AMENDED IN SENATE MARCH 11, 2009

AMENDED IN SENATE FEBRUARY 25, 2009

SENATE BILL No. 92

Introduced by Senator Aanestad

January 21, 2009

An act to amend Section 2069 of*, and to add Section 734 to,* 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*, 1367.63, 1367.635,* 1374.32, 1374.33,~~ and 1374.58~~ *1374.58, and 1395* 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*, 10123.86, 10123.88,* 10123.136, and 12938.1~~ to, to add Chapter 9.7 (commencing with Section 10920) to Part 2 of Division 2 of, and~~ *to,* to add Article 7 (commencing with Section 11885) to Chapter 4 of Part 3 of Division 2 of*, and to add Chapter 9.7 (commencing with Section 10920) to Part 2 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~~ *specify that only a California* licensed health care professional~~, other than a person licensed to practice medicine, to~~ *may,* deny, *delay,* or modify requests ~~only with respect to~~ *for authorization of health care services. The bill would limit that licensee's review to* services that fall within his or her scope of practice and *would make that review* subject to standardized protocol limitations or supervision requirements applicable under his or her license. *The bill would also require the licensee to have at least the same scope of practice as the provider submitting the request for authorization.* The bill would ~~also~~ prohibit a ~~physician or other health care professional~~ *licensee* from denying, *delaying,* or modifying a request without first conducting a good faith examination of the enrollee *or insured*, except as specified, *and would make a violation of that requirement unprofessional conduct and grounds for disciplinary action. The bill would specify that the primary obligation of that licensee is to the enrollee or insured*. The bill would *also* 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~~ *the* medical professionals selected by that organization to conduct reviews

to 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~~ *persons*, 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, *and would make a failure to conduct that examination unprofessional conduct and grounds for disciplinary action. The bill would specify that the primary obligation of these reviewers is to the enrollee or insured*.

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 the 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 ⅔ 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 ⅔ 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: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 734 is added to the Business and Professions Code, to read:

734. The failure of a person licensed under this division or under an initiative act referred to in this division to conduct a good faith examination as required under any of the following provisions constitutes unprofessional conduct and grounds for disciplinary action by the person's licensing board:

(a) Paragraph (3) of subdivision (e) of Section 1367.01 of the Health and Safety Code or paragraph (3) of subdivision (e) of Section 10123.135 of the Insurance Code.

(b) Subdivision (b) of Section 1367.63 of the Health and Safety Code or subdivision (b) of Section 10123.88 of the Insurance Code.

(c) Subdivision (c) of Section 1367.635 of the Health and Safety Code or subdivision (c) of Section 10123.86 of the Insurance Code.

(d) Subdivision (a) of Section 1374.33 of the Health and Safety Code or subdivision (a) of Section 10169.3 of the Insurance Code.

~~SECTION 1.~~

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

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

~~SEC. 2.~~

SEC. 3. Section 1815.5 is added to the Financial Code, to read:

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

~~SEC. 3.~~

SEC. 4. Section 22830.5 is added to the Government Code, to read:

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

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

(c) The PHR shall incorporate personal health information, including, but not limited to, medical history, laboratory results, prescription history, and other personal health information authorized or provided by the enrollee. The PHR shall not be provided through the use of an Internet-based system. Inclusion of this additional data shall be at the option of the enrollee.

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

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

~~SEC. 4.~~

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

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

~~SEC. 5.~~

SEC. 6. Section 22869.5 is added to the Government Code, to read:

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

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

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

(2) The employee or annuitant shall also designate an additional amount to be deducted from his or her salary or retirement allowance for qualified medical expenses. The amount shall be no less than fifty dollars ($50) per month. The amount shall be deposited into the Public Employees' Health Savings Fund and shall be credited to a nominal, interest-bearing account in the name of the employee or annuitant.

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

(d) (1) The employer of an employee or annuitant who elects to participate in the Health Savings Account option shall contribute a portion, pursuant to Article 7 (commencing with Section 22870) or Article 8 (commencing with Section 22890), of the cost of

providing the benefit coverage under the high deductible health plan.

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

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

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

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

~~SEC. 6.~~

SEC. 7. Section 22917 is added to the Government Code, to read:

22917. (a) There is in the State Treasury a Public Employees' Health Savings Fund, the purpose of which is to pay the qualified medical expenses of holders of Health Savings Accounts pursuant to Section 22869.5 and pursuant to Section 223 of the Internal Revenue Code. The board shall have the exclusive control of the 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.~~

SEC. 8. 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 the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) "Solicitor" means any person who engages in the acts defined in subdivision (*l*).

(n) "Solicitor firm" means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (*l*).

(o) "Specialized health care service plan contract" means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses 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.

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

(q) Unless the context indicates otherwise, "plan" refers to health care service plans and specialized health care service plans.

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

(s) 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.

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

~~SEC. 8.~~

SEC. 9. Section 1346.2 is added to the Health and Safety Code, to read:

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

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

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

(2) The director 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 enrolled in a health care service plan contract as a result of the requirements described in subdivisions (a) and (b).

~~SEC. 9.~~

SEC. 10. Section 1349.3 is added to the Health and Safety Code, to read:

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

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

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

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

~~SEC. 10.~~

SEC. 11. 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 any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

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

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

(d) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association or an eligible association as well as any other person eligible to purchase through the guaranteed association or eligible association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's or eligible association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association or eligible association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation,

divorce, loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

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

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

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

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

(B) In the case of an association member who did not purchase coverage through a guaranteed association or eligible association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible members of the association at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association or eligible association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association or eligible association,

the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

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

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

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage 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.

(e) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

(10) A health benefit plan under Section 5(e) of the Peace Corps 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)).

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

(i) "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.

(j) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. 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.

(k) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan 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 plan contract will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans 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.

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

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

may be noncontiguous. No plan shall have less than one geographic area.

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

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

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

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the 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 tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract 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 (n), that purchases health coverage for members of the association.

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

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

(n) "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 (*l*), (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 to 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 plan contract that is purchased to all individual members and employer members in this state, (7) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (8) covers at least 100 persons with the health care service plan with which it contracts. The requirement of 100 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 100 persons in the aggregate.

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

(o) "Members of a guaranteed association" or "members of an eligible association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired

members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association or members of the eligible association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

(q) "Eligible association" means a community or civic group or a charitable or religious organization.

~~SEC. 11.~~

SEC. 12. Section 1357.03 of the Health and Safety Code is amended to read:

1357.03. (a) A plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to small employers or to associations that include small employers to all small employers in each service area in which the plan provides or arranges for the provision of health care services, regardless of the employer's implementation of, or intent to implement, any form of claim or benefit support to covered employees. A plan contracting to participate in the voluntary purchasing pool for small employers provided for under Article 4 (commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code shall be deemed in compliance with this requirement for a contract offered through the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code in those geographic regions in which plans participate in the pool, if the contract is offered exclusively through the pool. Each plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state, regardless of the employer's implementation of, or intent to implement, any form of claim or benefit support to covered employees. No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with the employee's

employment or membership in a guaranteed association or an eligible association.

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

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

(1) The small employer, as defined by paragraph (1) of subdivision (*l*) of Section 1357, offers health benefits to 100 percent of its eligible employees, as defined by paragraph (1) of subdivision (b) of Section 1357. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor 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).

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

(1) Health status.

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

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

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

(8) Disability.

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

~~SEC. 12.~~

SEC. 13. Section 1357.06 of the Health and Safety Code is amended to read:

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

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

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

(d) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), health plans 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 article shall become effective. During the waiting or affiliation period, no premiums shall be charged to the enrollee or the subscriber.

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

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

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

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

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

~~SEC. 13.~~

SEC. 14. Section 1357.14 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(3) Provide to small employers and solicitors, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted employee risk rates. When requesting this information, small employers, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the small employer's risk adjusted employee risk rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 14.~~

SEC. 15. Section 1367.01 of the Health and Safety Code is amended to read:

1367.01. (a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, 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 enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan 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 plan enrollees. 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 Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or

concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, 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 pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, 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 enrollees, complies with the requirements of this section.

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

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

~~(2) A licensed health care professional, other than a person licensed to practice medicine pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, may deny~~

(2) A licensee described in paragraph (1) may deny, delay, or modify requests for authorization of health care services for an enrollee for reasons of medical necessity only with respect to services that fall within his or her scope of practice. ~~That professional's~~ *The licensee shall have at least the same scope of practice as the provider submitting the request for authorization. The licensee's* review shall also be subject to standardized protocol

limitations or supervision requirements applicable under his or her license.

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

(4) The primary obligation of the licensee acting pursuant to this subdivision shall be to the enrollee.

~~(4)~~

(5) The decision of the ~~physician or other health care professional described in~~ *licensee acting pursuant to* this subdivision shall be communicated to the provider and the enrollee pursuant to subdivision (h).

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

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

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

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination, including, but not limited to, information from the good faith examination

conducted pursuant to subdivision (e). In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, including, but not limited to, information from the good faith examination conducted pursuant to subdivision (e), and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

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

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been

notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

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

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan 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 plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that

it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan 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 plan 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 plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director 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, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

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

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

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall

include a discussion of compliance with this section as part of its report issued pursuant to that section.

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

(m) Nothing in this section shall cause a health care service plan 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 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

~~SEC. 15.~~

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

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

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

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

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

(3) Incentives or rewards for enrollees to become more engaged in their health care and to make appropriate choices that support good health, including obtaining health risk appraisals, screening services, immunizations, or participating in healthy lifestyle programs and practices. These programs and practices may include, but need not be limited to, smoking cessation, physical activity, or nutrition. Incentives may include, but need not be limited to, health premium reductions, differential copayment or coinsurance amounts, and cash payments. Rewards may include, but need not be limited to, nonprescription pharmacy products or services not otherwise covered under an enrollee's health plan contract, exercise classes, gym memberships, and weight management programs.

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

SEC. 17. Section 1367.63 of the Health and Safety Code is amended to read:

1367.63. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require a plan to provide coverage for cosmetic surgery, as defined in subdivision (d).

(b) No individual, other than a *California* licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual~~,~~ *who is licensed in California and is* competent to evaluate the specific clinical issues involved in the care requested. *A licensee acting pursuant to this subdivision shall have a primary obligation to the enrollee and shall not deny a treatment authorization request without first conducting a good faith examination of the enrollee.*

(c) "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital

defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function.

(2) To create a normal appearance, to the extent possible.

(d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

(e) In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:

(1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.

(2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.

(3) Denial of payment for procedures performed without prior authorization.

(4) For services provided under the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the enrollee, as may be defined in any regulations that may be promulgated by the State Department of Health Services.

SEC. 18. Section 1367.635 of the Health and Safety Code is amended to read:

1367.635. (a) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 1999, that provides coverage for surgical procedures known as mastectomies and lymph node dissections, shall do all of the following:

(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. No health care service plan shall require a treating physician and surgeon to receive prior approval from the plan in determining the length of hospital stay following those procedures.

(2) Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applicable to other benefits.

(3) Cover all complications from a mastectomy, including lymphedema.

(b) As used in this section, all of the following definitions apply:

(1) "Coverage for prosthetic devices or reconstructive surgery" means any initial and subsequent reconstructive surgeries or prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.

(2) "Prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

(3) "Mastectomy" shall have the same meaning as in Section 1367.6.

(4) "To restore and achieve symmetry" means that, in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

(c) No individual, other than a *California* licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section. *A licensee acting pursuant to this subdivision shall have a primary obligation to the enrollee and shall not deny the request for authorization without first conducting a good faith examination of the enrollee.*

(d) No health care service plan shall do any of the following in providing the coverage described in subdivision (a):

(1) Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee or subscriber in accordance with the coverage requirements.

(2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee or subscriber in a manner inconsistent with the coverage requirements.

(3) Provide monetary payments or rebates to an individual enrollee or subscriber to encourage acceptance of less than the coverage requirements.

(e) On or after July 1, 1999, every health care service plan shall include notice of the coverage required by this section in the plan's evidence of coverage.

(f) Nothing in this section shall be construed to limit retrospective utilization review and quality assurance activities by the plan.

~~SEC. 16.~~

SEC. 19. Section 1374.32 of the Health and Safety Code is amended to read:

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

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

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

(1) The plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) The medical professional shall be a clinician knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review. Review by a ~~medical professional, other than a physician licensed to practice medicine pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, shall be limited to services~~ *medical professional shall be limited to services* that fall within that professional's scope of practice and shall be subject to standardized protocol limitations or supervision requirements applicable under his or her license. *In addition, the medical professional reviewer or reviewers shall have at least the same scope of practice as the health care professional that denied, delayed, or modified the health care service in question.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 17.~~

SEC. 20. Section 1374.33 of the Health and Safety Code is amended to read:

1374.33. (a) *(1)* Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the enrollee, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers.

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

(2) In acting pursuant to this section, the primary obligation of the reviewer or reviewers shall be to the enrollee.

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

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

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

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

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

involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

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

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

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

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

~~SEC. 18.~~

SEC. 21. Section 1374.58 of the Health and Safety Code is amended to read:

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

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

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

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

(2) Notwithstanding paragraph (1), a health care service plan may require the information described in that paragraph only if it also requests from the employee or subscriber whose spouse is provided coverage, verification of marital status and notification 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. 22. Section 1395 of the Health and Safety Code is amended to read:

1395. (a) *(1)* Notwithstanding Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code, any health care service plan or specialized health care service plan may, except as limited by this subdivision, solicit or advertise with regard to the cost of subscription or enrollment, facilities and services rendered, provided, however, Article 5 (commencing with Section 600) of Chapter 1 of Division 2 of the Business and Professions Code remains in effect. Any price advertisement shall be exact, without the use of such phrases as "as low as," "and up," "lowest prices" or words or phrases of similar import. Any advertisement that refers to services, or costs for the services, and that uses words of comparison must be based on verifiable data substantiating the comparison. Any health care service plan or specialized health care service plan so advertising shall be prepared to provide information sufficient to establish the accuracy of the comparison. Price advertising shall not be fraudulent, deceitful, or misleading, nor contain any offers of discounts, premiums, gifts, or bait of similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(2) Benefits offered pursuant to a Healthy Action Incentives and Rewards Program described in Section 1367.38 shall not be

considered discounts, premiums, gifts, or bait of similar nature under paragraph (1).

(b) Plans licensed under this chapter shall not be deemed to be engaged in the practice of a profession, and may employ, or contract with, any professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code to deliver professional services. Employment by or a contract with a plan as a provider of professional services shall not constitute a ground for disciplinary action against a health professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code by a licensing agency regulating a particular health care profession.

(c) A health care service plan licensed under this chapter may directly own, and may directly operate through its professional employees or contracted licensed professionals, offices and subsidiary corporations, including pharmacies that satisfy the requirements of subdivision (d) of Section 4080.5 of the Business and Professions Code, as are necessary to provide health care services to the plan's subscribers and enrollees.

(d) A professional licensed pursuant to the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code who is employed by, or under contract to, a plan may not own or control offices or branch offices beyond those expressly permitted by the provisions of the Business and Professions Code.

(e) Nothing in this chapter shall be construed to repeal, abolish, or diminish the effect of Section 129450 of the Health and Safety Code.

(f) Except as specifically provided in this chapter, nothing in this chapter shall be construed to limit the effect of the laws governing professional corporations, as they appear in applicable provisions of the Business and Professions Code, upon specialized health care service plans.

(g) No representative of a participating health, dental, or vision plan or its subcontractor representative shall in any manner use false or misleading claims to misrepresent itself, the plan, the subcontractor, or the Healthy Families or Medi-Cal program while engaging in application assistance activities that are subject to this section. Notwithstanding any other provision of this chapter, any representative of the health, dental, or vision care plan or of the

health, dental, or vision care plan's subcontractor who violates any of the provisions of Section 12693.325 of the Insurance Code shall only be subject to a fine of five hundred dollars ($500) for each of those violations.

(h) A health care service plan shall comply with Section 12693.325 of the Insurance Code and Section 14409 of the Welfare and Institutions Code. In addition to any other disciplinary powers provided by this chapter, if a health care service plan violates any of the provisions of Section 12693.325 of the Insurance Code, the department may prohibit the health care service plan from providing application assistance and contacting applicants pursuant to Section 12693.325 of the Insurance Code.

~~SEC. 19.~~

SEC. 23. 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

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

~~SEC. 20.~~

SEC. 24. Section 699.6 is added to the Insurance Code, to read:

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

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

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

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

~~SEC. 21.~~

SEC. 25. Section 10121.7 of the Insurance Code is amended to read:

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

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

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

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

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

(2) Notwithstanding paragraph (1), a policy may require the information described in that paragraph only if it also requests from the employee, insured, or policyholder whose spouse is provided coverage, verification of marital status and notification 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 group health insurance policy 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, insured, or policyholder.

~~SEC. 22.~~

SEC. 26. Section 10123.56 is added to the Insurance Code, to read:

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

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

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

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

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

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

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

SEC. 27. Section 10123.86 of the Insurance Code is amended to read:

10123.86. (a) Every policy of disability insurance covering hospital, surgical, or medical expenses that is issued, amended,

renewed, or delivered on or after January 1, 1999, that provides coverage for surgical procedures known as mastectomies and lymph node dissections, shall do all of the following:

(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. No disability insurer shall require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following those procedures.

(2) Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applicable to other benefits.

(3) Cover all complications from a mastectomy, including lymphedema.

(b) As used in this section, all of the following definitions apply:

(1) "Coverage for prosthetic devices or reconstructive surgery" means any initial and subsequent reconstructive surgeries or prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.

(2) "Prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

(3) "Mastectomy" shall have the same meaning as in Section 10123.8.

(4) "To restore and achieve symmetry" means that, in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

(c) No individual, other than a *California* licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section. *A licensee acting pursuant to this subdivision shall have a primary obligation to the insured and shall not deny the request for authorization without first conducting a good faith examination of the insured.*

(d) No insurer shall do any of the following in providing the coverage described in subdivision (a):

(1) Reduce or limit the reimbursement of the attending provider for providing care to an insured in accordance with the coverage requirements.

(2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with the coverage requirements.

(3) Provide monetary payments or rebates to an insured to encourage acceptance of less than the coverage requirements.

(e) On or after July 1, 1999, every insurer shall include notice of the coverage required by this section in the insurer's evidence of coverage or certificate of insurance.

(f) Nothing in this section shall be construed to limit retrospective utilization review and quality assurance activities by the insurer.

(g) This section shall only apply to health benefit plans, as defined in subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity insurance, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

SEC. 28. Section 10123.88 of the Insurance Code is amended to read:

10123.88. (a) Every policy of disability insurance covering hospital, medical, or surgical expenses that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require a policy to provide coverage for cosmetic surgery, as defined in subdivision (d). This section shall only apply to health benefit plans, as defined in subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity insurance, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. Nothing in this section shall be construed as imposing a

new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(b) No individual, other than a *California* licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual~~,~~ *who is licensed in California and is* competent to evaluate the specific clinical issues involved in the care requested. *A licensee acting pursuant to this subdivision shall have a primary obligation to the insured and shall not deny a treatment authorization request without first conducting a good faith examination of the insured.*

(c) "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function.

(2) To create a normal appearance, to the extent possible.

(d) Nothing in this section shall be construed to require an insurer to provide coverage for cosmetic surgery. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

(e) In interpreting the definition of reconstructive surgery, an insurer may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:

(1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.

(2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.

(3) Denial of payment for procedures performed without prior authorization.

~~SEC. 23.~~

SEC. 29. Section 10123.135 of the Insurance Code is amended 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

California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer 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, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

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

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

~~(2) A licensed health care professional, other than a person licensed to practice medicine pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act,~~

(2) A licensee described in paragraph (1) may deny, *delay,* or modify requests for authorization of health care services for an insured for reasons of medical necessity only with respect to services that fall within his or her scope of practice. ~~That professional's~~ *The licensee shall have at least the same scope of practice as the provider submitting the request for authorization. The licensee's* review shall also be subject to standardized protocol limitations or supervision requirements applicable under his or her license.

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

(4) The primary obligation of the licensee acting pursuant to this subdivision shall be to the insured.

~~(4)~~

(5) The decision of the ~~physician or other health care provider described in~~ *licensee acting pursuant to* this subdivision shall be communicated to the provider and the insured pursuant to subdivision (h).

(f) (1) An insurer shall disclose, or provide for the disclosure, 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 shall request only the information reasonably necessary to make the determination.

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

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

(2) When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain

maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours after the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination, including, but not limited to, information from the good faith examination conducted pursuant to subdivision (e).

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

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall be communicated to insureds in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the insurer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification or a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health

care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 and the regulations adopted 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 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

~~SEC. 24.~~

SEC. 30. Section 10123.136 is added to the Insurance Code, to read:

10123.136. For purposes of this code, with respect to a policy of health insurance, 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.

~~SEC. 25.~~

SEC. 31. Section 10169.2 of the Insurance Code is amended to read:

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

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

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

(1) The insurer.

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

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

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

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

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

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

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

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

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

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

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

(D) The names and biographical sketches of all directors, officers, and executives of the independent medical review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with

any health care service plan, disability insurer, managed care organization, provider group, or board or committee of an insurer, a plan, a managed care organization, or a provider group.

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

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

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

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

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

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

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

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

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

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

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

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

(A) The medical professional shall be a clinician knowledgeable in the treatment of the insured's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review. Review by a ~~medical professional, other than a physician licensed to practice medicine pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, shall be limited to services~~ *medical professional shall be limited to services* that fall within that professional's scope of practice and shall be subject to standardized protocol limitations or supervision requirements applicable under his or her license. *In addition, the medical professional reviewer or reviewers shall have at least the same scope of practice as the health care professional that denied, delayed, or modified the health care service in question.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 26.~~

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

10169.3. (a) *(1)* Upon receipt of information and documents related to a case, the medical professional reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the insured, provider reports, as well as any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers. If reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (b). In addition, at least one medical professional reviewer selected to conduct the review shall conduct a good faith examination of the insured. This good faith examination shall not be required if the insured's policy explicitly excludes coverage of the disputed health care service.

(2) In acting pursuant to this section, the primary obligation of the reviewer or reviewers shall be to the insured.

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

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

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

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

(c) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, including, but not limited to, information from the good faith examination conducted pursuant to subdivision (a), or within less time as prescribed by the commissioner. If the disputed health care service has not been

provided and the insured's provider or the department certifies in writing that an imminent and serious threat to the health of the insured may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information, including, but not limited to, information from the good faith examination conducted pursuant to subdivision (a). Subject to the approval of the department, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the commissioner for up to three days in extraordinary circumstances or for good cause.

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

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

(f) The commissioner shall immediately adopt the determination of the independent medical review organization, and shall promptly

issue a written decision to the parties that shall be binding on the insurer.

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

~~SEC. 27.~~

SEC. 33. Section 10700 of the Insurance Code is amended to read:

10700. As used in this chapter:

(a) "Agent or broker" means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

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

(c) "Board" means the Major Risk Medical Insurance Board.

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

(e) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan 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 (z).

(f) "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, in the small employer's regular place 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 they are included as employees under a health benefit plan 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. A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all four of the following apply:

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

(B) The employer offers the employee 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 insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

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

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

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

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

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

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

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

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

(*l*) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association or an eligible association as well as any other person eligible to purchase through the guaranteed association or eligible association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's or eligible association's health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association or an eligible association pursuant to

subdivision (z), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

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

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

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

(4) (A) In the case of an eligible employee as defined in paragraph (1) of subdivision (f), the carrier cannot produce a written statement from the employer stating that the individual or the person through whom an individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed acknowledgment of, an explicit written notice in

boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) In the case of an eligible employee who is a guaranteed association member or an eligible association member, the plan cannot produce a written statement from the guaranteed association or eligible association stating that the association sent a written notice in boldface type to all potentially eligible members of the association at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

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

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

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program as a result of exceeding the program's

income or age limits or no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage 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 treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(r) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

(10) A health benefit plan under Section 5(e) of the Peace Corps 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.

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

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

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

(1) Any person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar

year, employed at least two, but not more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (b) and (h) of Section 10705, the 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 choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (8) covers at least 100 persons with the carrier with which it contracts. The requirement of 100 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 100 persons in the aggregate.

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

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

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

(ab) "Eligible association" means a community or civic group or a charitable or religious organization.

~~SEC. 28.~~

SEC. 34. Section 10705 of the Insurance Code is amended to read:

10705. (a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10717.

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

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

(2) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association 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 employees. Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

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

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

(2) For each benefit plan design, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making selections of benefit plan designs. An entity that provides administrative services only with regard to a benefit plan

design written or issued by another carrier shall not be required to prepare an evidence of coverage for that benefit plan design.

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

(4) Provide copies of the current summary brochure to all agents or brokers who represent the carrier and, upon updating the brochure, send copies of the updated brochure to agents and brokers representing the carrier for the purpose of selling health benefit plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The small employer as defined by paragraph (1) of subdivision (w) of Section 10700 offers health benefits to 100 percent of its eligible employees as defined in paragraph (1) of

subdivision (f) of Section 10700. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

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

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

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

(A) 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.

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

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

(A) 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.

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

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

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

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

(2) This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent 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 coverage to any small employers under any health benefit plans during the remainder of the current year. If the certification is not approved, the carrier shall continue to issue coverage as required by subdivision (d) and be subject to administrative penalties as established in Section 10718.

~~SEC. 29.~~

SEC. 35. Section 10706 of the Insurance Code is amended to read:

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

~~SEC. 30.~~

SEC. 36. Section 10708 of the Insurance Code is amended to read:

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

(b) A carrier that does not utilize a preexisting condition provision may impose 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 subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any postenrollment or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

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

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

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered 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. 31.~~

SEC. 37. 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.

(c) Before a health insurance policy 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 insurer has explained the contents of the disclosure and that he or she understands those contents.

~~SEC. 32.~~

SEC. 38. Article 7 (commencing with Section 11885) is added to Chapter 4 of Part 3 of Division 2 of the Insurance Code, to read:

Article 7. 24-Hour Care Policies

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

~~SEC. 33.~~

SEC. 39. Section 12938.1 is added to the Insurance Code, to read:

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

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

(c) (1) The commissioner shall report to the chair and to the vice chairs of the Senate Committee on Banking, Finance and Insurance, the Senate Committee on Appropriations, the Assembly Committee on Insurance, and the Assembly Committee on Appropriations prior to December 31, 2010, on the status of the requirements imposed by subdivisions (a) and (b) and on the number of health insurers that have applied to the department for initial review and approval of new health insurance policies on 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. 34.~~

SEC. 40. 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. 35.~~

SEC. 41. 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 compensation pursuant to this section. An employee shall provide a voluntary, signed written request that includes the start date of the alternative workweek schedule and the days and the number of hours per day for the alternative workweek schedule. If agreed, the employer and employee shall execute a written agreement that includes the start date of the alternative workweek schedule and the days and the number of hours per day for the alternative workweek schedule. The employer shall maintain the written agreement as a record for three years beyond the termination of the alternative workweek agreement. The employee or employer may terminate the agreement at any time upon seven days' advance written notice.

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

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

(e) An employer shall make a reasonable effort to find a work schedule not to exceed eight hours in a workday, in order to accommodate any affected employee who was eligible to vote in an election authorized by subdivision (a) and who is unable to work the alternative schedule hours established as the result of that election. An employer shall be permitted to provide a work schedule not to exceed eight hours in a workday to accommodate any employee who was hired after the date of the election and who is unable to work the alternative schedule established as the result of that election. An employer shall explore any available reasonable alternative means of accommodating the religious belief or observance of an affected employee that conflicts with an adopted alternative workweek schedule, in the manner provided by subdivision (i) of Section 12940 of the Government Code.

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

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

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

provisions of Wage Order Number 4 or 5 that were in effect prior to 1998.

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

~~SEC. 36.~~

SEC. 42. 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 1/40th 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. 37.~~

SEC. 43. 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.

~~SEC. 38.~~

SEC. 44. Section 17053.77 is added to the Revenue and Taxation Code, to read:

17053.77. (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 "net tax," as defined in Section 17039, 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.

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

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

(e) 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.

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

~~SEC. 39.~~

SEC. 45. Section 17053.91 is added to the Revenue and Taxation Code, to read:

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

(b) For purposes of this section:

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

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

(c) 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. 46. Section 17053.102 is added to the Revenue and Taxation Code, to read:

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

(b) For purposes of this section:

(1) "Physician" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California.

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

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

(c) 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. 41.~~

SEC. 47. Section 17053.103 is added to the Revenue and Taxation Code, to read:

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

(b) For purposes of this section, "primary care provider" means a physician and surgeon, a nurse practitioner, or a physician's assistant.

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

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

(e) In the case of a primary care provider who is a physician and surgeon who changes his or her practice from primary care to specialty care, any credit previously allowed by this section shall be recaptured by adding the amount of the credit to the "net tax" 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. 42.~~

SEC. 48. 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. 43.~~

SEC. 49. 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. 44.~~

SEC. 50. 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. 45.~~

SEC. 51. 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. 46.~~

SEC. 52. Section 17215 of the Revenue and Taxation Code is amended to read:

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

accounts, on the federal income tax return filed for the same taxable year by that individual.

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

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

(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. 53. Section 17216 is added to the Revenue and Taxation Code, to read:

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

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

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

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

~~SEC. 48.~~

SEC. 54. Section 19184 of the Revenue and Taxation Code is amended to read:

19184. (a) A penalty of fifty dollars ($50) shall be imposed for each failure, unless it is shown that the failure is due to

reasonable cause, by any person required to file who fails to file a report at the time and in the manner required by any of the following provisions:

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

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

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

(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. 49.~~

SEC. 55. 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. 50.~~

SEC. 56. 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.

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

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

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

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

~~SEC. 51.~~

SEC. 57. Section 14026.7 is added to the Welfare and Institutions Code, to read:

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

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

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

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

(b) When the department receives an alert from the computer modeling program established pursuant to subdivision (a), the department shall conduct a Medi-Cal fraud investigation if the

department determines an investigation is appropriate under the circumstances.

~~SEC. 52.~~

SEC. 58. Section 14029.7 is added to the Welfare and 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. 53.~~

SEC. 59. 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 and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

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

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

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

(d) (1) Except as provided in paragraph (4), if the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants

and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

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

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

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

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

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

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders

to identify similar criteria for other providers so that they may be considered as preferred providers.

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

(i) Dentists.

(ii) Physicians and surgeons.

(iii) Osteopathic physicians and surgeons.

(iv) Nurse anesthetists.

(v) Nurse practitioners.

(vi) Physician assistants.

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

(i) The applicant is in good standing as a provider under the federal Medicare Program.

(ii) The applicant is in good standing with his or her state licensing board.

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

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

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

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

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal

program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall issue the applicant a provider number or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

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

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

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California, or from the date of the notice to that physician or physician group that does not qualify as a preferred provider under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it is issued, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to

deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(*l*) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) The amendments to subdivision (b), which implement a change of location form, and the addition of paragraph (2) to subdivision (c), the amendments to subdivision (e), and the addition of subdivision (g), which prescribe different processing timeframes for physicians and physician groups, as contained in Chapter 693 of the Statutes of 2007, shall become operative on July 1, 2008.

~~SEC. 54.~~

SEC. 60. Section 14079.7 is added to the Welfare and Institutions Code, to read:

14079.7. (a) (1) Notwithstanding any other provision of this chapter, on January 1, 2010, the reimbursement levels for fee-for-service physician services under Medi-Cal shall be increased to 80 percent of the amount that the federal Medicare Program reimburses for these same services in Area 9 (Santa Clara County). This reimbursement change shall apply only to services reimbursed at rates below 80 percent of the amount that the federal Medicare Program reimburses for these same services in Area 9.

(2) After the implementation of the rate increase described in paragraph (1), physician rates shall be increased annually in accordance with the California Consumer Price Index.

(b) The increase of reimbursement rates described in subdivision (a) shall be made for fee-for-service physician services rendered on or after January 1, 2010.

~~SEC. 55.~~

SEC. 61. Article 2.94 (commencing with Section 14091.50) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.94. The Medi-Cal Empowerment Act

14091.50. This article shall be known, and may be cited, as the "Medi-Cal Empowerment Act."

14091.51. The Legislature finds and declares the following:

(a) Medi-Cal provides health coverage to approximately 6.6 million low-income, aged, and disabled beneficiaries at a total projected cost for the 2006–07 fiscal year of $35 billion, $13.7 billion from the General Fund.

(b) Since 2000, General Fund expenditures on Medi-Cal have risen by 44 percent.

(c) In 2000, Medi-Cal expenditures comprised 13 percent of the General Fund budget, but are projected to rise to 21 percent of the General Fund budget by 2015.

(d) Including federal funds, Medi-Cal expended about three thousand seven hundred dollars ($3,700) per enrollee in the 2006–07 fiscal year.

(e) Cost increases to the Medi-Cal program are unsustainable without reductions in eligibility or benefits.

(f) Medi-Cal is a large purchaser of health care services and should share in the responsibility of helping stabilize runaway

health care costs that can contribute towards increasing the population of the uninsured.

(g) Empowering Medi-Cal beneficiaries to become more active participants in their utilization of health care services will help reduce the perceived or actual stigma associated with receiving 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 the per enrollee Medi-Cal cost in each county as well as the overall Medi-Cal cost per county.

(b) An eligible individual shall be enrolled into the demonstration program only if the individual voluntarily enrolls.

(c) Enrollment shall be effective for a period of 12 months, and may be extended for additional periods of 12 months each with the consent of the individual.

(d) An individual who, for any reason, is disenrolled from the demonstration program under this section shall not be permitted to reenroll earlier than one year after disenrollment.

14091.55. (a) Insurance plans offered to enrollees who volunteer to participate in the demonstration shall encompass all standard Medi-Cal benefits.

(b) The amount of the annual deductible shall be at least 100 percent and no more than 110 percent of the amount of the contribution to the HOA.

(c) The number of individuals enrolled in any managed care organization that participate in this demonstration project shall not be either of the following:

(1) In excess of 5 percent of the total number of individuals enrolled in the organization.

(2) Significantly disproportionate to the proportion of similar enrollees in other participating managed care organizations.

(d) The state shall provide an adjustment in the per capita payments to a participating managed care organization to account for participation in the HOA. This shall take into account the difference in the likely use of health care services between managed care enrollees who participate in the HOA and managed care enrollees who do not participate in the HOA.

14091.56. (a) The department may consider each participating enrollee's health to determine the state's contribution into an enrollee's HOA.

(b) Funds in an individual's HOA may be used for the purchase of medical services and private health care coverage authorized by the department or offered by the individual's employer.

(c) Charitable organizations may also contribute to an individual's HOA.

(d) After the individual has satisfied the annual deductible, alternative benefits for an eligible individual shall consist of at least the benefits that would otherwise be provided to the individual, including cost sharing relating to those benefits, if the individual was not enrolled in the demonstration project.

(e) After one year of participation in the program, an individual may use HOA funds for job training or tuition expenses.

(f) Any remaining funds in the individual's HOA shall carry over into subsequent years, provided that the individual is enrolled in an approved plan.

(g) If an individual disenrolls from the program, all of the following shall occur:

(1) The state shall cease all contributions.

(2) The HOA administrator shall remit 50 percent of the account to the General Fund.

(3) The remaining funds shall be used by the individual within three years to purchase health insurance coverage or on any other qualifying expenses, which may include job training or tuition expenses.

14091.57. (a) The following individuals shall not be enrolled in the demonstration project during the first five years after it is approved:

(1) Individuals who are 65 years of age or older.

(2) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this title is based on that disability.

(3) Individuals who are eligible for medical assistance under this title only because they are, or were, within the previous 60 days, pregnant.

(4) Individuals who have been eligible for medical assistance for a continuous period of less than three months.

(b) The following individuals within a category of assistance described in Section 1937(a)(2)(B) of the federal Social Security Act (42 U.S.C. Sec. 13960-7(a)(2)(B)) shall not be enrolled in the demonstration project:

(1) The individual is a pregnant woman who is required to be covered under the state plan under Section 1902(a)(10)(A)(i) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)).

(2) The individual qualifies for medical assistance under the state plan on the basis of being blind or disabled, or being treated as being blind or disabled, without regard to whether the individual is eligible for supplemental security income benefits under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.) on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of Section 1902(e)(3) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(3)).

(3) The individual is entitled to Medicare benefits under any part of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) The individual is terminally ill and is receiving Medicare benefits for hospice care.

(5) The individual is an inpatient in a health facility, and is required, as a condition of receiving services in that facility under the state plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(6) The individual is medically frail or otherwise an individual with special medical needs as defined in Section 438.50(d) of Title 42 of the Code of Federal Regulations.

(7) The individual qualifies based on medical condition for medical assistance for long-term care services described in Section 1917(c)(I)(C) of the federal Social Security Act (42 U.S.C. Sec. 1396p(c)(I)(C)).

(8) The individual is an individual with respect to whom aid or assistance is made available under Part B (commencing with Section 450) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 650 et seq.) to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under Part E (commencing with Section 470) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 670 et seq.), without regard to age.

(9) The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a state plan funded under Part A (commencing with Section 401) of Title IV of the federal Social Security Act (42 U.S.C. Sec. 601 et seq.), as in effect on or after August 26, 1996.

(10) The individual is a woman who is receiving medical assistance by virtue of the application of Section

1902(a)(10)(ii)(XVIII) of the federal Social Security Act (42 U.S.C. 1396a(a)(10)(ii)(XVIII)), and Section 1902(aa) of the federal Social Security Act (42 U.S.C. Sec. 1396a(aa)).

(11) The individual qualifies for medical assistance on the basis of Section 1902(a)(10)(A)(ii)(XII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XII)) or is not a qualified alien (as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with Section 1903(v) of the federal Social Security Act (42 U.S.C. Sec. 1396b(v)).

14091.58. The department shall coordinate administration of HOAs through the use of a third-party administrator and may implement appropriate policies and procedures for implementation of this demonstration project consistent with federal laws, regulations, and other guidance.

14091.59. The department shall annually report to the Governor and the Legislature on the results of this demonstration project.

~~SEC. 56.~~

SEC. 62. Section 14132.104 is added to the Welfare and Institutions Code, to read:

14132.104. (a) On or before January 1, 2011, the department shall provide or arrange for the provision of an electronic personal health record (PHR) and an electronic personal benefits record (PBR) for beneficiaries under the Medi-Cal program. The records shall be provided for the purpose of providing beneficiaries with information to assist them in understanding their coverage benefits and managing their health care.

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

(c) The PHR shall incorporate personal health information, including, but not limited to, medical history, laboratory results, prescription history, and other personal health information authorized or provided by the beneficiary. The PHR shall not be provided through the use of an Internet-based system. Inclusion of this additional data shall be at the option of the beneficiary.

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

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

~~SEC. 57.~~

SEC. 63. 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. 58.~~

SEC. 64. Section 14133 of the Welfare and Institutions Code is amended to read:

14133. Utilization controls that may be applied to the services set forth in Section 14132 which are subject to utilization controls shall be limited to:

(a) Prior authorization, which is approval by a department consultant, of a specified service in advance of the rendering of that service based upon a determination that the service is covered under Medi-Cal.

(b) Postservice prepayment audit, which is review for program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was not a covered benefit. Nothing in this subdivision shall supersede the claims processing deadlines provided by Section 14104.3.

(c) Postservice postpayment audit, which is review for program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.

(d) Limitation on number of services, which means certain services may be restricted as to number within a specified time frame.

(e) Review of services pursuant to Professional Standards Review Organization agreements entered into in accordance with Section 14104.

~~SEC. 59.~~

SEC. 65. Section 14164.5 is added to the Welfare and Institutions Code, to read:

14164.5. Before making any adjustment to Medi-Cal reimbursement rates, the State Department of Health Care Services shall consider the extent to which Medi-Cal beneficiaries have the ability to access physician services by geography and specialty and shall also 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.

~~SEC. 60.~~

SEC. 66. Division 23 (commencing with Section 23000) is added to the Welfare and Institutions Code, to read:

DIVISION 23. PAYMENT OF HOSPITALS AND HEALTH CARE PROVIDERS PROVIDING SERVICES TO UNINSURED PERSONS

23000. (a) For purposes of this division, the following definitions shall apply:

(1) "Claimant" means a hospital or health care provider that has filed a claim with the department for unpaid health care services pursuant to this division.

(2) "Debtor" means an individual who received health care services from claimant, has not paid for those services, and was not covered by a health insurance policy or plan and was not eligible to receive health care benefits under a government program at the time he or she received services from the claimant.

(3) "Department" means the State Department of Health Care Services.

(4) "Director" means the Director of Health Care Services.

(5) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act, or certified pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(b) A hospital or health care provider may file a claim with the department to be reimbursed for health care services it has provided if both of the following conditions have been met:

(1) The health care services were provided to an individual who, at the time he or she received health care services from the claimant, was not covered by a health insurance policy or plan and was not eligible to receive health care benefits under a government program.

(2) The individual who received the health care services has not paid the hospital or health care provider for those services.

(c) Both of the following conditions shall apply to a claim filed pursuant to subdivision (b):

(1) The claim is filed 90 days or more after the health care services were provided to the debtor.

(2) The claimant includes the following information in the claim:

(A) The identity of the debtor.

(B) The amount owed to the claimant for health care services provided.

(d) Upon receiving the claim, the director shall determine whether the claim is meritorious on its face. If the director determines the claim is meritorious on its face, he or she shall certify the debt to the Franchise Tax Board and the California Lottery Commission to have the debt satisfied with any tax refund or lottery prize money owed to the debtor.

(e) When a claim is certified to the Franchise Tax Board and the California Lottery Commission, the certification shall include the following:

(1) Identity of the debtor.

(2) Amount of money owed to the claimant.

(f) If the director certifies the debt, the debt shall constitute a debt owed to the department.

(g) Upon receiving a certification of debt pursuant to this section, the Franchise Tax Board and the California Lottery Commission shall, respectively, determine if the debtor is owed a tax refund or lottery prize money. If the debtor is owed a tax refund or lottery prize money, the Franchise Tax Board or the California Lottery Commission, as appropriate, shall notify the debtor by certified mail of the following:

(1) The amount of money owed to the claimant for health care services.

(2) That the debtor's tax refund or lottery prize money shall be reduced by the amount owed to the claimant.

(3) The debtor's right to a fair hearing, pursuant to subdivision (h), to object to the Franchise Tax Board's or California Lottery Commission's actions.

(h) The Franchise Tax Board and the California Lottery Commission shall comply with the following when deducting money from the debtor's tax refund or lottery prize money:

(1) If the tax refund or lottery prize money is more than the debt owed to the claimant, the debtor shall receive the remaining

difference within a reasonable time after the excess amount is determined.

(2) Under no circumstances shall the money deducted from the tax refund or lottery prize money exceed the sum of the amount owed to the claimant and any administrative costs incurred by the department and the Franchise Tax Board or California Lottery Commission in implementing this division.

(3) Delinquent taxes owed by the debtor shall be paid off using the debtor's tax refund or lottery prize money before any deductions are made from the tax refund or lottery prize money to settle the debt owed by the debtor to the department pursuant to this division.

(i) If the debtor disagrees with actions taken by the Franchise Tax Board or California Lottery Commission pursuant to this division, he or she shall have the right to receive a fair hearing from the board or commission, as applicable.

(j) After the Franchise Tax Board deducts money from the debtor's tax refund or the California Lottery Commission deducts money from the debtor's lottery prize money, the Franchise Tax Board and California Lottery Commission shall transfer the money to the department.

(k) Upon receiving the money from the debtor's tax refund or lottery prize money, or both, the department shall settle the debt owed to the claimant. At the time of settlement, the claimant shall be charged by the department for administrative expenses associated with implementing this division, but under no circumstances shall the administrative expenses exceed 20 percent of the collected amount.

(*l*) The director, the Franchise Tax Board, and the California Lottery Commission shall jointly promulgate regulations necessary to administer the provisions of this division.

~~SEC. 61.~~

SEC. 67. On or before March 1, 2014, the Legislative Analyst shall report to the Legislature on the effectiveness of the tax credits provided by Sections 17053.77 and 23677 of the Revenue and Taxation Code, as added by this act, upon employed Californians' ability to meet deductible medical expenses incurred under qualified health insurance plans.

~~SEC. 62.~~

SEC. 68. (a) The amendments made by this act to Sections 17072, 17215, and 19184 of the Revenue and Taxation Code incorporate, by reference, the provisions of Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), which added Section 223 of the Internal Revenue Code to Part VII of Subchapter B of Chapter 1 of Subtitle A of the Internal Revenue Code and amended Sections 62, 106, 125, and 220 of the Internal Revenue Code, and shall apply retroactively to taxable years beginning on or after January 1, 2009.

(b) The Legislature finds and declares that this act fulfills a statewide public purpose because of the following:

The State of California has not yet conformed its state income tax law to the provisions of Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173). As a result, the taxpayers who have converted their Archer Medical Savings Accounts into Health Savings Accounts pursuant to Sections 220 and 223 of the Internal Revenue Code may be subject to tax and penalties under state, but not federal, income tax laws. This act provides necessary relief from the tax and penalties to the taxpayers who have converted their Archer Medical Savings Accounts into Health Savings Accounts in taxable years beginning on or after January 1, 2009.

(c) If, by the operation of any law or rule of law, including res judicata, a refund or credit of any overpayment of tax resulting from the retroactive application of the amendments made to Sections 17072, 17215, and 19184 of the Revenue and Taxation Code by this act is prevented at any time before the close of the two-year period beginning on the effective date of this act, that refund or credit may nonetheless be made or allowed, provided that the claim for refund or credit is filed before the close of that period.

~~SEC. 63.~~

SEC. 69. (a) The Legislature finds and declares all of the following:

(1) Currently, a significant percentage of Californians seek nonemergency health care services from hospital emergency departments.

(2) A hospital emergency department is an expensive place to seek primary care services.

(3) Community-based primary care clinics offer a cost-effective, high-quality alternative to hospital emergency departments for people seeking access to primary care services.

(4) Expanded primary care clinic capacity will mean that fewer people will seek nonemergency services from hospital emergency departments, which will allow these emergency departments to better focus on patients with truly emergent conditions.

(5) As expanded primary care clinic capacity will result in fewer people seeking services from expensive emergency departments, it is appropriate to redirect funds currently going to hospitals for the care of Medi-Cal beneficiaries and the uninsured, and use these funds to expand the capacity of existing clinics and increase the overall number of clinics in California.

(b) Notwithstanding any other provision of law, the Director of Health Care Services shall provide to the Legislature, no later than July 1, 2010, a plan to permit funds currently available to hospitals pursuant to Article 5.2 (commencing with Section 14166) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to be used instead to increase access to primary care services through the creation of new clinics and the expansion of existing clinics, as defined in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(c) The director shall determine the amount of funds to be redirected annually pursuant to the plan using a methodology that considers both anticipated and actual changes in the numbers of patients seeking nonemergency services at clinics and hospital emergency departments. The director may include other relevant data in the methodology.

(d) The plan developed pursuant to subdivision (b) shall do both of the following:

(1) Give priority access of the redirected funds to interested clinics and organizations that have an explicit commitment to, and a demonstrated record of, serving uninsured individuals and those enrolled in public programs, such as the Medi-Cal program and the Healthy Families Program.

(2) Include a transition plan that minimizes disruptions in existing patient access to health care services and to the hospitals currently receiving the funding.

(e) The director shall seek all necessary federal waivers in order to implement the plan developed pursuant to subdivision (b). The plan shall not be implemented without subsequent statutory authorization.

~~SEC. 64.~~

SEC. 70. It is 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.

~~SEC. 65.~~

SEC. 71. It is 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.

~~SEC. 66.~~

SEC. 72. It is 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.

~~SEC. 67.~~

SEC. 73. The Legislature hereby finds and declares all of the following:

(a) Federal law requires hospitals to provide health care services to anyone who enters an emergency room, regardless of ability to pay or immigration status.

(b) The federal government does not provide full compensation to cover the costs of providing this health care coverage.

(c) The Legislature hereby memorializes 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.

~~SEC. 68.~~

SEC. 74. It is the intent of the Legislature to enact legislation that would relieve the overutilization of hospital emergency rooms by allowing hospitals to offer preventative medical services delivered through the hospital's primary care or community-based clinic.

~~SEC. 69.~~

SEC. 75. It is the intent of the Legislature to enact legislation that would impose consequences on attorneys and litigants who do either of the following:

(a) File at least two lawsuits within a five-year period against one or more health care providers if the providers are found to have given appropriate care that did not contribute to a patient's complications.

(b) File a lawsuit against a health care provider that is dismissed with prejudice.

~~SEC. 70.~~

SEC. 76. It is the intent of the Legislature to enact legislation that would provide incentives to employers who offer health insurance, flex-time work schedules, and other benefits agreed upon by employers and employees.

~~SEC. 71.~~

SEC. 77. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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