

## Assembly Bill No. 1126

### CHAPTER 623

An act to amend Section 6254 of the Government Code, to amend Section 101755 of the Health and Safety Code, and to add and repeal Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, relating to children, and making an appropriation therefor.

[Approved by Governor October 2, 1997. Filed  
with Secretary of State October 3, 1997.]

#### LEGISLATIVE COUNSEL'S DIGEST

AB 1126, Villaraigosa. Children's health coverage.

Existing law establishes various health care programs to provide health care to low-income uninsured persons.

This bill would create the Healthy Families Program, to be administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health services to eligible children. Coverage would be afforded using a purchasing pool model, issuance of insurance purchasing credits, or other appropriate means, and would be provided by a broad range of health plans, including insurers, health care service plans, county organized health systems, health care authorities, and local initiatives. Medical, dental, and vision services would be provided, as specified.

The bill would provide for eligibility of persons older than 12 months, and less than 19 years of age, who meet other criteria, including having a gross annual household income equal to or less than 200% of the federal poverty level and meeting citizenship and immigration requirements. The bill would limit premiums and copayments.

The bill would enact related provisions.

The bill would establish the Healthy Families Fund, which would be continuously appropriated for the purposes of the bill.

These provisions would be implemented only if federal financial participation is provided, as specified. They would remain in effect only until January 1, 2004, and as of that date would be repealed.

The bill would become operative only if SB 903 is enacted.

Because a violation of certain provisions would be a crime, it would create a state-mandated local program.

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.

Appropriation: yes.

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

SECTION 1. Section 6254 of the Government Code is amended to read:

6254. Except as provided in Sections 6254.7 and 6254.13, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary course of business, provided that the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, which are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes,



except that state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (c) of Section 13960, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflect the analysis or conclusions of the investigating officer.

Other provisions of this subdivision notwithstanding, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 261, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime,



information disclosing that the person is a victim of a crime defined by Section 220, 261, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code, except that the address of the victim of any crime defined by Section 220, 261, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph shall not be used directly or indirectly to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(l) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's legal affairs secretary, provided that public records shall



not be transferred to the custody of the Governor's legal affairs secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public data base maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application which are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, that reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Articles 2.6 (commencing with Section 14081), 2.8 (commencing with Section 14087.5), and 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. In the event that a contract for



inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places maintained by the Native American Heritage Commission.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of Health Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) Information contained in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant's medical or psychological history or that of members of his or her family.

(v) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695), and Part 6.5 (commencing with Section 12700), of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.



(2) (A) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Part 6.3 (commencing with Section 12695), or Part 6.5 (commencing with Section 12700), of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract for health coverage that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of the Department of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or, financial data regarding the funded



accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code, on or after January 1, 1998, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act.

SEC. 2. Part 6.2 (commencing with Section 12693) is added to Division 2 of the Insurance Code, to read:

## PART 6.2. HEALTHY FAMILIES

### CHAPTER 1. PURPOSE

12693. The Legislature declares all of the following:



(a) Approximately 1.6 million California children, 17 percent of children ages 17 and under, have no health insurance. One in four California children, which is 2.3 million, rely on Medi-Cal for insurance coverage, while just over half of the state's children, 53 percent, have employment-based coverage through a parent.

(b) Most uninsured California children come from low-income families, with nearly 75 percent of uninsured children (1.2 million) living in families with incomes below 200 percent of the federal poverty level. Children whose families earn incomes between 100 and 200 percent of the federal poverty level, an estimated 580,000 children, are among the most vulnerable of populations. Their families make too much money to generally qualify for free Medi-Cal, are employed in working class jobs that typically do not offer insurance, and cannot afford private health insurance. In short, affordability remains a major barrier to obtaining coverage.

(c) Notwithstanding the generally good health of children, health insurance coverage is important to ensure that they receive the health care that is essential to monitor their growth, nutrition, and development and to address potential health problems early.

(d) Lack of insurance coverage for children results in reduced access to medical services, resulting in restricted access to primary and preventive care and increased reliance on emergency rooms and hospitals for treatment. Timely treatment for infectious and chronic diseases can prevent more serious medical conditions in children of all ages.

(e) When a child is seriously ill or injured, the costs of needed medical care can force families into financial ruin.

(f) That by July 1, 1998, there shall be in place a program providing access to health coverage to all children residing in households with family incomes below 200 percent of the federal poverty level.

(g) It is the intent of the Legislature that the program comply with the requirements of Title XXI of the Social Security Act, also known as the State Children's Health Insurance Program.

## CHAPTER 2. DEFINITIONS

12693.01. For purposes of this part, the definitions contained in this chapter shall govern the construction of this part, unless the context requires otherwise.

12693.02. "Applicant" means a person over the age of 18 years who is a natural or adoptive parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. "Applicant" also means a person 18 years of age who is applying on his or her own behalf for coverage under the program.

12693.03. "Board" means the Managed Risk Medical Insurance Board.



12693.04. “Child” means a person who is under 19 years of age who is eligible for the program pursuant to Chapter 9 (commencing with Section 12693.70).

12693.045. “Community provider plan” means that participating health plan in each geographic area that has been designated by the board as having the highest percentage of traditional and safety net providers in its provider network.

12693.05. “County organized health system” means a health care organization that contracts with the State Department of Health Services to provide comprehensive health care to all eligible Medi-Cal beneficiaries residing in the county, and that is operated directly by a public entity established by a county government pursuant to Section 14087.51 or 14087.54 of the Welfare and Institutions Code, or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

12693.06. “Family contribution” means the cost to an applicant to enable herself or himself or an eligible child or children to enroll in and participate in the program. Family contribution does not include copayments for insured services.

12693.065. “Family value package” means the combination of participating health, dental, and vision plans available to subscribers in each geographic area offering the lowest prices to the program. The board may define the family value package to include not only the combination of participating health, dental, and vision plans offering the absolute lowest price to the program but also the combination of health, dental, and vision plans within a fixed percentage or dollar amount of the absolute lowest price.

12693.07. “Fund” means the Healthy Families Fund.

12693.08. “Local initiative” means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries. The entities established pursuant to the following sections of the Welfare and Institutions Code are local initiatives: Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96.

12693.09. “Participating dental plan” means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the board to provide coverage to program subscribers:

(a) A dental insurer holding a valid outstanding certificate of authority from the commissioner.

(b) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.



12693.10. “Participating health plan” means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the board to provide coverage to program subscribers:

- (a) A private health insurer holding a valid outstanding certificate of authority from the commissioner.
- (b) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.
- (c) A county organized health system.
- (d) A local initiative.

12693.11. “Participating vision care plan” means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the board to provide coverage to program subscribers:

- (a) A vision insurer holding a valid outstanding certificate of authority from the commissioner.
- (b) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

12693.12. “Program” means the Healthy Families Program, which includes a purchasing pool providing health coverage for children in families without access to affordable employer based dependent coverage and a purchasing credit mechanism through which families with access to employer based dependent coverage can receive financial assistance with the cost of dependent coverage for children.

12693.13. “Purchasing credit member” means an applicant 18 years of age or a child who is eligible for and participates in the purchasing credit component of the program.

12693.14. “Subscriber” means an applicant 18 years of age or a child who is eligible for and participates in the purchasing pool component of the program.

12693.15. “Supplemental coverage” means coverage purchased by the program from (a) a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner, or (b) a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code to bring the coverage available to purchasing credit members into at least 95 percent actuarial equivalence with the coverage provided to subscribers through the purchasing pool component of the program. The coverage shall provide for any necessary adjustment of the cost-sharing levels charged to purchasing credit members to be



equivalent to those charged to subscribers through the purchasing pool component of the program. Subscriber costs and benefits for the purchasing credit members shall be at least 95 percent actuarially equivalent to subscriber costs and benefits in the purchasing pool component.

#### CHAPTER 3. CREATION OF PROGRAM AND POWERS OF THE BOARD

12693.20. The Healthy Families Program is hereby created and shall be administered by the Managed Risk Medical Insurance Board.

12693.21. The board may do all of the following consistent with the standards in this part:

- (a) Determine eligibility criteria for the program.
- (b) Determine the participation requirements of applicants, subscribers, purchasing credit members, and participating health, dental, and vision plans.
- (c) Determine when subscribers' coverage begins and the extent and scope of coverage.
- (d) Determine family contribution amount schedules and collect the contributions.
- (e) Provide or make available subsidized coverage through participating health, dental, and vision plans, in a purchasing pool, which may include the use of a purchasing credit mechanism, through supplemental coverage, or through coordination with other state programs.
- (f) Provide for the processing of applications, the enrollment of subscribers, and the distribution of purchasing credits.
- (g) Determine and approve the benefit designs and copayments required by health, dental, or vision plans participating in the purchasing pool component program.
- (h) Approve those health plans eligible to receive purchasing credits.
- (i) Enter into contracts.
- (j) Sue and be sued.
- (k) Employ necessary staff.
- (l) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.
- (m) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Healthy Families Fund and if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.
- (n) Issue rules and regulations, as necessary. Until January 1, 2000, any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with



Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

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

CHAPTER 4. ADMINISTRATION

12693.25. The board may use a purchasing pool model, issuance of purchasing credits, supplemental coverage, or other means as appropriate to meet the purposes of this part.

12693.26. The board shall establish a purchasing pool for coverage of program subscribers to enable applicants without access to affordable and comprehensive employer-sponsored dependent coverage to provide their eligible children with health, dental, and vision benefits. The board shall negotiate separate contracts with participating health, dental, and vision plans for each of the benefit packages described in Chapters 5 (commencing with Section 12693.60), 6 (commencing with Section 12693.63), and 7 (commencing with Section 12693.65).

12693.27. (a) The board shall develop a purchasing credit mechanism to enable applicants with access to affordable and comprehensive employer-sponsored dependent coverage to have an eligible child enrolled in the employer's health plan. Children enrolled in the purchasing credit mechanism may receive dental and vision benefits through the purchasing pool component of the program.

(b) In order to be eligible for a purchasing credit, the employer shall make a meaningful contribution toward the cost of coverage for an employee's dependents for whom an application is made for a purchasing credit. An employer's contribution, including any increases or decreases in the contribution made after the effective date of this part, may not vary among employees based on wage base or job classification.

(c) The board shall adopt appropriate mechanisms to recoup purchasing credit expenditures from an employer plan when the employees or dependents on behalf of whose coverage the payments are made are no longer enrolled in that plan.

(d) An employer utilizing a purchasing credit arrangement and a participating health plan receiving a purchasing credit must use 100 percent of the funds for the purchase of coverage for purchasing credit members including dependent coverage.

(e) A participating plan shall not assess the board for any portion of late fees, returned checks, or other fees in connection with an



employer with group coverage who is also participating in the purchasing credit arrangement.

(f) An applicant may begin coverage for dependents using a purchasing credit arrangement at any time. Purchasing credit members enrolling in employer-sponsored coverage shall not be considered late enrollees for the purposes of subdivision (d) of Section 1357 and subdivision (b) of Section 1357.50 of the Health and Safety Code, and subdivision (b) of Section 10198.6 and subdivision (l) of Section 10700.

(g) Under no circumstances shall the employee's share of cost, including, deductibles, copayments, and coinsurance, for dependent coverage, including any supplemental coverage necessary to meet the 95 percent actuarial standard established in Section 12693.15 be more than that required as the employee's share of premium if the employee's children were enrolled in the purchasing pool component of the program.

(h) The board may limit participation in the purchasing credit program to those employers that provide employee health benefits through participation in public or private purchasing cooperatives.

12693.28. The program shall be administered without regard to gender, race, creed, color, sexual orientation, health status, disability, or occupation.

12693.29. (a) The board shall use appropriate and efficient means to notify families of the availability of health coverage from the program.

(b) The State Department of Health Services in conjunction with the board shall conduct a community outreach and education campaign in accordance with Section 14067 of the Welfare and Institutions Code to assist in notifying families of the availability of health coverage for their children.

(c) The board shall use appropriate materials, which may include brochures, pamphlets, fliers, posters, and other promotional items, to notify families of the availability of coverage through the program.

12693.30. (a) The board shall assure that written enrollment information issued or provided by the program is available to program subscribers and applicants in each of the languages identified pursuant to Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code.

(b) The board shall assure that phone services provided to program subscribers and applicants by the program are available in all of the languages identified pursuant to Chapter 17.5 (commencing with Sec. 7290) of Division 7 of Title 1 of the Government Code.

(c) The board shall assure that interpreter services are available between subscribers and contracting plans. The board shall assure that subscribers are provided information within provider network directories of available linguistically diverse providers.



(d) The board shall assure that participating health, dental, and vision plans provide documentation on how they provide linguistically and culturally appropriate services, including marketing materials, to subscribers.

12693.31. No participating health, dental, or vision plan shall, in an area served by the program, directly, or through an employee, agent, or contractor, provide an applicant, or a child with any marketing material relating to benefits or rates provided under the program unless the material has been both reviewed and approved by the board.

12693.32. (a) The board may pay designated individuals or organizations an application assistance fee, if the individual or organization assists an applicant to complete the program application, and the applicant is enrolled in the program as a result of the application.

(b) The board may establish the list of eligible individuals, or categories of individuals and organizations, the amount of the application assistance payment and rules necessary to assure the integrity of the payment process.

(c) The board, as part of its community outreach and education campaign, may include community-based face-to-face initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process. Those entities undertaking outreach efforts shall not include as part of their responsibilities the selection of a health plan and provider for the applicant. Participating plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment except through employers with employees eligible to participate in the purchasing credit mechanism. However, information approved by the board on the providers and plans available to prospective subscribers in their geographic areas shall be distributed through any door-to-door activities for potentially eligible applicants and their children.

12693.33. To the extent feasible and permissible under federal law and with receipt of necessary federal approvals, the State Department of Health Services and the board shall develop a joint Medi-Cal and program application and enrollment form for children. The department shall seek any federal approval necessary to implement a combined application form.

12693.34. (a) The board may establish geographic areas within which participating health, dental, and vision plans may offer coverage to subscribers.

(b) Nothing in this section shall restrict a county organized health system or a local initiative from providing service to program subscribers in their licensed geographic service area.



12693.35. Participating health, dental, and vision plans shall have, but need not be limited to, all of the following operating characteristics satisfactory to the board in consultation with the plan's licensing or regulatory oversight agency:

(a) Strong financial condition, including the ability to assume the risk of providing and paying for covered services. A participating plan may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk.

(b) Adequate administrative management.

(c) A satisfactory grievance procedure.

(d) Participating plans that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the board:

(1) Review the quality of care covered.

(2) Review the appropriateness of care covered.

(3) Provide accessible health care services.

(e) (1) Before the effective date of the contract, the participating health plan shall have devised a system for identifying in a simple and clear fashion both in its own records and in the medical records of subscribers the fact that the services provided are provided under the program.

(2) Throughout the duration of the contract, the plan shall use the system described in paragraph (1).

(f) Plans licensed by the Department of Corporations shall be deemed to meet the requirements of subdivisions (a) to (d), inclusive, of this section.

12693.36. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Corporations, as the case may be.

(b) Participating health, dental, and vision plans that contract with the program and are regulated by either the Insurance Commissioner or the Department of Corporations shall be licensed and in good standing with their respective licensing agencies. In their application to the program, those entities shall provide assurance of their standing with the appropriate licensing entity.

(c) Local initiatives that have a contract with the State Department of Health Services, and that contract with the program, and that are licensed by the Department of Corporations but do not have a commercial license from the Department of Corporations, may contract with the board for a maximum of 18 months. During this 18-month period, those plans shall be in good standing with the Department of Corporations and shall demonstrate to the board that they are making a good faith effort to obtain a commercial license with the Department of Corporations. The board may extend this period to 24 months if the board determines the additional time is necessary to comply with this requirement. In their application to the



program, those entities shall provide assurance of their standing with the Department of Corporations and shall outline their plans for obtaining commercial licensure.

(d) County organized health systems and the special health care authority established under Section 101675 of the Health and Safety Code that have a contract with the State Department of Health Services, and that contract with the program, and that are not licensed by either the Insurance Commissioner or the Department of Corporations may contract with the board for a maximum of 24 months. During this 24-month period those plans shall be in good standing with the state agency providing oversight to their operations and shall demonstrate to the board that they are making a good faith effort to obtain licensure with the Department of Insurance or the Department of Corporations. In their application to the program, those entities shall provide assurance of their standing with the appropriate state oversight entity and shall outline their plans for obtaining licensure from the Department of Insurance or the Department of Corporations.

12693.37. (a) The board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice from among a reasonable number and types of competing health plans. The board shall develop and make available objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Health plan selection shall be based on the criteria developed by the board.

(b) (1) In its selection of participating plans the board shall take all reasonable steps to assure the range of choices available to each applicant, other than a purchasing credit member, shall include plans that include in their provider networks and have signed contracts with traditional and safety net providers.

(2) Participating health plans shall be required to submit to the board on an annual basis a report summarizing their provider network. The report shall provide, as available, information on the provider network as it relates to:

(A) Geographic access for the subscribers.

(B) Linguistic services.

(C) The ethnic composition of providers.

(D) The number of subscribers who selected traditional and safety net providers.

(c) (1) The board shall not rely solely on the Department of Corporations' determination of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census,



and other data to provide to prospective local initiatives, health plans, or specialized health plans, as defined in this act, specific provider contracting target areas with significant numbers of uninsured children in low-income families. The board shall give priority to those plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.

(2) Targeted contracting areas are those ZIP Codes or groups of ZIP Codes or census tracts or groups of census tracts that have a percentage of uninsured children in low-income families greater than the overall percentage of uninsured children in low-income families in that county.

(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan which has the highest percentage of traditional and safety net providers in its network. Subscribers selecting such a plan shall be given a family contribution discount as described in Section 12693.43.

(e) The board shall establish reasonable limits on health plan administrative costs.

12693.38. The board shall contract with a sufficient number of dental and vision plans to assure that dental and vision benefits are available to all subscribers. The board shall develop and make available objective criteria for dental and vision plan selection and provide adequate notice of the application process to permit all dental and vision plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating dental and vision plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this part. Dental and vision plan selection shall be based on the criteria developed by the board.

12693.39. The board shall establish a process for determining which employer-sponsored health plans are eligible to receive a purchasing credit issued by the program. The process shall assure that the benefits, copayments, coinsurance, and deductibles are no less than 95 percent actuarially equivalent to those provided to program subscribers enrolled in the purchasing pool.

12693.40. The board shall contract with health plans to provide coverage supplemental to that provided by an applicant's or applicant's spouse's employer-sponsored health plan for the purchasing credit member, if the employer-sponsored plan's benefits are not 95 percent actuarially equivalent to those provided to subscribers. If supplemental coverage is available and provided, the plan may then, notwithstanding Section 12693.39, become eligible to receive purchasing credits.

12693.41. (a) Upon the effective date of coverage of a child eligible for the program, the board shall arrange for payment of providers who participate in the Child Health and Disability



Prevention Program pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, for well-child health assessments, immunizations, and initial treatment provided up to 30 days prior to the effective date of coverage.

(b) The board shall pay only for those services that are eligible for federal financial participation under Section 2105 of Title XXI of the Social Security Act and that are approved in the required state plan under that title.

(c) (1) Child Health and Disability Prevention Program providers shall submit charges for the services under subdivision (a) on the form or in the format specified by the department for the Child Health and Disability Prevention Program. Those providers shall be reimbursed at the rates established for these services by the Child Health and Disability Prevention Program once coverage under the program is established.

(2) Those providers shall submit charges for services reimbursable under Medi-Cal on the form or in the format specified by the department for Medi-Cal. Those providers shall be reimbursed at the rates established for these services by Medi-Cal once coverage under Medi-Cal is established.

(d) (1) The board may use the state fiscal intermediary for medicaid to process the payments authorized in subdivision (a).

(2) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of contractual claims processing services by the state fiscal intermediary.

12693.42. Any purchasing credit issued by the board, or a contractor acting on behalf of the board, pursuant to this part shall have an overall cost to the program no greater than the cost to the program to enroll the subscriber in the lowest cost plan available to the subscriber through the purchasing pool. Administrative costs and the cost to the program of any supplemental product shall be included in the calculation of the cost of the purchasing credit program and deducted from the amount of the purchasing credit.

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.



(b) In each geographic area the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars (\$7) per child with a maximum required contribution of fourteen dollars (\$14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars (\$9) per child with a maximum required contribution of twenty-seven dollars (\$27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area which has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars (\$4) per child with a maximum required contribution of eight dollars (\$8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars (\$6) per child with a maximum required contribution of eighteen dollars (\$18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(e) Applicants who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

12693.44. (a) The board shall establish family contribution amounts for purchasing credit members that are equivalent to the amounts charged to subscribers participating in the purchasing pool portion of the program. Purchasing credit members shall not be required to pay family contribution amounts greater than the cost to the applicant if the purchasing credit members were enrolled in the purchasing pool component of the program. When calculating the cost to the applicant to participate in the purchasing pool, the family



contribution discounts provided in subdivisions (c), (d), and (e) of Section 12693.34 shall not be considered. Purchasing credit members shall be eligible for dental and vision coverage through the purchasing pool at no additional premium charge.

(b) The family contribution amounts paid on behalf of a purchasing credit member may be paid directly to the applicant's employer through a payroll deduction or other mechanism.

12693.45. (a) After 60 days of nonpayment of family contributions by an applicant, and a reasonable written notice period of no less than 30 days is provided to the applicant, subscribers or purchasing credit members may be disenrolled for an applicant's failure to pay family contributions and shall not be permitted to reenter the program for a period of six months. The board may impose or contract for collection actions to collect unpaid family contributions.

(b) Disenrollments shall be effective as of the last period for which full family contributions were paid. The disenrollments may be retroactive.

(c) The board may waive the period of exclusion in subdivision (a) if good cause is found, such as being laid off from employment or catastrophic illness.

12693.46. The board may prohibit applicants who drop coverage after enrolling in the pool from reenrollment in the program for up to six months.

12693.47. The program may place a lien on compensation or benefits, recovered or recoverable by a subscriber or applicant from any party or parties responsible for the compensation or benefits for which benefits have been provided under a policy issued under this part.

12693.48. The board may adjust payments made to a participating health plan if the board finds that the plan has a significantly disproportionate share of high- or low-risk subscribers. Prior to making this finding, the program shall obtain validated data from participating health plans. Reporting requirements shall be administratively compatible with the methods of operation of the health plans. Any adjustments to payments shall utilize demographic and other factors which are actuarially related to risk.

12693.49. (a) When an applicant is dissatisfied with any action or inaction of a participating plan in which a subscriber is enrolled through the purchasing pool, the applicant shall first attempt to resolve the dispute with the participating plan according to its established policies and procedures.

(b) The board shall assure that all participating health, dental, and vision plans make subscribers aware of the regulatory oversight available to the applicant by the participating health, dental, or vision plan's licensing or state oversight entity.



(c) The board shall assure that all participating health, dental, and vision plans report to the board, at least once a year, the number and types of benefit grievances filed by applicants on behalf of subscribers in the program. This information shall be available to applicants upon request in a format determined by the board.

12693.51. (a) A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the board.

(b) The board shall provide for the transfer of coverage of any subscriber to another participating plan (1) if a contract with any participating plan under which the subscriber receives coverage is canceled or not renewed and (2) at least once a year upon request in a manner as determined by the board, and (3) if a subscriber moves to an area that the current health plan does not serve.

12693.52. The board may negotiate or arrange for stop-loss insurance coverage that limits the program's fiscal responsibility for the total costs of health services provided to program subscribers, or arrange for participating health plans to share or assure the financial risk for a portion of the total cost of health care services to program subscribers, or both.

12693.53. The board shall develop and utilize appropriate cost containment measures to maximize the coverage offered under the program. Those measures may include limiting the expenditure of state funds for this purpose to the price to the state for the lowest cost plan contracting with the program and creation of program rules that restrict the ability of employers or applicants to drop existing coverage in order to qualify children for the program.

12693.54. A contract entered pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual subscriber enrollments to a total amount not to exceed the amount appropriate for the program including family contributions.

#### CHAPTER 5. HEALTH BENEFITS AND COPAYMENTS

12693.60. Coverage provided to subscribers shall meet the federal coverage requirements in Section 2103 of Title XXI of the Social Security Act. The covered health benefits provided to subscribers shall be equivalent to those provided to state employees through the Public Employees' Retirement System on January 1, 1998, except that the plans may provide a mechanism for inpatient hospital care provided under the mental health benefit through which applicants may agree to a treatment plan in which each inpatient day may be



substituted for two residential treatment days or three day treatment program days.

12693.61. The following provisions apply for subscribers who have been identified by the participating health plans as potentially seriously emotionally disturbed.

(a) Participating plans, to the extent feasible, including plans receiving purchasing credits shall develop memoranda of understanding, consistent with criteria established by the board in consultation with the State Department of Mental Health, for referral of subscribers who are seriously emotionally disturbed to a county mental health department. This referral does not relieve a participating plan from providing the mental health coverage specified in its contract, including assessment of, and development of, a treatment plan for serious emotional disturbance. Plans may contract with county mental health departments to provide for all, or a portion of, the services provided under the program's mental health benefit.

(b) The board shall establish an accounting process under which counties providing services to subscribers who have been determined to be seriously emotionally disturbed pursuant to Section 5600.3 of the Welfare and Institutions Code can claim federal reimbursement for the services. The board shall reimburse counties pursuant to the rates set by the State Department of Mental Health in accordance with Sections 5705, 5716, 5718, 5720, 5724, and 5778 of the Welfare and Institutions Code. The actual amount reimbursed by the board shall be the federal share of the cost of the subscriber.

(c) This section shall only become operative with federal approval of the State Child Health Plan and the approval of federal financial participation.

(d) Counties choosing to enter into a memorandum of understanding pursuant to subdivision (a) shall provide the nonfederal share of cost for the subscriber.

12693.615. (a) The board shall establish the required subscriber copayment levels for specific benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels established for state employees, effective January 1, 1998, through the Public Employees' Retirement System. Under no circumstances shall copayments exceed the copayment level established for state employees, effective, January 1, 1998, through the Public Employees' Retirement System. Total annual copayments charged to subscribers shall not exceed two hundred fifty dollars (\$250) per family. The board shall instruct participating health plans to work with their provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are charged. The board shall track the number of subscribers who meet the copayment maximum in each



year and make adjustments in the amount if a significant number of subscribers reach the copayment maximum.

(b) No deductibles shall be charged to subscribers for health benefits.

(c) Coverage provided to subscribers shall not contain any preexisting condition exclusion requirements.

(d) No participating health, dental, or vision plan shall exclude any subscriber on the basis of any actual or expected health condition or claims experience of that subscriber or a member of that subscriber's family.

(e) There shall be no variations in rates charged to subscribers including premiums and copayments, on the basis of any actual or expected health condition or claims experience of any subscriber or subscriber's family member. The only variation in rates charged to subscribers, including copayments and premiums, that shall be permitted is that which is expressly authorized by Section 12693.43.

(f) There shall be no copayments for preventive services as defined in Section 1367.35 of the Health and Safety Code.

(g) There shall be no annual or lifetime benefit maximums in any of the coverage provided under the program.

(h) Plans that receive purchasing credits pursuant to Section 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and (g).

12693.62. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

#### CHAPTER 6. DENTAL BENEFITS AND COPAYMENTS

12693.63. (a) The board shall determine the dental benefits to be provided to subscribers by the program. Such benefits shall be consistent with those provided to state employees through the Department of Personnel Administration on July 1, 1997, except that orthodontia shall only be a benefit when it is determined to be medically necessary.

(b) The board shall establish the required subscriber copayment levels for dental benefits. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels provided to state employees through the Department of Personnel



Administration on July 1, 1997, except that no copayment shall be charged for medically necessary orthodontia services. There shall be no subscriber copayments for preventive and diagnostic services, including, but not limited to, examinations, teeth cleaning, X-rays, topical fluoride treatments, space maintainers, and sealants.

(c) No deductible shall be charged to subscribers for dental benefits.

12693.64. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

CHAPTER 7. VISION BENEFITS AND COPAYMENTS

12693.65. (a) Vision benefits shall be provided to subscribers and shall meet the federal coverage requirements in Section 2103 of Title XXI of the Social Security Act.

(b) The covered benefits shall be equivalent to those provided to state employees through the Department of Personnel Administration on July 1, 1997.

(c) The board shall establish the required subscriber copayment levels for vision benefits consistent with the limitations of Section 2103 of Title XXI of the Social Security Act. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels provided to state employees through the Department of Personnel Administration on July 1, 1997.

12693.66. Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services Program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.



## CHAPTER 8. LINKAGES WITH PUBLIC PROGRAMS

12693.68. The board shall encourage all plans, including those receiving purchasing credits, that provide services under the program to have viable protocols for screening and referring children needing supplemental services outside of the scope of the screening, preventive, and medically necessary and therapeutic services covered by the contract to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the plan and the public programs. The public programs for which plans may be required to develop screening, referral, and care coordination protocols may include the California Children's Services Program, the regional centers, county mental health programs, programs administered by the Department of Alcohol and Drug Programs, and programs administered by local education agencies.

## CHAPTER 9. ELIGIBILITY

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Greater than 12 months of age and less than 19 years of age. An application may be made on behalf of a child less than 12 months of age for coverage to begin as early as the child's first birthday.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) A child who meets citizenship and immigration status requirements that are applicable to persons participating in the program established by Title XXI of the Social Security Act.

(5) A resident of the State of California pursuant to Section 244 of the Government Code.

(6) In a family with a gross annual household income equal to or less than 200 percent of the federal poverty level.

(b) If the applicant is applying for the purchasing pool, the applicant shall pay the first month's family contribution and agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

12693.71. (a) The board shall monitor applications to determine whether employers and employees have dropped employer-sponsored dependent coverage in order to participate in the program.



(b) The board may disapprove an application if it is determined that the children to be covered under the application were covered by an employer-sponsored insurance within the last three months.

(c) If the board imposes the limitation identified in subdivision (b) or (d), it shall also establish exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of the program. This shall include, but not be limited to:

(1) Loss of employment due to factors other than voluntary termination.

(2) Change to a new employer that does not provide an option for dependent coverage.

(3) Change of address so that no employer sponsored coverage is available.

(4) Discontinuation of health benefits to all employees of the applicant's employer.

(5) Expiration of COBRA coverage period.

(6) Coverage provided pursuant to an exemption authorized under subdivision (i) of Section 1367 of the Health and Safety Code.

(d) If the board determines, based on evidence gathered during a reasonable period of program operation, that a substantial share of funds expended for the program are providing health coverage for children that have discontinued employer-based coverage in order to enter the program or if required by the federal government for state plan approval, the board may take actions to increase the three-month time limit specified in subdivision (b), to such a time limit that cannot exceed six months.

12693.72. (a) The board may disapprove an application if it is determined that the children to be covered under the application were covered by an individual health care service plan contract or individual disability insurance policy during a specified period of time prior to the date of application only if required by the federal government for state plan approval. This time limitation period shall not exceed the time period required by the federal government.

(b) If the board imposes the time limitation identified in subdivision (a), it shall also establish exceptions to this limitation in cases where the prior coverage ended due to reasons unrelated to the availability of the program. This shall include, but not be limited to, the prior coverage being pursuant to a health plan operating pursuant to an exemption authorized by subdivision (i) of Section 1367 of the Health and Safety Code.

12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program.

12693.74. Subscribers shall continue to be eligible for the program for a period of 12 months from the month eligibility is established.

12693.75. The program shall make use of a simple and easy to understand mail-in application process.



## CHAPTER 10. FISCAL INTEGRITY

12693.77. (a) The board shall develop safeguards to assure the fiscal integrity of the program.

(b) The program shall ensure that subscribers are not eligible for no-cost full-scope Medi-Cal coverage. The board may provide data on applicants and subscribers to the State Department of Health Services for determination of Medi-Cal eligibility. The State Department of Health Services shall identify those subscribers enrolled in the program who are concurrently enrolled in Medi-Cal with no share of cost.

(c) Any person who intentionally makes false declarations as to his or her eligibility or any person who intentionally makes false declarations as to eligibility on behalf of any other person seeking eligibility under this part for which that person is not eligible shall be guilty of a misdemeanor.

(d) Plans and providers shall be subject to Section 550 of the Penal Code.

(e) Any person who intentionally makes false declarations as to his or her eligibility or any person who intentionally makes false declarations as to eligibility on behalf of any other person seeking eligibility under this part for which that person is not eligible may be denied coverage for up to one year from the date of the denial of coverage by the board.

## CHAPTER 11. PROTECTION AGAINST SUBSTITUTION OF BENEFITS

12693.80. The board shall use due diligence in the creation of participation standards for the program that minimize the incentive for employers or applicants to drop or reduce dependent health coverage.

12693.81. (a) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759, to refer an individual employee or employee's dependent to the program, or arrange for an individual employee or employee's dependent to apply for the program, for the purpose of separating that employee or employee's dependent from group health coverage in connection with the employee's employment.

(b) Any employee applicant in subdivision (a) shall have personal right of action to enforce subdivision (a).

12693.82. It shall constitute an unfair labor practice contrary to public policy, and enforceable under Section 95 of the Labor Code, for any employer to refer an individual employee or employee's dependent to the program, or to arrange for an individual employee or employee's dependent to apply to the program, for the purpose



of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

12693.83. (a) It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to change the employee-employer share-of-cost ratio based upon the employee's wage base or job classification or to make any modification of coverage for employees and employee's dependents in order that the employees or employee's dependents enroll in the program established pursuant to this part.

12693.84. For purposes of Sections 12693.82 and 12693.83, group health coverage includes any group disability insurance policy covering hospital, medical, or surgical expenses, group health care service plan contract, or self-insured employee welfare benefit plan.

#### CHAPTER 12. APPEALS

12693.85. Program decisions described in this section may be appealed to the board. If an applicant believes that a written decision on one of the following specified issues was made in violation of the program statutes or regulations, or other written representation of program policy made to the individual by the program or the board, that individual may file an appeal with the board. Decisions that may be appealed are the following:

(a) A decision that a child is not qualified to participate or continue to participate in the program.

(b) A decision that a child is not eligible for enrollment or continuing enrollment in the program.

(c) A decision as to the effective date of coverage.

12693.86. (a) An appeal shall be filed in writing with the executive director within 60 calendar days of the date of the notice of the decision being appealed.

(b) An appeal shall include all of the following:

(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed.

(2) A statement specifically describing the issues that are disputed by the appellant.

(3) A statement specifically describing the program statute or regulation, or other written representation of program policy that the appellant believes the program or board violated.

(4) A statement of the resolution requested by the appellant.

(5) Any other relevant information the appellant wants to include.

(c) Any appeal that does not specifically allege a violation of a program statute or regulation, or other written representation of program policy will be deemed to be a request for program review pursuant to Section 12693.88.



(d) An appeal that specifically alleges a violation of program statute or regulation or other written representation of program policy, but fails to include any other necessary information, shall be returned to the appellant without review. The appellant may resubmit the appeal. The resubmittal shall be filed within the time limits of subdivision (a) or within 20 calendar days of the receipt of the returned appeal, whichever is later.

12693.87. (a) Any appellant who files an appeal pursuant to Section 12693.85 shall receive an initial administrative review of the appeal.

(b) Administrative reviews of appeals shall be conducted in two steps. Each appeal will be reviewed by the program to determine if the requested resolution is required by the statutes and regulations governing the program, or required in order to be consistent with a written representation of program policy made by the program or the board. If so, the appropriate action will be taken within 30 days of the receipt of the appeal, and the appellant will be notified. If not, the appellant will be so notified within 30 days of the receipt of the appeal and informed that he or she may request review by the executive director. This request must be filed in writing with the executive director within 30 days of the date of the notice of the program determination and shall include the information specified in subdivision (b) of Section 12693.86.

(c) In conducting an administrative review of an appeal, the executive director may contact the appellant and any other party for further information.

(d) The executive director's decision shall be in writing.

(e) The appellant retains the right to request an administrative hearing if the appellant is not satisfied with the decision of the executive director. Such a request shall be filed within 30 calendar days of receipt of the executive director's decision. It shall include a clear and concise statement of what action is being appealed, and the reasons the executive director's decision is not correct.

12693.88. In addition to the appeal process established above, the board shall establish a program review process. If a subscriber or purchasing credit member is not eligible to file an appeal pursuant to Section 12693.85, but wants to have any program decision reviewed, he or she may request that the program review the decision. A review pursuant to this section is separate from and independent of an appeal pursuant to Section 12693.85, and a person that files a request pursuant to this section shall not, thereby, gain any right of appeal. Pursuant to Section 12693.49, any dissatisfaction with an action of a participating health, vision, or dental plan shall be resolved with the plan rather than by requesting program review. When an appeal that requests an administrative hearing is received, the appeal shall be set for hearing as provided in Section 12693.89.



12693.89. (a) Administrative hearings of appeals shall be conducted according to the appeal procedures, including pre- and post-hearing procedures, set forth in Article 3 (commencing with Section 1140) of Chapter 2 of Division 2 of Title 1 of the California Code of Regulations. Article 3 (commencing with Section 1140) is hereby incorporated by reference, subject to the following modifications:

(1) Reference to the Health and Welfare Agency or the component department shall be deemed reference to the Managed Risk Medical Insurance Board.

(2) Reference to the private nonprofit human service organization shall be deemed reference to the appellant.

(3) Reference to Health and Safety Code sections providing the bases, grounds, authorization, or procedures for appeals shall be deemed reference to the bases and authorization, for appeal found in Section 12693.85 and the appeal procedures found in this section.

(4) The 30-day time period specified in subdivision (b) of Section 1140 of Title 1 of the California Code of Regulations shall be extended to 60 days, and the 10-day time period in subdivision (a) of Section 1141 of Title 1 of the California Code of Regulations shall be extended to 30 days.

(5) If the proposed decision submitted to the board is not adopted as the decision, the board may itself decide the case on the record, or may refer the case to the same hearing officer to take additional evidence. If the case is referred back to the hearing officer, the hearing officer shall prepare a new proposed decision based on the additional evidence and the record of the prior hearing.

(6) The decision of the board shall be issued within 90 days following the initial hearing or, if the case is referred back to the hearing officer, within 90 days of the second hearing.

(b) The board may elect to have a hearing conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

#### CHAPTER 13. HEALTHY FAMILIES ADVISORY BOARD

12693.90. (a) The board shall appoint a 14-member advisory panel to advise the board, the chair of which may serve as an ex officio, nonvoting member of the board. The panel shall be appointed and ready to perform its duties by no later than February 1, 1998.

(b) The membership of the advisory panel shall be composed of all of the following:

- (1) Three representatives from the subscriber population.
- (2) One physician and surgeon who is board certified in pediatrics.



(3) One physician and surgeon who is board certified in the area of family practice medicine.

(4) One representative from a licensed nonprofit primary care clinic.

(5) One representative from a licensed hospital that is on the disproportionate share list maintained by the State Department of Health Services.

(6) One representative of the mental health provider community.

(7) One representative of the substance abuse provider community.

(8) One representative of the county public health provider community.

(9) One representative from the education community.

(10) One representative from the health plan community.

(11) One representative from the business community.

(12) One representative from an eligible family with children with special needs.

(c) The advisory board members shall have demonstrated expertise in the provision of health-related services to children aged 18 years and under, as applicable.

(d) The advisory board members shall be composed of representatives of the geographic, cultural, economic, and other social factors of the state.

(e) The panel shall elect, from among its members, its chair.

(f) The panel shall have all of the following powers and duties:

(1) To advise the board on all policies, regulations, operations, and implementation of the program.

(2) To consider all written recommendations of the panel and respond in writing when the board rejects the advice of the panel.

(3) To meet at least quarterly, unless deemed unnecessary by the chair.

(g) The members of the panel shall be reimbursed for all necessary travel expenses associated with the activities of the panel.

(h) The members of the panel who represent the subscriber population may receive per diem compensation if they are otherwise economically unable to meet panel responsibilities.

CHAPTER 14. RURAL DEMONSTRATION PROJECT

12693.91. (a) The State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board, the County Medical Services Program board, and the Rural Health Policy Council, may develop and administer up to five demonstration projects in rural areas that are likely to contain a significant level of uninsured children, including seasonal and migratory worker dependents.



(b) The purpose of the demonstration projects shall be to fund rural collaborative health care networks to alleviate unique problems of access to health care in rural areas.

(c) The State Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board and Rural Health Policy Council, shall establish the criteria and standards for eligibility to be used in requests for proposals or requests for application, the application review process, determining the maximum amount and number of grants to be awarded, preference and priority of projects, and compliance monitoring after receiving comment from the public.

(d) This section shall only become operative upon federal approval of the state plan or subsequent amendments for the program and approval of federal financial participation.

(e) This section shall become inoperative on July 1, 2003.

#### CHAPTER 15. REPORTS

12693.92. (a) The program shall prepare an annual report in conformance with the requirements of Section 2108 of Title XXI of the Social Security Act (P.L. 105-33). A copy of the report shall be provided to the Legislature and other interested parties.

(b) As soon as possible, but no later than July 1, 2000, the board shall include in its annual report information on (1) how assurance of preventive services by health plans and health care providers is achieved; (2) the performance of health plans and providers in providing preventive services and addressing barriers to service delivery; and (3) the mechanism or mechanisms that will be used to identify changes over time in the health status of children enrolled in the program. Beginning no later than July 1, 2001, the report shall include information about changes in the health status of children participating in the program.

(c) The board shall immediately provide the fiscal and policy committees of the Legislature with a copy of their submittal to the federal government to meet the requirements for state plan provisions as contained in Chapter 1 of Title XXI of the Social Security Act. Any and all subsequent amendments to the state plan shall also be provided accordingly.

12693.93. The board shall prepare an evaluation of the program and other state efforts to expand coverage to children in conformance with Section 2108 of Title XXI of the Social Security Act. The evaluation shall incorporate measurement of the delivery of preventive services by health plans and health care providers and assessment of changes over time in the health status of children participating in the program. A copy of the report shall be provided to the Legislature and other interested parties.



12693.94. On or before January 15, 1999, the board shall report to the Legislature on the policies and procedures that would be necessary to ensure the feasibility of allowing families with incomes above 200 percent of the federal poverty level to buy coverage through the program, at their cost. The board shall review the need for changes in both government and private health coverage programs and make recommendations to the Legislature on specific statutory and regulatory changes that would be required.

12693.95. The board in consultation with the Department of Alcohol and Drug Programs shall provide the Legislature by April 15, 1998, a proposal assessing the viability of providing additional drug and alcohol treatment services for children enrolled in the program.

If the board determines that it is feasible to provide additional federal funds received pursuant to Title XXI (commencing with Section 2101) of the Social Security Act to counties to finance drug and alcohol services and required federal approval is obtained, the board shall negotiate with participating health plans to establish memoranda of understanding between plans and counties to facilitate referral of children in need of these services.

#### CHAPTER 16. FUNDS

12963.96. (a) There is hereby created in the State Treasury the Healthy Families Fund which is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in this part.

(b) The board shall authorize the expenditure from the fund any state funds, federal funds, or family contributions deposited into the fund.

(c) Notwithstanding any other provision of law, this part shall be implemented only if, and to the extent that, as provided under Title XXI of the Social Security Act, federal financial participation is available and state plan approval is obtained.

(d) Nothing in this part is intended to establish an entitlement for individual coverage.

12963.97. The State Department of Health Services and the board may explore and utilize any options available under federal law to allow the use of charitable funding as a match for federal funds for use in the provision of coverage by private and public not-for-profit organizations consistent with the provisions of this part.

#### CHAPTER 17. REPEAL

12693.99. This part shall remain in effect only until January 1, 2004, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2004, deletes or extends that date.



SEC. 3. This act shall become operative only if SB 903 is enacted on or before January 1, 1998.

SEC. 4. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

