

AMENDED IN SENATE APRIL 21, 2003

SENATE BILL

No. 921

**Introduced by ~~Senators Kuehl, Cedillo, Florez, and Perata~~
*Senator Kuehl***

(Principal coauthor: Assembly Member Goldberg)

(Coauthors: *Senators Alarcon, Cedillo, Florez, Perata, and Soto*)

*(Coauthors: Assembly Members ~~Goldberg~~ Chan, Hancock, Koretz,
Levine, Lieber, Longville, Lowenthal, Pavley, and Steinberg)*

February 21, 2003

An act to add Division 112 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 921, as amended, Kuehl. Single payer health care coverage.

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

This bill would establish the California Health Care System to be administered by the newly created *California* Health Care Agency under the control of an elected Health Care Commissioner. The bill would make all California residents eligible for specified health care benefits under the California Health Care System, which would, on a

single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would prohibit deductibles or copayments during the initial first 2 years of operation of the health care system, but would authorize the commissioner to establish deductibles and copayments thereafter. *The bill would require the health care system to be operational by January 1, 2006, and would enact various transition provisions.*

This bill would declare the intent of the Legislature to impose taxes at unspecified rates on unearned income, tobacco, alcohol, employers, and employees that would be dedicated to fund the California Health Care System and would be deposited in the newly created Health Care Fund. The bill would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California Health Care System, which would then assume responsibility for all benefits and services previously paid for with those funds.

The bill would create a Health Policy Board to establish policy on medical issues and various other matters relating to the health care system. The bill would create the Office of Consumer Advocacy within the agency to represent the interests of health care consumers relative to the health care system. The bill would create the Office of Medical Practice Standards within the agency, headed by the chief medical officer, to establish standards of best medical practice, including evaluation of pharmaceuticals and medical and surgical treatment, and in conjunction with that office, would create the Medical Practice Standards Advisory Board with specified advisory duties. ~~The bill would require the establishment of regional health agencies throughout the state.~~ The bill would create the Office of Inspector General for the California Health Care System within the Attorney General's office, which would have various oversight powers. The bill would extend the application of certain insurance fraud laws to providers of services and products under the health care system, thereby imposing a state-mandated local program by revising the definition of a crime. The bill would enact other related provisions relative to *budgeting*, federal preemption, subrogation, collective bargaining agreements, and associated matters.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state.



Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. Division 112 (commencing with Section 140000) is added to the Health and Safety Code, to read:

DIVISION 112. CALIFORNIA HEALTH CARE SYSTEM

CHAPTER 1. GENERAL PROVISIONS

140000. There is hereby established in state government the California Health Care System, which shall be administered by the California Health Care Agency, an independent agency under the control of the Health Care Commissioner.

140001. This division shall be known as and may be cited as the Health Care for All Californians Act.

140002. This division shall be liberally construed to accomplish its purposes.

140003. The California Health Care Agency is hereby designated as the single state agency with full power to supervise every phase of the administration of the California Health Care System and to receive grants-in-aid made by the United States government or by the state in order to secure full compliance with the applicable provisions of state and federal law.

140004. The California Health Care Agency shall be comprised of the following entities:

(a) The Health Policy Board.

(b) The Office of Consumer Advocacy.

(c) The Office of Medical Practice Standards.

~~(d) The Regional Health Agencies.~~

~~140005. Findings and declarations [RESERVED]—The Legislature finds and declares all of the following:~~

- 1 (a) More than 6 million Californians lacked health insurance
2 coverage at some time in 2001 and 3.6 million had no health
3 insurance coverage at any time.
- 4 (b) Since 2001, the number of uninsured Californians has risen
5 significantly.
- 6 (c) More than 10 million Californians have no coverage for
7 prescription drugs. Millions of Californians lacking prescription
8 drug coverage are otherwise insured.
- 9 (d) Efforts to control health care costs and growth of health
10 care spending have been unsuccessful.
- 11 (e) Employers, retirement funds, and unions that offer and
12 negotiate for health insurance and benefits and individuals who
13 purchase health insurance are experiencing substantial increases
14 in health care costs and decreases in health care benefits.
- 15 (f) Unstable and affordable rate increases have caused
16 significant economic hardship for California residents and their
17 employers.
- 18 (g) Nearly 63 percent of all personal bankruptcies in the United
19 States are the result of health care costs.
- 20 (h) California does not perform well on standard health
21 outcome measurements.
- 22 (i) Unacceptable health access disparities exist by region,
23 ethnicity, income, and gender.
- 24 (j) Eleven of California's rural counties have no health
25 maintenance organizations that provide coverage to the county on
26 a countywide basis and 21 rural counties no longer have a
27 Medicare+Choice HMO.
- 28 (k) More than 80 percent of all Medi-Cal and uninsured patient
29 visits to emergency facilities are for conditions that could have
30 been treated in a non-emergency setting.
- 31 (l) Emergency departments and trauma centers face growing
32 financial losses.
- 33 (m) Advances in medical technology are not available to all
34 Californians who need them.
- 35 (n) Health care providers express significant professional
36 dissatisfaction with the current health care systems, as do health
37 care consumers.
- 38 (o) The California Medical Association found in 2001 that
39 uncompensated care totaled five hundred forty million dollars
40 (\$540 million). Uncompensated care has caused 60 emergency



1 departments (15 percent of the departments in the state) to close
2 since 1990.

3 (p) The California Medical Association found in January of
4 2001 that increasing patient volume and a decline in the number
5 of emergency rooms have made multiple hour waits for emergency
6 care the norm and that ambulance diversion is becoming a
7 common method of dealing with emergency department
8 overcrowding. These developments pose significant dangers for
9 both insured and uninsured Californians.

10 (q) A quantitative analysis performed by the independent
11 economic consulting firm, Lewin Inc., indicated that under a
12 single payer health insurance system, California could afford to
13 cover all California residents at no new cost to the state.

14 (r) According to the same report and numerous other studies,
15 by simplifying administration, achieving bulk purchase discounts
16 on pharmaceuticals, and reducing the use of emergency facilities
17 for primary care, California could divert billions of dollars toward
18 providing direct health care and improved quality and access.

19 140006. ~~Purposes [RESERVED]~~ This division shall have all
20 of the following purposes:

21 (a) To provide universal and affordable health care coverage
22 for all California residents.

23 (b) To provide California residents with an extensive benefit
24 package that includes prescription drugs.

25 (c) To control health care costs and the growth of health care
26 spending.

27 (d) To achieve measurable improvement in health care
28 outcomes.

29 (e) To increase provider, consumer, employee, and employer
30 satisfaction with the health care system.

31 (f) To implement policies that strengthen and improve
32 culturally and linguistically sensitive care.

33 (g) To develop an integrated health care database to support
34 health care planning.

35 140007. As used in this division, the following terms have the
36 following meanings:.

37 (a) "Agency" means the California Health Care Agency.

38 (b) "Commissioner" means the Health Care Commissioner.

39 (c) "System" or "health care system" means the California
40 Health Care System.

1 140008. The definitions contained in Section 140007 shall
2 govern the construction of this division, unless the context requires
3 otherwise.

4
5 CHAPTER 2. GOVERNANCE
6

7 140100. (a) The commissioner shall be the chief officer of
8 the agency.

9 (b) Except as provided in subdivision (d), the commissioner
10 shall be elected by the people in the same time, place, and manner
11 as the Governor and shall serve a term of four years.

12 (c) Should a vacancy occur during the term of office, legislative
13 confirmation shall be required for the position of the
14 commissioner in the same manner and procedure as that required
15 by Section 5 of Article V of the California Constitution.

16 (d) The first commissioner shall be appointed by the Governor
17 not less than 75 nor more than 100 days following the operative
18 date of this division, and shall be subject to confirmation by the
19 Senate within 30 days of nomination. If the Senate does not take
20 up the nomination within 30 days of nomination, the nominee shall
21 be considered to have been confirmed and may take office.

22 (e) Should the Senate fail to confirm the nominee, the
23 Governor shall appoint a new nominee, subject to the confirmation
24 of the Senate as provided in subdivision (d).

25 (f) If the commissioner is at any time unable to perform the
26 duties of the office, a deputy health commissioner shall perform
27 those duties for a period of up to 90 days.

28 (g) In the event of a vacancy, or inability of the commissioner
29 to perform the duties of office for a period of more than 90 days,
30 an acting commissioner shall be appointed by the Governor and
31 confirmed by the Senate for the balance of the commissioner's
32 term pursuant to the same process provided in subdivision (d).

33 (h) The commissioner is subject to impeachment pursuant to
34 Section 18 of Article IV of the California Constitution.

35 (i) The compensation and benefits of the commissioner shall be
36 determined pursuant to the same process as provided in Section 8
37 of Article III of the California Constitution.

38 (j) The commissioner shall be subject to Title 9 (commencing
39 with Section 81000) of the Government Code.

1 140101. (a) The commissioner shall be responsible for the
2 performance of all duties, the exercise of all powers and
3 jurisdiction, and the assumption and discharge of all
4 responsibilities vested by law in the agency. The commissioner
5 shall perform all duties imposed upon the commissioner by this
6 division and other laws related to health care and shall enforce the
7 execution of those provisions and laws to promote their underlying
8 aims and purposes. These broad powers include, but are not
9 limited to, the power to set rates and to promulgate generally
10 binding regulations concerning any and all matters relating to the
11 implementation of this division and its purposes.

12 (b) The commissioner shall appoint the deputy health
13 commissioner, the ~~Director~~ *director* of the Health Care Fund, the
14 ~~directors of the regional health agencies, the Director of the Office~~
15 ~~of Consumer Advocacy~~ *consumer advocate*, the chief medical
16 officer, and the members of the Medical Practice Standards
17 Advisory Board.

18 (c) In accordance with the laws governing the state civil
19 service, the commissioner shall employ and, with the approval of
20 the Department of Finance, fix the compensation of personnel as
21 the commissioner needs to properly discharge the duties imposed
22 upon the commissioner by law, including, but not limited to, a
23 deputy commissioner, a public information officer, a chief
24 enforcement counsel, a director of the ~~health care fund, directors~~
25 ~~of the regional health agencies~~ *Health Care Fund* a chief medical
26 officer, a ~~director of the office of consumer advocacy~~ *the*
27 *consumer advocate*, and legal counsel in any action brought by or
28 against the ~~director~~ *commissioner* under or pursuant to any
29 provision of any law under the commissioner's jurisdiction, or in
30 which the commissioner joins or intervenes as to a matter within
31 the commissioner's jurisdiction, as a friend of the court or
32 otherwise, and stenographic reporters to take and transcribe the
33 testimony in any formal hearing or investigation before the
34 commissioner or before a person authorized by the commissioner.
35 The personnel of the agency shall perform duties as assigned to
36 them by the commissioner. The commissioner shall designate
37 certain employees by rule or order that are to take and subscribe
38 to the constitutional oath of office within 15 days after their
39 appointments, and to file that oath with the Secretary of State. The
40 commissioner shall also designate those employees that are to be

1 subject to Title 9 (commencing with Section 81000) of the
2 Government Code.

3 (d) The commissioner shall adopt a seal bearing the inscription:
4 “Commissioner, Health Care Agency, State of California.” The
5 seal shall be affixed to or imprinted on all orders and certificates
6 issued by him or her and other instruments as he or she directs. All
7 courts shall take judicial notice of this seal.

8 (e) The administration of the agency shall be supported from
9 the Health Care Fund created pursuant to Section 140200.

10 (f) The commissioner, as a general rule, shall publish or make
11 available for public inspection any information filed with or
12 obtained by the agency, unless the commissioner finds that this
13 availability or publication is contrary to law. No provision of this
14 division authorizes the commissioner or any of the
15 commissioner’s assistants, clerks, or deputies to disclose any
16 information withheld from public inspection except among
17 themselves or when necessary or appropriate in a proceeding or
18 investigation under this division or to other federal or state
19 regulatory agencies. No provision of this division either creates or
20 derogates from any privilege that exists at common law or
21 otherwise when documentary or other evidence is sought under a
22 subpoena directed to the commissioner or any of his or her
23 assistants, clerks, or deputies.

24 (g) It is unlawful for the commissioner or any of his or her
25 assistants, clerks, or deputies to use for personal benefit any
26 information that is filed with or obtained by the commissioner and
27 that is not then generally available to the public.

28 (h) The commissioner, in pursuit of his or her duties, shall have
29 unlimited access to all nonconfidential and all nonprivileged
30 documents in the custody and control of the agency.

31 (i) The Attorney General shall render to the commissioner
32 opinions upon all questions of law, relating to the construction or
33 interpretation of any law under the commissioner’s jurisdiction or
34 arising in the administration thereof, that may be submitted to the
35 Attorney General by the commissioner and upon the
36 commissioner’s request shall act as the attorney for the
37 commissioner in actions and proceedings brought by or against the
38 commissioner or under or pursuant to any provision of any law
39 under the commissioner’s jurisdiction.

40 (j) The commissioner shall do all of the following:



1 (1) Implement statutory eligibility standards.

2 (2) Adopt annually a benefits package for consumers. The
3 benefits package shall meet or exceed the minimums required by
4 law.

5 (3) Act directly or through one or more contractors, as the
6 single payer for all claims for services provided under this
7 division.

8 (4) Develop and implement separate formulae for determining
9 budgets pursuant to Chapter 3 (commencing with Section
10 140200).

11 (5) Review the formulae described in paragraph (4) annually
12 for appropriateness and sufficiency of rates, fees, and prices.

13 (6) Provide for timely payments to professional providers and
14 health facilities and clinics through a structure that is efficient to
15 administer and that eliminates unnecessary administrative costs.

16 (7) Implement, to the extent permitted by federal law,
17 standardized claims and reporting methods under this division.

18 (8) *Develop a system of centralized electronic claims and*
19 *payments.*

20 (9) Establish an enrollment system that will ensure that all
21 eligible California residents, including those who travel
22 frequently, those who cannot read, and those who do not speak
23 English, are aware of their right to health care, and are formally
24 enrolled.

25 ~~(9) Determine, with the advice of the Health Policy Board, the~~
26 ~~number and precise geographical composition of the system's~~
27 ~~regions, based on criteria of common economic and demographic~~
28 ~~features and geographic contiguity.~~

29 (10) Report annually to the Legislature and the Governor on or
30 before October 1 on the performance of the health care system, its
31 fiscal condition and need for rate adjustments, consumer
32 copayments, or consumer deductible payments, recommendations
33 for statutory changes, receipt of payments from the federal
34 government, whether current year goals and priorities were met,
35 future goals and priorities, and major new technology or
36 prescription drugs that may affect the cost of health care.

37 (11) ~~Bid~~ *Negotiate* for prescription drug and durable *and*
38 *nondurable* medical equipment to achieve the lowest possible cost
39 available under the system formulary.

1 (12) Negotiate for, or set, rates, fees and prices involving any
2 aspect of the health system, and establish procedures relating
3 thereto.

4 (13) Administer the revenues of the Health Care Fund pursuant
5 to Section 140200.

6 (14) Procure funds, including loans, lease or purchase property,
7 obtain appropriate liability and other forms of insurance for the
8 system, its employees and agents.

9 (15) Establish, appoint, and fund as part of the administration
10 of the agency, the following:

11 (A) A Health Policy Board pursuant to Section 140102.

12 (B) An Office of Consumer Advocacy with ~~appropriate staff~~
13 ~~for each region, pursuant to 140103~~ *offices convenient to all the*
14 *residents of the state.*

15 (C) An Office of Medical Practice Standards and a Medical
16 Practice Standards Advisory Board ~~with appropriate staff,~~
17 ~~pursuant to Section 140104.~~

18 ~~(D) Directors of agencies with appropriate staff for each~~
19 ~~region, pursuant to Section 140108.~~

20 (16) Administer all aspects of the agency that include, but are
21 not limited to, all of the following:

22 (A) Establish standards and criteria for allocation of operating
23 funds and funds from the Health Care Fund as described in Chapter
24 3 (commencing with Section 140200).

25 (B) Meet regularly with the ~~directors of the regional agencies,~~
26 ~~and the chief medical officer, and the Director of the Office of~~
27 ~~Consumer Advocacy~~ *chief medical officer and the consumer*
28 *advocate* to review the impact of the agency and its policies on the
29 regions.

30 ~~(C) Budget the _____ accounts for each region in a manner to~~
31 ~~meet most equitably the health needs of the population of the state~~
32 ~~as a whole and the population within each region.~~

33 ~~(D)~~

34 (C) Establish health system goals in measurable terms.

35 ~~(E)~~

36 (D) Establish statewide health care databases to support health
37 care planning.

38 ~~(F)~~

(E) Implement policies to assure culturally competent and linguistically sensitive care and develop mechanisms and incentives to achieve this purpose.

140102. (a) The commissioner shall establish a Health Policy Board and shall be president of the board. The board shall consist of the following members:

(1) The commissioner.

(2) The deputy commissioner.

(3) The Secretary of the Health and Welfare Agency.

(4) The Director of Health Services.

~~(5) The directors of the regional agencies.~~

~~(6) The Health Care Fund Director.~~

~~(7) The Director of the Office of Consumer Advocacy.~~

~~(8)~~

(5) The director of the Health Care Fund.

(6) The consumer advocate.

(7) The chief medical officer.

~~(9)~~

(8) Two physicians. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one of these members.

~~(10)~~

(9) One registered nurse. The Governor shall appoint this member.

~~(11)~~

(10) One licensed vocational nurse. The Senate Committee on Rules shall appoint this member.

~~(12)~~

(11) One licensed allied health practitioner. The Speaker of the Assembly shall appoint this member.

~~(13)~~

(12) One representative of public hospitals. The Governor shall each appoint this member.

~~(14)~~

(13) One representative of private hospitals. The Senate Committee on Rules shall appoint this member.

~~(15)~~

(14) Four consumers of health care. The Governor shall appoint two of these members, of whom one shall be a member of the disability community. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one of these members.

1 ~~(16)~~

2 (15) One representative of organized labor. The Speaker of the
3 Assembly shall appoint this member.

4 ~~(17)~~

5 (16) One representative of the business community. The
6 Governor shall appoint this member.

7 ~~(18)~~

8 (17) One representative of community clinics. The Senate
9 Committee on Rules shall appoint this member.

10 ~~(19)~~

11 (18) One representative of retail businesses that dispense
12 pharmaceuticals or durable medical equipment. The Speaker of
13 the Assembly shall appoint this member.

14 (b) In making their appointment pursuant to this section, the
15 Governor, the Senate Committee on Rules, and the Speaker of the
16 Assembly shall make good faith efforts to assure that their
17 appointments, as a whole, reflect, to the greatest extent feasible,
18 the social and geographic diversity of the state.

19 (c) Any member appointed by the Governor, the Senate
20 Committee on Rules, or the Speaker of the Assembly, ~~or the~~
21 ~~regional directors~~ shall serve for a four-year term. These members
22 may be reappointed for succeeding four-year terms.

23 (d) Vacancies that occur shall be filled within 30 days after the
24 occurrence of the vacancy, and shall be filled in the same manner
25 in which the vacating member was selected or appointed. The
26 commissioner shall notify the appropriate appointing authority of
27 any expected vacancies on the board.

28 (e) Members of the board shall serve without compensation,
29 but shall be reimbursed for actual and necessary expenses incurred
30 in the performance of their duties to the extent that reimbursement
31 for those expenses is not otherwise provided or payable by another
32 public agency or agencies, and shall receive ____ dollars (\$__) for
33 each full day of attending meetings of the board. For purposes of
34 this section, “full day of attending a meeting” means presence at,
35 and participation in, not less than 75 percent of the total meeting
36 time of the board during any particular 24-hour period.

37 (f) The board shall meet at least six times a year in a place
38 convenient to the public. All meetings of the board shall be open
39 to the public. A majority of the membership of the board shall
40 constitute a quorum. Any action taken by the board under this

division requires a majority of the members present at a meeting of the board at which a quorum is present.

(g) The Health Policy Board shall do all of the following:

(1) Establish policy on medical issues, population-based public health issues, research priorities, scope of services, expanding access to care, and evaluation of the performance of the system.

(2) Investigate proposals for innovative approaches to health promotion, disease and injury prevention, education, research, and health care delivery.

(3) Establish standards and criteria by which requests by health facilities for capital improvements shall be evaluated.

(h) It is unlawful for the board or any of its assistants, clerks, or deputies to use for personal benefit any information that is filed with or obtained by the board and that is not then generally available to the public.

(i) No member of the board shall make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest.

(j) Members of the board shall be subject to Title 9 (commencing with Section 81000) of the Government Code.

140103. (a) There is within the agency an Office of Consumer Advocacy to represent the interests of the consumers of health care. The goal of the office shall be to help residents of the state secure the health care services and benefits to which they are entitled under the laws administered by the agency and to advocate on behalf of and represent the interests of consumers in governance bodies created by this division and in other forums.

(b) The office shall be headed by a ~~director~~ *consumer advocate* appointed by the commissioner.

(c) The ~~director~~ *consumer advocate* shall establish an office in the City of Sacramento and, ~~at minimum, in each regional district~~ *other offices throughout the state that shall provide convenient access to residents.*

(d) The duties of the ~~director~~ *consumer advocate* shall be determined by the commissioner, and shall include, but not be limited to, the following:

(1) Developing standards and procedures for resolving consumer disputes with the agency.

(2) Developing educational and informational guides for consumers describing their rights and responsibilities, and informing them on effective ways to exercise their rights to secure health care services. The guides shall be easy to read and understand, available in English and other languages, and shall be made available to the public by the agency, including access on the agency's Internet Web site and through public outreach and educational programs.

(3) Establishing a toll-free telephone number to receive complaints regarding the agency and its services. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers to contact the Office of Consumer Advocacy. The agency's Internet Web site shall have complaint forms and instructions online.

(4) Examining complaints and suggestions from the public.

(5) Recommending improvements to the agency, the office of the commissioner, the Health Policy Board, the Office of Medical Practice Standards, and the Medical Standards Practice Board.

(6) Examining the extent to which individual health facilities and clinics ~~in a region~~ meet the needs of the community in which they are located

(7) Receiving, investigating, and responding to complaints from any source about any aspect of the ~~health care system~~ system, referring the results of investigations to the appropriate professional provider or facility licensing boards or law enforcement agencies, as appropriate.

(8) Publishing an annual report to the public and the Legislature containing a statewide evaluation of the agency, ~~as well as an evaluation of each regional agency.~~

(9) Holding public hearings, at least annually, ~~within each region~~ *throughout the state* concerning complaints and suggestions from the public.

(e) The ~~director~~ *consumer advocate*, in pursuit of his or her duties, shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the agency.

(f) Nothing in this division shall prohibit a consumer or class of consumers or the ~~director~~ *consumer advocate* from seeking relief through the judicial system.

140104. There is within the agency an Office of Medical Practice Standards which shall establish standards of best medical

1 practice, including evaluation of pharmaceuticals and medical and
2 surgical treatments, based on credible evidence of benefit, for care
3 provided pursuant to this division. The office shall be headed by
4 the chief medical officer, who is appointed by the commissioner.

5 140105. (a) The chief medical officer shall do all of the
6 following:

7 (1) Serve as president of the Medical Practice Standards
8 Advisory Board.

9 (2) In consultation with the Medical Practice Standards
10 Advisory Board:

11 (A) Study and report on the efficacy of health care treatments
12 and of drugs for particular conditions.

13 (B) Evaluate medical services to determine credible evidence
14 of significant benefit.

15 (C) Identify causes of medical errors and procedures that
16 would decrease those errors.

17 (D) Establish an evidence-based formulary.

18 (E) Identify treatments and medications that are unsafe or of no
19 proven value.

20 (3) Establish a process for soliciting information on these
21 standards from health care providers and consumers.

22 140106. (a) There is within the Office of Medical Practice
23 Standards the Medical Practice Standards Advisory Board. The
24 commissioner shall appoint the members of the board. The board
25 shall consist of the following members:

26 (1) Six physicians and surgeons or osteopathic physicians.

27 (2) One physician assistant.

28 (3) One nurse practitioner.

29 (4) One dentist.

30 (5) One pharmacist.

31 (6) One psychologist.

32 (7) One chiropractor.

33 (8) One optometrist.

34 (9) One podiatrist.

35 (10) One member of an allied licensed health care profession.

36 (11) The chief medical officer.

37 (12) Four health care consumers, one of whom shall have a
38 disability.

39 (b) In making these appointments, the commissioner shall
40 make a good faith effort to assure that the appointments, as a

1 whole, reflect, to the greatest extent feasible, the social and
2 geographic diversity of the state. The commissioner, in appointing
3 the licensed members of the board, shall include members whose
4 health care practice or employment includes fee-for-service,
5 group practice, clinics, hospitals, and integrated health delivery
6 systems.

7 (c) Members of the board shall serve without compensation,
8 but shall be reimbursed for actual and necessary expenses incurred
9 in the performance of their duties to the extent that reimbursement
10 for those expenses is not otherwise provided or payable by another
11 public agency or agencies, and shall receive ____ dollars (\$__) for
12 each full day of attending meetings of the board. For purposes of
13 this section, “full day of attending a meeting” means presence at,
14 and participation in, not less than 75 percent of the total meeting
15 time of the board during any particular 24-hour period.

16 (d) The board shall meet at least six times a year in a place
17 convenient to the public. All meetings of the board shall be open
18 to the public. A majority of the membership of the board shall
19 constitute a quorum. Any action taken by the board under this
20 division requires a majority of the members present at a meeting
21 of the board at which a quorum is present.

22 (e) Members of the board shall be subject to Title 9
23 (commencing with Section 81000) of the Government Code.

24 140107. (a) The Medical Practice Standards Advisory Board
25 shall advise the chief medical officer on the following:

26 (1) The efficacy of health care treatments and of drugs for
27 particular conditions.

28 (2) Medical services for which there is credible evidence of
29 significant benefit.

30 (3) Causes of medical errors and procedures that would
31 decrease those errors.

32 (4) The establishment of an evidence-based formulary.

33 (5) Treatments and medications that are unsafe or of no proven
34 value.

35 (b) No member of the board shall make, participate in making,
36 or in any way attempt to use his or her official position to influence
37 a governmental decision in which he or she knows or has reason
38 to know that he or she has a financial interest.

39 ~~140108. There shall be established regional health agencies~~
40 ~~throughout the state, as determined by the commissioner.~~

1 140109. There is within the Office of the Attorney General an
2 Office of Inspector General for the California Health Care System.
3 The Inspector General shall be appointed by the Governor and
4 subject to Senate confirmation. The Inspector General shall be
5 subject to the direction of the Attorney General.

6 140110. The Inspector General shall have broad powers to
7 investigate and review the financial and business records of
8 individuals, public and private agencies and institutions, and
9 private corporations that provide services or products to the
10 system, the costs of which are reimbursed by the system. The
11 Inspector General shall investigate allegations of misconduct on
12 the part of an employee or appointee of the agency and on the part
13 of any provider of services that are reimbursed by the system and
14 shall report any findings of misconduct to the Attorney General.
15 The Inspector General shall investigate patterns of medical
16 practice that may indicate fraud and abuse related to over or under
17 utilization or other inappropriate utilization of medical products
18 and services. The Inspector General shall arrange for the collection
19 and analysis of data needed to investigate the inappropriate
20 utilization of these products and services. The Inspector General
21 shall conduct additional reviews or investigations of financial and
22 business records when requested by the Governor or by any
23 member of the Legislature and shall report findings of the review
24 or investigation to the Governor and the Legislature. The Inspector
25 General shall annually report recommendations for improvements
26 to the system or the agency to the Governor and the Legislature.

27 140111. The provisions of the Insurance Fraud Prevention
28 Act (Chapter 12 (commencing with Section 1871) of Division 1
29 of the Insurance Code) and the provisions of Article 6
30 (commencing with Section 650) of Chapter 1 of Division 2 of the
31 Business and Professions Code, shall be applicable to providers of
32 services and products, payment for which is made through the
33 system under this division.

34 140112. Nothing contained in this division is intended to
35 repeal any legislation or regulation governing the professional
36 conduct of any person licensed by the State of California or any
37 legislation governing the licensure of any facility licensed by the
38 State of California. All federal legislation and regulations
39 governing referral fees and fee-splitting, including, but not limited
40 to, Sections 1370a-7b and 1395nn of Title 42 of the United States

Code shall be applicable to all providers of services reimbursed under this division, whether or not that provider is paid with funds coming from the federal government.

140113. (a) *The health care system shall be operational no later than January 1, 2006.*

(b) (1) *The commissioner shall appoint a transition advisory group to assist with the transition to the system. The transition advisory group shall include, but not be limited to, the following members:*

(A) *The commissioner.*

(B) *Experts in health care financing and health care administration.*

(C) *Health care practitioners.*

(D) *Representatives of retirement boards.*

(E) *Employer and employee representatives.*

(F) *Hospital, clinic, and long term care facility representatives.*

(G) *Representatives from state departments and regulatory bodies that shall or may relinquish some or all parts of their delivery of health service to the system.*

(H) *Representatives of counties.*

(I) *Consumers of health care.*

(2) *The transition advisory group shall advise the commissioner on all aspects of the implementation of this division.*

(3) *The transition advisory group shall make recommendations to the commissioner, the Governor, and the Legislature on how to integrate health care delivery services and responsibilities of the following departments and agencies into the system.*

(A) *The State Department of Health Services.*

(B) *The Department of Managed Health Care.*

(C) *The Department of Aging.*

(D) *The Department of Developmental Services.*

(E) *The Health and Welfare Data Center.*

(F) *The Department of Mental Health.*

(G) *The Department of Alcohol and Drugs.*

(H) *The Department of Rehabilitation.*

(I) *The Emergency Medical Services Authority.*

(J) *The Managed Risk Medical Insurance Board.*

(K) *The Office of Statewide Health Planning and Development.*

(L) *The Medical Board of California and other California regulatory boards.*

1 (4) *The transition advisory group shall investigate the*
2 *feasibility and costs of including the delivery of health care aspects*
3 *of the following into the system:*

4 (A) *Workers' compensation.*

5 (B) *State disability insurance.*

6 (5) *The transition advisory group shall report its findings to the*
7 *commissioner, the Governor, and the Legislature. The transition to*
8 *the system shall not adversely affect publicly funded programs*
9 *currently providing health care services.*

10 (c) *The transition shall be funded from a loan from the General*
11 *Fund.*

12
13 CHAPTER 3. FUNDING

14
15 Article 1. General Provisions

16
17 140200. (a) *In order to support the agency effectively in the*
18 *administration of this division, there is hereby established in the*
19 *State Treasury the Health Care Fund. The fund shall be*
20 *administered by a director, appointed by the commissioner.*

21 ~~All~~

22 (b) *All moneys collected, received, and transferred pursuant to*
23 *this division shall be transmitted to the State Treasury to be*
24 *deposited to the credit of the Health Care Fund for the purpose of*
25 *financing the California Health Care System.*

26 (c) *All claims for health care services rendered shall be made*
27 *to the Health Care Fund.*

28 (d) *All payments made for health care service shall be*
29 *disbursed from the Health Care Fund.*

30 140201. (a) *The director of the Health Care Fund shall*
31 *establish the following accounts within the Health Care Fund:*

32 (1) *A system account to provide for all annual state*
33 *expenditures for the health care system.*

34 (2) *A reserve account to protect the system from unforeseen*
35 *costs.*

36 (b) *During the first five years of the operation of the system, the*
37 *director shall maintain a reserve account that equals, at minimum,*
38 *5 percent of the system's budget. After five years of the system's*
39 *operation, the director, at the request of the commissioner, may*

1 reduce the minimum reserve requirement to 3 percent of the
2 system's budget.

3 (c) The director of the Health Care Fund shall immediately
4 notify the commissioner when annual costs appear to exceed
5 annual revenues. The commissioner shall determine the cause of
6 excessive costs and implement cost control measures.

7 (d) The commissioner shall seek either a special appropriation
8 or an increase in health care taxes if cost control measures are
9 insufficient to maintain the system.

10 (e) If, on June 30 of any year, the Budget Act for the fiscal year
11 beginning on July 1 has not been enacted, all monies in the reserve
12 account of the Health Care Fund shall be used to implement this
13 division until funds are available through the Budget Act.

14 (f) Notwithstanding any other provision of law and without
15 regard to fiscal year, if the annual State Budget is not enacted by
16 June 30 of any fiscal year preceding the fiscal year to which the
17 budget would apply and if the commissioner determines that funds
18 in the reserve account are depleted, the following shall occur:

19 (1) The Controller shall annually transfer from the General
20 Fund, in the form of one or more loans, an amount not to exceed
21 a cumulative total of one billion dollars (\$1,000,000,000) in any
22 fiscal year, to the Health Care Fund for the purpose of making
23 payments to providers of health care services.

24 (2) Upon enactment of the annual Budget Act in any fiscal year
25 to which paragraph (1) applies, the Controller shall transfer all
26 expenditures and unexpended funds loaned to the Health Care
27 Fund to the appropriate Budget Act item.

28 (3) The amount of any loan made pursuant to subdivision (a)
29 and for which moneys were expended from the Health Care Fund
30 shall be repaid by debiting the appropriate Budget Act item in
31 accordance with the procedure prescribed by the Department of
32 Finance.

33 140202. (a) The commissioner shall prepare the annual state
34 budget for health care. The budget shall specify and set a limit on
35 total annual state expenditures for health care provided pursuant
36 to this division. The budget shall include all of the following:

37 (1) A system budget that includes all expenditures for the
38 system.

39 (2) Facility and provider budgets for each of the two principal
40 mechanisms of professional provider reimbursement

1 *(fee-for-service and integrated health delivery system, and for*
2 *individual health facilities and their associated clinics).*

3 *(3) A capital investment budget.*

4 *(4) A purchasing budget.*

5 *(5) A research and innovation budget.*

6 *(6) A workforce development budget.*

7 *(b) In preparing for the budgets, the commissioner shall*
8 *consider anticipated increased expenditures and savings,*
9 *including, but not limited to, the following:*

10 *(1) Projected increases in expenditures due to improved access*
11 *for underserved populations and improved reimbursement for*
12 *primary care.*

13 *(2) Projected administrative savings under the single payer*
14 *mechanism.*

15 *(3) Projected savings in prescription drug expenditures under*
16 *competitive bidding and a single buyer.*

17 *(4) Projected savings due to provision of primary care rather*
18 *than emergency room treatment.*

19 *140203. (a) The system budget shall be comprised of the cost*
20 *of the system, including the cost of services and benefits provided,*
21 *administration, data gathering, planning, and other activities, and*
22 *revenues deposited with the system account.*

23 *(b) The commissioner shall limit administrative costs to 5*
24 *percent and shall annually evaluate methods to reduce*
25 *administrative costs and report the results of that evaluation to the*
26 *Legislature.*

27 *(c) The commissioner shall limit growth of health care costs in*
28 *the system budget by reference to changes to state gross domestic*
29 *product, population, employment rates, and other demographic*
30 *indicators, as appropriate.*

31 *(d) Monies in the Reserve Account shall not be considered as*
32 *available revenues for purposes of preparing the system budget.*

33 *140204. (a) The facility and provider budgets shall include*
34 *allocations for each of the following:*

35 *(1) Fee-for-service providers.*

36 *(2) Health facilities and associated clinics that are not part of*
37 *a capitated provider network.*

38 *(3) Capitated providers.*

39 *(b) Providers and facilities shall choose whether they will be*
40 *recompensed as fee-for-services providers or as part of a capitated*

1 provider network. The commissioner shall prohibit charges to the
2 system for medical services other than those established by
3 regulation or negotiation.

4 (c) The allocations in subdivision (a) shall consider the relative
5 usage of fee-for-service providers, capitated providers, and health
6 facilities and associated clinics that are not part of a capitated
7 provider network.

8 (d) The provider and facility budget shall be adjusted annually
9 to reflect changes in the utilization of services, changes in any
10 co-payment or deductible payment for covered services, and the
11 addition or exclusion of covered services made by the
12 commissioner upon the recommendation of the Medical Practice
13 Standards Advisory Board.

14 (e) No provider may charge or receive any payments for
15 covered services except those provided for under this division.

16 (f) Licensed health care providers who provide services not
17 covered by this division may charge patients for those services.

18 140205. (a) The budget for fee-for-services providers shall
19 be divided among categories of licensed health care providers, in
20 order to establish a total annual budget for each category. Each
21 of these category budgets shall be sufficient to cover all included
22 services anticipated to be required by eligible individuals choosing
23 fee-for-service at the rates negotiated or set by the commissioner,
24 except as necessary for cost containment purposes pursuant to
25 Section 140212.

26 (b) The commissioner shall negotiate fee-for-service
27 reimbursement rates or salaries for licensed health care providers.
28 In the event negotiations are not concluded in a timely manner, the
29 commissioner shall establish the reimbursement rates.
30 Reimbursement rates shall reflect the goals of the system.

31 140206. (a) The budget shall encompass all operating
32 expenses for health facilities or clinics that are not part of a
33 capitated provider network. In establishing a facility budget, the
34 commissioner shall develop and utilize separate formulae that
35 reflect the differences in cost of primary, secondary, and tertiary
36 care services and health care services provided by academic
37 medical centers.

38 (b) The commissioner shall negotiate facility reimbursement
39 rates with facilities and clinics. Reimbursement rates shall reflect
40 the goals of the system.



1 140207. (a) The budget for capitated providers shall be
2 sufficient to cover all eligible individuals choosing an integrated
3 health care delivery system at the rates negotiated or set by the
4 commissioner.

5 (b) The commissioner shall prepare an annual operating
6 budget for all care provided by facilities, group practices, and
7 integrated health care systems, including the labor costs of
8 providing care. All facilities, group practices, and integrated
9 health care systems shall submit annual operating budget requests
10 to the commissioner and may choose to be reimbursed through a
11 global facility budget or on a capitated basis.

12 (c) The commissioner shall adjust budgets on the basis of the
13 health risk of enrollees, the scope of services provided, proposed
14 innovative programs that improve quality, workplace safety,
15 consumer, provider and employee satisfaction, costs of providing
16 care for non-members, and an appropriate operating margin.

17 (d) Providers and facilities that choose to operate a facility on
18 a capitated basis shall not be paid additionally on a fee-for-service
19 basis unless they are providing services in a separate private
20 medical practice or facility.

21 (e) Facilities and providers that operate on a capitated basis
22 shall report immediately any projected operating deficits to the
23 commissioner. The commissioner shall determine whether the
24 projected deficits reflect appropriate increases in health care
25 needs, in which case the commissioner shall adjust the facility
26 budget appropriately. If the commissioner determines that the
27 deficit is not justifiable, no adjustment shall be made.

28 (f) The commissioner may terminate the funding for facilities,
29 group practices, and integrated health care systems or particular
30 services provided by them if they fail to meet standards of care and
31 practice established by the commissioner. The commissioner shall
32 make future funding contingent on measurable improvements in
33 quality of care and health care outcomes.

34 140208. (a) The commissioner, with the advice of the Health
35 Policy Board, shall establish an annual budget for capital
36 maintenance and development, determine capital investment
37 priorities, and evaluate whether the capital investment program
38 has improved access to services and has eliminated redundant
39 capital investments.

1 (b) All capital investments valued at \$500,000 or greater,
2 including the costs of studies, surveys, design plans and working
3 drawing specifications or other activities essential to planning and
4 execution of capital investment, or capital investment that changes
5 the bed capacity of a facility or adds a new service or license
6 category incurred by any health system entity shall require the
7 approval of the commissioner.

8 (c) When a health facility, or individual acting on behalf of a
9 health facility, or any other purchaser, obtains by lease or
10 comparable arrangement, any facility or part thereof, or any
11 equipment for a facility, the market value of which would have
12 been a capital expenditure, the lease or arrangement shall be
13 considered a capital expenditure for purposes of this division.

14 (d) Health care facilities shall provide the commissioner with
15 three months' advance notice of planned capital investments of
16 more than \$50,000 but less than \$500,000. These capital
17 investments shall minimize unneeded expansion of facilities and
18 services based on the priorities and goals for capital investment
19 established by the commissioner.

20 (e) No capital investment may be undertaken using funds from
21 a facility operating budget.

22 (f) The costs of mandatory earthquake retrofits to health
23 facilities shall not be the responsibility of the system.

24 140209. The commissioner shall establish a budget for the
25 purchase of prescription drugs and durable and non-durable
26 medical equipment for the system. The commissioner shall
27 purchase all prescription drugs and durable and non-durable
28 medical equipment for the system from this budget.

29 140210. The commissioner shall establish a budget to support
30 research and innovation that has been recommended by the
31 commissioner, the Health Policy Board, the chief medical officer,
32 and the consumer advocate. This research and innovation
33 includes, but is not limited to, methods of improving the
34 administration of the system, improving the quality of health care,
35 educating patients, and improving communication among health
36 care providers.

37 140211. The commissioner shall establish a budget to support
38 the development and training of a health system workforce
39 sufficient to meet the health care needs of the population. The
40 commissioner shall give special consideration for training to

workers who may have been displaced from employment due to the inception of the system.

140212. (a) The commissioner shall implement cost controls pursuant to subdivision (c) of Section 140201. No cost control measure shall limit access to care that is needed on an emergency basis or that is determined by a patient's provider to be medically appropriate for a patient's condition.

(b) Mandatory cost control measures shall include, but not be limited to, some or all of the following:

(1) Postponement of introduction of new benefits or benefit improvements.

(2) Postponement of new capital investment.

(3) Adjustment of provider budgets to correct for inappropriate provider utilization.

(4) Limitations on provider reimbursement above a specified amount of aggregate billing.

(5) Deferred funding of the Reserve Account.

(6) Establishment of a limit on aggregate reimbursements to pharmaceutical manufacturers.

(7) Imposition of co-payments or deductible payments pursuant to provisions of Section 140504.

(8) Imposition of an eligibility waiting period in event of substantial influx of individuals into the state for purpose of obtaining health care through the system.

Article 2. Revenue

140220. It is the intent of the Legislature to dedicate revenue from the following sources for deposit in the Health Care Fund:

(a) A personal income tax surtax for health care on unearned income at the rate of ___ percent, pursuant to Section ___ of the Revenue and Taxation Code.

(b) A cigarette and tobacco products surtax for health care, imposed pursuant to Section ___ of the Revenue and Taxation Code, as follows:

(1) On all cigarettes sold in this state, ___ on each pack of cigarettes.

(2) On tobacco products other than cigarettes sold in this state, a tax rate determined by the State Board of Equalization that is equivalent to the tax imposed on cigarettes.

(c) An alcohol surtax for health care, imposed pursuant to Section ___ of the Revenue and Taxation Code, as follows:

(1) On all beer sold in this state, ___ on each 12-ounce can and at a proportionate rate for any other quantity.

(2) On all still wines containing not more than 14 percent of absolute alcohol by volume that are sold in this state, ___ on each 750 milliliter bottle and at a proportionate rate for any other quantity.

(3) On champagne, sparkling wine, and sparkling hard cider whether naturally or artificially carbonated, sold in this state, ___ on each 750 milliliter bottle and at a proportionate rate for any other quantity.

(4) On all distilled spirits sold in this state, ___ on each 1.75 liter bottle and at a proportionate rate for any other quantity.

Article 3. Governmental Payments

140240. The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current federal payments to the state for health care shall be paid directly to the California Health Care System, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the federal government a contribution for health care services in California that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

140241. The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current state payments for health care shall be paid directly to the system, which shall then assume responsibility for all benefits and services previously paid for by state government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek from the Legislature a contribution for health care services that shall not decrease in relation to state government expenditures for health care services in the year that this division was enacted, corrected for change in state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

140242. The commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current county or other local government agency payments for *direct* health care; ~~including to residents, as well as~~ employee health benefits and health benefits for retired employees, shall be paid directly to the system, which shall then assume responsibility for all benefits and services previously paid for by a county or local government agency with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek contributions for health care services that shall not decrease in relation to expenditures for health care services in the year of passage of the division, corrected for change in gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

140243. The system's responsibility for providing care shall be secondary to existing federal, state or local governmental programs for health care services to the extent that funding for these programs are not transferred to the Health Care Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the system.

140244. In order to minimize the administrative burden of maintaining eligibility records for programs transferred to the system, the commissioner shall strive to reach an agreement with federal, state, and local governments in which their contributions to the Health Care Fund shall be fixed to the rate of change of the state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

140245. If, and to the extent that, federal law and regulations allows the transfer of Medi-Cal funding to the system, the commissioner shall pay all premiums, deductible payments, and coinsurance for qualified Medicare beneficiaries who are receiving benefits pursuant to Chapter 3 (commencing with Section 12000) of Part 3 of Division 9 of the Welfare and Institutions Code.

140246. In the event and to the extent that the commissioner obtains authorization to incorporate Medicare revenues into the Health Care Fund, Medicare Part B payments that previously were made by individuals or the commissioner shall be paid by the system for all individuals eligible for both the system and the Medicare program.

Article 4. Employee Contributions

140260. (a) Commencing on January 1 of the second year following passage of this division and quarterly thereafter, it is the intent of the Legislature to require all persons employed in this state to pay a health care tax of ___ percent on their wage income pursuant to Section ___ of the Unemployment Insurance Code. The tax payments shall be withheld by employers pursuant to Chapter 2 (commencing with Section 13020) of Division 6 of the Unemployment Insurance Code.

(b) Nothing in this section shall invalidate an employer's existing obligation under a collective bargaining agreement to pay an employee's health care benefits. If an existing contractual agreement requires an employer to pay the entire cost of an employee's health care premium, the employer shall pay the employee's portion of the health care tax.

Article 5. Employer Contributions

140280. Commencing on January 1 of the second year following passage of this division and quarterly thereafter, it is the intent of the Legislature to require all employers of resident employees to pay a health care tax of ___ percent of total payroll pursuant to Section ____ of the Unemployment Insurance Code.

Article 6. Federal Preemption

140300. An employer is exempt from the payroll tax requirements of Section 140280 if the employer has established an employee benefit plan subject to federal law which preempts the funding provisions of this division.

140301. (a) The commissioner shall pursue all reasonable means to secure a repeal or a waiver of any provision of federal law that preempts any provision of this division.

(b) In the event that a repeal or a waiver cannot be secured, the commissioner shall exercise his or her powers to promulgate rules and regulations, or seek conforming state legislation, consistent with federal law, in an effort to best fulfill the purposes of this division.

140302. (a) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan which, under federal law, preempts provisions of this division, shall first seek benefits under that contract or plan before receiving benefits from the system under this division.

(b) No benefits shall be denied under the system created by this division unless the employee has failed to take reasonable steps to secure like benefits from the contract or plan, if those benefits are available.

(c) Nothing in this section shall preclude an employee from receiving benefits from the system under this division that are superior to benefits available to the employee under the contract or plan.

(d) Nothing in this division is intended, nor shall this division be construed, to discourage recourse to contracts or plans that are protected by federal law.

(e) To the extent permitted by federal law, a provider shall first seek payment from the contract or plan, before submitting bills to the health care system.

Article 7. Subrogation

140320. (a) It is the intent of this division to establish a single public payer for all health care in the State of California. However, until such time as the role of all other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(b) As used in this article, the term collateral source includes all of the following:

(1) Insurance policies written by insurers, including the medical components of automobile, homeowners, and other forms of insurance.

(2) Health care service plans and pension plans.

(3) Employers.

(4) Employee benefit contracts.

(5) Government benefit programs.

1 (6) A judgment for damages for personal injury.

2 (7) Any third party who is or may be liable to an individual for
3 health care services or costs.

4 (c) The term collateral source does not include either of the
5 following:

6 (1) A contract or plan subject to federal preemption.

7 (2) Any governmental unit, agency or service, to the extent that
8 subrogation is prohibited by law. An entity described in
9 subdivision (b) is not excluded from the obligations imposed by
10 this article by virtue of a contract or relationship with a
11 governmental unit, agency, or service.

12 (d) The commissioner shall attempt to negotiate waivers, seek
13 federal legislation, or make other arrangements to incorporate
14 collateral sources in California into the health care system.

15 140321. Whenever an individual receives health care services
16 under the system and he or she is entitled to coverage,
17 reimbursement, indemnity, or other compensation from a
18 collateral source, he or she shall notify the health care provider and
19 provide information identifying the collateral source, the nature
20 and extent of coverage or entitlement, and other relevant
21 information. The health care provider shall forward this
22 information to the commissioner. The individual entitled to
23 coverage, reimbursement, indemnity, or other compensation from
24 a collateral source shall provide additional information as
25 requested by the commissioner.

26 140322. (a) The system shall seek reimbursement from the
27 collateral source for services provided to the individual, and may
28 institute appropriate action, including suit, to recover the
29 reimbursement. Upon demand, the collateral source shall pay to
30 the Health Care Fund the sums it would have paid or expended on
31 behalf of the individual for the health care services provided by the
32 system.

33 (b) In addition to any other right to recovery provided in this
34 article, the commissioner shall have the same right to recover the
35 reasonable value of benefits from a collateral source as provided
36 to the Director of Health Services by Article 3.5 (commencing
37 with Section 14124.70) of Chapter 7 of Part 3 of Division 9, in the
38 manner so provided.

39 140323. (a) If a collateral source is exempt from subrogation
40 or the obligation to reimburse the system as provided in this article,

the commissioner may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the system.

(b) To the extent permitted by federal law, contractual retiree health benefits provided by employers shall be subject to the same subrogation as other contracts, allowing the health care system to recover the cost of services provided to individuals covered by the retiree benefits, unless and until arrangements are made to transfer the revenues of the benefits directly to the health care system.

(c) In the event of unanticipated expenditures in excess of _____, or if cost control mechanisms indicated under _____ are unable to lower expenditures without endangering the health of Californians, the commissioner shall request the Legislature to increase system funding either by increasing tax rates on the sources described in this division or from other revenue sources.

140324. (a) Default, underpayment, or late payment of any tax or other obligation imposed by this division shall result in the remedies and penalties provided by law except as provided in this section.

(b) Eligibility for benefits under Chapter 4 (commencing with Section 140400) shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by this chapter.

140325. The agency and the commissioner shall be exempt from the regulatory oversight and review procedures empowered to the Office of Administrative Law pursuant to Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code. Actions taken by the agency, including, but not limited to, the negotiating or setting of rates, fees, or prices, and the promulgation of any and all regulations, shall be exempt from any review by the Office of Administrative Law, except for Sections 11344.1, 11344.2, 11344.3, and 11344.6 of the Government Code, addressing the publication of regulations.

CHAPTER 4. ELIGIBILITY

140400. All California residents shall be eligible for the California Health Care System. Residency shall be based upon physical presence in the state with the intent to reside. The

1 commissioner shall establish standards and a simplified procedure
2 to demonstrate proof of residency.

3 140401. The commissioner shall establish a procedure to
4 enroll eligible residents and provide each eligible individual with
5 identification that can be used by providers to determine eligibility
6 for services.

7 140402. The commissioner shall determine eligibility
8 standards for residents temporarily out of state and for
9 nonresidents temporarily employed in California. Coverage for
10 emergency care shall be at prevailing local rates. Coverage for
11 nonemergency care shall be according to rates and conditions
12 established by the commissioner. The commissioner may require
13 that a resident be transported back to California when prolonged
14 treatment of an emergency condition is necessary.

15 140403. Visitors to California shall be billed for all services
16 received under the system. The commissioner may establish
17 intergovernmental arrangements with other states and countries to
18 provide reciprocal coverage for temporary visitors.

19 140404. All persons eligible for health benefits from
20 California employers but who are residing in another jurisdiction
21 shall be eligible for health ~~benefit~~ *benefits* under this division
22 providing that they make payments equivalent to the payments
23 they would be required to make if they were residing in California.

24 140405. Unmarried, unemancipated minors shall be deemed
25 to have the residency of their parent or guardian. If a minor's
26 parents are deceased and a legal guardian has not been appointed,
27 or if a minor has been emancipated by court order, the minor may
28 establish his or her own residency.

29 140406. (a) An individual shall be presumed to be eligible if
30 he or she arrives at a health facility or clinic and is unconscious,
31 comatose, or otherwise unable, because of his or her physical or
32 mental condition, to document eligibility or to act in his or her own
33 behalf, or if the patient is a minor, the patient shall be presumed to
34 be eligible, and the health facility or clinic shall provide care as if
35 the patient were eligible.

36 (b) Any individual shall be presumed to be eligible when
37 brought to a health facility pursuant to any provision of Section
38 5150 of the Welfare and Institutions Code.

39 (c) Any individual involuntarily committed to an acute
40 psychiatric facility or to a hospital with psychiatric beds pursuant

1 to any provision of Section 5150 of the Welfare and Institutions
2 Code, providing for involuntary commitment, shall be presumed
3 eligible.

4 (d) All health care facilities subject to provisions governing
5 emergency medical treatment and active labor shall comply with
6 those provisions.

7
8 CHAPTER 5. BENEFITS
9

10 140500. Any eligible individual may choose to receive
11 services under the California Health Care System from any willing
12 professional provider participating in the system. No provider may
13 refuse to care for a patient solely because of race, religious creed,
14 color, national origin, ancestry, physical disability, mental
15 disability, medical condition, marital status, sex, age, or sexual
16 orientation *whether actual or perceived*.

17 140501. Covered benefits in this chapter shall include all
18 medical care determined to be medically appropriate by the
19 consumer's health care provider. These benefits include, but are
20 not limited to, all of the following:

21 (a) Inpatient and outpatient health facility or clinic services.

22 (b) Inpatient and outpatient professional provider services by
23 licensed health care professionals.

24 (c) Diagnostic imaging, laboratory services, and other
25 diagnostic and evaluative services.

26 (d) Durable medical equipment, appliances, and assistive
27 technology including prosthetics, eyeglasses, and hearing aids and
28 their repair.

29 (e) Rehabilitative care.

30 (f) Emergency transportation and necessary transportation for
31 health care services for disabled persons.

32 (g) Language interpretation for health care services, including
33 sign language for those unable to speak, or hear, or who are
34 language impaired, and braille translation or other services for
35 those with no or low vision.

36 (h) Child and adult immunizations and preventive care.

37 (i) Health education.

38 (j) Hospice care.

39 (k) Home health care.

- 1 (l) Prescription drugs that are listed on the system formulary.
2 Nonformulary prescription drugs may be included where special
3 standards and criteria are met.
- 4 (m) Mental health care.
5 (n) Dental care.
6 (o) Podiatric care.
7 (p) Chiropractic care.
8 (q) Acupuncture.
9 (r) Blood and blood products.
10 (s) Emergency care services.
11 (t) Vision care.
12 (u) Adult day care.
13 (v) Case management and coordination to ensure services
14 necessary to enable a person to remain safely in the least restrictive
15 setting.
16 (w) Substance abuse treatment.
17 (x) Care of up to ~~seven~~ 100 days in a skilled nursing facility
18 following hospitalization.
19 (y) Dialysis.
- 20 140502. (a) The commissioner may expand benefits beyond
21 the minimum benefits described in this chapter when expansion
22 meets the intent of this division and there are sufficient funds to
23 cover the expansion.
- 24 (b) *The commissioner, with the advice of the chief medical*
25 *officer and the Medical Practices Advisory Board, shall remove or*
26 *exclude treatments from the benefit package that are unsafe or of*
27 *no proven value.*
- 28 (c) *The commissioner, with the advice of the chief medical*
29 *officer and the Medical Practices Advisory Board, shall remove or*
30 *exclude prescription drugs from the formulary that add no*
31 *therapeutic advantage.*
- 32 140503. The following health care services shall be excluded
33 from coverage by the system:
- 34 (a) Health care services determined to have no medical
35 indication by the chief medical officer and the Medical Practice
36 Standards Advisory Board.
- 37 (b) Surgery, dermatology, orthodontia, prescription drugs, and
38 other procedures primarily for cosmetic purposes, unless required
39 to correct a congenital defect, restore or correct a part of the body
40 that has been altered as a result of injury, disease, or surgery, or

1 determined to be medically necessary by a qualified, licensed
2 health care provider in the system.

3 (c) Private rooms in inpatient facilities, unless determined to be
4 medically necessary by a qualified, licensed provider in the
5 system.

6 (d) Services of a professional health care provider or facility
7 that is not licensed or accredited by the state.

8 140504. (a) The commissioner shall institute no deductible
9 payments or copayments during the initial two years of the systems
10 operation. The commissioner and the Health Policy Board shall
11 review this policy annually, beginning in the third year of
12 operation, and determine whether deductible payments or
13 copayments should be established.

14 (b) If the commissioner establishes copayments consistent with
15 subdivision (a), they shall be limited to two hundred fifty dollars
16 (\$250) per person per year and five hundred dollars (\$500) per
17 family per year.

18 (c) If the commissioner establishes deductible payments
19 consistent with subdivision (a), they shall be limited to two
20 hundred fifty dollars (\$250) per person per year and five hundred
21 dollars (\$500) per family per year.

22 (d) Copayments shall be imposed first on individuals who
23 obtain specialist care and are not referred for that care by their
24 primary health care provider. These copayments shall not be
25 included in the individual's or family's copayment limit.

26 (e) No copayments or deductible payments may be established
27 for preventive care as determined by a patient's primary care
28 provider.

29 (f) No copayments or deductible payments may be established
30 when prohibited by federal law.

31 (g) The commissioner shall establish standards and procedures
32 for waiving copayments or deductible payments. Waivers of
33 copayments or deductible payments shall not affect the
34 reimbursement of facilities and providers of care.

35 (h) Any copayments established pursuant to subdivision (b)
36 and collected by health care providers or facilities shall be
37 transmitted to the Treasurer to be deposited to the credit of the
38 Health Care Fund.

(i) Nothing in this division shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(j) Nothing in this division shall preclude employees from receiving benefits available to them under a collective bargaining agreement or other employee-employer agreement that are superior to benefits under this division.

CHAPTER 6. DELIVERY OF CARE

140600. (a) All health care providers licensed to practice in California may participate in the Health Care System.

(b) All integrated health care systems, group medical practices, clinics, and hospitals accredited and licensed in California that provide services covered by this division, may participate in the system.

(c) No health care practitioner or health care facility whose license or accreditation is under suspension or who is under disciplinary action may be a participating provider of care.

(d) Providers shall allow eligible persons to enroll for care in the order of time of application and by the provider's ability to provide services needed by the applicant.

(e) No health care provider or group of providers or integrated health care system may refuse to enroll an individual solely because of a preexisting health condition, age, sex, race, national origin, ancestry, sexual orientation, gender, disability, ethnicity or religion, whether actual or perceived.

(f) The commissioner and the chief medical officer shall establish methods to detect, correct, and decrease medical errors.

(g) Persons who are eligible for health care services under this division may choose their health care provider. However, persons electing to enroll in integrated health care systems or group medical practices shall retain membership for at least one year after an initial three-month evaluation period during which time they may withdraw for any reason. Persons who want to withdraw after an initial three-month period may appeal to the consumer advocate who may authorize early disenrollment.

140601. (a) The commissioner, with the advice of the Health Policy Board, and the chief medical officer, with the advice of the Medical Practices Advisory Board, shall develop guidelines and

1 incentives for providers and facilities to encourage all of the
2 following:

3 (1) Comprehensive services.

4 (2) Information on standards of care for health care
5 practitioners.

6 (3) Prevention and disease management programs to patients.

7 (4) Peer review of health care practitioner performance and
8 early intervention to correct practitioner problems.

9 (5) Medical error reduction.

10 (6) Patient satisfaction and response to patient concerns.

11 (7) Reimbursement for performance and accountability.

12 (8) Provider satisfaction.

13 (9) Improvements to access of care.

14 (10) Workplace safety.

15 (11) Reduction in administrative costs.

16 (12) Sufficient primary care practitioners to meet the needs of
17 the population.

18 However, no incentive may adversely affect the care a patient
19 receives or the care recommended by a provider. Nor shall any
20 incentive reward overutilization or underutilization of care.

21 (b) Physicians in private practice may choose to be reimbursed
22 on a fee-for-service basis or on a salaried basis.

23 (c) The commissioner and the chief medical officer shall assess
24 the number of primary and specialist care providers needed to
25 supply adequate health care services to all residents and shall
26 develop a plan to meet those needs. The commissioner shall
27 develop incentives for health care practitioners and facilities to
28 increase access to health care services in unserved or underserved
29 areas.

30 (d) The chief medical officer shall establish guidelines for
31 prescribing drugs and medical equipment outside of an
32 evidence-based formulary. The guidelines shall not impose an
33 undue administrative burden on licensed health care providers,
34 pharmacists, or pharmacies.

35 (e) The commissioner shall establish cultural and linguistic
36 standards for the system. The standards shall include, but not be
37 limited to, the following:

38 (1) The State Department of Health Services and the
39 Department of Managed Health Care guidelines for culturally
40 competent and linguistically sensitive care.

1 (2) *Medi-Cal Managed Care Division (MMCD) Policy Letters*
2 *99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural*
3 *and Linguistic Standards Task Force and the State Department of*
4 *Health Services.*

5 (3) *Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section*
6 *2000d)*

7 (4) *The United States Department of Health and Human*
8 *Services' Office of Civil Rights; Title VI of the Civil Rights Act of*
9 *1964; Policy Guidance on Prohibition Against National Origin*
10 *Discrimination as It Affects Persons with Limited English*
11 *Proficiency (February 1, 2002).*

12 (5) *The United States Department of Health and Human*
13 *Services' Office of Minority Health; National Standards on*
14 *Culturally and Linguistically Appropriate Services (CLAS) in*
15 *Health Care--Final Report (December 22, 2000).*

16 (f) *The commissioner annually shall evaluate residents' access*
17 *to trauma care and shall establish measures to ensure equitable*
18 *access for all residents.*

19 (g) *The commissioner shall establish measures to ensure*
20 *equitable access for all residents to specialized medical*
21 *procedures and technology.*

22 140602. (a) *The commissioner, with the advice of the Health*
23 *Policy Board, and the chief medical officer shall define*
24 *performance criteria and goals for the health care system and shall*
25 *report to the Legislature at least annually on the system*
26 *performance.*

27 (b) *The commissioner shall establish a system to monitor the*
28 *quality of care and patient and provider satisfaction and to develop*
29 *measures to ensure improvements.*

30 (c) *All health care practitioners, health care facilities,*
31 *employers, and other public or private agencies providing services*
32 *under the system shall provide data as required by the*
33 *commissioner to maintain and improve health care services under*
34 *this division. The commissioner shall establish an enforcement*
35 *mechanism, including penalties, to ensure implementation of this*
36 *provision.*

37 140603. (a) *The commissioner, with the advice of the Health*
38 *Policy Board, shall coordinate health care planning with other*
39 *state and local agencies that provide direct health care to*
40 *residents.*

1 ***(b) In planning for the health care needs of the population, the***
2 ***commissioner shall do all of the following:***

3 ***(1) Establish annual goals and priorities for health outcomes.***

4 ***(2) Develop equitable access to services for eligible residents.***

5 ***(3) Develop equitable distribution of health care resources and***
6 ***personnel.***

7 ***(4) Ensure culturally and linguistically competent care.***

8 ***(5) Develop statewide health care databases.***

9 ***(6) Assess the capacity of health care training programs to***
10 ***provide an adequate health care workforce.***

11 ***(7) Develop a professional and non-professional health care***
12 ***workforce to provide sufficient services to residents.***

13 ***(8) Measure provider, consumer, and employer satisfaction as***
14 ***a factor of the performance of the health care system.***

15 ***(9) Promote workplace safety.***

16 ***(10) Develop quality of care education programs for health***
17 ***care providers and the health care workforce.***

18 ***(11) Assess and improve capital infrastructure.***

19 ***(12) Improve the enrollment system to ensure its ease of use.***

20 ***(13) Develop protocols to ensure the privacy rights of patients.***

21 ***(14) Ensure continuing compliance with the federal Health***
22 ***Insurance Accountability and Portability Act of 1996.***

23 ***(15) Assist in the implementation of public health programs.***

24 ***(16) Develop protocols to decrease medical errors.***

25 SEC. 2. No reimbursement is required by this act pursuant to
26 Section 6 of Article XIII B of the California Constitution because
27 the only costs that may be incurred by a local agency or school
28 district will be incurred because this act creates a new crime or
29 infraction, eliminates a crime or infraction, or changes the penalty
30 for a crime or infraction, within the meaning of Section 17556 of
31 the Government Code, or changes the definition of a crime within
32 the meaning of Section 6 of Article XIII B of the California
33 Constitution.