

AMENDED IN SENATE FEBRUARY 25, 2009

SENATE BILL

No. 92

Introduced by Senator Aanestad

January 21, 2009

An act to amend Section 2069 of the Business and Professions Code, to add Section 1815.5 to the Financial Code, to add Sections 22830.5, 22830.6, 22869.5, and 22917 to the Government Code, to amend Sections 1345, 1357, 1357.03, 1357.06, 1357.14, 1367.01, 1374.32, 1374.33, and 1374.58 of, to add Sections 1346.2, 1349.3, and 1367.38 to, and to add Article 12 (commencing with Section 1399.830) to Chapter 2.2 of Division 2 of, the Health and Safety Code, to amend Sections 10121.7, 10123.135, 10169.2, 10169.3, 10700, 10705, 10706, and 10708 of, to add Sections 699.6, 10123.56, 10123.136, and 12938.1 to, to add Chapter 9.7 (commencing with Section 10920) to Part 2 of Division 2 of, and to add Article 7 (commencing with Section 11885) to Chapter 4 of Part 3 of Division 2 of, the Insurance Code, to amend Sections 511 and 515 of, and to add Section 96.8 to, the Labor Code, to amend Sections 17072, 17215, and 19184 of, to add Sections 17053.91, 17053.102, 17053.103, 17138.5, 17138.6, and 17216 to, and to add and repeal Sections 17053.58, 17053.77, 17204, 23658, and 23677 of, the Revenue and Taxation Code, and to amend Sections 14043.26 and 14133 of, to add Sections 14026.7, 14029.7, 14079.7, 14132.104, 14132.105, and 14164.5 to, to add Article 2.94 (commencing with Section 14091.50) to Chapter 7 of Part 3 of Division 9 of, and to add Division 23 (commencing with Section 23000) to, the Welfare and Institutions Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 92, as amended, Aanestad. Health care reform.

(1) 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 and makes a willful violation of the Knox-Keene Act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

The Knox-Keene Act requires, subject to specified exceptions, that a health care service plan be licensed by the department and provide basic health care services, as defined, among other benefits, unless exempted from that requirement by the director of the department. Existing law also requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state and that the insurer operate in accordance with specified requirements.

This bill would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan contract or a health insurance policy in this state without holding a license issued by the department or a certificate of authority issued by the commissioner. The bill would exempt the carrier's plan contract or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state if the plan contract or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan contract or policy in that state and to transact business there.

The bill would also authorize health care service plans and health insurers to offer, market, and sell individual health care service plan contracts and individual health insurance policies that do not include all of the benefits mandated under state law to individuals with income below 350% of the federal poverty level if the individual waives those benefits, as specified, and the plan contract or insurance policy is approved by the Director of the Department of Managed Health Care or the Insurance Commissioner.

(2) Under existing law, health care service plans and health insurers are required to include certain benefits in their contracts and policies. Existing federal law authorizes an individual who has a high deductible health plan to make tax deductible contributions to a Health Savings Account that may be used to pay medical expenses.

This bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to encourage the design of health care service plan contracts and health insurance policies that conform to current federal requirements for high deductible health plans used in conjunction with Health Savings Accounts and to standardize the process used to review and approve new health care service plan contracts and health insurance policies. The bill would require the director and the commissioner to report specified information to the Legislature regarding those requirements.

The bill would also authorize group health care service plan contracts and group health insurance policies to offer to include a Healthy Action Incentives and Rewards Program, as specified.

(3) Existing law imposes certain requirements on health care service plans and health insurers to enable small employers to access health care coverage. Existing law requires health care service plans and health insurers to sell to any small employer any of the benefit plan designs it offers to small employers and prohibits plans and insurers, among others, from encouraging or directing small employers to refrain from filing an application for coverage with the plan or insurer, and from encouraging or directing small employers to seek coverage from another carrier, because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

This bill would also prohibit a plan or insurer from taking either of those actions because of the employer's implementation of, or intent to implement, any form of claim support for covered employees, as specified.

Existing law defines "small employer" for these purposes to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard.

This bill would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill would reduce the required number of persons covered by health coverage provided through the guaranteed association from

1,000 to 100. The bill would also define “small employer” to include an eligible association that purchases health care coverage for its members and would define an eligible association as a community or civic group or a charitable or religious organization.

Because a willful violation of these requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

(4) Existing law requires health care service plans and specified disability insurers to have written policies and procedures establishing the process by which the plans or insurers prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers of health care services for enrollees or insureds. Existing law imposes specified requirements on that process and specifies that only a licensed physician or licensed health care professional with specified competency may deny or modify requests for authorization of health care services.

This bill would authorize a licensed health care professional, other than a person licensed to practice medicine, to deny or modify requests only with respect to services that fall within his or her scope of practice and subject to standardized protocol limitations or supervision requirements applicable under his or her license. The bill would also prohibit a physician or other health care professional from denying or modifying a request without first conducting a good faith examination of the enrollee, except as specified. *The bill would provide that a service is medically necessary or a medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.*

Existing law establishes an independent medical review system in which an independent medical review organization reviews grievances involving a disputed health care service under a health care service plan contract or disability insurance policy. Existing law requires that medical professionals selected by that organization to conduct reviews be either physicians holding a specified certification or other appropriate providers holding a nonrestricted license in any state.

This bill would require those physicians and other providers to be licensed in California and would limit the reviews conducted by those other providers, as specified.

Existing law requires the medical reviewers selected to conduct a review to review specified information, including, but not limited to,

provider reports and all pertinent medical records of the enrollee or insured.

This bill would also require that at least one of those medical professional reviewers conduct a good faith examination of the enrollee, except as specified.

Because a willful violation of these requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

(5) Existing law provides for insurers to be admitted to transact business in specified types of insurance, including workers' compensation insurance.

This bill would allow any insurer admitted to transact health insurance or workers' compensation insurance, or a health care service plan licensed pursuant to the Knox-Keene Act, to make written application to the commissioner for a license to offer a single policy that provides health care coverage and workers' compensation benefits.

(6) 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 various health care services and benefits. Existing law prescribes various requirements governing reimbursement rates for these services.

This bill would require, on January 1, 2010, the reimbursement levels for fee-for-service physician services under Medi-Cal to be increased to 80% of the amount that the federal Medicare Program reimburses for these same services in Area 9 (Santa Clara County), and would thereafter require the rates to be increased annually in accordance with the California Consumer Price Index.

The bill would require the department, before making any adjustment to Medi-Cal reimbursement rates, to consider the ability of Medi-Cal beneficiaries to access physician services by geography and specialty and to request data from the Office of Statewide Health Planning and Development to allow the department to determine the extent of Medi-Cal physician shortages, if any, by geography and specialty.

The bill would require the department to ensure the existence and operation of a single searchable Internet Web site, accessible by the public at no cost, that specifies Medi-Cal expenditures, including a line item breakdown of administrative overhead and provider and health care expenses.

The bill would require the department to prepare and submit a proposal for a demonstration project by July 31, 2010, for participation in the

federal Medicaid Demonstration Project for Health Opportunity Accounts and would specify the details of that demonstration project.

The bill would also require the department, on or before January 1, 2011, to provide or arrange for the provision of an electronic personal health record and an electronic personal benefits record for beneficiaries of the Medi-Cal program. The bill would additionally authorize the department to establish a Healthy Action Incentives and Rewards Program as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval.

The bill would state the intent of the Legislature to enact legislation that would realign Medi-Cal benefits to more closely resemble benefits offered through private health care coverage.

The bill would also state the intent of the Legislature to enact legislation that would establish a pilot project that utilizes a self-directed “cash and counseling” model for providing Medi-Cal services to disabled Medi-Cal enrollees. Under a “cash and counseling” model, disabled Medi-Cal enrollees, with assistance from family members and Medi-Cal case managers, would be given an individual budget to manage and direct payment for their personal care services and enable them to determine which supportive services they want and from whom they wish to have these services delivered.

Under existing law, the Director of Health Care Services may contract with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries subject to specified requirements.

This bill would state the intent of the Legislature to enact legislation that would establish a pilot project in which Medi-Cal managed care is used as a platform to transition from a defined-benefit system, where the state pays for services used based on a defined set of benefits, to a defined-contribution system, where Medi-Cal enrollees would be assigned a risk-adjusted amount to purchase private health care coverage.

Existing law requires an applicant that is not currently enrolled as a provider in the Medi-Cal program, a provider required to apply for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide Medi-Cal goods or services to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location, except as specified. Existing law requires the department to provide, within 30 days of receipt, written notice that the application package has been received, except as

specified. Applicants or providers that meet certain criteria may be granted preferred provisional provider status for up to 18 months.

This bill would, notwithstanding any other provision of law, additionally provide that, on and after January 1, 2010, certain licensed health care providers submitting an application to the department pursuant to the above provisions shall be granted preferred provisional provider status, effective from the date the department received their application, if the applicant is in good standing as a provider under the federal Medicare Program and with his or her state licensing board.

This bill would require the department to provide written notice to the applicant that the application package has been received within 15 days after receiving the application. The bill would require the department to provide successful applicants with written notice of their preferred provisional provider status within 30 days after receiving the application.

Existing law establishes, within the office of the Attorney General, the Bureau of Medi-Cal Fraud for the investigation and prosecution of violations of applicable laws pertaining to the Medi-Cal program, and to review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the Medi-Cal program.

This bill would require the State Department of Health Care Services to establish a computer modeling program to be used to prevent and identify Medi-Cal fraud. The bill would require the computer modeling program to alert the department when providers engage in specified billing behavior. The bill would require the department, upon receiving the alert, to conduct a Medi-Cal fraud investigation if the department determines an investigation is appropriate under the circumstances.

Existing law, administered by the State Department of Public Health, provides for the licensure and regulation of various clinics, including primary care clinics, as defined.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act that revises hospital reimbursement methodologies in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals.

This bill would require the Director of Health Care Services to provide to the Legislature, no later than July 1, 2010, a plan to permit these funds to be used for the purpose of creating new, and expanding existing, primary care clinics.

Under existing law, one of the utilization controls to which services are subject under the Medi-Cal program is the treatment authorization request process, which is approval by a department consultant of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Other utilization controls include postservice prepayment audits and postservice postpayment audits, that involve reviews for medical necessity and program coverage.

This bill would, instead, provide that treatment authorization requests shall be approved based upon a determination that the service is covered under Medi-Cal. The bill would also provide that postservice prepayment audits and postservice postpayment audits shall only involve reviews for program coverage.

(7) Existing law allows the Controller, in his or her discretion, to offset any amount due to a state agency by a person or entity against any amount owed to that person or entity by a state agency.

Existing law requires the Controller, to the extent feasible, to offset any amount overdue and unpaid for a fine, penalty, assessment, bail, vehicle parking penalty, or court-ordered reimbursement for court-related services, from a person or entity, against any amount owed to the person or entity by a state agency on a claim for a refund from the Franchise Tax Board under the Personal Income Tax Law or the Bank and Corporation Tax Law or from winnings in the California State Lottery.

This bill would permit a hospital or health care provider, as defined, that provides health care services to an uninsured individual who does not qualify for government health care benefits to file a claim with the State Department of Health Care Services to be reimbursed for those services if the recipient of the services does not pay for those services. The bill would require the Director of Health Care Services to certify the debt owed to the hospital or health care provider to the Franchise Tax Board and the California Lottery Commission in order to have the debt satisfied with any tax refund or lottery winnings owed to the debtor, as specified.

(8) Under the Public Employees' Medical and Hospital Care Act, the Board of Administration of the Public Employees' Retirement System contracts for and administers health care benefit plans for public employees and annuitants. Existing state and federal income tax laws allow a deduction for contributions to a qualifying medical savings account by a taxpayer who is covered under a high deductible health

plan, as defined. Money within this type of account may be used to pay for qualified medical expenses, as defined.

This bill would require the board to offer a high deductible health plan, as defined in the federal tax law, and a Health Savings Account option to public employees and annuitants, as specified. The bill would establish the Public Employees' Health Savings Fund, a continuously appropriated trust fund within the State Treasury, for payment of qualified medical expenses of eligible employees and annuitants who elect to enroll in the high deductible health plan and participate in the Health Savings Account option, and would require those employees and annuitants, and their employers, to make specified contributions to that fund, thereby making an appropriation.

The bill would also require the board, on or before January 1, 2011, to provide or arrange for the provision of an electronic personal health record and an electronic personal benefits record for enrollees receiving health care benefits. The bill would additionally authorize the board to provide a Healthy Action Incentives and Rewards Program to its enrollees, as specified.

(9) The Personal Income Tax Law and the Corporation Tax Law authorize various credits against the taxes imposed by those laws.

This bill would authorize a credit against those taxes for each taxable year beginning on or after January 1, 2010, and before January 1, 2015, in an amount equal to the amount paid or incurred during the taxable year for qualified health expenses, as defined, that do not exceed specified amounts.

This bill would authorize a credit against personal income taxes for each taxable year beginning on or after January 1, 2009, in an amount equal to 25% of the tax imposed on a medical care professional who provides medical services in a rural area. The bill would also authorize a credit against personal income taxes, as specified, for a primary care provider, as defined, and for uncompensated medical care provided by a physician.

This bill would authorize a credit under the Personal Income Tax Law and the Corporation Tax Law for each taxable year beginning on or after January 1, 2009, and before January 1, 2015, in an amount equal to 15% of the amount paid or incurred by a qualified taxpayer, as defined, during the taxable year for qualified health insurance, as defined, for employees of the taxpayer. This bill would require the Legislative Analyst to report to the Legislature on or before March 1, 2014, on the effectiveness of the credit, as specified.

The Personal Income Tax Law authorizes various deductions in computing income subject to taxation.

This bill would allow a deduction in computing adjusted gross income for the costs of health insurance, as provided. This bill would also 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 also provide related conformity to that federal law with respect to treatment of the account as a tax-exempt trust, the allowance of rollovers from Archer Medical Savings Accounts to a Health Savings Account, and penalties in connection therewith.

(10) Existing law, with certain exceptions, establishes 8 hours as a day's work and a 40-hour workweek, and requires payment of prescribed overtime compensation for additional hours worked. Existing law authorizes the adoption by $\frac{2}{3}$ of employees in a work unit of alternative workweek schedules providing for workdays no longer than 10 hours within a 40-hour workweek.

This bill would authorize an individual employee employed by an employer with 50 or fewer employees that offers health care coverage benefits to its employees to request a work schedule of up to 10 hours per day within a 40-hour workweek, and would authorize an employer to implement this schedule without any obligation to pay overtime compensation for hours worked as part of the schedule. The bill would enact related provisions and would make other conforming and technical changes.

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. In addition, the bill would state the intent of the Legislature to enact legislation providing incentives to employers who offer health insurance, flex-time work schedules, and other benefits agreed upon by employers and employees.

(11) Existing law defines the term "medical assistant" and sets forth the scope of services a medical assistant is authorized to perform. 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.

(12) Existing law provides for the licensure and regulation by the Commissioner of Financial Institutions of money transmitters, who receive money in this state for transmission to foreign countries, and makes a violation of these provisions a crime.

This bill would require a licensee, or its agent, to collect a 3% fee on any money transmission received from a client who is unable to provide documentation of lawful presence in the United States. The bill would require the deposit of the fee in an unspecified fund to be used to pay for emergency medical care provided in this state to persons without documentation of legal residence in the United States.

Because a violation of this requirement would be a crime, the bill would impose a state-mandated local program.

In addition, the bill would memorialize the Congress and President of the United States to enact legislation that would provide full reimbursement for the costs of providing federally mandated health care services to anyone, regardless of immigration status.

(13) Existing law regulates the establishment and operation of hospitals, including emergency rooms.

This bill would state the intent of the Legislature to enact legislation that would allow hospitals to offer preventative medical services delivered through the hospital's primary care or community-based clinic.

(14) The bill would enact other related provisions and make various technical, nonsubstantive changes.

(15) This bill would result in a change in state taxes for the purpose of increasing state revenues within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $\frac{2}{3}$ of the membership of each house of the Legislature.

(16) 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 no reimbursement is required by this act for a specified reason.

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes.
State-mandated local program: yes.

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

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

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

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

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

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

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

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

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

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

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

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

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

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

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

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

1 general acute care hospital as defined in subdivision (a) of Section
2 1250 of the Health and Safety Code.

3 (e) Nothing in this section shall be construed as authorizing a
4 medical assistant to perform any clinical laboratory test or
5 examination for which he or she is not authorized by Chapter 3
6 (commencing with Section 1200). Nothing in this section shall be
7 construed as authorizing a nurse practitioner, nurse-midwife, or
8 physician assistant to be a laboratory director of a clinical
9 laboratory, as those terms are defined in paragraph (7) of
10 subdivision (a) of Section 1206 and subdivision (a) of Section
11 1209.

12 SEC. 2. Section 1815.5 is added to the Financial Code, to read:

13 1815.5. A licensee, or its agent, shall collect a 3 percent fee
14 on transmission money received from a customer who is unable
15 to provide documentation of lawful presence in the United States.
16 This fee shall be deposited in the ____ Fund, which is hereby
17 established in the State Treasury, to be used to pay for emergency
18 medical care provided in this state to persons without
19 documentation of legal residence in the United States. The fee
20 imposed pursuant to this subdivision shall be in addition to any
21 other applicable fees.

22 SEC. 3. Section 22830.5 is added to the Government Code, to
23 read:

24 22830.5. (a) On or before January 1, 2011, the board shall
25 provide or arrange for the provision of an electronic personal health
26 record (PHR) and an electronic personal benefits record (PBR) for
27 enrollees receiving health care benefits. The records shall be
28 provided for the purpose of providing enrollees with information
29 to assist them in understanding their coverage benefits and
30 managing their health care.

31 (b) The PBR shall provide access to real-time, patient-specific
32 information regarding eligibility for covered benefits, cost-sharing
33 requirements, and claims history. That access may be provided
34 through the use of an Internet-based system. Inclusion of this data
35 shall be at the option of the enrollee.

36 (c) The PHR shall incorporate personal health information,
37 including, but not limited to, medical history, laboratory results,
38 prescription history, and other personal health information
39 authorized or provided by the enrollee. The PHR shall not be

1 provided through the use of an Internet-based system. Inclusion
2 of this additional data shall be at the option of the enrollee.

3 (d) Systems, software, or devices that pertain to the PBR and
4 PHR shall adhere to accepted national standards for
5 interoperability, privacy, and data exchange, or shall be certified
6 by a nationally recognized certification body.

7 (e) The PBR and PHR shall comply with applicable state and
8 federal confidentiality and data security requirements.

9 SEC. 4. Section 22830.6 is added to the Government Code, to
10 read:

11 22830.6. The board may provide or arrange for the provision
12 of a Healthy Action Incentives and Rewards Program, as described
13 in subdivision (b) of Section 1367.38 of the Health and Safety
14 Code, to all enrollees.

15 SEC. 5. Section 22869.5 is added to the Government Code, to
16 read:

17 22869.5. (a) The board shall offer a Health Savings Account
18 option to all employees and annuitants. In addition to the basic
19 health benefit plans described in Sections 22830 and 22850, and
20 notwithstanding any other provision of this part, the board shall
21 approve at least one high deductible health plan, as defined in
22 Section 223(c)(2) of the Internal Revenue Code.

23 (b) The design and administration of the Health Savings Account
24 option shall comply with the standards provided in Section 223 of
25 the Internal Revenue Code and any other applicable revenue
26 procedures or provisions of the Internal Revenue Code and the
27 Revenue and Taxation Code.

28 (c) (1) An employee or annuitant who qualifies as an eligible
29 individual, as defined in Section 223(c)(1)(A) of the Internal
30 Revenue Code, and who elects to participate in the Health Savings
31 Account option shall enroll in a high deductible health plan offered
32 by the board and shall contribute the total cost per month of the
33 benefit coverage afforded him or her under that plan less the portion
34 thereof to be contributed by the employer.

35 (2) The employee or annuitant shall also designate an additional
36 amount to be deducted from his or her salary or retirement
37 allowance for qualified medical expenses. The amount shall be no
38 less than fifty dollars (\$50) per month. The amount shall be
39 deposited into the Public Employees' Health Savings Fund and

1 shall be credited to a nominal, interest-bearing account in the name
2 of the employee or annuitant.

3 (3) For purposes of this section, “qualified medical expenses”
4 means those expenses as defined in Section 223(d)(2) of the
5 Internal Revenue Code.

6 (d) (1) The employer of an employee or annuitant who elects
7 to participate in the Health Savings Account option shall contribute
8 a portion, pursuant to Article 7 (commencing with Section 22870)
9 or Article 8 (commencing with Section 22890), of the cost of
10 providing the benefit coverage under the high deductible health
11 plan.

12 (2) The employer shall also contribute an amount equal to the
13 difference between the amount contributed pursuant to paragraph
14 (1) and the weighted average of the health benefit plan premiums
15 the employer would have paid if the employee or annuitant had
16 enrolled in a plan other than the high deductible health plan, and
17 that amount shall be deposited into the Public Employees’ Health
18 Savings Fund and shall be credited to a nominal account in the
19 name of the employee or annuitant.

20 (e) The limit on contributions made to an employee’s or
21 annuitant’s Health Savings Account by the employee, annuitant,
22 or the employer of the employee or annuitant shall not exceed the
23 maximum limit set by the Internal Revenue Code for a Health
24 Savings Account.

25 (f) Moneys credited to the employee’s or annuitant’s nominal
26 account in the Public Employees’ Health Savings Fund shall be
27 disbursed to pay qualified medical expenses incurred by the
28 employee or annuitant, in accordance with Section 223 of the
29 Internal Revenue Code.

30 (g) The board shall adopt regulations necessary to implement
31 this section.

32 SEC. 6. Section 22917 is added to the Government Code, to
33 read:

34 22917. (a) There is in the State Treasury a Public Employees’
35 Health Savings Fund, the purpose of which is to pay the qualified
36 medical expenses of holders of Health Savings Accounts pursuant
37 to Section 22869.5 and pursuant to Section 223 of the Internal
38 Revenue Code. The board shall have the exclusive control of the
39 administration and investment of the fund.

(b) The Public Employees' Health Savings Fund shall consist of moneys deducted from the salary or retirement allowance of an employee or annuitant, and moneys contributed by the employee's or annuitant's employer, for qualified medical expenses pursuant to Section 22869.5. Those moneys shall earn interest income.

(c) The board may invest funds in the Public Employees' Health Savings Fund pursuant to the law governing its investment of the retirement fund, subject to the limitations contained in Section 223 of the Internal Revenue Code. Income, of whatever nature, earned on the fund during any fiscal year shall be credited to the fund.

(d) Notwithstanding Section 13340, the Public Employees' Health Savings Fund is continuously appropriated, without regard to fiscal years, to reimburse qualified medical expenses of holders of Health Savings Accounts.

(e) The Legislature finds and declares that the Public Employees' Health Savings Fund is a trust fund held for the exclusive benefit of employees and annuitants who elect the Health Savings Account option pursuant to Section 22869.5.

SEC. 7. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) "Advertisement" means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) "Basic health care services" means all of the following:

- (1) Physician services, including consultation and referral.
- (2) Hospital inpatient services and ambulatory care services.
- (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.
- (4) Home health services.
- (5) Preventive health services.
- (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.
- (7) Hospice care pursuant to Section 1368.2.

(c) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) “Evidence of coverage” means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) “Group contract” means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) “Health care service plan” or “specialized health care service plan” means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) “License” means, and “licensed” refers to, a license as a plan pursuant to Section 1353.

(h) “Out-of-area coverage,” for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee’s health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan’s service area.

(i) “Provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) “Person” means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) “Service area” means a geographical area designated by the plan within which a plan shall provide health care services.

(l) “Solicitation” means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding

1 the plan, or services offered and charges therefor, is disseminated
2 for the purpose of inducing persons to subscribe to, or enroll in,
3 the plan.

4 (m) “Solicitor” means any person who engages in the acts
5 defined in subdivision (l).

6 (n) “Solicitor firm” means any person, other than a plan, who
7 through one or more solicitors engages in the acts defined in
8 subdivision (l).

9 (o) “Specialized health care service plan contract” means a
10 contract for health care services in a single specialized area of
11 health care, including dental care, for subscribers or enrollees, or
12 which pays for or which reimburses any part of the cost for those
13 services, in return for a prepaid or periodic charge paid by or on
14 behalf of the subscribers or enrollees.

15 (p) “Subscriber” means the person who is responsible for
16 payment to a plan or whose employment or other status, except
17 for family dependency, is the basis for eligibility for membership
18 in the plan.

19 (q) Unless the context indicates otherwise, “plan” refers to health
20 care service plans and specialized health care service plans.

21 (r) “Plan contract” means a contract between a plan and its
22 subscribers or enrollees or a person contracting on their behalf
23 pursuant to which health care services, including basic health care
24 services, are furnished; and unless the context otherwise indicates
25 it includes specialized health care service plan contracts; and unless
26 the context otherwise indicates it includes group contracts.

27 (s) A service is “medically necessary” or a “medical necessity”
28 when it is reasonable and necessary to protect life, to prevent
29 significant illness or significant disability, or to alleviate severe
30 pain.

31 (s)

32 (t) All references in this chapter to financial statements, assets,
33 liabilities, and other accounting items mean those financial
34 statements and accounting items prepared or determined in
35 accordance with generally accepted accounting principles, and
36 fairly presenting the matters which they purport to present, subject
37 to any specific requirement imposed by this chapter or by the
38 director.

1 ~~SEC. 7.~~

2 SEC. 8. Section 1346.2 is added to the Health and Safety Code,
3 to read:

4 1346.2. (a) The director shall encourage the design of health
5 care service plan contracts that conform to current requirements
6 under federal law for a high deductible health plan used in
7 conjunction with a Health Savings Account.

8 (b) The director and the Insurance Commissioner shall
9 standardize the process used for the initial review and approval of
10 a health care service plan contract and for the initial review and
11 approval of a health insurance policy.

12 (c) (1) The director shall report to the chair and to the vice
13 chairs of the Senate Committee on Banking, Finance and Insurance,
14 the Senate Committee on Appropriations, the Assembly Committee
15 on Insurance, and the Assembly Committee on Appropriations
16 prior to December 31, 2010, on the status of the requirements
17 imposed by subdivisions (a) and (b) and on the number of health
18 care service plans that have applied to the department for initial
19 review and approval of health care service plan contracts on and
20 after the effective date of this section.

21 (2) The director shall also report to the chair and to the vice
22 chairs of the committees listed in paragraph (1) prior to December
23 31, 2011, on the increase in the number of persons enrolled in a
24 health care service plan contract as a result of the requirements
25 described in subdivisions (a) and (b).

26 ~~SEC. 8.~~

27 SEC. 9. Section 1349.3 is added to the Health and Safety Code,
28 to read:

29 1349.3. (a) Notwithstanding any other provision of law, a
30 carrier domiciled in another state is exempt from Section 1349, if
31 it meets the following criteria:

32 (1) It offers, sells, or renews a health care service plan contract
33 in this state that complies with all of the requirements of the
34 domiciliary state applicable to the plan contract.

35 (2) It is authorized to issue the plan contract in the state where
36 it is domiciled and to transact business there.

37 (b) Notwithstanding any other provision of law, a health care
38 service plan contract offered, sold, or renewed in this state by a
39 carrier that satisfies the criteria of subdivision (a) is exempt from
40 all other provisions of this chapter.

~~SEC. 9.~~

SEC. 10. Section 1357 of the Health and Safety Code is amended to read:

1357. As used in this article:

(a) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members and dependents of eligible association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

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

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

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

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

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

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request

1 any necessary information to document the hours and time period
2 in question, including, but not limited to, payroll records and
3 employee wage and tax filings.

4 (2) Any member of a guaranteed association or member of an
5 eligible association as defined in subdivision (o).

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

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

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

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

31 (B) He or she certified at the time of the initial enrollment that
32 coverage under another employer health benefit plan, the Healthy
33 Families Program, or no share-of-cost Medi-Cal coverage was the
34 reason for declining enrollment, provided that, if the individual
35 was covered under another employer health plan, the individual
36 was given the opportunity to make the certification required by
37 this subdivision and was notified that failure to do so could result
38 in later treatment as a late enrollee.

39 (C) He or she has lost or will lose coverage under another
40 employer health benefit plan as a result of termination of

1 employment of the individual or of a person through whom the
2 individual was covered as a dependent, change in employment
3 status of the individual or of a person through whom the individual
4 was covered as a dependent, termination of the other plan's
5 coverage, cessation of an employer's contribution toward an
6 employee or dependent's coverage, death of the person through
7 whom the individual was covered as a dependent, legal separation,
8 divorce, loss of coverage under the Healthy Families Program as
9 a result of exceeding the program's income or age limits, or loss
10 of no share-of-cost Medi-Cal coverage.

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

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

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

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

30 (B) In the case of an association member who did not purchase
31 coverage through a guaranteed association or eligible association,
32 the plan cannot produce a written statement from the association
33 stating that the association sent a written notice in boldface type
34 to all potentially eligible members of the association at their last
35 known address prior to the initial enrollment period informing
36 members that failure to elect coverage during the initial enrollment
37 period permits the plan to impose, at the time of the member's
38 later decision to elect coverage, an exclusion from coverage for a
39 period of 12 months as well as a six-month preexisting condition
40 exclusion unless the member can demonstrate that he or she meets

1 the requirements of subparagraphs (A), (C), and (D) of paragraph
2 (1) or meets the requirements of paragraph (2) or (3).

3 (C) In the case of an employer or person who is not a member
4 of an association, was eligible to purchase coverage through a
5 guaranteed association or eligible association, and did not do so,
6 and would not be eligible to purchase guaranteed coverage unless
7 purchased through a guaranteed association or eligible association,
8 the employer or person can demonstrate that he or she meets the
9 requirements of subparagraphs (A), (C), and (D) of paragraph (1),
10 or meets the requirements of paragraph (2) or (3), or that he or she
11 recently had a change in status that would make him or her eligible
12 and that application for enrollment was made within 30 days of
13 the change.

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

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

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

1 (8) The individual is an eligible employee who has declined
2 coverage for himself or herself or his or her dependents during a
3 previous enrollment period because his or her dependents were
4 covered by another employer health benefit plan at the time of the
5 previous enrollment period. That individual may enroll himself or
6 herself or his or her dependents for plan coverage during a special
7 open enrollment opportunity if his or her dependents have lost or
8 will lose coverage under that other employer health benefit plan.
9 The special open enrollment opportunity shall be requested by the
10 employee not more than 30 days after the date that the other health
11 coverage is exhausted or terminated. Upon enrollment, coverage
12 shall be effective not later than the first day of the first calendar
13 month beginning after the date the request for enrollment is
14 received. Notice of the special enrollment rights contained in this
15 paragraph shall be provided by the employer to an employee at or
16 before the time the employee is offered an opportunity to enroll
17 in plan coverage.

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

20 (f) “Preexisting condition provision” means a contract provision
21 that excludes coverage for charges or expenses incurred during a
22 specified period following the employee’s effective date of
23 coverage, as to a condition for which medical advice, diagnosis,
24 care, or treatment was recommended or received during a specified
25 period immediately preceding the effective date of coverage.

26 (g) “Creditable coverage” means:

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

1 contained in any liability insurance policy or equivalent
2 self-insurance.

3 (2) The federal Medicare Program pursuant to Title XVIII of
4 the Social Security Act.

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

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

9 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
10 (Civilian Health and Medical Program of the Uniformed Services
11 (CHAMPUS)).

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

14 (7) A state health benefits risk pool.

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

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

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

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

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

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

33 (j) "Risk adjustment factor" means the percentage adjustment
34 to be applied equally to each standard employee risk rate for a
35 particular small employer, based upon any expected deviations
36 from standard cost of services. This factor may not be more than
37 120 percent or less than 80 percent until July 1, 1996. Effective
38 July 1, 1996, this factor may not be more than 110 percent or less
39 than 90 percent.

1 (k) “Risk category” means the following characteristics of an
2 eligible employee: age, geographic region, and family composition
3 of the employee, plus the health benefit plan selected by the small
4 employer.

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

7 Under 30

8 30–39

9 40–49

10 50–54

11 55–59

12 60–64

13 65 and over

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

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

22 (A) Single.

23 (B) Married couple.

24 (C) One adult and child or children.

25 (D) Married couple and child or children.

26 (3) (A) In determining rates for small employers, a plan that
27 operates statewide shall use no more than nine geographic regions
28 in the state, have no region smaller than an area in which the first
29 three digits of all its ZIP Codes are in common within a county,
30 and divide no county into more than two regions. Plans shall be
31 deemed to be operating statewide if their coverage area includes
32 90 percent or more of the state’s population. Geographic regions
33 established pursuant to this section shall, as a group, cover the
34 entire state, and the area encompassed in a geographic region shall
35 be separate and distinct from areas encompassed in other
36 geographic regions. Geographic regions may be noncontiguous.

37 (B) (i) In determining rates for small employers, a plan that
38 does not operate statewide shall use no more than the number of
39 geographic regions in the state that is determined by the following
40 formula: the population, as determined in the last federal census,

1 of all counties that are included in their entirety in a plan's service
2 area divided by the total population of the state, as determined in
3 the last federal census, multiplied by nine. The resulting number
4 shall be rounded to the nearest whole integer. No region may be
5 smaller than an area in which the first three digits of all its ZIP
6 Codes are in common within a county and no county may be
7 divided into more than two regions. The area encompassed in a
8 geographic region shall be separate and distinct from areas
9 encompassed in other geographic regions. Geographic regions
10 may be noncontiguous. No plan shall have less than one geographic
11 area.

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

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

20 (l) "Small employer" means any of the following:

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

1 size of a small employer shall be determined annually. Except as
2 otherwise specifically provided in this article, provisions of this
3 article that apply to a small employer shall continue to apply until
4 the plan contract anniversary following the date the employer no
5 longer meets the requirements of this definition. It includes any
6 small employer as defined in this paragraph who purchases
7 coverage through a guaranteed association or an eligible
8 association, and any employer purchasing coverage for employees
9 through a guaranteed association or an eligible association.

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

12 (3) Any eligible association, as defined in subdivision (q), that
13 purchases health coverage for members of the association.

14 (m) “Standard employee risk rate” means the rate applicable to
15 an eligible employee in a particular risk category in a small
16 employer group.

17 (n) “Guaranteed association” means a nonprofit organization
18 comprised of a group of individuals or employers who associate
19 based solely on participation in a specified profession or industry,
20 accepting for membership any individual or employer meeting its
21 membership criteria, and that (1) includes one or more small
22 employers as defined in paragraph (1) of subdivision (l), (2) does
23 not condition membership directly or indirectly on the health or
24 claims history of any person, (3) uses membership dues solely for
25 and in consideration of the membership and membership benefits,
26 except that the amount of the dues shall not depend on whether
27 the member applies for or purchases insurance offered to the
28 association, (4) is organized and maintained in good faith for
29 purposes unrelated to insurance, (5) has a constitution and bylaws,
30 or other analogous governing documents that provide for election
31 of the governing board of the association by its members, (6) offers
32 any plan contract that is purchased to all individual members and
33 employer members in this state, (7) includes any member choosing
34 to enroll in the plan contracts offered to the association provided
35 that the member has agreed to make the required premium
36 payments, and (8) covers at least 100 persons with the health care
37 service plan with which it contracts. The requirement of 100
38 persons may be met if component chapters of a statewide
39 association contracting separately with the same carrier cover at
40 least 100 persons in the aggregate.

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

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

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

20 (q) “Eligible association” means a community or civic group
21 or a charitable or religious organization.

22 ~~SEC. 10.~~

23 *SEC. 11.* Section 1357.03 of the Health and Safety Code is
24 amended to read:

25 1357.03. (a) A plan shall fairly and affirmatively offer, market,
26 and sell all of the plan’s health care service plan contracts that are
27 sold to small employers or to associations that include small
28 employers to all small employers in each service area in which the
29 plan provides or arranges for the provision of health care services,
30 regardless of the employer’s implementation of, or intent to
31 implement, any form of claim or benefit support to covered
32 employees. A plan contracting to participate in the voluntary
33 purchasing pool for small employers provided for under Article 4
34 (commencing with Section 10730) of Chapter 8 of Part 2 of
35 Division 2 of the Insurance Code shall be deemed in compliance
36 with this requirement for a contract offered through the voluntary
37 purchasing pool established under Article 4 (commencing with
38 Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance
39 Code in those geographic regions in which plans participate in the
40 pool, if the contract is offered exclusively through the pool. Each

1 plan shall make available to each small employer all small
2 employer health care service plan contracts that the plan offers
3 and sells to small employers or to associations that include small
4 employers in this state, regardless of the employer's
5 implementation of, or intent to implement, any form of claim or
6 benefit support to covered employees. No plan or solicitor shall
7 induce or otherwise encourage a small employer to separate or
8 otherwise exclude an eligible employee from a health care service
9 plan contract that is provided in connection with the employee's
10 employment or membership in a guaranteed association or an
11 eligible association.

12 (b) Every plan shall file with the director the reasonable
13 employee participation requirements and employer contribution
14 requirements that will be applied in offering its plan contracts.
15 Participation requirements shall be applied uniformly among all
16 small employer groups, except that a plan may vary application
17 of minimum employee participation requirements by the size of
18 the small employer group and whether the employer contributes
19 100 percent of the eligible employee's premium. Employer
20 contribution requirements shall not vary by employer size. A health
21 care service plan shall not establish a participation requirement
22 that (1) requires a person who meets the definition of a dependent
23 in subdivision (a) of Section 1357 to enroll as a dependent if he
24 or she is otherwise eligible for coverage and wishes to enroll as
25 an eligible employee and (2) allows a plan to reject an otherwise
26 eligible small employer because of the number of persons that
27 waive coverage due to coverage through another employer.
28 Members of an association eligible for health coverage under
29 subdivision (o) of Section 1357, but not electing any health
30 coverage through the association, shall not be counted as eligible
31 employees for purposes of determining whether the guaranteed
32 association or eligible association meets a plan's reasonable
33 participation standards.

34 (c) The plan shall not reject an application from a small
35 employer for a health care service plan contract if all of the
36 following are met:

37 (1) The small employer, as defined by paragraph (1) of
38 subdivision (l) of Section 1357, offers health benefits to 100
39 percent of its eligible employees, as defined by paragraph (1) of
40 subdivision (b) of Section 1357. Employees who waive coverage

1 on the grounds that they have other group coverage shall not be
2 counted as eligible employees.

3 (2) The small employer agrees to make the required premium
4 payments.

5 (3) The small employer agrees to inform the small employers'
6 employees of the availability of coverage and the provision that
7 those not electing coverage must wait one year to obtain coverage
8 through the group if they later decide they would like to have
9 coverage.

10 (4) The employees and their dependents who are to be covered
11 by the plan contract work or reside in the service area in which
12 the plan provides or otherwise arranges for the provision of health
13 care services.

14 (d) No plan or solicitor shall, directly or indirectly, engage in
15 the following activities:

16 (1) Encourage or direct small employers to refrain from filing
17 an application for coverage with a plan because of either of the
18 following:

19 (A) The health status, claims experience, industry, occupation
20 of the small employer, or geographic location provided that it is
21 within the plan's approved service area.

22 (B) The small employer's implementation of, or intent to
23 implement, any form of claim or benefit support for its covered
24 employees through a health reimbursement arrangement, a medical
25 expense reimbursement plan, a limited purpose flexible spending
26 account, or any other form of wraparound plan or payment for any
27 portion of claims that apply to the health plan deductible or other
28 benefits.

29 (2) Encourage or direct small employers to seek coverage from
30 another plan or the voluntary purchasing pool established under
31 Article 4 (commencing with Section 10730) of Chapter 8 of Part
32 2 of Division 2 of the Insurance Code because of either of the
33 following:

34 (A) The health status, claims experience, industry, occupation
35 of the small employer, or geographic location provided that it is
36 within the plan's approved service area.

37 (B) The small employer's implementation of, or intent to
38 implement, any form of claim or benefit support for its covered
39 employees through a health reimbursement arrangement, a medical
40 expense reimbursement plan, a limited purpose flexible spending

1 account, or any other form of wraparound plan or payment for any
2 portion of claims that apply to the health plan deductible or other
3 benefits.

4 (e) (1) A plan shall not, directly or indirectly, enter into any
5 contract, agreement, or arrangement with a solicitor that provides
6 for or results in the compensation paid to a solicitor for the sale of
7 a health care service plan contract to be varied because of either
8 of the following:

9 (A) The health status, claims experience, industry, occupation,
10 or geographic location of the small employer.

11 (B) The small employer's implementation of, or intent to
12 implement, any form of claim or benefit support for its covered
13 employees through a health reimbursement arrangement, a medical
14 expense reimbursement plan, a limited purpose flexible spending
15 account, or any other form of wraparound plan or payment for any
16 portion of claims that apply to the health plan deductible or other
17 benefits.

18 (2) This subdivision does not apply to a compensation
19 arrangement that provides compensation to a solicitor on the basis
20 of percentage of premium, provided that the percentage shall not
21 vary because of the factors described in subparagraph (A) or (B)
22 of paragraph (1).

23 (f) A policy or contract that covers two or more employees shall
24 not establish rules for eligibility, including continued eligibility,
25 of an individual, or dependent of an individual, to enroll under the
26 terms of the plan based on any of the following health status-related
27 factors:

28 (1) Health status.

29 (2) Medical condition, including physical and mental illnesses.

30 (3) Claims experience.

31 (4) Receipt of health care.

32 (5) Medical history.

33 (6) Genetic information.

34 (7) Evidence of insurability, including conditions arising out of
35 acts of domestic violence.

36 (8) Disability.

37 (g) A plan shall comply with the requirements of Section 1374.3.

38 ~~SEC. 11.~~

39 *SEC. 12.* Section 1357.06 of the Health and Safety Code is
40 amended to read:

1 1357.06. (a) Preexisting condition provisions of a plan contract
2 shall not exclude coverage for a period beyond six months
3 following the individual's effective date of coverage and may only
4 relate to conditions for which medical advice, diagnosis, care, or
5 treatment, including prescription drugs, was recommended or
6 received from a licensed health practitioner during the six months
7 immediately preceding the effective date of coverage.

8 (b) A plan that does not utilize a preexisting condition provision
9 may impose a waiting or affiliation period, not to exceed 60 days,
10 before the coverage issued subject to this article shall become
11 effective. During the waiting or affiliation period no premiums
12 shall be charged to the enrollee or the subscriber.

13 (c) In determining whether a preexisting condition provision or
14 a waiting or affiliation period applies to any person, a plan shall
15 credit the time the person was covered under creditable coverage,
16 provided the person becomes eligible for coverage under the
17 succeeding plan contract within 62 days of termination of prior
18 coverage, exclusive of any waiting or affiliation period, and applies
19 for coverage with the succeeding plan contract within the applicable
20 enrollment period. A plan shall also credit any time an eligible
21 employee must wait before enrolling in the plan, including any
22 affiliation or employer-imposed waiting or affiliation period.
23 However, if a person's employment has ended, the availability of
24 health coverage offered through employment or sponsored by an
25 employer has terminated, or an employer's contribution toward
26 health coverage has terminated, a plan shall credit the time the
27 person was covered under creditable coverage if the person
28 becomes eligible for health coverage offered through employment
29 or sponsored by an employer within 180 days, exclusive of any
30 waiting or affiliation period, and applies for coverage under the
31 succeeding plan contract within the applicable enrollment period.

32 (d) In addition to the preexisting condition exclusions authorized
33 by subdivision (a) and the waiting or affiliation period authorized
34 by subdivision (b), health plans providing coverage to a guaranteed
35 association or an eligible association may impose on employers
36 or individuals purchasing coverage who would not be eligible for
37 guaranteed coverage if they were not purchasing through the
38 association a waiting or affiliation period, not to exceed 60 days,
39 before the coverage issued subject to this article shall become

1 effective. During the waiting or affiliation period, no premiums
2 shall be charged to the enrollee or the subscriber.

3 (e) An individual's period of creditable coverage shall be
4 certified pursuant to subdivision (e) of Section 2701 of Title XXVII
5 of the federal Public Health Services Act (42 U.S.C. Sec.
6 300gg(e)).

7 (f) A health care service plan issuing group coverage may not
8 impose a preexisting condition exclusion to any of the following:

9 (1) To a newborn individual, who, as of the last day of the
10 30-day period beginning with the date of birth, has applied for
11 coverage through the employer-sponsored plan.

12 (2) To a child who is adopted or placed for adoption before
13 attaining 18 years of age and who, as of the last day of the 30-day
14 period beginning with the date of adoption or placement for
15 adoption, is covered under creditable coverage and applies for
16 coverage through the employer-sponsored plan. This provision
17 shall not apply if, for 63 continuous days, the child is not covered
18 under any creditable coverage.

19 (3) To a condition relating to benefits for pregnancy or maternity
20 care.

21 ~~SEC. 12.~~

22 *SEC. 13.* Section 1357.14 of the Health and Safety Code is
23 amended to read:

24 1357.14. In connection with the offering for sale of any plan
25 contract to a small employer, each plan shall make a reasonable
26 disclosure, as part of its solicitation and sales materials, of the
27 following:

28 (a) The extent to which premium rates for a specified small
29 employer are established or adjusted in part based upon the actual
30 or expected variation in service costs or actual or expected variation
31 in health condition of the employees and dependents of the small
32 employer.

33 (b) The provisions concerning the plan's right to change
34 premium rates and the factors other than provision of services
35 experience that affect changes in premium rates.

36 (c) Provisions relating to the guaranteed issue and renewal of
37 contracts.

38 (d) Provisions relating to the effect of any preexisting condition
39 provision.

1 (e) Provisions relating to the small employer's right to apply
2 for any contract written, issued, or administered by the plan at the
3 time of application for a new health care service plan contract, or
4 at the time of renewal of a health care service plan contract,
5 regardless of the employer's implementation of, or intent to
6 implement, any form of claim or benefit support to covered
7 employees.

8 (f) The availability, upon request, of a listing of all the plan's
9 contracts and benefit plan designs offered to small employers,
10 including the rates for each contract.

11 (g) At the time it offers a contract to a small employer, each
12 plan shall provide the small employer with a statement of all of
13 its plan contracts offered to small employers, including the rates
14 for each plan contract, in the service area in which the employer's
15 employees and eligible dependents who are to be covered by the
16 plan contract work or reside. For purposes of this subdivision,
17 plans that are affiliated plans or that are eligible to file a
18 consolidated income tax return shall be treated as one health plan.

19 (h) Each plan shall do all of the following:

20 (1) Prepare a brochure that summarizes all of its plan contracts
21 offered to small employers and to make this summary available
22 to any small employer and to solicitors upon request. The summary
23 shall include for each contract information on benefits provided,
24 a generic description of the manner in which services are provided,
25 such as how access to providers is limited, benefit limitations,
26 required copayments and deductibles, standard employee risk rates,
27 an explanation of the manner in which creditable coverage is
28 calculated if a preexisting condition or affiliation period is imposed,
29 and a phone number that can be called for more detailed benefit
30 information. Plans are required to keep the information contained
31 in the brochure accurate and up to date and, upon updating the
32 brochure, send copies to solicitors and solicitor firms with whom
33 the plan contracts to solicit enrollments or subscriptions.

34 (2) For each contract, prepare a more detailed evidence of
35 coverage and make it available to small employers, solicitors, and
36 solicitor firms upon request. The evidence of coverage shall contain
37 all information that a prudent buyer would need to be aware of in
38 making contract selections.

39 (3) Provide to small employers and solicitors, upon request, for
40 any given small employer the sum of the standard employee risk

1 rates and the sum of the risk adjusted employee risk rates. When
2 requesting this information, small employers, solicitors, and
3 solicitor firms shall provide the plan with the information the plan
4 needs to determine the small employer's risk adjusted employee
5 risk rate.

6 (4) Provide copies of the current summary brochure to all
7 solicitors and solicitor firms contracting with the plan to solicit
8 enrollments or subscriptions from small employers.

9 For purposes of this subdivision, plans that are affiliated plans
10 or that are eligible to file a consolidated income tax return shall
11 be treated as one health plan.

12 (i) Every solicitor or solicitor firm contracting with one or more
13 plans to solicit enrollments or subscriptions from small employers
14 shall do all of the following:

15 (1) When providing information on contracts to a small
16 employer but making no specific recommendations on particular
17 plan contracts:

18 (A) Advise the small employer of the plan's obligation to sell
19 to any small employer any plan contract it offers to small
20 employers, regardless of the employer's implementation of, or
21 intent to implement, any form of claim or benefit support to
22 covered employees, and provide them, upon request, with the
23 actual rates that would be charged to that employer for a given
24 contract.

25 (B) Notify the small employer that the solicitor or solicitor firm
26 will procure rate and benefit information for the small employer
27 on any plan contract offered by a plan whose contract the solicitor
28 sells.

29 (C) Notify the small employer that upon request the solicitor or
30 solicitor firm will provide the small employer with the summary
31 brochure required under paragraph (1) of subdivision (h) for any
32 plan contract offered by a plan with whom the solicitor or solicitor
33 firm has contracted with to solicit enrollments or subscriptions.

34 (2) When recommending a particular benefit plan design or
35 designs, advise the small employer that, upon request, the agent
36 will provide the small employer with the brochure required by
37 paragraph (1) of subdivision (h) containing the benefit plan design
38 or designs being recommended by the agent or broker.

39 (3) Prior to filing an application for a small employer for a
40 particular contract:

1 (A) For each of the plan contracts offered by the plan whose
2 contract the solicitor or solicitor firm is offering, provide the small
3 employer with the benefit summary required in paragraph (1) of
4 subdivision (h) and the sum of the standard employee risk rates
5 for that particular employer.

6 (B) Notify the small employer that, upon request, the solicitor
7 or solicitor firm will provide the small employer with an evidence
8 of coverage brochure for each contract the plan offers.

9 (C) Notify the small employer that actual rates may be 10
10 percent higher or lower than the sum of the standard employee
11 risk rates, depending on how the plan assesses the risk of the small
12 employer's group.

13 (D) Notify the small employer that, upon request, the solicitor
14 or solicitor firm will submit information to the plan to ascertain
15 the small employer's sum of the risk adjusted employee risk rate
16 for any contract the plan offers.

17 (E) Obtain a signed statement from the small employer
18 acknowledging that the small employer has received the disclosures
19 required by this section.

20 ~~SEC. 13.~~

21 *SEC. 14.* 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) (1) No individual, other than a person licensed to practice
29 medicine pursuant to Section 2050 of the Business and Professions
30 Code or pursuant to the Osteopathic Act, or a licensed health care
31 professional acting within the limitations of paragraph (2), may
32 deny or modify requests for authorization of health care services
33 for an enrollee for reasons of medical necessity.

34 (2) A licensed health care professional, other than a person
35 licensed to practice medicine pursuant to Section 2050 of the
36 Business and Professions Code or pursuant to the Osteopathic Act,
37 may deny or modify requests for authorization of health care
38 services for an enrollee for reasons of medical necessity only with
39 respect to services that fall within his or her scope of practice. That
40 professional's review shall also be subject to standardized protocol

1 limitations or supervision requirements applicable under his or her
2 license.

3 (3) The physician or other health care professional described in
4 this subdivision shall not deny or modify a request for authorization
5 of a health care service for an enrollee for reasons of medical
6 necessity without first conducting a good faith examination of the
7 enrollee. This good faith examination shall not be required if the
8 enrollee's contract explicitly excludes coverage of the health care
9 service in question.

10 (4) The decision of the physician or other health care
11 professional described in this subdivision shall be communicated
12 to the provider and the enrollee pursuant to subdivision (h).

13 (f) The criteria or guidelines used by the health care service
14 plan to determine whether to approve, modify, or deny requests
15 by providers prior to, retrospectively, or concurrent with, the
16 provision of health care services to enrollees shall be consistent
17 with clinical principles and processes. These criteria and guidelines
18 shall be developed pursuant to the requirements of Section 1363.5.

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

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

28 (1) Decisions to approve, modify, or deny, based on medical
29 necessity, requests by providers prior to, or concurrent with the
30 provision of health care services to enrollees that do not meet the
31 requirements for the 72-hour review required by paragraph (2),
32 shall be made in a timely fashion appropriate for the nature of the
33 enrollee's condition, not to exceed five business days from the
34 plan's receipt of the information reasonably necessary and
35 requested by the plan to make the determination, including, but
36 not limited to, information from the good faith examination
37 conducted pursuant to subdivision (e). In cases where the review
38 is retrospective, the decision shall be communicated to the
39 individual who received services, or to the individual's designee,
40 within 30 days of the receipt of information that is reasonably

1 necessary to make this determination, including, but not limited
2 to, information from the good faith examination conducted pursuant
3 to subdivision (e), and shall be communicated to the provider in
4 a manner that is consistent with current law. For purposes of this
5 section, retrospective reviews shall be for care rendered on or after
6 January 1, 2000.

7 (2) When the enrollee's condition is such that the enrollee faces
8 an imminent and serious threat to his or her health, including, but
9 not limited to, the potential loss of life, limb, or other major bodily
10 function, or the normal timeframe for the decisionmaking process,
11 as described in paragraph (1), would be detrimental to the enrollee's
12 life or health or could jeopardize the enrollee's ability to regain
13 maximum function, decisions to approve, modify, or deny requests
14 by providers prior to, or concurrent with, the provision of health
15 care services to enrollees, shall be made in a timely fashion
16 appropriate for the nature of the enrollee's condition, not to exceed
17 72 hours after the plan's receipt of the information reasonably
18 necessary and requested by the plan to make the determination,
19 including, but not limited to, information from the good faith
20 examination conducted pursuant to subdivision (e). Nothing in
21 this section shall be construed to alter the requirements of
22 subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4,
23 the requirements of this division shall be applicable to all health
24 plans and other entities conducting utilization review or utilization
25 management.

26 (3) Decisions to approve, modify, or deny requests by providers
27 for authorization prior to, or concurrent with, the provision of
28 health care services to enrollees shall be communicated to the
29 requesting provider within 24 hours of the decision. Except for
30 concurrent review decisions pertaining to care that is underway,
31 which shall be communicated to the enrollee's treating provider
32 within 24 hours, decisions resulting in denial, delay, or
33 modification of all or part of the requested health care service shall
34 be communicated to the enrollee in writing within two business
35 days of the decision. In the case of concurrent review, care shall
36 not be discontinued until the enrollee's treating provider has been
37 notified of the plan's decision and a care plan has been agreed
38 upon by the treating provider that is appropriate for the medical
39 needs of that patient.

1 (4) Communications regarding decisions to approve requests
2 by providers prior to, retrospectively, or concurrent with the
3 provision of health care services to enrollees shall specify the
4 specific health care service approved. Responses regarding
5 decisions to deny, delay, or modify health care services requested
6 by providers prior to, retrospectively, or concurrent with the
7 provision of health care services to enrollees shall be
8 communicated to the enrollee in writing, and to providers initially
9 by telephone or facsimile, except with regard to decisions rendered
10 retrospectively, and then in writing, and shall include a clear and
11 concise explanation of the reasons for the plan's decision, a
12 description of the criteria or guidelines used, and the clinical
13 reasons for the decisions regarding medical necessity. Any written
14 communication to a physician or other health care provider of a
15 denial, delay, or modification of a request shall include the name
16 and telephone number of the health care professional responsible
17 for the denial, delay, or modification. The telephone number
18 provided shall be a direct number or an extension, to allow the
19 physician or health care provider easily to contact the professional
20 responsible for the denial, delay, or modification. Responses shall
21 also include information as to how the enrollee may file a grievance
22 with the plan pursuant to Section 1368, and in the case of Medi-Cal
23 enrollees, shall explain how to request an administrative hearing
24 and aid paid pending under Sections 51014.1 and 51014.2 of Title
25 22 of the California Code of Regulations.

26 (5) If the health care service plan cannot make a decision to
27 approve, modify, or deny the request for authorization within the
28 timeframes specified in paragraph (1) or (2) because the plan is
29 not in receipt of all of the information reasonably necessary and
30 requested, including, but not limited to, information from the good
31 faith examination conducted pursuant to subdivision (e), or because
32 the plan requires consultation by an expert reviewer, or because
33 the plan has asked that an additional examination or test be
34 performed upon the enrollee, provided the examination or test is
35 reasonable and consistent with good medical practice, the plan
36 shall, immediately upon the expiration of the timeframe specified
37 in paragraph (1) or (2) or as soon as the plan becomes aware that
38 it will not meet the timeframe, whichever occurs first, notify the
39 provider and the enrollee, in writing, that the plan cannot make a
40 decision to approve, modify, or deny the request for authorization

1 within the required timeframe, and specify the information
2 requested but not received, or the expert reviewer to be consulted,
3 or the additional examinations or tests required. The plan shall
4 also notify the provider and enrollee of the anticipated date on
5 which a decision may be rendered. Upon receipt of all information
6 reasonably necessary and requested by the plan, the plan shall
7 approve, modify, or deny the request for authorization within the
8 timeframes specified in paragraph (1) or (2), whichever applies.

9 (6) If the director determines that a health care service plan has
10 failed to meet any of the timeframes in this section, or has failed
11 to meet any other requirement of this section, the director may
12 assess, by order, administrative penalties for each failure. A
13 proceeding for the issuance of an order assessing administrative
14 penalties shall be subject to appropriate notice to, and an
15 opportunity for a hearing with regard to, the person affected, in
16 accordance with subdivision (a) of Section 1397. The
17 administrative penalties shall not be deemed an exclusive remedy
18 for the director. These penalties shall be paid to the Managed Care
19 Administrative Fines and Penalties Fund and shall be used for the
20 purposes specified in Section 1341.45.

21 (i) A health care service plan subject to this section shall
22 maintain telephone access for providers to request authorization
23 for health care services.

24 (j) A health care service plan subject to this section that reviews
25 requests by providers prior to, retrospectively, or concurrent with,
26 the provision of health care services to enrollees shall establish,
27 as part of the quality assurance program required by Section 1370,
28 a process by which the plan's compliance with this section is
29 assessed and evaluated. The process shall include provisions for
30 evaluation of complaints, assessment of trends, implementation
31 of actions to correct identified problems, mechanisms to
32 communicate actions and results to the appropriate health plan
33 employees and contracting providers, and provisions for evaluation
34 of any corrective action plan and measurements of performance.

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

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

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

11 ~~SEC. 14.~~

12 *SEC. 15.* Section 1367.38 is added to the Health and Safety
13 Code, to read:

14 1367.38. (a) Every health care service plan, except for a
15 Medicare supplement plan, that covers hospital, medical, or
16 surgical expenses on a group basis may offer to include a Healthy
17 Action Incentives and Rewards Program, as described in
18 subdivision (b), to be implemented in connection with a health
19 care service plan, under such terms and conditions as may be
20 agreed upon between the subscriber group and the health care
21 service plan. Every plan that offers a Healthy Action Incentive
22 and Rewards Program shall communicate the availability of the
23 program to all prospective group subscribers with whom it is
24 negotiating and to existing group subscribers upon renewal.

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

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

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

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 include,
3 but need not be limited to, smoking cessation, physical activity,
4 or nutrition. Incentives may include, but need not be limited to,
5 health premium reductions, differential copayment or coinsurance
6 amounts, and cash payments. Rewards may include, but need not
7 be limited to, nonprescription pharmacy products or services not
8 otherwise covered under an enrollee's health plan contract, exercise
9 classes, gym memberships, and weight management programs.

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

14 ~~SEC. 15:~~

15 *SEC. 16.* Section 1374.32 of the Health and Safety Code is
16 amended to read:

17 1374.32. (a) The department shall contract with one or more
18 independent medical review organizations in the state to conduct
19 reviews for purposes of this article. The independent medical
20 review organizations shall be independent of any health care service
21 plan doing business in this state. The director may establish
22 additional requirements, including conflict-of-interest standards,
23 consistent with the purposes of this article, that an organization
24 shall be required to meet in order to qualify for participation in the
25 Independent Medical Review System and to assist the department
26 in carrying out its responsibilities.

27 (b) The independent medical review organizations and the
28 medical professionals retained to conduct reviews shall be deemed
29 to be medical consultants for purposes of Section 43.98 of the Civil
30 Code.

31 (c) The independent medical review organization, any experts
32 it designates to conduct a review, or any officer, director, or
33 employee of the independent medical review organization shall
34 not have any material professional, familial, or financial affiliation,
35 as determined by the director, with any of the following:

36 (1) The plan.

37 (2) Any officer, director, or employee of the plan.

38 (3) A physician, the physician's medical group, or the
39 independent practice association involved in the health care service
40 in dispute.

1 (4) The facility or institution at which either the proposed health
2 care service, or the alternative service, if any, recommended by
3 the plan, would be provided.

4 (5) The development or manufacture of the principal drug,
5 device, procedure, or other therapy proposed by the enrollee whose
6 treatment is under review, or the alternative therapy, if any,
7 recommended by the plan.

8 (6) The enrollee or the enrollee's immediate family.

9 (d) In order to contract with the department for purposes of this
10 article, an independent medical review organization shall meet all
11 of the following requirements:

12 (1) The organization shall not be an affiliate or a subsidiary of,
13 nor in any way be owned or controlled by, a health plan or a trade
14 association of health plans. A board member, director, officer, or
15 employee of the independent medical review organization shall
16 not serve as a board member, director, or employee of a health
17 care service plan. A board member, director, or officer of a health
18 plan or a trade association of health plans shall not serve as a board
19 member, director, officer, or employee of an independent medical
20 review organization.

21 (2) The organization shall submit to the department the
22 following information upon initial application to contract for
23 purposes of this article and, except as otherwise provided, annually
24 thereafter upon any change to any of the following information:

25 (A) The names of all stockholders and owners of more than 5
26 percent of any stock or options, if a publicly held organization.

27 (B) The names of all holders of bonds or notes in excess of one
28 hundred thousand dollars (\$100,000), if any.

29 (C) The names of all corporations and organizations that the
30 independent medical review organization controls or is affiliated
31 with, and the nature and extent of any ownership or control,
32 including the affiliated organization's type of business.

33 (D) The names and biographical sketches of all directors,
34 officers, and executives of the independent medical review
35 organization, as well as a statement regarding any past or present
36 relationships the directors, officers, and executives may have with
37 any health care service plan, disability insurer, managed care
38 organization, provider group, or board or committee of a plan,
39 managed care organization, or provider group.

1 (E) (i) The percentage of revenue the independent medical
2 review organization receives from expert reviews, including, but
3 not limited to, external medical reviews, quality assurance reviews,
4 and utilization reviews.

5 (ii) The names of any health care service plan or provider group
6 for which the independent medical review organization provides
7 review services, including, but not limited to, utilization review,
8 quality assurance review, and external medical review. Any change
9 in this information shall be reported to the department within five
10 business days of the change.

11 (F) A description of the review process including, but not limited
12 to, the method of selecting expert reviewers and matching the
13 expert reviewers to specific cases.

14 (G) A description of the system the independent medical review
15 organization uses to identify and recruit medical professionals to
16 review treatment and treatment recommendation decisions, the
17 number of medical professionals credentialed, and the types of
18 cases and areas of expertise that the medical professionals are
19 credentialed to review.

20 (H) A description of how the independent medical review
21 organization ensures compliance with the conflict-of-interest
22 provisions of this section.

23 (3) The organization shall demonstrate that it has a quality
24 assurance mechanism in place that does the following:

25 (A) Ensures that the medical professionals retained are
26 appropriately credentialed and privileged.

27 (B) Ensures that the reviews provided by the medical
28 professionals are timely, clear, and credible, and that reviews are
29 monitored for quality on an ongoing basis.

30 (C) Ensures that the method of selecting medical professionals
31 for individual cases achieves a fair and impartial panel of medical
32 professionals who are qualified to render recommendations
33 regarding the clinical conditions and the medical necessity of
34 treatments or therapies in question.

35 (D) Ensures the confidentiality of medical records and the
36 review materials, consistent with the requirements of this section
37 and applicable state and federal law.

38 (E) Ensures the independence of the medical professionals
39 retained to perform the reviews through conflict-of-interest policies

1 and prohibitions, and ensures adequate screening for
2 conflicts-of-interest, pursuant to paragraph (5).

3 (4) Medical professionals selected by independent medical
4 review organizations to review medical treatment decisions shall
5 be physicians or other appropriate providers who meet the
6 following minimum requirements:

7 (A) The medical professional shall be a clinician knowledgeable
8 in the treatment of the enrollee's medical condition, knowledgeable
9 about the proposed treatment, and familiar with guidelines and
10 protocols in the area of treatment under review. Review by a
11 medical professional, other than a physician licensed to practice
12 medicine pursuant to Section 2050 of the Business and Professions
13 Code or pursuant to the Osteopathic Act, shall be limited to services
14 that fall within that professional's scope of practice and shall be
15 subject to standardized protocol limitations or supervision
16 requirements applicable under his or her license.

17 (B) Notwithstanding any other provision of law, the medical
18 professional shall hold a nonrestricted California license, and for
19 physicians, a current license to practice medicine pursuant to
20 Section 2050 of the Business and Professions Code or pursuant to
21 the Osteopathic Act.

22 (C) The medical professional shall have no history of
23 disciplinary action or sanctions, including, but not limited to, loss
24 of staff privileges or participation restrictions, taken or pending
25 by any hospital, government, or regulatory body.

26 (5) Neither the expert reviewer, nor the independent medical
27 review organization, shall have any material professional, material
28 familial, or material financial affiliation with any of the following:

29 (A) The plan or a provider group of the plan, except that an
30 academic medical center under contract to the plan to provide
31 services to enrollees may qualify as an independent medical review
32 organization provided it will not provide the service and provided
33 the center is not the developer or manufacturer of the proposed
34 treatment.

35 (B) Any officer, director, or management employee of the plan.

36 (C) The physician, the physician's medical group, or the
37 independent practice association (IPA) proposing the treatment.

38 (D) The institution at which the treatment would be provided.

39 (E) The development or manufacture of the treatment proposed
40 for the enrollee whose condition is under review.

1 (F) The enrollee or the enrollee's immediate family.

2 (6) For purposes of this section, the following terms shall have
3 the following meanings:

4 (A) "Material familial affiliation" means any relationship as a
5 spouse, child, parent, sibling, spouse's parent, or child's spouse.

6 (B) "Material professional affiliation" means any
7 physician-patient relationship, any partnership or employment
8 relationship, a shareholder or similar ownership interest in a
9 professional corporation, or any independent contractor
10 arrangement that constitutes a material financial affiliation with
11 any expert or any officer or director of the independent medical
12 review organization. "Material professional affiliation" does not
13 include affiliations that are limited to staff privileges at a health
14 facility.

15 (C) "Material financial affiliation" means any financial interest
16 of more than 5 percent of total annual revenue or total annual
17 income of an independent medical review organization or
18 individual to which this subdivision applies. "Material financial
19 affiliation" does not include payment by the plan to the independent
20 medical review organization for the services required by this
21 section, nor does "material financial affiliation" include an expert's
22 participation as a contracting plan provider where the expert is
23 affiliated with an academic medical center or a National Cancer
24 Institute-designated clinical cancer research center.

25 (e) The department shall provide, upon the request of any
26 interested person, a copy of all nonproprietary information, as
27 determined by the director, filed with it by an independent medical
28 review organization seeking to contract under this article. The
29 department may charge a nominal fee to the interested person for
30 photocopying the requested information.

31 ~~SEC. 16.~~

32 *SEC. 17.* Section 1374.33 of the Health and Safety Code is
33 amended to read:

34 1374.33. (a) Upon receipt of information and documents
35 related to a case, the medical professional reviewer or reviewers
36 selected to conduct the review by the independent medical review
37 organization shall promptly review all pertinent medical records
38 of the enrollee, provider reports, as well as any other information
39 submitted to the organization as authorized by the department or
40 requested from any of the parties to the dispute by the reviewers.

1 If reviewers request information from any of the parties, a copy
2 of the request and the response shall be provided to all of the
3 parties. The reviewer or reviewers shall also review relevant
4 information related to the criteria set forth in subdivision (b). In
5 addition, at least one medical professional reviewer selected to
6 conduct the review shall conduct a good faith examination of the
7 enrollee. This good faith examination shall not be required if the
8 enrollee's contract explicitly excludes coverage of the disputed
9 health care service.

10 (b) Following its review, the reviewer or reviewers shall
11 determine whether the disputed health care service was medically
12 necessary based on the specific medical needs of the enrollee and
13 any of the following:

14 (1) Peer-reviewed scientific and medical evidence regarding
15 the effectiveness of the disputed service.

16 (2) Nationally recognized professional standards.

17 (3) Expert opinion.

18 (4) Generally accepted standards of medical practice.

19 (5) Treatments that are likely to provide a benefit to a patient
20 for conditions for which other treatments are not clinically
21 efficacious.

22 (c) The organization shall complete its review and make its
23 determination in writing, and in layperson's terms to the maximum
24 extent practicable, within 30 days of the receipt of the application
25 for review and supporting documentation, including, but not limited
26 to, information from the good faith examination conducted pursuant
27 to subdivision (a), or within less time as prescribed by the director.
28 If the disputed health care service has not been provided and the
29 enrollee's provider or the department certifies in writing that an
30 imminent and serious threat to the health of the enrollee may exist,
31 including, but not limited to, serious pain, the potential loss of life,
32 limb, or major bodily function, or the immediate and serious
33 deterioration of the health of the enrollee, the analyses and
34 determinations of the reviewers shall be expedited and rendered
35 within three days of the receipt of the information, including, but
36 not limited to, information from the good faith examination
37 conducted pursuant to subdivision (a). Subject to the approval of
38 the department, the deadlines for analyses and determinations
39 involving both regular and expedited reviews may be extended by

1 the director for up to three days in extraordinary circumstances or
2 for good cause.

3 (d) The medical professionals' analyses and determinations
4 shall state whether the disputed health care service is medically
5 necessary. Each analysis shall cite the enrollee's medical condition,
6 the relevant documents in the record, the relevant results of the
7 good faith examination, and the relevant findings associated with
8 the provisions of subdivision (b) to support the determination. If
9 more than one medical professional reviews the case, the
10 recommendation of the majority shall prevail. If the medical
11 professionals reviewing the case are evenly split as to whether the
12 disputed health care service should be provided, the decision shall
13 be in favor of providing the service.

14 (e) The independent medical review organization shall provide
15 the director, the plan, the enrollee, and the enrollee's provider with
16 the analyses and determinations of the medical professionals
17 reviewing the case, and a description of the qualifications of the
18 medical professionals. The independent medical review
19 organization shall keep the names of the reviewers confidential in
20 all communications with entities or individuals outside the
21 independent medical review organization, except in cases where
22 the reviewer is called to testify and in response to court orders. If
23 more than one medical professional reviewed the case and the
24 result was differing determinations, the independent medical review
25 organization shall provide each of the separate reviewer's analyses
26 and determinations.

27 (f) The director shall immediately adopt the determination of
28 the independent medical review organization, and shall promptly
29 issue a written decision to the parties that shall be binding on the
30 plan.

31 (g) After removing the names of the parties, including, but not
32 limited to, the enrollee, all medical providers, the plan, and any of
33 the insurer's employees or contractors, director decisions adopting
34 a determination of an independent medical review organization
35 shall be made available by the department to the public upon
36 request, at the department's cost and after considering applicable
37 laws governing disclosure of public records, confidentiality, and
38 personal privacy.

1 ~~SEC. 17.~~

2 *SEC. 18.* Section 1374.58 of the Health and Safety Code is
3 amended to read:

4 1374.58. (a) A group health care service plan that provides
5 hospital, medical, or surgical expense benefits shall provide equal
6 coverage to employers, guaranteed associations, or eligible
7 associations, as defined in Section 1357, for the registered domestic
8 partner of an employee or subscriber to the same extent, and subject
9 to the same terms and conditions, as provided to a spouse of the
10 employee or subscriber, and shall inform employers, guaranteed
11 associations, and eligible associations of this coverage. A plan
12 may not offer or provide coverage for a registered domestic partner
13 that is not equal to the coverage provided to the spouse of an
14 employee or subscriber.

15 (b) If an employer, guaranteed association, or eligible association
16 has purchased coverage for spouses and registered domestic
17 partners pursuant to subdivision (a), a health care service plan that
18 provides hospital, medical, or surgical expense benefits for
19 employees or subscribers and their spouses shall enroll, upon
20 application by the employer or group administrator, a registered
21 domestic partner of an employee or subscriber in accordance with
22 the terms and conditions of the group contract that apply generally
23 to all spouses under the plan, including coordination of benefits.

24 (c) For purposes of this section, the term “domestic partner”
25 shall have the same meaning as that term is used in Section 297
26 of the Family Code.

27 (d) (1) A health care service plan may require that the employee
28 or subscriber verify the status of the domestic partnership by
29 providing to the plan a copy of a valid Declaration of Domestic
30 Partnership filed with the Secretary of State pursuant to Section
31 298 of the Family Code or an equivalent document issued by a
32 local agency of this state, another state, or a local agency of another
33 state under which the partnership was created. The plan may also
34 require that the employee or subscriber notify the plan upon the
35 termination of the domestic partnership.

36 (2) Notwithstanding paragraph (1), a health care service plan
37 may require the information described in that paragraph only if it
38 also requests from the employee or subscriber whose spouse is
39 provided coverage, verification of marital status and notification
40 of dissolution of the marriage.

(e) Nothing in this section shall be construed to expand the requirements of Section 4980B of Title 26 of the United States Code, Section 1161, and following, of Title 29 of the United States Code, or Section 300bb-1, and following, of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as those provisions may be later amended.

(f) A plan subject to this section that is issued, amended, delivered, or renewed in this state on or after January 2, 2005, shall be deemed to provide coverage for registered domestic partners that is equal to the coverage provided to a spouse of an employee or subscriber.

~~SEC. 18.~~

SEC. 19. Article 12 (commencing with Section 1399.830) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 12. Mandate-Free Individual Coverage

1399.830. (a) Notwithstanding any other provision of this chapter, on and after January 1, 2011, a health care service plan may offer, market, and sell an individual health care service plan contract that does not include all of the health benefits mandated under this chapter to an individual if all of the following requirements are met:

(1) The individual has an income below 350 percent of the federal poverty level.

(2) The individual waives the benefits pursuant to subdivision (c).

(3) The plan contract is approved by the director.

(b) The director, in consultation with the Insurance Commissioner, shall prepare a disclosure form prior to July 1, 2010, that is easily understood and that summarizes the benefits a health care service plan is required to include in its health care service plan contract under this chapter.

(c) Before a health care service plan contract described in subdivision (a) may be issued, the individual shall sign the disclosure form described in subdivision (b), specifying the benefits he or she is waiving and indicating that the plan has explained the

1 contents of the disclosure and that he or she understands those
2 contents.

3 ~~SEC. 19.~~

4 *SEC. 20.* Section 699.6 is added to the Insurance Code, to read:

5 699.6. (a) Notwithstanding any other provision of law, a carrier
6 domiciled in another state is exempt from Section 700, if it meets
7 the following criteria:

8 (1) It offers, sells, or renews a health insurance policy in this
9 state that complies with all of the requirements of the domiciliary
10 state applicable to the policy.

11 (2) It is authorized to issue the policy in the state where it is
12 domiciled and to transact business there.

13 (b) Notwithstanding any other provision of law, a health
14 insurance policy offered, sold, or renewed in this state by a carrier
15 that satisfies the criteria of subdivision (a) is exempt from all other
16 provisions of this code.

17 ~~SEC. 20.~~

18 *SEC. 21.* Section 10121.7 of the Insurance Code is amended
19 to read:

20 10121.7. (a) A policy of group health insurance that provides
21 hospital, medical, or surgical expense benefits shall provide equal
22 coverage to employers, guaranteed associations, or eligible
23 associations, as defined in Section 10700, for the registered
24 domestic partner of an employee, insured, or policyholder to the
25 same extent, and subject to the same terms and conditions, as
26 provided to a spouse of the employee, insured, or policyholder,
27 and shall inform employers, guaranteed associations, and eligible
28 associations of this coverage. A policy may not offer or provide
29 coverage for a registered domestic partner that is not equal to the
30 coverage provided to the spouse of an employee, insured, or
31 policyholder.

32 (b) If an employer, guaranteed association, or eligible association
33 has purchased coverage for spouses and registered domestic
34 partners pursuant to subdivision (a), a health insurer that provides
35 hospital, medical, or surgical expense benefits for employees,
36 insureds, or policyholders and their spouses shall enroll, upon
37 application by the employer or group administrator, a registered
38 domestic partner of the employee, insured, or policyholder in
39 accordance with the terms and conditions of the group contract

1 that apply generally to all spouses under the policy, including
2 coordination of benefits.

3 (c) For purposes of this section, the term “domestic partner”
4 shall have the same meaning as that term is used in Section 297
5 of the Family Code.

6 (d) (1) A policy of group health insurance may require that the
7 employee, insured, or policyholder verify the status of the domestic
8 partnership by providing to the insurer a copy of a valid Declaration
9 of Domestic Partnership filed with the Secretary of State pursuant
10 to Section 298 of the Family Code or an equivalent document
11 issued by a local agency of this state, another state, or a local
12 agency of another state under which the partnership was created.
13 The policy may also require that the employee, insured, or
14 policyholder notify the insurer upon the termination of the domestic
15 partnership.

16 (2) Notwithstanding paragraph (1), a policy may require the
17 information described in that paragraph only if it also requests
18 from the employee, insured, or policyholder whose spouse is
19 provided coverage, verification of marital status and notification
20 of dissolution of the marriage.

21 (e) Nothing in this section shall be construed to expand the
22 requirements of Section 4980B of Title 26 of the United States
23 Code, Section 1161, and following, of Title 29 of the United States
24 Code, or Section 300bb-1, and following, of Title 42 of the United
25 States Code, as added by the Consolidated Omnibus Budget
26 Reconciliation Act of 1985 (Public Law 99-272), and as those
27 provisions may be later amended.

28 (f) A group health insurance policy subject to this section that
29 is issued, amended, delivered, or renewed in this state on or after
30 January 2, 2005, shall be deemed to provide coverage for registered
31 domestic partners that is equal to the coverage provided to a spouse
32 of an employee, insured, or policyholder.

33 ~~SEC. 21.~~

34 SEC. 22. Section 10123.56 is added to the Insurance Code, to
35 read:

36 10123.56. (a) Every policy of health insurance, except for a
37 Medicare supplement policy, that covers hospital, medical, or
38 surgical expenses on a group basis may offer to include a Healthy
39 Action Incentives and Rewards Program, as described in
40 subdivision (b), to be implemented in connection with a health

1 insurance policy, under such terms and conditions as may be agreed
2 upon between the group policyholder and the health insurer. Every
3 insurer that offers a Healthy Action Incentives and Rewards
4 Program shall communicate the availability of that program to all
5 prospective group policyholders with whom it is negotiating and
6 to existing group policyholders upon renewal.

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

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

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

20 (3) Incentives or rewards for policyholders to become more
21 engaged in their health care and to make appropriate choices that
22 support good health, including obtaining health risk appraisals,
23 screening services, immunizations, or participating in healthy
24 lifestyle programs and practices. These programs and practices
25 may include, but need not be limited to, smoking cessation,
26 physical activity, or nutrition. Incentives may include, but need
27 not be limited to, health premium reductions, differential
28 copayment or coinsurance amounts, and cash payments. Rewards
29 may include, but need not be limited to, nonprescription pharmacy
30 products or services not otherwise covered under a policyholder's
31 health insurance policy, exercise classes, gym memberships, and
32 weight management programs.

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

37 ~~SEC. 22.~~

38 *SEC. 23.* Section 10123.135 of the Insurance Code is amended
39 to read:

10123.135. (a) Every disability insurer, or an entity with which it contracts for services that include utilization review or utilization management functions, that covers hospital, medical, or surgical expenses and that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A disability insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for insureds. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to subdivision (f). These policies and procedures, and a description of the process by which an insurer, or an entity with which an insurer contracts for services that include utilization review or utilization management functions, reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed by the insurer to insureds and providers upon request, and by the insurer to the public upon request.

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or the Osteopathic Initiative Act, or the insurer may employ a clinical director licensed in California whose scope of practice under

1 California law includes the right to independently perform all those
2 services covered by the insurer. The medical director or clinical
3 director shall ensure that the process by which the insurer reviews
4 and approves, modifies, delays, or denies, based in whole or in
5 part on medical necessity, requests by providers prior to,
6 retrospectively, or concurrent with the provision of health care
7 services to insureds, complies with the requirements of this section.
8 Nothing in this subdivision shall be construed as restricting the
9 existing authority of the Medical Board of California.

10 (d) If an insurer subject to this section, or individuals under
11 contract to the insurer to review requests by providers, approve
12 the provider's request pursuant to subdivision (b), the decision
13 shall be communicated to the provider pursuant to subdivision (h).

14 (e) (1) An individual, other than a person licensed to practice
15 medicine pursuant to Section 2050 of the Business and Professions
16 Code or pursuant to the Osteopathic Act, or a licensed health care
17 professional acting within the limitations of paragraph (2), may
18 not deny or modify requests for authorization of health care
19 services for an insured for reasons of medical necessity.

20 (2) A licensed health care professional, other than a person
21 licensed to practice medicine pursuant to Section 2050 of the
22 Business and Professions Code or pursuant to the Osteopathic Act,
23 may deny or modify requests for authorization of health care
24 services for an insured for reasons of medical necessity only with
25 respect to services that fall within his or her scope of practice. That
26 professional's review shall also be subject to standardized protocol
27 limitations or supervision requirements applicable under his or her
28 license.

29 (3) The physician or other health care professional described in
30 this subdivision shall not deny or modify a request for authorization
31 of a health care service for an insured for reasons of medical
32 necessity without first conducting a good faith examination of the
33 insured. This good faith examination shall not be required if the
34 insured's policy explicitly excludes coverage of the health care
35 service in question.

36 (4) The decision of the physician or other health care provider
37 described in this subdivision shall be communicated to the provider
38 and the insured pursuant to subdivision (h).

39 (f) (1) An insurer shall disclose, or provide for the disclosure,
40 to the commissioner and to network providers, the process the

insurer, its contracting provider groups, or any entity with which it contracts for services that include utilization review or utilization management functions, uses to authorize, delay, modify, or deny health care services under the benefits provided by the insurance contract, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. An insurer shall also disclose those processes to policyholders or persons designated by a policyholder, or to any other person or organization, upon request.

(2) The criteria or guidelines used by an insurer, or an entity with which an insurer contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services, shall comply with all of the following:

(A) Be developed with involvement from actively practicing health care providers.

(B) Be consistent with sound clinical principles and processes.

(C) Be evaluated, and updated if necessary, at least annually.

(D) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the policyholder in that specified case.

(E) Be available to the public upon request. An insurer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An insurer may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph that are limited to copying and postage costs. The insurer may also make the criteria or guidelines available through electronic communication means.

(3) The disclosure required by subparagraph (E) of paragraph (2) shall be accompanied by the following notice: “The materials provided to you are guidelines used by this insurer to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your insurance contract.”

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer

1 shall request only the information reasonably necessary to make
2 the determination.

3 (h) In determining whether to approve, modify, or deny requests
4 by providers prior to, retrospectively, or concurrent with the
5 provision of health care services to insureds, based in whole or in
6 part on medical necessity, every insurer subject to this section shall
7 meet the following requirements:

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

27 (2) When the insured's condition is such that the insured 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 insured's
32 life or health or could jeopardize the insured'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 insureds shall be made in a timely fashion,
36 appropriate for the nature of the insured's condition, but not to
37 exceed 72 hours after the insurer's receipt of the information
38 reasonably necessary and requested by the insurer to make the
39 determination, including, but not limited to, information from the
40 good faith examination conducted pursuant to subdivision (e).

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

15 (4) Communications regarding decisions to approve requests
16 by providers prior to, retrospectively, or concurrent with the
17 provision of health care services to insureds shall specify the
18 specific health care service approved. Responses regarding
19 decisions to deny, delay, or modify health care services requested
20 by providers prior to, retrospectively, or concurrent with the
21 provision of health care services to insureds shall be communicated
22 to insureds in writing, and to providers initially by telephone or
23 facsimile, except with regard to decisions rendered retrospectively,
24 and then in writing, and shall include a clear and concise
25 explanation of the reasons for the insurer's decision, a description
26 of the criteria or guidelines used, and the clinical reasons for the
27 decisions regarding medical necessity. Any written communication
28 to a physician or other health care provider of a denial, delay, or
29 modification or a request shall include the name and telephone
30 number of the health care professional responsible for the denial,
31 delay, or modification. The telephone number provided shall be a
32 direct number or an extension, to allow the physician or health
33 care provider easily to contact the professional responsible for the
34 denial, delay, or modification. Responses shall also include
35 information as to how the provider or the insured may file an appeal
36 with the insurer or seek department review under the unfair
37 practices provisions of Article 6.5 (commencing with Section 790)
38 of Chapter 1 of Part 2 of Division 1 and the regulations adopted
39 thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, including, but not limited to, information from the good faith examination conducted pursuant to subdivision (e), or because the insurer requires consultation by an expert reviewer, or because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The insurer shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the commissioner determines that an insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the commissioner may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed an exclusive remedy for the commissioner. These penalties shall be paid to the Insurance Fund.

(i) Every insurer subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil

1 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
2 Code of Civil Procedure.

3 *SEC. 24. Section 10123.136 is added to the Insurance Code,*
4 *to read:*

5 *10123.136. For purposes of this code, with respect to a policy*
6 *of health insurance, a service is “medically necessary” or a*
7 *“medical necessity” when it is reasonable and necessary to protect*
8 *life, to prevent significant illness or significant disability, or to*
9 *alleviate severe pain.*

10 ~~SEC. 23.~~

11 *SEC. 25. Section 10169.2 of the Insurance Code is amended*
12 *to read:*

13 10169.2. (a) The department shall contract with one or more
14 independent medical review organizations in the state to conduct
15 reviews for purposes of this article. The independent medical
16 review organizations shall be independent of any disability insurer
17 doing business in this state. The commissioner may establish
18 additional requirements, including conflict-of-interest standards,
19 consistent with the purposes of this article, that an organization
20 shall be required to meet in order to qualify for participation in the
21 Independent Medical Review System and to assist the department
22 in carrying out its responsibilities.

23 (b) The independent medical review organizations and the
24 medical professionals retained to conduct reviews shall be deemed
25 to be medical consultants for purposes of Section 43.98 of the Civil
26 Code.

27 (c) The independent medical review organization, any experts
28 it designates to conduct a review, or any officer, director, or
29 employee of the independent medical review organization shall
30 not have any material professional, familial, or financial affiliation,
31 as determined by the commissioner, with any of the following:

32 (1) The insurer.

33 (2) Any officer, director, or employee of the insurer.

34 (3) A physician, the physician’s medical group, or the
35 independent practice association involved in the health care service
36 in dispute.

37 (4) The facility or institution at which either the proposed health
38 care service, or the alternative service, if any, recommended by
39 the insurer, would be provided.

1 (5) The development or manufacture of the principal drug,
2 device, procedure, or other therapy proposed by the insured whose
3 treatment is under review, or the alternative therapy, if any,
4 recommended by the insurer.

5 (6) The insured or the insured's immediate family.

6 (d) In order to contract with the department for purposes of this
7 article, an independent medical review organization shall meet all
8 of the following requirements:

9 (1) The organization shall not be an affiliate or a subsidiary of,
10 nor in any way be owned or controlled by, a disability insurer or
11 a trade association of insurers. A board member, director, officer,
12 or employee of the independent medical review organization shall
13 not serve as a board member, director, or employee of a disability
14 insurer. A board member, director, or officer of a disability insurer
15 or a trade association of insurers shall not serve as a board member,
16 director, officer, or employee of an independent medical review
17 organization.

18 (2) The organization shall submit to the department the
19 following information upon initial application to contract for
20 purposes of this article and, except as otherwise provided, annually
21 thereafter upon any change to any of the following information:

22 (A) The names of all stockholders and owners of more than 5
23 percent of any stock or options, if a publicly held organization.

24 (B) The names of all holders of bonds or notes in excess of one
25 hundred thousand dollars (\$100,000), if any.

26 (C) The names of all corporations and organizations that the
27 independent medical review organization controls or is affiliated
28 with, and the nature and extent of any ownership or control,
29 including the affiliated organization's type of business.

30 (D) The names and biographical sketches of all directors,
31 officers, and executives of the independent medical review
32 organization, as well as a statement regarding any past or present
33 relationships the directors, officers, and executives may have with
34 any health care service plan, disability insurer, managed care
35 organization, provider group, or board or committee of an insurer,
36 a plan, a managed care organization, or a provider group.

37 (E) (i) The percentage of revenue the independent medical
38 review organization receives from expert reviews, including, but
39 not limited to, external medical reviews, quality assurance reviews,
40 and utilization reviews.

1 (ii) The names of any insurer or provider group for which the
2 independent medical review organization provides review services,
3 including, but not limited to, utilization review, quality assurance
4 review, and external medical review. Any change in this
5 information shall be reported to the department within five business
6 days of the change.

7 (F) A description of the review process including, but not limited
8 to, the method of selecting expert reviewers and matching the
9 expert reviewers to specific cases.

10 (G) A description of the system the independent medical review
11 organization uses to identify and recruit medical professionals to
12 review treatment and treatment recommendation decisions, the
13 number of medical professionals credentialed, and the types of
14 cases and areas of expertise that the medical professionals are
15 credentialed to review.

16 (H) A description of how the independent medical review
17 organization ensures compliance with the conflict-of-interest
18 provisions of this section.

19 (3) The organization shall demonstrate that it has a quality
20 assurance mechanism in place that does the following:

21 (A) Ensures that the medical professionals retained are
22 appropriately credentialed and privileged.

23 (B) Ensures that the reviews provided by the medical
24 professionals are timely, clear, and credible, and that reviews are
25 monitored for quality on an ongoing basis.

26 (C) Ensures that the method of selecting medical professionals
27 for individual cases achieves a fair and impartial panel of medical
28 professionals who are qualified to render recommendations
29 regarding the clinical conditions and the medical necessity of
30 treatments or therapies in question.

31 (D) Ensures the confidentiality of medical records and the
32 review materials, consistent with the requirements of this section
33 and applicable state and federal law.

34 (E) Ensures the independence of the medical professionals
35 retained to perform the reviews through conflict-of-interest policies
36 and prohibitions, and ensures adequate screening for
37 conflicts-of-interest, pursuant to paragraph (5).

38 (4) Medical professionals selected by independent medical
39 review organizations to review medical treatment decisions shall

1 be physicians or other appropriate providers who meet the
2 following minimum requirements:

3 (A) The medical professional shall be a clinician knowledgeable
4 in the treatment of the insured's medical condition, knowledgeable
5 about the proposed treatment, and familiar with guidelines and
6 protocols in the area of treatment under review. Review by a
7 medical professional, other than a physician licensed to practice
8 medicine pursuant to Section 2050 of the Business and Professions
9 Code or pursuant to the Osteopathic Act, shall be limited to services
10 that fall within that professional's scope of practice and shall be
11 subject to standardized protocol limitations or supervision
12 requirements applicable under his or her license.

13 (B) Notwithstanding any other provision of law, the medical
14 professional shall hold a nonrestricted California license, and for
15 physicians, a current license to practice medicine pursuant to
16 Section 2050 of the Business and Professions Code or pursuant to
17 the Osteopathic Act.

18 (C) The medical professional shall have no history of
19 disciplinary action or sanctions, including, but not limited to, loss
20 of staff privileges or participation restrictions, taken or pending
21 by any hospital, government, or regulatory body.

22 (5) Neither the expert reviewer, nor the independent medical
23 review organization, shall have any material professional, material
24 familial, or material financial affiliation with any of the following:

25 (A) The disability insurer or a provider group of the insurer,
26 except that an academic medical center under contract to the insurer
27 to provide services to insureds may qualify as an independent
28 medical review organization provided it will not provide the service
29 and provided the center is not the developer or manufacturer of
30 the proposed treatment.

31 (B) Any officer, director, or management employee of the
32 insurer.

33 (C) The physician, the physician's medical group, or the
34 independent practice association (IPA) proposing the treatment.

35 (D) The institution at which the treatment would be provided.

36 (E) The development or manufacture of the treatment proposed
37 for the insured whose condition is under review.

38 (F) The insured or the insured's immediate family.

39 (6) For purposes of this section, the following terms shall have
40 the following meanings:

1 (A) “Material familial affiliation” means any relationship as a
2 spouse, child, parent, sibling, spouse’s parent, or child’s spouse.

3 (B) “Material professional affiliation” means any
4 physician-patient relationship, any partnership or employment
5 relationship, a shareholder or similar ownership interest in a
6 professional corporation, or any independent contractor
7 arrangement that constitutes a material financial affiliation with
8 any expert or any officer or director of the independent medical
9 review organization. “Material professional affiliation” does not
10 include affiliations that are limited to staff privileges at a health
11 facility.

12 (C) “Material financial affiliation” means any financial interest
13 of more than 5 percent of total annual revenue or total annual
14 income of an independent medical review organization or
15 individual to which this subdivision applies. “Material financial
16 affiliation” does not include payment by the insurer to the
17 independent medical review organization for the services required
18 by this section, nor does “material financial affiliation” include an
19 expert’s participation as a contracting provider where the expert
20 is affiliated with an academic medical center or a National Cancer
21 Institute-designated clinical cancer research center.

22 (e) The department shall provide, upon the request of any
23 interested person, a copy of all nonproprietary information, as
24 determined by the commissioner, filed with it by an independent
25 medical review organization seeking to contract under this article.
26 The department may charge a nominal fee to the interested person
27 for photocopying the requested information.

28 (f) The commissioner may contract with the Department of
29 Managed Health Care to administer the independent medical review
30 process established by this article.

31 ~~SEC. 24.~~

32 *SEC. 26.* Section 10169.3 of the Insurance Code is amended
33 to read:

34 10169.3. (a) Upon receipt of information and documents
35 related to a case, the medical professional reviewer or reviewers
36 selected to conduct the review by the independent medical review
37 organization shall promptly review all pertinent medical records
38 of the insured, provider reports, as well as any other information
39 submitted to the organization as authorized by the department or
40 requested from any of the parties to the dispute by the reviewers.

1 If reviewers request information from any of the parties, a copy
2 of the request and the response shall be provided to all of the
3 parties. The reviewer or reviewers shall also review relevant
4 information related to the criteria set forth in subdivision (b). In
5 addition, at least one medical professional reviewer selected to
6 conduct the review shall conduct a good faith examination of the
7 insured. This good faith examination shall not be required if the
8 insured's policy explicitly excludes coverage of the disputed health
9 care service.

10 (b) Following its review, the reviewer or reviewers shall
11 determine whether the disputed health care service was medically
12 necessary based on the specific medical needs of the insured and
13 any of the following:

14 ~~(A)~~

15 (1) Peer-reviewed scientific and medical evidence regarding
16 the effectiveness of the disputed service.

17 ~~(B)~~

18 (2) Nationally recognized professional standards.

19 ~~(C)~~

20 (3) Expert opinion.

21 ~~(D)~~

22 (4) Generally accepted standards of medical practice.

23 ~~(E)~~

24 (5) Treatments that are likely to provide a benefit to a patient
25 for conditions for which other treatments are not clinically
26 efficacious.

27 (c) The organization shall complete its review and make its
28 determination in writing, and in layperson's terms to the maximum
29 extent practicable, within 30 days of the receipt of the application
30 for review and supporting documentation, including, but not limited
31 to, information from the good faith examination conducted pursuant
32 to subdivision (a), or within less time as prescribed by the
33 commissioner. If the disputed health care service has not been
34 provided and the insured's provider or the department certifies in
35 writing that an imminent and serious threat to the health of the
36 insured may exist, including, but not limited to, serious pain, the
37 potential loss of life, limb, or major bodily function, or the
38 immediate and serious deterioration of the health of the insured,
39 the analyses and determinations of the reviewers shall be expedited
40 and rendered within three days of the receipt of the information,

1 including, but not limited to, information from the good faith
2 examination conducted pursuant to subdivision (a). Subject to the
3 approval of the department, the deadlines for analyses and
4 determinations involving both regular and expedited reviews may
5 be extended by the commissioner for up to three days in
6 extraordinary circumstances or for good cause.

7 (d) The medical professionals' analyses and determinations
8 shall state whether the disputed health care service is medically
9 necessary. Each analysis shall cite the insured's medical condition,
10 the relevant documents in the record, the relevant results of the
11 good faith examination, and the relevant findings associated with
12 the provisions of subdivision (b) to support the determination. If
13 more than one medical professional reviews the case, the
14 recommendation of the majority shall prevail. If the medical
15 professionals reviewing the case are evenly split as to whether the
16 disputed health care service should be provided, the decision shall
17 be in favor of providing the service.

18 (e) The independent medical review organization shall provide
19 the director, the insurer, the insured, and the insured's provider
20 with the analyses and determinations of the medical professionals
21 reviewing the case, and a description of the qualifications of the
22 medical professionals. The independent medical review
23 organization shall keep the names of the reviewers confidential in
24 all communications with entities or individuals outside the
25 independent medical review organization, except in cases where
26 the reviewer is called to testify and in response to court orders. If
27 more than one medical professional reviewed the case and the
28 result was differing determinations, the independent medical review
29 organization shall provide each of the separate reviewer's analyses
30 and determinations.

31 (f) The commissioner shall immediately adopt the determination
32 of the independent medical review organization, and shall promptly
33 issue a written decision to the parties that shall be binding on the
34 insurer.

35 (g) After removing the names of the parties, including, but not
36 limited to, the insured, all medical providers, the insurer, and any
37 of the insurer's employees or contractors, commissioner decisions
38 adopting a determination of an independent medical review
39 organization shall be made available by the department to the
40 public upon request, at the department's cost and after considering

1 applicable laws governing disclosure of public records,
2 confidentiality, and personal privacy.

3 ~~SEC. 25.~~

4 *SEC. 27.* Section 10700 of the Insurance Code is amended to
5 read:

6 10700. As used in this chapter:

7 (a) “Agent or broker” means a person or entity licensed under
8 Chapter 5 (commencing with Section 1621) of Part 2 of Division
9 1.

10 (b) “Benefit plan design” means a specific health coverage
11 product issued by a carrier to small employers, to trustees of
12 associations that include small employers, or to individuals if the
13 coverage is offered through employment or sponsored by an
14 employer. It includes services covered and the levels of copayment
15 and deductibles, and it may include the professional providers who
16 are to provide those services and the sites where those services are
17 to be provided. A benefit plan design may also be an integrated
18 system for the financing and delivery of quality health care services
19 which has significant incentives for the covered individuals to use
20 the system.

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

22 (d) “Carrier” means any disability insurance company or any
23 other entity that writes, issues, or administers health benefit plans
24 that cover the employees of small employers, regardless of the
25 situs of the contract or master policyholder. For the purposes of
26 Articles 3 (commencing with Section 10719) and 4 (commencing
27 with Section 10730), “carrier” also includes health care service
28 plans.

29 (e) “Dependent” means the spouse or child of an eligible
30 employee, subject to applicable terms of the health benefit plan
31 covering the employee, and includes dependents of guaranteed
32 association members and dependents of eligible association
33 members if the association elects to include dependents under its
34 health coverage at the same time it determines its membership
35 composition pursuant to subdivision (z).

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

37 (1) Any permanent employee who is actively engaged on a
38 full-time basis in the conduct of the business of the small employer
39 with a normal workweek of at least 30 hours, in the small
40 employer’s regular place of business, who has met any statutorily

1 authorized applicable waiting period requirements. The term
2 includes sole proprietors or partners of a partnership, if they are
3 actively engaged on a full-time basis in the small employer's
4 business, and they are included as employees under a health benefit
5 plan of a small employer, but does not include employees who
6 work on a part-time, temporary, or substitute basis. It includes any
7 eligible employee as defined in this paragraph who obtains
8 coverage through a guaranteed association or an eligible
9 association. Employees of employers purchasing through a
10 guaranteed association or an eligible association shall be deemed
11 to be eligible employees if they would otherwise meet the definition
12 except for the number of persons employed by the employer. A
13 permanent employee who works at least 20 hours but not more
14 than 29 hours is deemed to be an eligible employee if all four of
15 the following apply:

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

18 (B) The employer offers the employee health coverage under a
19 health benefit plan.

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

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

28 (2) Any member of a guaranteed association or member of an
29 eligible association as defined in subdivision (z).

30 (g) "Enrollee" means an eligible employee or dependent who
31 receives health coverage through the program from a participating
32 carrier.

33 (h) "Financially impaired" means, for the purposes of this
34 chapter, a carrier that, on or after the effective date of this chapter,
35 is not insolvent and is either:

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

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

40 (i) "Fund" means the California Small Group Reinsurance Fund.

1 (j) “Health benefit plan” means a policy or contract written or
2 administered by a carrier that arranges or provides health care
3 benefits for the covered eligible employees of a small employer
4 and their dependents. The term does not include accident only,
5 credit, disability income, coverage of Medicare services pursuant
6 to contracts with the United States government, Medicare
7 supplement, long-term care insurance, dental, vision, coverage
8 issued as a supplement to liability insurance, automobile medical
9 payment insurance, or insurance under which benefits are payable
10 with or without regard to fault and that is statutorily required to
11 be contained in any liability insurance policy or equivalent
12 self-insurance.

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

15 (l) “Late enrollee” means an eligible employee or dependent
16 who has declined health coverage under a health benefit plan
17 offered by a small employer at the time of the initial enrollment
18 period provided under the terms of the health benefit plan, and
19 who subsequently requests enrollment in a health benefit plan of
20 that small employer, provided that the initial enrollment period
21 shall be a period of at least 30 days. It also means any member of
22 an association that is a guaranteed association or an eligible
23 association as well as any other person eligible to purchase through
24 the guaranteed association or eligible association when that person
25 has failed to purchase coverage during the initial enrollment period
26 provided under the terms of the guaranteed association’s or eligible
27 association’s health benefit plan and who subsequently requests
28 enrollment in the plan, provided that the initial enrollment period
29 shall be a period of at least 30 days. However, an eligible
30 employee, another person eligible for coverage through a
31 guaranteed association or an eligible association pursuant to
32 subdivision (z), or an eligible dependent shall not be considered
33 a late enrollee if any of the following is applicable:

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

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

38 (B) He or she certified at the time of the initial enrollment that
39 coverage under another employer health benefit plan, the Healthy
40 Families Program, or no share-of-cost Medi-Cal coverage was the

1 reason for declining enrollment provided that, if the individual
2 was covered under another employer health plan, the individual
3 was given the opportunity to make the certification required by
4 this subdivision and was notified that failure to do so could result
5 in later treatment as a late enrollee.

6 (C) He or she has lost or will lose coverage under another
7 employer health benefit plan as a result of termination of
8 employment of the individual or of a person through whom the
9 individual was covered as a dependent, change in employment
10 status of the individual, or of a person through whom the individual
11 was covered as a dependent, the termination of the other plan's
12 coverage, cessation of an employer's contribution toward an
13 employee or dependent's coverage, death of the person through
14 whom the individual was covered as a dependent, legal separation,
15 divorce, loss of coverage under the Healthy Families Program as
16 a result of exceeding the program's income or age limits, or loss
17 of no share-of-cost Medi-Cal coverage.

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

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

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

26 (4) (A) In the case of an eligible employee as defined in
27 paragraph (1) of subdivision (f), the carrier cannot produce a
28 written statement from the employer stating that the individual or
29 the person through whom an individual was eligible to be covered
30 as a dependent, prior to declining coverage, was provided with,
31 and signed acknowledgment of, an explicit written notice in
32 boldface type specifying that failure to elect coverage during the
33 initial enrollment period permits the carrier to impose, at the time
34 of the individual's later decision to elect coverage, an exclusion
35 from coverage for a period of 12 months as well as a six-month
36 preexisting condition exclusion unless the individual meets the
37 criteria specified in paragraph (1), (2), or (3).

38 (B) In the case of an eligible employee who is a guaranteed
39 association member or an eligible association member, the plan
40 cannot produce a written statement from the guaranteed association

1 or eligible association stating that the association sent a written
2 notice in boldface type to all potentially eligible members of the
3 association at their last known address prior to the initial enrollment
4 period informing members that failure to elect coverage during
5 the initial enrollment period permits the plan to impose, at the time
6 of the member's later decision to elect coverage, an exclusion from
7 coverage for a period of 12 months as well as a six-month
8 preexisting condition exclusion unless the member can demonstrate
9 that he or she meets the requirements of subparagraphs (A), (C),
10 and (D) of paragraph (1) or meets the requirements of paragraph
11 (2) or (3).

12 (C) In the case of an employer or person who is not a member
13 of an association, was eligible to purchase coverage through a
14 guaranteed association or eligible association, and did not do so,
15 and would not be eligible to purchase guaranteed coverage unless
16 purchased through a guaranteed association or eligible association,
17 the employer or person can demonstrate that he or she meets the
18 requirements of subparagraphs (A), (C), and (D) of paragraph (1),
19 or meets the requirements of paragraph (2) or (3), or that he or she
20 recently had a change in status that would make him or her eligible
21 and that application for coverage was made within 30 days of the
22 change.

23 (5) The individual is an employee or dependent who meets the
24 criteria described in paragraph (1) and was under a COBRA
25 continuation provision and the coverage under that provision has
26 been exhausted. For purposes of this section, the definition of
27 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
28 apply.

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

35 (7) The individual is an eligible employee who previously
36 declined coverage under an employer health benefit plan and who
37 has subsequently acquired a dependent who would be eligible for
38 coverage as a dependent of the employee through marriage, birth,
39 adoption, or placement for adoption, and who enrolls for coverage
40 under that employer health benefit plan on his or her behalf, and

on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

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

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

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

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

(q) “Preexisting condition provision” means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured’s effective date of coverage, as to a condition for which medical advice, diagnosis, care, or

1 treatment was recommended or received during a specified period
2 immediately preceding the effective date of coverage.

3 (r) “Creditable coverage” means:

4 (1) Any individual or group policy, contract, or program, that
5 is written or administered by a disability insurer, health care service
6 plan, fraternal benefits society, self-insured employer plan, or any
7 other entity, in this state or elsewhere, and that arranges or provides
8 medical, hospital, and surgical coverage not designed to supplement
9 other private or governmental plans. The term includes continuation
10 or conversion coverage but does not include accident only, credit,
11 coverage for onsite medical clinics, disability income, Medicare
12 supplement, long-term care, dental, vision, coverage issued as a
13 supplement to liability insurance, insurance arising out of a
14 workers’ compensation or similar law, automobile medical payment
15 insurance, or insurance under which benefits are payable with or
16 without regard to fault and that is statutorily required to be
17 contained in any liability insurance policy or equivalent
18 self-insurance.

19 (2) The federal Medicare Program pursuant to Title XVIII of
20 the Social Security Act.

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

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

25 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
26 (Civilian Health and Medical Program of the Uniformed Services
27 (CHAMPUS)).

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

30 (7) A state health benefits risk pool.

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

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

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

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

(s) “Rating period” means the period for which premium rates established by a carrier are in effect and shall be no less than six months.

(t) “Risk adjusted employee risk rate” means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(u) “Risk adjustment factor” means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(v) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

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

Under 30

30–39

40–49

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 benefit plan will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act.

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

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

1 (3) (A) In determining rates for small employers, a carrier that
2 operates statewide shall use no more than nine geographic regions
3 in the state, have no region smaller than an area in which the first
4 three digits of all its ZIP Codes are in common within a county
5 and shall divide no county into more than two regions. Carriers
6 shall be deemed to be operating statewide if their coverage area
7 includes 90 percent or more of the state's population. Geographic
8 regions established pursuant to this section shall, as a group, cover
9 the entire state, and the area encompassed in a geographic region
10 shall be separate and distinct from areas encompassed in other
11 geographic regions. Geographic regions may be noncontiguous.

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

27 (w) "Small employer" means any of the following:

28 (1) Any person, proprietary or nonprofit firm, corporation,
29 partnership, public agency, or association that is actively engaged
30 in business or service that, on at least 50 percent of its working
31 days during the preceding calendar quarter, or preceding calendar
32 year, employed at least two, but not more than 50, eligible
33 employees, the majority of whom were employed within this state,
34 that was not formed primarily for purposes of buying health
35 insurance and in which a bona fide employer-employee relationship
36 exists. In determining whether to apply the calendar quarter or
37 calendar year test, the insurer shall use the test that ensures
38 eligibility if only one test would establish eligibility. However,
39 for purposes of subdivisions (b) and (h) of Section 10705, the
40 definition shall include employers with at least three eligible

employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply until the health benefit plan anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association or an eligible association, and any employer purchasing coverage for employees through a guaranteed association or an eligible association.

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

(3) Any eligible association, as defined in subdivision (ab), that purchases health coverage for members of the association.

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

(y) “Guaranteed association” means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (6) offers any benefit plan design that is purchased to all individual members and employer members in this state, (7) includes any member

1 choosing to enroll in the benefit plan design offered to the
2 association provided that the member has agreed to make the
3 required premium payments, and (8) covers at least 100 persons
4 with the carrier with which it contracts. The requirement of 100
5 persons may be met if component chapters of a statewide
6 association contracting separately with the same carrier cover at
7 least 100 persons in the aggregate.

8 This subdivision applies regardless of whether a master policy
9 by an admitted insurer is delivered directly to the association or a
10 trust formed for or sponsored by an association to administer
11 benefits for association members.

12 (z) “Members of a guaranteed association” or “members of an
13 eligible association” means any individual or employer meeting
14 the association’s membership criteria if that person is a member
15 of the association and chooses to purchase health coverage through
16 the association. At the association’s discretion, it may also include
17 employees of association members, association staff, retired
18 members, retired employees of members, and surviving spouses
19 and dependents of deceased members. However, if an association
20 chooses to include those persons as members of the guaranteed
21 association or members of the eligible association, the association
22 must so elect in advance of purchasing coverage from a plan.
23 Health plans may require an association to adhere to the
24 membership composition it selects for up to 12 months.

25 (aa) “Affiliation period” means a period that, under the terms
26 of the health benefit plan, must expire before health care services
27 under the plan become effective.

28 (ab) “Eligible association” means a community or civic group
29 or a charitable or religious organization.

30 ~~SEC. 26.~~

31 *SEC. 28.* Section 10705 of the Insurance Code is amended to
32 read:

33 10705. (a) No group or individual policy or contract or
34 certificate of group insurance or statement of group coverage
35 providing benefits to employees of small employers as defined in
36 this chapter shall be issued or delivered by a carrier subject to the
37 jurisdiction of the commissioner regardless of the situs of the
38 contract or master policyholder or of the domicile of the carrier
39 nor, except as otherwise provided in Sections 10270.91 and
40 10270.92, shall a carrier provide coverage subject to this chapter

1 until a copy of the form of the policy, contract, certificate, or
2 statement of coverage is filed with and approved by the
3 commissioner in accordance with Sections 10290 and 10291, and
4 the carrier has complied with the requirements of Section 10717.

5 (b) Each carrier, except a self-funded employer, shall fairly and
6 affirmatively offer, market, and sell all of the carrier's benefit plan
7 designs that are sold to, offered through, or sponsored by, small
8 employers or associations that include small employers to all small
9 employers in each geographic region in which the carrier makes
10 coverage available or provides benefits, regardless of the
11 employer's implementation of, or intent to implement, any form
12 of claim or benefit support to covered employees. A carrier
13 contracting to participate in the Voluntary Alliance Uniting
14 Employers Purchasing Program shall be deemed to be in
15 compliance with this requirement for a benefit plan design offered
16 through the program in those geographic regions in which the
17 carrier participates in the program and the benefit plan design is
18 offered exclusively through the program.

19 (1) Nothing in this section shall be construed to require an
20 association, or a trust established and maintained by an association
21 to receive a master insurance policy issued by an admitted insurer
22 and to administer the benefits thereof solely for association
23 members, to offer, market or sell a benefit plan design to those
24 who are not members of the association. However, if the
25 association markets, offers or sells a benefit plan design to those
26 who are not members of the association it is subject to the
27 requirements of this section. This shall apply to an association that
28 otherwise meets the requirements of paragraph (5).

29 (2) A carrier which (A) effective January 1, 1992, and at least
30 20 years prior to that date, markets, offers, or sells benefit plan
31 designs only to all members of one association and (B) does not
32 market, offer or sell any other individual, selected group, or group
33 policy or contract providing medical, hospital and surgical benefits
34 shall not be required to market, offer, or sell to those who are not
35 members of the association. However, if the carrier markets, offers
36 or sells any benefit plan design or any other individual, selected
37 group, or group policy or contract providing medical, hospital and
38 surgical benefits to those who are not members of the association
39 it is subject to the requirements of this section.

(3) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (2) shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (2) and which, for the one association, lists all the information required by paragraph (4).

(4) Each carrier that sells health benefit plans to members of any association shall submit an annual statement to the commissioner which lists each association to which the carrier sells health benefit plans, the industry, profession, community or civic group, or charitable or religious organization which is served by the association, the association's membership criteria, a list of officers, the state in which the association is organized, and the site of its principal office.

(5) For purposes of paragraphs (1) and (2), an association is one of the following:

(A) A nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(B) A community or civic group or a charitable or religious organization that has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(c) Each carrier shall make available to each small employer all benefit plan designs that the carrier offers or sells to small employers or to associations that include small employers regardless of the employer's implementation of, or intent to implement, any form of claim or benefit support to covered

1 employees. Notwithstanding subdivision (d) of Section 10700, for
2 purposes of this subdivision, companies that are affiliated
3 companies or that are eligible to file a consolidated income tax
4 return shall be treated as one carrier.

5 (d) Each carrier shall do all of the following:

6 (1) Prepare a brochure that summarizes all of its benefit plan
7 designs and make this summary available to small employers,
8 agents and brokers upon request. The summary shall include for
9 each benefit plan design information on benefits provided, a generic
10 description of the manner in which services are provided, such as
11 how access to providers is limited, benefit limitations, required
12 copayments and deductibles, standard employee risk rates, an
13 explanation of how creditable coverage is calculated if a preexisting
14 condition or affiliation period is imposed, and a telephone number
15 that can be called for more detailed benefit information. Carriers
16 are required to keep the information contained in the brochure
17 accurate and up to date, and, upon updating the brochure, send
18 copies to agents and brokers representing the carrier. Any entity
19 that provides administrative services only with regard to a benefit
20 plan design written or issued by another carrier shall not be
21 required to prepare a summary brochure which includes that benefit
22 plan design.

23 (2) For each benefit plan design, prepare a more detailed
24 evidence of coverage and make it available to small employers,
25 agents and brokers upon request. The evidence of coverage shall
26 contain all information that a prudent buyer would need to be aware
27 of in making selections of benefit plan designs. An entity that
28 provides administrative services only with regard to a benefit plan
29 design written or issued by another carrier shall not be required to
30 prepare an evidence of coverage for that benefit plan design.

31 (3) Provide to small employers, agents, and brokers, upon
32 request, for any given small employer the sum of the standard
33 employee risk rates and the sum of the risk adjusted standard
34 employee risk rates. When requesting this information, small
35 employers, agents and brokers shall provide the carrier with the
36 information the carrier needs to determine the small employer's
37 risk adjusted employee risk rate.

38 (4) Provide copies of the current summary brochure to all agents
39 or brokers who represent the carrier and, upon updating the
40 brochure, send copies of the updated brochure to agents and brokers

1 representing the carrier for the purpose of selling health benefit
2 plans.

3 (5) Notwithstanding subdivision (d) of Section 10700, for
4 purposes of this subdivision, companies that are affiliated
5 companies or that are eligible to file a consolidated income tax
6 return shall be treated as one carrier.

7 (e) Every agent or broker representing one or more carriers for
8 the purpose of selling health benefit plans to small employers shall
9 do all of the following:

10 (1) When providing information on a health benefit plan to a
11 small employer but making no specific recommendations on
12 particular benefit plan designs:

13 (A) Advise the small employer of the carrier's obligation to sell
14 to any small employer any of the benefit plan designs it offers to
15 small employers, regardless of the employer's implementation of,
16 or intent to implement, any form of claim or benefit support to
17 covered employees, and provide them, upon request, with the
18 actual rates that would be charged to that employer for a given
19 benefit plan design.

20 (B) Notify the small employer that the agent or broker will
21 procure rate and benefit information for the small employer on
22 any benefit plan design offered by a carrier for whom the agent or
23 broker sells health benefit plans.

24 (C) Notify the small employer that, upon request, the agent or
25 broker will provide the small employer with the summary brochure
26 required in paragraph (1) of subdivision (d) for any benefit plan
27 design offered by a carrier whom the agent or broker represents.

28 (2) When recommending a particular benefit plan design or
29 designs, advise the small employer that, upon request, the agent
30 will provide the small employer with the brochure required by
31 paragraph (1) of subdivision (d) containing the benefit plan design
32 or designs being recommended by the agent or broker.

33 (3) Prior to filing an application for a small employer for a
34 particular health benefit plan:

35 (A) For each of the benefit plan designs offered by the carrier
36 whose benefit plan design the agent or broker is presenting, provide
37 the small employer with the benefit summary required in paragraph
38 (1) of subdivision (d) and the sum of the standard employee risk
39 rates for that particular employer.

1 (B) Notify the small employer that, upon request, the agent or
2 broker will provide the small employer with an evidence of
3 coverage brochure for each benefit plan design the carrier offers.

4 (C) Notify the small employer that actual rates may be 10
5 percent higher or lower than the sum of the standard employee
6 risk rates depending on how the carrier assesses the risk of the
7 small employer's group.

8 (D) Notify the small employer that, upon request, the agent or
9 broker will submit information to the carrier to ascertain the small
10 employer's sum of the risk adjusted standard employee risk rate
11 for any benefit plan design the carrier offers.

12 (E) Obtain a signed statement from the small employer
13 acknowledging that the small employer has received the disclosures
14 required by paragraph (3) of subdivision (e) and by Section 10716.

15 (f) No carrier, agent, or broker shall induce or otherwise
16 encourage a small employer to separate or otherwise exclude an
17 eligible employee from a health benefit plan which, in the case of
18 an eligible employee meeting the definition in paragraph (1) of
19 subdivision (f) of Section 10700, is provided in connection with
20 the employee's employment or which, in the case of an eligible
21 employee as defined in paragraph (2) of subdivision (f) of Section
22 10700, is provided in connection with a guaranteed association or
23 an eligible association.

24 (g) No carrier shall reject an application from a small employer
25 for a benefit plan design provided:

26 (1) The small employer as defined by paragraph (1) of
27 subdivision (w) of Section 10700 offers health benefits to 100
28 percent of its eligible employees as defined in paragraph (1) of
29 subdivision (f) of Section 10700. Employees who waive coverage
30 on the grounds that they have other group coverage shall not be
31 counted as eligible employees.

32 (2) The small employer agrees to make the required premium
33 payments.

34 (h) No carrier or agent or broker shall, directly or indirectly,
35 engage in the following activities:

36 (1) Encourage or direct small employers to refrain from filing
37 an application for coverage with a carrier because of either of the
38 following:

1 (A) The health status, claims experience, industry, occupation,
2 or geographic location within the carrier's approved service area
3 of the small employer or the small employer's employees.

4 (B) The small employer's implementation of, or intent to
5 implement, any form of claim or benefit support for its covered
6 employees through a health reimbursement arrangement, a medical
7 expense reimbursement plan, a limited purpose flexible spending
8 account, or any other form of wraparound plan or payment for any
9 portion of claims that apply to the health plan deductible or other
10 benefits.

11 (2) Encourage or direct small employers to seek coverage from
12 another carrier or the program because of either of the following:

13 (A) The health status, claims experience, industry, occupation,
14 or geographic location within the carrier's approved service area
15 of the small employer or the small employer's employees.

16 (B) The small employer's implementation of, or intent to
17 implement, any form of claim or benefit support for its covered
18 employees through a health reimbursement arrangement, a medical
19 expense reimbursement plan, a limited purpose flexible spending
20 account, or any other form of wraparound plan or payment for any
21 portion of claims that apply to the health plan deductible or other
22 benefits.

23 (i) (1) No carrier shall, directly or indirectly, enter into any
24 contract, agreement, or arrangement with an agent or broker that
25 provides for or results in the compensation paid to an agent or
26 broker for a health benefit plan to be varied because of either of
27 the following:

28 (A) The health status, claims experience, industry, occupation,
29 or geographic location of the small employer or the small
30 employer's employees.

31 (B) The small employer's implementation of, or intent to
32 implement, any form of claim or benefit support for its covered
33 employees through a health reimbursement arrangement, a medical
34 expense reimbursement plan, a limited purpose flexible spending
35 account, or any other form of wraparound plan or payment for any
36 portion of claims that apply to the health plan deductible or other
37 benefits.

38 (2) This subdivision shall not apply with respect to a
39 compensation arrangement that provides compensation to an agent
40 or broker on the basis of percentage of premium, provided that the

percentage shall not vary because of the factors described in subparagraph (A) or (B) of paragraph (1).

(j) Except in the case of a late insured, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7 or 10708.

(k) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(l) (1) With respect to the obligation to provide coverage newly issued under subdivision (d), the carrier may cease enrolling new small employer groups and new eligible employees as defined by paragraph (2) of subdivision (f) of Section 10700 if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.

(2) Certification shall be deemed approved if not disapproved within 45 days after submission to the commissioner. If that certification is approved, the small employer carrier shall not offer

1 coverage to any small employers under any health benefit plans
2 during the remainder of the current year. If the certification is not
3 approved, the carrier shall continue to issue coverage as required
4 by subdivision (d) and be subject to administrative penalties as
5 established in Section 10718.

6 ~~SEC. 27.~~

7 *SEC. 29.* Section 10706 of the Insurance Code is amended to
8 read:

9 10706. Every carrier shall file with the commissioner the
10 reasonable participation requirements and employer contribution
11 requirements that are to be included in its health benefit plans.
12 Participation requirements shall be applied uniformly among all
13 small employer groups, except that a carrier may vary application
14 of minimum employer participation requirements by the size of
15 the small employer group and whether the employer contributes
16 100 percent of the eligible employee's premium. Employer
17 contribution requirements shall not vary by employer size. A carrier
18 shall not establish a participation requirement that (1) requires a
19 person who meets the definition of a dependent in subdivision (e)
20 of Section 10700 to enroll as a dependent if he or she is otherwise
21 eligible for coverage and wishes to enroll as an eligible employee
22 and (2) allows a carrier to reject an otherwise eligible small
23 employer because of the number of persons that waive coverage
24 due to coverage through another employer. Members of an
25 association eligible for health coverage eligible under subdivision
26 (z) of Section 10700 but not electing any health coverage through
27 the association shall not be counted as eligible employees for
28 purposes of determining whether the guaranteed association or the
29 eligible association meets a carrier's reasonable participation
30 standards.

31 ~~SEC. 28.~~

32 *SEC. 30.* Section 10708 of the Insurance Code is amended to
33 read:

34 10708. (a) Preexisting condition provisions of health benefit
35 plans shall not exclude coverage for a period beyond six months
36 following the individual's effective date of coverage and may only
37 relate to conditions for which medical advice, diagnosis, care, or
38 treatment, including the use of prescription medications, was
39 recommended by or received from a licensed health practitioner

1 during the six months immediately preceding the effective date of
2 coverage.

3 (b) A carrier that does not utilize a preexisting condition
4 provision may impose a waiting or affiliation period, not to exceed
5 60 days, before the coverage issued subject to this chapter shall
6 become effective. During the waiting or affiliation period, the
7 carrier is not required to provide health care benefits and no
8 premiums shall be charged to the subscriber or enrollee.

9 (c) In determining whether a preexisting condition provision or
10 a waiting period applies to any person, a plan shall credit the time
11 the person was covered under creditable coverage, provided the
12 person becomes eligible for coverage under the succeeding plan
13 contract within 62 days of termination of prior coverage, exclusive
14 of any waiting or affiliation period, and applies for coverage with
15 the succeeding health benefit plan contract within the applicable
16 enrollment period. A plan shall also credit any time an eligible
17 employee must wait before enrolling in the health benefit plan,
18 including any postenrollment or employer-imposed waiting or
19 affiliation period. However, if a person's employment has ended,
20 the availability of health coverage offered through employment
21 or sponsored by an employer has terminated, or an employer's
22 contribution toward health coverage has terminated, a plan shall
23 credit the time the person was covered under creditable coverage
24 if the person becomes eligible for health coverage offered through
25 employment or sponsored by an employer within 180 days,
26 exclusive of any waiting or affiliation period, and applies for
27 coverage under the succeeding health benefit plan within the
28 applicable enrollment period.

29 (d) Group health benefit plans may not impose a preexisting
30 conditions exclusion to the following:

31 (1) To a newborn individual, who, as of the last day of the
32 30-day period beginning with the date of birth, applied for coverage
33 through the employer-sponsored plan.

34 (2) To a child who is adopted or placed for adoption before
35 attaining 18 years of age and who, as of the last day of the 30-day
36 period beginning with the date of adoption or placement for
37 adoption, is covered under creditable coverage and applies for
38 coverage through the employer-sponsored plan. This provision
39 shall not apply if, for 63 continuous days, the child is not covered
40 under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

(e) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and waiting or affiliation periods.

(f) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), carriers providing coverage to a guaranteed association or an eligible association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the insured.

~~SEC. 29.~~

SEC. 31. Chapter 9.7 (commencing with Section 10920) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.7. MANDATE-FREE INDIVIDUAL COVERAGE

10920. (a) Notwithstanding any other provision of this code, on and after January 1, 2011, a health insurer may offer, market, and sell an individual health insurance policy that does not include all of the health benefits mandated under this code to an individual if all of the following requirements are met:

(1) The individual has an income below 350 percent of the federal poverty level.

(2) The individual waives the benefits pursuant to subdivision (c).

(3) The insurance policy is approved by the commissioner.

(b) The commissioner, in consultation with the Director of the Department of Managed Health Care, shall prepare a disclosure form prior to July 1, 2010, that is easily understood and that summarizes the benefits a health insurer is required to include in its health insurance policy under this code.

1 (c) Before a health insurance policy described in subdivision
2 (a) may be issued, the individual shall sign the disclosure form
3 described in subdivision (b), specifying the benefits he or she is
4 waiving and indicating that the insurer has explained the contents
5 of the disclosure and that he or she understands those contents.

6 ~~SEC. 30.~~

7 SEC. 32. Article 7 (commencing with Section 11885) is added
8 to Chapter 4 of Part 3 of Division 2 of the Insurance Code, to read:

9
10 Article 7. 24-Hour Care Policies

11
12 11885. Any insurer admitted to transact health insurance or
13 workers' compensation insurance, or a health care service plan
14 licensed pursuant to the Knox-Keene Health Care Service Plan
15 Act of 1975 (Chapter 2.2 (commencing with Section 1340) of
16 Division 2 of the Health and Safety Code), may make a written
17 application to the commissioner for a license to offer a single policy
18 that provides health care coverage and workers' compensation
19 benefits.

20 ~~SEC. 31.~~

21 SEC. 33. Section 12938.1 is added to the Insurance Code, to
22 read:

23 12938.1. (a) The commissioner shall encourage the design of
24 health insurance policies that conform to current requirements
25 under federal law for a high deductible health plan used in
26 conjunction with a Health Savings Account.

27 (b) The commissioner and the Director of the Department of
28 Managed Health Care shall standardize the process used for the
29 initial review and approval of a health care service plan contract
30 and for the initial review and approval of a health insurance policy.

31 (c) (1) The commissioner shall report to the chair and to the
32 vice chairs of the Senate Committee on Banking, Finance and
33 Insurance, the Senate Committee on Appropriations, the Assembly
34 Committee on Insurance, and the Assembly Committee on
35 Appropriations prior to December 31, 2010, on the status of the
36 requirements imposed by subdivisions (a) and (b) and on the
37 number of health insurers that have applied to the department for
38 initial review and approval of new health insurance policies on
39 and after the effective date of this section.

(2) The commissioner shall also report to the chair and to the vice chairs of the committees listed in paragraph (1), prior to December 31, 2011, on the increase in the number of persons insured by a health insurance policy as a result of the requirements described in subdivisions (a) and (b).

~~SEC. 32.~~

SEC. 34. Section 96.8 is added to the Labor Code, to read:

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

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

~~SEC. 33.~~

SEC. 35. Section 511 of the Labor Code is amended to read:

511. (a) Upon the proposal of an employer, the employees of an employer may adopt a regularly scheduled alternative workweek that authorizes work by the affected employees for no longer than 10 hours per day within a 40-hour workweek without the payment to the affected employees of an overtime rate of compensation pursuant to this section. A proposal to adopt an alternative workweek schedule shall be deemed adopted only if it receives approval in a secret ballot election by at least two-thirds of affected employees in a work unit. The regularly scheduled alternative workweek proposed by an employer for adoption by employees may be a single work schedule that would become the standard schedule for workers in the work unit, or a menu of work schedule options, from which each employee in the unit would be entitled to choose.

(b) This subdivision shall be known as the "Small Business Family Scheduling Option." Notwithstanding subdivision (a), an employer with 50 or fewer employees that offers health care coverage benefits to its employees may approve a written request of an employee to work an alternative workweek schedule for no longer than 10 hours per day within a 40-hour workweek without the payment to the affected employee of an overtime rate of

1 compensation pursuant to this section. An employee shall provide
2 a voluntary, signed written request that includes the start date of
3 the alternative workweek schedule and the days and the number
4 of hours per day for the alternative workweek schedule. If agreed,
5 the employer and employee shall execute a written agreement that
6 includes the start date of the alternative workweek schedule and
7 the days and the number of hours per day for the alternative
8 workweek schedule. The employer shall maintain the written
9 agreement as a record for three years beyond the termination of
10 the alternative workweek agreement. The employee or employer
11 may terminate the agreement at any time upon seven days' advance
12 written notice.

13 (c) An affected employee working longer than eight hours but
14 not more than 12 hours in a day pursuant to an alternative
15 workweek schedule adopted pursuant to this section shall be paid
16 an overtime rate of compensation of no less than one and one-half
17 times the regular rate of pay of the employee for any work in excess
18 of the regularly scheduled hours established by the alternative
19 workweek agreement and for any work in excess of 40 hours per
20 week. An overtime rate of compensation of no less than double
21 the regular rate of pay of the employee shall be paid for any work
22 in excess of 12 hours per day and for any work in excess of eight
23 hours on those days worked beyond the regularly scheduled
24 workdays established by the alternative workweek agreement.
25 Nothing in this section requires an employer to combine more than
26 one rate of overtime compensation in order to calculate the amount
27 to be paid to an employee for any hour of overtime work.

28 (d) An employer shall not reduce an employee's regular rate of
29 hourly pay as a result of the adoption, repeal, termination, or
30 nullification of an alternative workweek schedule.

31 (e) An employer shall make a reasonable effort to find a work
32 schedule not to exceed eight hours in a workday, in order to
33 accommodate any affected employee who was eligible to vote in
34 an election authorized by subdivision (a) and who is unable to
35 work the alternative schedule hours established as the result of
36 that election. An employer shall be permitted to provide a work
37 schedule not to exceed eight hours in a workday to accommodate
38 any employee who was hired after the date of the election and who
39 is unable to work the alternative schedule established as the result
40 of that election. An employer shall explore any available reasonable

1 alternative means of accommodating the religious belief or
2 observance of an affected employee that conflicts with an adopted
3 alternative workweek schedule, in the manner provided by
4 subdivision (i) of Section 12940 of the Government Code.

5 (f) The results of any election conducted pursuant to subdivision
6 (a) shall be reported by an employer to the Division of Labor
7 Statistics and Research within 30 days after the results are final.

8 (g) Any type of alternative workweek schedule that is authorized
9 by this code and that was in effect on January 1, 2000, may be
10 repealed by the affected employees pursuant to this section. Any
11 alternative workweek schedule that was adopted pursuant to Wage
12 Order Numbers 1, 4, 5, 7, or 9 of the Industrial Welfare
13 Commission is null and void, except for an alternative workweek
14 providing for a regular schedule of no more than 10 hours' work
15 in a workday that was adopted by a two-thirds vote of affected
16 employees in a secret ballot election pursuant to wage orders of
17 the Industrial Welfare Commission in effect prior to 1998. This
18 subdivision does not apply to exemptions authorized pursuant to
19 Section 515.

20 (h) Notwithstanding subdivision (g), an alternative workweek
21 schedule in the health care industry adopted by a two-thirds vote
22 of affected employees in a secret ballot election pursuant to Wage
23 Order Numbers 4 and 5 in effect prior to 1998 that provided for
24 workdays exceeding 10 hours but not exceeding 12 hours in a day
25 without the payment of overtime compensation shall be valid until
26 July 1, 2000. An employer in the health care industry shall make
27 a reasonable effort to accommodate any employee in the health
28 care industry who is unable to work the alternative schedule
29 established as the result of a valid election held in accordance with
30 provisions of Wage Order Number 4 or 5 that were in effect prior
31 to 1998.

32 (i) Notwithstanding subdivision (g), if an employee is voluntarily
33 working an alternative workweek schedule providing for a regular
34 work schedule of not more than 10 hours work in a workday as of
35 July 1, 1999, an employee may continue to work that alternative
36 workweek schedule without the entitlement of the payment of
37 daily overtime compensation for the hours provided in that
38 schedule if the employer approves a written request of the
39 employee to work that schedule.

~~SEC. 34.~~

SEC. 36. Section 515 of the Labor Code is amended to read:

515. (a) The Industrial Welfare Commission may establish exemptions from the requirement that an overtime rate of compensation be paid pursuant to Sections 510 and 511 for executive, administrative, and professional employees, provided that the employee is primarily engaged in the duties that meet the test of the exemption, customarily and regularly exercises discretion and independent judgment in performing those duties, and earns a monthly salary equivalent to no less than two times the state minimum wage for full-time employment. The commission shall conduct a review of the duties that meet the test of the exemption. The commission may, based upon this review, convene a public hearing to adopt or modify regulations at that hearing pertaining to duties that meet the test of the exemption without convening wage boards. Any hearing conducted pursuant to this subdivision shall be concluded not later than July 1, 2000.

(b) Except as otherwise provided in this section and in subdivision (h) of Section 511, nothing in this section requires the commission to alter any exemption from provisions regulating hours of work that was contained in any valid wage order in effect in 1997. Except as otherwise provided in this division, the commission may review, retain, or eliminate any exemption from provisions regulating hours of work that was contained in any valid wage order in effect in 1997.

(c) For purposes of this section, “full-time employment” means employment in which an employee is employed for 40 hours per week.

(d) For the purpose of computing the overtime rate of compensation required to be paid to a nonexempt full-time salaried employee, the employee’s regular hourly rate shall be $\frac{1}{40}$ th of the employee’s weekly salary.

(e) For purposes of this section, “primarily” means more than one-half of the employee’s worktime.

(f) (1) In addition to the requirements of subdivision (a), registered nurses employed to engage in the practice of nursing shall not be exempted from coverage under any part of the orders of the Industrial Welfare Commission, unless they individually meet the criteria for exemptions established for executive or administrative employees.

(2) This subdivision does not apply to any of the following:

(A) A certified nurse midwife who is primarily engaged in performing duties for which certification is required pursuant to Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code.

(B) A certified nurse anesthetist who is primarily engaged in performing duties for which certification is required pursuant to Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(C) A certified nurse practitioner who is primarily engaged in performing duties for which certification is required pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(D) Nothing in this paragraph shall exempt the occupations set forth in subparagraphs (A), (B), and (C) from meeting the requirements of subdivision (a).

~~SEC. 35.~~

SEC. 37. Section 17053.58 is added to the Revenue and Taxation Code, to read:

17053.58. (a) For each taxable year beginning on or after January 1, 2010, and before January 1, 2015, there shall be allowed as a credit against the “net tax,” as defined in Section 17039, an amount equal to the amount paid or incurred by the taxpayer during the taxable year for qualified health expenses. The credit shall not exceed any of the following for the taxable year:

(1) Seven and one-half percent of the taxpayer gross income.

(2) Two thousand five hundred dollars (\$2,500) per each individual covered by the plan.

(3) Five thousand dollars (\$5,000) for all individuals covered by the plan.

(b) For purposes of this section, “qualified health expenses” means the total amount the taxpayer paid or incurred during the taxable year for health insurance and health care service plans for the taxpayer and his or her spouse and dependents.

(c) No other credit or deduction shall be allowed under other provisions of this part for qualified health expenses for which a credit is taken under this section.

(d) This section shall remain in effect only until December 1, 2015, and as of that date is repealed.

1 ~~SEC. 36.~~

2 SEC. 38. Section 17053.77 is added to the Revenue and
3 Taxation Code, to read:

4 17053.77. (a) For each taxable year beginning on or after
5 January 1, 2009, and before January 1, 2015, there shall be allowed
6 as a credit against the “net tax,” as defined in Section 17039, an
7 amount equal to 15 percent of the amount paid or incurred by a
8 qualified taxpayer during the taxable year for qualified health
9 insurance for employees of the taxpayer who perform services in
10 this state.

11 (b) For purposes of this section:

12 (1) “Qualified health insurance” means amounts paid on behalf
13 of employees to a high deductible health plan, as defined by Section
14 223(c)(2) of the Internal Revenue Code, or to a Health Savings
15 Account, as defined by Section 223(d) of the Internal Revenue
16 Code.

17 (2) “Qualified taxpayer” means any small or medium employer,
18 or any small or medium employer that, during the five taxable
19 years immediately preceding the taxable year, has not provided
20 health insurance to employees employed by the employer in this
21 state.

22 (3) For purposes of this paragraph:

23 (A) “Small employer” means a person, as defined in Section
24 7701(a) of the Internal Revenue Code, employing, for wages or
25 salary, at least two but no more than 50 persons.

26 (B) “Medium employer” means a person, as defined in Section
27 7701(a) of the Internal Revenue Code, employing, for wages or
28 salary, at least 51 but no more than 250 persons.

29 (c) The credit allowed by this section shall be in lieu of any
30 deduction to which the taxpayer otherwise may be entitled for
31 expenses on which a credit under this section is claimed.

32 (d) On or before September 1, 2013, the Franchise Tax Board
33 shall report to the Legislature on the usage of the credit under this
34 section.

35 (e) In the case where the credit allowed by this section exceeds
36 the “net tax,” the excess may be carried over to reduce the “net
37 tax” in the following year, and succeeding years if necessary, until
38 the credit is exhausted.

39 (f) This section shall remain in effect only until December 1,
40 2015, and as of that date is repealed, unless a later enacted statute,

1 that is enacted before December 1, 2015, deletes or extends that
2 date.

3 ~~SEC. 37.~~

4 *SEC. 39.* Section 17053.91 is added to the Revenue and
5 Taxation Code, to read:

6 17053.91. (a) For each taxable year beginning on or after
7 January 1, 2009, there shall be allowed as a credit against the “net
8 tax,” as defined in Section 17039, an amount equal to 25 percent
9 of the “net tax,” of an individual who is a qualified medical care
10 professional.

11 (b) For purposes of this section:

12 (1) “Qualified medical care professional” means any individual,
13 licensed as a healing arts practitioner under Division 2
14 (commencing with Section 500) of the Business and Professions
15 Code, who provides medical services in a rural area.

16 (2) “Rural area” means any open country or any place, town,
17 village, or city which, by itself, and taken together with any other
18 places, towns, villages, or cities that it is part of, or associated
19 with, either has a population not exceeding 10,000, or has a
20 population not exceeding 20,000 and is contained within a
21 nonmetropolitan area. “Rural area” also includes any open country,
22 place, town, village, or city located within a standard metropolitan
23 statistical area within this state, as established by the United States
24 Office of Management and Budget, if the population thereof does
25 not exceed 20,000 and the area is not part of, or associated with,
26 an urban area and is rural in character.

27 (c) In the case where the credit allowed by this section exceeds
28 the “net tax,” the excess may be carried over to reduce the “net
29 tax” in the following year, and succeeding years if necessary, until
30 the credit is exhausted.

31 ~~SEC. 38.~~

32 *SEC. 40.* Section 17053.102 is added to the Revenue and
33 Taxation Code, to read:

34 17053.102. (a) There shall be allowed as a credit against the
35 “net tax,” as defined by Section 17039, an amount equal to 50
36 percent of the fair market value of uncompensated medical care
37 provided by a physician during the taxable year to an eligible
38 individual.

39 (b) For purposes of this section:

1 (1) “Physician” means a physician and surgeon licensed by the
2 Medical Board of California or the Osteopathic Medical Board of
3 California.

4 (2) “Eligible individual” means a resident of this state who is
5 not covered by health insurance and is a member of a household
6 whose combined household adjusted gross income for the taxable
7 year is less than 150 percent of the federal poverty level for that
8 household for the applicable taxable year.

9 (3) “Fair market value of uncompensated medical care” shall
10 include only those medical procedures covered by Medicare or
11 Medi-Cal and shall not exceed the Area 9 (Santa Clara County)
12 reimbursement rate authorized under Medicare for any medical
13 procedure for which a credit is allowed by this section.

14 (c) In the case where the credit allowed by this section exceeds
15 the “net tax,” the excess may be carried over to reduce the “net
16 tax” in the following year, and succeeding years if necessary, until
17 the credit is exhausted.

18 ~~SEC. 39.~~

19 *SEC. 41.* Section 17053.103 is added to the Revenue and
20 Taxation Code, to read:

21 17053.103. (a) There shall be allowed a credit against the “net
22 tax,” as defined by Section 17039, an amount equal to 10 percent
23 of the “net tax” for the taxable year to a primary care provider who
24 provides primary care for patients in this state during the taxable
25 year.

26 (b) For purposes of this section, “primary care provider” means
27 a physician and surgeon, a nurse practitioner, or a physician’s
28 assistant.

29 (c) The credit shall be allowed by this section only to a primary
30 care provider who first commences providing primary care services
31 in this state on or after January 1, 2007.

32 (d) The credit shall be allowed by this section only for the first
33 10 taxable years for which the primary care provider provides
34 primary care services in this state.

35 (e) In the case of a primary care provider who is a physician
36 and surgeon who changes his or her practice from primary care to
37 specialty care, any credit previously allowed by this section shall
38 be recaptured by adding the amount of the credit to the “net tax”
39 for the taxable year in which the change of practice occurs.

(f) In the case where the credit allowed by this section exceeds the “net tax,” the excess may be carried over to reduce the “net tax” in the following year, and succeeding years if necessary, until the credit is exhausted.

~~SEC. 40.~~

SEC. 42. Section 17072 of the Revenue and Taxation Code is amended to read:

17072. (a) Section 62 of the Internal Revenue Code, relating to adjusted gross income defined, shall apply, except as otherwise 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 17204, relating to medical care, shall be allowed in computing adjusted gross incomes.

(d) The deduction allowed by Section 17216, relating to Health Savings Accounts, shall be allowed in computing adjusted gross income. This subdivision shall apply only to each taxable year beginning on or after January 1, 2009.

~~SEC. 41.~~

SEC. 43. 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 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. 42.~~

SEC. 44. 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. 43.~~

SEC. 45. Section 17204 is added to the Revenue and Taxation Code, to read:

17204. (a) For each taxable year beginning on or after January 1, 2010, and before January 1, 2015, there shall be allowed a deduction in an amount equal to the cost, not compensated by insurance or otherwise, paid or incurred during the taxable year by the taxpayer for medical care for the taxpayer, his or her spouse, his or her dependents, and, in the case of a married couple, any dependents of each spouse. The deduction shall not exceed any of the following for the taxable year:

(1) Seven and one-half percent of the taxpayer's gross income.

(2) Two thousand dollars (\$2,000) per person.

(3) Five thousand dollars (\$5,000) per family.

(b) For purposes of this section:

(1) "Taxpayer" means any person subject to the tax imposed by this part.

(2) "Dependent" has the same meaning ascribed to that term by Section 17056.

(3) "Medical care" has the same meaning ascribed to that term by Section 213(d) of the Internal Revenue Code.

(c) The deduction allowed by this section shall be in lieu of any other deduction otherwise allowable by this part for the costs for which the deduction is allowed by this section.

(d) This section shall remain in effect only until December 1, 2015, and as of that date is repealed.

~~SEC. 44.~~

SEC. 46. 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

1 108-173), relating to rollovers from Archer MSAs permitted, shall
2 apply, except as otherwise provided.

3 (d) The amendments made to this section by the act adding this
4 subdivision shall apply only to each taxable year beginning on or
5 after January 1, 2009.

6 ~~SEC. 45.~~

7 *SEC. 47.* Section 17216 is added to the Revenue and Taxation
8 Code, to read:

9 17216. For each taxable year beginning on or after January 1,
10 2009, all of the following apply:

11 (a) Section 223 of the Internal Revenue Code, as added by
12 Section 1201 of the Medicare Prescription Drug, Improvement,
13 and Modernization Act of 2003 (Public Law 108-173), relating to
14 Health Savings Accounts, shall apply, except as otherwise
15 provided.

16 (b) Section 223(e)(1) of the Internal Revenue Code, as added
17 by Section 1201 of the Medicare Prescription Drug, Improvement,
18 and Modernization Act of 2003 (Public Law 108-173), shall be
19 modified by substituting the phrase “Section 17651” for the phrase
20 “section 511 (relating to imposition of tax of unrelated business
21 income of charitable, etc., organizations),” contained therein.

22 (c) Section 223(f)(4)(A) of the Internal Revenue Code, as added
23 by Section 1201 of the Medicare Prescription Drug, Improvement,
24 and Modernization Act of 2003 (Public Law 108-173), shall be
25 modified by substituting “2½ percent” for “10 percent,” contained
26 therein.

27 ~~SEC. 46.~~

28 *SEC. 48.* Section 19184 of the Revenue and Taxation Code is
29 amended to read:

30 19184. (a) A penalty of fifty dollars (\$50) shall be imposed
31 for each failure, unless it is shown that the failure is due to
32 reasonable cause, by any person required to file who fails to file
33 a report at the time and in the manner required by any of the
34 following provisions:

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

37 (2) Section 220(h) of the Internal Revenue Code, relating to
38 medical savings accounts for taxable years beginning on or after
39 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.

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

(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 only to each taxable year beginning on or after January 1, 2009.

~~SEC. 47.~~

SEC. 49. Section 23658 is added to the Revenue and Taxation Code, to read:

23658. (a) For each taxable year beginning on or after January 1, 2010, and before January 1, 2015, there shall be allowed as a credit against the "tax," as defined in Section 23036, an amount equal to the amount paid or incurred by the taxpayer during the taxable year for qualified health expenses. The credit shall not exceed any of the following for the taxable year:

(1) Seven and one-half percent of the taxpayer's gross income.

(2) Two thousand five hundred dollars (\$2,500) per each individual covered by the plan.

(3) Five thousand dollars (\$5,000) for all individuals covered by the plan.

(b) For purposes of this section “qualified health expenses” means the total amount the taxpayer paid or incurred during the taxable year for health insurance and health care service plans for the taxpayer and his or her spouse and dependents.

(c) No other credit or deduction shall be allowed under other provisions of this part for qualified health expenses for which a credit is taken under this section.

(d) This section shall remain in effect only until December 1, 2015, and as of that date is repealed.

~~SEC. 48.~~

SEC. 50. Section 23677 is added to the Revenue and Taxation Code, to read:

23677. (a) For each taxable year beginning on or after January 1, 2009, and before January 1, 2015, there shall be allowed as a credit against the “tax,” as defined in Section 23036, an amount equal to 15 percent of the amount paid or incurred by a qualified taxpayer during the taxable year for qualified health insurance for employees of the taxpayer who perform services in this state.

(b) For purposes of this section:

(1) “Qualified health insurance” means amounts paid on behalf of employees to a high deductible health plan, as defined by Section 223(c)(2) of the Internal Revenue Code, or to a Health Savings Account, as defined by Section 223(d) of the Internal Revenue Code.

(2) “Qualified taxpayer” means any small or medium employer, or any small or medium employer that, during the five taxable years immediately preceding the taxable year, has not provided health insurance to employees employed by the employer in this state.

(3) For purposes of this paragraph:

(A) “Small employer” means a person, as defined in Section 7701(a) of the Internal Revenue Code, employing, for wages or salary, at least two but no more than 50 persons.

(B) “Medium employer” means a person, as defined in Section 7701(a) of the Internal Revenue Code, employing, for wages or salary, at least 51 but no more than 250 persons.

1 (c) The credit allowed by this section shall be in lieu of any
2 deduction to which the taxpayer otherwise may be entitled for
3 expenses on which a credit under this section is claimed.

4 (d) On or before September 1, 2013, the Franchise Tax Board
5 shall report to the Legislature on the usage of the credit under this
6 section.

7 (e) In the case where the credit allowed by this section exceeds
8 the “tax,” the excess may be carried over to reduce the “tax” in
9 the following year, and succeeding years if necessary, until the
10 credit is exhausted.

11 (f) This section shall remain in effect only until December 1,
12 2015, and as of that date is repealed, unless a later enacted statute,
13 that is enacted before December 1, 2015, deletes or extends that
14 date.

15 ~~SEC. 49.~~

16 *SEC. 51.* Section 14026.7 is added to the Welfare and
17 Institutions Code, to read:

18 14026.7. (a) The State Department of Health Care Services
19 shall establish a computer modeling program to be used to prevent
20 and identify Medi-Cal fraud. The computer modeling program
21 shall alert the department when a provider does any of the
22 following:

23 (1) Bills the department for a service or procedure using a high
24 acuity Current Procedural Terminology (CPT) code with a
25 frequency over 20 percent higher than the frequency the average
26 provider in the same specialty or setting uses the same code.

27 (2) Bills the department with the identical CPT code more than
28 once for the same patient for the same date of service.

29 (3) Bills the department for the identical procedural service,
30 which does not include an office visit, for the same patient more
31 than once within a 12-month period.

32 (b) When the department receives an alert from the computer
33 modeling program established pursuant to subdivision (a), the
34 department shall conduct a Medi-Cal fraud investigation if the
35 department determines an investigation is appropriate under the
36 circumstances.

37 ~~SEC. 50.~~

38 *SEC. 52.* Section 14029.7 is added to the Welfare and
39 Institutions Code, to read:

14029.7. The State Department of Health Care Services shall ensure the existence and operation of a single searchable Internet Web site, accessible by the public at no cost, that specifies Medi-Cal expenditures, including a line item breakdown of administrative overhead and provider and health care expenses.

~~SEC. 51.~~

SEC. 53. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code

1 and certified by the department to participate in the Medi-Cal
2 program shall not be subject to this section.

3 (b) A physician and surgeon licensed by the Medical Board of
4 California or the Osteopathic Medical Board of California
5 practicing in an individual physician practice, who is enrolled and
6 in good standing in the Medi-Cal program, and who is changing
7 locations of that individual physician practice within the same
8 county, shall be eligible to continue enrollment at the new location
9 by filing a change of location form to be developed by the
10 department. The form shall comply with all minimum federal
11 requirements related to Medicaid provider enrollment. Filing this
12 form shall be in lieu of submitting a complete application package
13 pursuant to subdivision (a).

14 (c) (1) Except as provided in paragraph (2), within 30 days
15 after receiving an application package submitted pursuant to
16 subdivision (a), the department shall provide written notice that
17 the application package has been received and, if applicable, that
18 there is a moratorium on the enrollment of providers in the specific
19 provider of service category or subgroup of the category to which
20 the applicant or provider belongs. This moratorium shall bar further
21 processing of the application package.

22 (2) Within 15 days after receiving an application package from
23 a physician, or a group of physicians, licensed by the Medical
24 Board of California or the Osteopathic Medical Board of California,
25 or a change of location form pursuant to subdivision (b), the
26 department shall provide written notice that the application package
27 or the change of location form has been received.

28 (d) (1) Except as provided in paragraph (4), if the application
29 package submitted pursuant to subdivision (a) is from an applicant
30 or provider who meets the criteria listed in paragraph (2), the
31 applicant or provider shall be considered a preferred provider and
32 shall be granted preferred provisional provider status pursuant to
33 this section and for a period of no longer than 18 months, effective
34 from the date on the notice from the department. The ability to
35 request consideration as a preferred provider and the criteria
36 necessary for the consideration shall be publicized to all applicants
37 and providers. An applicant or provider who desires consideration
38 as a preferred provider pursuant to this subdivision shall request
39 consideration from the department by making a notation to that
40 effect on the application package, by cover letter, or by other means

1 identified by the department in a provider bulletin. Request for
2 consideration as a preferred provider shall be made with each
3 application package submitted in order for the department to grant
4 the consideration. An applicant or provider who requests
5 consideration as a preferred provider shall be notified within 60
6 days whether the applicant or provider meets or does not meet the
7 criteria listed in paragraph (2). If an applicant or provider is notified
8 that the applicant or provider does not meet the criteria for a
9 preferred provider, the application package submitted shall be
10 processed in accordance with the remainder of this section.

11 (2) Except as provided in paragraph (4), to be considered a
12 preferred provider, the applicant or provider shall meet all of the
13 following criteria:

14 (A) Hold a current license as a physician and surgeon issued by
15 the Medical Board of California or the Osteopathic Medical Board
16 of California, which license shall not have been revoked, whether
17 stayed or not, suspended, placed on probation, or subject to other
18 limitation.

19 (B) Be a current faculty member of a teaching hospital or a
20 children's hospital, as defined in Section 10727, accredited by the
21 Joint Commission or the American Osteopathic Association, or
22 be credentialed by a health care service plan that is licensed under
23 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
24 2.2 (commencing with Section 1340) of Division 2 of the Health
25 and Safety Code) or county organized health system, or be a current
26 member in good standing of a group that is credentialed by a health
27 care service plan that is licensed under the Knox-Keene Act.

28 (C) Have full, current, unrevoked, and unsuspended privileges
29 at a Joint Commission or American Osteopathic Association
30 accredited general acute care hospital.

31 (D) Not have any adverse entries in the federal Healthcare
32 Integrity and Protection Data Bank.

33 (3) The department may recognize other providers as qualifying
34 as preferred providers if criteria similar to those set forth in
35 paragraph (2) are identified for the other providers. The department
36 shall consult with interested parties and appropriate stakeholders
37 to identify similar criteria for other providers so that they may be
38 considered as preferred providers.

39 (4) (A) For purposes of this paragraph, an applicant shall only
40 include the following:

- 1 (i) Dentists.
- 2 (ii) Physicians and surgeons.
- 3 (iii) Osteopathic physicians and surgeons.
- 4 (iv) Nurse anesthetists.
- 5 (v) Nurse practitioners.
- 6 (vi) Physician assistants.

7 (B) Notwithstanding paragraphs (1) and (2) or any other
8 provision of law, on and after January 1, 2010, an applicant
9 submitting an application to the department pursuant to subdivision
10 (a) shall be granted preferred provisional provider status if he or
11 she meets both the following conditions:

- 12 (i) The applicant is in good standing as a provider under the
13 federal Medicare Program.
- 14 (ii) The applicant is in good standing with his or her state
15 licensing board.

16 (C) In order for the department to determine if the applicant
17 satisfies the conditions specified in subparagraph (B), the
18 application package shall include the applicant's National Provider
19 Identifier issued pursuant to Subpart D of Part 162 of Title 42 of
20 the Code of Federal Regulations and state professional license
21 number.

22 (D) Within 15 days after receiving an application package
23 submitted pursuant to subdivision (a) from a provider to which
24 this paragraph applies, the department shall provide written notice
25 that the application package has been received.

26 (E) (i) If the application package is from an applicant who
27 satisfies the conditions specified in subparagraph (B), the applicant
28 shall be considered a preferred provisional provider and shall be
29 granted preferred provisional provider status, effective from the
30 date the department received the application package.

31 (ii) The department shall provide written notice to an applicant
32 or provider informing them whether they meet the criteria listed
33 in subparagraph (B) within 30 days after receiving the application
34 package.

35 (e) (1) If a Medi-Cal applicant meets the criteria listed in
36 paragraph (2), the applicant shall be enrolled in the Medi-Cal
37 program after submission and review of a short form application
38 to be developed by the department. The form shall comply with
39 all minimum federal requirements related to Medicaid provider
40 enrollment. The department shall notify the applicant that the

1 department has received the application within 15 days of receipt
2 of the application. The department shall issue the applicant a
3 provider number or notify the applicant that the applicant does not
4 meet the criteria listed in paragraph (2) within 90 days of receipt
5 of the application.

6 (2) Notwithstanding any other provision of law, an applicant or
7 provider who meets all of the following criteria shall be eligible
8 for enrollment in the Medi-Cal program pursuant to this
9 subdivision, after submission and review of a short form
10 application:

11 (A) The applicant's or provider's practice is based in one or
12 more of the following: a general acute care hospital, a rural general
13 acute care hospital, or an acute psychiatric hospital, as defined in
14 subdivisions (a) and (b) of Section 1250 of the Health and Safety
15 Code.

16 (B) The applicant or provider holds a current, unrevoked, or
17 unsuspended license as a physician and surgeon issued by the
18 Medical Board of California or the Osteopathic Medical Board of
19 California. An applicant or provider shall not be in compliance
20 with this subparagraph if a license revocation has been stayed, the
21 licensee has been placed on probation, or the license is subject to
22 any other limitation.

23 (C) The applicant or provider does not have an adverse entry
24 in the federal Healthcare Integrity and Protection Data Bank.

25 (3) An applicant shall be granted provisional provider status
26 under this subdivision for a period of 12 months.

27 (f) Except as provided in subdivision (g), within 180 days after
28 receiving an application package submitted pursuant to subdivision
29 (a), or from the date of the notice to an applicant or provider that
30 the applicant or provider does not qualify as a preferred provider
31 under subdivision (d), the department shall give written notice to
32 the applicant or provider that any of the following applies, or shall
33 on the 181st day grant the applicant or provider provisional
34 provider status pursuant to this section for a period no longer than
35 12 months, effective from the 181st day:

36 (1) The applicant or provider is being granted provisional
37 provider status for a period of 12 months, effective from the date
38 on the notice.

1 (2) The application package is incomplete. The notice shall
2 identify additional information or documentation that is needed to
3 complete the application package.

4 (3) The department is exercising its authority under Section
5 14043.37, 14043.4, or 14043.7, and is conducting background
6 checks, preenrollment inspections, or unannounced visits.

7 (4) The application package is denied for any of the following
8 reasons:

9 (A) Pursuant to Section 14043.2 or 14043.36.

10 (B) For lack of a license necessary to perform the health care
11 services or to provide the goods, supplies, or merchandise directly
12 or indirectly to a Medi-Cal beneficiary, within the applicable
13 provider of service category or subgroup of that category.

14 (C) The period of time during which an applicant or provider
15 has been barred from reapplying has not passed.

16 (D) For other stated reasons authorized by law.

17 (g) Notwithstanding subdivision (f), within 90 days after
18 receiving an application package submitted pursuant to subdivision
19 (a) from a physician or physician group licensed by the Medical
20 Board of California or the Osteopathic Medical Board of California,
21 or from the date of the notice to that physician or physician group
22 that does not qualify as a preferred provider under subdivision (d),
23 or within 90 days after receiving a change of location form
24 submitted pursuant to subdivision (b), the department shall give
25 written notice to the applicant or provider that either paragraph
26 (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st
27 day grant the applicant or provider provisional provider status
28 pursuant to this section for a period no longer than 12 months,
29 effective from the 91st day.

30 (h) (1) If the application package that was noticed as incomplete
31 under paragraph (2) of subdivision (f) is resubmitted with all
32 requested information and documentation, and received by the
33 department within 60 days of the date on the notice, the department
34 shall, within 60 days of the resubmission, send a notice that any
35 of the following applies:

36 (A) The applicant or provider is being granted provisional
37 provider status for a period of 12 months, effective from the date
38 on the notice.

39 (B) The application package is denied for any other reasons
40 provided for in paragraph (4) of subdivision (f).

1 (C) The department is exercising its authority under Section
2 14043.37, 14043.4, or 14043.7 to conduct background checks,
3 preenrollment inspections, or unannounced visits.

4 (2) (A) If the application package that was noticed as
5 incomplete under paragraph (2) of subdivision (f) is not resubmitted
6 with all requested information and documentation and received
7 by the department within 60 days of the date on the notice, the
8 application package shall be denied by operation of law. The
9 applicant or provider may reapply by submitting a new application
10 package that shall be reviewed de novo.

11 (B) If the failure to resubmit is by a provider applying for
12 continued enrollment, the failure shall make the provider also
13 subject to deactivation of the provider's number and all of the
14 business addresses used by the provider to provide services, goods,
15 supplies, or merchandise to Medi-Cal beneficiaries.

16 (C) Notwithstanding subparagraph (A), if the notice of an
17 incomplete application package included a request for information
18 or documentation related to grounds for denial under Section
19 14043.2 or 14043.36, the applicant or provider shall not reapply
20 for enrollment or continued enrollment in the Medi-Cal program
21 or for participation in any health care program administered by
22 the department or its agents or contractors for a period of three
23 years.

24 (i) (1) If the department exercises its authority under Section
25 14043.37, 14043.4, or 14043.7 to conduct background checks,
26 preenrollment inspections, or unannounced visits, the applicant or
27 provider shall receive notice, from the department, after the
28 conclusion of the background check, preenrollment inspection, or
29 unannounced visit of either of the following:

30 (A) The applicant or provider is granted provisional provider
31 status for a period of 12 months, effective from the date on the
32 notice.

33 (B) Discrepancies or failure to meet program requirements, as
34 prescribed by the department, have been found to exist during the
35 preenrollment period.

36 (2) (A) The notice shall identify the discrepancies or failures,
37 and whether remediation can be made or not, and if so, the time
38 period within which remediation must be accomplished. Failure
39 to remediate discrepancies and failures as prescribed by the
40 department, or notification that remediation is not available, shall

1 result in denial of the application by operation of law. The applicant
2 or provider may reapply by submitting a new application package
3 that shall be reviewed de novo.

4 (B) If the failure to remediate is by a provider applying for
5 continued enrollment, the failure shall make the provider also
6 subject to deactivation of the provider's number and all of the
7 business addresses used by the provider to provide services, goods,
8 supplies, or merchandise to Medi-Cal beneficiaries.

9 (C) Notwithstanding subparagraph (A), if the discrepancies or
10 failure to meet program requirements, as prescribed by the director,
11 included in the notice were related to grounds for denial under
12 Section 14043.2 or 14043.36, the applicant or provider shall not
13 reapply for three years.

14 (j) If provisional provider status or preferred provisional provider
15 status is granted pursuant to this section, a provider number shall
16 be used by the provider for each business address for which an
17 application package has been approved. This provider number
18 shall be used exclusively for the locations for which it is issued,
19 unless the practice of the provider's profession or delivery of
20 services, goods, supplies, or merchandise is such that services,
21 goods, supplies, or merchandise are rendered or delivered at
22 locations other than the provider's business address and this
23 practice or delivery of services, goods, supplies, or merchandise
24 has been disclosed in the application package approved by the
25 department when the provisional provider status or preferred
26 provisional provider status was granted.

27 (k) Except for providers subject to subdivision (c) of Section
28 14043.47, a provider currently enrolled in the Medi-Cal program
29 at one or more locations who has submitted an application package
30 for enrollment at a new location or a change in location pursuant
31 to subdivision (a), or filed a change of location form pursuant to
32 subdivision (b), may submit claims for services, goods, supplies,
33 or merchandise rendered at the new location until the application
34 package or change of location form is approved or denied under
35 this section, and shall not be subject, during that period, to
36 deactivation, or be subject to any delay or nonpayment of claims
37 as a result of billing for services rendered at the new location as
38 herein authorized. However, the provider shall be considered during
39 that period to have been granted provisional provider status or
40 preferred provisional provider status and be subject to termination

1 of that status pursuant to Section 14043.27. A provider that is
2 subject to subdivision (c) of Section 14043.47 may come within
3 the scope of this subdivision upon submitting documentation in
4 the application package that identifies the physician providing
5 supervision for every three locations. If a provider submits claims
6 for services rendered at a new location before the application for
7 that location is received by the department, the department may
8 deny the claim.

9 (l) An applicant or a provider whose application for enrollment,
10 continued enrollment, or a new location or change in location has
11 been denied pursuant to this section, may appeal the denial in
12 accordance with Section 14043.65.

13 (m) (1) Upon receipt of a complete and accurate claim for an
14 individual nurse provider, the department shall adjudicate the claim
15 within an average of 30 days.

16 (2) During the budget proceedings of the 2006–07 fiscal year,
17 and each fiscal year thereafter, the department shall provide data
18 to the Legislature specifying the timeframe under which it has
19 processed and approved the provider applications submitted by
20 individual nurse providers.

21 (3) For purposes of this subdivision, “individual nurse providers”
22 are providers authorized under certain home- and community-based
23 waivers and under the state plan to provide nursing services to
24 Medi-Cal recipients in the recipients’ own homes rather than in
25 institutional settings.

26 (n) The amendments to subdivision (b), which implement a
27 change of location form, and the addition of paragraph (2) to
28 subdivision (c), the amendments to subdivision (e), and the addition
29 of subdivision (g), which prescribe different processing timeframes
30 for physicians and physician groups, as contained in Chapter 693
31 of the Statutes of 2007, shall become operative on July 1, 2008.

32 ~~SEC. 52:~~

33 *SEC. 54.* Section 14079.7 is added to the Welfare and
34 Institutions Code, to read:

35 14079.7. (a) (1) Notwithstanding any other provision of this
36 chapter, on January 1, 2010, the reimbursement levels for
37 fee-for-service physician services under Medi-Cal shall be
38 increased to 80 percent of the amount that the federal Medicare
39 Program reimburses for these same services in Area 9 (Santa Clara
40 County). This reimbursement change shall apply only to services

1 reimbursed at rates below 80 percent of the amount that the federal
2 Medicare Program reimburses for these same services in Area 9.

3 (2) After the implementation of the rate increase described in
4 paragraph (1), physician rates shall be increased annually in
5 accordance with the California Consumer Price Index.

6 (b) The increase of reimbursement rates described in subdivision
7 (a) shall be made for fee-for-service physician services rendered
8 on or after January 1, 2010.

9 ~~SEC. 53.~~

10 SEC. 55. Article 2.94 (commencing with Section 14091.50) is
11 added to Chapter 7 of Part 3 of Division 9 of the Welfare and
12 Institutions Code, to read:

13
14 Article 2.94. The Medi-Cal Empowerment Act

15
16 14091.50. This article shall be known, and may be cited, as
17 the “Medi-Cal Empowerment Act.”

18 14091.51. The Legislature finds and declares the following:

19 (a) Medi-Cal provides health coverage to approximately 6.6
20 million low-income, aged, and disabled beneficiaries at a total
21 projected cost for the 2006–07 fiscal year of \$35 billion, \$13.7
22 billion from the General Fund.

23 (b) Since 2000, General Fund expenditures on Medi-Cal have
24 risen by 44 percent.

25 (c) In 2000, Medi-Cal expenditures comprised 13 percent of
26 the General Fund budget, but are projected to rise to 21 percent of
27 the General Fund budget by 2015.

28 (d) Including federal funds, Medi-Cal expended about three
29 thousand seven hundred dollars (\$3,700) per enrollee in the
30 2006–07 fiscal year.

31 (e) Cost increases to the Medi-Cal program are unsustainable
32 without reductions in eligibility or benefits.

33 (f) Medi-Cal is a large purchaser of health care services and
34 should share in the responsibility of helping stabilize runaway
35 health care costs that can contribute towards increasing the
36 population of the uninsured.

37 (g) Empowering Medi-Cal beneficiaries to become more active
38 participants in their utilization of health care services will help
39 reduce the perceived or actual stigma associated with receiving
40 government assistance.

(h) The federal Deficit Reduction Act of 2005 authorizes Medicaid Demonstration Projects for up to 10 states to implement Health Opportunity Accounts, that allow states to use federal matching dollars to deposit up to two thousand five hundred dollars (\$2,500) per adult and one thousand dollars (\$1,000) per child into an account accessible by a Medicaid enrollee that can be used to pay for out-of-pocket medical expenses to meet the deductible of an approved insurance product of the enrollee's choice. As a national leader, California should be one of these states.

14091.52. The State Department of Health Care Services shall prepare and submit a proposal to the federal government by July 31, 2010, for participation in the Medicaid Demonstration Project for Health Opportunity Accounts (HOA) in accordance with the federal Deficit Reduction Act of 2005.

14091.53. The program design shall achieve the following:

(a) Create patient awareness of the high cost of medical care.

(b) Provide incentives to patients to seek preventive care services, including one or more of the following:

(1) Additional account contributions for an individual demonstrating healthy prevention practices.

(2) Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.

(3) Routine prenatal and well-child care.

(4) Child and adult immunizations.

(5) Tobacco cessation programs.

(6) Obesity weight loss programs.

(7) Screening services.

(8) Other incentives as determined by the department and agreed to by the federal government under the demonstration project.

(c) Reduce inappropriate use of health care services.

(d) Enable patients to take responsibility for health outcomes.

(e) Provide enrollment counselors and ongoing education activities.

(f) Allow transactions involving HOAs to be conducted electronically and without cash.

(g) Provide access to negotiated provider payment rates.

14091.54. (a) The department shall select up to 10 counties in which to implement this demonstration project after considering

1 the per enrollee Medi-Cal cost in each county as well as the overall
2 Medi-Cal cost per county.

3 (b) An eligible individual shall be enrolled into the
4 demonstration program only if the individual voluntarily enrolls.

5 (c) Enrollment shall be effective for a period of 12 months, and
6 may be extended for additional periods of 12 months each with
7 the consent of the individual.

8 (d) An individual who, for any reason, is disenrolled from the
9 demonstration program under this section shall not be permitted
10 to reenroll earlier than one year after disenrollment.

11 14091.55. (a) Insurance plans offered to enrollees who
12 volunteer to participate in the demonstration shall encompass all
13 standard Medi-Cal benefits.

14 (b) The amount of the annual deductible shall be at least 100
15 percent and no more than 110 percent of the amount of the
16 contribution to the HOA.

17 (c) The number of individuals enrolled in any managed care
18 organization that participate in this demonstration project shall not
19 be either of the following:

20 (1) In excess of 5 percent of the total number of individuals
21 enrolled in the organization.

22 (2) Significantly disproportionate to the proportion of similar
23 enrollees in other participating managed care organizations.

24 (d) The state shall provide an adjustment in the per capita
25 payments to a participating managed care organization to account
26 for participation in the HOA. This shall take into account the
27 difference in the likely use of health care services between managed
28 care enrollees who participate in the HOA and managed care
29 enrollees who do not participate in the HOA.

30 14091.56. (a) The department may consider each participating
31 enrollee's health to determine the state's contribution into an
32 enrollee's HOA.

33 (b) Funds in an individual's HOA may be used for the purchase
34 of medical services and private health care coverage authorized
35 by the department or offered by the individual's employer.

36 (c) Charitable organizations may also contribute to an
37 individual's HOA.

38 (d) After the individual has satisfied the annual deductible,
39 alternative benefits for an eligible individual shall consist of at
40 least the benefits that would otherwise be provided to the

1 individual, including cost sharing relating to those benefits, if the
2 individual was not enrolled in the demonstration project.

3 (e) After one year of participation in the program, an individual
4 may use HOA funds for job training or tuition expenses.

5 (f) Any remaining funds in the individual's HOA shall carry
6 over into subsequent years, provided that the individual is enrolled
7 in an approved plan.

8 (g) If an individual disenrolls from the program, all of the
9 following shall occur:

10 (1) The state shall cease all contributions.

11 (2) The HOA administrator shall remit 50 percent of the account
12 to the General Fund.

13 (3) The remaining funds shall be used by the individual within
14 three years to purchase health insurance coverage or on any other
15 qualifying expenses, which may include job training or tuition
16 expenses.

17 14091.57. (a) The following individuals shall not be enrolled
18 in the demonstration project during the first five years after it is
19 approved:

20 (1) Individuals who are 65 years of age or older.

21 (2) Individuals who are disabled, regardless of whether or not
22 their eligibility for medical assistance under this title is based on
23 that disability.

24 (3) Individuals who are eligible for medical assistance under
25 this title only because they are, or were, within the previous 60
26 days, pregnant.

27 (4) Individuals who have been eligible for medical assistance
28 for a continuous period of less than three months.

29 (b) The following individuals within a category of assistance
30 described in Section 1937(a)(2)(B) of the federal Social Security
31 Act (42 U.S.C. Sec. 13960-7(a)(2)(B)) shall not be enrolled in the
32 demonstration project:

33 (1) The individual is a pregnant woman who is required to be
34 covered under the state plan under Section 1902(a)(10)(A)(i) of
35 the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

36 (2) The individual qualifies for medical assistance under the
37 state plan on the basis of being blind or disabled, or being treated
38 as being blind or disabled, without regard to whether the individual
39 is eligible for supplemental security income benefits under Title
40 XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et

1 seq.) on the basis of being blind or disabled and including an
2 individual who is eligible for medical assistance on the basis of
3 Section 1902(e)(3) of the federal Social Security Act (42 U.S.C.
4 Sec. 1396a(e)(3)).

5 (3) The individual is entitled to Medicare benefits under any
6 part of Title XVIII of the federal Social Security Act (42 U.S.C.
7 Sec. 1395 et seq.).

8 (4) The individual is terminally ill and is receiving Medicare
9 benefits for hospice care.

10 (5) The individual is an inpatient in a health facility, and is
11 required, as a condition of receiving services in that facility under
12 the state plan, to spend for costs of medical care all but a minimal
13 amount of the individual's income required for personal needs.

14 (6) The individual is medically frail or otherwise an individual
15 with special medical needs as defined in Section 438.50(d) of Title
16 42 of the Code of Federal Regulations.

17 (7) The individual qualifies based on medical condition for
18 medical assistance for long-term care services described in Section
19 1917(c)(I)(C) of the federal Social Security Act (42 U.S.C. Sec.
20 1396p(c)(I)(C)).

21 (8) The individual is an individual with respect to whom aid or
22 assistance is made available under Part B (commencing with
23 Section 450) of Title IV of the federal Social Security Act (42
24 U.S.C. Sec. 650 et seq.) to children in foster care, and individuals
25 with respect to whom adoption or foster care assistance is made
26 available under Part E (commencing with Section 470) of Title IV
27 of the federal Social Security Act (42 U.S.C. Sec. 670 et seq.),
28 without regard to age.

29 (9) The individual qualifies for medical assistance on the basis
30 of eligibility to receive assistance under a state plan funded under
31 Part A (commencing with Section 401) of Title IV of the federal
32 Social Security Act (42 U.S.C. Sec. 601 et seq.), as in effect on or
33 after August 26, 1996.

34 (10) The individual is a woman who is receiving medical
35 assistance by virtue of the application of Section
36 1902(a)(10)(ii)(XVIII) of the federal Social Security Act (42 U.S.C.
37 1396a(a)(10)(ii)(XVIII)), and Section 1902(aa) of the federal Social
38 Security Act (42 U.S.C. Sec. 1396a(aa)).

39 (11) The individual qualifies for medical assistance on the basis
40 of Section 1902(a)(10)(A)(ii)(XII) of the federal Social Security

1 Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XII)) or is not a qualified
2 alien (as defined in the Personal Responsibility and Work
3 Opportunity Reconciliation Act of 1996) and receives care and
4 services necessary for the treatment of an emergency medical
5 condition in accordance with Section 1903(v) of the federal Social
6 Security Act (42 U.S.C. Sec. 1396b(v)).

7 14091.58. The department shall coordinate administration of
8 HOAs through the use of a third-party administrator and may
9 implement appropriate policies and procedures for implementation
10 of this demonstration project consistent with federal laws,
11 regulations, and other guidance.

12 14091.59. The department shall annually report to the Governor
13 and the Legislature on the results of this demonstration project.

14 ~~SEC. 54.~~

15 *SEC. 56.* Section 14132.104 is added to the Welfare and
16 Institutions Code, to read:

17 14132.104. (a) On or before January 1, 2011, the department
18 shall provide or arrange for the provision of an electronic personal
19 health record (PHR) and an electronic personal benefits record
20 (PBR) for beneficiaries under the Medi-Cal program. The records
21 shall be provided for the purpose of providing beneficiaries with
22 information to assist them in understanding their coverage benefits
23 and managing their health care.

24 (b) The PBR shall provide access to real-time, patient-specific
25 information regarding eligibility for covered benefits, cost-sharing
26 requirements, and claims history. That access can be provided
27 through the use of an Internet-based system. Inclusion of this data
28 shall be at the option of the beneficiary.

29 (c) The PHR shall incorporate personal health information,
30 including, but not limited to, medical history, laboratory results,
31 prescription history, and other personal health information
32 authorized or provided by the beneficiary. The PHR shall not be
33 provided through the use of an Internet-based system. Inclusion
34 of this additional data shall be at the option of the beneficiary.

35 (d) Systems, software, or devices that pertain to the PBR and
36 PHR shall adhere to accepted national standards for
37 interoperability, privacy, and data exchange, or shall be certified
38 by a nationally recognized certification body.

39 (e) The PBR and PHR shall comply with applicable state and
40 federal confidentiality and data security requirements.

~~SEC. 55.~~

SEC. 57. Section 14132.105 is added to the Welfare and Institutions Code, to read:

14132.105. (a) (1) The department may establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under the Medi-Cal program.

(2) The benefits described in this section shall only be provided under the terms and conditions determined by the department.

(b) For purposes of this section, the Healthy Action Incentives and Rewards Program may include, but need not be limited to, all of the following:

(1) Health risk appraisals that collect information from eligible beneficiaries to assess overall health status and identify risk factors, including, but not limited to, smoking and smokeless tobacco use, alcohol abuse, drug use, nutrition, and physical activity practices.

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

(3) Incentives or rewards or both for eligible beneficiaries to become more engaged in their health care and to make appropriate choices that support good health, including obtaining health risk appraisals, screening services, immunizations, or participating in 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, nonmedical pharmacy products or services not otherwise covered under this chapter, gym memberships, and weight management programs.

(c) The department shall seek and obtain federal financial participation and secure all federal approvals, including all required state plan amendments or waivers, necessary to implement and fund the services authorized under this section.

(d) This section shall be implemented only if and to the extent that federal financial participation is available and has been obtained.

~~SEC. 56.~~

SEC. 58. Section 14133 of the Welfare and Institutions Code is amended to read:

1 14133. Utilization controls that may be applied to the services
2 set forth in Section 14132 which are subject to utilization controls
3 shall be limited to:

4 (a) Prior authorization, which is approval by a department
5 consultant, of a specified service in advance of the rendering of
6 that service based upon a determination that the service is covered
7 under Medi-Cal.

8 (b) Postservice prepayment audit, which is review for program
9 coverage after service was rendered but before payment is made.
10 Payment may be withheld or reduced if the service rendered was
11 not a covered benefit. Nothing in this subdivision shall supersede
12 the claims processing deadlines provided by Section 14104.3.

13 (c) Postservice postpayment audit, which is review for program
14 coverage after service was rendered and the claim paid. The
15 department may take appropriate steps to recover payments made
16 if subsequent investigation uncovers evidence that the claim should
17 not have been paid.

18 (d) Limitation on number of services, which means certain
19 services may be restricted as to number within a specified time
20 frame.

21 (e) Review of services pursuant to Professional Standards
22 Review Organization agreements entered into in accordance with
23 Section 14104.

24 ~~SEC. 57.~~

25 SEC. 59. Section 14164.5 is added to the Welfare and
26 Institutions Code, to read:

27 14164.5. Before making any adjustment to Medi-Cal
28 reimbursement rates, the State Department of Health Care Services
29 shall consider the extent to which Medi-Cal beneficiaries have the
30 ability to access physician services by geography and specialty
31 and shall also request data from the Office of Statewide Health
32 Planning and Development to allow the department to determine
33 the extent of Medi-Cal physician shortages, if any, by geography
34 and specialty.

35 ~~SEC. 58.~~

36 SEC. 60. Division 23 (commencing with Section 23000) is
37 added to the Welfare and Institutions Code, to read:

1 DIVISION 23. PAYMENT OF HOSPITALS AND HEALTH
2 CARE PROVIDERS PROVIDING SERVICES TO UNINSURED
3 PERSONS
4

5 23000. (a) For purposes of this division, the following
6 definitions shall apply:

7 (1) “Claimant” means a hospital or health care provider that has
8 filed a claim with the department for unpaid health care services
9 pursuant to this division.

10 (2) “Debtor” means an individual who received health care
11 services from claimant, has not paid for those services, and was
12 not covered by a health insurance policy or plan and was not
13 eligible to receive health care benefits under a government program
14 at the time he or she received services from the claimant.

15 (3) “Department” means the State Department of Health Care
16 Services.

17 (4) “Director” means the Director of Health Care Services.

18 (5) “Health care provider” means any person licensed or certified
19 pursuant to Division 2 (commencing with Section 500) of the
20 Business and Professions Code, or licensed pursuant to the
21 Osteopathic Initiative Act or the Chiropractic Initiative Act, or
22 certified pursuant to Chapter 2.5 (commencing with Section 1440)
23 of Division 2 of the Health and Safety Code, and any clinic, health
24 dispensary, or health facility licensed pursuant to Division 2
25 (commencing with Section 1200) of the Health and Safety Code.

26 (b) A hospital or health care provider may file a claim with the
27 department to be reimbursed for health care services it has provided
28 if both of the following conditions have been met:

29 (1) The health care services were provided to an individual who,
30 at the time he or she received health care services from the
31 claimant, was not covered by a health insurance policy or plan and
32 was not eligible to receive health care benefits under a government
33 program.

34 (2) The individual who received the health care services has not
35 paid the hospital or health care provider for those services.

36 (c) Both of the following conditions shall apply to a claim filed
37 pursuant to subdivision (b):

38 (1) The claim is filed 90 days or more after the health care
39 services were provided to the debtor.

40 (2) The claimant includes the following information in the claim:

1 (A) The identity of the debtor.

2 (B) The amount owed to the claimant for health care services
3 provided.

4 (d) Upon receiving the claim, the director shall determine
5 whether the claim is meritorious on its face. If the director
6 determines the claim is meritorious on its face, he or she shall
7 certify the debt to the Franchise Tax Board and the California
8 Lottery Commission to have the debt satisfied with any tax refund
9 or lottery prize money owed to the debtor.

10 (e) When a claim is certified to the Franchise Tax Board and
11 the California Lottery Commission, the certification shall include
12 the following:

13 (1) Identity of the debtor.

14 (2) Amount of money owed to the claimant.

15 (f) If the director certifies the debt, the debt shall constitute a
16 debt owed to the department.

17 (g) Upon receiving a certification of debt pursuant to this
18 section, the Franchise Tax Board and the California Lottery
19 Commission shall, respectively, determine if the debtor is owed a
20 tax refund or lottery prize money. If the debtor is owed a tax refund
21 or lottery prize money, the Franchise Tax Board or the California
22 Lottery Commission, as appropriate, shall notify the debtor by
23 certified mail of the following:

24 (1) The amount of money owed to the claimant for health care
25 services.

26 (2) That the debtor's tax refund or lottery prize money shall be
27 reduced by the amount owed to the claimant.

28 (3) The debtor's right to a fair hearing, pursuant to subdivision
29 (h), to object to the Franchise Tax Board's or California Lottery
30 Commission's actions.

31 (h) The Franchise Tax Board and the California Lottery
32 Commission shall comply with the following when deducting
33 money from the debtor's tax refund or lottery prize money:

34 (1) If the tax refund or lottery prize money is more than the debt
35 owed to the claimant, the debtor shall receive the remaining
36 difference within a reasonable time after the excess amount is
37 determined.

38 (2) Under no circumstances shall the money deducted from the
39 tax refund or lottery prize money exceed the sum of the amount
40 owed to the claimant and any administrative costs incurred by the

1 department and the Franchise Tax Board or California Lottery
2 Commission in implementing this division.

3 (3) Delinquent taxes owed by the debtor shall be paid off using
4 the debtor's tax refund or lottery prize money before any
5 deductions are made from the tax refund or lottery prize money
6 to settle the debt owed by the debtor to the department pursuant
7 to this division.

8 (i) If the debtor disagrees with actions taken by the Franchise
9 Tax Board or California Lottery Commission pursuant to this
10 division, he or she shall have the right to receive a fair hearing
11 from the board or commission, as applicable.

12 (j) After the Franchise Tax Board deducts money from the
13 debtor's tax refund or the California Lottery Commission deducts
14 money from the debtor's lottery prize money, the Franchise Tax
15 Board and California Lottery Commission shall transfer the money
16 to the department.

17 (k) Upon receiving the money from the debtor's tax refund or
18 lottery prize money, or both, the department shall settle the debt
19 owed to the claimant. At the time of settlement, the claimant shall
20 be charged by the department for administrative expenses
21 associated with implementing this division, but under no
22 circumstances shall the administrative expenses exceed 20 percent
23 of the collected amount.

24 (l) The director, the Franchise Tax Board, and the California
25 Lottery Commission shall jointly promulgate regulations necessary
26 to administer the provisions of this division.

27 ~~SEC. 59.~~

28 *SEC. 61.* On or before March 1, 2014, the Legislative Analyst
29 shall report to the Legislature on the effectiveness of the tax credits
30 provided by Sections 17053.77 and 23677 of the Revenue and
31 Taxation Code, as added by this act, upon employed Californians'
32 ability to meet deductible medical expenses incurred under
33 qualified health insurance plans.

34 ~~SEC. 60.~~

35 *SEC. 62.* (a) The amendments made by this act to Sections
36 17072, 17215, and 19184 of the Revenue and Taxation Code
37 incorporate, by reference, the provisions of Section 1201 of the
38 Medicare Prescription Drug, Improvement, and Modernization
39 Act of 2003 (Public Law 108-173), which added Section 223 of
40 the Internal Revenue Code to Part VII of Subchapter B of Chapter

1 1 of Subtitle A of the Internal Revenue Code and amended Sections
2 62, 106, 125, and 220 of the Internal Revenue Code, and shall
3 apply retroactively to taxable years beginning on or after January
4 1, 2009.

5 (b) The Legislature finds and declares that this act fulfills a
6 statewide public purpose because of the following:

7 The State of California has not yet conformed its state income
8 tax law to the provisions of Section 1201 of the Medicare
9 Prescription Drug, Improvement, and Modernization Act of 2003
10 (Public Law 108-173). As a result, the taxpayers who have
11 converted their Archer Medical Savings Accounts into Health
12 Savings Accounts pursuant to Sections 220 and 223 of the Internal
13 Revenue Code may be subject to tax and penalties under state, but
14 not federal, income tax laws. This act provides necessary relief
15 from the tax and penalties to the taxpayers who have converted
16 their Archer Medical Savings Accounts into Health Savings
17 Accounts in taxable years beginning on or after January 1, 2009.

18 (c) If, by the operation of any law or rule of law, including res
19 judicata, a refund or credit of any overpayment of tax resulting
20 from the retroactive application of the amendments made to
21 Sections 17072, 17215, and 19184 of the Revenue and Taxation
22 Code by this act is prevented at any time before the close of the
23 two-year period beginning on the effective date of this act, that
24 refund or credit may nonetheless be made or allowed, provided
25 that the claim for refund or credit is filed before the close of that
26 period.

27 ~~SEC. 61.~~

28 SEC. 63. (a) The Legislature finds and declares all of the
29 following:

30 (1) Currently, a significant percentage of Californians seek
31 nonemergency health care services from hospital emergency
32 departments.

33 (2) A hospital emergency department is an expensive place to
34 seek primary care services.

35 (3) Community-based primary care clinics offer a cost-effective,
36 high-quality alternative to hospital emergency departments for
37 people seeking access to primary care services.

38 (4) Expanded primary care clinic capacity will mean that fewer
39 people will seek nonemergency services from hospital emergency

1 departments, which will allow these emergency departments to
2 better focus on patients with truly emergent conditions.

3 (5) As expanded primary care clinic capacity will result in fewer
4 people seeking services from expensive emergency departments,
5 it is appropriate to redirect funds currently going to hospitals for
6 the care of Medi-Cal beneficiaries and the uninsured, and use these
7 funds to expand the capacity of existing clinics and increase the
8 overall number of clinics in California.

9 (b) Notwithstanding any other provision of law, the Director of
10 Health Care Services shall provide to the Legislature, no later than
11 July 1, 2010, a plan to permit funds currently available to hospitals
12 pursuant to Article 5.2 (commencing with Section 14166) of
13 Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions
14 Code, to be used instead to increase access to primary care services
15 through the creation of new clinics and the expansion of existing
16 clinics, as defined in Chapter 1 (commencing with Section 1200)
17 of Division 2 of the Health and Safety Code.

18 (c) The director shall determine the amount of funds to be
19 redirected annually pursuant to the plan using a methodology that
20 considers both anticipated and actual changes in the numbers of
21 patients seeking nonemergency services at clinics and hospital
22 emergency departments. The director may include other relevant
23 data in the methodology.

24 (d) The plan developed pursuant to subdivision (b) shall do both
25 of the following:

26 (1) Give priority access of the redirected funds to interested
27 clinics and organizations that have an explicit commitment to, and
28 a demonstrated record of, serving uninsured individuals and those
29 enrolled in public programs, such as the Medi-Cal program and
30 the Healthy Families Program.

31 (2) Include a transition plan that minimizes disruptions in
32 existing patient access to health care services and to the hospitals
33 currently receiving the funding.

34 (e) The director shall seek all necessary federal waivers in order
35 to implement the plan developed pursuant to subdivision (b). The
36 plan shall not be implemented without subsequent statutory
37 authorization.

1 ~~SEC. 62.~~

2 *SEC. 64.* It is the intent of the Legislature to enact legislation
3 that would realign Medi-Cal benefits to more closely resemble
4 benefits offered through private health care coverage.

5 ~~SEC. 63.~~

6 *SEC. 65.* It is the intent of the Legislature to enact legislation
7 that would establish a pilot project in which Medi-Cal managed
8 care is used as a platform to transition from a defined-benefit
9 system, where the state pays for services used based on a defined
10 set of benefits, to a defined-contribution system, where Medi-Cal
11 enrollees would be assigned a risk-adjusted amount to purchase
12 private health care coverage.

13 ~~SEC. 64.~~

14 *SEC. 66.* It is the intent of the Legislature to enact legislation
15 that would establish a pilot project that utilizes a self-directed “cash
16 and counseling” model for providing Medi-Cal services to disabled
17 Medi-Cal enrollees. Under a “cash and counseling” model, disabled
18 Medi-Cal enrollees, with assistance from family members and
19 Medi-Cal case managers, would be given an individual budget to
20 manage and direct payment for their personal care services and
21 enable them to determine which supportive services they want and
22 from whom they wish to have these services delivered.

23 ~~SEC. 65.~~

24 *SEC. 67.* The Legislature hereby finds and declares all of the
25 following:

26 (a) Federal law requires hospitals to provide health care services
27 to anyone who enters an emergency room, regardless of ability to
28 pay or immigration status.

29 (b) The federal government does not provide full compensation
30 to cover the costs of providing this health care coverage.

31 (c) The Legislature hereby memorializes the Congress and
32 President of the United States to enact legislation that would
33 provide full reimbursement for the costs of providing federally
34 mandated health care services to anyone, regardless of immigration
35 status.

36 ~~SEC. 66.~~

37 *SEC. 68.* It is the intent of the Legislature to enact legislation
38 that would relieve the overutilization of hospital emergency rooms
39 by allowing hospitals to offer preventative medical services

1 delivered through the hospital's primary care or community-based
2 clinic.

3 ~~SEC. 67.~~

4 *SEC. 69.* It is the intent of the Legislature to enact legislation
5 that would impose consequences on attorneys and litigants who
6 do either of the following:

7 (a) File at least two lawsuits within a five-year period against
8 one or more health care providers if the providers are found to
9 have given appropriate care that did not contribute to a patient's
10 complications.

11 (b) File a lawsuit against a health care provider that is dismissed
12 with prejudice.

13 ~~SEC. 68.~~

14 *SEC. 70.* It is the intent of the Legislature to enact legislation
15 that would provide incentives to employers who offer health
16 insurance, flex-time work schedules, and other benefits agreed
17 upon by employers and employees.

18 ~~SEC. 69.~~

19 *SEC. 71.* No reimbursement is required by this act pursuant to
20 Section 6 of Article XIII B of the California Constitution because
21 the only costs that may be incurred by a local agency or school
22 district will be incurred because this act creates a new crime or
23 infraction, eliminates a crime or infraction, or changes the penalty
24 for a crime or infraction, within the meaning of Section 17556 of
25 the Government Code, or changes the definition of a crime within
26 the meaning of Section 6 of Article XIII B of the California
27 Constitution.