

AMENDED IN ASSEMBLY AUGUST 8, 2008

**SENATE BILL**

**No. 1379**

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**Introduced by Senator Ducheny**

February 21, 2008

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*An act to amend Section 2455 of, and to add Section 2455.1 to, the Business and Professions Code, to amend Sections 1367.01, 1367.03, 1368, 1368.04, 1374.9, 1374.34, 1393.6, 128553, and 128555 of, and to add Section 1341.45 to, the Health and Safety Code, and to amend Section 12739 of the Insurance Code, relating to health care service plans, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1379, as amended, Ducheny. ~~Fines and penalties: physician loan repayment.~~ *Physician and surgeon loan repayment: osteopathic physicians and surgeons: health care service plans.*

Existing law establishes the ~~Medically Underserved Account for Physicians within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development.~~ Under existing law, the primary purpose of the account is to fund the Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of educational loans, as specified, obtained by a physician and surgeon who practices in a medically underserved area of the state, as defined. Under existing law, funds placed in the account for those purposes are continuously appropriated ~~Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of educational loans, as specified, obtained by a physician and surgeon who practices in a medically underserved area of the state, as defined.~~ Existing law establishes the *Medically Underserved Account for*

*Physicians within the Health Professions Education Fund for the purpose of funding the loan repayment program and specifies that funds placed in the account are continuously appropriated for those purposes. Existing law requires that applicants for the loan repayment program be licensed by the Medical Board of California.*

*Existing law provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California and imposes various fees on those licensees.*

*This bill would make osteopathic physicians and surgeons eligible for the loan repayment program and would require the Osteopathic Medical Board of California to assess an additional \$50 licensure fee, as specified. The bill would specify that payment of the fee is voluntary and would direct the deposit of those fees into the Medically Underserved Account for Physicians for purposes of the loan repayment program. By increasing the amount of revenue in a continuously appropriated account, the bill would make an appropriation.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (*the Knox-Keene Act*), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law subjects health care service plans to various fines and administrative penalties for failing to comply with specified provisions of the act and requires that certain administrative penalties be deposited in the Managed Care Fund. Existing law also requires health care service plans to pay specified assessments each fiscal year as a reimbursement of their share of the costs and expenses reasonably incurred in the administration of the act. Existing law requires the adjustment of those assessments and other charges set forth in the act if the director of the department determines that they are in excess of the amount necessary, or are insufficient, to meet the expenses of the act. *Under existing law, the Managed Risk Medical Insurance Board manages the California Major Risk Medical Insurance Program to provide major risk medical insurance coverage to eligible persons who have been rejected for health care coverage by at least one private health plan. Existing law creates the Major Risk Medical Insurance Fund, and continuously appropriates the fund to the board for purposes of the program.*

This bill would prohibit using the fines and administrative penalties authorized by the ~~act~~ *Knox-Keene Act* to reduce those assessments. The bill would ~~also~~ require that the *first \$1,000,000* in fines and administrative penalties authorized pursuant to the act be paid to the Medically Underserved Account for Physicians to be used, upon

appropriation by the Legislature, for the purposes of the ~~Physician Corps Loan Repayment Program~~ *loan repayment program*. The bill would require that the remaining fines and administrative penalties, over the first \$1,000,000, be paid to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for purposes of the program. The bill would specify that those funds are not continuously appropriated.

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

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

1 SECTION 1. ~~Section 1341.45 is added to the Health and Safety Code, to read:~~

2  
3 ~~1341.45. The fines and administrative penalties authorized pursuant to this chapter shall be paid to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program. Notwithstanding Section 1356.1, these fines and penalties shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.~~

15 SECTION 1. *Section 2455 of the Business and Professions Code is amended to read:*

16  
17 2455. The amount of fees and refunds is that established by the following schedule for any certificate issued by the Osteopathic Medical Board of California. All other fees and refunds for any certificate issued by the Osteopathic Medical Board of California which are not prescribed in this schedule, are prescribed in ~~Section~~ Sections 2455.1 and 2456. Any and all fees received by the Osteopathic Medical Board of California shall be for the sole purpose of the operation of the board and shall not be used for any other purpose.

26 (a) Each applicant for an original or reciprocity Physicians and Surgeons Certificate shall pay an application fee in a sum not to

1 exceed four hundred dollars (\$400) at the time his or her  
2 application is filed.

3 (b) The biennial license fee, unless otherwise provided, shall  
4 be set by the board on or before November 1 of each year for the  
5 ensuing calendar year at a sum as the board determines necessary  
6 to defray the expenses of administering this chapter, under the  
7 Osteopathic Act, relating to the issuance of certificates to those  
8 applicants, which sum, however, shall not exceed four hundred  
9 dollars (\$400) nor be less than twenty-five dollars (\$25).

10 (c) The board shall set a biennial license fee in an amount less  
11 than that levied pursuant to subdivision (b) that shall be paid by  
12 any applicant who indicates to the board in writing that he or she  
13 does not intend to practice under the Osteopathic Act during the  
14 current renewal period.

15 (d) The fee for failure to pay the biennial license fee shall be  
16 50 percent of the renewal fee but not more than two hundred dollars  
17 (\$200).

18 *SEC. 2. Section 2455.1 is added to the Business and Professions*  
19 *Code, to read:*

20 *2455.1. (a) In addition to the fees charged pursuant to Section*  
21 *2455, and at the time those fees are charged, the board shall*  
22 *charge each applicant for an original or reciprocity certificate or*  
23 *for a biennial license an additional fifty-dollar (\$50) fee for the*  
24 *purposes of this section.*

25 *(b) Payment of this fifty-dollar (\$50) fee shall be voluntary, and*  
26 *shall be paid at the time of application for an initial or reciprocity*  
27 *certificate or for a biennial license. The fifty-dollar (\$50) fee shall*  
28 *be due and payable along with the fee for the initial or reciprocal*  
29 *certificate or the biennial license.*

30 *(c) The board shall transfer all funds collected pursuant to this*  
31 *section, on a monthly basis, to the Medically Underserved Account*  
32 *for Physicians created by Section 128555 of the Health and Safety*  
33 *Code for the purposes of the Steven M. Thompson Physician Corps*  
34 *Loan Repayment Program. Notwithstanding Section 128555 of*  
35 *the Health and Safety Code, these funds shall not be used to*  
36 *provide funding for the Physician Volunteer Program.*

37 *SEC. 3. Section 1341.45 is added to the Health and Safety*  
38 *Code, to read:*

39 *1341.45. (a) The fines and administrative penalties authorized*  
40 *pursuant to this chapter shall be paid as follows:*

1 (1) *The first one million dollars (\$1,000,000) shall be paid to*  
2 *the Medically Underserved Account for Physicians within the*  
3 *Health Professions Education Fund and shall, upon appropriation*  
4 *by the Legislature, be used for the purposes of the Steven M.*  
5 *Thompson Physician Corps Loan Repayment Program, as specified*  
6 *in Article 5 (commencing with Section 128550) of Chapter 5 of*  
7 *Part 3 of Division 107 and, notwithstanding Section 128555, shall*  
8 *not be used to provide funding for the Physician Volunteer*  
9 *Program.*

10 (2) *Any amount over the first one million dollars (\$1,000,000)*  
11 *shall be paid to the Major Risk Medical Insurance Fund created*  
12 *pursuant to Section 12739 of the Insurance Code and shall, upon*  
13 *appropriation by the Legislature, be used by the Major Risk*  
14 *Medical Insurance Program for the purposes specified in Section*  
15 *12739.1 of the Insurance Code.*

16 (b) *Notwithstanding Section 1356.1, the fines and administrative*  
17 *penalties authorized pursuant to this chapter shall not be used to*  
18 *reduce the assessments imposed on health care service plans*  
19 *pursuant to Section 1356.*

20 ~~SEC. 2:~~

21 *SEC. 4.* Section 1367.01 of the Health and Safety Code is  
22 amended to read:

23 1367.01. (a) A health care service plan and any entity with  
24 which it contracts for services that include utilization review or  
25 utilization management functions, that prospectively,  
26 retrospectively, or concurrently reviews and approves, modifies,  
27 delays, or denies, based in whole or in part on medical necessity,  
28 requests by providers prior to, retrospectively, or concurrent with  
29 the provision of health care services to enrollees, or that delegates  
30 these functions to medical groups or independent practice  
31 associations or to other contracting providers, shall comply with  
32 this section.

33 (b) A health care service plan that is subject to this section shall  
34 have written policies and procedures establishing the process by  
35 which the plan prospectively, retrospectively, or concurrently  
36 reviews and approves, modifies, delays, or denies, based in whole  
37 or in part on medical necessity, requests by providers of health  
38 care services for plan enrollees. These policies and procedures  
39 shall ensure that decisions based on the medical necessity of  
40 proposed health care services are consistent with criteria or

1 guidelines that are supported by clinical principles and processes.  
2 These criteria and guidelines shall be developed pursuant to Section  
3 1363.5. These policies and procedures, and a description of the  
4 process by which the plan reviews and approves, modifies, delays,  
5 or denies requests by providers prior to, retrospectively, or  
6 concurrent with the provision of health care services to enrollees,  
7 shall be filed with the director for review and approval, and shall  
8 be disclosed by the plan to providers and enrollees upon request,  
9 and by the plan to the public upon request.

10 (c) A health care service plan subject to this section, except a  
11 plan that meets the requirements of Section 1351.2, shall employ  
12 or designate a medical director who holds an unrestricted license  
13 to practice medicine in this state issued pursuant to Section 2050  
14 of the Business and Professions Code or pursuant to the  
15 Osteopathic Act, or, if the plan is a specialized health care service  
16 plan, a clinical director with California licensure in a clinical area  
17 appropriate to the type of care provided by the specialized health  
18 care service plan. The medical director or clinical director shall  
19 ensure that the process by which the plan reviews and approves,  
20 modifies, or denies, based in whole or in part on medical necessity,  
21 requests by providers prior to, retrospectively, or concurrent with  
22 the provision of health care services to enrollees, complies with  
23 the requirements of this section.

24 (d) If health plan personnel, or individuals under contract to the  
25 plan to review requests by providers, approve the provider's  
26 request, pursuant to subdivision (b), the decision shall be  
27 communicated to the provider pursuant to subdivision (h).

28 (e) No individual, other than a licensed physician or a licensed  
29 health care professional who is competent to evaluate the specific  
30 clinical issues involved in the health care services requested by  
31 the provider, may deny or modify requests for authorization of  
32 health care services for an enrollee for reasons of medical necessity.  
33 The decision of the physician or other health care professional  
34 shall be communicated to the provider and the enrollee pursuant  
35 to subdivision (h).

36 (f) The criteria or guidelines used by the health care service  
37 plan to determine whether to approve, modify, or deny requests  
38 by providers prior to, retrospectively, or concurrent with, the  
39 provision of health care services to enrollees shall be consistent

1 with clinical principles and processes. These criteria and guidelines  
2 shall be developed pursuant to the requirements of Section 1363.5.

3 (g) If the health care service plan requests medical information  
4 from providers in order to determine whether to approve, modify,  
5 or deny requests for authorization, the plan shall request only the  
6 information reasonably necessary to make the determination.

7 (h) In determining whether to approve, modify, or deny requests  
8 by providers prior to, retrospectively, or concurrent with the  
9 provision of health care services to enrollees, based in whole or  
10 in part on medical necessity, a health care service plan subject to  
11 this section shall meet the following requirements:

12 (1) Decisions to approve, modify, or deny, based on medical  
13 necessity, requests by providers prior to, or concurrent with the  
14 provision of health care services to enrollees that do not meet the  
15 requirements for the 72-hour review required by paragraph (2),  
16 shall be made in a timely fashion appropriate for the nature of the  
17 enrollee's condition, not to exceed five business days from the  
18 plan's receipt of the information reasonably necessary and  
19 requested by the plan to make the determination. In cases where  
20 the review is retrospective, the decision shall be communicated to  
21 the individual who received services, or to the individual's  
22 designee, within 30 days of the receipt of information that is  
23 reasonably necessary to make this determination, and shall be  
24 communicated to the provider in a manner that is consistent with  
25 current law. For purposes of this section, retrospective reviews  
26 shall be for care rendered on or after January 1, 2000.

27 (2) When the enrollee's condition is such that the enrollee faces  
28 an imminent and serious threat to his or her health, including, but  
29 not limited to, the potential loss of life, limb, or other major bodily  
30 function, or the normal timeframe for the decisionmaking process,  
31 as described in paragraph (1), would be detrimental to the enrollee's  
32 life or health or could jeopardize the enrollee's ability to regain  
33 maximum function, decisions to approve, modify, or deny requests  
34 by providers prior to, or concurrent with, the provision of health  
35 care services to enrollees, shall be made in a timely fashion  
36 appropriate for the nature of the enrollee's condition, not to exceed  
37 72 hours after the plan's receipt of the information reasonably  
38 necessary and requested by the plan to make the determination.  
39 Nothing in this section shall be construed to alter the requirements  
40 of subdivision (b) of Section 1371.4. Notwithstanding Section

1 1371.4, the requirements of this division shall be applicable to all  
2 health plans and other entities conducting utilization review or  
3 utilization management.

4 (3) Decisions to approve, modify, or deny requests by providers  
5 for authorization prior to, or concurrent with, the provision of  
6 health care services to enrollees shall be communicated to the  
7 requesting provider within 24 hours of the decision. Except for  
8 concurrent review decisions pertaining to care that is underway,  
9 which shall be communicated to the enrollee's treating provider  
10 within 24 hours, decisions resulting in denial, delay, or  
11 modification of all or part of the requested health care service shall  
12 be communicated to the enrollee in writing within two business  
13 days of the decision. In the case of concurrent review, care shall  
14 not be discontinued until the enrollee's treating provider has been  
15 notified of the plan's decision and a care plan has been agreed  
16 upon by the treating provider that is appropriate for the medical  
17 needs of that patient.

18 (4) Communications regarding decisions to approve requests  
19 by providers prior to, retrospectively, or concurrent with the  
20 provision of health care services to enrollees shall specify the  
21 specific health care service approved. Responses regarding  
22 decisions to deny, delay, or modify health care services requested  
23 by providers prior to, retrospectively, or concurrent with the  
24 provision of health care services to enrollees shall be  
25 communicated to the enrollee in writing, and to providers initially  
26 by telephone or facsimile, except with regard to decisions rendered  
27 retrospectively, and then in writing, and shall include a clear and  
28 concise explanation of the reasons for the plan's decision, a  
29 description of the criteria or guidelines used, and the clinical  
30 reasons for the decisions regarding medical necessity. Any written  
31 communication to a physician or other health care provider of a  
32 denial, delay, or modification of a request shall include the name  
33 and telephone number of the health care professional responsible  
34 for the denial, delay, or modification. The telephone number  
35 provided shall be a direct number or an extension, to allow the  
36 physician or health care provider easily to contact the professional  
37 responsible for the denial, delay, or modification. Responses shall  
38 also include information as to how the enrollee may file a grievance  
39 with the plan pursuant to Section 1368, and in the case of Medi-Cal  
40 enrollees, shall explain how to request an administrative hearing

1 and aid paid pending under Sections 51014.1 and 51014.2 of Title  
2 22 of the California Code of Regulations.

3 (5) If the health care service plan cannot make a decision to  
4 approve, modify, or deny the request for authorization within the  
5 timeframes specified in paragraph (1) or (2) because the plan is  
6 not in receipt of all of the information reasonably necessary and  
7 requested, or because the plan requires consultation by an expert  
8 reviewer, or because the plan has asked that an additional  
9 examination or test be performed upon the enrollee, provided the  
10 examination or test is reasonable and consistent with good medical  
11 practice, the plan shall, immediately upon the expiration of the  
12 timeframe specified in paragraph (1) or (2) or as soon as the plan  
13 becomes aware that it will not meet the timeframe, whichever  
14 occurs first, notify the provider and the enrollee, in writing, that  
15 the plan cannot make a decision to approve, modify, or deny the  
16 request for authorization within the required timeframe, and specify  
17 the information requested but not received, or the expert reviewer  
18 to be consulted, or the additional examinations or tests required.  
19 The plan shall also notify the provider and enrollee of the  
20 anticipated date on which a decision may be rendered. Upon receipt  
21 of all information reasonably necessary and requested by the plan,  
22 the plan shall approve, modify, or deny the request for authorization  
23 within the timeframes specified in paragraph (1) or (2), whichever  
24 applies.

25 (6) If the director determines that a health care service plan has  
26 failed to meet any of the timeframes in this section, or has failed  
27 to meet any other requirement of this section, the director may  
28 assess, by order, administrative penalties for each failure. A  
29 proceeding for the issuance of an order assessing administrative  
30 penalties shall be subject to appropriate notice to, and an  
31 opportunity for a hearing with regard to, the person affected, in  
32 accordance with subdivision (a) of Section 1397. The  
33 administrative penalties shall not be deemed an exclusive remedy  
34 for the director.

35 (i) A health care service plan subject to this section shall  
36 maintain telephone access for providers to request authorization  
37 for health care services.

38 (j) A health care service plan subject to this section that reviews  
39 requests by providers prior to, retrospectively, or concurrent with,  
40 the provision of health care services to enrollees shall establish,

1 as part of the quality assurance program required by Section 1370,  
2 a process by which the plan's compliance with this section is  
3 assessed and evaluated. The process shall include provisions for  
4 evaluation of complaints, assessment of trends, implementation  
5 of actions to correct identified problems, mechanisms to  
6 communicate actions and results to the appropriate health plan  
7 employees and contracting providers, and provisions for evaluation  
8 of any corrective action plan and measurements of performance.

9 (k) The director shall review a health care service plan's  
10 compliance with this section as part of its periodic onsite medical  
11 survey of each plan undertaken pursuant to Section 1380, and shall  
12 include a discussion of compliance with this section as part of its  
13 report issued pursuant to that section.

14 (l) This section shall not apply to decisions made for the care  
15 or treatment of the sick who depend upon prayer or spiritual means  
16 for healing in the practice of religion as set forth in subdivision  
17 (a) of Section 1270.

18 (m) Nothing in this section shall cause a health care service plan  
19 to be defined as a health care provider for purposes of any provision  
20 of law, including, but not limited to, Section 6146 of the Business  
21 and Professions Code, Sections 3333.1 and 3333.2 of the Civil  
22 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the  
23 Code of Civil Procedure.

24 ~~SEC. 3.~~

25 *SEC. 5.* Section 1367.03 of the Health and Safety Code is  
26 amended to read:

27 1367.03. (a) Not later than January 1, 2004, the department  
28 shall develop and adopt regulations to ensure that enrollees have  
29 access to needed health care services in a timely manner. In  
30 developing these regulations, the department shall develop  
31 indicators of timeliness of access to care and, in so doing, shall  
32 consider the following as indicators of timeliness of access to care:

33 (1) Waiting times for appointments with physicians, including  
34 primary care and specialty physicians.

35 (2) Timeliness of care in an episode of illness, including the  
36 timeliness of referrals and obtaining other services, if needed.

37 (3) Waiting time to speak to a physician, registered nurse, or  
38 other qualified health professional acting within his or her scope  
39 of practice who is trained to screen or triage an enrollee who may  
40 need care.

1 (b) In developing these standards for timeliness of access, the  
2 department shall consider the following:

3 (1) Clinical appropriateness.

4 (2) The nature of the specialty.

5 (3) The urgency of care.

6 (4) The requirements of other provisions of law, including  
7 Section 1367.01 governing utilization review, that may affect  
8 timeliness of access.

9 (c) The department may adopt standards other than the time  
10 elapsed between the time an enrollee seeks health care and obtains  
11 care. If the department chooses a standard other than the time  
12 elapsed between the time an enrollee first seeks health care and  
13 obtains it, the department shall demonstrate why that standard is  
14 more appropriate. In developing these standards, the department  
15 shall consider the nature of the plan network.

16 (d) The department shall review and adopt standards, as needed,  
17 concerning the availability of primary care physicians, specialty  
18 physicians, hospital care, and other health care, so that consumers  
19 have timely access to care. In so doing, the department shall  
20 consider the nature of physician practices, including individual  
21 and group practices as well as the nature of the plan network. The  
22 department shall also consider various circumstances affecting the  
23 delivery of care, including urgent care, care provided on the same  
24 day, and requests for specific providers. If the department finds  
25 that health care service plans and health care providers have  
26 difficulty meeting these standards, the department may make  
27 recommendations to the Assembly Committee on Health and the  
28 Senate Committee on Insurance of the Legislature pursuant to  
29 subdivision (i).

30 (e) In developing standards under subdivision (a), the department  
31 shall consider requirements under federal law, requirements under  
32 other state programs, standards adopted by other states, nationally  
33 recognized accrediting organizations, and professional associations.  
34 The department shall further consider the needs of rural areas,  
35 specifically those in which health facilities are more than 30 miles  
36 apart and any requirements imposed by the State Department of  
37 Health Care Services on health care service plans that contract  
38 with the State Department of Health Care Services to provide  
39 Medi-Cal managed care.

1 (f) (1) Contracts between health care service plans and health  
2 care providers shall assure compliance with the standards  
3 developed under this section. These contracts shall require  
4 reporting by health care providers to health care service plans and  
5 by health care service plans to the department to ensure compliance  
6 with the standards.

7 (2) Health care service plans shall report annually to the  
8 department on compliance with the standards in a manner specified  
9 by the department. The reported information shall allow consumers  
10 to compare the performance of plans and their contracting providers  
11 in complying with the standards, as well as changes in the  
12 compliance of plans with these standards.

13 (g) (1) When evaluating compliance with the standards, the  
14 department shall focus more upon patterns of noncompliance rather  
15 than isolated episodes of noncompliance.

16 (2) The director may investigate and take enforcement action  
17 against plans regarding noncompliance with the requirements of  
18 this section. Where substantial harm to an enrollee has occurred  
19 as a result of plan noncompliance, the director may, by order,  
20 assess administrative penalties subject to appropriate notice of,  
21 and the opportunity for, a hearing in accordance with Section 1397.  
22 The plan may provide to the director, and the director may  
23 consider, information regarding the plan's overall compliance with  
24 the requirements of this section. The administrative penalties shall  
25 not be deemed an exclusive remedy available to the director. The  
26 director shall periodically evaluate grievances to determine if any  
27 audit, investigative, or enforcement actions should be undertaken  
28 by the department.

29 (3) The director may, after appropriate notice and opportunity  
30 for hearing in accordance with Section 1397, by order, assess  
31 administrative penalties if the director determines that a health  
32 care service plan has knowingly committed, or has performed with  
33 a frequency that indicates a general business practice, either of the  
34 following:

35 (A) Repeated failure to act promptly and reasonably to assure  
36 timely access to care consistent with this chapter.

37 (B) Repeated failure to act promptly and reasonably to require  
38 contracting providers to assure timely access that the plan is  
39 required to perform under this chapter and that have been delegated

1 by the plan to the contracting provider when the obligation of the  
2 plan to the enrollee or subscriber is reasonably clear.

3 (C) The administrative penalties available to the director  
4 pursuant to this section are not exclusive, and may be sought and  
5 employed in any combination with civil, criminal, and other  
6 administrative remedies deemed warranted by the director to  
7 enforce this chapter.

8 (h) The department shall work with the patient advocate to  
9 assure that the quality of care report card incorporates information  
10 provided pursuant to subdivision (f) regarding the degree to which  
11 health care service plans and health care providers comply with  
12 the requirements for timely access to care.

13 (i) The department shall report to the Assembly Committee on  
14 Health and the Senate Committee on Insurance of the Legislature  
15 on March 1, 2003, and on March 1, 2004, regarding the progress  
16 toward the implementation of this section.

17 (j) Every three years, the department shall review information  
18 regarding compliance with the standards developed under this  
19 section and shall make recommendations for changes that further  
20 protect enrollees.

21 ~~SEC. 4.~~

22 *SEC. 6.* Section 1368 of the Health and Safety Code is amended  
23 to read:

24 1368. (a) Every plan shall do all of the following:

25 (1) Establish and maintain a grievance system approved by the  
26 department under which enrollees may submit their grievances to  
27 the plan. Each system shall provide reasonable procedures in  
28 accordance with department regulations that shall ensure adequate  
29 consideration of enrollee grievances and rectification when  
30 appropriate.

31 (2) Inform its subscribers and enrollees upon enrollment in the  
32 plan and annually thereafter of the procedure for processing and  
33 resolving grievances. The information shall include the location  
34 and telephone number where grievances may be submitted.

35 (3) Provide forms for grievances to be given to subscribers and  
36 enrollees who wish to register written grievances. The forms used  
37 by plans licensed pursuant to Section 1353 shall be approved by  
38 the director in advance as to format.

39 (4) (A) Provide for a written acknowledgment within five  
40 calendar days of the receipt of a grievance, except as noted in

1 subparagraph (B). The acknowledgment shall advise the  
2 complainant of the following:

3 (i) That the grievance has been received.

4 (ii) The date of receipt.

5 (iii) The name of the plan representative and the telephone  
6 number and address of the plan representative who may be  
7 contacted about the grievance.

8 (B) Grievances received by telephone, by facsimile, by e-mail,  
9 or online through the plan's *Internet* Web site pursuant to Section  
10 1368.015, that are not coverage disputes, disputed health care  
11 services involving medical necessity, or experimental or  
12 investigational treatment and that are resolved by the next business  
13 day following receipt are exempt from the requirements of  
14 subparagraph (A) and paragraph (5). The plan shall maintain a log  
15 of all these grievances. The log shall be periodically reviewed by  
16 the plan and shall include the following information for each  
17 complaint:

18 (i) The date of the call.

19 (ii) The name of the complainant.

20 (iii) The complainant's member identification number.

21 (iv) The nature of the grievance.

22 (v) The nature of the resolution.

23 (vi) The name of the plan representative who took the call and  
24 resolved the grievance.

25 (5) Provide subscribers and enrollees with written responses to  
26 grievances, with a clear and concise explanation of the reasons for  
27 the plan's response. For grievances involving the delay, denial, or  
28 modification of health care services, the plan response shall  
29 describe the criteria used and the clinical reasons for its decision,  
30 including all criteria and clinical reasons related to medical  
31 necessity. If a plan, or one of its contracting providers, issues a  
32 decision delaying, denying, or modifying health care services based  
33 in whole or in part on a finding that the proposed health care  
34 services are not a covered benefit under the contract that applies  
35 to the enrollee, the decision shall clearly specify the provisions in  
36 the contract that exclude that coverage.

37 (6) Keep in its files all copies of grievances, and the responses  
38 thereto, for a period of five years.

39 (b) (1) (A) After either completing the grievance process  
40 described in subdivision (a), or participating in the process for at

1 least 30 days, a subscriber or enrollee may submit the grievance  
2 to the department for review. In any case determined by the  
3 department to be a case involving an imminent and serious threat  
4 to the health of the patient, including, but not limited to, severe  
5 pain, the potential loss of life, limb, or major bodily function, or  
6 in any other case where the department determines that an earlier  
7 review is warranted, a subscriber or enrollee shall not be required  
8 to complete the grievance process or to participate in the process  
9 for at least 30 days before submitting a grievance to the department  
10 for review.

11 (B) A grievance may be submitted to the department for review  
12 and resolution prior to any arbitration.

13 (C) Notwithstanding subparagraphs (A) and (B), the department  
14 may refer any grievance that does not pertain to compliance with  
15 this chapter to the State Department of Health Services, the  
16 California Department of Aging, the federal Health Care Financing  
17 Administration, or any other appropriate governmental entity for  
18 investigation and resolution.

19 (2) If the subscriber or enrollee is a minor, or is incompetent or  
20 incapacitated, the parent, guardian, conservator, relative, or other  
21 designee of the subscriber or enrollee, as appropriate, may submit  
22 the grievance to the department as the agent of the subscriber or  
23 enrollee. Further, a provider may join with, or otherwise assist, a  
24 subscriber or enrollee, or the agent, to submit the grievance to the  
25 department. In addition, following submission of the grievance to  
26 the department, the subscriber or enrollee, or the agent, may  
27 authorize the provider to assist, including advocating on behalf of  
28 the subscriber or enrollee. For purposes of this section, a “relative”  
29 includes the parent, stepparent, spouse, adult son or daughter,  
30 grandparent, brother, sister, uncle, or aunt of the subscriber or  
31 enrollee.

32 (3) The department shall review the written documents submitted  
33 with the subscriber’s or the enrollee’s request for review, or  
34 submitted by the agent on behalf of the subscriber or enrollee. The  
35 department may ask for additional information, and may hold an  
36 informal meeting with the involved parties, including providers  
37 who have joined in submitting the grievance or who are otherwise  
38 assisting or advocating on behalf of the subscriber or enrollee. If  
39 after reviewing the record, the department concludes that the  
40 grievance, in whole or in part, is eligible for review under the

1 independent medical review system established pursuant to Article  
 2 5.55 (commencing with Section 1374.30), the department shall  
 3 immediately notify the subscriber or enrollee, or agent, of that  
 4 option and shall, if requested orally or in writing, assist the  
 5 subscriber or enrollee in participating in the independent medical  
 6 review system.

7 (4) If after reviewing the record of a grievance, the department  
 8 concludes that a health care service eligible for coverage and  
 9 payment under a health care service plan contract has been delayed,  
 10 denied, or modified by a plan, or by one of its contracting  
 11 providers, in whole or in part due to a determination that the service  
 12 is not medically necessary, and that determination was not  
 13 communicated to the enrollee in writing along with a notice of the  
 14 enrollee’s potential right to participate in the independent medical  
 15 review system, as required by this chapter, the director shall, by  
 16 order, assess administrative penalties. A proceeding for the issuance  
 17 of an order assessing administrative penalties shall be subject to  
 18 appropriate notice of, and the opportunity for, a hearing with regard  
 19 to the person affected in accordance with Section 1397. The  
 20 administrative penalties shall not be deemed an exclusive remedy  
 21 available to the director.

22 (5) The department shall send a written notice of the final  
 23 disposition of the grievance, and the reasons therefor, to the  
 24 subscriber or enrollee, the agent, to any provider that has joined  
 25 with or is otherwise assisting the subscriber or enrollee, and to the  
 26 plan, within 30 calendar days of receipt of the request for review  
 27 unless the director, in his or her discretion, determines that  
 28 additional time is reasonably necessary to fully and fairly evaluate  
 29 the relevant grievance. In any case not eligible for the independent  
 30 medical review system established pursuant to Article 5.55  
 31 (commencing with Section 1374.30), the department’s written  
 32 notice shall include, at a minimum, the following:

33 (A) A summary of its findings and the reasons why the  
 34 department found the plan to be, or not to be, in compliance with  
 35 any applicable laws, regulations, or orders of the director.

36 (B) A discussion of the department’s contact with any medical  
 37 provider, or any other independent expert relied on by the  
 38 department, along with a summary of the views and qualifications  
 39 of that provider or expert.

1 (C) If the enrollee’s grievance is sustained in whole or *in part*,  
2 information about any corrective action taken.

3 (6) In any department review of a grievance involving a disputed  
4 health care service, as defined in subdivision (b) of Section  
5 1374.30, that is not eligible for the independent medical review  
6 system established pursuant to Article 5.55 (commencing with  
7 Section 1374.30), in which the department finds that the plan has  
8 delayed, denied, or modified health care services that are medically  
9 necessary, based on the specific medical circumstances of the  
10 enrollee, and those services are a covered benefit under the terms  
11 and conditions of the health care service plan contract, the  
12 department’s written notice shall do either of the following:

13 (A) Order the plan to promptly offer and provide those health  
14 care services to the enrollee.

15 (B) Order the plan to promptly reimburse the enrollee for any  
16 reasonable costs associated with urgent care or emergency services,  
17 or other extraordinary and compelling health care services, when  
18 the department finds that the enrollee’s decision to secure those  
19 services outside of the plan network was reasonable under the  
20 circumstances.

21 The department’s order shall be binding on the plan.

22 (7) Distribution of the written notice shall not be deemed a  
23 waiver of any exemption or privilege under existing law, including,  
24 but not limited to, Section 6254.5 of the Government Code, for  
25 any information in connection with and including the written  
26 notice, nor shall any person employed or in any way retained by  
27 the department be required to testify as to that information or  
28 notice.

29 (8) The director shall establish and maintain a system of aging  
30 of grievances that are pending and unresolved for 30 days or more  
31 that shall include a brief explanation of the reasons each grievance  
32 is pending and unresolved for 30 days or more.

33 (9) A subscriber or enrollee, or the agent acting on behalf of a  
34 subscriber or enrollee, may also request voluntary mediation with  
35 the plan prior to exercising the right to submit a grievance to the  
36 department. The use of mediation services shall not preclude the  
37 right to submit a grievance to the department upon completion of  
38 mediation. In order to initiate mediation, the subscriber or enrollee,  
39 or the agent acting on behalf of the subscriber or enrollee, and the  
40 plan shall voluntarily agree to mediation. Expenses for mediation

1 shall be borne equally by both sides. The department shall have  
2 no administrative or enforcement responsibilities in connection  
3 with the voluntary mediation process authorized by this paragraph.

4 (c) The plan's grievance system shall include a system of aging  
5 of grievances that are pending and unresolved for 30 days or more.  
6 The plan shall provide a quarterly report to the director of  
7 grievances pending and unresolved for 30 or more days with  
8 separate categories of grievances for Medicare enrollees and  
9 Medi-Cal enrollees. The plan shall include with the report a brief  
10 explanation of the reasons each grievance is pending and  
11 unresolved for 30 days or more. The plan may include the  
12 following statement in the quarterly report that is made available  
13 to the public by the director:

14 "Under Medicare and Medi-Cal law, Medicare enrollees and  
15 Medi-Cal enrollees each have separate avenues of appeal that  
16 are not available to other enrollees. Therefore, grievances  
17 pending and unresolved may reflect enrollees pursuing their  
18 Medicare or Medi-Cal appeal rights."

19 If requested by a plan, the director shall include this statement in  
20 a written report made available to the public and prepared by the  
21 director that describes or compares grievances that are pending  
22 and unresolved with the plan for 30 days or more. Additionally,  
23 the director shall, if requested by a plan, append to that written  
24 report a brief explanation, provided in writing by the plan, of the  
25 reasons why grievances described in that written report are pending  
26 and unresolved for 30 days or more. The director shall not be  
27 required to include a statement or append a brief explanation to a  
28 written report that the director is required to prepare under this  
29 chapter, including Sections 1380 and 1397.5.

30 (d) Subject to subparagraph (C) of paragraph (1) of subdivision  
31 (b), the grievance or resolution procedures authorized by this  
32 section shall be in addition to any other procedures that may be  
33 available to any person, and failure to pursue, exhaust, or engage  
34 in the procedures described in this section shall not preclude the  
35 use of any other remedy provided by law.

36 (e) Nothing in this section shall be construed to allow the  
37 submission to the department of any provider grievance under this  
38 section. However, as part of a provider's duty to advocate for  
39 medically appropriate health care for his or her patients pursuant  
40 to Sections 510 and 2056 of the Business and Professions Code,

1 nothing in this subdivision shall be construed to prohibit a provider  
2 from contacting and informing the department about any concerns  
3 he or she has regarding compliance with or enforcement of this  
4 chapter.

5 ~~SEC. 5.~~

6 *SEC. 7.* Section 1368.04 of the Health and Safety Code is  
7 amended to read:

8 1368.04. (a) The director shall investigate and take  
9 enforcement action against plans regarding grievances reviewed  
10 and found by the department to involve noncompliance with the  
11 requirements of this chapter, including grievances that have been  
12 reviewed pursuant to the independent medical review system  
13 established pursuant to Article 5.55 (commencing with Section  
14 1374.30). Where substantial harm to an enrollee has occurred as  
15 a result of plan noncompliance, the director shall, by order, assess  
16 administrative penalties subject to appropriate notice of, and the  
17 opportunity for, a hearing with regard to the person affected in  
18 accordance with Section 1397. The administrative penalties shall  
19 not be deemed an exclusive remedy available to the director. The  
20 director shall periodically evaluate grievances to determine if any  
21 audit, investigative, or enforcement actions should be undertaken  
22 by the department.

23 (b) The director may, after appropriate notice and opportunity  
24 for hearing in accordance with Section 1397, by order, assess  
25 administrative penalties if the director determines that a health  
26 care service plan has knowingly committed, or has performed with  
27 a frequency that indicates a general business practice, either of the  
28 following:

29 (1) Repeated failure to act promptly and reasonably to  
30 investigate and resolve grievances in accordance with Section  
31 1368.01.

32 (2) Repeated failure to act promptly and reasonably to resolve  
33 grievances when the obligation of the plan to the enrollee or  
34 subscriber is reasonably clear.

35 (c) The administrative penalties available to the director pursuant  
36 to this section are not exclusive, and may be sought and employed  
37 in any combination with civil, criminal, and other administrative  
38 remedies deemed warranted by the director to enforce this chapter.

1 ~~SEC. 6.~~

2 *SEC. 8.* Section 1374.9 of the Health and Safety Code is  
3 amended to read:

4 1374.9. For violations of Section 1374.7, the director may,  
5 after appropriate notice and opportunity for hearing, by order, levy  
6 administrative penalties as follows:

7 (a) Any health care service plan that violates Section 1374.7,  
8 or that violates any rule or order adopted or issued pursuant to this  
9 section, is liable for administrative penalties of not less than two  
10 thousand five hundred dollars (\$2,500) for each first violation, and  
11 of not less than five thousand dollars (\$5,000) nor more than ten  
12 thousand dollars (\$10,000) for each second violation, and of not  
13 less than fifteen thousand dollars (\$15,000) and not more than one  
14 hundred thousand dollars (\$100,000) for each subsequent violation.

15 (b) The administrative penalties available to the director pursuant  
16 to this section are not exclusive, and may be sought and employed  
17 in any combination with civil, criminal, and other administrative  
18 remedies deemed advisable by the director to enforce the provisions  
19 of this chapter.

20 ~~SEC. 7.~~

21 *SEC. 9.* Section 1374.34 of the Health and Safety Code is  
22 amended to read:

23 1374.34. (a) Upon receiving the decision adopted by the  
24 director pursuant to Section 1374.33 that a disputed health care  
25 service is medically necessary, the plan shall promptly implement  
26 the decision. In the case of reimbursement for services already  
27 rendered, the plan shall reimburse the provider or enrollee,  
28 whichever applies, within five working days. In the case of services  
29 not yet rendered, the plan shall authorize the services within five  
30 working days of receipt of the written decision from the director,  
31 or sooner if appropriate for the nature of the enrollee’s medical  
32 condition, and shall inform the enrollee and provider of the  
33 authorization in accordance with the requirements of paragraph  
34 (3) of subdivision (h) of Section 1367.01.

35 (b) A plan shall not engage in any conduct that has the effect  
36 of prolonging the independent review process. The engaging in  
37 that conduct or the failure of the plan to promptly implement the  
38 decision is a violation of this chapter and, in addition to any other  
39 fines, penalties, and other remedies available to the director under  
40 this chapter, the plan shall be subject to an administrative penalty

1 of not less than five thousand dollars (\$5,000) for each day that  
2 the decision is not implemented.

3 (c) The director shall require the plan to promptly reimburse  
4 the enrollee for any reasonable costs associated with those services  
5 when the director finds that the disputed health care services were  
6 a covered benefit under the terms and conditions of the health care  
7 service plan contract, and the services are found by the independent  
8 medical review organization to have been medically necessary  
9 pursuant to Section 1374.33, and either the enrollee's decision to  
10 secure the services outside of the plan provider network was  
11 reasonable under the emergency or urgent medical circumstances,  
12 or the health care service plan contract does not require or provide  
13 prior authorization before the health care services are provided to  
14 the enrollee.

15 (d) In addition to requiring plan compliance regarding  
16 subdivisions (a), (b), and (c) the director shall review individual  
17 cases submitted for independent medical review to determine  
18 whether any enforcement actions, including penalties, may be  
19 appropriate. In particular, where substantial harm, as defined in  
20 Section 3428 of the Civil Code, to an enrollee has already occurred  
21 because of the decision of a plan, or one of its contracting  
22 providers, to delay, deny, or modify covered health care services  
23 that an independent medical review determines to be medically  
24 necessary pursuant to Section 1374.33, the director shall impose  
25 penalties.

26 (e) Pursuant to Section 1368.04, the director shall perform an  
27 annual audit of independent medical review cases for the dual  
28 purposes of education and the opportunity to determine if any  
29 investigative or enforcement actions should be undertaken by the  
30 department, particularly if a plan repeatedly fails to act promptly  
31 and reasonably to resolve grievances associated with a delay,  
32 denial, or modification of medically necessary health care services  
33 when the obligation of the plan to provide those health care services  
34 to enrollees or subscribers is reasonably clear.

35 ~~SEC. 8.~~

36 *SEC. 10.* Section 1393.6 of the Health and Safety Code is  
37 amended to read:

38 1393.6. For violations of Article 3.1 (commencing with Section  
39 1357) and Article 3.15 (commencing with Section 1357.50), the

1 director may, after appropriate notice and opportunity for hearing,  
2 by order levy administrative penalties as follows:

3 (a) Any person, solicitor, or solicitor firm, other than a health  
4 care service plan, who willfully violates any provision of this  
5 chapter, or who willfully violates any rule or order adopted or  
6 issued pursuant to this chapter, is liable for administrative penalties  
7 of not less than two hundred fifty dollars (\$250) for each first  
8 violation, and of not less than one thousand dollars (\$1,000) and  
9 not more than two thousand five hundred dollars (\$2,500) for each  
10 subsequent violation.

11 (b) Any health care service plan that willfully violates any  
12 provision of this chapter, or that willfully violates any rule or order  
13 adopted or issued pursuant to this chapter, is liable for  
14 administrative penalties of not less than two thousand five hundred  
15 dollars (\$2,500) for each first violation, and of not less than five  
16 thousand dollars (\$5,000) nor more than ten thousand dollars  
17 (\$10,000) for each second violation, and of not less than fifteen  
18 thousand dollars (\$15,000) and not more than one hundred  
19 thousand dollars (\$100,000) for each subsequent violation.

20 (c) The administrative penalties available to the director pursuant  
21 to this section are not exclusive, and may be sought and employed  
22 in any combination with civil, criminal, and other administrative  
23 remedies deemed advisable by the director to enforce the provisions  
24 of this chapter.

25 *SEC. 11. Section 128553 of the Health and Safety Code is*  
26 *amended to read:*

27 128553. (a) Program applicants shall possess a current valid  
28 license to practice medicine in this state issued pursuant to Section  
29 2050 of the Business and Professions Code *or pursuant to the*  
30 *Osteopathic Act.*

31 (b) The foundation, in consultation with those identified in  
32 subdivision (b) of Section 123551, shall use guidelines developed  
33 by the Medical Board of California for selection and placement  
34 of applicants until the office adopts other guidelines by regulation.

35 (c) The guidelines shall meet all of the following criteria:

36 (1) Provide priority consideration to applicants that are best  
37 suited to meet the cultural and linguistic needs and demands of  
38 patients from medically underserved populations and who meet  
39 one or more of the following criteria:

40 (A) Speak a Medi-Cal threshold language.

- 1 (B) Come from an economically disadvantaged background.  
2 (C) Have received significant training in cultural and  
3 linguistically appropriate service delivery.  
4 (D) Have three years of experience working in medically  
5 underserved areas or with medically underserved populations.  
6 (E) Have recently obtained a license to practice medicine.  
7 (2) Include a process for determining the needs for physician  
8 services identified by the practice setting and for ensuring that the  
9 practice setting meets the definition specified in subdivision (h)  
10 of Section 128552.  
11 (3) Give preference to applicants who have completed a  
12 three-year residency in a primary specialty.  
13 (4) Seek to place the most qualified applicants under this section  
14 in the areas with the greatest need.  
15 (5) Include a factor ensuring geographic distribution of  
16 placements.  
17 (d) (1) The foundation may appoint a selection committee that  
18 provides policy direction and guidance over the program and that  
19 complies with the requirements of subdivision (l) of Section  
20 128552.  
21 (2) The selection committee may fill up to 20 percent of the  
22 available positions with program applicants from specialties outside  
23 of the primary care specialties.  
24 (e) Program participants shall meet all of the following  
25 requirements:  
26 (1) Shall be working in or have a signed agreement with an  
27 eligible practice setting.  
28 (2) Shall have full-time status at the practice setting. Full-time  
29 status shall be defined by the board and the selection committee  
30 may establish exemptions from this requirement on a case-by-case  
31 basis.  
32 (3) Shall commit to a minimum of three years of service in a  
33 medically underserved area. Leaves of absence shall be permitted  
34 for serious illness, pregnancy, or other natural causes. The selection  
35 committee shall develop the process for determining the maximum  
36 permissible length of an absence and the process for reinstatement.  
37 Loan repayment shall be deferred until the physician is back to  
38 full-time status.  
39 (f) The office shall adopt a process that applies if a physician  
40 is unable to complete his or her three-year obligation.

1 (g) The foundation, in consultation with those identified in  
2 subdivision (b) of Section 128551, shall develop a process for  
3 outreach to potentially eligible applicants.

4 (h) The foundation may recommend to the office any other  
5 standards of eligibility, placement, and termination appropriate to  
6 achieve the aim of providing competent health care services in  
7 approved practice settings.

8 ~~SEC. 9.~~

9 *SEC. 12.* Section 128555 of the Health and Safety Code is  
10 amended to read:

11 128555. (a) The Medically Underserved Account for  
12 Physicians is hereby established within the Health Professions  
13 Education Fund. The primary purpose of this account is to provide  
14 funding for the ongoing operations of the Steven M. Thompson  
15 Physician Corps Loan Repayment Program provided for under  
16 this article. This account also may be used to provide funding for  
17 the Physician Volunteer Program provided for under this article.

18 (b) All moneys in the Medically Underserved Account contained  
19 within the Contingent Fund of the Medical Board of California  
20 shall be transferred to the Medically Underserved Account for  
21 Physicians on July 1, 2006.

22 (c) Funds in the account shall be used to repay loans as follows  
23 per agreements made with physicians:

24 (1) Funds paid out for loan repayment may have a funding match  
25 from foundations or other private sources.

26 (2) Loan repayments may not exceed one hundred five thousand  
27 dollars (\$105,000) per individual licensed physician.

28 (3) Loan repayments may not exceed the amount of the  
29 educational loans incurred by the physician participant.

30 (d) Notwithstanding Section 11105 of the Government Code,  
31 effective January 1, 2006, the foundation may seek and receive  
32 matching funds from foundations and private sources to be placed  
33 in the account. "Matching funds" shall not be construed to be  
34 limited to a dollar-for-dollar match of funds.

35 (e) Funds placed in the account for purposes of this article,  
36 including funds received pursuant to subdivision (d), are,  
37 notwithstanding Section 13340 of the Government Code,  
38 continuously appropriated for the repayment of loans. This  
39 subdivision shall not apply to funds placed in the account pursuant  
40 to Section 1341.45.

1 (f) The account shall also be used to pay for the cost of  
2 administering the program and for any other purpose authorized  
3 by this article. The costs for administration of the program may  
4 be up to 5 percent of the total state appropriation for the program  
5 and shall be subject to review and approval annually through the  
6 state budget process. This limitation shall only apply to the state  
7 appropriation for the program.

8 (g) The office and the foundation shall manage the account  
9 established by this section prudently in accordance with the other  
10 provisions of law.

11 *SEC. 13. Section 12739 of the Insurance Code is amended to*  
12 *read:*

13 12739. (a) There is hereby created in the State Treasury a  
14 special fund known as the Major Risk Medical Insurance Fund  
15 that is, notwithstanding Section 13340 of the Government Code,  
16 continuously appropriated to the board for the purposes specified  
17 in Sections 10127.15 and 12739.1 and Section 1373.62 of the  
18 Health and Safety Code.

19 (b) After June 30, 1991, the following amounts shall be  
20 deposited annually in the Major Risk Medical Insurance Fund:

21 (1) Eighteen million dollars (\$18,000,000) from the Hospital  
22 Services Account in the Cigarette and Tobacco Products Surtax  
23 Fund.

24 (2) (A) Eleven million dollars (\$11,000,000) from the Physician  
25 Services Account in the Cigarette and Tobacco Products Surtax  
26 Fund.

27 (B) Notwithstanding subparagraph (A), for the 2007–08 fiscal  
28 year only, the Controller shall reduce the amount deposited into  
29 the Major Risk Medical Insurance Fund from the Physician  
30 Services Account in the Cigarette and Tobacco Products Surtax  
31 Fund to one million dollars (\$1,000,000).

32 (3) One million dollars (\$1,000,000) from the Unallocated  
33 Account in the Cigarette and Tobacco Products Surtax Fund.

34 (c) *Funds placed in the Major Risk Medical Insurance Fund*  
35 *pursuant to Section 1341.45 of the Health and Safety Code shall*  
36 *not be continuously appropriated.*