

# LEGISLATIVE INTENT SERVICE, INC.

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## DECLARATION OF FILOMENA M. YEROSHEK

I, Filomena M. Yeroshek, declare:

I am an attorney licensed to practice before the courts of the State of California, State Bar No. 125625, and am employed by Legislative Intent Service, Inc. a company specializing in researching the history and intent of legislation.

The following list identifies documents obtained by the staff of Legislative Intent Service, Inc. on Assembly Bill 1 of the First Extraordinary Session of 2008 (hereafter referred to as Assembly Bill 1x). All documents gathered by Legislative Intent Service, Inc. and all copies forwarded with this Declaration are true and correct copies of the originals located by Legislative Intent Service, Inc.

### ASSEMBLY BILL 1X OF 2008X:

1. Assembly Bill 1x (Nunez) as amended in the Senate on January 16, 2008;
2. Procedural history of Assembly Bill 1x from the 2007-08 Complete Bill History;
3. News articles from Assembly member Nunez's Official California State website regarding Assembly Bill 1x, <http://democrats.assembly.ca.gov/members/a46/issues-healthcare.aspx>;
4. Excerpt regarding Joint Rule 62(a) from the 2007-08 "California Legislature Handbook."

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed this 18th day of September, 2008 at Woodland, California.

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FILOMENA M. YEROSHEK

AMENDED IN SENATE JANUARY 16, 2008  
AMENDED IN ASSEMBLY DECEMBER 17, 2007  
AMENDED IN ASSEMBLY DECEMBER 13, 2007  
AMENDED IN ASSEMBLY NOVEMBER 8, 2007

CALIFORNIA LEGISLATURE—2007–08 FIRST EXTRAORDINARY SESSION

**ASSEMBLY BILL**

**No. 1**

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**Introduced by Assembly Member Nunez**  
(Principal coauthor: Senator Perata)

September 11, 2007

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An act to amend Section 2069 of, to add Sections 4040.1, 4071.2, 4071.3, and 4071.4 to, and to add and repeal Section 2838 of, the Business and Professions Code, to add Section 49452.9 to the Education Code, to add Sections 12803.2, 12803.25, 22830.5, and 22830.6 to, and to add Chapter 15 (commencing with Section 8899.50) to Division 1 of Title 2 of, the Government Code, to amend Sections 1357.54, 1365, 124900, 124905, 124910, 124920, 128745, and 128748 of, to amend, repeal, and add Section 1399.56 of, to add Sections 1262.9, 1342.9, 1347, 1356.2, 1367.16, 1367.205, 1367.38, 1368.025, 1378.1, 1395.2, 1399.58, 104376, 124905.1, 124946, and 130545 to, to add Chapter 1.6 (commencing with Section 155) to Part 1 of Division 1 of, to add Article 11.6 (commencing with Section 1399.820) to Chapter 2.2 of Division 2 of, to add Article 1 (commencing with Section 104250) to Chapter 4 of Part 1 of Division 103 of, to add Article 3 (commencing with Section 104705) to Chapter 2 of Part 3 of Division 103 of, and to add Chapter 4 (commencing with Section 128850) to Part 5 of Division 107 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, and 12693.76 of, to amend, repeal, and add Section 796.02 of, to add Sections 796.05, 10113.10, 10113.11, 10123.56, 10176.15,

10273.6, 12693.56, 12693.57, 12693.58, 12693.59, 12693.766, 12886, and 12887 to, to add Chapter 9.6 (commencing with Section 10919) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) and Part 6.7 (commencing with Section 12739.50) to Division 2 of, the Insurance Code, to add Section 96.8 to the Labor Code, to amend Sections 19167 and 19611 of, to add Sections 17052.31, 17052.32, 19528.5, and 19553.5 to, and to add and repeal Section 17052.30 of, the Revenue and Taxation Code, to add Sections 301.1 and 1120 to, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 12306.1, 14005.30, and 14011.16 of, to add Sections 14005.301, 14005.305, 14005.306, 14005.310, 14005.311, 14005.331, 14005.333, 14011.16.1, 14074.5, 14081.6, 14092.5, 14132.105, and 14137.10 to, and to add Article 5.215 (commencing with Section 14167.22) to, and to add and repeal Article 5.21 (commencing with Section 14167.1) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1, as amended, Nuncz. Health care reform.

(1) Existing law creates the California Health and Human Services Agency.

This bill would require the agency, in consultation with the Board of Administration of the Public Employees' Retirement System (PERS), to assume lead agency responsibility for professional review and development of best practice standards for high-cost chronic diseases that state health care programs would be required to implement upon their adoption. The bill would additionally require the agency, in consultation with PERS and health care provider groups, to develop health care provider performance measurement benchmarks, as specified.

The bill, effective July 1, 2008, would create the California Health Care Cost and Quality Transparency Committee in the California Health and Human Services Agency, with various powers and duties, including the development and periodic review of a health care cost and quality transparency plan. The bill would require the Office of Statewide Health Planning and Development to assist the committee in that regard. The bill would require the Secretary of California Health and Human Services to track and assess the effects of health care reform and to

report to the Legislature by March 1, 2012, and biennially thereafter. The bill would also create the California Health Benefits Service within the State Department of Health Care Services, with various powers and duties relative to creation of joint ventures between certain county-organized health plans and various other entities. The bill would require these joint ventures to be licensed as health care service plans and would create a stakeholder committee.

(2) Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage 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 Care Services and county welfare departments.

This bill would require California residents, subject to certain exceptions, to enroll in and maintain at least minimum creditable health care coverage, as determined by the Managed Risk Medical Insurance Board, for themselves and their dependents, as defined. The bill would require the board to establish, by regulation, the definition and standards for minimum creditable coverage, including an affordability standard and hardship exemptions, by March 1, 2009, and would require the board to facilitate enrollment in public or private coverage and to establish an education and awareness program, by January 1, 2010, relating to the requirement to obtain minimum creditable coverage. The bill would enact related provisions, including authorizing a school district, on and after January 1, 2010, to provide parents and guardians information explaining these health care coverage requirements.

The bill would, as of January 1, 2009, create the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), which would function as a statewide purchasing pool for health care coverage and be administered by the Managed Risk Medical Insurance Board. The bill would specify eligibility for Cal-CHIPP and would require the board to develop and offer a variety of benefit plan designs, including the Cal-CHIPP Healthy Families plan in which enrollment would be restricted to specified low-income persons. The bill would authorize

an employer to pay all or a part of the premium payment required of its employees enrolled in Cal-CHIPP. The bill would make it an unfair labor practice for an employer to refer an employee, or his or her dependent, to Cal-CHIPP or to arrange for their application to that program to separate them from group coverage provided through the employment relationship, and for an employer to change the share-of-cost ratio or modify coverage in order for an employee or his or her dependents to enroll in that program. Because an unfair labor practice may be punishable as a crime, the bill would impose a state-mandated local program. The bill would create the California Health Trust Fund in the State Treasury for the purposes of this act. The bill would require the State Department of Health Care Services to seek any necessary federal approval to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the California Health Trust Fund. The bill, on and after July 1, 2010, would also extend Medi-Cal benefits to parents and caretaker relatives and various other persons meeting certain eligibility requirements. The bill would require certain of these individuals to receive their benefits in the form of a benchmark package, which would be the Cal-CHIPP Healthy Families benefit package. The bill would provide for the benchmark benefits to be administered by the Managed Risk Medical Insurance Board, pursuant to an interagency agreement with the department. The bill would make these provisions subject to federal financial participation and approval, as specified.

The bill would require the State Department of Health Care Services to establish a Healthy Action Incentives and Rewards Program to be provided as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval. The bill would also require the Director of Health Care Services to establish a local coverage option program for low-income adults that would be the exclusive Medi-Cal coverage for a 4-year period beginning with the program's commencement, for county residents who, among other requirements, have a family income at or below 100% of the federal poverty level and are not otherwise eligible for the Medi-Cal program. The bill would specify that the program would become operational for services rendered on or after July 1, 2010. The bill would specify that coverage under the program would be provided at a county's option and only by a county that operates a designated public hospital, subject to approval by the State Department of Health Care Services and contingent on

establishment of a county share of cost. The bill would require the State Department of Health Care Services, by January 1, 2010, to contract with an independent 3rd party to develop an assessment tool to measure the care provided under the program. The bill would require the department, after 3 years of the program's operation, to evaluate the program using the assessment tool and would extend the program for an additional 2 years if the program substantially met certain criteria and would terminate the program if it did not. The bill would enact other related provisions.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program on and after July 1, 2009. The bill would, on and after July 1, 2009, delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child satisfy citizen and immigration status requirements applicable to the programs under federal law, thereby creating a state-only element of the programs. The bill would additionally, on and after July 1, 2009, disregard all income over 250% but less than or equal to 300% of the federal poverty level and would apply Medi-Cal program income deductions to a family income greater than 300% of the federal poverty level in determining eligibility for the Healthy Families Program. The bill would authorize the board to provide, or arrange for the provision of, an electronic personal health record under the Healthy Families Program, to the extent funds are appropriated for that purpose, and would provide for the confidentiality of information obtained pursuant to the program.

The bill would require the department to exercise its federal option as necessary to simplify Medi-Cal eligibility by exempting all resources for certain applicants and recipients, commencing July 1, 2010.

The bill would enact the Medi-Cal Physician Services Rate Increase Act, which would establish, with respect to services rendered to Medi-Cal beneficiaries on and after July 1, 2010, to the extent funds are appropriated in the annual Budget Act, increased reimbursements of up to 100% of the Medicare rate for physicians, physician groups, as defined, and others that are enrolled Medi-Cal providers eligible to receive payments for Medi-Cal services. The bill would permit some of these rate increases to be linked to specified performance measures and would provide that these rate increases would be implemented only to the extent that state funds are appropriated for the nonfederal share of these increases. The bill would require the Director of Health Care Services to seek federal approval of the rate methodology set forth in

the act and would prohibit the methodology from being implemented if federal approval is not obtained.

Because each county is required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

This bill would also enact the Medi-Cal Hospital Rate Stabilization Act, which would revise the methodology by which safety net care pool funds are paid to designated public hospitals for providing uncompensated care to the uninsured. The bill would require the State Department of Health Care Services to determine an outpatient base rate and an inpatient base rate, as defined, for various types of hospitals. The bill would also, commencing July 1, 2010, establish specified reimbursement rate methodologies under the Medi-Cal program for hospital services, as defined, that are rendered by designated public hospitals and for managed health care plans, as specified, and would require managed health care plans to expend 100% of moneys received under the increased rates for payments to hospitals for providing services to Medi-Cal patients. The bill would make implementation of certain of these provisions contingent on the establishment of certain requirements under which counties pay a share of cost for persons enrolled in the Medi-Cal program, and would make implementation of all of these provisions contingent on the imposition of a 4% fee on the net patient revenue of general acute care hospitals.

This bill would also require a portion of the nonfederal share of the reimbursement for designated public hospitals be transferred to the Workforce Development Program Fund, which the bill would create in the State Treasury. Moneys in the fund would, upon appropriation, be used exclusively for retraining county hospital and clinic systems' health care workers and be allocated by the Office of Statewide Health Planning and Development.

(3) Existing law provides for the county administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization.

Existing law permits services to be provided under the IHSS program either through the employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium.

Existing law provides that when any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium, the county shall use county only funds for the state and county share of any increase in the program, unless otherwise provided in the Budget Act or appropriated by statute.

Existing law establishes a formula with regard to provider wages or benefits increases negotiated or agreed to by a public authority or nonprofit consortium, and specifies the percentages required to be paid by the state and counties, beginning with the 2000-01 fiscal year, with regard to the nonfederal share of any increases.

This bill would revise the formula for state participation in provider health benefit increases. The bill would also authorize a county employee representative to elect to provide health benefits through a trust fund, as specified.

(4) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would enact various health insurance market reforms, to be operative on specified dates, including requirements for guarantee issue of individual health care service plan contracts and health insurance policies and other requirements relating to individual coverage, modified disclosures, and other related changes. The bill, on and after July 1, 2010, would require at least 85% of full-service health care service plan dues, fees, and other periodic payments and health insurance premiums to be spent on health care benefits and not on administrative costs. The bill would allow a health care service plan and a health insurer to provide notices by electronic transmission using specified procedures.

The bill would require a health care service plan providing prescription drug benefits and maintaining a drug formulary to, commencing on or before January 1, 2010, make the most current formularies available electronically to prescribers and pharmacies and would require health care service plans that provide services to certain beneficiaries under a Medi-Cal managed care program to be subject solely to the filing, reporting, monitoring, and survey requirements established by the State Department of Health Care Services for the Medi-Cal managed care program for designated subjects. The bill would require the department and the State Department of Health Care Services to develop a joint filing and review process for medical quality surveys.

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The bill would also require group health care service plan contracts and group health insurance policies offered, amended, or renewed on or after January 1, 2009, to offer to include a Healthy Action Incentives and Rewards Program, as specified. The bill would also authorize an employer to provide health coverage that includes a Healthy Action Incentives and Rewards Program to his or her employees.

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

(5) The Personal Income Tax Law authorizes various credits against the taxes imposed by that law.

This bill would, for taxable years beginning on or after January 1, 2010, and before January 1, 2015, allow to a qualified taxpayer, as defined, a refundable credit against those taxes in an amount equal to those qualified health care plan premium costs, as defined, that are in excess of 5.5% of a qualified taxpayer's adjusted gross income for the taxable year, except as provided. This bill would, upon appropriation by the Legislature, require that all amounts deposited into the California Health Trust Fund be transferred to the Managed Risk Medical Insurance Board for purposes of advancing the refundable credit and to the Franchise Tax Board for purposes of recovering amounts expended for the refunds, as provided.

(6) Existing law creates the Employment Development Department in the Labor and Workforce Development Agency and vests that department with the duties, purposes, responsibilities, and jurisdiction previously exercised by the State Department of Benefit Payments or the California Health and Human Services Agency with respect to job creation activities.

This bill would require the department to establish data collection and reporting methods and requirements, as specified, to collect and report information related to employer health expenditures on behalf of their employees. The bill would require the department to report on that data to the Managed Risk Medical Insurance Board and the Legislature on an annual basis commencing April 1, 2011, and would authorize the department to adopt regulations to implement these provisions.

(7) Under existing federal law, a cafeteria plan is a written plan through which employees choose among 2 or more benefits consisting of cash and qualified benefits. Existing federal law provides that, except as specified, no amount is included in the gross income of a participant

in a cafeteria plan solely because the participant may choose among the benefits of the plan.

This bill would, beginning January 1, 2010, require an employer to adopt and maintain a cafeteria plan to allow employees to pay premiums for health care coverage to the extent amounts for that coverage are excludable from the gross income of the employee, as specified. The bill would require an employer who fails to establish or maintain a cafeteria plan to pay a penalty of \$100 or \$500 per employee, as specified.

(8) Existing law authorizes the Board of Administration of the Public Employees' Retirement System to contract with carriers offering health benefit plans for coverage for eligible employees and annuitants.

This bill would require the board, on or before January 1, 2010, to provide or arrange for the provision of an electronic personal health record for enrollees receiving health care benefits.

(9) Existing law establishes the State Department of Public Health, which licenses and regulates health facilities and also administers funds for programs relating to smoking cessation. Under existing law, a noncontracting hospital is required to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee for inpatient poststabilization care, as defined, or prior to transferring the enrollee, if certain conditions apply. Existing law prohibits the hospital from billing the enrollee for poststabilization care if it is required to, and fails to, contact the enrollee's health care service plan. Under existing law, a violation of any of these provisions is punishable as a misdemeanor.

This bill would prohibit a noncontracting hospital, as defined, from billing a covered patient for emergency health care services and poststabilizing care except for applicable copayments and cost shares. By changing the definition of an existing crime, this bill would impose a state-mandated local program.

The bill would also require the department to maintain the California Diabetes Program to provide information and assistance pertaining to the prevention and treatment of diabetes. The bill would also establish the Comprehensive Diabetes Services Program in the State Department of Health Care Services to provide diabetes prevention and management services to certain beneficiaries in the Medi-Cal program, to the extent funding is available for this purpose. The bill would also require the department, in consultation with the Department of Managed Health Care, the State Department of Health Care Services, the Managed Risk

Medical Insurance Board, and the Department of Insurance, to annually identify the 10 largest providers of health care coverage in the state, to ascertain and summarize the smoking cessation benefits provided by those coverage providers, to publish the benefit summary on the department's Internet Web site, to include the benefit summary as part of its preventive health education against tobacco use campaign, and to evaluate any changes in connection with the smoking cessation benefits provided by the coverage providers, as provided. The bill would also require the department, to the extent that funds are available and appropriated for this purpose, to increase the capacity of effective smoking cessation services available from, and expand the awareness of, services available through, the California Smokers' Helpline, as prescribed.

The bill would also create the Community Makeover Grant program that would be administered by the department and would require it to award grants to local health departments in cities and counties, which would serve as the local lead agencies in administering the program, for the purpose of developing new programs or improving existing programs that promote active living and healthy eating. The bill would require the department to issue guidelines and to specify data reporting requirements for local lead agencies to comply with various requirements relating to the administration of the program. The bill would also require the department to develop a sustained media campaign to educate the public about the importance of obesity prevention.

(10) Existing law requires the State Department of Health Care Services to select certain primary care clinics to be reimbursed for delivering medical services, including preventive health care and smoking prevention and cessation health education, to program beneficiaries, based upon specified criteria. Existing law requires that a clinic meet specified requirements in order to receive a reimbursement. Under existing law, a program beneficiary is a person whose income is at or below 200% of the federal poverty level. Existing law requires the department to utilize existing contractual claims processing services to promote efficiency and maximize the use of funds.

This bill would additionally require that, in order receive a reimbursement, a clinic serve as a designated primary care medical home for program beneficiaries, as specified. The bill would also revise the definition of program beneficiary to mean a person whose income is at or below 250% of the poverty level and who either does not have

private or employer-based health care coverage or is not enrolled in or is ineligible for public health care coverage programs. This bill would delete the provision requiring the department to utilize existing contractual claims processing services and instead authorize the department to contract with public and private entities or utilize existing health care service provider enrollment and payment mechanisms in order to perform its duties, as specified. The bill would additionally require that the department maximize the availability of federal funding for services provided pursuant to these provisions. The bill would make related changes.

(11) Existing law provides for the Office of Statewide Health Planning and Development, which has specified powers and duties. Existing law requires the office to publish specified reports.

This bill would require the office to publish risk-adjusted outcome reports for percutaneous coronary interventions, commencing January 1, 2010, and would require the office to establish a clinical data collection program to collect data on percutaneous coronary interventions and establish by regulation the data to be reported by each hospital.

(12) Existing law provides for the certification and regulation of nurses, including nurse practitioners and nurse-midwives, by the Board of Registered Nursing and for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law provides that a medical assistant may administer medication upon the specific authorization and supervision of a licensed physician and surgeon or licensed podiatrist or, in specified clinic settings, upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant.

This bill would remove the requirement that a medical assistant's administration of medication upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant occur in specified clinic settings, and would make related changes.

(13) Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing which is within the Department of Consumer Affairs.

This bill would, until July 1, 2011, create the Task Force on Nurse Practitioner Scope of Practice that would consist of specified members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. The bill would make the task force responsible for developing a recommended scope of practice for nurse practitioners

and would require the task force to report the recommended scope of practice to the Governor and the Legislature on or before June 30, 2009. The bill would require the Director of Consumer Affairs, on or before July 1, 2010, to promulgate regulations that adopt the recommended scope of practice. The bill would require the aforementioned boards to pay the state administrative costs of implementing these provisions.

(14) Existing law, the Pharmacy Law, defines an electronic transmission prescription and sets forth the requirements for those types of prescriptions.

This bill would require electronic prescribing systems to meet specified standards and requirements and would require a prescriber or prescriber's authorized agent to offer patients a written receipt of information transmitted electronically, including the patient's name and the drug prescribed, and would require the State Department of Health Care Services to develop a pilot program to foster the adoption and use of electronic prescribing by health care providers that contract with the Medi-Cal program, as specified. The bill would require every licensed prescriber, or prescriber's authorized agent, or pharmacy operating in California, on or before January 1, 2010, to have the ability to transmit and receive prescriptions by electronic data transmission.

(15) This bill would give the State Department of Health Care Services, in consultation with the Department of Finance, authority to take various actions as necessary to implement the bill, including promoting flexibility of implementation and maximizing federal financial participation. The bill would require the Director of Health Care Services to notify the Chair of the Joint Legislative Budget Committee prior to exercising this flexibility. The bill would declare the intent of the Legislature to implement the bill to harmonize and best effectuate the purposes and intent of the bill.

(16) This bill would declare the Legislature's intent that the act's provisions be financed by contributions from various sources, including payments by acute care hospitals and employers, and by increasing the taxes on cigarettes and other tobacco products.

(17) The bill would make its provisions operative upon the date that the Director of Finance files a finding with the Secretary of State that, among other circumstances, sufficient state resources will exist in the Health Care Trust Fund to implement those provisions. The bill would also require the director to transmit that finding to the Chief Clerk of the Assembly, the Secretary of the Senate, and the chairs of the

appropriate committees of the Legislature at least 90 days prior to implementation of its provisions.

(18) The bill would require that all of its provisions become inoperative, as specified, if any portion of the bill is held to be invalid, as determined by a final judgment of a court of competent jurisdiction.

(19) 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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

1 SECTION 1. This act shall be known and may be cited as the  
2 Health Care Security and Cost Reduction Act.

3 SEC. 2. It is the intent of the Legislature to accomplish the  
4 goal of universal health care for all California residents. To  
5 accomplish this goal, the Legislature proposes to take all of the  
6 following steps:

7 (a) Ensure that all Californians have access to affordable,  
8 comprehensive health care.

9 (b) Leverage available federal funds to the greatest extent  
10 possible through existing federal programs.

11 (c) Maintain and strengthen the health insurance system and  
12 improve availability and affordability of private health care  
13 coverage for all purchasers through (1) insurance market reforms;  
14 (2) enhanced access to effective primary and preventive services,  
15 including management of chronic illnesses; (3) promotion of  
16 cost-effective health technologies; and (4) implementation of  
17 meaningful, systemwide cost containment strategies.

18 (d) Engage in early and systematic evaluation at each step of  
19 the implementation process to identify the impacts on state costs,  
20 the costs of coverage, employment and insurance markets, health

1 delivery systems, quality of care, and overall progress in moving  
2 toward universal coverage.

3 SEC. 3. Section 2069 of the Business and Professions Code is  
4 amended to read:

5 2069. (a) (1) Notwithstanding any other provision of law, a  
6 medical assistant may administer medication only by intradermal,  
7 subcutaneous, or intramuscular injections and perform skin tests  
8 and additional technical supportive services upon the specific  
9 authorization and supervision of a licensed physician and surgeon,  
10 nurse practitioner, nurse-midwife, physician assistant, or licensed  
11 podiatrist.

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

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

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

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

34 (1) "Medical assistant" means a person who may be unlicensed,  
35 who performs basic administrative, clerical, and technical  
36 supportive services in compliance with this section and Section  
37 2070 for a licensed physician and surgeon or a licensed podiatrist,  
38 or group thereof, for a medical, nursing, or podiatry corporation,  
39 for a physician assistant, a nurse practitioner, or a nurse-midwife  
40 as provided in subdivision (a), or for a health care service plan,

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

8 (2) "Specific authorization" means a specific written order  
 9 prepared by the licensed physician and surgeon, nurse practitioner,  
 10 nurse-midwife, physician assistant, or licensed podiatrist  
 11 authorizing the procedures to be performed on a patient, which  
 12 shall be placed in the patient's medical record, or a standing order  
 13 prepared by the licensed physician and surgeon, nurse practitioner,  
 14 nurse-midwife, physician assistant, or licensed podiatrist,  
 15 authorizing the procedures to be performed, the duration of which  
 16 shall be consistent with accepted medical practice. A notation of  
 17 the standing order shall be placed on the patient's medical record.

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

- 23 (A) A licensed physician and surgeon.
- 24 (B) A licensed podiatrist.
- 25 (C) A physician assistant, nurse practitioner, or nurse-midwife.
- 26 (4) "Technical supportive services" means simple routine  
 27 medical tasks and procedures that may be safely performed by a  
 28 medical assistant who has limited training and who functions under  
 29 the supervision of a licensed physician and surgeon, a licensed  
 30 podiatrist, a physician assistant, a nurse practitioner, or a  
 31 nurse-midwife.

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

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

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

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

12 SEC. 5. Section 2838 is added to the Business and Professions  
13 Code, to read:

14 2838. (a) The Task Force on Nurse Practitioner Scope of  
15 Practice is hereby created and shall consist of the following  
16 members:

17 (1) The Director of Consumer Affairs, who shall serve as an ex  
18 officio member of the task force and shall cast the deciding vote  
19 in any matter voted upon by the task force that results in a tie vote.

20 (2) Three members of the Medical Board of California, two of  
21 whom shall be appointed to the task force by the Governor, and  
22 one of whom shall be appointed to the task force by the Speaker  
23 of the Assembly.

24 (3) Three members of the Board of Registered Nursing, two of  
25 whom shall be appointed to the task force by the Governor, and  
26 one of whom shall be appointed to the task force by the Senate  
27 Committee on Rules.

28 (4) Two representatives of an institution of higher education,  
29 who shall be appointed to the task force by the Governor as  
30 nonvoting members.

31 (b) The duty of the task force shall be to develop a recommended  
32 scope of practice for nurse practitioners.

33 (c) The task force shall report its recommended scope of practice  
34 for nurse practitioners to the Governor and the Legislature on or  
35 before June 30, 2009.

36 (d) On or before July 1, 2010, the Director of Consumer Affairs  
37 shall promulgate regulations *consistent with existing law* that adopt  
38 the task force's recommended scope of practice.

1 (e) The Medical Board of California and the Board of Registered  
 2 Nursing shall pay the state administrative costs of implementing  
 3 this section.

4 (f) This section shall become inoperative on July 1, 2011, and,  
 5 as of January 1, 2012, is repealed, unless a later enacted statute,  
 6 that is enacted before January 1, 2012, deletes or extends the dates  
 7 on which it becomes inoperative and is repealed.

8 SEC. 7. Section 4040.1 is added to the Business and Professions  
 9 Code, to read:

10 4040.1. (a) Electronic prescribing shall not interfere with a  
 11 patient’s existing freedom to choose a pharmacy, and shall not  
 12 interfere with the prescribing decision at the point of care.

13 (b) Notwithstanding subdivision (c) of Section 4040, “electronic  
 14 prescribing” or “e-prescribing” means a prescription or  
 15 prescription-related information transmitted between the point of  
 16 care and the pharmacy using electronic media.

17 SEC. 8. Section 4071.2 is added to the Business and Professions  
 18 Code, to read:

19 4071.2. (a) On or before January 1, 2012, every licensed  
 20 prescriber, prescriber’s authorized agent, or pharmacy operating  
 21 in California shall have the ability to transmit and receive  
 22 prescriptions by electronic data transmission.

23 (b) The Medical Board of California, the State Board of  
 24 Optometry, the Bureau of Naturopathic Medicine, the Dental Board  
 25 of California, the Osteopathic Medical Board of California, the  
 26 Board of Registered Nursing, and the Physician Assistant  
 27 Committee shall have authority with the California State Board of  
 28 Pharmacy to ensure compliance with this section, and those boards  
 29 are specifically charged with the enforcement of this section with  
 30 respect to their respective licensees.

31 (c) Nothing in this section shall be construed to diminish or  
 32 modify any requirements or protections provided for in the  
 33 prescription of controlled substances as otherwise established by  
 34 this chapter or by the California Uniform Controlled Substances  
 35 Act (Division 10 (commencing with Section 11000) of the Health  
 36 and Safety Code).

37 SEC. 9. Section 4071.3 is added to the Business and Professions  
 38 Code, to read:

39 4071.3. Every electronic prescription system shall meet all of  
 40 the following requirements:

□

1 (a) Comply with nationally recognized or certified standards  
2 for data exchange or be accredited by a recognized accreditation  
3 organization.

4 (b) Allow real-time verification of an individual’s eligibility for  
5 benefits and whether the prescribed medication is a covered benefit.

6 (c) Comply with applicable state and federal confidentiality and  
7 data security requirements.

8 (d) Comply with applicable state record retention and reporting  
9 requirements.

10 SEC. 10. Section 4071.4 is added to the Business and  
11 Professions Code, to read:

12 4071.4. A prescriber or prescriber’s authorized agent using an  
13 electronic prescription system shall offer patients a written receipt  
14 of the information that has been transmitted electronically to the  
15 pharmacy. The receipt shall include the patient’s name, the dosage  
16 and drug prescribed, the name of the pharmacy where the electronic  
17 prescription was sent, and shall indicate that the receipt cannot be  
18 used as a duplicate order for the same medicine.

19 SEC. 11. Section 49452.9 is added to the Education Code, to  
20 read:

21 49452.9. (a) On and after January 1, 2010, the school district  
22 may provide an information sheet regarding health insurance  
23 requirements to the parent or guardian of all of the following:

- 24 (1) A pupil enrolled in kindergarten.
- 25 (2) A pupil enrolled in first grade if the pupil was not previously  
26 enrolled in kindergarten.
- 27 (3) A pupil enrolled during the course of the year in the case of  
28 children who have recently arrived, and intend to remain, in  
29 California.

30 (b) The information sheet described in subdivision (a) shall  
31 include all of the following:

- 32 (1) An explanation of the health insurance requirements under  
33 Section 8899.50 of the Government Code.
- 34 (2) Information on the important relationship between health  
35 and learning.
- 36 (3) A toll-free telephone number to request an application for  
37 Healthy Families, Medi-Cal, or other government-subsidized health  
38 insurance programs.
- 39 (4) Contact information for county public health departments.

1 (5) A statement of privacy applicable under state and federal  
2 laws and regulations.

3 (c) By January 1, 2010, the State Department of Education shall,  
4 in consultation with the State Department of Health Care Services  
5 and the Managed Risk Medical Insurance Board, develop a  
6 standardized template for the information sheet required by this  
7 section. To the extent possible, the information provided pursuant  
8 to this section shall be consolidated with the information listed in  
9 subdivision (c) of Section 49452.8 into one document. The State  
10 Department of Education shall make the template available on its  
11 Internet Web site and shall, upon request, provide written copies  
12 of the template to a school district.

13 SEC. 12. Chapter 15 (commencing with Section 8899.50) is  
14 added to Division 1 of Title 2 of the Government Code, to read:

15  
16 CHAPTER 15. MINIMUM HEALTH CARE COVERAGE

17  
18 8899.50. (a) On and after July 1, 2010, every California  
19 resident shall be enrolled in and maintain at least minimum  
20 creditable coverage, as defined by the Managed Risk Medical  
21 Insurance Board pursuant to Section 12739.50 of the Insurance  
22 Code, unless otherwise exempt pursuant to subdivision (d).

23 (b) On and after July 1, 2010, a subscriber shall obtain and  
24 maintain at least minimum creditable coverage, as defined by the  
25 Managed Risk Medical Insurance Board, for any person who  
26 qualifies as his or her dependent. For purposes of this chapter, the  
27 term "dependent" means the spouse, registered domestic partner,  
28 minor child of the subscriber, or a child 18 years of age and over  
29 who is dependent on the subscriber, as defined by the Managed  
30 Risk Medical Insurance Board.

31 (c) Notwithstanding subdivisions (a) and (b), compliance with  
32 those subdivisions shall not be required until Sections 12739.50,  
33 12739.51, and 12699.211.01 of the Insurance Code, Section  
34 17052.30 of the Revenue and Taxation Code, and Sections  
35 14005.301 and 14005.305 of the Welfare and Institutions Code  
36 are implemented, and only so long as these sections remain  
37 operative, and the Managed Risk Medical Insurance Board has  
38 defined by regulation the minimum creditable coverage that will  
39 satisfy the requirements of this section.

1 (d) An individual shall not be subject to the requirements of  
 2 subdivisions (a) and (b) if the Managed Risk Medical Insurance  
 3 Board, pursuant to Section 12739.501 of the Insurance Code,  
 4 determines that health care coverage meeting the definition of  
 5 minimum creditable coverage is not affordable for that individual  
 6 or that the purchase of minimum creditable coverage would  
 7 constitute an undue hardship for that individual, or if the person  
 8 or family has an income at or below 250 percent of the federal  
 9 poverty level and the person’s or family’s share of the premium  
 10 for minimum creditable coverage exceeds 5 percent of his or her  
 11 family’s income.

12 (e) An individual shall not be subject to the requirements of  
 13 subdivisions (a) and (b) if the individual has been in California for  
 14 six months or less and is not eligible for guaranteed issue of health  
 15 care coverage under Section 1399.829 of the Health and Safety  
 16 Code or Section 10928 of the Insurance Code.

17 (f) “California resident” means an individual who is a resident  
 18 of the state pursuant to Section 244 or is physically present in the  
 19 state for at least six months, having entered the state with an  
 20 employment commitment or to obtain employment, whether or  
 21 not employed at the time of application for health care coverage  
 22 or after acceptance.

23 (g) “Subscriber” means an individual with dependents, as  
 24 determined by the Managed Risk Medical Insurance Board  
 25 consistent with subdivision (b), who is generally eligible to enroll  
 26 dependents for health care coverage purposes, including, but not  
 27 limited to, an individual whose employment status, or status as  
 28 head of household, parent, spouse, or other status, makes the  
 29 individual eligible to enroll his or her dependents for health care  
 30 coverage purposes.

31 *8899.501. For purposes of subdivisions (e) and (f) of Section*  
 32 *8899.50, subdivision (d) of Section 1399.836 of the Health and*  
 33 *Safety Code, and subdivision (g) of Section 10928 of the Insurance*  
 34 *Code, the reference to an individual or person who has been a*  
 35 *resident of California for six months or less and the definition of*  
 36 *“California resident” as an individual who is a resident of the*  
 37 *state for at least six months shall mean a six-month period or any*  
 38 *lesser period required by federal and state law.*

39 SEC. 13. Section 12803.2 is added to the Government Code,  
 40 to read:

1 12803.2. The California Health and Human Services Agency,  
2 in consultation with the Board of Administration of the Public  
3 Employees' Retirement System, and after consultation with  
4 affected health care provider groups, shall develop health care  
5 provider performance measurement benchmarks and incorporate  
6 these benchmarks into a common pay-for-performance model to  
7 be offered in every state-administered health care program,  
8 including, but not limited to, the Public Employees' Medical and  
9 Hospital Care Act, the Healthy Families Program, the Major Risk  
10 Medical Insurance Program, the Medi-Cal program, and the  
11 California Cooperative Health Insurance Purchasing Program.  
12 These benchmarks shall be developed to advance a common  
13 statewide framework for health care quality measurement and  
14 reporting, including, but not limited to, measures that have been  
15 approved by the National Quality Forum (NQF) such as the Health  
16 Plan Employer Data and Information Set (HEDIS) and the Joint  
17 Commission on Accreditation of Health Care Organizations  
18 (JCAHO), and that have been adopted by the Hospitals Quality  
19 Alliance and other national and statewide groups concerned with  
20 quality. The provisions of Section 14167.25 of the Welfare and  
21 Institutions Code shall be implemented in addition to the  
22 requirements of this section in such a manner that they are  
23 appropriately integrated with the pay-for-performance model  
24 required under this section.

25 SEC. 14. Section 12803.25 is added to the Government Code,  
26 to read:

27 12803.25. (a) The Secretary of California Health and Human  
28 Services, in collaboration with other relevant state agencies, shall  
29 track and assess the effects of health care reform as set forth in the  
30 act enacting this section. The secretary shall either complete the  
31 assessment or contract for its preparation. The secretary may seek  
32 other sources of funding, including grants, to fund the assessment.  
33 The assessment shall include, at minimum, the following  
34 components:

35 (1) An assessment of the sustainability and solvency of the  
36 program established pursuant to Part 6.45 (commencing with  
37 Section 12699.201) of Division 2 of the Insurance Code. This  
38 assessment shall include data regarding persons purchasing health  
39 care coverage through that program.

1 (2) An assessment of the cost and affordability of health care  
 2 in California. This assessment shall include the cost of health care  
 3 coverage products for individuals and families obtained through  
 4 employers, city and county governments, the Medi-Cal program,  
 5 the Healthy Families Program, the Public Employees' Medical  
 6 and Hospital Care Act, Medicare Advantage plans, and the  
 7 individual market.

8 (3) An assessment of the health care coverage market in  
 9 California, including a review of the various insurers and health  
 10 care service plans, their offerings, their efficiency in providing  
 11 health care services, and their financial conditions, including their  
 12 medical loss ratios.

13 (4) An assessment of the effect on employers and employment,  
 14 including employer administrative costs, employee turnover rate,  
 15 and wages categorized by the type of employer and the size of the  
 16 business. The assessment shall also review if there have been  
 17 significant changes to the labor market and increased underground  
 18 economy activity.

19 (5) An assessment of the racial and ethnic disparities in access  
 20 and availability of health care, including cultural competency and  
 21 language access, and what effects the act adding this section has  
 22 had in reducing these disparities.

23 (6) An assessment of the change in access and availability of  
 24 health care coverage throughout the state, including tracking the  
 25 availability of health care coverage products in rural and other  
 26 underserved areas of the state and assessing the adequacy of the  
 27 health care delivery infrastructure to meet the need for health care  
 28 services. This assessment shall include a more in-depth review of  
 29 areas of the state that were determined to be medically underserved  
 30 in 2007.

31 (7) An assessment of the impact on the county health care safety  
 32 net system, including a review of the amount of uncompensated  
 33 care and emergency room use.

34 (8) An overall assessment of health care coverage.

35 (9) An assessment of the capacity of the various health care  
 36 professions and facilities to provide care to Californians.

37 (b) An advisory body of individuals with knowledge and  
 38 expertise in health care policy and financing shall provide input  
 39 on the assessment described in subdivision (a). The Governor shall  
 40 appoint five members to the advisory body, the Senate Committee

1 on Rules shall appoint two members, and the Speaker of the  
2 Assembly shall appoint two members.

3 (c) To the extent possible, the assessment described in  
4 subdivision (a) shall maximize the use of current surveys and  
5 databases.

6 (d) To the extent feasible, in order to track the effect of health  
7 care reform on ongoing trends in the health care field, the  
8 assessment described in subdivision (a) shall include data from  
9 years prior to the enactment of the program established pursuant  
10 to Part 6.45 (commencing with Section 12699.201) of Division 2  
11 of the Insurance Code.

12 (e) All state agencies shall cooperate with the secretary in  
13 implementing the provisions of this section.

14 (f) The Secretary of California Health and Human Services shall  
15 submit the assessment described in subdivision (a) to the  
16 appropriate policy and fiscal committees of the Legislature on or  
17 before March 1, 2012. The secretary shall update the assessment  
18 biennially.

19 SEC. 15. Section 22830.5 is added to the Government Code,  
20 to read:

21 22830.5. (a) On or before January 1, 2010, the board shall  
22 provide or arrange for the provision of an electronic personal health  
23 record for enrollees receiving health care benefits. The record shall  
24 be provided for the purpose of providing enrollees with information  
25 to assist them in understanding their coverage benefits and  
26 managing their health care.

27 (b) At a minimum, the personal health record shall provide  
28 access to real-time, patient-specific information regarding  
29 eligibility for covered benefits and cost sharing requirements. Such  
30 access can be provided through the use of an Internet-based system.

31 (c) In addition to the data required pursuant to subdivision (b),  
32 the board may determine that the personal health record shall also  
33 incorporate additional data, such as laboratory results, prescription  
34 history, claims history, and personal health information authorized  
35 or provided by the enrollee. Inclusion of this additional data shall  
36 be at the option of the enrollee.

37 (d) Systems or software that pertain to the personal health record  
38 shall adhere to accepted national standards for interoperability,  
39 privacy, and data exchange, or shall be certified by a nationally  
40 recognized certification body.

1 (e) The personal health record shall comply with applicable  
2 state and federal confidentiality and data security requirements.

3 SEC. 16. Section 22830.6 is added to the Government Code,  
4 to read:

5 22830.6. On or before January 1, 2010, the board shall provide  
6 or arrange for the provision of a Healthy Action Incentives and  
7 Rewards Program, as described in subdivision (c) of Section  
8 1367.38 of the Health and Safety Code, to all enrollees.

9 SEC. 17. Chapter 1.6 (commencing with Section 155) is added  
10 to Part 1 of Division 1 of the Health and Safety Code, to read:

11

12 CHAPTER 1.6. CALIFORNIA HEALTH BENEFITS SERVICE

13

14 155. (a) The California Health Benefits Service Program is  
15 hereby created within the State Department of Health Care Services  
16 for the purposes of expanding cost-effective health coverage  
17 options to purchasers governed by the Health Care Security and  
18 Cost Reduction Act. The program shall do all of the following:

19 (1) Identify statutory, regulatory, or financial barriers or  
20 incentives that should be addressed to facilitate the establishment  
21 and maintenance of one or more joint ventures between health  
22 plans that contract with, or are governed, owned, or operated by,  
23 a county board of supervisors, a county special commission, a  
24 county-organized health system or a county health authority  
25 authorized by Section 14018.7, 14087.31, 14087.35, 14087.36,  
26 14087.38, 14087.96 or Article 2.8 (commencing with Section  
27 14087.5) of Chapter 7 of Division 9 of Part 3 of the Welfare and  
28 Institutions Code, as well as the County Medical Services Program.

29 (2) Identify statutory, regulatory, or financial barriers or  
30 incentives that should be addressed before joint ventures among  
31 these health plans may be formed, or existing health plans or the  
32 County Medical Services Program may expand to serve other  
33 geographic areas, for the purposes of providing public health care  
34 services in counties where there is not a local initiative or  
35 county-organized health plan that contracts with the State  
36 Department of Health Care Services, or the County Medical  
37 Services Program, participating in these joint ventures.

38 (3) Report these initial findings to the committees of jurisdiction  
39 in the Senate and Assembly on or before January 15, 2009.

1 (4) Provide technical assistance to local health care delivery  
2 entities, including local initiatives, county-organized health  
3 systems, and the County Medical Services Program, to support  
4 joint ventures and efforts by these entities to expand to serve other  
5 geographic areas and specified populations, or to contract with  
6 providers to provide health care services in counties where there  
7 is not a local initiative or county-organized health plan that  
8 contracts with the State Department of Health Care Services that  
9 opts to participate in such joint ventures, or participation from the  
10 County Medical Services Program.

11 (5) Consistent with the report and recommendations provided  
12 pursuant to this section and consistent with existing law, the  
13 department is authorized to enter into contracts with joint ventures  
14 authorized pursuant to this section to provide medical services to  
15 specified populations, as determined by the program.

16 (b) Health plans that contract with or are governed, owned, or  
17 operated by, a county board of supervisors, a county special  
18 commission, a county-organized health system, or county health  
19 authority authorized by Section 14018.7, 14087.31, 14087.35,  
20 14087.36, 14087.38, or 14087.96 or Article 2.8 (commencing with  
21 Section 14087.5) of Chapter 7 of Division 9 of Part 3 of the  
22 Welfare and Institutions Code, and the County Medical Services  
23 Program, are authorized to form joint ventures to create integrated  
24 networks of public health plans that pool risk and share networks.

25 (1) In forming joint ventures, participating health plans shall  
26 seek to contract with designated public hospitals, county health  
27 clinics, community health centers, and other traditional safety net  
28 providers.

29 (2) All joint ventures and health care networks established  
30 pursuant to this section shall seek licensure as a health care service  
31 plan consistent with the Knox-Keene Health Care Service Plan  
32 Act of 1975 (Chapter 2.2 (commencing with Section 1340) of  
33 Division 2 of the Health and Safety Code). Prior to commencement  
34 of enrollment, the joint venture or health care network shall be  
35 licensed pursuant to that act.

36 (c) There is hereby created the California Health Benefits  
37 Service Program Stakeholder Committee. The committee shall be  
38 comprised of 10 members appointed by the Director of Health  
39 Care Services, the Senate Committee on Rules, and the Speaker  
40 of the Assembly. The director shall appoint six members including

1 two representatives of local initiatives authorized under the Welfare  
2 and Institutions Code, a representative of county-organized health  
3 systems, a representative of the County Medical Services Program,  
4 a representative of health care providers, and a representative of  
5 employers. The Senate Committee on Rules shall appoint two  
6 members including a labor representative and a representative of  
7 health care consumers. The Speaker of the Assembly shall appoint  
8 two members, including a representative of local initiatives  
9 authorized under the Welfare and Institutions Code, and a  
10 representative of organized labor. The committee shall meet at  
11 least quarterly to provide input to the program and assist the  
12 program in carrying out its responsibilities as outlined in this  
13 section.

14 (d) On or before November 1, 2009, and annually thereafter,  
15 the department, with input from the committee, shall update the  
16 committees of jurisdiction in the Senate and Assembly on  
17 implementation of this section and make recommendations, as  
18 applicable, on changes necessary to implement this section. The  
19 update shall also include progress on fulfilling the intent of the  
20 Health Care Security and Cost Reduction Act and recommendations  
21 on resources, policy, and legislative changes necessary to build  
22 and implement a system of public health coverage throughout  
23 California. The update shall describe the projects proposed or  
24 established pursuant to this section, including, but not limited to,  
25 the participating providers, the groups covered, the physicians and  
26 hospitals in the network, and the counties served.

27 (e) The program shall consult with relevant departments,  
28 including the Department of Managed Health Care, in the  
29 implementation of this section.

30 (f) Nothing in this section shall be construed to prohibit any  
31 other licensed health care service plan not mentioned in  
32 subdivisions (b) and (c) from entering in joint ventures or contracts  
33 with the State Department of Health Care Services to provide  
34 services in counties in which there is not a Medi-Cal managed care  
35 health plan that contracts with the department.

36 SEC. 18. Section 1262.9 is added to the Health and Safety  
37 Code, to read:

38 1262.9. (a) If a patient has coverage for emergency health care  
39 services and poststabilizing care, a noncontracting hospital shall  
40 not bill the patient for emergency health care services and

1 poststabilizing care, except for applicable copayments and cost  
2 shares.

3 (b) The noncontracting hospital and the health care service plan  
4 or health insurer shall each retain their right to pursue all currently  
5 available legal remedies they may have against each other,  
6 including the right to determine the final payment due.

7 (c) For the purposes of this section:

8 (1) "Noncontracting hospital" means a general acute care  
9 hospital as defined in subdivision (a) of Section 1250 that has a  
10 special permit to operate an emergency medical service and does  
11 not have a contract with a health care service plan or a health  
12 insurer for the provision of emergency health care services and  
13 poststabilizing care to the patient, who is one of that health care  
14 service plan's or health insurer's enrollees, members, or insureds.

15 (2) "Emergency health care services and poststabilizing care"  
16 means emergency services and out-of-area urgent services provided  
17 in an emergency department and a hospital through discharge in  
18 compliance with Sections 1262.8 and 1317 and, in the case of  
19 health care service plans, the services required to be covered  
20 pursuant to paragraph (6) of subdivision (b) of Section 1345,  
21 subdivision (i) of Section 1367, Sections 1371.4, and 1371.5, of  
22 this code, and Sections 1300.67(g) and 1300.71.4 of Title 28 of  
23 the California Code of Regulations.

24 SEC. 19. Section 1342.9 is added to the Health and Safety  
25 Code, to read:

26 1342.9. (a) Notwithstanding any other provision of this chapter,  
27 a health care service plan that provides services to a beneficiary  
28 of the Medi-Cal program pursuant to Article 2.7 (commencing  
29 with Section 14087.3), Article 2.8 (commencing with Section  
30 14087.5), or Article 2.91 (commencing with Section 14089) of  
31 Chapter 7 of, or Article 1 (commencing with Section 14200) or  
32 Article 7 (commencing with Section 14490) of Chapter 8 of, Part  
33 3 of Division 9 of the Welfare and Institutions Code shall,  
34 regarding coverage for participants in a Medi-Cal managed care  
35 program, be subject solely to the filing, reporting, monitoring, and  
36 survey requirements established by the State Department of Health  
37 Care Services for the Medi-Cal managed care program as those  
38 requirements pertain to the following subjects: advertising and  
39 marketing; member materials, including member handbooks,  
40 evidences of coverage, and disclosure forms; and product design.

1 including its scope and limitations. A health care service plan that  
2 satisfies any of the foregoing filing, reporting, monitoring, or  
3 survey requirements shall be deemed in compliance with  
4 corresponding provisions, if any, of this chapter.

5 (b) The department and the State Department of Health Care  
6 Services shall develop a joint filing and review process for medical  
7 quality surveys required pursuant to Section 1380 and pursuant to  
8 Chapter 8 (commencing with Section 14200) of Part 3 of Division  
9 of the Welfare and Institutions Code.

10 SEC. 20. Section 1347 is added to the Health and Safety Code,  
11 to read:

12 1347. The director is authorized to provide regulatory and  
13 program flexibilities to facilitate new, modified, or combined  
14 licenses of local initiatives and county-organized health systems,  
15 created pursuant to Section 155 or the California Health Benefits  
16 Service Program (Chapter 1.6 (commencing with Section 155) of  
17 Part 1 of Division 1), that seek licensure for regional or statewide  
18 networks for the purposes of contracting with the Managed Risk  
19 Medical Insurance Board as a participating plan in the California  
20 Cooperative Health Insurance Purchasing Program, or for the  
21 purposes of providing coverage in the individual and group  
22 coverage markets. In providing those flexibilities, the director shall  
23 ensure that the health plans established pursuant to this section  
24 meet essential financial, capacity, and consumer protection  
25 requirements of this chapter.

26 SEC. 20.5. Section 1356.2 is added to the Health and Safety  
27 Code, to read:

28 1356.2. (a) It is the intent of the Legislature to establish  
29 mechanisms by which the state may defray the costs of an  
30 enrollee's public program participation. The state's efforts may  
31 include, but shall not be limited to, creating mechanisms to take  
32 advantage of other opportunities for coverage available to that  
33 enrollee, to access nonstate resources available to fund care for  
34 that enrollee, or other mechanisms to minimize state costs.

35 (b) (1) The State Department of Health Care Services, in  
36 consultation with the Department of Insurance and the Department  
37 of Managed Health Care, shall evaluate and consider the options  
38 to effectuate the intent of this section and determine the process  
39 and procedures to implement subdivision (a). The departments  
40 shall assess the fiscal ramifications and administrative feasibility

1 of potential options, and determine the requirements that best  
2 effectuate and implement this section. The department shall report  
3 its findings to the Joint Legislative Budget Committee by July 1,  
4 2009.

5 (2) Ninety days following the department’s notification to the  
6 Joint Legislative Budget Committee pursuant to paragraph (1), the  
7 departments shall implement the policies, procedures, and  
8 requirements described in its report.

9 (c) To the extent necessary to achieve the purposes of  
10 subdivision (a), the State Department of Health Care Services may  
11 implement Section 1396e of Title 42 of the United States Code.  
12 To the extent necessary to achieve the purposes of this section,  
13 this option shall be exercised in conjunction with the benchmark  
14 authority provided in Section 1396u-7 of Title 42 of the United  
15 States Code.

16 (d) To the extent necessary to achieve the purposes of  
17 subdivision (a), the Department of Insurance and the Department  
18 of Managed Health Care shall establish appropriate licensing  
19 requirements for health insurers and health care service plans to  
20 permit the state to access funds and contributions available to  
21 enrollees to reduce the cost of subsidized coverage.

22 (e) For the purposes of implementing this section, the State  
23 Department of Health Care Services, the Department of Insurance,  
24 and the Department of Managed Health Care shall promulgate  
25 regulations in accordance with the requirements of Chapter 3.5  
26 (commencing with Section 11340) of Part 1 of Division 3 of Title  
27 2 of the Government Code.

28 (f) For the purposes of this section, “subsidized coverage” means  
29 coverage provided under either of the following:

30 (1) Part 6.45 (commencing with Section 12699.201) of Division  
31 2 of the Insurance Code through a Cal-CHIPP Healthy Families  
32 plan.

33 (2) Section 14005.333 of the Welfare and Institutions Code.

34 (g) This section shall be implemented no later than one year  
35 from the date that the act enacting this section becomes operative.

36 SEC. 21. Section 1357.54 of the Health and Safety Code is  
37 amended to read:

38 1357.54. All individual health benefit plans, except for  
39 short-term limited duration insurance, shall be renewable with

1 respect to all eligible individuals or dependents at the option of  
2 the individual except as follows:

3 (a) For nonpayment of the required premiums or contributions  
4 by the individual in accordance with the terms of the health  
5 insurance coverage or the timeliness of the payments.

6 (b) For fraud or intentional misrepresentation of material fact  
7 under the terms of the coverage by the individual.

8 (c) Movement of the individual contractholder outside the  
9 service area, but only if the coverage is terminated uniformly  
10 without regard to any health status-related factor of covered  
11 individuals.

12 (d) If the plan ceases to provide or arrange for the provision of  
13 health care services for new individual health benefit plans in this  
14 state; provided, however, that the following conditions are satisfied:

15 (1) Notice of the decision to cease new or existing individual  
16 health benefit plans in the state is provided to the director and to  
17 the individual at least 180 days prior to discontinuation of that  
18 coverage.

19 (2) Individual health benefit plans shall not be canceled for 180  
20 days after the date of the notice required under paragraph (1) and  
21 for that business of a plan that remains in force, any plan that ceases  
22 to offer for sale new individual health benefit plans shall continue  
23 to be governed by this section with respect to business conducted  
24 under this section.

25 (3) A plan that ceases to write new individual health benefit  
26 plans in this state after the effective date of this section shall be  
27 prohibited from offering for sale individual health benefit plans  
28 in this state for a period of five years from the date of notice to the  
29 director.

30 (e) If the plan withdraws an individual health benefit plan from  
31 the market; provided, that the plan notifies all affected individuals  
32 and the director at least 90 days prior to the discontinuation of  
33 these plans, and that the plan makes available to the individual all  
34 health benefit plans that it makes available to new individual  
35 business without regard to any health status-related factor of  
36 enrolled individuals or individuals who may become eligible for  
37 the coverage.

38 This section shall become inoperative on the date that Section  
39 1399.829 becomes operative.

1 SEC. 22. Section 1365 of the Health and Safety Code is  
2 amended to read:

3 1365. (a) An enrollment or a subscription may not be canceled  
4 or not renewed except for the following:

5 (1) Failure to pay the charge for such coverage if the subscriber  
6 has been duly notified and billed for the charge and at least 15  
7 days has elapsed since the date of notification.

8 (2) Fraud or deception in the use of the services or facilities of  
9 the plan or knowingly permitting such fraud or deception by  
10 another.

11 (3) Such other good cause as is agreed upon in the contract  
12 between the plan and a group or the subscriber.

13 (b) An enrollee or subscriber who alleges that an enrollment or  
14 subscription has been canceled or not renewed because of the  
15 enrollee's or subscriber's health status or requirements for health  
16 care services may request a review by the director. If the director  
17 determines that a proper complaint exists under the provisions of  
18 this section, the director shall notify the plan. Within 15 days after  
19 receipt of such notice, the plan shall either request a hearing or  
20 reinstate the enrollee or subscriber. If, after hearing, the director  
21 determines that the cancellation or failure to renew is contrary to  
22 subdivision (a), the director shall order the plan to reinstate the  
23 enrollee or subscriber. A reinstatement pursuant to this subdivision  
24 shall be retroactive to the time of cancellation or failure to renew  
25 and the plan shall be liable for the expenses incurred by the  
26 subscriber or enrollee for covered health care services from the  
27 date of cancellation or nonrenewal to and including the date of  
28 reinstatement.

29 (c) This section shall not abrogate any preexisting contracts  
30 entered into prior to the effective date of this chapter between a  
31 subscriber or enrollee and a health care service plan or a specialized  
32 health care service plan including, but not limited to, the financial  
33 liability of that plan, except that each plan shall, if directed to do  
34 so by the director, exercise its authority, if any, under any such  
35 preexisting contracts to conform them to the provisions of  
36 subdivision (a).

37 (d) On and after the date that Section 1399.829 becomes  
38 operative, this section shall not apply to individual health plan  
39 contracts.

1 SEC. 22.7. Section 1367.16 is added to the Health and Safety  
2 Code, to read:

3 1367.16. For purposes of subdivision (c) of Section 1367.15,  
4 “comparable benefits” means any health plan contract in the same  
5 coverage choice category, as determined by the department and  
6 the Department of Insurance pursuant to Section 1399.832, that a  
7 closed block of business would have been in, had that block of  
8 business not been closed. If the coverage benefits provided in the  
9 closed block of business do not meet or exceed the minimum health  
10 care coverage requirements of Section 1399.824, they shall be  
11 deemed comparable to the lowest coverage choice category.

12 SEC. 23. Section 1367.205 is added to the Health and Safety  
13 Code, to read:

14 1367.205. Commencing on or before January 1, 2010, a health  
15 care service plan that provides prescription drug benefits and  
16 maintains one or more drug formularies shall make the most current  
17 formularies available electronically to prescribers and pharmacies.

18 SEC. 24. Section 1367.38 is added to the Health and Safety  
19 Code, to read:

20 1367.38. (a) On and after January 1, 2009, every health care  
21 service plan, except for a Medicare supplement plan, that covers  
22 hospital, medical, or surgical expenses on a group basis shall offer  
23 to include a Healthy Action Incentives and Rewards Program, as  
24 described in subdivision (b), to be implemented in connection with  
25 a health care service plan, under such terms and conditions as may  
26 be agreed upon between the subscriber group and the health care  
27 service plan. Every plan shall communicate the availability of that  
28 program to all prospective subscriber groups with whom it is  
29 negotiating and to existing subscriber groups upon renewal.

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

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

37 (2) Enrollee access to an appropriate health care provider, as  
38 medically necessary, to review and address the results of the health  
39 risk appraisal. In addition, where appropriate, the Healthy Action  
40 Incentives and Rewards Program may include followup through

1 a Web-based tool or a nurse hotline either in combination with a  
2 referral to a provider or separately.

3 (3) Incentives or rewards for enrollees to become more engaged  
4 in their health care and to make appropriate choices that support  
5 good health, including obtaining health risk appraisals, screening  
6 services, immunizations, or participating in healthy lifestyle  
7 programs and practices. These programs and practices may include,  
8 but need not be limited to, smoking cessation, physical activity,  
9 or nutrition. Incentives may include, but need not be limited to,  
10 health premium reductions, differential copayment or coinsurance  
11 amounts, and cash payments. Rewards may include, but need not  
12 be limited to, nonprescription pharmacy products or services not  
13 otherwise covered under an enrollee's health plan contract, exercise  
14 classes, gym memberships, and weight management programs. If  
15 a health care service plan elects to offer an incentive in the form  
16 of a reduction in the premium amount, the premium reduction shall  
17 be standardized and uniform for all groups and subscribers and  
18 shall be offered only after the successful completion of the  
19 specified program or practice by the enrollee or subscriber.

20 (c) (1) A health care service plan subject to this section shall  
21 offer and price all Healthy Action Incentives and Rewards  
22 Programs approved by the director consistently across all groups,  
23 potential groups, and individuals and offer and price the programs  
24 without regard to the health status, prior claims experience, or risk  
25 profile of the members of a group. A health plan shall not condition  
26 the offer, delivery, or renewal of a contract that covers hospital,  
27 medical, or surgical expenses on the group's purchase, acceptance,  
28 or enrollment in a Healthy Action Incentives and Rewards Program.  
29 Rewards and incentives established in the program may not be  
30 designed, provided, or withheld based on the actual health service  
31 utilization or health care claims experience of the group, members  
32 of the group, or the individual.

33 (2) In order to demonstrate compliance with this section, a health  
34 care service plan shall file the program description and design as  
35 an amendment to its application for licensure pursuant to  
36 subdivision (a) of Section 1352. The director shall disapprove,  
37 suspend, or withdraw any product or program developed pursuant  
38 to this section if the director determines that the product or product  
39 design has the effect of allowing health care service plans to  
40 market, sell, or price health coverage for healthier lower risk profile

1 groups in a preferential manner that is inconsistent with the  
2 requirement to offer, market, and sell products pursuant to Article  
3 3.1 (commencing with Section 1357) and Article 11.6  
4 (commencing with Section 1399.820).

5 (d) This section shall supplement, and not supplant, any other  
6 section in this chapter concerning requirements for plans to provide  
7 health care services, childhood immunizations, adult  
8 immunizations, and preventive care services.

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

13 SEC. 25. Section 1368.025 is added to the Health and Safety  
14 Code, to read:

15 1368.025. In addition to the duties listed in paragraph (3) of  
16 subdivision (c) of Section 1368.02, the duties of the Office of  
17 Patient Advocate shall include providing access to the public to  
18 reports and data obtained by the Office of Statewide Health  
19 Planning and Development in a format and through mechanisms,  
20 including, but not limited to, the Internet, that allow the public to  
21 use the information to assist them in making informed selections  
22 of health plans, hospitals, medical groups, nursing homes, and  
23 other providers about whom the office has collected information.

24 SEC. 26. Section 1378.1 is added to the Health and Safety  
25 Code, to read:

26 1378.1. (a) Except as provided in subdivision (f), a full-service  
27 health care service plan shall, on and after July 1, 2010, expend  
28 in the form of health care benefits no less than 85 percent of the  
29 aggregate dues, fees, premiums, or other periodic payments  
30 received by the plan. For purposes of this section, the plan may  
31 deduct from the aggregate dues, fees, premiums, or other periodic  
32 payments received by the plan the amount of income taxes or other  
33 taxes that the plan expensed. For purposes of this section, "health  
34 care benefits" shall mean health care services that are either  
35 provided by or reimbursed by the plan or its contracted providers  
36 as plan benefits.

37 (b) (1) In addition to the health care benefits defined in  
38 subdivision (a), health care benefits shall include:

39 (A) The costs of programs or activities, including training and  
40 the provision of informational materials that are determined as

1 part of the regulations under subdivision (d) to improve the  
 2 provision of quality care, improve health care outcomes, or  
 3 encourage the use of evidence-based medicine.

4 (B) Disease management expenses using cost-effective  
 5 evidence-based guidelines.

6 (C) Plan medical advice by telephone.

7 (D) Payments to providers as risk pool payments of  
 8 pay-for-performance initiatives.

9 (2) Health care benefits shall not include administrative costs  
 10 listed in Section 1300.78 of Title 28 of the California Code of  
 11 Regulations in effect on January 1, 2007.

12 (c) To assess compliance with this section, a plan licensed to  
 13 operate in California may average its total costs across all health  
 14 care service plan contracts issued, amended, or renewed in  
 15 California, and all health insurance policies issued, amended, or  
 16 renewed by its affiliated disability insurers with valid California  
 17 certificates of authority, except for those policies listed in  
 18 subdivision (f) of Section 10113.10 of the Insurance Code.

19 (d) The department and the Department of Insurance shall jointly  
 20 adopt and amend regulations to implement this section and Section  
 21 10113.10 of the Insurance Code to establish uniform reporting by  
 22 plans and insurers of the information necessary to determine  
 23 compliance with this section. These regulations may include  
 24 additional elements in the definition of health care benefits not  
 25 identified in paragraph (1) of subdivision (b) in order to  
 26 consistently operationalize the requirements of this section among  
 27 health plans and health insurers, but such regulatory additions shall  
 28 be consistent with the legislative intent that health plans expend  
 29 at least 85 percent of aggregate payments as provided in  
 30 subdivision (a) on health care benefits.

31 (e) The department may exclude from the determination of  
 32 compliance with the requirement of subdivision (a) any new health  
 33 care service plan contracts for up to the first two years that these  
 34 contracts are offered for sale in California, provided that the  
 35 director determines that the new contracts are substantially different  
 36 from the existing contracts being issued, amended, or renewed by  
 37 the health plan seeking the exclusion.

38 (f) This section shall not apply to Medicare supplement plans  
 39 or to coverage offered by specialized health care service plans,

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1 including, but not limited to, ambulance, dental, vision, behavioral  
 2 health, chiropractic, and naturopathic.

3 SEC. 27. Section 1395.2 is added to the Health and Safety  
 4 Code, to read:

5 1395.2. (a) A health care service plan may provide notice by  
 6 electronic transmission and shall be deemed to have fully complied  
 7 with the specific statutory or regulatory requirements to provide  
 8 notice by United States mail to an applicant, enrollee, or subscriber,  
 9 if it complies with all of the following requirements:

10 (1) Obtains authorization from the applicant, enrollee, or  
 11 subscriber to provide notices by electronic transmission and to  
 12 cease providing notices by United States mail. "Authorization"  
 13 means the agreement by the applicant, enrollee, or subscriber  
 14 through interactive voice response, the Internet or other similar  
 15 medium, or in writing, to receive notices by electronic transmission.

16 (2) Uses an authorization process, approved by the department,  
 17 in which the applicant, enrollee, or subscriber confirms  
 18 understanding of and agreement with the specific notices or  
 19 materials that will be provided by electronic transmission.

20 (3) Complies with the specific statutory or regulatory  
 21 requirements as to the content of the notices it sends by electronic  
 22 transmission.

23 (4) Provides for the privacy of the notice as required by state  
 24 and federal laws and regulations.

25 (5) Allows the applicant, enrollee, or subscriber at any time to  
 26 terminate the authorization to provide notices by electronic  
 27 transmission and receive the notices through the United States  
 28 mail, if specific statutory or regulatory requirements require notice  
 29 by mail.

30 (6) Sends the electronic transmission of a notice to the last  
 31 known electronic address of the applicant, enrollee, or subscriber.  
 32 If the electronic transmission fails to reach its intended recipient  
 33 twice, the health care service plan shall resume sending all notices  
 34 to the last known United States mail address of the applicant,  
 35 enrollee, or subscriber.

36 (7) Maintains an Internet Web site where the applicant, enrollee,  
 37 or subscriber may access the notices sent by electronic  
 38 transmission.

1 (8) Informs the applicant, enrollee, or subscriber how to  
2 terminate the authorization to provide notices sent by electronic  
3 transmission.

4 (b) A health care service plan shall not use the electronic mail  
5 address of an applicant, enrollee, or subscriber that it obtained for  
6 the purposes of providing notice pursuant to subdivision (a) for  
7 any purpose other than communicating with the enrollee, applicant,  
8 or subscriber about his or her policy, plan, or benefits.

9 (c) No person other than the applicant, enrollee, or subscriber  
10 to whom the medical information in the notice pertains or a  
11 representative lawfully authorized to act on behalf of the applicant,  
12 enrollee, or subscriber, may authorize the transmission of medical  
13 information by electronic transmission. "Medical information" for  
14 these purposes shall have the meaning set forth in subdivision (g)  
15 of Section 56.05 of the Civil Code. The transmission of any  
16 medical information, as that term is used in subdivision (g) of  
17 Section 56.05 of the Civil Code, shall comply with the  
18 Confidentiality of Medical Information Act (Part 2.6 (commencing  
19 with Section 56) of Division 1 of the Civil Code).

20 (d) A notice transmitted electronically pursuant to this section  
21 is a private and confidential communication, and it shall constitute  
22 a violation of this chapter for a person, other than the applicant,  
23 enrollee, or subscriber to whom the notice is addressed, to read or  
24 otherwise gain access to the notice without the express, specific  
25 permission of the notice's addressee. This subdivision shall not  
26 apply to a health care provider, health care service plan, or  
27 contractor of a health care provider or health care service plan, of  
28 an applicant, enrollee, or subscriber if the health care provider,  
29 health care service plan, or contractor of a health care provider or  
30 health care service plan is authorized to have access to the medical  
31 information pursuant to the Confidentiality of Medical Information  
32 Act (Part 2.6 (commencing with Section 56) of Division 1 of the  
33 Civil Code).

34 (e) A health care service plan shall not impose additional fees  
35 or a differential if an applicant, enrollee, or subscriber elects not  
36 to receive notices by electronic transmission.

37 (f) Notices that may be made by electronic transmission include  
38 an explanation of benefits; responses to inquiries from an applicant,  
39 enrollee, or subscriber; underwriting decisions; distribution of plan  
40 contracts, including evidence of coverage and disclosure forms

1 pursuant to Sections 1300.63.1 and 1300.63.2 of Title 28 of the  
2 California Code of Regulations; a list of contracting providers  
3 pursuant to Section 1367.26; and changes in rates or coverage  
4 pursuant to Sections 1374.21, 1374.22, and 1374.23. A plan may  
5 not transmit through electronic means any notice that may affect  
6 the eligibility for, or continued enrollment in, coverage.

7 SEC. 27.3. Section 1399.56 of the Health and Safety Code is  
8 amended to read:

9 1399.56. (a) Compensation of a person retained by a health  
10 care service plan to review claims for health care services shall  
11 not be based on either of the following:

12 (1) A percentage of the amount by which a claim is reduced for  
13 payment.

14 (2) The number of claims or the cost of services for which the  
15 person has denied authorization or payment.

16 (b) This section shall become inoperative on December 1, 2008,  
17 and, as of January 1, 2009, is repealed, unless a later enacted  
18 statute, that becomes operative on or before January 1, 2009,  
19 deletes or extends the dates on which it becomes inoperative and  
20 is repealed.

21 SEC. 27.5. Section 1399.56 is added to the Health and Safety  
22 Code, to read:

23 1399.56. (a) Compensation of a person employed by or  
24 contracted with a health care service plan to review claims or  
25 eligibility for health care services shall not be based on either of  
26 the following:

27 (1) A percentage of the amount by which a claim is reduced for  
28 payment.

29 (2) The number of claims or the cost of services for which the  
30 person has denied authorization or payment.

31 (b) This section shall become operative on December 1, 2008.

32 SEC. 28. Section 1399.58 is added to the Health and Safety  
33 Code, to read:

34 1399.58. (a) No health care service plan shall set performance  
35 goals or quotas or provide additional compensation to any person  
36 employed by or contracted with the health care service plan based  
37 on the number of persons for which coverage is rescinded or the  
38 financial savings to the health care service plan associated with  
39 the rescission of coverage.

40 (b) This section shall become operative on December 1, 2008.

1 SEC. 28.5. Article 11.6 (commencing with Section 1399.820)  
2 is added to Chapter 2.2 of Division 2 of the Health and Safety  
3 Code, to read:

4  
5 Article 11.6. Individual Market Reform and Guarantee Issue

6  
7 1399.820. It is the intent of the Legislature to do both of the  
8 following:

9 (a) Guarantee the availability and renewability of health  
10 coverage to individuals through the private health insurance market.

11 (b) Require that health care service plans and health insurers  
12 issuing coverage in the individual market compete on the basis of  
13 price, quality, and service, and not on risk selection.

14 1399.821. For purposes of this article, the following terms shall  
15 have the following meanings:

16 (a) "Anniversary date" means the calendar date one year from,  
17 and each subsequent year thereafter, the date an individual enrolls  
18 in a health plan contract.

19 (b) "Coverage choice category" means the category of health  
20 plan contracts and health insurance policies established by the  
21 department and the Department of Insurance pursuant to Section  
22 1399.832.

23 (c) "Dependent" means the spouse, registered domestic partner,  
24 or child of an individual, subject to applicable terms of the health  
25 plan contract covering the individual.

26 (d) "Health insurance policy" means an individual disability  
27 insurance policy offered, sold, amended, or renewed to individuals  
28 and their dependents and that provides coverage for hospital,  
29 medical, or surgical benefits. The term shall not include any of the  
30 following kinds of insurance:

31 (1) Accidental death and accidental death and dismemberment.

32 (2) Disability insurance, including hospital indemnity,  
33 accident-only, and specified disease insurance that pays benefits  
34 on a fixed benefit, cash-payment-only basis.

35 (3) Credit disability, as defined in Section 779.2 of the Insurance  
36 Code.

37 (4) Coverage issued as a supplement to liability insurance.

38 (5) Disability income, as defined in subdivision (i) of Section  
39 799.01 of the Insurance Code.

[1]

- 1 (6) Insurance under which benefits are payable with or without  
2 regard to fault and that is statutorily required to be contained in  
3 any liability insurance policy or equivalent self-insurance.
- 4 (7) Insurance arising out of a workers' compensation or similar  
5 law.
- 6 (8) Long-term care coverage.
- 7 (9) Dental coverage.
- 8 (10) Vision coverage.
- 9 (11) Medicare supplement, CHAMPUS-supplement or  
10 Tricare-supplement, behavioral health-only, pharmacy-only,  
11 hospital indemnity, hospital-only, accident-only, or specified  
12 disease insurance that does not pay benefits on a fixed benefit,  
13 cash-payment-only basis.
- 14 (e) "Health insurer" means a disability insurer that offers and  
15 sells health insurance.
- 16 (f) "Health plan" means a health care service plan, as defined  
17 in subdivision (f) of Section 1345, that is lawfully engaged in  
18 providing, arranging, paying for, or reimbursing the cost of health  
19 care services and is offering or selling health care service plan  
20 contracts in the individual market. A health plan shall not include  
21 a specialized health care service plan.
- 22 (g) "Health plan contract" means an individual health care  
23 service plan contract offered, sold, amended, or renewed to  
24 individuals and their dependents. The term shall not include  
25 long-term care insurance, dental, or vision coverage. In addition,  
26 the term shall not include a specialized health care service plan  
27 contract, as defined in subdivision (o) of Section 1345.
- 28 (h) "Purchasing pool" means the program established under  
29 Part 6.45 (commencing with Section 12699.201) of Division 2 of  
30 the Insurance Code.
- 31 (i) "Rating period" means the period for which premium rates  
32 established by a plan are in effect and shall be no less than 12  
33 months beginning on the effective date of the subscriber's health  
34 plan contract.
- 35 (j) "Risk adjustment factor" means the percentage adjustment  
36 to be applied to the standard risk rate for a particular individual,  
37 based upon any expected deviations from standard claims due to  
38 the health status of the individual.

1 (k) “Risk category” means the following characteristics of an  
2 individual: age, geographic region, and family composition of the  
3 individual, plus the health plan contract selected by the individual.

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

6 Under 1.

7 1–18.

8 19–24.

9 25–29.

10 30–34.

11 35–39.

12 40–44.

13 45–49.

14 50–54.

15 55–59.

16 60–64.

17 65 and over.

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

23 (2) Health plans shall determine rates using no more than the  
24 following family size categories:

25 (A) Single.

26 (B) More than one child 18 years of age or under and no adults.

27 (C) Married couple or registered domestic partners.

28 (D) One adult and child.

29 (E) One adult and children.

30 (F) Married couple and child or children, or registered domestic  
31 partners and child or children.

32 (3) (A) In determining rates for individuals, a health plan that  
33 operates statewide shall use no more than nine geographic regions  
34 in the state, have no region smaller than an area in which the first  
35 three digits of all its ZIP Codes are in common within a county,  
36 and divide no county into more than two regions. Health plans  
37 shall be deemed to be operating statewide if their coverage area  
38 includes 90 percent or more of the state’s population. Geographic  
39 regions established pursuant to this section shall, as a group, cover  
40 the entire state, and the area encompassed in a geographic region

1 shall be separate and distinct from areas encompassed in other  
2 geographic regions. Geographic regions may be noncontiguous.

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

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

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

26 (4) A health plan may rate its entire portfolio of health plan  
27 contracts in accordance with expected costs or other market  
28 considerations, but the rate for each health plan contract shall be  
29 set in relation to the balance of the portfolio, as certified by an  
30 actuary.

31 (5) Each health plan contract shall be priced as determined by  
32 each health plan to reflect the difference in benefit variation, or  
33 the effectiveness of a provider network, and each health plan may  
34 adjust the rate for a specific plan contract for risk selection only  
35 to the extent permitted by subdivision (d) of Section 1399.840.

36 (l) "Standard risk rate" means the rate applicable to an individual  
37 in a particular risk category.

38 (m) "Subscriber" means the individual who is enrolled in a  
39 health plan contract, is the basis for eligibility for enrollment in  
40 the contract, and is responsible for payment to the health plan.

1 1399.823. On and after March 31, 2009, a health plan shall not  
2 offer to an individual a health plan contract that provides less than  
3 minimum creditable coverage as defined by the Managed Risk  
4 Medical Insurance Board pursuant to Section 12739.50 of the  
5 Insurance Code.

6 1399.826. (a) Notwithstanding Chapter 15 (commencing with  
7 Section 8899.50) of Division 1 of Title 2 of the Government Code  
8 and Section 1399.823, a health plan may renew an individual health  
9 care benefit plan for anyone enrolled on March 1, 2009, indefinitely  
10 without increasing benefits to meet the required minimum  
11 creditable coverage established by the Managed Risk Medical  
12 Insurance Board pursuant to Section 12739.50 of the Insurance  
13 Code. Those individual health care benefit plans, however, may  
14 not be offered to new enrollment, unless they are amended to meet  
15 the minimum creditable coverage established by the Managed Risk  
16 Medical Insurance Board pursuant to Section 12739.50 of the  
17 Insurance Code. In offering those plans for renewal, rates  
18 determined by health plans shall meet the requirements of Sections  
19 1399.821 and 1399.840. An individual who maintains coverage  
20 in a health plan contract pursuant to this section shall be deemed  
21 to be in compliance with Section 8899.50 of the Government Code.

22 (b) A health plan shall not cease to renew coverage in an  
23 individual health plan contract described in subdivision (a) except  
24 as permitted pursuant to Section 1367.15.

25 (c) On and after March 1, 2009, the director shall not approve  
26 for offer and sale in this state any new individual health plan  
27 contract that does not meet or exceed the requirements for  
28 minimum creditable coverage established by the Managed Risk  
29 Medical Insurance Board pursuant to Section 12739.50 of the  
30 Insurance Code.

31 (d) Effective July 1, 2010, all individual health plan contracts  
32 approved, offered, and sold prior to March 1, 2009, which do not  
33 comply with minimum creditable coverage standards adopted by  
34 the Managed Risk Medical Insurance Board pursuant to Section  
35 12739.50 of the Insurance Code, exclusively because the contract  
36 includes a lifetime benefit maximum inconsistent with minimum  
37 creditable coverage requirements, shall be modified to comply  
38 with the minimum creditable coverage standard.

39 (e) This section shall become operative on January 1, 2009.

1 1399.827. A health plan shall, in addition to complying with  
2 this chapter and the rules of the director, comply with this article.

3 1399.828. This article shall not apply to health plan contracts  
4 for coverage of Medicare services pursuant to contracts with the  
5 United States government, Medicare supplement, Medi-Cal  
6 contracts with the State Department of Health Care Services,  
7 Healthy Families Program contracts with the Managed Risk  
8 Medical Insurance Board, long-term care coverage, specialized  
9 health care service plan contracts, as defined in subdivision (o) of  
10 Section 1345, or the purchasing pool established under Part 6.45  
11 (commencing with Section 12699.201) of Division 2 of the  
12 Insurance Code.

13 1399.829. (a) Except for the health plan contracts described  
14 in subdivision (a) of Section 1399.826, a health plan shall fairly  
15 and affirmatively offer, market, and sell all of the plan's contracts  
16 that are sold to individuals to all individuals in each service area  
17 in which the health plan provides or arranges for the provision of  
18 health care services.

19 (b) A health plan may not reject an application from an  
20 individual, or his or her dependents, for a health plan contract, or  
21 refuse to renew an individual health plan contract, if all of the  
22 following requirements are met:

23 (1) The individual agrees to make the required premium  
24 payments.

25 (2) The individual and his or her dependents who are to be  
26 covered by the health plan contract work or reside in the service  
27 area in which the health plan provides or otherwise arranges for  
28 the provision of health care services.

29 (3) The individual provides the information requested on the  
30 application to determine the appropriate rate.

31 (c) Notwithstanding subdivision (b), if an individual, or his or  
32 her dependents, applies for a health plan contract in a coverage  
33 choice category for which he or she is not eligible pursuant to  
34 Section 1399.837, the health plan may reject that application  
35 provided that the plan also offers the individual and his or her  
36 dependents coverage in the appropriate coverage choice category.

37 (d) Notwithstanding subdivision (b), a health plan is not required  
38 to renew an individual health plan contract if any of the conditions  
39 listed in subdivision (a) of Section 1399.839 are met.

1 (e) Notwithstanding any other provision of this chapter or of a  
2 health plan contract, every health plan shall comply with the  
3 requirements of Chapter 7 (commencing with Section 3750) of  
4 Part 1 of Division 9 of the Family Code and Section 14124.94 of  
5 the Welfare and Institutions Code.

6 (f) A health plan may require an individual to provide  
7 information on his or her health status or health history, or that of  
8 his or her dependents, in the application for enrollment to the extent  
9 required to apply the risk adjustment factor permitted pursuant to  
10 subdivision (d) of Section 1399.840. The health plan shall use the  
11 standardized form and process developed by the department  
12 pursuant to Section 1399.840. After the health plan contract's  
13 effective date of coverage, a health plan may request that the  
14 subscriber provide information voluntarily on his or her health  
15 history or health status, or that of his or her dependents, for  
16 purposes of providing care management services, including disease  
17 management services.

18 (g) Notwithstanding subdivision (b), a health plan may reject  
19 an application for any person who has been a resident of California  
20 for six months or less unless one of the following applies: (1) the  
21 person is a federally eligible defined individual as defined in  
22 Section 1399.801 or Section 10785 of the Insurance Code; or (2)  
23 the individual can demonstrate a minimum of two years of prior  
24 creditable coverage at least equivalent to the minimum creditable  
25 coverage developed by the Managed Risk Medical Insurance Board  
26 pursuant to Section 12739.50 of the Insurance Code and provided  
27 the person applies for coverage in California within 62 days of  
28 termination or cancellation of the prior creditable coverage.

29 (h) Notwithstanding subdivision (b), a health plan may reject  
30 an application for coverage from either of the following:

31 (1) A person who is exempt from the requirements of Section  
32 8899.50 of the Government Code because the person or family  
33 has an income at or below 250 percent of the federal poverty level  
34 and the person's or family's share of premium for minimum  
35 creditable coverage exceeds 5 percent of his or her family income,  
36 except for those individuals meeting the criteria in paragraph (1)  
37 or (2) of subdivision (g).

38 (2) A person exempted from the requirements of Section 8899.50  
39 of the Government Code pursuant to any exemption authorized or  
40 granted by the Managed Risk Medical Insurance Board pursuant

1 to Section 12739.501 of the Insurance Code, for the time period  
2 of the exemption, as determined by the board.

3 (i) Notwithstanding Section 1399.846, this section shall not  
4 become operative until Section 12739.51 of the Insurance Code  
5 is implemented.

6 1399.831. (a) A health plan shall not impose any preexisting  
7 condition exclusions, waived conditions, or postenrollment  
8 waiting or affiliation periods on any health plan contract issued,  
9 amended, or renewed pursuant to this article, except as provided  
10 under subdivision (b) of this section.

11 (b) After the requirement to guarantee issue of coverage under  
12 Section 1399.826 has been in effect for nine months, a health plan  
13 may impose a preexisting condition exclusion of up to 12 months  
14 for any person who fails to comply for more than 62 days with the  
15 requirement to maintain coverage under Section 8899.50 of the  
16 Government Code, providing, however, that the exclusion may  
17 not exceed the length of time that the person failed to comply with  
18 the requirements of that section. "Preexisting condition exclusion"  
19 means a contract provision that excludes coverage for charges or  
20 expenses incurred during a specified period following the  
21 individual's effective date of coverage, as to a condition for which  
22 medical advice, diagnosis, care, or treatment was recommended  
23 or received during a specified period immediately preceding the  
24 effective date of coverage. For purposes of this section, preexisting  
25 condition provisions contained in plan contracts may relate only  
26 to conditions for which medical advice, diagnosis, care, or  
27 treatment, including use of prescription drugs, was recommended  
28 or received from a licensed health practitioner during the 12 months  
29 immediately preceding the effective date of coverage.

30 1399.832. (a) On or before April 1, 2009, the department and  
31 the Department of Insurance shall jointly, by regulation, develop  
32 a system to categorize all health plan contracts and health insurance  
33 policies offered and sold to individuals pursuant to this article and  
34 Chapter 9.6 (commencing with Section 10920) of Part 2 of Division  
35 2 of the Insurance Code into five coverage choice categories. These  
36 coverage choice categories shall do all of the following:

37 (1) Reflect a reasonable continuum between the coverage choice  
38 category with the lowest level of health care benefits and the  
39 coverage choice category with the highest level of health care  
40 benefits.

1 (2) Permit reasonable benefit variation that will allow for a  
2 diverse market within each coverage choice category.

3 (3) Be enforced consistently between health plans and health  
4 insurers in the same marketplace regardless of licensure.

5 (4) Within each coverage choice category, include one standard  
6 health maintenance organization (HMO) and one standard preferred  
7 provider organization (PPO), each of which is the health plan  
8 contract with the lowest benefit level in that category and for that  
9 type of contract.

10 (b) All health plans shall submit filings required pursuant to  
11 Section 1399.842 no later than October 1, 2009, for all individual  
12 health plan contracts to be offered or sold on or after July 1, 2010,  
13 to comply with this article, and thereafter any additional health  
14 plan contracts shall be filed pursuant to Section 1399.842. The  
15 director shall categorize each health plan contract offered by a  
16 health plan into the appropriate coverage choice category on or  
17 before March 31, 2010.

18 (c) To facilitate consumer comparison shopping, all health plans  
19 that offer coverage on an individual basis shall offer at least one  
20 health plan contract in each coverage choice category, including  
21 offering at least one of the standard contracts developed pursuant  
22 to paragraph (4) of subdivision (a), but a health plan may offer  
23 multiple products in each category.

24 (d) If a health plan offers a specific type of health plan contract  
25 in one coverage choice category, it must offer that specific type  
26 of health plan contract in each coverage choice category. A “type  
27 of health plan contract” includes a preferred provider organization,  
28 an exclusive provider organization model plan, a point of service  
29 model plan, and a health maintenance organization model plan.

30 (e) Health plans shall have flexibility in establishing provider  
31 networks, provided that access to care standards pursuant to this  
32 chapter are met, and provided that the provider network offered  
33 for one health plan contract in one coverage choice category is  
34 offered for at least one health plan contract in each coverage choice  
35 category.

36 (f) A health plan shall establish prices for its products that reflect  
37 a reasonable continuum between the products offered in the  
38 coverage choice category with the lowest level of benefits and the  
39 products offered in the coverage choice category with the highest  
40 level of benefits. A health plan shall not establish a standard risk

1 rate for a product in a coverage choice category at a lower rate  
2 than a product offered in a lower coverage choice category.

3 (g) The coverage choice category with the lowest level of  
4 benefits shall include the benefits which meet the requirement of  
5 minimum creditable coverage as determined by the Managed Risk  
6 Medical Insurance Board pursuant to Section 12739.50 of the  
7 Insurance Code.

8 1399.833. A health plan shall offer coverage for a Healthy  
9 Action Incentives and Rewards Program that complies with the  
10 requirements of Section 1367.38 in at least one health plan contract  
11 in every coverage choice category.

12 1399.834. The Office of the Patient Advocate shall develop  
13 and maintain on its Internet Web site a uniform benefits matrix of  
14 all available individual health plan contracts and individual health  
15 insurance policies arranged by coverage choice category. This  
16 uniform benefit matrix shall include all of the following:

17 (a) Benefit information submitted by health plans pursuant to  
18 Section 1399.843 and by health insurers pursuant to Section 10940  
19 of the Insurance Code, including, but not limited to, the following  
20 category descriptions:

- 21 (1) Deductibles.
- 22 (2) Copayments or coinsurance, as applicable.
- 23 (3) Annual out-of-pocket maximums.
- 24 (4) Professional services.
- 25 (5) Outpatient services.
- 26 (6) Preventive services.
- 27 (7) Hospitalization services.
- 28 (8) Emergency health services.
- 29 (9) Ambulance services.
- 30 (10) Prescription drug coverage.
- 31 (11) Durable medical equipment.
- 32 (12) Mental health and substance abuse services.
- 33 (13) Home health services.
- 34 (14) Other.

35 (b) The telephone number or numbers that may be used by an  
36 applicant to contact either the department or the Department of  
37 Insurance, as appropriate, for additional assistance.

38 1399.835. When an individual submits a premium payment,  
39 based on the quoted premium charges, and that payment is  
40 delivered or postmarked, whichever occurs earlier, within the first

1 15 days of the month, coverage under the health plan contract shall  
 2 become effective no later than the first day of the following month.  
 3 When that payment is either delivered or postmarked after the 15th  
 4 day of a month, coverage shall become effective no later than the  
 5 first day of the second month following delivery or postmark of  
 6 the payment.

7 1399.836. Except as provided in Section 1399.829, a health  
 8 plan is not required to offer an individual health plan contract and  
 9 may reject an application for an individual health plan contract in  
 10 the case of any of the following:

11 (a) The individual and dependents who are to be covered by the  
 12 health plan contract do not work or reside in a health plan's  
 13 approved service area.

14 (b) (1) Within a specific service area or portion of a service  
 15 area, if a health plan reasonably anticipates and demonstrates to  
 16 the satisfaction of the director that it will not have sufficient health  
 17 care delivery resources to assure that health care services will be  
 18 available and accessible to the eligible individual and dependents  
 19 of the individual because of its obligations to existing enrollees.

20 (2) A health plan that cannot offer a health plan contract to  
 21 individuals because it is lacking in sufficient health care delivery  
 22 resources within a service area or a portion of a service area may  
 23 not offer a health plan contract in the area in which the health plan  
 24 is not offering coverage to individuals until the health plan notifies  
 25 the director that it has the ability to deliver services to new  
 26 enrollees, and certifies to the director that from the date of the  
 27 notice it will enroll all individuals and groups requesting coverage  
 28 in that area from the health plan.

29 (c) The plan is licensed in California and meets all of the  
 30 following criteria: (1) does not offer coverage to individuals in the  
 31 commercial market; (2) requires that its members qualify through  
 32 the Medicare Program or Medi-Cal program or their successors;  
 33 and (3) 75 percent or more of the organization's total enrollment  
 34 premiums are paid by the Medi-Cal program or Medicare Program,  
 35 or by a combination of Medi-Cal and Medicare payments. In no  
 36 event shall this exemption be based upon enrollment in Medicare  
 37 supplement contracts, as described in Article 3.5 (commencing  
 38 with Section 1358).

39 (d) Any person who has been a resident of California for six  
 40 months or less unless one of the following applies: (1) the person

1 is a federally eligible defined individual as defined in Section  
2 1399.801 or Section 10785 of the Insurance Code, or (2) the person  
3 can demonstrate a minimum of two years of prior creditable  
4 coverage at least equivalent to the minimum creditable coverage  
5 developed by the Managed Risk Medical Insurance Board pursuant  
6 to Section 12739.50 of the Insurance Code and providing the  
7 person applies for coverage in California within 62 days of  
8 termination or cancellation of the prior creditable coverage.

9 (e) Any person who has been granted a temporary or permanent  
10 hardship exemption from the requirement to maintain minimum  
11 creditable coverage by the Managed Risk Medical Insurance Board  
12 pursuant to Section 12739.501 of the Insurance Code during the  
13 time period of the exemption as determined by the board.

14 1399.837. (a) If an individual disenrolls from a health plan  
15 contract or health insurance policy or if the individual's health  
16 plan contract or health insurance policy is canceled pursuant to  
17 Section 1399.839 or Section 10936 of the Insurance Code prior to  
18 the anniversary date of the health plan contract or health insurance  
19 policy, subsequent enrollment in an individual health plan contract  
20 or an individual health insurance policy shall be limited to the  
21 same coverage choice category the individual was enrolled in prior  
22 to disenrollment or cancellation.

23 (b) (1) An individual may change to a health plan contract in  
24 a different coverage choice category only on the anniversary date  
25 of the subscriber or upon a qualifying event.

26 (2) In no case, however, may an individual move up more than  
27 one coverage choice category on the anniversary date of the  
28 subscriber unless there is also a qualifying event.

29 (c) An individual health plan contract described in subdivision  
30 (a) of Section 1399.826 that does not meet or exceed the  
31 requirements for minimum creditable coverage established by the  
32 Managed Risk Medical Insurance Board shall be deemed to be the  
33 lowest coverage choice category for purposes of this section.

34 (d) On and after January 1, 2011, an individual who fails to  
35 comply with the provisions of Chapter 15 (commencing with  
36 Section 8899.50) of Division 1 of Title 2 of the Government Code  
37 for more than 62 days may only enroll in a health plan contract or  
38 health insurance policy in the lowest coverage choice category.  
39 Upon the individual's anniversary date, the individual may move  
40 to a higher coverage choice category pursuant to subdivision (b).

- 1 (e) For purposes of this section, a qualifying event occurs upon
- 2 any of the following:
- 3 (1) Upon the death of the subscriber, on whose qualifying
- 4 coverage an individual was a dependent.
- 5 (2) Upon marriage of the subscriber or entrance by the subscriber
- 6 into a domestic partnership pursuant to Section 298.5 of the Family
- 7 Code.
- 8 (3) Upon divorce or legal separation of an individual from the
- 9 subscriber.
- 10 (4) Upon loss of dependent status by a dependent enrolled in
- 11 group health care coverage through a health care service plan or
- 12 a health insurer.
- 13 (5) Upon the birth or adoption of a child.
- 14 (6) Upon the loss of minimum creditable coverage as defined
- 15 by the Managed Risk Medical Insurance Board pursuant to Section
- 16 12739.50 of the Insurance Code.
- 17 1399.838. The director may require a health plan to discontinue
- 18 the offering of contracts or acceptance of applications from any
- 19 individual upon a determination by the director that the health plan
- 20 does not have sufficient financial viability, or organizational and
- 21 administrative capacity to ensure the delivery of health care
- 22 services to its enrollees.
- 23 1399.839. (a) All health plan contracts offered pursuant to this
- 24 article shall be renewable with respect to all individuals and
- 25 dependents at the option of the subscriber and shall not be canceled
- 26 except for the following reasons:
- 27 (1) Failure to pay any charges for coverage provided pursuant
- 28 to the contract if the subscriber has been duly notified and billed
- 29 for those charges and at least 15 days has elapsed since the date
- 30 of notification.
- 31 (2) Fraud or intentional misrepresentation of material fact under
- 32 the terms of the health plan contract by the individual.
- 33 (3) Fraud or deception in the use of the services or facilities of
- 34 the plan or knowingly permitting that fraud or deception by
- 35 another.
- 36 (4) Movement of the subscriber outside the health plan's service
- 37 area.
- 38 (5) If the health plan ceases to provide or arrange for the
- 39 provision of health care services for new or existing individual

1 health plan contracts in this state, provided, however, that the  
2 following conditions are satisfied:

3 (A) Notice of the decision to cease new or existing individual  
4 health plan contracts in the state is provided to the director and to  
5 the individual at least 180 days prior to discontinuation of that  
6 coverage.

7 (B) Individual health plan contracts shall not be canceled for  
8 180 days after the date of the notice required under subparagraph  
9 (A) and for that business of a health plan that remains in force,  
10 any health plan that ceases to offer for sale new individual health  
11 plan contracts shall continue to be governed by this article with  
12 respect to business conducted under this article.

13 (C) A health plan that ceases to write new individual health plan  
14 contracts in this state after the effective date of this section shall  
15 be prohibited from offering for sale individual health plan contracts  
16 in this state for a period of five years from the date of notice to the  
17 director. The director may permit a health plan to offer and sell  
18 individual health plan contracts in this state before the five-year  
19 time period has expired if the director determines that it is in the  
20 best interest of the state and necessary to preserve the integrity of  
21 the health care market.

22 (6) If the health plan withdraws an individual health plan  
23 contract from the market, provided that the health plan notifies all  
24 affected individuals and the director at least 90 days prior to the  
25 discontinuation of these health plan contracts, and that the health  
26 plan makes available to the individual all health plan contracts  
27 with comparable benefits that it makes available to new individual  
28 business.

29 (b) On or after July 1, 2010, a health plan shall not rescind the  
30 health plan contract of any individual.

31 (c) Nothing in this article shall limit any other remedies available  
32 at law to a health plan.

33 1399.840. Premiums for health plan contracts offered, renewed,  
34 or delivered by health plans on or after the effective date of this  
35 article shall be subject to the following requirements:

36 (a) The premium for new or existing business shall be the  
37 standard risk rate for an individual in a particular risk category.

38 (b) The premium rates shall be in effect for no less than 12  
39 months from the date of the health plan contract.

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1 (c) When determining the premium rate for more than one  
2 covered individual, the health plan shall determine the rate based  
3 on the standard risk rate for the subscriber. If more than one  
4 individual is a subscriber, the premium rate shall be based on the  
5 age of the youngest spouse or registered domestic partner.

6 (d) (1) Notwithstanding subdivision (a), for the first two years  
7 following the implementation of this section, a health plan may  
8 apply a risk adjustment factor to the standard risk rate that may  
9 not be more than 120 percent or less than 80 percent of the  
10 applicable standard risk rate. In determining the risk adjustment  
11 factor, a health plan shall use the standardized form and uniform  
12 process developed by the director pursuant to subdivision (f).

13 (2) After the first two years following the implementation of  
14 this section, the adjustments applicable under paragraph (1) shall  
15 not be more than 110 percent or less than 90 percent of the standard  
16 risk rate.

17 (3) Upon the renewal of any contract, the risk adjustment factor  
18 applied to the individual's rate may not be more than 5 percentage  
19 points different than the factor applied to that rate prior to renewal.  
20 The same limitation shall be applied to individuals with respect to  
21 the risk adjustment factor applicable for the purchase of a new  
22 product where the individual's prior health plan has discontinued  
23 that product.

24 (4) After the first four years following the implementation of  
25 this section, a health plan shall base rates on the standard risk rate  
26 with no risk adjustment factor.

27 (e) The director and the Insurance Commissioner shall jointly  
28 establish a maximum limit on the ratio between the standard risk  
29 rates for contracts for individuals in the 60 to 64 years of age,  
30 inclusive, category and contracts for individuals in the 30 to 34  
31 years of age, inclusive, category.

32 (f) On or before March 1, 2009, the director shall, in consultation  
33 with the Insurance Commissioner and the Managed Risk Medical  
34 Insurance Board and using a qualified independent actuary, develop  
35 a standardized form and uniform evaluation process to be used by  
36 all health care service plans and all disability insurers exclusively  
37 for the purpose of determining any risk adjustment rating factor  
38 to be applied to an individual's premium rate based on actual or  
39 expected health care use. Health plans shall base the risk  
40 adjustment factors as authorized in this section solely on the results

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1 of the standardized form and uniform evaluation process developed  
2 by the director.

3 1399.841. (a) In connection with the offering for sale of any  
4 health plan contract to an individual, each health plan shall make  
5 a reasonable disclosure, as part of its solicitation and sales  
6 materials, of all of the following:

7 (1) The provisions concerning the health plan's right to change  
8 premium rates on an annual basis and the factors other than  
9 provision of services experience that affect changes in premium  
10 rates.

11 (2) Provisions relating to the guaranteed issue and renewal of  
12 health plan contracts.

13 (3) Provisions relating to the individual's right to obtain any  
14 health plan contract the individual is eligible to enroll in pursuant  
15 to Sections 1399.829 and 1399.837.

16 (4) The availability, upon request, of a listing of all the health  
17 plan's contracts, including the rates for each health plan contract.

18 (b) Every solicitor or solicitor firm contracting with one or more  
19 health plans to solicit enrollments or subscriptions from individuals  
20 shall, when providing information on health plan contracts to an  
21 individual but making no specific recommendations on particular  
22 health plan contracts, do both of the following:

23 (1) Advise the individual of the health plan's obligation to sell  
24 to any individual any health plan contract it offers to individuals  
25 and provide him or her, upon request, with the actual rates that  
26 would be charged to that individual for a given health plan contract.

27 (2) Notify the individual that the solicitor or solicitor firm will  
28 procure rate and benefit information for the individual on any  
29 health plan contract offered by a health plan whose contract the  
30 solicitor sells.

31 (c) Prior to filing an application for a particular individual health  
32 plan contract, the health plan shall obtain a signed statement from  
33 the individual acknowledging that the individual has received the  
34 disclosures required by this section.

35 1399.842. (a) At least 20 business days prior to offering a  
36 health plan contract subject to this article, all health plans shall  
37 file a notice of material modification with the director in  
38 accordance with the provisions of Section 1352. The notice of  
39 material modification shall include a statement certifying that the  
40 health plan is in compliance with Sections 1399.821 and 1399.840.

1 The certified statement shall set forth the standard risk rate for  
2 each risk category that will be used in setting the rates at which  
3 the contract will be offered. Any action by the director, as permitted  
4 under Section 1352, to disapprove, suspend, or postpone the health  
5 plan's use of a health plan contract shall be in writing, specifying  
6 the reasons that the health plan contract does not comply with the  
7 requirements of this article.

8 (b) Prior to making any changes in the standard risk rates filed  
9 with the director pursuant to subdivision (a), the health plan shall  
10 file as an amendment a statement setting forth the changes and  
11 certifying that the health plan is in compliance with Sections  
12 1399.821 and 1399.840. If the standard risk rate is being changed,  
13 a health plan may commence offering health plan contracts utilizing  
14 the changed standard risk rate upon filing the certified statement  
15 unless the director disapproves the amendment by written notice.

16 (c) Periodic changes to the standard risk rate that a health plan  
17 proposes to implement over the course of up to 12 consecutive  
18 months may be filed in conjunction with the certified statement  
19 filed under subdivision (a) or (b).

20 (d) Each health plan shall maintain at its principal place of  
21 business all of the information required to be filed with the director  
22 pursuant to this article.

23 (e) This section shall become operative on July 1, 2009.

24 1399.843. (a) A health plan shall include all of the following  
25 in the material modification notice filed pursuant to subdivision  
26 (a) of Section 1399.842:

27 (1) A summary explanation of the following for each health  
28 plan contract offered to individuals:

29 (A) Eligibility requirements.

30 (B) The full premium cost of each health plan contract in each  
31 risk category, as defined in subdivision (k) of Section 1399.821.

32 (C) When and under what circumstances benefits cease.

33 (D) Other coverage that may be available if benefits under the  
34 described health plan contract cease.

35 (E) The circumstances under which choice in the selection of  
36 physicians and providers is permitted.

37 (F) Deductibles.

38 (G) Annual out-of-pocket maximums.

39 (2) A summary explanation of coverage for the following,  
40 together with the corresponding copayments, coinsurance, and

1 applicable limitations for each health plan contract offered to  
 2 individuals:

- 3 (A) Professional services.
- 4 (B) Outpatient services.
- 5 (C) Preventive services.
- 6 (D) Hospitalization services.
- 7 (E) Emergency health coverage.
- 8 (F) Ambulance services.
- 9 (G) Prescription drug coverage.
- 10 (H) Durable medical equipment.
- 11 (I) Mental health and substance abuse services.
- 12 (J) Home health services.

13 (3) The telephone number or numbers that may be used by an  
 14 applicant to access a health plan customer service representative  
 15 to request additional information about the health plan contract.

16 (b) The department shall share the information provided by  
 17 health plans pursuant to this article with the Office of the Patient  
 18 Advocate for purposes of the development, creation, and  
 19 maintenance of the comparative benefits matrix.

20 1399.844. (a) The Director of the Department of Managed  
 21 Health Care shall, in consultation with the Insurance  
 22 Commissioner, an outside actuarial firm, and health plans and  
 23 insurers participating in the individual market, no later than July  
 24 1, 2010, develop and implement mechanisms to assist health plans  
 25 and health insurers in managing the risk of providing health  
 26 coverage in the individual market on a guarantee issue basis to the  
 27 extent that these mechanisms can improve access to individual  
 28 coverage.

29 (b) The mechanisms required under subdivision (a) shall include  
 30 methods for collecting information regarding the enrollment, prices,  
 31 rate variance, and any other information that may be required to  
 32 monitor the condition of the individual market, the risk exposure  
 33 of individual health plans and insurers, and to implement  
 34 subdivisions (c) and (d).

35 (c) (1) The mechanisms developed pursuant to subdivision (a)  
 36 shall include a method by which an assessment is made of the  
 37 health status risk mix of a plan's guarantee issue products. To the  
 38 extent any plan's risk mix is disproportionately high compared to  
 39 the overall risk mix of all enrollees in guarantee issue products in  
 40 the individual market, the mechanisms developed pursuant to

□

1 subdivision (a) shall include provisions designed to make  
2 adjustments among plans and insurers based on the relative health  
3 risk of individuals enrolled in different health plans and health  
4 insurers. Methods to compensate for the relative health risk  
5 assumed by health plans and insurers shall include the ability to  
6 spread the costs to all health plan contracts and health insurance  
7 policies in the individual market.

8 (2) The director and the commissioner shall jointly adopt  
9 regulations identifying health plans and insurers that are required  
10 to participate in the mechanisms established pursuant to this  
11 subdivision.

12 (d) (1) The director and the commissioner shall also develop  
13 as part of the mechanisms under subdivision (a) a method for the  
14 provision of reinsurance for health plans or insurers offering  
15 guarantee issue products in the individual market if the age adjusted  
16 marketwide incidence of high-cost cases or high-risk categories  
17 significantly exceed the incidence of those cases or categories  
18 among enrollees of the California Cooperative Health Insurance  
19 Purchasing Pool (Cal-CHIPP) who are ineligible for the Cal-CHIPP  
20 Healthy Families plan. This reinsurance mechanism shall be based  
21 on a uniform standard set of service payment levels based on a  
22 methodology to be determined by the director and the  
23 commissioner.

24 (2) This subdivision shall be implemented on July 1, 2010, or  
25 the operative date of this section, whichever is later, and shall  
26 continue to be implemented until one year after the implementation  
27 of paragraph (4) of subdivision (d) of Section 1399.840.

28 (e) The director and the commissioner may contract with a  
29 qualified actuarial firm or other entities to accomplish the  
30 requirements of this section.

31 (f) No later than two years following implementation of  
32 guarantee issue pursuant to Section 1399.829 and Section 10928  
33 of the Insurance Code, the director and the commissioner shall  
34 make a finding whether and to what extent the relative risk profile  
35 of persons enrolled in individual coverage is higher than the risk  
36 profile of those of specified Cal-CHIPP enrollees, based on data  
37 following the first nine months of guarantee issue. If the risk profile  
38 of those enrolled in individual coverage is more than 5 percent  
39 higher than that of the specified Cal-CHIPP enrollees, the director  
40 and the commissioner shall establish a reinsurance program for

1 individual market health plans and insurers to compensate for the  
 2 adverse risk selection. ~~The costs of reinsurance pursuant to this~~  
 3 ~~section in order to compensate for risk profile differentials of up~~  
 4 ~~to 10 percent shall be funded by a broad-based assessment across~~  
 5 ~~health care service plans and health insurers.~~ Funding to  
 6 compensate for risk profile differentials exceeding 10 percent shall  
 7 be paid by funds appropriated from the California Health Trust  
 8 Fund.

9 1399.845. (a) The director may issue regulations that are  
 10 necessary to carry out the purposes of this article.

11 (b) Nothing in this article shall be construed as providing the  
 12 director with rate regulation authority.

13 1399.846. Sections 1399.823, 1399.826, and 1399.832 shall  
 14 become operative on January 1, 2009, and Section 1399.842 shall  
 15 become operative on July 1, 2009. The remaining sections in this  
 16 article shall become operative on July 1, 2010.

17 SEC. 29. Article 1 (commencing with Section 104250) is added  
 18 to Chapter 4 of Part 1 of Division 103 of the Health and Safety  
 19 Code, to read:

20  
 21 Article 1. California Diabetes Program  
 22

23 104250. The State Department of Public Health shall maintain  
 24 the California Diabetes Program, including, but not limited to, the  
 25 following:

26 (a) Provide information on diabetes prevention and management  
 27 to the public, including health care providers.

28 (b) Provide technical assistance to the Medi-Cal program,  
 29 including participating providers and Medi-Cal managed care  
 30 plans, regarding the proper scope of benefits to be provided to  
 31 eligible individuals under Section 14137.10 of the Welfare and  
 32 Institutions Code. The assistance may include, but shall not be  
 33 limited to, all of the following:

34 (1) Provide information on evidence-based screening guidelines,  
 35 tools, and protocols, including the distribution of these guidelines,  
 36 tools, and protocols.

37 (2) Develop, with assistance from the State Department of  
 38 Health Care Services, the Comprehensive Diabetes Services  
 39 Program operational screening guidelines and protocols, utilizing

1 the most current American Diabetes Association screening criteria  
2 for diabetes testing in adults.

3 (3) Provide the Comprehensive Diabetes Services Program  
4 operational screening guidelines, tools, and protocols, including  
5 the distribution of those guidelines, tools, and protocols.

6 (4) Provide screening service criteria for diabetes and  
7 prediabetes in accordance with the guidelines developed for the  
8 Comprehensive Diabetes Services Program.

9 (5) Provide information regarding culturally and linguistically  
10 appropriate lifestyle coaching and self-management training for  
11 eligible adults with prediabetes and diabetes, in accordance with  
12 evidence-based interventions to avoid unhealthy blood sugar levels  
13 that contribute to the progression of diabetes and its complications.

14 (c) Provide technical assistance to the State Department of  
15 Health Care Services, including assistance on data collection and  
16 evaluation of the Medi-Cal program's Comprehensive Diabetes  
17 Services Program, established pursuant to Section 14137.10 of the  
18 Welfare and Institutions Code.

19 (d) This section shall be implemented only to the extent funds  
20 are appropriated for purposes of this section in the annual Budget  
21 Act or in another statute.

22 SEC. 30. Section 104376 is added to the Health and Safety  
23 Code, to read:

24 104376. (a) (1) The department, in consultation with the  
25 Department of Managed Health Care, the State Department of  
26 Health Care Services, the Managed Risk Medical Insurance Board,  
27 and the Department of Insurance, shall annually identify, on the  
28 basis of the number of persons insured, the 10 largest providers  
29 of health care coverage, including both public and private entities,  
30 and ascertain the smoking cessation benefits provided by each of  
31 these coverage providers.

32 (2) The department shall summarize the smoking cessation  
33 benefit information gathered under this subdivision and make the  
34 benefit summary available on the Internet, including the  
35 department's Web site.

36 (b) The department shall, where appropriate, include the  
37 smoking cessation benefit information as part of its educational  
38 efforts to prevent tobacco use that it renders to the public and to  
39 health care providers.

1 (c) The department shall conduct an evaluation, commencing  
2 one year following the publication of the smoking cessation benefit  
3 information on the department's Web site as provided in this  
4 section, to assess all of the following:

5 (1) Any changes in the awareness of the beneficiaries of the 10  
6 largest providers of health care coverage as to the availability of  
7 smoking cessation benefits.

8 (2) Any changes in the awareness of health care providers as to  
9 the availability of smoking cessation benefits.

10 (3) The extent to which smoking cessation benefits are utilized  
11 by beneficiaries of the 10 largest providers of health care coverage,  
12 and any changes in the utilization rate of these benefits as  
13 determined by a comparison with any available preexisting  
14 information.

15 (4) Smoking-related indicators available through the Health  
16 Plan Employer Data and Information Set.

17 (5) Any changes to the smoking cessation benefit coverage of  
18 the 10 largest providers of health care coverage.

19 (6) The impact on smoking rates based on the expansion of  
20 counseling services and the direct provision of tobacco cessation  
21 pharmacotherapy by the California Smokers' Helpline.

22 (d) To the extent funds are appropriated for these purposes, the  
23 department shall increase its efforts to do all of the following:

24 (1) Reduce smoking by increasing the capacity of effective  
25 cessation services available from the California Smokers' Helpline,  
26 including tobacco cessation pharmacotherapy.

27 (2) Expand public awareness about the services that are available  
28 through the California Smokers' Helpline.

29 (3) Expand public awareness and use of existing cessation  
30 benefits that are available to California smokers through their  
31 public and private providers of health care coverage.

32 SEC. 31. Article 3 (commencing with Section 104705) is added  
33 to Chapter 2 of Part 3 of Division 103 of the Health and Safety  
34 Code, to read:

35

36 Article 3. Community Makeover Grants

37

38 104705. (a) The Community Makeover Grant program is  
39 hereby created and shall be administered by the department. The

1 department shall award grants to local health departments to serve  
2 as local lead agencies in accordance with this article.

3 (b) For purposes of determining the amount of each grant  
4 awarded under this article, local health departments shall be  
5 allocated, at a minimum, base funding in proportion to total  
6 available funding.

7 (c) Except as provided in subdivision (b), local health  
8 departments shall receive an allocation based on each county's or  
9 city's proportion of the statewide population, to be expended for  
10 purposes that include, but need not be limited to:

11 (1) Creating a community infrastructure that promotes active  
12 living and healthy eating.

13 (2) Coordinating with, at minimum, city, county, and school  
14 partners to facilitate community level, multisector collaboration  
15 for the development and implementation of strategies to facilitate  
16 active living and healthy eating.

17 (3) Conducting competitive grant application processes to  
18 support local grants. These local grants may be used to develop  
19 new programs and improve existing programs to promote physical  
20 activity for children, improve access to healthy foods, and better  
21 utilize community recreation facilities.

22 (4) Preparing program interventions and materials that will be  
23 available in accessible, and culturally and linguistically appropriate,  
24 formats.

25 (d) The department shall issue guidelines for local lead agencies  
26 on how to prepare a local plan for a comprehensive community  
27 intervention program that includes changes to promote active living  
28 and healthy eating, and to prevent obesity and other related chronic  
29 diseases.

30 (e) The department shall specify data reporting requirements  
31 for local lead agencies and their subcontractors.

32 (f) (1) The department shall conduct a fiscal and program  
33 review on a regular basis.

34 (2) If the department determines that any local lead agency is  
35 not in compliance with any provision of this article, the local lead  
36 agency shall submit to the department, within 60 days, a plan for  
37 complying with this article.

38 (3) The department may withhold funds allocated under this  
39 section from local lead agencies that are not in compliance with  
40 this article.

1 (g) For purposes of this article, “department” means the State  
2 Department of Public Health.

3 104710. (a) The department may provide a variety of training,  
4 consultation, and technical assistance to support local programs.

5 (b) Notwithstanding any other provision of law, the department  
6 may use a request for proposal process or may directly award  
7 contracts to provide the assistance described in subdivision (a) to  
8 another state, federal, or auxiliary organization.

9 (c) Any organization awarded a contract under this section shall  
10 demonstrate the ability to provide statewide assistance to accelerate  
11 progress, and to ensure the long-term impact of local obesity  
12 prevention programs.

13 104715. (a) The department shall track and evaluate  
14 obesity-related measures, including, but not limited to, active  
15 living, healthy eating, and community environment indicators.  
16 These tracking and evaluation activities shall utilize scientifically  
17 appropriate methods, and may include, but need not be limited to,  
18 the following:

19 (1) Track statewide health indicators.

20 (2) Evaluate funded projects, determining baseline measures  
21 and progress toward goals, as well as capturing successes and  
22 emerging models.

23 (3) Compare the effectiveness of individual programs to inform  
24 funding decisions and program modifications.

25 (4) Incorporate other aspects into the evaluation that have been  
26 identified by the department in consultation with state and local  
27 advisory groups, local health departments, and other interested  
28 parties.

29 (5) Forecast health and economic cost consequences associated  
30 with obesity.

31 (6) Funds permitting, utilize a sample size that is adequate to  
32 produce county-, ethnic-, and disability-specific estimates.

33 (b) The purpose of the evaluation shall be to direct the most  
34 efficient allocation of resources appropriated under this article to  
35 accomplish the maximum reduction of obesity rates. The  
36 comprehensive evaluation shall be designed to measure the extent  
37 to which programs funded pursuant to this article promote the  
38 goals identified in the California Obesity Prevention Plan.

39 104720. The department shall develop a campaign to educate  
40 the public about the importance of obesity prevention that frames

1 active living and healthy eating as “California living.” The  
2 campaign-centered efforts shall be closely linked with  
3 community-level program change efforts and shall be available in  
4 accessible and culturally and linguistically appropriate formats.

5 104721. The department shall provide assistance and other  
6 support for schools to promote the availability and consumption  
7 of fresh fruits and vegetables and foods with whole grains.

8 104725. The department shall provide technical assistance to  
9 help employers integrate wellness policies and programs into  
10 employee benefit plans and worksites.

11 104726. Notwithstanding any other provision of law, this article  
12 shall be implemented only to the extent funds are appropriated for  
13 purposes of this article in the annual Budget Act or in another  
14 statute.

15 SEC. 31.1. Section 124900 of the Health and Safety Code is  
16 amended to read:

17 124900. (a) (1) The State Department of Health Care Services  
18 shall select primary care clinics that are licensed under paragraph  
19 (1) or (2) of subdivision (a) of Section 1204, or are exempt from  
20 licensure under subdivision (c) of Section 1206, to be reimbursed  
21 for delivering medical services, including preventive health care,  
22 and smoking prevention and cessation health education, to program  
23 beneficiaries.

24 (2) In order to be eligible to receive funds under this article a  
25 clinic shall meet all of the following conditions, at a minimum:

26 (A) Provide medical diagnosis and treatment.

27 (B) Provide medical support services of patients in all stages of  
28 illness.

29 (C) Provide communication of information about diagnosis,  
30 treatment, prevention, and prognosis.

31 (D) Provide maintenance of patients with chronic illness.

32 (E) Provide prevention of disability and disease through  
33 detection, education, persuasion, and preventive treatment.

34 (F) Meet one or both of the following conditions:

35 (i) Are located in an area or a facility federally designated as a  
36 health professional shortage area, medically underserved area, or  
37 medically underserved population.

38 (ii) Are clinics that are able to demonstrate that at least 50  
39 percent of the patients served are persons with incomes at or below  
40 250 percent of the federal poverty level.

1 (G) Serve as a designated primary care medical home for  
2 program beneficiaries, as described in subdivision (c) of Section  
3 124905.

4 (3) Notwithstanding the requirements of paragraph (2), all clinics  
5 that received funds under this article in the 1997–98 fiscal year  
6 shall continue to be eligible to receive funds under this article.

7 (b) As a part of the award process for funding pursuant to this  
8 article, the department shall take into account the availability of  
9 primary care services in the various geographic areas of the state.  
10 The department shall determine which areas within the state have  
11 populations which have clear and compelling difficulty in obtaining  
12 access to primary care. The department shall consider proposals  
13 from new and existing eligible providers to extend clinic services  
14 to these populations.

15 (c) Each primary care clinic applying for funds pursuant to this  
16 article shall demonstrate that the funds shall be used to expand  
17 medical services, including preventive health care, and smoking  
18 prevention and cessation health education, for program  
19 beneficiaries above the level of services provided in the 1988  
20 calendar year or in the year prior to the first year a clinic receives  
21 funds under this article if the clinic did not receive funds in the  
22 1989 calendar year.

23 (d) (1) The department, in consultation with clinics funded  
24 under this article, shall develop a formula for allocation of funds  
25 available. It is the intent of the Legislature that the funds allocated  
26 pursuant to this article promote stability for those clinics  
27 participating in programs under this article as part of the state's  
28 health care safety net and at the same time be distributed in a  
29 manner that best promotes access to health care to uninsured  
30 populations.

31 (2) The formula shall be based on both of the following:

32 (A) A hold harmless for clinics funded in the 1997–98 fiscal  
33 year to continue to reimburse them for some portion of their  
34 uncompensated care.

35 (B) Demonstrated unmet need by both new and existing clinics,  
36 as reflected in their levels of uncompensated care reported to the  
37 department. For purposes of this article, “uncompensated care”  
38 means clinic patient visits for persons with incomes at or below  
39 250 percent of the federal poverty level for which there is no

1 encounter-based third-party reimbursement which includes, but is  
2 not limited to, unpaid expanded access to primary care claims.

3 (3) The department shall allocate available funds, for a  
4 three-year period, as follows:

5 (A) Clinics that received funding in the prior fiscal year shall  
6 receive 90 percent of their prior fiscal year allocation, subject to  
7 available funds, provided that the funding award is substantiated  
8 by the clinics' reported levels of uncompensated care.

9 (B) The remaining funds beyond 90 percent shall be awarded  
10 to new and existing applicants based on the clinics' reported levels  
11 of uncompensated care as verified by the department according to  
12 subparagraph (B) of paragraph (4). The department shall seek input  
13 from stakeholders to discuss any adjustments to award levels that  
14 the department deems reasonable, such as including base amounts  
15 for new applicant clinics.

16 (C) New applicants shall be awarded funds pursuant to this  
17 subdivision if they meet the minimum requirements for funding  
18 under this article based on the clinics' reported levels of  
19 uncompensated care as verified by the department according to  
20 subparagraph (A) of paragraph (4). New applicants include  
21 applicants for any new site expansions by existing applicants.

22 (4) In assessing reported levels of uncompensated care, the  
23 department shall utilize the data available from the Office of  
24 Statewide Health Planning and Development's (OSHPD)  
25 completed analysis of the "Annual Report of Primary Care Clinics"  
26 for the prior fiscal year, or if more recent data is available, then  
27 the most recent data. If this data is unavailable for an existing  
28 applicant to assess reported levels of uncompensated care, the  
29 existing applicant shall receive an allocation pursuant to  
30 subparagraph (A) of paragraph (3).

31 (A) The department shall utilize the most recent data available  
32 from OSHPD's completed analysis of the "Annual Report of  
33 Primary Care Clinics" for the prior fiscal year, or if more recent  
34 data is available, then the most recent data.

35 (B) If the funds allocated to the program are less than the prior  
36 year, the department shall allocate available funds to existing  
37 program providers only.

38 (5) The department shall establish a base funding level, subject  
39 to available funds, of no less than thirty-five thousand dollars  
40 (\$35,000) for frontier clinics and Native American

[1]

1 reservation-based clinics. For purposes of this article, "frontier  
2 clinics" means clinics located in a medical services study area with  
3 a population of fewer than 11 persons per square mile.

4 (6) The department shall develop, in consultation with clinics  
5 funded pursuant to this article, a formula for reallocation of unused  
6 funds to other participating clinics to reimburse for uncompensated  
7 care. The department shall allocate the unused funds remaining  
8 on October 30, for the prior fiscal year to other participating clinics  
9 to reimburse for uncompensated care.

10 (e) In applying for funds, eligible clinics shall submit a single  
11 application per clinic corporation. Applicants with multiple sites  
12 shall apply for all eligible clinics, and shall report to the department  
13 the allocation of funds among their corporate sites in the prior  
14 year. A corporation may only claim reimbursement for services  
15 provided at a program-eligible clinic site identified in the corporate  
16 entity's application for funds, and approved for funding by the  
17 department. A corporation may increase or decrease the number  
18 of its program-eligible clinic sites on an annual basis, at the time  
19 of the annual application update for the subsequent fiscal years of  
20 any multiple-year application period.

21 (f) Grant allocations pursuant to this article shall be based on  
22 the formula developed by the department, notwithstanding a merger  
23 of one or more licensed primary care clinics participating in the  
24 program.

25 (g) A clinic that is eligible for the program in every other  
26 respect, but that provides dental services only, rather than the full  
27 range of primary care medical services, shall only be eligible to  
28 receive funds under this article on an exception basis. A dental-only  
29 provider's application shall include a memorandum of  
30 understanding (MOU) with a primary care clinic funded under this  
31 article. The MOU shall include medical protocols for making  
32 referrals by the primary care clinic to the dental clinic and from  
33 the dental clinic to the primary care clinic, and ensure that case  
34 management services are provided and that the patient is being  
35 provided comprehensive primary care as defined in subdivision  
36 (a).

37 (h) (1) For purposes of this article, an outpatient visit shall  
38 include diagnosis and medical treatment services, including the  
39 associated pharmacy, X-ray, and laboratory services, and  
40 prevention health and case management services that are needed

