include accident only, credit, disability income, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. 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 below 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 accord 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 July 1, 2009, a health plan shall not offer to an individual a health plan contract that provides less than minimum health care coverage.

1399.824. (a) Minimum heath care coverage that must be maintained by an individual pursuant to Section 8899.50 of the Government Code shall be established by the Secretary of California Health and Human Services through the adoption of regulations pursuant to this section. That coverage shall include hospital, medical, and preventive services.

(b) In determining the scope of services, and the enrollee and dependent deductible, coinsurance, and copayment requirements, the secretary shall consider whether those costs would deter an enrollee or his or her dependents from obtaining appropriate and timely care, including consideration of preventive services outside any deductible.

(c) In determining the scope of services, and the enrollee and dependent deductible, coinsurance, and copayment requirements, and any coverage of services outside the deductible, the secretary shall consider whether the resulting premium cost would prevent an enrollee from obtaining coverage at a reasonable price.

(d) The secretary shall consult with the Insurance Commissioner and the Director of the Department of Managed Health Care in the development of these regulations.

(e) The secretary shall adopt regulations establishing the minimum healthcare coverage pursuant to subdivision (a) on or

1 *before March 1, 2009. Upon adoption, these regulations shall not*
2 *be amended unless expressly permitted by a subsequent statute.*
3 *(f) The secretary may designate an administrative entity within*
4 *the agency to accomplish the requirements of this section.*
5 *1399.825. [Reserved]*
6 *1399.826. (a) Notwithstanding Chapter 15 (commencing with*
7 *Section 8899.50) of Division 1 of Title 2 of the Government Code*
8 *and Section 1399.823, an individual enrolled in any individual*
9 *health plan contract prior to March 1, 2009, may maintain*
10 *coverage in that health plan contract indefinitely. An individual*
11 *who maintains coverage in a health plan contract pursuant to this*
12 *section shall be deemed to be in compliance with Section 8899.50*
13 *of the Government Code.*
14 *(b) A health plan shall not cease to renew coverage in an*
15 *individual health plan contract described in subdivision (a) except*
16 *as permitted pursuant to Section 1367.15.*
17 *(c) On and after March 1, 2009, the director shall not approve*
18 *for offer and sale in this state any benefit design that was not*
19 *approved prior to that date that does not meet or exceed the*
20 *minimum health care coverage requirements of Section 1399.824.*
21 *(d) This section shall become operative on January 1, 2009.*
22 *1399.827. A health plan shall, in addition to complying with*
23 *this chapter and the rules of the director, comply with this article.*
24 *1399.828. This article shall not apply to health plan contracts*
25 *for coverage of Medicare services pursuant to contracts with the*
26 *United States government, Medicare supplement, Medi-Cal*
27 *contracts with the State Department of Health Care Services,*
28 *Healthy Families Program contracts with the Managed Risk*
29 *Medical Insurance Board, long-term care coverage, specialized*
30 *health care service plan contracts, as defined in subdivision (o)*
31 *of Section 1345, or the purchasing pool established under Part*
32 *6.45 (commencing with Section 12699.201) of Division 2 of the*
33 *Insurance Code.*
34 *1399.829. (a) Except for the health plan contracts described*
35 *in subdivision (a) of Section 1399.826, a health plan shall fairly*
36 *and affirmatively offer, market, and sell all of the plan's contracts*
37 *that are sold to individuals to all individuals in each service area*
38 *in which the health plan provides or arranges for the provision of*
39 *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 request 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. 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 Section 1399.846, this section shall not become operative until the authority under Section 8899.52 of the Government Code is implemented.

1399.830. [Reserved]

1399.831. 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.

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.

(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) All health plans that offer coverage on an individual basis shall offer at least one health plan contract in each coverage choice 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

1 *chapter are met, and provided that the provider network offered*
2 *for one health plan contract in one coverage choice category is*
3 *offered for at least one health plan contract in each coverage*
4 *choice category.*
5 *(f) A health plan shall establish prices for its products that*
6 *reflect a reasonable continuum between the products offered in*
7 *the coverage choice category with the lowest level of benefits and*
8 *the products offered in the coverage choice category with the*
9 *highest level of benefits. A health plan shall not establish a*
10 *standard risk rate for a product in a coverage choice category at*
11 *a lower rate than a product offered in a lower coverage choice*
12 *category.*
13 *(g) The coverage choice category with the lowest level of*
14 *benefits shall include the benefits specified in Section 1399.824.*
15 *1399.833. A health plan shall offer coverage for a Healthy*
16 *Action Incentives and Rewards Program that complies with the*
17 *requirements of subdivision (c) of Section 1367.38 in at least one*
18 *health plan contract in every coverage choice category.*
19 *1399.834. The Office of the Patient Advocate shall develop*
20 *and maintain on its Internet Web site a uniform benefits matrix of*
21 *all available individual health plan contracts and individual health*
22 *insurance policies arranged by coverage choice category. This*
23 *uniform benefit matrix shall include all of the following:*
24 *(a) Benefit information submitted by health plans pursuant to*
25 *Section 1399.843 and by health insurers pursuant to Section 10940*
26 *of the Insurance Code, including, but not limited to, the following*
27 *category descriptions:*
28 *(1) Deductibles.*
29 *(2) Copayments or coinsurance, as applicable.*
30 *(3) Annual out-of-pocket maximums.*
31 *(4) Professional services.*
32 *(5) Outpatient services.*
33 *(6) Preventive services.*
34 *(7) Hospitalization services.*
35 *(8) Emergency health services.*
36 *(9) Ambulance services.*
37 *(10) Prescription drug coverage.*
38 *(11) Durable medical equipment.*
39 *(12) Mental health and substance abuse services.*
40 *(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) A social health maintenance organization, as described in subdivision (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (Public Law 98-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has 50 percent or more of the organization's total enrollment premiums

1 *paid by the Medi-Cal program or Medicare programs, or by a*
2 *combination of Medi-Cal and Medicare. In no event shall this*
3 *exemption be based upon enrollment in Medicare supplement*
4 *contracts, as described in Article 3.5 (commencing with Section*
5 *1358).*
6 *1399.837. (a) If an individual disenrolls from a health plan*
7 *contract or health insurance policy or if the individual's health*
8 *plan contract or health insurance policy is canceled pursuant to*
9 *Section 1399.839 or Section 10936 of the Insurance Code prior*
10 *to the anniversary date of the health plan contract or health*
11 *insurance policy, subsequent enrollment in any individual product*
12 *shall be in the same coverage choice category the individual was*
13 *enrolled in prior to disenrollment or cancellation.*
14 *(b) (1) An individual may change to a health plan contract in*
15 *a different coverage choice category only on the anniversary date*
16 *of the subscriber or upon a qualifying event.*
17 *(2) In no case, however, may an individual move up more than*
18 *one coverage choice category on the anniversary date of the*
19 *subscriber unless there is also a qualifying event.*
20 *(c) An individual health plan contract described in subdivision*
21 *(a) of Section 1399.826 that does not meet or exceed the minimum*
22 *health care coverage requirements of Section 1399.824 shall be*
23 *deemed to be the lowest coverage choice category for purposes of*
24 *this section.*
25 *(d) On and after January 1, 2011, an individual who fails to*
26 *comply with the provisions of Chapter 15 (commencing with*
27 *Section 8899.50) of Division 1 of Title 2 of the Government Code*
28 *for more than 30 days may only enroll in a health plan contract*
29 *or health insurance policy in the lowest coverage choice category.*
30 *Upon the individual's anniversary date, the individual may move*
31 *to a higher coverage choice category pursuant to subdivision (b).*
32 *(e) For purposes of this section, a qualifying event occurs upon*
33 *any of the following:*
34 *(1) Upon the death of the subscriber, on whose qualifying*
35 *coverage an individual was a dependent.*
36 *(2) Upon marriage of the subscriber or entrance by the*
37 *subscriber into a domestic partnership pursuant to Section 298.5*
38 *of the Family Code.*
39 *(3) Upon divorce or legal separation of an individual from the*
40 *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 health care coverage as defined in paragraphs (3) to (19), inclusive, of subdivision (a) of Section 8899.51 of the Government 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 assure 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 cancelled 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 such 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 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 three 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.

(2) After the first three 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 10 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 six years following the implementation of this section, a health plan shall base rates on the standard risk rate. However, the director and the Insurance Commissioner may jointly delay implementation of this paragraph for one year if required to ensure availability of coverage in the individual market. At the end of that year, the director and the Insurance Commissioner shall review the necessity for the delay and may extend the delay for an additional year.

(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 category and contracts for individuals in the 30 to 35 years of age category.

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 may 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 subdivision (k) of Section 1399.821 and Section 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 subdivision (k) of Section 1399.821 and Section 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 chapter 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 in the individual market. 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 normalize the risk between plans.

(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 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. 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 commissioner.

(2) This subdivision shall be implemented on July 1, 2010, or the operative date of this section, whichever is later, and shall

1 *continue to be implemented until one year after the implementation*
2 *of paragraph (4) of subdivision (d) of Section 1399.840.*
3 *(3) Notwithstanding paragraph (2), implementation of this*
4 *subdivision is contingent on the appropriation of funds for its*
5 *purposes.*
6 *(e) The director and the commissioner may contract with a*
7 *qualified actuarial firm or other entities to accomplish the*
8 *requirements of this section.*
9 *1399.845. (a) The director may issue regulations that are*
10 *necessary to carry out the purposes of this article.*
11 *(b) Nothing in this article shall be construed as providing the*
12 *director with rate regulation authority.*
13 *1399.846. Sections 1399.824, 1399.826, and 1399.832 shall*
14 *become operative on January 1, 2009, and Section 1399.842 shall*
15 *become operative on July 1, 2009. The remaining sections in this*
16 *article shall become operative on July 1, 2010.*
17 *SEC. 30. Article 1 (commencing with Section 104250) is added*
18 *to Chapter 4 of Part 1 of Division 103 of the Health and Safety*
19 *Code, to read:*
20
21 *Article 1. California Diabetes Program*
22
23 *104250. The State Department of Public Health shall maintain*
24 *the California Diabetes Program, including, but not limited to,*
25 *the following:*
26 *(a) Provide information on diabetes prevention and management*
27 *to the public, including health care providers.*
28 *(b) Provide technical assistance to the Medi-Cal program,*
29 *including participating providers and Medi-Cal managed care*
30 *plans, regarding the proper scope of benefits to be provided to*
31 *eligible individuals under Section 14132.23 of the Welfare and*
32 *Institutions Code. The assistance may include, but shall not be*
33 *limited to, all of the following:*
34 *(1) Provide information on evidence-based screening guidelines,*
35 *tools, and protocols, including the distribution of these guidelines,*
36 *tools, and protocols.*
37 *(2) Develop, with assistance from the Department of Health*
38 *Care Services, the Comprehensive Diabetes Services Program*
39 *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 14132.23 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. 31. 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. 32. 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

1 *department shall award grants to local health departments to serve*
2 *as local lead agencies in accordance with this article.*
3 *(b) For purposes of determining the amount of each grant*
4 *awarded under this article, local health departments shall be*
5 *allocated, at a minimum, base funding in proportion to total*
6 *available funding.*
7 *(c) Except as provided in subdivision (b), local health*
8 *departments shall receive an allocation based on each county's*
9 *or city's proportion of the statewide population, to be expended*
10 *for purposes that include, but need not be limited to:*
11 *(1) Creating a community infrastructure that promotes active*
12 *living and healthy eating.*
13 *(2) Coordinating with, at minimum, city, county, and school*
14 *partners to facilitate community level, multisector collaboration*
15 *for the development and implementation of strategies to facilitate*
16 *active living and healthy eating.*
17 *(3) Conducting competitive grant application processes to*
18 *support local grants. These local grants may be used to develop*
19 *new programs and improve existing programs to promote physical*
20 *activity for children, improve access to healthy foods, and better*
21 *utilize community recreation facilities.*
22 *(4) Preparing program interventions and materials that will be*
23 *available in accessible, and culturally and linguistically*
24 *appropriate, formats.*
25 *(d) The department shall issue guidelines for local lead agencies*
26 *on how to prepare a local plan for a comprehensive community*
27 *intervention program that includes changes to promote active*
28 *living and healthy eating, and to prevent obesity and other related*
29 *chronic diseases.*
30 *(e) The department shall specify data reporting requirements*
31 *for local lead agencies and their subcontractors.*
32 *(f) (1) The department shall conduct a fiscal and program*
33 *review on a regular basis.*
34 *(2) If the department determines that any local lead agency is*
35 *not in compliance with any provision of this article, the local lead*
36 *agency shall submit to the department, within 60 days, a plan for*
37 *complying with this article.*
38 *(3) The department may withhold funds allocated under this*
39 *section from local lead agencies that are not in compliance with*
40 *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

1 *active living and healthy eating as "California living." The*
2 *campaign-centered efforts shall be closely linked with*
3 *community-level program change efforts and shall be available*
4 *in accessible and culturally and linguistically appropriate formats.*
5 *104721. The department shall provide assistance and other*
6 *support for schools to promote the availability and consumption*
7 *of fresh fruits and vegetables and foods with whole grains.*
8 *104725. The department shall provide technical assistance to*
9 *help employers integrate wellness policies and programs into*
10 *employee benefit plans and worksites.*
11 *104726. Notwithstanding any other provision of law, this article*
12 *shall be implemented only to the extent funds are appropriated for*
13 *purposes of this article in the annual Budget Act or in another*
14 *statute.*
15 *SEC. 33. Section 128745.1 is added to the Health and Safety*
16 *Code, to read:*
17 *128745.1. (a) In addition to any other established and pending*
18 *reports, commencing January 1, 2010, and every year thereafter,*
19 *the office shall publish risk-adjusted outcome reports for*
20 *percutaneous coronary interventions, including, but not limited*
21 *to, the use of angioplasty or stents. In each year, the reports shall*
22 *compare risk-adjusted outcomes by hospital, and in at least every*
23 *other year, by hospital and physician. Upon the recommendation*
24 *of the technical advisory committee based on statistical and*
25 *technical considerations, information on individual hospitals and*
26 *surgeons may be excluded from the reports.*
27 *(b) The office shall establish a clinical data collection program*
28 *to collect data on percutaneous coronary interventions, including,*
29 *but not limited to, the use of angioplasty or stents, performed in*
30 *hospitals. The office shall establish by regulation the data to be*
31 *reported by each hospital at which percutaneous coronary*
32 *interventions are performed. In establishing the data to be*
33 *reported, the office shall consult with the clinical panel established*
34 *pursuant to Section 128748.*
35 *SEC. 34. Chapter 4 (commencing with Section 128850) is*
36 *added to Part 5 of Division 107 of theHealth and Safety Code, to*
37 *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 and improvements in life expectancy, reduced death rates, and improved overall public health.

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

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

(e) Establishing statewide data and common measurement and analyses 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.

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

(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 health professional, medical provider group, laboratory, pharmacy, hospital, imaging center, or any other facility or person who is requesting payment for the provision of medical care.

1 *(b) "Data source" means any licensed health professional,*
2 *medical provider group, health facility, health care service plan*
3 *licensed by the Department of Managed Health Care, health*
4 *insurer certificated by the Insurance Commissioner to sell health*
5 *insurance, any state agency providing or paying for health care*
6 *or collecting health care data or information, or any other payer*
7 *for health care services in California.*
8 *(c) "Encounter data" means data relating to treatment or*
9 *services rendered by licensed health professionals to patients and*
10 *that may be reimbursed on a fee-for-service or capitation basis.*
11 *(d) "Group" or "medical provider group" means an affiliation*
12 *of physicians and other health care professionals, whether a*
13 *partnership, corporation, or other legal form, with the primary*
14 *purpose of providing medical care.*
15 *(e) "Health facility" or "health facilities" means health facilities*
16 *required to be licensed pursuant to Chapter 2 (commencing with*
17 *Section 1250) of Division 2.*
18 *(f) "Lead agency" means the administrative entity designated*
19 *by the secretary to undertake the duties specified by this chapter.*
20 *(g) "Risk-adjusted outcomes" means the clinical outcomes of*
21 *patients grouped by diagnoses or procedures that have been*
22 *adjusted for demographic and clinical factors.*
23 *(h) "Secretary" is the Secretary of California Health and*
24 *Human Services.*
25
26 *Article 2. Health Care Cost and Quality Transparency*
27 *Committee*
28
29 *128852. There is hereby created the Health Care Cost and*
30 *Quality Transparency Committee composed of seven members.*
31 *The committee shall be charged with providing information and*
32 *recommendations to the secretary on the measurement and*
33 *reporting of public and private health care quality and*
34 *performance measures to promote efficiency, cost-effectiveness,*
35 *transparency, and informed choice by purchasers and consumers.*
36 *The lead agency shall provide administrative support to the*
37 *committee. The appointments shall be made as follows:*
38 *(a) The Governor shall appoint five members as follows:*
39 *(1) One academic with experience in health care data and cost*
40 *efficiency research.*

(2) One representative of hospitals.
(3) One representative of physicians and surgeons.
(4) One representative of employers that purchase group health care for employees and who is not also a supplier or broker of health care services or coverage.
(5) One representative of health insurers or health care service plans.
(b) The Senate Committee or Rules shall appoint one member who is a representative of consumers.
(c) The Speaker of the Assembly shall appoint one member who is a leader of an organization that represents employees.
(d) The following members shall serve in an ex officio 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.
128853. The committee shall meet at least once every month until the plan developed pursuant to Section 128865 has been submitted to the secretary. The committee shall be abolished on January 1, 2011.
128854. The members of the committee shall receive reimbursement for any actual and necessary expenses incurred in connection with their duties as members of the committee.
128855. (a) In fulfilling the duties associated with the Health Care Cost and Quality Transparency Committee, the lead agency may appoint at least one technical advisory committee, and may appoint additional technical advisory committees as the lead agency deems appropriate, and may include on each committee academic and professional experts with expertise related to the activities of the committee.
(b) In fulfilling the duties associated with the Health Care Cost and Quality Transparency Committee, the lead agency may appoint at least one clinical advisory committee and may appoint additional advisory committees specific to issues that require additional or different clinical expertise. Each clinical advisory committee shall include clinicians and others with expertise related to the activities of the committee.
(c) The lead agency may, as appropriate, refer technical and clinical issues, including issues related to risk adjustment

methodology, to an advisory committee for recommendation. The advisory committee shall, within the time period specified by the lead agency, issue a written recommendation to the lead agency concerning the issue referred to the advisory committee.

(d) The members of the technical and clinical advisory committees appointed by the lead agency shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the advisory committee.

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

128856. The committee and advisory members shall be subject to the lead agency's conflict-of-interest policy.

Article 3. Health Care Cost and Quality Transparency Plan

128860. (a) The Health Care Cost and Quality Transparency Committee shall, within one year after its first meeting, develop a health care cost and quality transparency plan. The purpose of the plan shall be to assist in efforts to reduce health care costs in the system, improve health system performance, and promote quality patient outcomes. The plan shall be presented to the secretary. After review of the plan, the secretary, in consideration of the recommendations contained in the plan, may implement strategies and timelines for the implementation of this article.

(b) The plan shall include, but not be limited to, recommended 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, and licensed health professionals.

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

(3) Develop a valid 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.

(4) Use and build on existing data collection standards and methods to the greatest extent possible to accomplish the goals of this article in an efficient and effective manner.

1 *(5) Incorporate and utilize administrative claims data to the*
2 *extent it is the most efficient method of collecting data.*
3 *(6) Improve coordination of data collection, state and federal*
4 *reporting practices and standards, and existing mandatory and*
5 *voluntary measurement and reporting activities by existing public*
6 *and private entities.*
7 *(7) Provide reports, analyses, and data on the health care*
8 *quality and performance measures of health plans and insurers,*
9 *medical groups, health facilities, and licensed health professionals.*
10 *(8) Maintain patient confidentiality consistent with state and*
11 *federal medical and patient privacy laws.*
12 *(9) Review existing data gathering, reporting activities, and*
13 *related entities within state government and recommend areas to*
14 *coordinate and streamline data collection.*
15
16 *Article 4. Implementation of Strategies to Improve Health Care*
17 *Quality and Transparency*
18
19 *128861. (a) At the direction of the secretary, the lead agency*
20 *shall implement strategies to improve health care quality and*
21 *performance measures consistent with the intent of this chapter.*
22 *The authority and responsibilities of the lead agency shall include,*
23 *but not be limited to, the following:*
24 *(1) Determine the data to be collected, and the methods of*
25 *collection to implement this chapter.*
26 *(2) Determine the measures necessary to implement the*
27 *reporting requirements in a manner that is cost-effective and*
28 *reasonable for data sources and is timely, relevant, and reliable.*
29 *(3) Collect the data consistent with the data reporting*
30 *requirements recommended and approved by the secretary,*
31 *including, but not limited to, data on quality, health outcomes,*
32 *cost, utilization, and pricing.*
33 *(4) Audit, as necessary, the accuracy of any or all data submitted*
34 *to the lead agency pursuant to this chapter.*
35 *(5) Seek to establish agreements for voluntary reporting of*
36 *health care claims and data from any and all health care payers*
37 *that are not subject to mandatory reporting pursuant to this*
38 *chapter, and subsequent regulations, in order to ensure availability*
39 *of the most comprehensive systemwide data on heath care costs*
40 *and quality.*

1 *(6) Fully protect patient privacy and confidentiality, in*
2 *compliance with state and federal privacy laws, while preserving*
3 *the lead agency's ability to analyze data. Any individual patient*
4 *information obtained pursuant to this chapter shall be exempt from*
5 *the disclosure requirements of the Public Records Act (Chapter*
6 *3.5 (commencing with Section 6250) of Division 7 of Title 1 of the*
7 *Government Code).*
8 *(b) All state agencies shall cooperate with the lead agency to*
9 *implement strategies to improve health care quality and*
10 *performance measures consistent with the direction of the*
11 *secretary.*
12 *(c) The lead agency shall adopt regulations as are necessary*
13 *to carry out the intent of this chapter.*
14 *128862. The lead agency may contract with a qualified public*
15 *or private agency or academic institution to assist in the review*
16 *of existing data collection programs or to conduct other research*
17 *or analysis the secretary, with the advice of the committee, deems*
18 *necessary to complete and implement the plan required pursuant*
19 *to Section 128865 or to meet any of its obligations under this*
20 *chapter.*
21 *128863. The lead agency shall provide the secretary with a*
22 *proposal that will, to the extent possible, identify possible financial*
23 *resources for the implementation of this chapter and allow for the*
24 *recovery of costs of implementing centralized data collection, and*
25 *effective analysis and reporting activities under this chapter. The*
26 *lead agency shall also provide fiscal information to the secretary*
27 *relative to the need to collect and analyze information from various*
28 *data sources, and the relative value to data sources and users.*
29 *SEC. 35. Section 130545 is added to the Health and Safety*
30 *Code, to read:*
31 *130545. (a) The State Department of Health Care Services*
32 *shall identify best practices related to e-prescribing modalities*
33 *and standards and shall make recommendations for statewide*
34 *adoption of e-prescribing on or before January 1, 2009.*
35 *(b) The State Department of Health Care Services shall develop*
36 *a pilot program to foster the adoption and use of electronic*
37 *prescribing by health care providers that contract with Medi-Cal.*
38 *The implementation of this Medi-Cal pilot is contingent upon the*
39 *availability of FFP or federal grant funds. The department may*

1 *provide electronic prescribing technology, including equipment*
2 *and software, to participating Medi-Cal prescribers.*
3 *SEC. 36. Section 10113.10 is added to the Insurance Code, to*
4 *read:*
5 *10113.10. (a) Notwithstanding Section 10270.95 and except*
6 *as provided in subdivision (f), a disability insurer selling health*
7 *insurance shall, on and after July 1, 2010, expend in the form of*
8 *health care benefits no less than 85 percent of the aggregate dues,*
9 *fees, premiums, or other periodic payments received by the insurer*
10 *during the insurer's fiscal year. For purposes of this section, the*
11 *insurer may deduct from the aggregate dues, fees, premiums, or*
12 *other periodic payments received by the insurer during the*
13 *insurer's fiscal year the amount of income taxes or other taxes*
14 *that the insurer expensed for the same fiscal year. For purposes*
15 *of this section, "health care benefits" shall mean health care*
16 *services that are either provided or reimbursed by the insurer or*
17 *its contracted providers as benefits to its policyholders and*
18 *insurers.*
19 *(b) (1) Health care benefits shall include:*
20 *(A) The costs of programs or activities, including training and*
21 *the provision of informational materials which improve the*
22 *provision of quality care, improve health care outcomes, and*
23 *encourage the use of evidence-based medicine.*
24 *(B) Disease management expenses based using cost-effective*
25 *evidence-based guidelines.*
26 *(C) Plan medical advice by telephone.*
27 *(D) Payments to providers as risk pool payments of*
28 *pay-for-performance initiatives.*
29 *(2) Health care benefits shall not include administrative costs*
30 *listed in Section 1300.78 of Title 28 of the California Code of*
31 *Regulations in effect on January 1, 2007.*
32 *(c) To assess compliance with this section, an insurer may*
33 *average its total costs across all health insurance policies approved*
34 *for sale in California, and all health care service plan contracts*
35 *of its affiliated health care service plan providers approved for*
36 *sale in California by the Department of Managed Health Care,*
37 *except for those contracts listed in subdivision (f) of Section 1378.1*
38 *of the Health and Safety Code.*
39 *(d) The department and the Department of Managed Health*
40 *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).

(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.

(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. 37. 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 written authorization from the applicant or insured to provide notices by electronic transmission and to cease providing notices by United States mail. The authorization shall be renewed by the insured on an annual basis. If the health insurer obtains an application for coverage by electronic transmission, it may obtain authorization by electronic transmission from the applicant or insured to provide notices by electronic transmission.

(2) Uses an authorization form, approved by the department, in which the applicant or insured confirms understanding of the type of notice 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.

(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.

(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 sending a notice as described in subdivision (a).

(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.

(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 provider of an applicant or insured if the provider 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) "Notice" for purposes of this section includes 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.

SEC. 38. Section 10123.56 is added to the Insurance Code, to read:

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

(b) Every policy of insurance that is offered, delivered, amended, or renewed on or after January 1, 2009, that covers hospital, medical, or surgical expenses on an individual basis shall offer individuals at least one coverage choice that includes a Healthy Action Incentives and Rewards Program that meets the requirements described in subdivision (c).

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

(1) Health risk appraisals that collect information from individuals to assess 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) 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 for policyholders to became 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 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, health premium reductions, differential copayment or coinsurance amounts, and cash payments. Rewards may include, but need not be limited to, nonmedical pharmacy products or

services not otherwise covered under a policyholder's health insurance contract, 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.

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

(e) (1) Notwithstanding any other provision of law, the provision of healthy incentives and rewards pursuant to this section by a health care provider, or his or her agent, that meets the requirements of this section, Section 1367.38 of the Health and Safety Code, or Section 14132.105 of the Welfare and Institutions Code shall not be considered or construed as an unlawful practice, act, kickback, bribe, rebate, remuneration, offer, coupon, product, payment, or any other form of compensation by a provider or his or her agent, directly or indirectly, overtly or covertly, in exchange for another to obtain, participate, or otherwise undergo or receive health care services.

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

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

(f) 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. 39. 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. 40. 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.

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

SEC. 41. Chapter 9.6 (commencing with Section 10920) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 9.6. Individual Market Reform and Guarantee Issue

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

(a) "Anniversary date" means the calendar date an individual has enrolled 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, child, or registered domestic partner 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 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.

1 *(3) Credit disability, as defined in Section 779.2.*
2 *(4) Coverage issued as a supplement to liability insurance.*
3 *(5) Disability income, as defined in subdivision (i) of Section*
4 *799.01.*
5 *(6) Insurance under which benefits are payable with or without*
6 *regard to fault and that is statutorily required to be contained in*
7 *any liability insurance policy or equivalent self-insurance.*
8 *(7) Insurance arising out of a workers' compensation or similar*
9 *law.*
10 *(8) Long-term care coverage.*
11 *(9) Dental coverage.*
12 *(10) Vision coverage.*
13 *(11) Medicare supplement, CHAMPUS-supplement or Tricare*
14 *supplement, behavioral health-only, pharmacy-only, hospital*
15 *indemnity, hospital-only, accident-only, or specified disease*
16 *insurance that does not pay benefits on a fixed benefit,*
17 *cash-payment-only basis.*
18 *(e) "Health insurer" means a disability insurer that offers and*
19 *sells health insurance.*
20 *(f) "Health plan" means a health care service plan, as defined*
21 *in subdivision (f) of Section 1345 of the Health and Safety Code,*
22 *that is lawfully engaged in providing, arranging, paying for, or*
23 *reimbursing the cost of health care services and is offering or*
24 *selling health care service plan contracts in the individual market.*
25 *A health plan shall not include a specialized health care service*
26 *plan.*
27 *(g) "Health plan contract" means a health care service plan*
28 *contract offered, sold, amended, or renewed to individuals and*
29 *their dependents. The term shall not include accident only, credit,*
30 *disability income, long-term care insurance, dental, vision,*
31 *coverage issued as a supplement to liability insurance, insurance*
32 *arising out of a workers' compensation or similar law, automobile*
33 *medical payment insurance, or insurance under which benefits*
34 *are payable with or without regard to fault and that is statutorily*
35 *required to be contained in any liability insurance policy or*
36 *equivalent self-insurance. In addition, the term shall not include*
37 *a specialized health care service plan contract, as defined in*
38 *subdivision (o) of Section 1345 of the Health and Safety Code.*
39 *(h) "Purchasing pool" means the program established under*
40 *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 below 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 accord with expected costs or other market considerations, but the rate for each health insurance policy shall

1 *be set in relation to the balance of the portfolio, as certified by an*
2 *actuary.*
3 *(5) Each health insurance policy shall be priced as determined*
4 *by each health insurer to reflect the difference in benefit variation,*
5 *or the effectiveness of a provider network, and each insurer may*
6 *adjust the rate for a specific policy for risk selection only to the*
7 *extent permitted by subdivision (d) of Section 10937.*
8 *(l) "Standard risk rate" means the rate applicable to an*
9 *individual in a particular risk category.*
10 *(m) "Subscriber" means the individual who is enrolled in a*
11 *health insurance policy, is the basis for eligibility for enrollment*
12 *in the policy, and is responsible for payment to the health insurer.*
13 *10922. On and after July 1, 2009, a health insurer shall not*
14 *offer to an individual a health insurance policy that provides less*
15 *than minimum health care coverage.*
16 *10923. (a) Minimum heath care coverage that must be*
17 *maintained by an individual pursuant to Section 8899.50 of the*
18 *Government Code shall be established by the Secretary of*
19 *California Health and Human Services through the adoption of*
20 *regulations pursuant to this section. That coverage shall include*
21 *hospital, medical, and preventive services.*
22 *(b) In determining the scope of services, and the insured and*
23 *dependent deductible, coinsurance, and copayment requirements,*
24 *the secretary shall consider whether those costs would deter an*
25 *insured or his or her dependents from obtaining appropriate and*
26 *timely care, including consideration of preventive services outside*
27 *any deductible.*
28 *(c) In determining the scope of services and the insured and*
29 *dependent deductible, coinsurance, and copayment requirements,*
30 *and any coverage of services outside the deductible, the secretary*
31 *shall consider whether the resulting premium cost would prevent*
32 *an insured from obtaining coverage at a reasonable price.*
33 *(d) The secretary shall consult with the Insurance Commissioner*
34 *and the Director of the Department of Managed Health Care in*
35 *the development of these regulations.*
36 *(e) The secretary shall adopt regulations establishing the*
37 *minimum coverage pursuant to subdivision (a) on or before March*
38 *1, 2009. Upon adoption, these regulations shall not be amended*
39 *unless expressly permitted by a subsequent statute.*

1 *(f) The secretary may designate an administrative entity within*
2 *the agency to accomplish the requirements of this section.*
3 *10924. [Reserved]*
4 *10925. (a) Notwithstanding Chapter 15 (commencing with*
5 *Section 8899.50) of Division 1 of Title 2 of the Government Code*
6 *and Section 10922, an individual enrolled in any individual health*
7 *insurance policy prior to March 1, 2009, may maintain coverage*
8 *in that health insurance policy indefinitely. An individual who*
9 *maintains coverage in a health insurance policy pursuant to this*
10 *section shall be deemed to be in compliance with Section 8899.50*
11 *of the Government Code.*
12 *(b) A health insurer shall not cease to renew coverage in an*
13 *individual health insurance policy described in subdivision (a)*
14 *except as permitted pursuant to Section 10176.10.*
15 *(c) On and after March 1, 2009, the commissioner shall not*
16 *approve for offer and sale in this state any benefit design that was*
17 *not approved prior to that date that does not meet or exceed the*
18 *minimum health care coverage requirements of Section 10923.*
19 *(d) This section shall become operative on January 1, 2009.*
20 *10926. A health insurer shall, in addition to complying with*
21 *the applicable provisions of this code and the applicable rules of*
22 *the commissioner, comply with this chapter.*
23 *10927. This chapter shall not apply to health insurance policies*
24 *for coverage of Medicare services pursuant to contracts with the*
25 *United States government, Medicare supplement, Medi-Cal*
26 *contracts with the State Department of Health Care Services,*
27 *Healthy Families Program contracts with the Managed Risk*
28 *Medical Insurance Board, long-term care coverage, specialized*
29 *health care service plan contracts, as defined in subdivision (o)*
30 *of Section 1345 of the Health and Safety Code, or the purchasing*
31 *pool established under Part 6.45 (commencing with Section*
32 *12699.201).*
33 *10928. (a) Except for the health insurance policies described*
34 *in subdivision (a) of Section 10925, a health insurer shall fairly*
35 *and affirmatively offer, market, and sell all of the insurer's policies*
36 *that are sold to individuals to all individuals in each service area*
37 *in which the health insurer provides or arranges for the provision*
38 *of health care services.*
39 *(b) A health insurer may not reject an application from an*
40 *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 request 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. 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 Section 10944, this section shall not become operative until the authority under Section 8899.52 of the Government Code is implemented.

10929. 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.

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 1399.821) 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.

(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) All health insurers that offer coverage on an individual basis shall offer at least one health insurance policy in each coverage choice 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 specified in Section 10923.

10931. A health insurer shall offer coverage for a Healthy Action Incentives and Rewards Program that complies with the requirements of subdivision (c) 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.

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 cancelled 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 shall be in 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 10923 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 30 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 health care coverage as defined in paragraphs (3) to (19), inclusive, of subdivision (a) of Section 8899.51 of the Government Code.

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 assure the delivery of health care services to its enrollees.

10936. (a) 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 cancelled 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 insurance policy by the individual.

(3) Fraud or deception in the use of the services or facilities of the health insurer or knowingly permitting such fraud or deception by another.

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

(5) 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:

(A) Notice of the decision to cease new or existing individual health insurance policies in the state is provided to the

1 *commissioner and to the individual at least 180 days prior to*
2 *discontinuation of that coverage.*
3 *(B) Individual health insurance policies shall not be canceled*
4 *for 180 days after the date of the notice required under*
5 *subparagraph (A) and for that business of a health insurer that*
6 *remains in force, any health insurer that ceases to offer for sale*
7 *new individual health insurance policies shall continue to be*
8 *governed by this chapter with respect to business conducted under*
9 *this chapter.*
10 *(C) A health insurer that ceases to write new individual health*
11 *insurance policies in this state after the effective date of this section*
12 *shall be prohibited from offering for sale individual health*
13 *insurance policies in this state for a period of five years from the*
14 *date of notice to the commissioner. The commissioner may permit*
15 *a health insurer to offer and sell individual health insurance*
16 *policies in this state before the five-year time period has expired*
17 *if the commissioner determines that it is in the best interest of the*
18 *state and necessary to preserve the integrity of the health care*
19 *market.*
20 *(6) If the health insurer withdraws an individual health*
21 *insurance policy from the market, provided that the health insurer*
22 *notifies all affected individuals and the commissioner at least 90*
23 *days prior to the discontinuation of these health insurance policies,*
24 *and that the health insurer makes available to the individual all*
25 *health insurance policies with comparable benefits that it makes*
26 *available to new individual business.*
27 *(b) On and after July 1, 2010, a health insurer shall not rescind*
28 *the health insurance policy of any individual.*
29 *(c) Nothing in this chapter shall limit any other remedies*
30 *available at law to a health insurer.*
31 *10937. Premiums for health insurance policies offered or*
32 *delivered by health insurers on or after the effective date of this*
33 *chapter shall be subject to the following requirements:*
34 *(a) The premium for new or existing business shall be the*
35 *standard risk rate for an individual in a particular risk category.*
36 *(b) The premium rates shall be in effect for no less than 12*
37 *months from the date of the health insurance policy.*
38 *(c) When determining the premium rate for more than one*
39 *covered individual, the health insurer shall determine the rate*
40 *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 three 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.

(2) After the first three 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 10 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 six years following the implementation of this section, a health insurer shall base rates on the standard risk rate. However, the commissioner and the Director of the Department of Managed Health Care may jointly delay implementation of this paragraph for one year if required to ensure availability of coverage in the individual market. At the end of that year, the commissioner and the director shall review the necessity for the delay and may extend the delay for an additional year.

(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 category and contracts for individuals in the 30 to 35 years of age 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.

1 *(2) Provisions relating to the guaranteed issue and renewal of*
2 *individual health insurance policies.*
3 *(3) Provisions relating to the individual's right to obtain any*
4 *health insurance policy the individual is eligible to enroll in*
5 *pursuant to Sections 10928 and 10934.*
6 *(4) The availability, upon request, of a listing of all the*
7 *individual health insurance policies offered by the health insurer,*
8 *including the rates for each health insurance policy.*
9 *(b) Every solicitor or solicitor firm contracting with one or more*
10 *health insurers to solicit enrollments or subscriptions from*
11 *individuals shall, when providing information on health insurance*
12 *policies to an individual but making no specific recommendations*
13 *on particular health insurance policies, do both of the following:*
14 *(1) Advise the individual of the health insurer's obligation to*
15 *sell to any individual any health insurance policy it offers to*
16 *individuals and provide him or her, upon request, with the actual*
17 *rates that would be charged to that individual for a given health*
18 *insurance policy.*
19 *(2) Notify the individual that the solicitor or solicitor firm will*
20 *procure rate and benefit information for the individual on any*
21 *health insurance policy offered by a health insurer whose policy*
22 *the solicitor sells.*
23 *(c) Prior to filing an application for a particular individual*
24 *health insurance policy, the health insurer may obtain a signed*
25 *statement from the individual acknowledging that the individual*
26 *has received the disclosures required by this section.*
27 *10939. (a) At least 20 business days prior to offering a health*
28 *insurance policy subject to this chapter, all health insurers shall*
29 *file with the commissioner a statement certifying that the health*
30 *insurer is in compliance with subdivision (k) of Section 10920 and*
31 *Section 10937. The certified statement shall set forth the standard*
32 *risk rate for each risk category that will be used in setting the rates*
33 *at which the contract will be offered. Any action by the*
34 *commissioner to disapprove, suspend, or postpone the health*
35 *insurer's use of a health insurance policy shall be in writing,*
36 *specifying the reasons that the health insurance policy does not*
37 *comply with the requirements of this chapter.*
38 *(b) Prior to making any changes in the standard risk rates filed*
39 *with the commissioner pursuant to subdivision (a), the health*
40 *insurer shall file as an amendment a statement setting forth the*

1 *changes and certifying that the health insurer is in compliance*
2 *with subdivision (k) of Section 10920 and Section 10937. If the*
3 *standard risk rate is being changed, a health insurer may*
4 *commence offering health insurance policies utilizing the changed*
5 *standard risk rate upon filing the certified statement unless the*
6 *commissioner disapproves the amendment by written notice.*
7 *(c) Periodic changes to the standard risk rate that a health*
8 *insurer proposes to implement over the course of up to 12*
9 *consecutive months may be filed in conjunction with the certified*
10 *statement filed under subdivision (a) or (b).*
11 *(d) Each health insurer shall maintain at its principal place of*
12 *business all of the information required to be filed with the*
13 *commissioner pursuant to this chapter.*
14 *(e) This section shall become operative on July 1, 2009.*
15 *10940. (a) A health insurer shall include all of the following*
16 *in the statement filed pursuant to subdivision (a) of Section 10939:*
17 *(1) A summary explanation of the following for each health*
18 *insurance policy offered to individuals:*
19 *(A) Eligibility requirements.*
20 *(B) The full premium cost of each health insurance policy in*
21 *each risk category, as defined in subdivision (k) of Section 10920.*
22 *(C) When and under what circumstances benefits cease.*
23 *(D) Other coverage that may be available if benefits under the*
24 *described health insurance policy cease.*
25 *(E) The circumstances under which choice in the selection of*
26 *physicians and providers is permitted.*
27 *(F) Deductibles.*
28 *(G) Annual out-of-pocket maximums.*
29 *(2) A summary explanation of coverage for the following,*
30 *together with the corresponding copayments, coinsurance, and*
31 *applicable limitations for each health insurance policy offered to*
32 *individuals:*
33 *(A) Professional services.*
34 *(B) Outpatient services.*
35 *(C) Preventive services.*
36 *(D) Hospitalization services.*
37 *(E) Emergency health coverage.*
38 *(F) Ambulance services.*
39 *(G) Prescription drug coverage.*
40 *(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 chapter 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 10923, 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. 42. 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.

1 (2) Nine dollars ($9) per child with a maximum required
2 contribution of twenty-seven dollars ($27) per month per family
3 for applicants with annual household incomes greater than 150
4 percent and up to and including 200 percent of the federal poverty
5 level and for applicants on behalf of children described in clause
6 (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of
7 Section 12693.70.
8 (3) On and after July 1, 2005, fifteen dollars ($15) per child
9 with a maximum required contribution of forty-five dollars ($45)
10 per month per family for applicants with annual household income
11 to which subparagraph (B) of paragraph (6) of subdivision (a) of
12 Section 12693.70 is applicable. Notwithstanding any other
13 provision of law, if an application with an effective date prior to
14 July 1, 2005, was based on annual household income to which
15 subparagraph (B) of paragraph (6) of subdivision (a) of Section
16 12693.70 is applicable, then this subparagraph shall be applicable
17 to the applicant on July 1, 2005, unless subparagraph (B) of
18 paragraph (6) of subdivision (a) of Section 12693.70 is no longer
19 applicable to the relevant family income. The program shall provide
20 prior notice to any applicant for currently enrolled subscribers
21 whose premium will increase on July 1, 2005, pursuant to this
22 subparagraph and, prior to the date the premium increase takes
23 effect, shall provide that applicant with an opportunity to
24 demonstrate that subparagraph (B) of paragraph (6) of subdivision
25 (a) of Section 12693.70 is no longer applicable to the relevant
26 family income. *On and after July 1, 2010, this paragraph shall*
27 *only apply to individuals to which clause (i), but not clause (ii),*
28 *of subparagraph (B) of paragraph (6) of subdivision (a) of Section*
29 *12693.70 is applicable.*
30 *(4) On and after July 1, 2010, twenty-five dollars ($25) per child*
31 *with a maximum required contribution of seventy-five dollars ($75)*
32 *per month per family for applicants with annual household income*
33 *to which clause (ii) of subparagraph (B) of paragraph (6) of*
34 *subdivision (a) of Section 12693.70 is applicable.*
35 (c) Combinations of health, dental, and vision plans that are
36 more expensive to the program than the highest cost Family Value
37 Package may be offered to and selected by applicants. However,
38 the cost to the program of those combinations that exceeds the
39 price to the program of the highest cost Family Value Package
40 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 subparagraph 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 subparagraph 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, 2010, 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, 2010, twenty-two dollars ($22) with a maximum required contribution of sixty-six dollars ($66) per month

1 *per family for applicants with annual household income to which*
2 *clause (ii) of subparagraph (B) of paragraph (6) of subdivision*
3 *(a) of Section 12693.70 is applicable.*
4 (e) Applicants, but not family contribution sponsors, who pay
5 three months of required family contributions in advance shall
6 receive the fourth consecutive month of coverage with no family
7 contribution required.
8 (f) Applicants, but not family contribution sponsors, who pay
9 the required family contributions by an approved means of
10 electronic fund transfer shall receive a 25-percent discount from
11 the required family contributions.
12 (g) It is the intent of the Legislature that the family contribution
13 amounts described in this section comply with the premium cost
14 sharing limits contained in Section 2103 of Title XXI of the Social
15 Security Act. If the amounts described in subdivision (a) are not
16 approved by the federal government, the board may adjust these
17 amounts to the extent required to achieve approval of the state
18 plan.
19 (h) The adoption and one readoption of regulations to implement
20 paragraph (3) of subdivision (b) and paragraph (3) of subdivision
21 (d) shall be deemed to be an emergency and necessary for the
22 immediate preservation of public peace, health, and safety, or
23 general welfare for purposes of Sections 11346.1 and 11349.6 of
24 the Government Code, and the board is hereby exempted from the
25 requirement that it describe specific facts showing the need for
26 immediate action and from review by the Office of Administrative
27 Law. For purpose of subdivision (e) of Section 11346.1 of the
28 Government code, the 120-day period, as applicable to the effective
29 period of an emergency regulatory action and submission of
30 specified materials to the Office of Administrative law, is hereby
31 extended to 180 days.
32 *SEC. 43. Section 12693.56 is added to the Insurance Code, to*
33 *read:*
34 *12693.56. (a) The board may provide or arrange for the*
35 *provision of an electronic personal health record for enrollees*
36 *receiving health care benefits, to the extent funds are appropriated*
37 *for this purpose. The record shall be provided for the purpose of*
38 *providing enrollees with information to assist them in*
39 *understanding their coverage benefits and managing their health*
40 *care.*

1 *(b) At a minimum, the personal health record shall provide*
2 *access to real-time, patient-specific information regarding*
3 *eligibility for covered benefits and cost sharing requirements. The*
4 *access may be provided through the use of an Internet-based*
5 *system.*
6 *(c) In addition to the data required pursuant to subdivision (b),*
7 *the board may determine that the personal health record shall also*
8 *incorporate additional data, including, but not limited to,*
9 *laboratory results, prescription history, claims history, and*
10 *personal health information authorized or provided by the enrollee.*
11 *Inclusion of this additional data shall be at the option of the*
12 *enrollee.*
13 *(d) Systems or software that pertain to the personal health*
14 *record shall adhere to accepted national standards for*
15 *interoperability, privacy, and data exchange, or shall be certified*
16 *by a nationally recognized certification body.*
17 *(e) The personal health record shall comply with applicable*
18 *state and federal confidentiality and data security requirements.*
19 *SEC. 44. Section 12693.58 is added to the Insurance Code, to*
20 *read:*
21 *12693.58. (a) All types of information, whether written or oral,*
22 *concerning an applicant, subscriber, or household member, made*
23 *or kept by any public officer or agency in connection with the*
24 *administration of this part shall be confidential, and shall not be*
25 *open to examination, other than for purposes directly connected*
26 *with the administration of the Healthy Families Program or the*
27 *Medi-Cal program.*
28 *(b) Except as provided in this section, and to the extent permitted*
29 *by federal law or regulation, information about applicants,*
30 *subscribers, and household members to be safeguarded as provided*
31 *for in subdivision (a) includes, but is not limited to, names and*
32 *addresses, medical services provided, social and economic*
33 *conditions or circumstances, agency evaluation of personal*
34 *information, and medical data, including diagnosis and past history*
35 *of disease or disability.*
36 *(c) Purposes directly connected with the administration of the*
37 *Healthy Families Program encompass all activities and*
38 *responsibilities in which the Managed Risk Medical Insurance*
39 *Board and its agents, officers, trustees, employees, consultants,*
40 *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 for that disclosure.

(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.

SEC. 45. 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.

1 (6) (A) In either of the following:
2 (i) In a family with an annual or monthly household income
3 equal to or less than 200 percent of the federal poverty level.
4 (ii) When implemented by the board, subject to subdivision (b)
5 of Section 12693.765 and pursuant to this section, a child under
6 the age of two years who was delivered by a mother enrolled in
7 the Access for Infants and Mothers Program as described in Part
8 6.3 (commencing with Section 12695). Commencing July 1, 2007,
9 eligibility under this subparagraph shall not include infants during
10 any time they are enrolled in employer-sponsored health insurance
11 or are subject to an exclusion pursuant to Section 12693.71 or
12 12693.72, or are enrolled in the full scope of benefits under the
13 Medi-Cal program at no share of cost. For purposes of this clause,
14 any infant born to a woman whose enrollment in the Access for
15 Infants and Mothers Program begins after June 30, 2004, shall be
16 automatically enrolled in the Healthy Families Program, except
17 during any time on or after July 1, 2007, that the infant is enrolled
18 in employer-sponsored health insurance or is subject to an
19 exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled
20 in the full scope of benefits under the Medi-Cal program at no
21 share of cost. Except as otherwise specified in this section, this
22 enrollment shall cover the first 12 months of the infant's life. At
23 the end of the 12 months, as a condition of continued eligibility,
24 the applicant shall provide income information. The infant shall
25 be disenrolled if the gross annual household income exceeds the
26 income eligibility standard that was in effect in the Access for
27 Infants and Mothers Program at the time the infant's mother
28 became eligible, or following the two-month period established
29 in Section 12693.981 if the infant is eligible for Medi-Cal with no
30 share of cost. At the end of the second year, infants shall again be
31 screened for program eligibility pursuant to this section, with
32 income eligibility evaluated pursuant to clause (i), subparagraphs
33 (B) and (C), and paragraph (2) of subdivision (a).
34 (B) *(i)* All income over 200 percent of the federal poverty level
35 but less than or equal to 250 percent of the federal poverty level
36 shall be disregarded in calculating annual or monthly household
37 income.
38 *(ii) On and after July 1, 2010, all income over 250 percent of*
39 *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) 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 *before July 1, 2010, or to 300 percent or less of the federal poverty level on and after July 1, 2010*, 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. 46. 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, commencing July 1, 2010, a child who is otherwise eligible for services under this article shall not be determined ineligible solely on the basis of his or her immigration status.

SEC. 47. Section 12693.766 is added to the Insurance Code, to read:

12693.766. In order to comply with federal requirements and to maximize federal funding, the board shall develop documentation requirements for individuals applying for benefits under subdivision (e) of Section 12693.76.

SEC. 48. Section 12694.5 is added to the Insurance Code, to read:

12694.5. Upon implementation of Section 14005.311 of the Welfare and Institutions Code, a county may make determinations of eligibility for the Healthy Families Program and for the subsidized coverage provided by the program established pursuant to Part 6.45 (commencing with Section 12699.201).

SEC. 49. Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE HEALTH CARE SECURITY AND COST REDUCTION 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) "Enrollee" means an individual who is eligible for, and participates in, the program.

(d) "Fund" means the California Health Trust Fund established pursuant to Section 12699.215.

(e) "Health Care Security and Cost Reduction Program" or "program" means the statewide purchasing pool established pursuant to this part and administered by the board.

(f) "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 sell dental coverage to enrollees.

(g) "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 sell coverage in the program and, pursuant to its contract with the board, provides, arranges, pays for, or reimburses the costs of health services for program enrollees.

(h) "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 sell vision coverage to enrollees.

Chapter 2. Administration

12699.202. (a) The board shall be responsible for establishing the program 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 the program consistent with the eligibility standards in Chapter 3 (commencing with Section 12699.211).

(2) Determine the participation requirements for enrollees.

(3) Determine the participation requirements and the standards and selection criteria for participating health, dental, and vision care plans.

(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 facilitate coverage for subscribers, or contract with participating health plans to provide or administer coverage in the program.

(8) Provide or facilitate coverage for subscribers, or contract with participating dental and vision plans to provide or administer coverage in the program.

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

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

(11) Enter into contracts.

(12) Sue and be sued.

(13) Employ necessary staff.

(14) Issue rules and regulations, as necessary.

(15) 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.

(16) Establish the criteria and procedures through which employers direct employees' premium dollars, withheld under the terms of cafeteria plans pursuant to Section 4801 of the Unemployment Insurance Code, to the program to be credited against the employees' premium obligations.

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

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

12699.202.1. In order for an otherwise eligible individual to be eligible for subsidized benefits through the program, 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.

12699.203. (a) The board shall establish the program to make the following benefits available to California residents through the program effective July 1, 2010.

(1) Subsidized, comprehensive health coverage for individuals eligible for subsidized coverage under this part. The benefits provided through that coverage shall be structured so that the coverage meets or exceeds the criteria for coverage under Section 1399.824 of the Health and Safety Code.

(2) Unsubsidized coverage providing at least minimum health care coverage described in Section 1399.824 of the Health and Safety Code, for individuals eligible for such coverage under this part.

(b) The board may make available, through the program, unsubsidized 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 *(1) Making that coverage available will provide a significant*
2 *benefit for the health coverage marketplace in the state.*
3 *(2) Making that coverage available will be cost effective.*
4 *(3) The board can make that coverage available on a guarantee*
5 *issue basis without undue risk of adverse selection.*
6 *(c) The board shall negotiate rates and other contract terms*
7 *with participating health, dental, and vision plans that offer*
8 *benefits through contracts that provide benefits to enrollees.*
9 *12699.203.1. The board shall consult and coordinate with the*
10 *State Department of Health Care Services in seeking federal*
11 *financial support, pursuant to Article 7 (commencing with Section*
12 *14199.10) of Chapter 7 of Part 3 of Division 9 of the Welfare and*
13 *Institutions Code, for subsidized health care coverage provided*
14 *pursuant to Section 12699.203. To the extent that the state obtains*
15 *federal financial support for that subsidized coverage, the coverage*
16 *will be subject to the terms, conditions, and duration of any*
17 *applicable state plan amendment or waiver. To the extent required*
18 *to obtain federal financial support, the board shall apply the*
19 *citizenship, immigration, and identity documentation standards*
20 *required in Title XIX of the federal Social Security Act.*
21 *12699.203.2. In developing the benefit plan designs, the board*
22 *shall comply with all of the following:*
23 *(a) The board shall take into consideration the levels of health*
24 *care coverage provided in the state and medical economic factors*
25 *as may be deemed appropriate.*
26 *(b) The subsidized benefit plan design shall meet the*
27 *requirements of the Knox-Keene Health Care Service Plan Act of*
28 *1975 (Chapter 2.2 (commencing with Section 1340) of Division 2*
29 *of the Health and Safety Code), and shall include prescription*
30 *drug benefits, combined with enrollee cost-sharing levels that*
31 *promote prevention and health maintenance, including appropriate*
32 *cost-sharing for physician office visits, diagnostic laboratory*
33 *services, and maintenance medications to manage chronic diseases.*
34 *(c) For unsubsidized coverage, the board shall make available,*
35 *at a minimum, one product that offers the same benefits as the*
36 *minimum health care coverage defined in Section 10923 and one*
37 *product each from coverage choice categories 3 and 5, established*
38 *pursuant to Section 10930. Notwithstanding Section 1399.828 of*
39 *the Health and Safety Code and Section 10927, this coverage shall*
40 *be subject to the same rules as set forth in Article 11.6*

1 *(commencing with Section 1399.821) of Chapters 2.2 of Division*
2 *2 of the Health and Safety Code or as set forth in Chapter 9.6*
3 *(commencing with Section 10920) of Part 2.*
4 *(d) In determining the enrollee and dependent deductibles,*
5 *coinsurance, and copayment requirements for the subsidized*
6 *coverage, the board shall consider whether those costs would deter*
7 *an enrollee or his or her dependents from obtaining appropriate*
8 *and timely care, including those enrollees with a low or moderate*
9 *family income. The board shall also consider the impact of these*
10 *costs on an enrollee's ability to afford health care services.*
11 *(e) The board shall consult with the Insurance Commissioner,*
12 *the Director of the Department of Managed Health Care, and the*
13 *Director of Health Care Services.*
14 *12699.204. The following premiums shall apply to coverage*
15 *under this part:*
16 *(a) For subsidized, comprehensive health care coverage made*
17 *available pursuant to paragraph (1) of subdivision (a) of Section*
18 *12699.203:*
19 *(1) For individuals with family incomes less than or equal to*
20 *150 percent of the federal poverty level, no premiums or*
21 *out-of-pocket costs shall be allowed.*
22 *(2) For individuals with family incomes above 150 percent but*
23 *less than or equal to 250 percent of the federal poverty level,*
24 *premiums shall not exceed 5 percent of family income net of*
25 *applicable deductions.*
26 *(b) For unsubsidized health care coverage made available*
27 *pursuant to paragraph (2) of subdivision (a) of Section 12699.203,*
28 *and for unsubsidized dental and vision coverage made available*
29 *pursuant to subdivision (b) of Section 12699.203, the applicable*
30 *premiums shall be commensurate with the cost of obtaining the*
31 *coverage from participating health plans and the administrative*
32 *cost associated with providing the coverage.*
33 *(c) Premiums paid by an individual for coverage under the*
34 *Healthy Families Program shall be included when calculating the*
35 *premium limitations specified in subdivision (a).*
36 *12699.205. The board, in a contract with a participating health*
37 *plan to provide benefits to enrollees, shall require that the plan*
38 *utilize efficient practices to improve and control costs. These*
39 *practices may include, but are not limited to, the following:*
40 *(a) Preventive care.*

(b) Care management for chronic diseases.
(c) Promotion of health information technology.
(d) Standardized billing practices.
(e) Reduction of medical errors.
(f) Incentives for healthy lifestyles.
(g) Patient cost-sharing to encourage the use of preventive and appropriate care.
(h) Evidence-based use of new technology.

12699.206. (a) All information, whether written or oral, concerning an applicant to the program, an enrollee in the program, 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" means all activities and responsibilities in which the board or the State Department of Health Care Services and its agents, officers, trustees, employees, consultants, and contractors are engaged 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) With regard to Medi-Cal beneficiaries, use and disclosure of information concerning an applicant or enrollee in the program who is a Medi-Cal applicant or enrollee shall be strictly limited to the circumstances provided for in Section 14100.2 of the Welfare and Institutions Code.

(e) Except as provided in subdivision (d), nothing in this section shall prohibit the disclosure of protected health information as

provided in Section 164.512 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 the program 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.

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

Chapter 3. Eligibility

12699.211. (a) To be eligible to enroll in subsidized, comprehensive health care coverage made available pursuant to paragraph (1) of subdivision (a) of Section 12699.203, an individual shall meet all of the following requirements:

(1) Is a resident of the state pursuant to Section 244 of the Government Code or is physically present in the state, having entered the state with an employment commitment or to obtain employment, whether or not employed at the time of application to the program or after enrollment in 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 either ineligible for Medi-Cal or eligible to participate in a benchmark package pursuant to Section 14005.306 of the Welfare and Institutions Code.

(6) Does not have access to employer-sponsored health care coverage. However, this provision shall not apply to a person with

1 *coverage under Section 14005.301 or 14005.305 of the Welfare*
2 *and Institutions Code.*
3 *(b) (1) Implementation of this section is contingent on the*
4 *establishment of the requirement as described in Section 14155*
5 *of the Welfare and Institutions Code.*
6 *(2) The provisions of paragraph (1) shall not apply to a person*
7 *with coverage under Section 14005.301 or 14005.305 of the*
8 *Welfare and Institutions Code.*
9 *12699.212. (a) To be eligible to enroll in unsubsidized,*
10 *comprehensive health care coverage made available pursuant to*
11 *paragraph (2) of subdivision (a) of Section 12699.203, an*
12 *individual shall meet the requirements in paragraphs (1) and (2),*
13 *except as provided in subdivision (b):*
14 *(1) Is a resident of the state pursuant to Section 244 of the*
15 *Government Code or is physically present in the state, having*
16 *entered the state with an employment commitment or to obtain*
17 *employment, whether or not employed at the time of application*
18 *to the program or after enrollment in the program.*
19 *(2) (A) Is an employee paying the full cost of health care*
20 *coverage through in an employee cafeteria plan established*
21 *pursuant to Section 4801 of the Unemployment Insurance Code,*
22 *where the employer designates the Health Care Security and Cost*
23 *Reduction Program in the cafeteria plan, (B) is eligible for a state*
24 *tax credit made available based on the cost of health insurance*
25 *and administered by the board, or (C) is an employee of an*
26 *employer that does not offer employment-based health coverage*
27 *with some portion of the cost borne by the employer.*
28 *(b) To be eligible to purchase unsubsidized dental and vision*
29 *coverage made available pursuant to subdivision (b) of Section*
30 *12699.203, an individual shall be enrolled in other health care*
31 *coverage through the program pursuant to this part.*
32 *12699.213. (a) The following program decisions may be*
33 *appealed to the board:*
34 *(1) A decision that an individual is not qualified to participate*
35 *or continue to participate in the program.*
36 *(2) A decision that an individual is not eligible for enrollment*
37 *or continuing enrollment in the program.*
38 *(3) A decision as to the effective date of coverage.*
39 *(b) An applicant or subscriber who appeals one of the decisions*
40 *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.

Chapter 4. Fiscal

12699.215. (a) The California Health Trust Fund is hereby created in the State Treasury and, notwithstanding Section 13340 of the Government Code, is continuously appropriated to the board for the purpose of providing health coverage under this part. Interest earned on deposits in the fund shall be retained in the fund.

(b) Amounts deposited in the fund shall be used only for the purposes specified in this part.

(c) The board shall authorize the expenditure from the fund of any state funds, federal funds, or other money transferred into the fund to cover program expenses for health coverage, including program expenses that exceed enrollee premiums.

(d) From money in the fund, the board may expend sufficient amounts for expenses incurred in carrying out this part.

12699.216. The board, subject to federal approval pursuant to Sections 14005.301 and 14005.305, shall pay the nonfederal share of cost from the fund for individuals eligible under that federal approval.

12699.217. This part shall become operative on January 1, 2009. The board shall provide health care coverage pursuant to this part beginning on July 1, 2010, or on the date that the authority under Section 8899.52 of the Government Code is implemented, whichever is later.

SEC. 50. Section 12885 is added to the Insurance Code, to read:

12885. It is the intent of the Legislature to establish a mechanism by which the state may defray the costs of an enrollee's public program participation by taking advantage of the other opportunities for coverage available to that enrollee.

SEC. 51. Section 12886 is added to the Insurance Code, to read:

1 *12886. It shall constitute an unfair labor practice contrary to*
2 *public policy, and enforceable under Section 95 of the Labor Code,*
3 *for an employer to refer an individual employee or employee's*
4 *dependent to the program established pursuant to Part 6.45*
5 *(commencing with Section 12699.201), or to arrange for an*
6 *individual employee or employee's dependent to apply to that*
7 *program, for the purpose of separating that employee or*
8 *employee's dependent from group health coverage provided in*
9 *connection with the employee's employment. An employer who*
10 *pays the premium for the employee in the program established*
11 *pursuant to Part 6.45 (commencing with Section 12699.201) shall*
12 *not, on the basis of that action, be deemed to be in violation of this*
13 *section.*
14 *SEC. 52. Section 12887 is added to the Insurance Code, to*
15 *read:*
16 *12887. It shall constitute an unfair labor practice contrary to*
17 *public policy and enforceable under Section 95 of the Labor Code*
18 *for an employer to change the employee-employer share-of-cost*
19 *ratio based upon the employee's wage base or job classification*
20 *or to make any modification of coverage for employees and*
21 *employees' dependents in order that the employees or employees'*
22 *dependents enroll in the program established pursuant to Part*
23 *6.45 (commencing with Section 12699.201).*
24 *SEC. 53. Section 96.8 is added to the Labor Code, to read:*
25 *96.8. (a) Notwithstanding any other provision in this chapter,*
26 *an employer may provide health coverage that includes a Healthy*
27 *Action Incentives and Rewards Program that meets the*
28 *requirements of Section 1367.38 of the Health and Safety Code,*
29 *or Section 10123.56 of the Insurance Code, to the employer's*
30 *employees.*
31 *(b) A Healthy Action Incentives and Rewards Program offered*
32 *pursuant to this section may include, but need not be limited to,*
33 *monetary incentives and health coverage premium cost reductions*
34 *for employees for nonsmokers and smoking cessation.*
35 *SEC. 54. Section 96.81 is added to the Labor Code, to read:*
36 *96.81. (a) (1) Notwithstanding any other provision of law,*
37 *the delivery or provision of Healthy Action Incentives and Rewards*
38 *Program benefits or coverage by the employer or the employer's*
39 *agents to employees for the purposes of and in accordance with*
40 *the criteria and requirements established under Section 96.8 shall*

not be considered or construed as an unlawful practice, act, kickback, bribe, rebate, remuneration, offer, payment, or any other form of compensation made directly or indirectly, overtly or covertly, in exchange for another to obtain, participate, or otherwise undergo or receive health care services.

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

(b) 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. 55. Section 17052 is added to the Revenue and Taxation Code, to read:

17052. (a) It is the intent of the Legislature to establish a tax credit to enhance the affordability of health care coverage for individuals and families not eligible for enrollment in publicly subsidized coverage. The provisions of the tax credit would be structured such that:

(1) For each taxable year beginning on or after January 1, 2010, there would 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 percent of the qualified taxpayer's adjusted gross income for that taxable year.

(2) No credit would be allowed under this provision to a qualified taxpayer with adjusted gross income in excess of 350 percent of the federal poverty level.

(3) (A) In the case of any taxpayer who is not a qualified taxpayer for the entire taxable year, the allowable credit under paragraph (1) would be computed by first dividing the total

1 *adjusted gross income of the qualified taxpayer by 12, and then*
2 *multiplying that amount by the number of months during the*
3 *taxable year that the taxpayer is a qualified taxpayer.*
4 *(B) The provisions of paragraphs (2) and (3) would apply to*
5 *any taxpayer described in subparagraph (A), without the*
6 *adjustment required under subparagraph (A).*
7 *(b) For purposes of this section:*
8 *(1) "Adjusted gross income" means adjusted gross income as*
9 *computed for purposes of Section 17072.*
10 *(2) "MRMIB" means the Managed Risk Medical Insurance*
11 *Board in its capacity in administering the program established*
12 *pursuant to Part 6.45 (commencing with Section 12699.201) of*
13 *Division 2 of the Insurance Code.*
14 *(3) "Federal poverty level" has the same meaning as poverty*
15 *guidelines updated periodically in the Federal Register by the*
16 *United States Department of Health and Human Services under*
17 *the authority of 42 U.S.C. Section 9902(2).*
18 *(4) "Premium for minimum coverage" means the standard risk*
19 *rate, on July 1, 2010, for unsubsidized health care coverage that*
20 *has the same benefits as minimum health care coverage as defined*
21 *in Section 10923 of the Insurance Code available through the*
22 *MRMIB, updated annually, based on the United States Consumer*
23 *Price Index-Medical.*
24 *(5) "Qualified health care plan" means unsubsidized coverage*
25 *purchased through the MRMIB that provides health care coverage*
26 *for the qualified taxpayers, their spouse, and their dependents.*
27 *(6) "Qualified health care plan premium cost" means amounts*
28 *paid by the qualified taxpayer during the taxable year for a*
29 *qualified health care plan that are equal to the lesser of:*
30 *(A) The qualified premiums paid during the taxable year by the*
31 *qualified taxpayer.*
32 *(B) The premium for minimum coverage, divided by 12, and*
33 *multiplied by the number of months during the taxable year that*
34 *the taxpayer is a qualified taxpayer.*
35 *(7) "Qualified premiums" means the amounts paid by a*
36 *qualified taxpayer to purchase a qualified health care plan through*
37 *the MRMIB. Any premium credit advance, as described in*
38 *subdivision (d), used by the MRMIB to pay all or a portion of*
39 *premiums payable with respect to qualified health care plan costs*
40 *of a qualified taxpayer are considered "qualified premiums."*

1 *(8) (A) "Qualified taxpayer" means any taxpayer whose*
2 *adjusted gross income for the taxable year is at least 250 percent*
3 *but not in excess of 350 percent of the federal poverty level*
4 *applicable for the calendar year that begins in the taxable year*
5 *for which the credit is claimed.*
6 *(B) Any taxpayer that is eligible to receive coverage under a*
7 *group health plan that is available through the taxpayer's*
8 *employment or through the employment of the taxpayer's spouse*
9 *is not a qualified taxpayer under subparagraph (A) during any*
10 *period that the taxpayer would be eligible to receive coverage as*
11 *described in this subparagraph.*
12 *(c) In the case where the credit allowed under this section would*
13 *exceed the qualified taxpayer's tax liability computed under this*
14 *part, the excess would be credited against other amounts due, if*
15 *any, by the qualified taxpayer and the balance, if any, would be*
16 *refunded to the qualified taxpayer.*
17 *(d) The term "premium credit advance" means, with respect to*
18 *any taxable year, the amount determined by the MRMIB, to*
19 *approximate the amount of the credit that would be allowed to a*
20 *qualified taxpayer pursuant to this section.*
21 *(e) The premium credit advance would always be paid on behalf*
22 *of a qualified taxpayer by the MRMIB for the purpose of paying*
23 *all or a portion of the cost of the qualified taxpayer's qualified*
24 *premiums and in no event shall any premium credit advance be*
25 *paid directly to the qualified taxpayer.*
26 *(f) If any premium credit advance is to be paid by the MRMIB*
27 *on behalf of a qualified taxpayer during the calendar year, then*
28 *the tax imposed by this part for the qualified taxpayer's taxable*
29 *year beginning in that calendar year would be increased by the*
30 *aggregate amount of those advances.*
31 *(g) Every qualified taxpayer for whom a premium credit advance*
32 *is paid by the MRMIB would file a return with the Franchise Tax*
33 *Board under subdivision (a) of Section 18501, notwithstanding*
34 *any other provision in Section 18501 that would otherwise exempt*
35 *that taxpayer from being required to file a return.*
36 *SEC. 56. Section 17072 of the Revenue and Taxation Code is*
37 *amended to read:*
38 17072. (a) Section 62 of the Internal Revenue Code, relating
39 to adjusted gross income defined, shall apply, except as otherwise
40 provided.

(b) Section 62(a)(2)(D) of the Internal Revenue Code, relating to certain expenses of elementary and secondary school teachers, shall not apply.

(c) The deduction allowed by Section 17216, relating to health savings accounts, is allowed in computing adjusted gross income.

(d) The amendments made to this section by the act adding this subdivision shall apply to taxable years beginning on or after January 1, 2010.

SEC. 57. Section 17131.4 of the Revenue and Taxation Code is amended to read:

17131.4. *(a)* Section 106(d) of the Internal Revenue Code, relating to contributions to health savings accounts, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2010.

SEC. 58. Section 17131.5 of the Revenue and Taxation Code is amended to read:

17131.5. *(a)* Section 125(d)(2)(D) of the Internal Revenue Code, relating to the exception for health savings accounts, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2010.

SEC. 59. Section 17138.5 is added to the Revenue and Taxation Code, to read:

17138.5. For each taxable year beginning on or after January 1, 2009, Section 106 of the Internal Revenue Code, as amended by Section 302 of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-432), relating to health savings accounts, shall apply, except as otherwise provided.

SEC. 60. Section 17138.6 is added to the Revenue and Taxation Code, to read:

17138.6. For each taxable year beginning on or after January 1, 2009, Section 125 of the Internal Revenue Code, as amended by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), relating to health savings accounts, shall apply, except as otherwise provided.

SEC. 61. Section 17215 of the Revenue and Taxation Code is amended to read:

17215. (a) Section 220(a) of the Internal Revenue Code, relating to deduction allowed, is modified to provide that the amount allowed as a deduction shall be an amount equal to the

amount allowed to that individual as a deduction under Section 220 of the Internal Revenue Code, relating to medical savings accounts, on the federal income tax return filed for the same taxable year by that individual.

(b) Section 220(f)(4) of the Internal Revenue Code, relating to additional tax on distributions not used for qualified medical expenses, is modified by substituting "10 percent" in lieu of "15 percent."

(c) Section 220(f)(5) of the Internal Revenue Code, as amended by Section 1201(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), relating to permitted rollovers from Archer Medical Savings Accounts, shall apply, except as otherwise provided.

(d) The amendments made to this section by the act adding this subdivision shall apply to taxable years beginning on or after January 1, 2010.

SEC. 62. Section 17215.1 of the Revenue and Taxation Code is amended to read:

17215.1. *(a)* Section 220(f)(5) of the Internal Revenue Code, relating to rollover contributions, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2010.

SEC. 63. Section 17215.4 of the Revenue and Taxation Code is amended to read:

17215.4. *(a)* Section 223 of the Internal Revenue Code, relating to health savings accounts, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2010.

SEC. 64. Section 17216 is added to the Revenue and Taxation Code, to read:

17216. For each taxable year beginning on or after January 1, 2010, all of the following shall apply:

(a) Section 223 of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), and as amended by Title III of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-432), relating to health savings accounts, shall apply, except as otherwise provided.

(b) Section 223(e)(1) of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement,

and Modernization Act of 2003 (Public Law 108-173), shall be modified by substituting the phrase “Section 17651” for the phrase “Section 511 (relating to imposition of tax of unrelated business income of charitable, etc., organizations),” contained therein.

(c) Section 223(f)(4)(A) of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), shall be modified by substituting the phrase “$2\frac{1}{2}$ percent” for “10 percent,” contained therein.

SEC. 65. Section 19184 of the Revenue and Taxation Code is amended to read:

19184. (a) A penalty of fifty dollars ($50) shall be imposed for each failure, unless it is shown that the failure is due to reasonable cause, by any person required to file who fails to file a report at the time and in the manner required by any of the following provisions:

(1) Subdivision (c) of Section 17507, relating to individual retirement accounts.

(2) Section 220(h) of the Internal Revenue Code, relating to medical savings accounts for taxable years beginning on or after January 1, 1997.

(3) Section 223(h) of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), relating to health savings accounts.

~~(3)~~

(4) Subdivision (b) of Section 17140.3 or subdivision (b) of Section 23711 relating to qualified tuition programs.

~~(4)~~

(5) Subdivision (e) of Section 23712, relating to Coverdell education savings accounts.

(b) (1) Any individual who:

(A) Is required to furnish information under Section 17508 as to the amount designated nondeductible contributions made for any taxable year, and

(B) Overstates the amount of those contributions made for that taxable year, shall pay a penalty of one hundred dollars ($100) for each overstatement unless it is shown that the overstatement is due to reasonable cause.

(2) Any individual who fails to file a form required to be filed by the Franchise Tax Board under Section 17508 shall pay a penalty of fifty dollars ($50) for each failure unless it is shown that the failure is due to reasonable cause.

(c) Article 3 (commencing with Section 19031) of this chapter (relating to deficiency assessments) shall not apply in respect of the assessment or collection of any penalty imposed under this section.

(d) The amendments made to this section by the act adding this subdivision shall apply to taxable years beginning on or after January 1, 2010.

SEC. 66. 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. 67. Division 1.2 (commencing with Section 4800) is added to the Unemployment Insurance Code, to read:

DIVISION 1.2. HEALTH CARE CAFETERIA PLAN

4800. This division shall be known and may be cited as the Health Care Cafeteria Plan.

4801. (a) Each employer of two or more full-time equivalent 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 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.

(5) "Full-time equivalent employees" means the number of employees expressed as the number of hours worked by all employees during a calendar quarter divided by 455.

(d) The department shall promulgate rules and regulations to implement the provisions of this division.

SEC. 68. Section 14005.01 is added to the Welfare and Institutions Code, to read:

14005.01. (a) Notwithstanding any other provision of law, the department may make statewide determinations and redeterminations of eligibility and may contract with a county or counties to perform these functions on its behalf regardless of whether the applicant or beneficiary is a resident of the county making the determination.

(b) The department may apply subdivision (a) to any group or subgroup of applicants or recipients, provided that the eligibility of that group or subgroup is not based on its status as aged, blind, or disabled.

(c) The department may contract with an agent or agents to make preliminary eligibility determinations and redeterminations under this section.

SEC. 69. 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

1 options under Section 1396u-1(b)(2)(C) made available to and
2 exercised by the state.
3 (2) The department shall exercise its option under Section
4 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt
5 less restrictive income and resource eligibility standards and
6 methodologies to the extent necessary to allow all recipients of
7 benefits under Chapter 2 (commencing with Section 11200) to be
8 eligible for Medi-Cal under paragraph (1).
9 (3) To the extent federal financial participation is available, the
10 department shall exercise its option under Section 1396u-1(b)(2)(C)
11 of Title 42 of the United States Code authorizing the state to
12 disregard all changes in income or assets of a beneficiary until the
13 next annual redetermination under Section 14012. The department
14 shall implement this paragraph only if, and to the extent that the
15 State Child Health Insurance Program waiver described in Section
16 12693.755 of the Insurance Code extending Healthy Families
17 Program eligibility to parents and certain other adults is approved
18 and implemented.
19 (b) *(1)* To the extent that federal financial participation is
20 available, the department shall exercise its option under Section
21 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary
22 to expand eligibility for Medi-Cal under subdivision (a) by
23 establishing the amount of countable resources individuals or
24 families are allowed to retain at the same amount medically needy
25 individuals and families are allowed to retain, except that a family
26 of one shall be allowed to retain countable resources in the amount
27 of three thousand dollars ($3,000). *This paragraph shall not be*
28 *operative during implementation of paragraph (2).*
29 *(2) To the extent that federal financial participation is available,*
30 *the department shall exercise its option under Section*
31 *1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary*
32 *to simplify eligibility for Medi-Cal under subdivision (a) by*
33 *exempting all resources for applicants and recipients, commencing*
34 *July 1, 2010.*
35 (c) To the extent federal financial participation is available, the
36 department shall, commencing March 1, 2000, adopt an income
37 disregard for applicants equal to the difference between the income
38 standard under the program adopted pursuant to Section 1931(b)
39 of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and
40 the amount equal to 100 percent of the federal poverty level

1 applicable to the size of the family. A recipient shall be entitled
2 to the same disregard, but only to the extent it is more beneficial
3 than, and is substituted for, the earned income disregard available
4 to recipients.
5 (d) For purposes of calculating income under this section during
6 any calendar year, increases in social security benefit payments
7 under Title II of the federal Social Security Act (42 U.S.C. Sec.
8 401 and following) arising from cost-of-living adjustments shall
9 be disregarded commencing in the month that these social security
10 benefit payments are increased by the cost-of-living adjustment
11 through the month before the month in which a change in the
12 federal poverty level requires the department to modify the income
13 disregard pursuant to subdivision (c) and in which new income
14 limits for the program established by this section are adopted by
15 the department.
16 ~~(e) Subdivision (b) shall be applied retroactively to January 1,~~
17 ~~1998.~~
18 ~~(f)~~
19 *(e)* Notwithstanding Chapter 3.5 (commencing with Section
20 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
21 the department shall implement, without taking regulatory action,
22 subdivisions (a) and (b) of this section by means of an all county
23 letter or similar instruction. Thereafter, the department shall adopt
24 regulations in accordance with the requirements of Chapter 3.5
25 (commencing with Section 11340) of Part 1 of Division 3 of Title
26 2 of the Government Code. Beginning six months after the effective
27 date of this section, the department shall provide a status report to
28 the Legislature on a semiannual basis until regulations have been
29 adopted.
30 *SEC. 70. Section 14005.301 is added to the Welfare and*
31 *Institutions Code, to read:*
32 *14005.301. (a) The department shall provide benefits pursuant*
33 *to Section 14005.306 to a population composed of parents and*
34 *other caretaker relatives who meet all of the following*
35 *requirements:*
36 *(1) Net family income is at or below 250 percent of the federal*
37 *poverty level.*
38 *(2) The individual is not otherwise eligible for full-scope benefits*
39 *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 subsidized purchasing pool population established pursuant to Section 12699.204 of the Insurance Code.

(e) To the extent necessary to implement this section, the department shall seek federal approval 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 8899.52 of the Government Code is implemented, whichever is later.

SEC. 71. 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

1 *age with income at or below 100 percent of the federal poverty*
2 *level.*
3 *(3) The individual is a citizen, national, or qualified alien*
4 *without regard to date of entry.*
5 *(b) The eligibility determination under this section shall not*
6 *include an asset test.*
7 *(c) The department shall implement this section by means of a*
8 *state plan amendment under Section 1902(a)(10)(A)(ii)(I) of the*
9 *federal Social Security Act (Title 42 U.S.C. Sec.*
10 *1396a(a)(10)(A)(ii)(I)), or by any other state plan amendment or*
11 *waiver, or combination thereof, as is necessary to accomplish the*
12 *intent of this section.*
13 *(d) The department shall seek federal approval to utilize the*
14 *same premiums and copayments for the population to whom this*
15 *section applies as are applied to the subsidized purchasing pool*
16 *population established pursuant to Section 12699.204 of the*
17 *Insurance Code.*
18 *(e) This section shall be implemented only if, and to the extent*
19 *that federal approval has been obtained to provide benchmark*
20 *benefits for individuals made eligible under this section with net*
21 *income over 100 percent of the federal poverty level in a manner*
22 *consistent with Section 14005.306.*
23 *(f) The income methodology for eligibility determinations under*
24 *this section shall be the methodology used for the federal poverty*
25 *level programs, but shall not include any income disregards*
26 *available under those programs.*
27 *(g) This section shall become operative on July 1, 2010, or on*
28 *the date that the authority under Section 8899.52 of the*
29 *Government Code is implemented, whichever is later, but only to*
30 *the extent federal financial participation is available.*
31 *SEC. 72. Section 14005.306 is added to the Welfare and*
32 *Institutions Code, to read:*
33 *14005.306. (a) Subject to the limitations provided in*
34 *subdivisions (b) and (c), a Medi-Cal beneficiary with a net family*
35 *income above 100 percent of the federal poverty level whose*
36 *eligibility is based on Section 14005.301 or Section 14005.305*
37 *and who is otherwise eligible for full-scope benefits, shall receive*
38 *his or her benefits by means of a benchmark package pursuant to*
39 *Section 1937 of the federal Social Security Act. This package shall*
40 *be the subsidized benefit package or packages established for the*

1 *program established pursuant to Part 6.45 (commencing with*
2 *Section 12699.201) of Division 2 of the Insurance Code.*
3 *(b) To the extent required by federal law, the categories of*
4 *beneficiaries listed in Section 1937(a)(2)(B) of the federal Social*
5 *Security Act (Title 42 U.S.C. Sec. 1396u-7(a)(2)(B)), are exempt*
6 *from mandatory enrollment in the benchmark package described*
7 *in subdivision (a).*
8 *(c) The department, with the concurrence of the Managed Risk*
9 *Medical Insurance Board, may identify groups of otherwise exempt*
10 *individuals that will be allowed a choice, at the beneficiary's*
11 *option, to participate in a benchmark package.*
12 *(d) The department, with concurrence of the Managed Risk*
13 *Medical Insurance Board, may exempt other groups or categories*
14 *of beneficiaries from the requirements provided in subdivision (a).*
15 *(e) To the extent federal approval is obtained, the appeals*
16 *process for issues relating to receipt of benefits through the*
17 *benchmark package shall be the process prescribed by the*
18 *Managed Risk Medical Insurance Board for the program*
19 *established pursuant to Part 6.45 (commencing with Section*
20 *12699.201) of Division 2 of the Insurance Code.*
21 *(f) This section shall be implemented only if and to the extent*
22 *that federal financial participation is available and all necessary*
23 *federal approvals have been obtained.*
24 *(g) The department shall accomplish the intent of this section*
25 *by means of a state plan amendment or by a waiver. If this section*
26 *is implemented in whole or in part by means of a state plan*
27 *amendment, all applicable federal requirements not otherwise*
28 *waived, including, but not limited to, requirements related to cost*
29 *sharing, shall apply.*
30 *SEC. 73. Section 14005.310 is added to the Welfare and*
31 *Institutions Code, to read:*
32 *14005.310. The department shall seek federal approval to*
33 *utilize an interval of one year in determining the cost amounts*
34 *specified in Section 12699.204 of the Insurance Code for persons*
35 *receiving benchmark benefits pursuant to Sections 14005.301 and*
36 *14005.305.*
37 *SEC. 74. Section 14005.311 is added to the Welfare and*
38 *Institutions Code, to read:*
39 *14005.311. (a) The department and the Managed Risk Medical*
40 *Insurance Board shall enter into a cooperative agreement under*

1 *which the board shall have authority and responsibility for*
2 *administering benchmark benefits under Sections 14005.301 and*
3 *14005.305 and for prescribing all rules and procedures necessary*
4 *for administering these benefits subject to the single state agency*
5 *oversight responsibilities of the department.*
6 *(b) This section shall be implemented only to the extent that*
7 *federal financial participation is not jeopardized.*
8 *SEC. 75. Section 14005.331 is added to the Welfare and*
9 *Institutions Code, to read:*
10 *14005.331. (a) An individual under the age of 19 years who*
11 *would be eligible for full-scope Medi-Cal benefits without a share*
12 *of cost, if not for his or her immigration status, shall be eligible*
13 *for full-scope Medi-Cal services under this section.*
14 *(b) In order to support federal claiming and to maximize federal*
15 *funding, the department shall develop documentation requirements*
16 *for an individual applying for benefits under subdivision (a).*
17 *(c) Any individual applying for benefits under subdivision (a)*
18 *who does not comply with subdivision (b) shall receive only the*
19 *benefits that are available for individuals who cannot demonstrate*
20 *eligibility for federally funded full-scope benefits.*
21 *(d) This section shall become operative on July 1, 2010, or on*
22 *the date that the authority under Section 8899.52 of the*
23 *Government Code is implemented, whichever is later.*
24 *SEC. 76. Section 14005.332 is added to the Welfare and*
25 *Institutions Code, to read:*
26 *14005.332. (a) The department shall design and implement a*
27 *program to provide the benefits described in subdivision (d) to the*
28 *population described in subdivision (c).*
29 *(b) The department shall seek to maximize the availability of*
30 *federal funding for this section under the terms of any existing*
31 *waiver, through amendment of any existing waiver, or by means*
32 *of a new waiver, or any combination thereof.*
33 *(c) The population eligible to receive benefits under this section*
34 *shall consist of all residents 21 years of age or older who meet all*
35 *of the following requirements.*
36 *(1) Their family income is at or below 100 percent of the federal*
37 *poverty level.*
38 *(2) They are not otherwise eligible for Medi-Cal.*
39 *(3) They would be eligible for full-scope Medi-Cal without a*
40 *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 do not have access to employer-sponsored health care coverage.

(d) Benefits available under this section shall consist of a benefit package that is designed by the department and is equivalent to the subsidized coverage made available in the program 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 shall not 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, 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.

1 *(j) Implementation of this section is contingent on the*
2 *establishment of the requirement as described in Section 14155.*
3 *(k) This section shall become operative on July 1, 2010, or on*
4 *the date that the authority under Section 8899.52 of the*
5 *Government Code is implemented, whichever is later.*
6 *SEC. 77. Section 14008.85 of the Welfare and Institutions Code*
7 *is amended to read:*
8 14008.85. (a) To the extent federal financial participation is
9 available, a parent who is the principal wage earner shall be
10 considered an unemployed parent for purposes of establishing
11 eligibility based upon deprivation of a child where any of the
12 following applies:
13 (1) The parent works less than 100 hours per month as
14 determined pursuant to the rules of the Aid to Families with
15 Dependent Children program as it existed on July 16, 1996,
16 including the rule allowing a temporary excess of hours due to
17 intermittent work.
18 (2) The total net nonexempt earned income for the family is not
19 more than 100 percent of the federal poverty level as most recently
20 calculated by the federal government. The department may adopt
21 additional deductions to be taken from a family's income.
22 (3) The parent is considered unemployed under the terms of an
23 existing federal waiver of the 100-hour rule for recipients under
24 the program established by Section 1931(b) of the federal Social
25 Security Act (42 U.S.C. Sec. 1396u-1).
26 *(b) The department shall seek any federal approval required to*
27 *waive or to increase the income limit in paragraph (2) of*
28 *subdivision (a), to the extent necessary to implement Sections*
29 *14005.301 and 14005.305.*
30 ~~(b)~~
31 *(c)* Notwithstanding Chapter 3.5 (commencing with Section
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
33 the department shall implement this section by means of an all
34 county letter or similar instruction without taking regulatory action.
35 Thereafter, the department shall adopt regulations in accordance
36 with the requirements of Chapter 3.5 (commencing with Section
37 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
38 ~~(c)~~
39 *(d)* This section shall become operative March 1, 2000.

SEC. 78. 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. 79. 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. 80. 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 subsidized health care 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. To achieve this purpose, the department may utilize or amend existing federal waivers, and may also seek new waivers.

SEC. 81. Article 2.96 (commencing with Section 14092.5) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.96. Local Coverage Options

14092.5. (a) There is hereby established the Local Coverage Options (LCO) program to expand health care coverage to certain low-income uninsured individuals in California.

(b) The department may implement this article by means of federal waiver as necessary to accomplish the intent of this article. The department shall seek to maximize the availability of federal funding for 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. The LCO program shall thereafter operate under the terms and conditions set forth in any applicable waiver.

(c) The population eligible to receive benefits under this article shall consist of residents of a county that contracts with the department pursuant to subdivision (d) and who are made eligible for services pursuant to Section 14005.332.

(d) The director may enter into a full-risk contract with any county that has a county hospital located to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries described under subdivision (c). County participation in the LCO program is voluntary.

(e) Services provided under the LCO program shall be those benefits described in Section 14005.306 and shall be made available to those eligible individuals described in subdivision (c) enrolled in the LCO program. The LCO program shall enroll and

1 *provide services to residents of the participating county that meet*
2 *the eligibility requirements set forth in subdivision (c).*
3 *(f) The department shall develop rates using actuarial methods*
4 *for LCO programs that contract with the department pursuant to*
5 *this article. Those actuarial methods shall develop rates that*
6 *compensate the LCO program for the projected cost of providing*
7 *care to the population served. Rates determined for the LCO*
8 *program pursuant to this article shall use the methodology set*
9 *forth in Article 3 (commencing with Section 14301.1) of Chapter*
10 *8, and may include establishing LCO or county specific rates by*
11 *utilizing a county and model specific rate methodology.*
12 *(g) Eligible counties shall contract with safety net hospitals in*
13 *their county and provide them with rates equal to Medi-Cal rates.*
14 *(h) Eligible counties shall contract with federally qualified*
15 *health centers in their county.*
16 *14092.51. The LCO program shall be designed and*
17 *implemented to achieve all of the following outcomes:*
18 *(a) Expand the number of Californians who have health care*
19 *coverage.*
20 *(b) Strengthen and build upon the local health care safety net*
21 *system, including disproportionate share hospitals, county clinics,*
22 *and community clinics.*
23 *(c) Improve access to high quality health care and health*
24 *outcomes for individuals.*
25 *(d) Create efficiencies in the delivery of health services that*
26 *could lead to savings in health care costs.*
27 *14092.52. (a) The department shall issue a request for*
28 *applications from applicable counties for the LCO program. The*
29 *department shall approve applications based on the criteria in*
30 *this section, and shall select a LCO only from those counties that*
31 *have a county hospital. Applicable counties may only submit one*
32 *application to be a LCO under this article.*
33 *(b) LCO programs must meet the requirements and desired*
34 *outcomes set forth in this article.*
35 *(c) The following elements shall be used in evaluating the*
36 *applications:*
37 *(1) Enrollment processes, with an identification system to*
38 *demonstrate enrollment of the uninsured into the program.*
39 *(2) Use of a medical record system, which may include*
40 *electronic medical records.*

(3) Designation of a medical home and assignment of eligible individuals to a primary care provider. For purposes of this paragraph, "medical home" means a single provider or facility that maintains an individual's medical information. The primary care provider shall be a provider from which the enrollee can access primary and preventive care.

(4) Provision of a benefit package of services as described Section 14005.306.

(5) Quality monitoring processes to assess the health care outcomes of individuals enrolled in the LCO program.

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

(7) Screening and enrollment processes for individuals who may qualify for enrollment into Medi-Cal, the Healthy Families Program, or the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code prior to enrollment into the LCO program.

(8) The ability to demonstrate how the LCO program will promote the viability of the existing safety net health care system.

(9) Demonstration of how the program will provide consumer assistance to individuals applying to, participating in, or accessing services in the program.

(10) The ability to meet the requirements described in subdivisions (g) and (h) of Section 14092.5.

14092.53. Applications submitted to the department shall include, but not be limited to, each of the following:

(a) A description of the proposed LCO program.

(b) Screening and enrollment processes that include point of service enrollment into the LCO program for eligible individuals, and that will identify individuals who may qualify for enrollment into Medi-Cal, the Healthy Families Program, or the Health Care Security and Cost Reduction Program.

(c) A description of the population to be served.

(d) A list of health care providers who have agreed to participate in the LCO program.

(e) A description of the organized health care delivery systems to be used for the LCO program, including, but not limited to, designation of a medical home and processes used to assign eligible individuals to a primary care provider.

1 *(f) A list of the benefits to be provided, including the preventive,*
2 *specialty, and primary care services.*
3 *(g) A description of the care management services to be*
4 *provided, and the providers of those services.*
5 *(h) A description of how the proposed LCO program will*
6 *strengthen the local health care safety net system.*
7 *(i) Use of a reliable medical record system that may include,*
8 *but need not be limited to, existing electronic medical records.*
9 *(j) A description of the quality monitoring system to be*
10 *implemented with the LCO program.*
11 *14092.54. (a) Commencing with the implementation of a LCO*
12 *program in a designated county, an eligible beneficiary shall have*
13 *a choice of primary care providers within the LCO.*
14 *(b) If an eligible beneficiary does not choose a primary care*
15 *provider or clinic, or does not select any primary care provider*
16 *who is available, the LCO program assigned to the beneficiary*
17 *shall ensure that the beneficiary selects a primary care provider*
18 *or clinic within 30 days after enrollment or is assigned to a primary*
19 *care provider within 40 days after enrollment.*
20 *(c) Any beneficiary dissatisfied with the primary care provider*
21 *shall be allowed to select or be assigned to another primary care*
22 *provider within the LCO program.*
23 *(d) The LCO shall notify a primary care provider when it has*
24 *been assigned to or selected by a beneficiary, and shall notify the*
25 *beneficiary of the assignment or acknowledge the beneficiary's*
26 *selection.*
27 *14092.55. (a) The provider network for LCO programs shall*
28 *center around the local public hospital system, including inpatient*
29 *and outpatient services. The provider network shall also include*
30 *community health centers.*
31 *(b) Each LCO shall contract with safety net providers, including,*
32 *but not limited to, disproportionate share hospitals and other*
33 *providers as needed, and offer the scope of benefits applicable to*
34 *the LCO program's eligible population as described in Section*
35 *14005.332.*
36 *(c) A LCO program shall offer the scope of benefits described*
37 *in Section 14005.332.*
38 *(d) The administrative structure of LCO programs may vary by*
39 *county, based upon requirements set by the department for*
40 *establishing an LCO, and may include, but are not limited to,*

having the LCO program administered by a local initiative two-plan model plan, a county organized health system plan, or a county entity plan.

(e) As a condition of contract award, a LCO shall agree to include in its health delivery system any federally qualified health center physically located and operating in the county that is willing to agree to provide services under the same terms and conditions that a LCO requires of any other similar provider to be included in a health care delivery system. Payments to federally qualified health centers shall be consistent with federal law.

(f) A LCO program shall provide reimbursement for emergency services provided anywhere in the country by noncontracting providers.

14092.56. (a) Newly enrolled Medi-Cal beneficiaries described in subdivision (c) of Section 14092.5 shall be enrolled in either the LCO program or the county organized health system (COHS) or the two-plan contractor in the county.

(b) Notwithstanding any other provision of law, a LCO shall have the ability to inquire into the eligibility of a patient seeking care at its facility and enroll persons meeting the eligibility standards for coverage described in subdivision (c) of Section 14092.5 into coverage under Medi-Cal and directly into the LCO.

(c) For the first three years of coverage, the county organized health system or local initiative within the county where a county hospital resides shall, as a condition of its contract with the state, contract with the LCO for provision of services to persons described in subdivision (c) of Section 14092.5 and provide rates using actuarial methods that reflect the cost for the LCO to provide care to the beneficiaries.

(d) During the three years after the date of implementation of a LCO health plan in a designated county, the COHS or the local initiative shall ensure that within county hospitals and clinics, the ratio of patients enrolled in coverage under Section 14005.332 to the total number of patients eligible for, but not enrolled in, coverage under that section is the same as the ratio of residents in that county enrolled in coverage under Section 14005.332 to the estimated number of persons in that county who are eligible for, but not enrolled in, coverage under that section.

(e) After three years from the first date of operations, the LCO program may compete with other managed care model plans in

1 *the geographic area for all eligible consumers. From that date*
2 *forward, Medi-Cal eligible beneficiaries as defined in subdivision*
3 *(c) of Section 14092.5 that do not choose another available*
4 *managed care plan shall be assigned to the LCO. A LCO shall not*
5 *receive default assignments of Medi-Cal beneficiaries other than*
6 *those defined in subdivision (c) of Section 14092.5.*
7 *(f) LCO programs shall be required by the department to meet*
8 *monitoring and quality of care guidelines and requirements in*
9 *order to ensure that individuals are receiving high quality care*
10 *through a coordinated system of care. The department shall*
11 *establish standards related to all of the following:*
12 *(1) Provision of basic health care services.*
13 *(2) Adequacy of provider networks for primary, specialty,*
14 *hospital, and outpatient care, including compliance with linguistic*
15 *access and timely access requirements.*
16 *(3) Provider contracts demonstrated to ensure the above.*
17 *(4) Utilization management capacity.*
18 *(5) Independent medical review and grievance processes.*
19 *(6) Quality assurance.*
20 *(7) Timely and accurate claims payment.*
21 *(8) Solvency and reserve requirements.*
22 *(9) Fraud and abuse.*
23 *If a LCO fails to meet the guidelines, requirements, and*
24 *standards set forth by the department, the department shall take*
25 *appropriate action. The department may, at its sole discretion,*
26 *suspend mandatory assignment set forth in subdivision (a).*
27 *(g) Cost and utilization data shall be provided by all LCO*
28 *programs to the department in a form and manner required by the*
29 *department and all applicable law, and as provided to the*
30 *department by other Medi-Cal managed care plans.*
31 *14092.57. (a) A LCO shall meet federal requirements for a*
32 *managed care organization.*
33 *(b) After a LCO has been in operation for three years, the LCO*
34 *shall be licensed by the Director of the Department of Managed*
35 *Health Care pursuant to the Knox-Keene Health Care Service*
36 *Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)*
37 *of Division 2 of the Health and Safety Code). If a LCO fails to*
38 *meet this licensing requirement, it shall cease to be eligible to*
39 *participate in the LCO program.*

(c) Sections 14408, 14409, 14410, and 14411 relating to enrollment practices shall apply to LCO programs.

14092.58. (a) To the extent necessary to implement this article, the department shall submit to the federal Centers for Medicare and Medicaid Services proposed waiver amendments on the structure of, and eligibility and benefits under, the LCO program.

(b) The request for applications, including any part of the process described herein for selecting entities to operate the health care coverage programs, and any agreements entered into with a county, city and county, consortium of counties, or health authority pursuant to this article shall be exempt and shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code, or the requirement of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of the Government Code.

(c) If any provision of this article is in conflict with any other provision of this chapter or any provision of Chapter 8 (commencing with Section 14200), or in any regulations promulgated therefrom, the provisions of this article shall be deemed to be controlling and shall supersede that other provision or regulation.

(d) The department shall consult with interested parties and appropriate stakeholders regarding the implementation and ongoing administration of this article.

14092.59. Implementation of this article is contingent on the establishment of a requirement as described in Section 14155.

SEC. 82. Section 14100.3 is added to the Welfare and Institutions Code, to read:

14100.3. (a) The department 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 purpose of the record shall be to provide 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 can be provided through the use of an Internet-based system.

1 *(c) In addition to the data required pursuant to subdivision (b),*
2 *the department may determine that the personal health record*
3 *shall also incorporate additional data such as laboratory results,*
4 *prescription history, claims history, and personal health*
5 *information authorized or provided by the enrollee. Inclusion of*
6 *this additional data shall be at the option of the enrollee.*
7 *(d) Systems or software that pertain to the personal health*
8 *record shall adhere to accepted national standards for*
9 *interoperability, privacy, and data exchange, or be certified by a*
10 *nationally recognized certification body.*
11 *(e) The personal health record shall comply with applicable*
12 *state and federal confidentiality and data security requirements.*
13 *SEC. 83. Section 14132.105 is added to the Welfare and*
14 *Institutions Code, to read:*
15 *14132.105. (a) (1) The department shall establish a Healthy*
16 *Action Incentives and Rewards Program to be provided as a*
17 *covered benefit under the Medi-Cal program.*
18 *(2) The benefits described in this section shall only be provided*
19 *under the terms and conditions determined by the department, and*
20 *shall meet all the requirements described in subdivision (b).*
21 *(b) For purposes of this section, the Healthy Action Incentives*
22 *and Rewards Program shall include, but need not be limited to,*
23 *all of the following:*
24 *(1) Health risk appraisals that collect information from eligible*
25 *beneficiaries to assess overall health status and identify risk*
26 *factors, including, but not limited to, smoking and smokeless*
27 *tobacco use, alcohol abuse, drug use, nutrition, and physical*
28 *activity practices.*
29 *(2) A followup appointment with a licensed health care*
30 *professional acting within his or her scope of practice to review*
31 *the results of the health risk appraisal and discuss any*
32 *recommended actions.*
33 *(3) Incentives or rewards or both for eligible beneficiaries to*
34 *become more engaged in their health care and to make appropriate*
35 *choices that support good health, including obtaining health risk*
36 *appraisals, screening services, immunizations, or participating in*
37 *health lifestyle programs or practices. These programs or practices*
38 *may include, but need not be limited to, smoking cessation, physical*
39 *activity, or nutrition. Incentives may include, but need not be*
40 *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.

(e) (1) Notwithstanding any other provision of law, the provision of healthy incentives and rewards pursuant to this section by a health care provider, or his or her agent, that meets the requirements of this section, Section 1367.38 of the Health and Safety Code, or Section 10123.56 of the Insurance Code shall not be considered or construed as an unlawful practice, act, kickback, bribe, rebate, remuneration, offer, coupon, product, payment, or any other form of compensation by a provider or his or her agent, directly or indirectly, overtly or covertly, in exchange for another to obtain, participate, or otherwise undergo or receive health care services.

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

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

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

SEC. 84. Section 14132.23 is added to the Welfare and Institutions Code, to read:

14132.23. (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 life-style 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

1 *required state plan amendments or waivers, necessary to implement*
2 *and fund the services authorized under this section.*
3 *(c) For the purposes of implementation of this section, the*
4 *director may enter into contracts for the purposes of providing the*
5 *benefits offered under the Comprehensive Diabetes Services*
6 *Program.*
7 *(d) This section shall be implemented only if and to the extent*
8 *that federal financial participation is available and has been*
9 *obtained.*
10 *(e) The Comprehensive Diabetes Services Program shall be*
11 *developed and implemented only to the extent that state funds are*
12 *appropriated annually for the services provided under this section.*
13 *(f) The department shall develop and implement incentives for*
14 *Medi-Cal fee-for-service eligible beneficiaries who participate in*
15 *the Comprehensive Diabetes Services Program and are compliant*
16 *with program requirements for screening and self-management*
17 *activities.*
18 *(g) The department shall develop and implement financial*
19 *incentives for Medi-Cal fee-for-service providers who participate*
20 *in the Comprehensive Diabetes Services Program and are*
21 *compliant with program requirements in the screening and*
22 *management of eligible beneficiaries who have been diagnosed*
23 *with prediabetes and diabetes.*
24 *(h) The department shall collect data including, but not be*
25 *limited to, laboratory values from screening and diagnostic tests*
26 *for the individual beneficiaries participating in the Comprehensive*
27 *Diabetes Services Program and monitor the health outcomes of*
28 *the participating individual beneficiaries.*
29 *(i) (1) Notwithstanding any other provision of law, the provision*
30 *of incentives pursuant to this section by a health care provider, or*
31 *his or her agent, that meets the requirements of this section, Section*
32 *1367.38 of the Health and Safety Code, or Section 10123.56 of the*
33 *Insurance Code shall not be considered or construed as an*
34 *unlawful practice, act, kickback, bribe, rebate, remuneration, offer,*
35 *coupon, product, payment, or any other form of compensation by*
36 *a provider or his or her agent, directly or indirectly, overtly or*
37 *covertly, in exchange for another to obtain, participate, or*
38 *otherwise undergo or receive health care services.*
39 *(2) Notwithstanding any other provision of law, incentives*
40 *authorized pursuant to this section are not subject to the penalties,*

1 *discipline, limitations, or sanctions imposed under law to preclude*
2 *or prohibit, as an unlawful practice, bribe, kickback or other act,*
3 *the offering or delivery of a rebate, remuneration, offer, coupon,*
4 *product, rebate, payment, or any other form of compensation by*
5 *the provider, or his or her agent, directly or indirectly, overtly or*
6 *covertly, in exchange for another to obtain, participate, or*
7 *otherwise undergo or receive health care services.*
8 *(j) This section shall only be implemented if, and to the extent,*
9 *allowed under federal law. If any portion of this section is found*
10 *to be invalid, as determined by a final judgment of a court of*
11 *complaint jurisdiction, this section shall become inoperative.*
12 *(k) The department shall, in consultation with the California*
13 *Diabetes Program in the State Department of Public Health,*
14 *contract with an independent organization to:*
15 *(1) Evaluate and report the health outcomes and cost savings*
16 *of the Comprehensive Diabetes Services program.*
17 *(2) Estimate the short- and long-term cost savings of expanding*
18 *the strategies of the Comprehensive Diabetes Services Program*
19 *statewide through the private or commercial insurance markets.*
20 *SEC. 85. Section 14155 is added to the Welfare and Institutions*
21 *Code, to read:*
22 *14155. The Legislature finds and declares all of the following:*
23 *(a) Chapters 85, 87, 89, and 91 of the Statutes of 1991 and*
24 *Chapter 100 of the Statutes of 1993 established state-local*
25 *responsibilities for a variety of health and mental health programs.*
26 *(b) The California Health Interview Survey estimated that there*
27 *were 4,856,000 Californians without health care coverage in 2005.*
28 *The Legislature finds that these Californians without health care*
29 *coverage frequently access the health care system through the*
30 *services provided pursuant to Chapters 85, 87, 89, and 91 of the*
31 *Statutes of 1991 and Chapter 100 of the Statutes of 1993.*
32 *(c) The health care reform provided by the act adding this*
33 *section, including the expansion of eligibility for the Medi-Cal*
34 *program and the provision of subsidies for low-income persons,*
35 *is estimated to significantly reduce the number of Californians*
36 *without health care coverage beginning in the 2010–11 fiscal year*
37 *and continuing in subsequent years.*
38 *(d) For these reasons, the Legislature finds that counties would*
39 *derive significant fiscal benefits from the health care reform*
40 *provided by the act adding this section and should contribute*

toward the cost of providing health care coverage to Californians who previously were without private coverage and ineligible for state coverage, by paying a participation payment related to the cost of providing coverage to each person.

(e) It is the intent of the Legislature to establish a mechanism whereby counties shall contribute to the cost of providing coverage to individuals currently relying on counties for medical services. Expansion of coverage to these individuals provided through Section 14005.332 and Section 12699.211 of the Insurance Code, except for persons eligible for coverage under Section 14005.301 or 14005.305, shall be contingent upon the implementation of a county contribution as specified in Section 14005.332 and Section 12699.211 of the Insurance Code.

SEC. 86. 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 effective 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) "Federal upper payment limit" means the upper payment limit on the applicable category of hospitals pursuant to federal law that will be allowed for purposes of federal financial participation. The federal upper payment limit for hospital outpatient services is as set forth in Section 447.321 of Title 42 of the Code of Federal Regulations. The federal upper payment limit for hospital inpatient services is as set forth in Section 447.272 of Title 42 of the Code of Federal Regulations.

(g) "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.

(h) "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.

(i) "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.

(j) "Implementation date" means the first day on which hospitals provide health care services to Medi-Cal beneficiaries that are reimbursed under this article.

(k) "Inpatient base rate" means the per diem rate, or per discharge rate if used by the department, established pursuant to Section 14167.4.

(l) "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

1 *Article 2.91 (commencing with Section 14089) of Chapter 7, or*
2 *Article 1 (commencing with Section 14200) or Article 7*
3 *(commencing with Section 14490) of Chapter 8.*
4 *(m) "Market basket index" means the hospital market basket*
5 *index used by the Medicare Program for the purpose of*
6 *determining payment rates for acute care inpatient hospital*
7 *services.*
8 *(n) "Medi-Cal fee-for-service payments" means all payments*
9 *made by the Medi-Cal program to hospitals as reimbursement for*
10 *hospital inpatient services furnished with respect to acute inpatient*
11 *days, including payments for both routine and ancillary services,*
12 *and payments described in subdivision (e) of Section 14167.4, but*
13 *excluding payments described in subdivision (f) of Section 14167.4.*
14 *(o) "New hospital" means a hospital that did not provide*
15 *hospital inpatient services to Medi-Cal beneficiaries under current*
16 *or prior ownership and has no history of Medi-Cal reimbursement.*
17 *(p) "Nondesignated public hospital" means a public hospital*
18 *that is licensed under subdivision (a) of Section 1250 of the Health*
19 *and Safety Code and is defined in paragraph (25) of subdivision*
20 *(a) of Section 14105.98, excluding designated public hospitals.*
21 *(q) "Outpatient base rates" means the Medi-Cal payment rates*
22 *for hospital outpatient services in effect on the date immediately*
23 *preceding the implementation date.*
24 *(r) "Private hospital" means a hospital licensed under*
25 *subdivision (a) of Section 1250 of the Health and Safety Code that*
26 *is a nonpublic hospital, nonpublic-converted hospital, or converted*
27 *hospital as those terms are defined in paragraphs (26) to (28),*
28 *inclusive, respectively, of subdivision (a) of Section 14105.98.*
29 *(s) "Safety net care pool" means the federal funds available to*
30 *ensure continued government support for the provision of health*
31 *care services to uninsured populations, as described in subdivision*
32 *(k) of Section 14166.1.*
33 *14167.2. (a) The department shall determine outpatient base*
34 *rates for hospital outpatient services furnished by nondesignated*
35 *public hospitals based on the payment methodology in effect on*
36 *the day immediately preceding the implementation date until the*
37 *department has developed new methods and standards for payment*
38 *of hospital outpatient services under subdivision (b). The*
39 *department shall increase the outpatient base rates by the*
40 *percentage the department determines is necessary to comply with*

1 *subdivision (c) so that each outpatient base rate is increased by*
2 *the same percentage, except as may be necessary to avoid*
3 *exceeding any applicable federal upper payment limit or to*
4 *otherwise comply with federal law.*
5 *(b) The department, in consultation with the hospital community,*
6 *and with input from others as deemed necessary and appropriate,*
7 *shall develop new methods and standards of payment for hospital*
8 *outpatient services. These new methods and standards shall comply*
9 *with the provisions of subdivision (c) and take into consideration*
10 *factors such as acuity and the cost incurred by hospitals in*
11 *providing services.*
12 *(c) Medi-Cal rates for hospital outpatient services furnished by*
13 *nondesignated public hospitals during a fiscal year shall be set to*
14 *result in aggregate payments equal to the federal upper payment*
15 *limit.*
16 *(d) The department shall establish rates of payment pursuant*
17 *to this section prior to the implementation date and prior to the*
18 *beginning of each state fiscal year commencing on or after the*
19 *implementation date. The department shall monitor payments*
20 *during the fiscal year and may make adjustments as may be*
21 *necessary to comply with subdivision (c).*
22 *14167.3. (a) The department shall determine outpatient base*
23 *rates for hospital outpatient services furnished by private hospitals*
24 *based on the payment methodology in effect on the day immediately*
25 *preceding the implementation date until the department has*
26 *developed new methods and standards for payment of hospital*
27 *outpatient services under subdivision (b). The department shall*
28 *increase the outpatient base rates by the percentage the department*
29 *determines is necessary to comply with subdivision (c) so that each*
30 *outpatient base rate is increased by the same percentage, except*
31 *as may be necessary to avoid exceeding any applicable federal*
32 *upper payment limit or to otherwise comply with federal law.*
33 *(b) The department, in consultation with the hospital community,*
34 *and with input from others as deemed necessary and appropriate,*
35 *shall develop new methods and standards of payments for hospital*
36 *outpatient services. These new methods and standards shall comply*
37 *with the provisions of subdivision (c) and take into consideration*
38 *factors such as acuity and the cost incurred by hospitals in*
39 *providing services.*

1 *(c) Medi-Cal rates for hospital outpatient services furnished by*
2 *private hospitals during a fiscal year shall be set to result in*
3 *aggregate payments equal to the federal upper payment limit.*
4 *(d) The department shall establish rates of payment pursuant*
5 *to this section prior to the implementation date and prior to the*
6 *beginning of each state fiscal year commencing on or after the*
7 *implementation date. The department shall monitor payments*
8 *during the fiscal year and may make adjustments as may be*
9 *necessary to comply with subdivision (c).*
10 *14167.4. (a) The department shall determine an inpatient base*
11 *rate for each private hospital and nondesignated public hospital.*
12 *(b) The inpatient base rate shall be an estimate of the hospital's*
13 *Medi-Cal fee-for-service payments per acute inpatient day, or per*
14 *acute inpatient discharge if used by the department, as of the day*
15 *immediately preceding the implementation date.*
16 *(c) Each hospital's inpatient base rate shall be determined as*
17 *follows:*
18 *(1) The department shall determine the hospital's total Medi-Cal*
19 *fee-for-service payments for services furnished during the base*
20 *period.*
21 *(2) The department shall determine the hospital's total Medi-Cal*
22 *acute inpatient days, or the number of acute inpatient discharges*
23 *if used by the department, for the base period.*
24 *(3) The department shall divide the result of paragraph (1) by*
25 *the result of paragraph (2).*
26 *(4) The department shall adjust the result of paragraph (3) by*
27 *the rate of increase in the market basket index from the midpoint*
28 *of the base period to the implementation date. The result shall be*
29 *the hospital's inpatient base rate.*
30 *(d) The department shall make available a paid claims summary*
31 *for each hospital that sets forth all of the Medi-Cal fee-for-service*
32 *payments made for services furnished during the hospital's base*
33 *period and the hospital's fee-for-service Medi-Cal acute inpatient*
34 *days for the base period, and any other data the department may*
35 *require to determine each hospital's base rate. The Medi-Cal*
36 *fee-for-service payments for hospitals reimbursed on a cost basis*
37 *shall be the hospital's interim payments. The department shall use*
38 *this data to compute the inpatient base rate.*
39 *(e) The department shall add to each hospital's Medi-Cal*
40 *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 ninety days before the implementation date. The department shall make available a final list of each hospital's inpatient base rate thirty days prior to the implementation date.

(h) A hospital's base rate shall be corrected if it 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

1 *first calendar quarter beginning after the date of the department's*
2 *determination. However, if the department receives a hospital's*
3 *request for a correction no later than thirty days after the*
4 *department publishes the preliminary list under subdivision (g),*
5 *any correction shall be effective as of the implementation date.*
6 *(k) The department shall develop an informal process for*
7 *reviewing and making decisions promptly concerning disputes by*
8 *hospitals of the department's action or proposed action under this*
9 *section or Section 14167.5, consistent with the provisions of this*
10 *section and Section 14167.5. The process shall be exempt from*
11 *the provisions of the Administrative Procedure Act.*
12 *(l) Notwithstanding any other provision of law, no change to a*
13 *hospital's base rate shall be applied to payments for services*
14 *rendered prior to the effective date of the change to the base rate.*
15 *14167.5. To the extent feasible, the department shall develop*
16 *a case mix adjustment factor to apply to inpatient base rates for*
17 *private and nondesignated public hospitals. If developed, the*
18 *department shall take all of the following steps:*
19 *(a) Each private and nondesignated public hospital's inpatient*
20 *base rate shall be adjusted to reflect changes in the hospital's*
21 *Medi-Cal case mix for fee-for-service Medi-Cal inpatients as*
22 *compared to the base period.*
23 *(b) Case mix adjustments shall be applied prospectively at the*
24 *beginning of each state fiscal year beginning with the first state*
25 *fiscal year that begins no less than 12 months after the*
26 *implementation date.*
27 *(c) The department shall compute a case mix adjustment factor*
28 *for each hospital for each state fiscal year. The case mix adjustment*
29 *factor shall be the hospital's case mix index for the most recent*
30 *calendar year divided by the case mix index for the base period.*
31 *(d) The department, in consultation with the hospital community,*
32 *and with input from others as deemed necessary and appropriate,*
33 *shall develop the methodology for computing the case mix index,*
34 *including the data to be used and the sources of the data. In*
35 *developing the case mix index methodology, the department shall*
36 *consider, at minimum, the following factors:*
37 *(1) The development of a methodology that reasonably measures*
38 *the relative cost that would be expected to be incurred in treating*
39 *different types of cases.*

1 *(2) The use of an approach using diagnosis related groups and*
2 *relative weights for such groups used by the Medicare Program*
3 *under the Medicare inpatient prospective payment system.*
4 *(3) The accuracy of applying weights used by the Medicare*
5 *Program for the purpose of measuring the Medi-Cal case mix.*
6 *(4) The available data.*
7 *(5) The comparability of the data available for the base period*
8 *and the data available for later years.*
9 *(6) The development of accurate measures of relative case mix*
10 *for pediatric patients.*
11 *(e) No later than 90 days prior to the beginning of the fiscal*
12 *period to which a case mix adjustment factor is applied, the*
13 *department shall determine each hospital's case mix adjustment*
14 *factor, advise each hospital of its case mix adjustment factor and*
15 *the case mix index factors used to compute the case mix adjustment*
16 *factor, and provide each hospital with the data used to compute*
17 *the case mix adjustment factor.*
18 *(f) The department shall correct a hospital's case mix adjustment*
19 *factor if the hospital demonstrates any of the following:*
20 *(1) The department made a mathematical error.*
21 *(2) The data used by the department is inaccurate.*
22 *(3) More accurate data is available.*
23 *(g) The department shall review and issue a determination*
24 *concerning a hospital's request for a correction under subdivision*
25 *(f) within 30 days of receipt of the request. Any correction that is*
26 *made shall be applied prospectively, beginning the first day of the*
27 *first calendar quarter beginning after the date of the department's*
28 *determination.*
29 *(h) (1) The department may make adjustments to a hospital's*
30 *base rate to take into account an event or series of events that may*
31 *significantly affect a hospital's costs of furnishing hospital inpatient*
32 *services that is not reflected in the case mix adjustment, such as*
33 *a merger or consolidation of hospitals, a substantial change in*
34 *the types of services furnished by a hospital, or a substantial*
35 *change in the acuity of the hospital's patients. An event or series*
36 *of events shall be deemed to significantly affect a hospital's costs*
37 *only if the department determines that the hospital's cost per day*
38 *has increased or decreased by 10 percent or more as a result of*
39 *the event or series of events. Events that are generally applicable*
40 *to multiple hospitals, such as a market basket increase in the costs*

1 *of goods or services purchased by hospitals, shall not be a basis*
2 *for an adjustment under this subdivision.*
3 *(2) The department shall notify the hospital in writing of any*
4 *adjustment it proposes to make under this subdivision. The notice*
5 *shall include an explanation of the department's reasons for*
6 *making the adjustment, the computation of the adjustment, and*
7 *the data relied on by the department in making the adjustment.*
8 *The hospital may dispute an adjustment within 30 days after receipt*
9 *of the notice described in this paragraph by providing written*
10 *notice to the person identified by the department in the notice. The*
11 *hospital shall include in the written notice of dispute the reasons*
12 *the hospital believes the adjustment should not be made as*
13 *proposed by the department, including all data supporting the*
14 *hospital's position. The department may not implement any*
15 *adjustment under this subdivision until it makes a final*
16 *determination concerning a notice of dispute.*
17 *(3) Any adjustment under this subdivision shall be made*
18 *prospectively beginning the first day of the calendar quarter*
19 *beginning no sooner than 60 days after the department issues a*
20 *notice to the hospital of the proposed adjustment. However, if the*
21 *hospital timely disputes the proposed adjustment, as specified in*
22 *paragraph (2), the proposed adjustment shall not be implemented*
23 *until the first day of the first calendar quarter beginning after the*
24 *department issues its decision concerning the dispute.*
25 *14167.6. (a) The department shall determine inpatient base*
26 *rates pursuant to Section 14167.4 for hospital inpatient services*
27 *provided by nondesignated public hospitals based on the payment*
28 *methodologies in effect on the day immediately preceding the*
29 *implementation date until the department has developed new*
30 *methods and standards under subdivision (b). The department*
31 *shall increase each hospital's inpatient base rate by the percentage*
32 *the department determines is necessary to comply with subdivision*
33 *(c), taking into account the additional payments made pursuant*
34 *to subdivision (e), so that each hospital's inpatient base rate is*
35 *increased by the same percentage, except as may be necessary to*
36 *avoid exceeding any applicable federal upper payment limit or to*
37 *otherwise comply with federal law. The department shall pay each*
38 *nondesignated public hospital for hospital inpatient services*
39 *provided prior to the implementation of new methods and standards*

1 *of payment developed pursuant to subdivision (b) based on its*
2 *inpatient base rate as increased pursuant to this subdivision.*
3 *(b) The department, in consultation with the hospital community,*
4 *and with input from others as deemed necessary and appropriate,*
5 *shall develop new methods and standards of payments for hospital*
6 *inpatient services provided by nondesignated public hospitals.*
7 *These new methods and standards shall comply with the provisions*
8 *of subdivision (c) and take into consideration factors such as*
9 *patient acuity, the cost incurred by hospitals in providing services,*
10 *and equitable payment for outlier patients.*
11 *(c) Medi-Cal rates for hospital inpatient services furnished by*
12 *nondesignated public hospitals during a state fiscal year shall be*
13 *set at an amount that results in aggregate payments equal to the*
14 *federal upper payment limit.*
15 *(d) The department shall establish rates of payment pursuant*
16 *to this section prior to the implementation date and prior to the*
17 *beginning of each state fiscal year beginning on or after the*
18 *implementation date. The department shall monitor payments*
19 *during the fiscal year, and may make adjustments that may be*
20 *necessary to comply with subdivision (c).*
21 *(e) The department shall develop a reimbursement methodology*
22 *to equitably compensate nondesignated public hospitals for the*
23 *delivery of Medi-Cal acute inpatient psychiatric services.*
24 *14167.7. (a) The department shall determine inpatient base*
25 *rates pursuant to Section 14167.4 for hospital inpatient services*
26 *provided by private hospitals based on the payment methodologies*
27 *in effect on the day immediately preceding the implementation*
28 *date until the department has developed new methods and*
29 *standards under subdivision (b). The department shall increase*
30 *each hospital's inpatient base rate by the percentage the*
31 *department determines is necessary to comply with subdivision*
32 *(c), taking into account the additional payments made under*
33 *subdivision (f), so that each hospital's inpatient base rate is*
34 *increased by the same percentage, except as may be necessary to*
35 *avoid exceeding any applicable federal upper payment limit or to*
36 *otherwise comply with federal law. The department shall pay each*
37 *private hospital for hospital impatient services provided prior to*
38 *the implementation of new methods and standards of payment*
39 *developed pursuant to subdivision (b) based on its inpatient base*
40 *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 comply with the provisions of 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 federal upper payment limit.

(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) The department shall establish rates of payment to major teaching institutions that have a formal academic affiliation with a designated public hospital that covers the cost of services.

(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 upper payment limit is satisfied only if, and to the extent, required by federal law.

(c) Each private and nondesignated public hospital, as a condition of receiving reimbursement under this section, shall keep, maintain, and have readily accessible, 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 make payments to providers under their contracts at the same level as is paid on a fee-for-service basis to the hospitals whose rates are governed by this article, subject to the limitations of federal law.

(b) Subject to subdivision (c), 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 total amount of the revenue resulting from payments of a fee from private hospitals and nondesignated public hospitals for patient days in a fiscal year is expended after making the expenditures for the payments under Sections 14167.2, 14167.3, 14167.6, and 14167.7.

(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 (k) of Section 14167.19, plus interest, penalties, and federal financial participation.

(2) The revenue derived from a fee, as described in subdivision (k) of Section 14167.19, 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 and nondesignated 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 such documentation as the department may require to demonstrate compliance with the provisions of this subdivision.

1 *14167.10. (a) Notwithstanding Article 5.2 (commencing with*
2 *Section 14166), for the period of time during which this article is*
3 *operative, safety net care pool funds, as defined in subdivision (s)*
4 *of Section 14167.1, shall be paid to the designated public hospitals,*
5 *as defined in subdivision (e) of Section 14167.1, in accordance*
6 *with this section, to the extent that those funds are available.*
7 *(b) (1) Each designated public hospital, or the governmental*
8 *entity with which it is affiliated, that operates nonhospital clinics*
9 *or provides other health care services that are not identified as*
10 *hospital services, may report and certify, in accordance with*
11 *Section 14166.8, all or a portion of its uncompensated costs of the*
12 *services furnished to the uninsured. Each designated public*
13 *hospital, or the governmental entity with which it is affiliated, shall*
14 *receive from the Health Care Support Fund, for each fiscal year,*
15 *an amount equal to the federal funds derived from the certification*
16 *of uncompensated care costs pursuant to the preceding sentence.*
17 *The maximum amount payable pursuant to this paragraph shall*
18 *be one hundred million dollars ($100,000,000).*
19 *(2) If, for any fiscal year, the amount payable from the Health*
20 *Care Support Fund is insufficient for purposes of the payments*
21 *described in paragraph (1), each designated public hospital, or*
22 *governmental entity with which it is affiliated, shall receive a pro*
23 *rata share of the amount specified in paragraph (1). The pro rata*
24 *amount determined for purposes of this paragraph shall be based*
25 *on the percentage that each designated public hospital's certified*
26 *uncompensated medical care costs of medical services provided*
27 *to uninsured individuals bears to the total amount of the costs*
28 *certified by all of the participating designated public hospitals or*
29 *governmental entity with which it is affiliated.*
30 *(3) Subdivision (a) of Section 14166.21 shall remain operative*
31 *for the period of time during which this article is operative, but*
32 *subdivision (b) of Section 14166.21 shall be inoperative for the*
33 *period of time during which this article is operative.*
34 *(c) Except as provided in subdivision (b), subdivision (g) of*
35 *Section 14166.8 shall be inoperative for the period of time during*
36 *which this article is operative. The department shall seek Medicaid*
37 *federal financial participation from the safety net care pool based*
38 *on qualifying expenditures from the designated public hospitals*
39 *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.

(f) Implementation of this section is contingent on the establishment of the requirement as described in Section 14155.

14167.11. (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 for the cost of inpatient and outpatient hospital services rendered to Medi-Cal beneficiaries based upon claims filed by the hospital in accordance with the claiming process set forth in Division 3 (commencing with Section 50000) of Title 22 of the California Code of Regulations. Inpatient hospital rates may be on a per diem or per discharge basis.

(3) The nonfederal share of the reimbursement specified in paragraph (2) shall consist of state appropriations made in the

annual Budget Act, which shall be limited for fiscal year 2010–11, and each fiscal year thereafter, to the full cost incurred by the particular hospital in fiscal year 2006–07, increased annually by the percentage increase in the rate of payments made to private hospitals or at the annual rate of growth in cost by that hospital, whichever is less.

(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 as described in paragraph (1) shall be certified as accurate by the unit of government that owns or operates the hospital submitting the estimated costs. The appropriate public official shall provide the certification required by this paragraph.

(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 (4).

(B) 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.

(C) 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) Implementation of this section is contingent on the establishment of the requirement as described in Section 14155.

14167.19. (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

1 *allow the department an opportunity to consider additional*
2 *information and engage in follow-up discussions.*
3 *(b) The director shall seek federal approval of each payment*
4 *methodology set forth in this article. The director, in consultation*
5 *with the hospital community, and with input from others as deemed*
6 *necessary and appropriate, may alter any methodology specified*
7 *in this article to the extent necessary to meet the requirements of*
8 *federal law or regulations or to obtain federal approval. If, after*
9 *seeking federal approval, federal approval is not obtained, that*
10 *methodology shall not be implemented.*
11 *(c) Payments made pursuant to this article are contingent on*
12 *the receipt of federal reimbursement.*
13 *(d) In implementing this article, the department may utilize the*
14 *services of the Medi-Cal fiscal intermediary through a change*
15 *order to the fiscal intermediary contract to administer this*
16 *program, consistent with the requirements of Sections 14104.6,*
17 *14104.7, 14104.8, and 14104.9. Contracts entered into with any*
18 *Medicare fiscal intermediary shall not be subject to Part 2*
19 *(commencing with Section 10100) of Division 2 of the Public*
20 *Contract Code.*
21 *(e) Except as otherwise provided in this article, Sections*
22 *14166.11 to 14166.14, inclusive, Sections 14166.17 to 14166.20,*
23 *inclusive, and Sections 14166.22 and 14166.23, shall be*
24 *inoperative for the period of time during which this article is*
25 *operative.*
26 *(f) This article shall become inoperative five years after the*
27 *implementation date of this article and as of January 1, 2016, is*
28 *repealed, unless a later enacted statute that is enacted on or before*
29 *January 1, 2016, extends or deletes the dates on which it becomes*
30 *inoperative and is repealed.*
31 *(g) This article shall be applicable to services rendered to*
32 *Medi-Cal beneficiaries on and after July 1, 2010. For services*
33 *that are paid under this article, any other provider rate*
34 *methodology, including those established by the California Medical*
35 *Assistance Commission pursuant to Article 2.6 (commencing with*
36 *Section 14081), shall become inoperative for those services on*
37 *and after that date.*
38 *(h) This article shall not apply to any service furnished prior*
39 *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 not be implemented unless and until a 4 percent fee is imposed on the net patient revenue of acute care hospitals.

SEC. 87. Article 5.22 (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 5.22. 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) It is the intent of the Legislature that, to the extent practicable, the director increase reimbursement rates to managed health care plans by the actuarial equivalent amount necessary

to ensure that managed health care plans make payments to the classes of providers whose rates are governed by this article at the same level as are made pursuant to this article.

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, including a certified family nurse practitioner and a certified pediatric 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 and as set forth in Section 51240 of Title 22 of the California Code of 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.

14167.24. (a) A physician, physician group, 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, commencing on July 1, 2010, reimbursement shall not be less than 80 percent of the amount that the federal Medicare Program would pay for the same physician service rendered on the same date. 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) 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 a rate that is not less than 80 percent of what Medicare would pay for that physician service.

(4) Physician services that are reimbursable under this section may be provided in any service location except for hospitals, federally qualified health centers, and rural health centers.

(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, 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, 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 a percentage 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, 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 (NQF).

(d) At a minimum, all of the following performance measures shall be used 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.

1 *(5) The quality assurance requirements set forth in Section*
2 *1300.70 of Title 28 of the California Code of Regulations.*
3 *(6) Efforts to promote healthy behaviors among Medi-Cal*
4 *beneficiaries pursuant to the Healthy Incentives and Rewards*
5 *Program described in Section 14132.105.*
6 *(7) The extent to which purchasers, payers, providers, and*
7 *consumers are able to monitor the quality and cost of health care*
8 *utilizing public reporting information published by the Office of*
9 *the Patient Advocate.*
10 *(8) The extent to which physicians, physician groups, podiatrists,*
11 *and nonphysician medical practitioners that provide services to*
12 *Medi-Cal beneficiaries on a fee-for-service basis implement*
13 *activities, such as telemedicine, electronic prescribing and the*
14 *electronic exchange of health information among various payers*
15 *and providers for the purpose of attaining health care safety and*
16 *quality improvements, informed clinical care decisions, the*
17 *increased use of interoperable platforms for the exchange of*
18 *relevant health care data, and more accurate and timely diagnosis*
19 *and treatment.*
20 *(9) Compliance with the federal Health Insurance Portability*
21 *and Accountability Act (HIPAA) (42 U.S.C. Sec. 300gg).*
22 *(e) The department shall consult with stakeholders, including,*
23 *but not limited to, representatives of patients, physicians, managed*
24 *care plans, payers, and other appropriate stakeholders, to*
25 *determine the means to measure and document implementation*
26 *by each physician, physician group, podiatrist, and nonphysician*
27 *medical practitioner of the performance measures developed*
28 *pursuant to subdivisions (c) and (d).*
29 *(f) The department may exempt classes of physicians, physician*
30 *groups, podiatrists, and nonphysician medical practitioners and*
31 *specific services from this section, if necessary to comply with the*
32 *requirements of federal law or regulations.*
33 *(g) The department may file one or more state plan amendments*
34 *to implement this section.*
35 *(h) The department shall seek necessary federal approvals for*
36 *implementation of this section. The department shall implement*
37 *this section only in a manner that is consistent with federal*
38 *Medicaid law and regulations. This section shall be implemented*
39 *only to the extent that federal approval is obtained and federal*
40 *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.

SEC. 88. Article 7 (commencing with Section 14199.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 7. Coordination with the California Health Trust Fund

14199.10. The department shall seek any necessary federal approval to enable the state to receive federal funds for coverage provided through the program established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, to persons who would be eligible for the Medi-Cal program if the state expanded eligibility to a population composed of parents and other caretaker relatives with a household income at or below 250 percent of the federal poverty level who are not otherwise eligible for full-scope benefits, including benchmark benefits, with no share of cost. Revenues in the California Health Trust Fund created pursuant to Section 12699.215 of the Insurance Code shall be used as state matching funds for receipt of federal funds resulting from the implementation of this section. All federal funds received pursuant to that federal approval shall be deposited in the California Health Trust Fund.

SEC. 89. (a) In order to achieve the purposes of this act, the Director 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 *(1) Make otherwise eligible individuals ineligible for health*
2 *coverage under the Medi-Cal program and the Healthy Families*
3 *Program.*
4 *(2) Increase cost-sharing amounts beyond levels established in*
5 *this act.*
6 *(3) Reduce benefits below those provided for in this act.*
7 *(4) Otherwise disadvantage applicants or recipients in a way*
8 *not contemplated by this act.*
9 *(c) The department shall take all reasonable steps necessary to*
10 *maximize federal financial participation and to support federal*
11 *claiming in the implementation of this act.*
12 *(d) It is the intent of the Legislature that the provisions of this*
13 *act shall be implemented simultaneously to the extent possible in*
14 *order to harmonize and best effectuate the purposes and intent of*
15 *this act.*
16 *(e) The director shall notify the Chair of the Joint Legislative*
17 *Budget Committee in any case when it is necessary to exercise the*
18 *flexibility provided under this section. This notification shall be*
19 *provided 30 days prior to exercising that flexibility.*
20 *SEC. 90. It is the intent of the Legislature that provisions of*
21 *this act shall be financed by contributions from employers;*
22 *individuals; federal, state, and local governments; and health care*
23 *providers. Specifically financial support shall include:*
24 *(a) Federal financial participation through the federal Medicaid*
25 *and S-CHIP programs.*
26 *(b) Revenue from counties, based on the approach identified in*
27 *Section 14155 of the Welfare and Institutions Code, to support the*
28 *cost of enrolling persons otherwise entitled to county-funded care.*
29 *(c) Fees paid by acute care hospitals at a rate of 4 percent of*
30 *net patient revenues.*
31 *(d) Fees paid by employers not expending an equivalent amount*
32 *for health care services at a rate ranging from 0 to 4 percent of*
33 *total payroll, based on social security wages and excluding any*
34 *gratuity as defined in Section 350 of the Labor Code. The fee level*
35 *shall vary based on each employer's size. Employers with a total*
36 *annual payroll up to one hundred thousand dollars ($100,000)*
37 *shall be exempt from payment of this fee. Employers with a total*
38 *annual payroll of one hundred thousand dollars ($100,000) to two*
39 *hundred thousand dollars ($200,000), inclusive, shall pay a fee of*
40 *2 percent of their total annual payroll, and employers with a total*

annual payroll of more than two hundred thousand dollars ($200,000) shall pay a fee of 4 percent of their total annual payroll.

(e) Premium contributions from currently offering employers when employees, eligible for employer-based coverage, choose to enroll in Medi-Cal or the Health Care Security and Cost Reduction Program.

(f) Premium payments for individuals enrolled in publicly subsidized coverage and coverage purchased in the individual market.

(g) Additional public funds obtained through licensing the State Lottery.

(h) Other state funds made available through savings generated through reduced demand for existing health care programs.

SEC. 91. (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 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 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. 92. 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.

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

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