AMENDED IN SENATE MAY 14, 2003

AMENDED IN SENATE APRIL 21, 2003

SENATE BILL No. 921

Introduced by Senator Kuehl
(Principal coauthor: Assembly Member Goldberg)
(Coauthors: Senators Alarcon, Cedillo, Florez, Perata, *Romero,* and Soto)
(Coauthors: Assembly Members Chan, *Diaz,* 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 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.

140005. The Legislature finds and declares all of the following:

(a) More than 6 million Californians lacked health insurance coverage at some time in 2001 and 3.6 million had no health insurance coverage at any time.

(b) Since 2001, the number of uninsured Californians has risen significantly.

(c) More than 10 million Californians have no coverage for prescription drugs. Millions of Californians lacking prescription drug coverage are otherwise insured.

(d) Efforts to control health care costs and growth of health care spending have been unsuccessful.

(e) Employers, retirement funds, and unions that offer and negotiate for health insurance and benefits and individuals who purchase health insurance are experiencing substantial increases in health care costs and decreases in health care benefits.

(f) Unstable and ~~affordable~~ *unaffordable* rate increases have caused significant economic hardship for California residents and their employers.

(g) Nearly 63 percent of all personal bankruptcies in the United States are the result of health care costs.

(h) California does not perform well on standard health outcome measurements.

(i) Unacceptable health access disparities exist by region, ethnicity, income, and gender.

(j) Eleven of California's rural counties have no health maintenance organizations that provide coverage to the county on a countywide basis and 21 rural counties no longer have a Medicare+Choice HMO.

(k) More than 80 percent of all Medi-Cal and uninsured patient visits to emergency facilities are for conditions that could have been treated in a nonemergency setting.

(*l*) Emergency departments and trauma centers face growing financial losses.

(m) Advances in medical technology are not available to all Californians who need them.

(n) Health care providers express significant professional dissatisfaction with the current health care systems, as do health care consumers.

(o) The California Medical Association found in 2001 that uncompensated care totaled five hundred forty million dollars ~~($540 million)~~ *($540,000,000)*. Uncompensated care has caused 60 emergency departments (15 percent of the departments in the state) to close since 1990.

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

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

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

140006. This division shall have all of the following purposes:

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

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

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

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

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

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

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

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

(a) ''Agency'' means the California Health Care Agency.

(b) ''Commissioner'' means the Health Care Commissioner.

(c) ''System'' or ''health care system'' means the California Health Care System.

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

CHAPTER 2. GOVERNANCE

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall appoint the deputy health commissioner, the director of the Health Care Fund, the consumer advocate,~~,~~ the chief medical officer, and the members of the Medical Practice Standards Advisory Board.

(c) In accordance with the laws governing the state civil service, the commissioner shall employ and, with the approval of the Department of Finance, fix the compensation of personnel as the commissioner needs to properly discharge the duties imposed upon the commissioner by law, including, but not limited to, a deputy commissioner, a public information officer, a chief enforcement counsel, a director of the Health Care Fund, a chief medical officer, the consumer advocate, and legal counsel in any action brought by or against the commissioner under or pursuant to any provision of any law under the commissioner's jurisdiction, or in which the commissioner joins or intervenes as to a matter within the commissioner's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the commissioner or before a person authorized by the commissioner. The personnel of the agency shall perform duties as assigned to them by the commissioner. The commissioner shall designate certain employees by rule or order that are to take and subscribe to the constitutional oath of office within 15 days after their appointments, and to file that oath with the Secretary of State. The commissioner shall also designate those employees that are to be subject to Title 9 (commencing with Section 81000) of the Government Code.

(d) The commissioner shall adopt a seal bearing the inscription: ''Commissioner, Health Care Agency, State of California.'' The

seal shall be affixed to or imprinted on all orders and certificates issued by him or her and other instruments as he or she directs. All courts shall take judicial notice of this seal.

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

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

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

(h) The commissioner, 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.

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

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

(1) Implement statutory eligibility standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) An Office of Consumer Advocacy with offices convenient to all the residents of the state.

(C) An Office of Medical Practice Standards and a Medical Practice Standards Advisory Board .

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

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

(B) Meet regularly with the chief medical officer and the consumer advocate to review the impact of the agency and its policies on the regions.

(C) Establish health system goals in measurable terms.

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

(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 director of the Health Care Fund.

(6) The consumer advocate.

(7) The chief medical officer.

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

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

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

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

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

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

(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.

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

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

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

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

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

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

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

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

(f) The board shall meet at least six times a year in a place convenient to the public. All meetings of the board shall be open to the public. A majority of the membership of the board shall 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 consumer advocate appointed by the commissioner.

(c) The consumer advocate shall establish an office in the City of Sacramento and other offices throughout the state that shall provide convenient access to residents.

(d) The duties of the 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 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 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.

(9) Holding public hearings, at least annually, throughout the state concerning complaints and suggestions from the public.

(e) The 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 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

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

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

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

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

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

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

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

(D) Establish an evidence-based formulary.

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

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

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

(1) Six physicians and surgeons or osteopathic physicians.

(2) One physician assistant.

(3) One nurse practitioner.

(4) One dentist.

(5) One pharmacist.

(6) One psychologist.

(7) One chiropractor.

(8) One optometrist.

(9) One podiatrist.

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

(11) The chief medical officer.

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

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

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

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

(d) The board shall meet at least six times a year in a place convenient to the public. All meetings of the board shall be open to the public. A majority of the membership of the board shall 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.

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

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

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

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

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

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

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

(b) 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.

140109. There is within the Office of the Attorney General an Office of Inspector General for the California Health Care System.

The Inspector General shall be appointed by the Governor and subject to Senate confirmation. The Inspector General shall be subject to the direction of the Attorney General.

140110. The Inspector General shall have broad powers to investigate and review the financial and business records of individuals, public and private agencies and institutions, and private corporations that provide services or products to the system, the costs of which are reimbursed by the system. The Inspector General shall investigate allegations of misconduct on the part of an employee or appointee of the agency and on the part of any provider of services that are reimbursed by the system and shall report any findings of misconduct to the Attorney General. The Inspector General shall investigate patterns of medical practice that may indicate fraud and abuse related to over or under utilization or other inappropriate utilization of medical products and services. The Inspector General shall arrange for the collection and analysis of data needed to investigate the inappropriate utilization of these products and services. The Inspector General shall conduct additional reviews or investigations of financial and business records when requested by the Governor or by any member of the Legislature and shall report findings of the review or investigation to the Governor and the Legislature. The Inspector General shall annually report recommendations for improvements to the system or the agency to the Governor and the Legislature.

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

140112. Nothing contained in this division is intended to repeal any legislation or regulation governing the professional conduct of any person licensed by the State of California or any legislation governing the licensure of any facility licensed by the State of California. All federal legislation and regulations governing referral fees and fee-splitting, including, but not limited 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.

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

(A) Workers' compensation.

(B) State disability insurance.

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

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

CHAPTER 3. FUNDING

Article 1. General Provisions

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

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

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

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

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

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

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

(b) During the first five years of the operation of the system, the director shall maintain a reserve account that equals, at minimum, 5 percent of the system's budget. After five years of the system's operation, the director, at the request of the commissioner, may reduce the minimum reserve requirement to 3 percent of the system's budget.

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

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

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

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

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

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

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

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

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

(2) Facility and provider budgets for each of the two principal mechanisms of professional provider reimbursement (fee-for-service and integrated health delivery system, and for individual health facilities and their associated clinics).

(3) A capital investment budget.
(4) A purchasing budget.
(5) A research and innovation budget.
(6) A workforce development budget.

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

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

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

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

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

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

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

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

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

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

(1) Fee-for-service providers.

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

(3) Capitated providers.

(b) Providers and facilities shall choose whether they will be recompensed as fee-for-services providers or as part of a capitated provider network. The commissioner shall prohibit charges to the

system for medical services other than those established by regulation or negotiation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) All capital investments valued at ~~$500,000~~ *five hundred thousand dollars ($500,000)* or greater, including the costs of studies, surveys, design plans and working drawing specifications or other activities essential to planning and execution of capital investment, or capital investment that changes the bed capacity of a facility or adds a new service or license category incurred by any health system entity shall require the approval of the commissioner.

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

(d) Health care facilities shall provide the commissioner with three months' advance notice of planned capital investments of more than ~~$50,000 but less than $500,000~~ *fifty thousand dollars ($50,000) but less than five hundred thousand dollars ($500,000)*. These capital investments shall minimize unneeded expansion of facilities and services based on the priorities and goals for capital investment established by the commissioner.

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

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

140209. The commissioner shall establish a budget for the purchase of prescription drugs and durable and nondurable medical equipment for the system. The commissioner shall purchase all prescription drugs and durable and nondurable medical equipment for the system from this budget.

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

140211. The commissioner shall establish a budget to support the development and training of a health system workforce

sufficient to meet the health care needs of the population. The 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 copayments or deductible payments pursuant to provisions of Section 140504.

(8) Imposition of an eligibility waiting period in *the* 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.~~

Article 2. 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 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.~~

Article 3. Federal Preemption

140300. (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.~~

140301. (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.~~ *4.* 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.

(6) A judgment for damages for personal injury.

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

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

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

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

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

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

140322. (a) The system shall seek reimbursement from the collateral source for services provided to the individual, and may institute appropriate action, including suit, to recover the reimbursement. Upon demand, the collateral source shall pay to

the Health Care Fund the sums it would have paid or expended on behalf of the individual for the health care services provided by the system.

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

140323. (a) If a collateral source is exempt from subrogation 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 commissioner shall establish standards and a simplified procedure to demonstrate proof of residency.

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

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

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

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

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

140406. (a) An individual shall be presumed to be eligible if he or she arrives at a health facility or clinic and is unconscious,

comatose, or otherwise unable, because of his or her physical or mental condition, to document eligibility or to act in his or her own behalf, or if the patient is a minor, the patient shall be presumed to be eligible, and the health facility or clinic shall provide care as if the patient were eligible.

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

(c) Any individual involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds pursuant to any provision of Section 5150 of the Welfare and Institutions Code, providing for involuntary commitment, shall be presumed eligible.

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

CHAPTER 5. BENEFITS

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

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

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

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

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

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

(e) Rehabilitative care.

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

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

(h) Child and adult immunizations and preventive care.

(i) Health education.

(j) Hospice care.

(k) Home health care.

(*l*) Prescription drugs that are listed on the system formulary. Nonformulary prescription drugs may be included where special standards and criteria are met.

(m) Mental health care.

(n) Dental care.

(o) Podiatric care.

(p) Chiropractic care.

(q) Acupuncture.

(r) Blood and blood products.

(s) Emergency care services.

(t) Vision care.

(u) Adult day care.

(v) Case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting.

(w) Substance abuse treatment.

(x) Care of up to 100 days in a skilled nursing facility following hospitalization.

(y) Dialysis.

140502. (a) The commissioner may expand benefits beyond the minimum benefits described in this chapter when expansion meets the intent of this division and there are sufficient funds to cover the expansion.

(b) The commissioner, with the advice of the chief medical officer and the Medical Practices Advisory Board, shall remove or exclude treatments from the benefit package that are unsafe or of no proven value.

(c) The commissioner, with the advice of the chief medical officer and the Medical Practices Advisory Board, shall remove or

exclude prescription drugs from the formulary that add no therapeutic advantage.

140503. The following health care services shall be excluded from coverage by the system:

(a) Health care services determined to have no medical indication by the chief medical officer and the Medical Practice Standards Advisory Board.

(b) Surgery, dermatology, orthodontia, prescription drugs, and other procedures primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body that has been altered as a result of injury, disease, or surgery, or determined to be medically necessary by a qualified, licensed health care provider in the system.

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

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

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

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

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

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

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

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

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

(h) Any copayments established pursuant to subdivision (b) and collected by health care providers or facilities shall be transmitted to the Treasurer to be deposited to the credit of the 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 incentives for providers and facilities to encourage all of the following:

(1) Comprehensive services.

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

(3) Prevention and disease management programs to patients.

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

(5) Medical error reduction.

(6) Patient satisfaction and response to patient concerns.

(7) Reimbursement for performance and accountability.

(8) Provider satisfaction.

(9) Improvements to access of care.

(10) Workplace safety.

(11) Reduction in administrative costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Ensure culturally and linguistically competent care.

(5) Develop statewide health care databases.

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

(7) Develop a professional and nonprofessional health care workforce to provide sufficient services to residents.

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

(9) Promote workplace safety.

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

(11) Assess and improve capital infrastructure.

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

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

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

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

(16) Develop protocols to decrease medical errors.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of

the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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