

Introduced by Senator AanestadJanuary 21, 2009

An act to amend Section 2069 of the Business and Professions Code, to add Section 1815.5 to the Financial Code, to add Sections 22830.5, 22830.6, 22869.5, and 22917 to the Government Code, to amend Sections 1357, 1357.03, 1357.06, 1357.14, 1367.01, 1374.32, 1374.33, and 1374.58 of, to add Sections 1346.2, 1349.3, and 1367.38 to, and to add Article 12 (commencing with Section 1399.830) to Chapter 2.2 of Division 2 of, the Health and Safety Code, to amend Sections 10121.7, 10123.135, 10169.2, 10169.3, 10700, 10705, 10706, and 10708 of, to add Sections 699.6, 10123.56, and 12938.1 to, to add Chapter 9.7 (commencing with Section 10920) to Part 2 of Division 2 of, and to add Article 7 (commencing with Section 11885) to Chapter 4 of Part 3 of Division 2 of, the Insurance Code, to amend Sections 511 and 515 of, and to add Section 96.8 to, the Labor Code, to amend Sections 17072, 17215, and 19184 of, to add Sections 17053.91, 17053.102, 17053.103, 17138.5, 17138.6, and 17216 to, and to add and repeal Sections 17053.58, 17053.77, 17204, 23658, and 23677 of, the Revenue and Taxation Code, and to amend Sections 14043.26 and 14133 of, to add Sections 14026.7, 14029.7, 14079.7, 14132.104, 14132.105, and 14164.5 to, to add Article 2.94 (commencing with Section 14091.50) to Chapter 7 of Part 3 of Division 9 of, and to add Division 23 (commencing with Section 23000) to, the Welfare and Institutions Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 92, as introduced, Aanestad. Health care reform.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation

of health care service plans by the Department of Managed Health Care and makes a willful violation of the Knox-Keene Act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

The Knox-Keene Act requires, subject to specified exceptions, that a health care service plan be licensed by the department and provide basic health care services, as defined, among other benefits, unless exempted from that requirement by the director of the department. Existing law also requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state and that the insurer operate in accordance with specified requirements.

This bill would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan contract or a health insurance policy in this state without holding a license issued by the department or a certificate of authority issued by the commissioner. The bill would exempt the carrier's plan contract or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state if the plan contract or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan contract or policy in that state and to transact business there.

The bill would also authorize health care service plans and health insurers to offer, market, and sell individual health care service plan contracts and individual health insurance policies that do not include all of the benefits mandated under state law to individuals with income below 350% of the federal poverty level if the individual waives those benefits, as specified, and the plan contract or insurance policy is approved by the Director of the Department of Managed Health Care or the Insurance Commissioner.

(2) Under existing law, health care service plans and health insurers are required to include certain benefits in their contracts and policies. Existing federal law authorizes an individual who has a high deductible health plan to make tax deductible contributions to a Health Savings Account that may be used to pay medical expenses.

This bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to encourage the design of health care service plan contracts and health insurance policies that conform to current federal requirements for high deductible health plans used in conjunction with Health Savings Accounts and to standardize the process used to review and approve new health care service plan

contracts and health insurance policies. The bill would require the director and the commissioner to report specified information to the Legislature regarding those requirements.

The bill would also authorize group health care service plan contracts and group health insurance policies to offer to include a Healthy Action Incentives and Rewards Program, as specified.

(3) Existing law imposes certain requirements on health care service plans and health insurers to enable small employers to access health care coverage. Existing law requires health care service plans and health insurers to sell to any small employer any of the benefit plan designs it offers to small employers and prohibits plans and insurers, among others, from encouraging or directing small employers to refrain from filing an application for coverage with the plan or insurer, and from encouraging or directing small employers to seek coverage from another carrier, because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

This bill would also prohibit a plan or insurer from taking either of those actions because of the employer's implementation of, or intent to implement, any form of claim support for covered employees, as specified.

Existing law defines "small employer" for these purposes to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard.

This bill would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill would reduce the required number of persons covered by health coverage provided through the guaranteed association from 1,000 to 100. The bill would also define "small employer" to include an eligible association that purchases health care coverage for its members and would define an eligible association as a community or civic group or a charitable or religious organization.

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

(4) Existing law requires health care service plans and specified disability insurers to have written policies and procedures establishing the process by which the plans or insurers prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers of health care services for enrollees or insureds. Existing law imposes specified requirements on that process and specifies that only a licensed physician or licensed health care professional with specified competency may deny or modify requests for authorization of health care services.

This bill would authorize a licensed health care professional, other than a person licensed to practice medicine, to deny or modify requests only with respect to services that fall within his or her scope of practice and subject to standardized protocol limitations or supervision requirements applicable under his or her license. The bill would also prohibit a physician or other health care professional from denying or modifying a request without first conducting a good faith examination of the enrollee, except as specified.

Existing law establishes an independent medical review system in which an independent medical review organization reviews grievances involving a disputed health care service under a health care service plan contract or disability insurance policy. Existing law requires that medical professionals selected by that organization to conduct reviews be either physicians holding a specified certification or other appropriate providers holding a nonrestricted license in any state.

This bill would require those physicians and other providers to be licensed in California and would limit the reviews conducted by those other providers, as specified.

Existing law requires the medical reviewers selected to conduct a review to review specified information, including, but not limited to, provider reports and all pertinent medical records of the enrollee or insured.

This bill would also require that at least one of those medical professional reviewers conduct a good faith examination of the enrollee, except as specified.

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

(5) Existing law provides for insurers to be admitted to transact business in specified types of insurance, including workers' compensation insurance.

This bill would allow any insurer admitted to transact health insurance or workers' compensation insurance, or a health care service plan licensed pursuant to the Knox-Keene Act, to make written application to the commissioner for a license to offer a single policy that provides health care coverage and workers' compensation benefits.

(6) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive various health care services and benefits. Existing law prescribes various requirements governing reimbursement rates for these services.

This bill would require, on January 1, 2010, the reimbursement levels for fee-for-service physician services under Medi-Cal to be increased to 80% of the amount that the federal Medicare Program reimburses for these same services in Area 9 (Santa Clara County), and would thereafter require the rates to be increased annually in accordance with the California Consumer Price Index.

The bill would require the department, before making any adjustment to Medi-Cal reimbursement rates, to consider the ability of Medi-Cal beneficiaries to access physician services by geography and specialty and to request data from the Office of Statewide Health Planning and Development to allow the department to determine the extent of Medi-Cal physician shortages, if any, by geography and specialty.

The bill would require the department to ensure the existence and operation of a single searchable Internet Web site, accessible by the public at no cost, that specifies Medi-Cal expenditures, including a line item breakdown of administrative overhead and provider and health care expenses.

The bill would require the department to prepare and submit a proposal for a demonstration project by July 31, 2010, for participation in the federal Medicaid Demonstration Project for Health Opportunity Accounts and would specify the details of that demonstration project.

The bill would also require the department, on or before January 1, 2011, to provide or arrange for the provision of an electronic personal health record and an electronic personal benefits record for beneficiaries of the Medi-Cal program. The bill would additionally authorize the department to establish a Healthy Action Incentives and Rewards

Program as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval.

The bill would state the intent of the Legislature to enact legislation that would realign Medi-Cal benefits to more closely resemble benefits offered through private health care coverage.

The bill would also state the intent of the Legislature to enact legislation that would establish a pilot project that utilizes a self-directed “cash and counseling” model for providing Medi-Cal services to disabled Medi-Cal enrollees. Under a “cash and counseling” model, disabled Medi-Cal enrollees, with assistance from family members and Medi-Cal case managers, would be given an individual budget to manage and direct payment for their personal care services and enable them to determine which supportive services they want and from whom they wish to have these services delivered.

Under existing law, the Director of Health Care Services may contract with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries subject to specified requirements.

This bill would state the intent of the Legislature to enact legislation that would establish a pilot project in which Medi-Cal managed care is used as a platform to transition from a defined-benefit system, where the state pays for services used based on a defined set of benefits, to a defined-contribution system, where Medi-Cal enrollees would be assigned a risk-adjusted amount to purchase private health care coverage.

Existing law requires an applicant that is not currently enrolled as a provider in the Medi-Cal program, a provider required to apply for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide Medi-Cal goods or services to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location, except as specified. Existing law requires the department to provide, within 30 days of receipt, written notice that the application package has been received, except as specified. Applicants or providers that meet certain criteria may be granted preferred provisional provider status for up to 18 months.

This bill would, notwithstanding any other provision of law, additionally provide that, on and after January 1, 2010, certain licensed health care providers submitting an application to the department pursuant to the above provisions shall be granted preferred provisional provider status, effective from the date the department received their

application, if the applicant is in good standing as a provider under the federal Medicare Program and with his or her state licensing board.

This bill would require the department to provide written notice to the applicant that the application package has been received within 15 days after receiving the application. The bill would require the department to provide successful applicants with written notice of their preferred provisional provider status within 30 days after receiving the application.

Existing law establishes, within the office of the Attorney General, the Bureau of Medi-Cal Fraud for the investigation and prosecution of violations of applicable laws pertaining to the Medi-Cal program, and to review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the Medi-Cal program.

This bill would require the State Department of Health Care Services to establish a computer modeling program to be used to prevent and identify Medi-Cal fraud. The bill would require the computer modeling program to alert the department when providers engage in specified billing behavior. The bill would require the department, upon receiving the alert, to conduct a Medi-Cal fraud investigation if the department determines an investigation is appropriate under the circumstances.

Existing law, administered by the State Department of Public Health, provides for the licensure and regulation of various clinics, including primary care clinics, as defined.

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act that revises hospital reimbursement methodologies in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals.

This bill would require the Director of Health Care Services to provide to the Legislature, no later than July 1, 2010, a plan to permit these funds to be used for the purpose of creating new, and expanding existing, primary care clinics.

Under existing law, one of the utilization controls to which services are subject under the Medi-Cal program is the treatment authorization request process, which is approval by a department consultant of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Other utilization controls include postservice prepayment audits and postservice postpayment audits, that involve reviews for medical necessity and program coverage.

This bill would, instead, provide that treatment authorization requests shall be approved based upon a determination that the service is covered under Medi-Cal. The bill would also provide that postservice prepayment audits and postservice postpayment audits shall only involve reviews for program coverage.

(7) Existing law allows the Controller, in his or her discretion, to offset any amount due to a state agency by a person or entity against any amount owed to that person or entity by a state agency.

Existing law requires the Controller, to the extent feasible, to offset any amount overdue and unpaid for a fine, penalty, assessment, bail, vehicle parking penalty, or court-ordered reimbursement for court-related services, from a person or entity, against any amount owed to the person or entity by a state agency on a claim for a refund from the Franchise Tax Board under the Personal Income Tax Law or the Bank and Corporation Tax Law or from winnings in the California State Lottery.

This bill would permit a hospital or health care provider, as defined, that provides health care services to an uninsured individual who does not qualify for government health care benefits to file a claim with the State Department of Health Care Services to be reimbursed for those services if the recipient of the services does not pay for those services. The bill would require the Director of Health Care Services to certify the debt owed to the hospital or health care provider to the Franchise Tax Board and the California Lottery Commission in order to have the debt satisfied with any tax refund or lottery winnings owed to the debtor, as specified.

(8) Under the Public Employees' Medical and Hospital Care Act, the Board of Administration of the Public Employees' Retirement System contracts for and administers health care benefit plans for public employees and annuitants. Existing state and federal income tax laws allow a deduction for contributions to a qualifying medical savings account by a taxpayer who is covered under a high deductible health plan, as defined. Money within this type of account may be used to pay for qualified medical expenses, as defined.

This bill would require the board to offer a high deductible health plan, as defined in the federal tax law, and a Health Savings Account option to public employees and annuitants, as specified. The bill would establish the Public Employees' Health Savings Fund, a continuously appropriated trust fund within the State Treasury, for payment of qualified medical expenses of eligible employees and annuitants who

elect to enroll in the high deductible health plan and participate in the Health Savings Account option, and would require those employees and annuitants, and their employers, to make specified contributions to that fund, thereby making an appropriation.

The bill would also require the board, on or before January 1, 2011, to provide or arrange for the provision of an electronic personal health record and an electronic personal benefits record for enrollees receiving health care benefits. The bill would additionally authorize the board to provide a Healthy Action Incentives and Rewards Program to its enrollees, as specified.

(9) The Personal Income Tax Law and the Corporation Tax Law authorize various credits against the taxes imposed by those laws.

This bill would authorize a credit against those taxes for each taxable year beginning on or after January 1, 2010, and before January 1, 2015, in an amount equal to the amount paid or incurred during the taxable year for qualified health expenses, as defined, that do not exceed specified amounts.

This bill would authorize a credit against personal income taxes for each taxable year beginning on or after January 1, 2009, in an amount equal to 25% of the tax imposed on a medical care professional who provides medical services in a rural area. The bill would also authorize a credit against personal income taxes, as specified, for a primary care provider, as defined, and for uncompensated medical care provided by a physician.

This bill would authorize a credit under the Personal Income Tax Law and the Corporation Tax Law for each taxable year beginning on or after January 1, 2009, and before January 1, 2015, in an amount equal to 15% of the amount paid or incurred by a qualified taxpayer, as defined, during the taxable year for qualified health insurance, as defined, for employees of the taxpayer. This bill would require the Legislative Analyst to report to the Legislature on or before March 1, 2014, on the effectiveness of the credit, as specified.

The Personal Income Tax Law authorizes various deductions in computing income subject to taxation.

This bill would allow a deduction in computing adjusted gross income for the costs of health insurance, as provided. This bill would also allow a deduction in connection with Health Savings Accounts in conformity with federal law. In general, the deduction would be an amount equal to the aggregate amount paid in cash during the taxable year by, or on behalf of, an eligible individual, as defined, to a Health Savings Account

of that individual, as provided. This bill would also provide related conformity to that federal law with respect to treatment of the account as a tax-exempt trust, the allowance of rollovers from Archer Medical Savings Accounts to a Health Savings Account, and penalties in connection therewith.

(10) Existing law, with certain exceptions, establishes 8 hours as a day's work and a 40-hour workweek, and requires payment of prescribed overtime compensation for additional hours worked. Existing law authorizes the adoption by $\frac{2}{3}$ of employees in a work unit of alternative workweek schedules providing for workdays no longer than 10 hours within a 40-hour workweek.

This bill would authorize an individual employee employed by an employer with 50 or fewer employees that offers health care coverage benefits to its employees to request a work schedule of up to 10 hours per day within a 40-hour workweek, and would authorize an employer to implement this schedule without any obligation to pay overtime compensation for hours worked as part of the schedule. The bill would enact related provisions and would make other conforming and technical changes.

The bill would also authorize an employer to provide health coverage that includes a Healthy Action Incentives and Rewards Program to his or her employees. In addition, the bill would state the intent of the Legislature to enact legislation providing incentives to employers who offer health insurance, flex-time work schedules, and other benefits agreed upon by employers and employees.

(11) Existing law defines the term "medical assistant" and sets forth the scope of services a medical assistant is authorized to perform. Existing law provides that a medical assistant may administer medication upon the specific authorization and supervision of a licensed physician and surgeon or licensed podiatrist or, in specified clinic settings, upon the specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant.

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

(12) Existing law provides for the licensure and regulation by the Commissioner of Financial Institutions of money transmitters, who receive money in this state for transmission to foreign countries, and makes a violation of these provisions a crime.

This bill would require a licensee, or its agent, to collect a 3% fee on any money transmission received from a client who is unable to provide documentation of lawful presence in the United States. The bill would require the deposit of the fee in an unspecified fund to be used to pay for emergency medical care provided in this state to persons without documentation of legal residence in the United States.

Because a violation of this requirement would be a crime, the bill would impose a state-mandated local program.

In addition, the bill would memorialize the Congress and President of the United States to enact legislation that would provide full reimbursement for the costs of providing federally mandated health care services to anyone, regardless of immigration status.

(13) Existing law regulates the establishment and operation of hospitals, including emergency rooms.

This bill would state the intent of the Legislature to enact legislation that would allow hospitals to offer preventative medical services delivered through the hospital’s primary care or community-based clinic.

(14) The bill would enact other related provisions and make various technical, nonsubstantive changes.

(15) This bill would result in a change in state taxes for the purpose of increasing state revenues within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $\frac{2}{3}$ of the membership of each house of the Legislature.

(16) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

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

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. Section 2069 of the Business and Professions
2 Code is amended to read:
3 2069. (a) (1) Notwithstanding any other provision of law, a
4 medical assistant may administer medication only by intradermal,
5 subcutaneous, or intramuscular injections and perform skin tests
6 and additional technical supportive services upon the specific

1 authorization and supervision of a licensed physician and surgeon,
2 *nurse practitioner, nurse-midwife, physician assistant, or a licensed*
3 *podiatrist. A medical assistant may also perform all these tasks*
4 *and services in a clinic licensed pursuant to subdivision (a) of*
5 *Section 1204 of the Health and Safety Code upon the specific*
6 *authorization of a physician assistant, a nurse practitioner, or a*
7 *nurse-midwife.*

8 (2) ~~The supervising licensed physician and surgeon at a clinic~~
9 ~~described in paragraph (1) may, at his or her discretion, in~~
10 ~~consultation with the nurse practitioner, nurse-midwife, or~~
11 ~~physician assistant, provide written instructions to be followed by~~
12 ~~a medical assistant in the performance of tasks or supportive~~
13 ~~services. These written instructions may provide that the~~
14 ~~supervisory function for the medical assistant for these tasks or~~
15 ~~supportive services may be delegated to the nurse practitioner,~~
16 ~~nurse-midwife, or physician assistant within the standardized~~
17 ~~procedures or protocol, and that tasks may be performed when the~~
18 ~~supervising licensed physician and surgeon is not onsite, so long~~
19 ~~as the following apply:~~

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

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

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

31 (1) “Medical assistant” means a person who may be unlicensed,
32 who performs basic administrative, clerical, and technical
33 supportive services in compliance with this section and Section
34 2070 for a licensed physician and surgeon or a licensed podiatrist,
35 or group thereof, for a medical, *nursing*, or podiatry corporation,
36 for a physician assistant, a nurse practitioner, or a nurse-midwife
37 as provided in subdivision (a), or for a health care service plan,
38 who is at least 18 years of age, and who has had at least the
39 minimum amount of hours of appropriate training pursuant to
40 standards established by the Division of Licensing. The medical

1 assistant shall be issued a certificate by the training institution or
2 instructor indicating satisfactory completion of the required
3 training. A copy of the certificate shall be retained as a record by
4 each employer of the medical assistant.

5 (2) “Specific authorization” means a specific written order
6 prepared by the ~~supervising~~ *licensed* physician and surgeon ~~or the~~
7 ~~supervising, licensed~~ podiatrist, ~~or the~~ physician assistant, the nurse
8 practitioner, or the nurse-midwife ~~as provided in subdivision (a)~~;
9 authorizing the procedures to be performed on a patient, which
10 shall be placed in the patient’s medical record, or a standing order
11 prepared by the ~~supervising~~ *licensed* physician and surgeon ~~or the~~
12 ~~supervising, licensed~~ podiatrist, ~~or the~~ physician assistant, the nurse
13 practitioner, or the nurse-midwife ~~as provided in subdivision (a)~~,
14 authorizing the procedures to be performed, the duration of which
15 shall be consistent with accepted medical practice. A notation of
16 the standing order shall be placed on the patient’s medical record.

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

22 (A) A licensed physician and surgeon.

23 (B) A licensed podiatrist.

24 (C) A physician assistant, nurse practitioner, or nurse-midwife
25 ~~as provided in subdivision (a)~~.

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 ~~or~~, a licensed
30 podiatrist, ~~or~~ a physician assistant, a nurse practitioner, or a
31 nurse-midwife ~~as provided in subdivision (a)~~.

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 ~~1206.5~~ 1200). Nothing in this section
7 shall be construed as authorizing a nurse practitioner,
8 nurse-midwife, or physician assistant to be a laboratory director
9 of a clinical laboratory, as those terms are defined in paragraph
10 (7) of subdivision (a) of Section 1206 and subdivision (a) of
11 Section 1209.

12 SEC. 2. Section 1815.5 is added to the Financial Code, to read:

13 1815.5. A licensee, or its agent, shall collect a 3 percent fee
14 on transmission money received from a customer who is unable
15 to provide documentation of lawful presence in the United States.
16 This fee shall be deposited in the ____ Fund, which is hereby
17 established in the State Treasury, to be used to pay for emergency
18 medical care provided in this state to persons without
19 documentation of legal residence in the United States. The fee
20 imposed pursuant to this subdivision shall be in addition to any
21 other applicable fees.

22 SEC. 3. Section 22830.5 is added to the Government Code, to
23 read:

24 22830.5. (a) On or before January 1, 2011, the board shall
25 provide or arrange for the provision of an electronic personal health
26 record (PHR) and an electronic personal benefits record (PBR) for
27 enrollees receiving health care benefits. The records shall be
28 provided for the purpose of providing enrollees with information
29 to assist them in understanding their coverage benefits and
30 managing their health care.

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

36 (c) The PHR shall incorporate personal health information,
37 including, but not limited to, medical history, laboratory results,
38 prescription history, and other personal health information
39 authorized or provided by the enrollee. The PHR shall not be

1 provided through the use of an Internet-based system. Inclusion
2 of this additional data shall be at the option of the enrollee.

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

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

9 SEC. 4. Section 22830.6 is added to the Government Code, to
10 read:

11 22830.6. The board may provide or arrange for the provision
12 of a Healthy Action Incentives and Rewards Program, as described
13 in subdivision (b) of Section 1367.38 of the Health and Safety
14 Code, to all enrollees.

15 SEC. 5. Section 22869.5 is added to the Government Code, to
16 read:

17 22869.5. (a) The board shall offer a Health Savings Account
18 option to all employees and annuitants. In addition to the basic
19 health benefit plans described in Sections 22830 and 22850, and
20 notwithstanding any other provision of this part, the board shall
21 approve at least one high deductible health plan, as defined in
22 Section 223(c)(2) of the Internal Revenue Code.

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

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

35 (2) The employee or annuitant shall also designate an additional
36 amount to be deducted from his or her salary or retirement
37 allowance for qualified medical expenses. The amount shall be no
38 less than fifty dollars (\$50) per month. The amount shall be
39 deposited into the Public Employees' Health Savings Fund and

1 shall be credited to a nominal, interest-bearing account in the name
2 of the employee or annuitant.

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

6 (d) (1) The employer of an employee or annuitant who elects
7 to participate in the Health Savings Account option shall contribute
8 a portion, pursuant to Article 7 (commencing with Section 22870)
9 or Article 8 (commencing with Section 22890), of the cost of
10 providing the benefit coverage under the high deductible health
11 plan.

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

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

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

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

32 SEC. 6. Section 22917 is added to the Government Code, to
33 read:

34 22917. (a) There is in the State Treasury a Public Employees’
35 Health Savings Fund, the purpose of which is to pay the qualified
36 medical expenses of holders of Health Savings Accounts pursuant
37 to Section 22869.5 and pursuant to Section 223 of the Internal
38 Revenue Code. The board shall have the exclusive control of the
39 administration and investment of the fund.

1 (b) The Public Employees' Health Savings Fund shall consist
2 of moneys deducted from the salary or retirement allowance of an
3 employee or annuitant, and moneys contributed by the employee's
4 or annuitant's employer, for qualified medical expenses pursuant
5 to Section 22869.5. Those moneys shall earn interest income.

6 (c) The board may invest funds in the Public Employees' Health
7 Savings Fund pursuant to the law governing its investment of the
8 retirement fund, subject to the limitations contained in Section 223
9 of the Internal Revenue Code. Income, of whatever nature, earned
10 on the fund during any fiscal year shall be credited to the fund.

11 (d) Notwithstanding Section 13340, the Public Employees'
12 Health Savings Fund is continuously appropriated, without regard
13 to fiscal years, to reimburse qualified medical expenses of holders
14 of Health Savings Accounts.

15 (e) The Legislature finds and declares that the Public
16 Employees' Health Savings Fund is a trust fund held for the
17 exclusive benefit of employees and annuitants who elect the Health
18 Savings Account option pursuant to Section 22869.5.

19 SEC. 7. Section 1346.2 is added to the Health and Safety Code,
20 to read:

21 1346.2. (a) The director shall encourage the design of health
22 care service plan contracts that conform to current requirements
23 under federal law for a high deductible health plan used in
24 conjunction with a Health Savings Account.

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

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

38 (2) The director shall also report to the chair and to the vice
39 chairs of the committees listed in paragraph (1) prior to December
40 31, 2011, on the increase in the number of persons enrolled in a

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

3 SEC. 8. Section 1349.3 is added to the Health and Safety Code,
4 to read:

5 1349.3. (a) Notwithstanding any other provision of law, a
6 carrier domiciled in another state is exempt from Section 1349, if
7 it meets the following criteria:

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

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

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

17 SEC. 9. Section 1357 of the Health and Safety Code is amended
18 to read:

19 1357. As used in this article:

20 (a) “Dependent” means the spouse or child of an eligible
21 employee, subject to applicable terms of the health care plan
22 contract covering the employee, and includes dependents of
23 guaranteed association members *and dependents of eligible*
24 *association members* if the association elects to include dependents
25 under its health coverage at the same time it determines its
26 membership composition pursuant to subdivision (o).

27 (b) “Eligible employee” means either of the following:

28 (1) Any permanent employee who is actively engaged on a
29 full-time basis in the conduct of the business of the small employer
30 with a normal workweek of at least 30 hours, at the small
31 employer’s regular places of business, who has met any statutorily
32 authorized applicable waiting period requirements. The term
33 includes sole proprietors or partners of a partnership, if they are
34 actively engaged on a full-time basis in the small employer’s
35 business and included as employees under a health care plan
36 contract of a small employer, but does not include employees who
37 work on a part-time, temporary, or substitute basis. It includes any
38 eligible employee, as defined in this paragraph, who obtains
39 coverage through a guaranteed association *or an eligible*
40 *association*. Employees of employers purchasing through a

1 guaranteed association *or an eligible association* shall be deemed
2 to be eligible employees if they would otherwise meet the definition
3 except for the number of persons employed by the employer.
4 Permanent employees who work at least 20 hours but not more
5 than 29 hours are deemed to be eligible employees if all four of
6 the following apply:

7 (A) They otherwise meet the definition of an eligible employee
8 except for the number of hours worked.

9 (B) The employer offers the employees health coverage under
10 a health benefit plan.

11 (C) All similarly situated individuals are offered coverage under
12 the health benefit plan.

13 (D) The employee must have worked at least 20 hours per
14 normal workweek for at least 50 percent of the weeks in the
15 previous calendar quarter. The health care service plan may request
16 any necessary information to document the hours and time period
17 in question, including, but not limited to, payroll records and
18 employee wage and tax filings.

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

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

23 (d) “Late enrollee” means an eligible employee or dependent
24 who has declined enrollment in a health benefit plan offered by a
25 small employer at the time of the initial enrollment period provided
26 under the terms of the health benefit plan and who subsequently
27 requests enrollment in a health benefit plan of that small employer,
28 provided that the initial enrollment period shall be a period of at
29 least 30 days. It also means any member of an association that is
30 a guaranteed association *or an eligible association* as well as any
31 other person eligible to purchase through the guaranteed association
32 *or eligible association* when that person has failed to purchase
33 coverage during the initial enrollment period provided under the
34 terms of the guaranteed association’s *or eligible association’s* plan
35 contract and who subsequently requests enrollment in the plan,
36 provided that the initial enrollment period shall be a period of at
37 least 30 days. However, an eligible employee, any other person
38 eligible for coverage through a guaranteed association *or eligible*
39 *association* pursuant to subdivision (o), or an eligible dependent

1 shall not be considered a late enrollee if any of the following is
2 applicable:

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

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

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

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

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

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

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

34 (4) (A) In the case of an eligible employee, as defined in
35 paragraph (1) of subdivision (b), the plan cannot produce a written
36 statement from the employer stating that the individual or the
37 person through whom the individual was eligible to be covered as
38 a dependent, prior to declining coverage, was provided with, and
39 signed, acknowledgment of an explicit written notice in boldface
40 type specifying that failure to elect coverage during the initial

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

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

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

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

37 (6) The individual is a dependent of an enrolled eligible
38 employee who has lost or will lose his or her coverage under the
39 Healthy Families Program as a result of exceeding the program's
40 income or age limits or no share-of-cost Medi-Cal coverage and

1 requests enrollment within 30 days after notification of this loss
2 of coverage.

3 (7) The individual is an eligible employee who previously
4 declined coverage under an employer health benefit plan and who
5 has subsequently acquired a dependent who would be eligible for
6 coverage as a dependent of the employee through marriage, birth,
7 adoption, or placement for adoption, and who enrolls for coverage
8 under that employer health benefit plan on his or her behalf and
9 on behalf of his or her dependent within 30 days following the
10 date of marriage, birth, adoption, or placement for adoption, in
11 which case the effective date of coverage shall be the first day of
12 the month following the date the completed request for enrollment
13 is received in the case of marriage, or the date of birth, or the date
14 of adoption or placement for adoption, whichever applies. Notice
15 of the special enrollment rights contained in this paragraph shall
16 be provided by the employer to an employee at or before the time
17 the employee is offered an opportunity to enroll in plan coverage.

18 (8) The individual is an eligible employee who has declined
19 coverage for himself or herself or his or her dependents during a
20 previous enrollment period because his or her dependents were
21 covered by another employer health benefit plan at the time of the
22 previous enrollment period. That individual may enroll himself or
23 herself or his or her dependents for plan coverage during a special
24 open enrollment opportunity if his or her dependents have lost or
25 will lose coverage under that other employer health benefit plan.
26 The special open enrollment opportunity shall be requested by the
27 employee not more than 30 days after the date that the other health
28 coverage is exhausted or terminated. Upon enrollment, coverage
29 shall be effective not later than the first day of the first calendar
30 month beginning after the date the request for enrollment is
31 received. Notice of the special enrollment rights contained in this
32 paragraph shall be provided by the employer to an employee at or
33 before the time the employee is offered an opportunity to enroll
34 in plan coverage.

35 (e) “New business” means a health care service plan contract
36 issued to a small employer that is not the plan’s in force business.

37 (f) “Preexisting condition provision” means a contract provision
38 that excludes coverage for charges or expenses incurred during a
39 specified period following the employee’s effective date of
40 coverage, as to a condition for which medical advice, diagnosis,

1 care, or treatment was recommended or received during a specified
2 period immediately preceding the effective date of coverage.

3 (g) “Creditable coverage” means:

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

19 (2) The federal Medicare ~~program~~ *Program* pursuant to Title
20 XVIII of the Social Security Act.

21 (3) The ~~medicaid~~ *Medicaid* program pursuant to Title XIX of
22 the Social Security Act.

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

25 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
26 (Civilian Health and Medical Program of the Uniformed Services
27 (CHAMPUS)).

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

30 (7) A state health benefits risk pool.

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

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

38 (10) A health benefit plan under Section 5(e) of the Peace Corps
39 Act (22 U.S.C. Sec. 2504(e)).

1 (11) Any other creditable coverage as defined by subdivision
 2 (c) of Section 2701 of Title XXVII of the federal Public Health
 3 Services Act (42 U.S.C. Sec. 300gg(c)).

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

7 (i) “Risk adjusted employee risk rate” means the rate determined
 8 for an eligible employee of a small employer in a particular risk
 9 category after applying the risk adjustment factor.

10 (j) “Risk adjustment factor” means the percentage adjustment
 11 to be applied equally to each standard employee risk rate for a
 12 particular small employer, based upon any expected deviations
 13 from standard cost of services. This factor may not be more than
 14 120 percent or less than 80 percent until July 1, 1996. Effective
 15 July 1, 1996, this factor may not be more than 110 percent or less
 16 than 90 percent.

17 (k) “Risk category” means the following characteristics of an
 18 eligible employee: age, geographic region, and family composition
 19 of the employee, plus the health benefit plan selected by the small
 20 employer.

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

- 23 Under 30
- 24 30–39
- 25 40–49
- 26 50–54
- 27 55–59
- 28 60–64
- 29 65 and over

30 However, for the 65 and over age category, separate premium
 31 rates may be specified depending upon whether coverage under
 32 the plan contract will be primary or secondary to benefits provided
 33 by the federal Medicare ~~program~~ *Program* pursuant to Title XVIII
 34 of the federal Social Security Act.

35 (2) Small employer health care service plans shall base rates to
 36 small employers using no more than the following family size
 37 categories:

- 38 (A) Single.
- 39 (B) Married couple.
- 40 (C) One adult and child or children.

1 (D) Married couple and child or children.

2 (3) (A) In determining rates for small employers, a plan that
3 operates statewide shall use no more than nine geographic regions
4 in the state, have no region smaller than an area in which the first
5 three digits of all its ZIP Codes are in common within a county,
6 and divide no county into more than two regions. Plans shall be
7 deemed to be operating statewide if their coverage area includes
8 90 percent or more of the state's population. Geographic regions
9 established pursuant to this section shall, as a group, cover the
10 entire state, and the area encompassed in a geographic region shall
11 be separate and distinct from areas encompassed in other
12 geographic regions. Geographic regions may be noncontiguous.

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

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

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

36 (l) "Small employer" means ~~either~~ any of the following:

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

1 year, employed at least two, but no more than 50, eligible
2 employees, the majority of whom were employed within this state,
3 that was not formed primarily for purposes of buying health care
4 service plan contracts, and in which a bona fide employer-employee
5 relationship exists. In determining whether to apply the calendar
6 quarter or calendar year test, a health care service plan shall use
7 the test that ensures eligibility if only one test would establish
8 eligibility. However, for purposes of subdivisions (a), (b), and (c)
9 of Section 1357.03, the definition shall include employers with at
10 least three eligible employees until July 1, 1997, and two eligible
11 employees thereafter. In determining the number of eligible
12 employees, companies that are affiliated companies and that are
13 eligible to file a combined tax return for purposes of state taxation
14 shall be considered one employer. Subsequent to the issuance of
15 a health care service plan contract to a small employer pursuant
16 to this article, and for the purpose of determining eligibility, the
17 size of a small employer shall be determined annually. Except as
18 otherwise specifically provided in this article, provisions of this
19 article that apply to a small employer shall continue to apply until
20 the plan contract anniversary following the date the employer no
21 longer meets the requirements of this definition. It includes any
22 small employer as defined in this paragraph who purchases
23 coverage through a guaranteed association *or an eligible*
24 *association*, and any employer purchasing coverage for employees
25 through a guaranteed association *or an eligible association*.

26 (2) Any guaranteed association, as defined in subdivision (n),
27 that purchases health coverage for members of the association.

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

30 (m) “Standard employee risk rate” means the rate applicable to
31 an eligible employee in a particular risk category in a small
32 employer group.

33 (n) “Guaranteed association” means a nonprofit organization
34 comprised of a group of individuals or employers who associate
35 based solely on participation in a specified profession or industry,
36 accepting for membership any individual or employer meeting its
37 membership criteria, and that (1) includes one or more small
38 employers as defined in paragraph (1) of subdivision (l), (2) does
39 not condition membership directly or indirectly on the health or
40 claims history of any person, (3) uses membership dues solely for

1 and in consideration of the membership and membership benefits,
2 except that the amount of the dues shall not depend on whether
3 the member applies for or purchases insurance offered to the
4 association, (4) is organized and maintained in good faith for
5 purposes unrelated to insurance, (5) ~~has been in active existence~~
6 ~~on January 1, 1992, and for at least five years prior to that date,~~
7 ~~(6) has included health insurance as a membership benefit for at~~
8 ~~least five years prior to January 1, 1992, (7) has a constitution and~~
9 ~~bylaws, or other analogous governing documents that provide for~~
10 ~~election of the governing board of the association by its members,~~
11 ~~(8) (6) offers any plan contract that is purchased to all individual~~
12 ~~members and employer members in this state, (9) (7) includes any~~
13 ~~member choosing to enroll in the plan contracts offered to the~~
14 ~~association provided that the member has agreed to make the~~
15 ~~required premium payments, and (10) (8) covers at least 1,000 100~~
16 ~~persons with the health care service plan with which it contracts.~~
17 The requirement of 1,000 100 persons may be met if component
18 chapters of a statewide association contracting separately with the
19 same carrier cover at least 1,000 100 persons in the aggregate.

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

23 For purposes of this subdivision, ~~an association formed by a~~
24 ~~merger of two or more associations after January 1, 1992, and~~
25 ~~otherwise meeting the criteria of this subdivision shall be deemed~~
26 ~~to have been in active existence on January 1, 1992, if its~~
27 ~~predecessor organizations had been in active existence on January~~
28 ~~1, 1992, and for at least five years prior to that date and otherwise~~
29 ~~met the criteria of this subdivision.~~

30 (o) “Members of a guaranteed association” or “*members of an*
31 *eligible association*” means any individual or employer meeting
32 the association’s membership criteria if that person is a member
33 of the association and chooses to purchase health coverage through
34 the association. At the association’s discretion, it also may include
35 employees of association members, association staff, retired
36 members, retired employees of members, and surviving spouses
37 and dependents of deceased members. However, if an association
38 chooses to include these persons as members of the guaranteed
39 association *or members of the eligible association*, the association
40 shall make that election in advance of purchasing a plan contract.

1 Health care service plans may require an association to adhere to
2 the membership composition it selects for up to 12 months.

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

6 (q) “*Eligible association*” means a community or civic group
7 or a charitable or religious organization.

8 SEC. 10. Section 1357.03 of the Health and Safety Code is
9 amended to read:

10 1357.03. (a) ~~Upon the effective date of this article, a~~ A plan
11 shall fairly and affirmatively offer, market, and sell all of the plan’s
12 health care service plan contracts that are sold to small employers
13 or to associations that include small employers to all small
14 employers in each service area in which the plan provides or
15 arranges for the provision of health care services, *regardless of*
16 *the employer’s implementation of, or intent to implement, any form*
17 *of claim or benefit support to covered employees.* A plan
18 contracting to participate in the voluntary purchasing pool for small
19 employers provided for under Article 4 (commencing with Section
20 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code
21 shall be deemed in compliance with this requirement for a contract
22 offered through the voluntary purchasing pool established under
23 Article 4 (commencing with Section 10730) of Chapter 8 of Part
24 2 of Division 2 of the Insurance Code in those geographic regions
25 in which plans participate in the pool, if the contract is offered
26 exclusively through the pool. Each plan shall make available to
27 each small employer all small employer health care service plan
28 contracts that the plan offers and sells to small employers or to
29 associations that include small employers in this state, *regardless*
30 *of the employer’s implementation of, or intent to implement, any*
31 *form of claim or benefit support to covered employees.* No plan
32 or solicitor shall induce or otherwise encourage a small employer
33 to separate or otherwise exclude an eligible employee from a health
34 care service plan contract that is provided in connection with the
35 employee’s employment or membership in a guaranteed association
36 or an *eligible association*.

37 (b) Every plan shall file with the director the reasonable
38 employee participation requirements and employer contribution
39 requirements that will be applied in offering its plan contracts.
40 Participation requirements shall be applied uniformly among all

1 small employer groups, except that a plan may vary application
2 of minimum employee participation requirements by the size of
3 the small employer group and whether the employer contributes
4 100 percent of the eligible employee's premium. Employer
5 contribution requirements shall not vary by employer size. A health
6 care service plan shall not establish a participation requirement
7 that (1) requires a person who meets the definition of a dependent
8 in subdivision (a) of Section 1357 to enroll as a dependent if he
9 or she is otherwise eligible for coverage and wishes to enroll as
10 an eligible employee and (2) allows a plan to reject an otherwise
11 eligible small employer because of the number of persons that
12 waive coverage due to coverage through another employer.
13 Members of an association eligible for health coverage under
14 subdivision (o) of Section 1357, but not electing any health
15 coverage through the association, shall not be counted as eligible
16 employees for purposes of determining whether the guaranteed
17 association *or eligible association* meets a plan's reasonable
18 participation standards.

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

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

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

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

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

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

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

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

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

14 (2) Encourage or direct small employers to seek coverage from
15 another plan or the voluntary purchasing pool established under
16 Article 4 (commencing with Section 10730) of Chapter 8 of Part
17 2 of Division 2 of the Insurance Code because of ~~the~~ *either of the*
18 *following*:

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

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

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

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

36 (B) *The small employer's implementation of, or intent to*
37 *implement, any form of claim or benefit support for its covered*
38 *employees through a health reimbursement arrangement, a medical*
39 *expense reimbursement plan, a limited purpose flexible spending*
40 *account, or any other form of wraparound plan or payment for*

1 *any portion of claims that apply to the health plan deductible or*
2 *other benefits.*

3 (2) *This subdivision does not apply to a compensation*
4 *arrangement that provides compensation to a solicitor on the basis*
5 *of percentage of premium, provided that the percentage shall not*
6 *vary because of the ~~health status, claims experience, industry,~~*
7 *~~occupation, or geographic area of the small employer factors~~*
8 *described in subparagraph (A) or (B) of paragraph (1).*

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

14 (1) Health status.

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

16 (3) Claims experience.

17 (4) Receipt of health care.

18 (5) Medical history.

19 (6) Genetic information.

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

22 (8) Disability.

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

24 SEC. 11. Section 1357.06 of the Health and Safety Code is
25 amended to read:

26 1357.06. (a) Preexisting condition provisions of a plan contract
27 shall not exclude coverage for a period beyond six months
28 following the individual's effective date of coverage and may only
29 relate to conditions for which medical advice, diagnosis, care, or
30 treatment, including prescription drugs, was recommended or
31 received from a licensed health practitioner during the six months
32 immediately preceding the effective date of coverage.

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

38 (c) In determining whether a preexisting condition provision or
39 a waiting or affiliation period applies to any person, a plan shall
40 credit the time the person was covered under creditable coverage,

1 provided the person becomes eligible for coverage under the
2 succeeding plan contract within 62 days of termination of prior
3 coverage, exclusive of any waiting or affiliation period, and applies
4 for coverage with the succeeding plan contract within the applicable
5 enrollment period. A plan shall also credit any time an eligible
6 employee must wait before enrolling in the plan, including any
7 affiliation or employer-imposed waiting or affiliation period.
8 However, if a person's employment has ended, the availability of
9 health coverage offered through employment or sponsored by an
10 employer has terminated, or an employer's contribution toward
11 health coverage has terminated, a plan shall credit the time the
12 person was covered under creditable coverage if the person
13 becomes eligible for health coverage offered through employment
14 or sponsored by an employer within 180 days, exclusive of any
15 waiting or affiliation period, and applies for coverage under the
16 succeeding plan contract within the applicable enrollment period.

17 (d) In addition to the preexisting condition exclusions authorized
18 by subdivision (a) and the waiting or affiliation period authorized
19 by subdivision (b), health plans providing coverage to a guaranteed
20 association *or an eligible association* may impose on employers
21 or individuals purchasing coverage who would not be eligible for
22 guaranteed coverage if they were not purchasing through the
23 association a waiting or affiliation period, not to exceed 60 days,
24 before the coverage issued subject to this article shall become
25 effective. During the waiting or affiliation period, no premiums
26 shall be charged to the enrollee or the subscriber.

27 (e) An individual's period of creditable coverage shall be
28 certified pursuant to subdivision (e) of Section 2701 of Title XXVII
29 of the federal Public Health Services Act (~~42 Act~~ (42 U.S.C. Sec.
30 300gg(e)).

31 (f) A health care service plan issuing group coverage may not
32 impose a preexisting condition exclusion to any of the following:
33 (1) To a newborn individual, who, as of the last day of the
34 30-day period beginning with the date of birth, has applied for
35 coverage through the employer-sponsored plan.

36 (2) To a child who is adopted or placed for adoption before
37 attaining 18 years of age and who, as of the last day of the 30-day
38 period beginning with the date of adoption or placement for
39 adoption, is covered under creditable coverage and applies for
40 coverage through the employer-sponsored plan. This provision

1 shall not apply if, for 63 continuous days, the child is not covered
2 under any creditable coverage.

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

5 SEC. 12. Section 1357.14 of the Health and Safety Code is
6 amended to read:

7 1357.14. In connection with the offering for sale of any plan
8 contract to a small employer, each plan shall make a reasonable
9 disclosure, as part of its solicitation and sales materials, of the
10 following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (C) Notify the small employer that, ~~from July 1, 1993, to July~~
32 ~~1, 1996, actual rates may be 20 percent higher or lower than the~~
33 ~~sum of the standard employee risk rates, and from July 1, 1996,~~
34 ~~and thereafter, actual rates may be 10 percent higher or lower than~~
35 ~~the sum of the standard employee risk rates, depending on how~~
36 ~~the plan assesses the risk of the small employer’s group.~~

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

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

4 SEC. 13. Section 1367.01 of the Health and Safety Code is
5 amended to read:

6 1367.01. (a) A health care service plan and any entity with
7 which it contracts for services that include utilization review or
8 utilization management functions, that prospectively,
9 retrospectively, or concurrently reviews and approves, modifies,
10 delays, or denies, based in whole or in part on medical necessity,
11 requests by providers prior to, retrospectively, or concurrent with
12 the provision of health care services to enrollees, or that delegates
13 these functions to medical groups or independent practice
14 associations or to other contracting providers, shall comply with
15 this section.

16 (b) A health care service plan that is subject to this section shall
17 have written policies and procedures establishing the process by
18 which the plan prospectively, retrospectively, or concurrently
19 reviews and approves, modifies, delays, or denies, based in whole
20 or in part on medical necessity, requests by providers of health
21 care services for plan enrollees. These policies and procedures
22 shall ensure that decisions based on the medical necessity of
23 proposed health care services are consistent with criteria or
24 guidelines that are supported by clinical principles and processes.
25 These criteria and guidelines shall be developed pursuant to Section
26 1363.5. These policies and procedures, and a description of the
27 process by which the plan reviews and approves, modifies, delays,
28 or denies requests by providers prior to, retrospectively, or
29 concurrent with the provision of health care services to enrollees,
30 shall be filed with the director for review and approval, and shall
31 be disclosed by the plan to providers and enrollees upon request,
32 and by the plan to the public upon request.

33 (c) A health care service plan subject to this section, except a
34 plan that meets the requirements of Section 1351.2, shall employ
35 or designate a medical director who holds an unrestricted license
36 to practice medicine in this state issued pursuant to Section 2050
37 of the Business and Professions Code or pursuant to the
38 Osteopathic Act, or, if the plan is a specialized health care service
39 plan, a clinical director with California licensure in a clinical area
40 appropriate to the type of care provided by the specialized health

1 care service plan. The medical director or clinical director shall
2 ensure that the process by which the plan reviews and approves,
3 modifies, or denies, based in whole or in part on medical necessity,
4 requests by providers prior to, retrospectively, or concurrent with
5 the provision of health care services to enrollees, complies with
6 the requirements of this section.

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

11 (e) ~~(1) No individual, other than a licensed physician or a~~
12 ~~licensed health care professional who is competent to evaluate the~~
13 ~~specific clinical issues involved in the health care services~~
14 ~~requested by the provider~~ *person licensed to practice medicine*
15 *pursuant to Section 2050 of the Business and Professions Code*
16 *or pursuant to the Osteopathic Act, or a licensed health care*
17 *professional acting within the limitations of paragraph (2), may*
18 *deny or modify requests for authorization of health care services*
19 *for an enrollee for reasons of medical necessity.* ~~The~~

20 *(2) A licensed health care professional, other than a person*
21 *licensed to practice medicine pursuant to Section 2050 of the*
22 *Business and Professions Code or pursuant to the Osteopathic*
23 *Act, may deny or modify requests for authorization of health care*
24 *services for an enrollee for reasons of medical necessity only with*
25 *respect to services that fall within his or her scope of practice.*
26 *That professional's review shall also be subject to standardized*
27 *protocol limitations or supervision requirements applicable under*
28 *his or her license.*

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

36 *(4) The decision of the physician or other health care*
37 *professional described in this subdivision shall be communicated*
38 *to the provider and the enrollee pursuant to subdivision (h).*

39 (f) The criteria or guidelines used by the health care service
40 plan to determine whether to approve, modify, or deny requests

1 by providers prior to, retrospectively, or concurrent with, the
2 provision of health care services to enrollees shall be consistent
3 with clinical principles and processes. These criteria and guidelines
4 shall be developed pursuant to the requirements of Section 1363.5.

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

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

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

33 (2) When the enrollee's condition is such that the enrollee faces
34 an imminent and serious threat to his or her health, including, but
35 not limited to, the potential loss of life, limb, or other major bodily
36 function, or the normal timeframe for the decisionmaking process,
37 as described in paragraph (1), would be detrimental to the enrollee's
38 life or health or could jeopardize the enrollee's ability to regain
39 maximum function, decisions to approve, modify, or deny requests
40 by providers prior to, or concurrent with, the provision of health

1 care services to enrollees, shall be made in a timely fashion
2 appropriate for the nature of the enrollee's condition, not to exceed
3 72 hours after the plan's receipt of the information reasonably
4 necessary and requested by the plan to make the determination,
5 *including, but not limited to, information from the good faith*
6 *examination conducted pursuant to subdivision (e).* Nothing in
7 this section shall be construed to alter the requirements of
8 subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4,
9 the requirements of this division shall be applicable to all health
10 plans and other entities conducting utilization review or utilization
11 management.

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

26 (4) Communications regarding decisions to approve requests
27 by providers prior to, retrospectively, or concurrent with the
28 provision of health care services to enrollees shall specify the
29 specific health care service approved. Responses regarding
30 decisions to deny, delay, or modify health care services requested
31 by providers prior to, retrospectively, or concurrent with the
32 provision of health care services to enrollees shall be
33 communicated to the enrollee in writing, and to providers initially
34 by telephone or facsimile, except with regard to decisions rendered
35 retrospectively, and then in writing, and shall include a clear and
36 concise explanation of the reasons for the plan's decision, a
37 description of the criteria or guidelines used, and the clinical
38 reasons for the decisions regarding medical necessity. Any written
39 communication to a physician or other health care provider of a
40 denial, delay, or modification of a request shall include the name

1 and telephone number of the health care professional responsible
2 for the denial, delay, or modification. The telephone number
3 provided shall be a direct number or an extension, to allow the
4 physician or health care provider easily to contact the professional
5 responsible for the denial, delay, or modification. Responses shall
6 also include information as to how the enrollee may file a grievance
7 with the plan pursuant to Section 1368, and in the case of Medi-Cal
8 enrollees, shall explain how to request an administrative hearing
9 and aid paid pending under Sections 51014.1 and 51014.2 of Title
10 22 of the California Code of Regulations.

11 (5) If the health care service plan cannot make a decision to
12 approve, modify, or deny the request for authorization within the
13 timeframes specified in paragraph (1) or (2) because the plan is
14 not in receipt of all of the information reasonably necessary and
15 requested, *including, but not limited to, information from the good*
16 *faith examination conducted pursuant to subdivision (e)*, or because
17 the plan requires consultation by an expert reviewer, or because
18 the plan has asked that an additional examination or test be
19 performed upon the enrollee, provided the examination or test is
20 reasonable and consistent with good medical practice, the plan
21 shall, immediately upon the expiration of the timeframe specified
22 in paragraph (1) or (2) or as soon as the plan becomes aware that
23 it will not meet the timeframe, whichever occurs first, notify the
24 provider and the enrollee, in writing, that the plan cannot make a
25 decision to approve, modify, or deny the request for authorization
26 within the required timeframe, and specify the information
27 requested but not received, or the expert reviewer to be consulted,
28 or the additional examinations or tests required. The plan shall
29 also notify the provider and enrollee of the anticipated date on
30 which a decision may be rendered. Upon receipt of all information
31 reasonably necessary and requested by the plan, the plan shall
32 approve, modify, or deny the request for authorization within the
33 timeframes specified in paragraph (1) or (2), whichever applies.

34 (6) If the director determines that a health care service plan has
35 failed to meet any of the timeframes in this section, or has failed
36 to meet any other requirement of this section, the director may
37 assess, by order, administrative penalties for each failure. A
38 proceeding for the issuance of an order assessing administrative
39 penalties shall be subject to appropriate notice to, and an
40 opportunity for a hearing with regard to, the person affected, in

1 accordance with subdivision (a) of Section 1397. The
2 administrative penalties shall not be deemed an exclusive remedy
3 for the director. These penalties shall be paid to the Managed Care
4 Administrative Fines and Penalties Fund and shall be used for the
5 purposes specified in Section 1341.45.

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

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

20 (k) The director shall review a health care service plan's
21 compliance with this section as part of its periodic onsite medical
22 survey of each plan undertaken pursuant to Section 1380, and shall
23 include a discussion of compliance with this section as part of its
24 report issued pursuant to that section.

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

29 (m) Nothing in this section shall cause a health care service plan
30 to be defined as a health care provider for purposes of any provision
31 of law, including, but not limited to, Section 6146 of the Business
32 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
33 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
34 Code of Civil Procedure.

35 SEC. 14. Section 1367.38 is added to the Health and Safety
36 Code, to read:

37 1367.38. (a) Every health care service plan, except for a
38 Medicare supplement plan, that covers hospital, medical, or
39 surgical expenses on a group basis may offer to include a Healthy
40 Action Incentives and Rewards Program, as described in

1 subdivision (b), to be implemented in connection with a health
2 care service plan, under such terms and conditions as may be
3 agreed upon between the subscriber group and the health care
4 service plan. Every plan that offers a Healthy Action Incentive
5 and Rewards Program shall communicate the availability of the
6 program to all prospective group subscribers with whom it is
7 negotiating and to existing group subscribers upon renewal.

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

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

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

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

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

37 SEC. 15. Section 1374.32 of the Health and Safety Code is
38 amended to read:

39 1374.32. (a) ~~By January 1, 2001, the~~ *The* department shall
40 contract with one or more independent medical review

1 organizations in the state to conduct reviews for purposes of this
2 article. The independent medical review organizations shall be
3 independent of any health care service plan doing business in this
4 state. The director may establish additional requirements, including
5 conflict-of-interest standards, consistent with the purposes of this
6 article, that an organization shall be required to meet in order to
7 qualify for participation in the Independent Medical Review System
8 and to assist the department in carrying out its responsibilities.

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

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

18 (1) The plan.

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

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

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

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

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

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

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

1 member, director, officer, or employee of an independent medical
2 review organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (A) The medical professional shall be a clinician knowledgeable
28 in the treatment of the enrollee's medical condition, knowledgeable
29 about the proposed treatment, and familiar with guidelines and
30 protocols in the area of treatment under review. *Review by a*
31 *medical professional, other than a physician licensed to practice*
32 *medicine pursuant to Section 2050 of the Business and Professions*
33 *Code or pursuant to the Osteopathic Act, shall be limited to*
34 *services that fall within that professional's scope of practice and*
35 *shall be subject to standardized protocol limitations or supervision*
36 *requirements applicable under his or her license.*

37 (B) Notwithstanding any other provision of law, the medical
38 professional shall hold a nonrestricted *California* license ~~in any~~
39 ~~state of the United States~~, and for physicians, a current certification
40 ~~by a recognized American medical specialty board in the area or~~

1 ~~areas appropriate to the condition or treatment under review. The~~
2 ~~independent medical review organization shall give preference to~~
3 ~~the use of a physician licensed in California as the reviewer, except~~
4 ~~when training and experience with the issue under review~~
5 ~~reasonably requires the use of an out-of-state reviewer license to~~
6 ~~practice medicine pursuant to Section 2050 of the Business and~~
7 ~~Professions Code or pursuant to the Osteopathic Act.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

17 SEC. 16. Section 1374.33 of the Health and Safety Code is
18 amended to read:

19 1374.33. (a) Upon receipt of information and documents
20 related to a case, the medical professional reviewer or reviewers
21 selected to conduct the review by the independent medical review
22 organization shall promptly review all pertinent medical records
23 of the enrollee, provider reports, as well as any other information
24 submitted to the organization as authorized by the department or
25 requested from any of the parties to the dispute by the reviewers.
26 If reviewers request information from any of the parties, a copy
27 of the request and the response shall be provided to all of the
28 parties. The reviewer or reviewers shall also review relevant
29 information related to the criteria set forth in subdivision (b). *In*
30 *addition, at least one medical professional reviewer selected to*
31 *conduct the review shall conduct a good faith examination of the*
32 *enrollee. This good faith examination shall not be required if the*
33 *enrollee’s contract explicitly excludes coverage of the disputed*
34 *health care service.*

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

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

- 1 (2) Nationally recognized professional standards.
- 2 (3) Expert opinion.
- 3 (4) Generally accepted standards of medical practice.
- 4 (5) Treatments that are likely to provide a benefit to a patient
- 5 for conditions for which other treatments are not clinically
- 6 efficacious.

7 (c) The organization shall complete its review and make its
8 determination in writing, and in layperson's terms to the maximum
9 extent practicable, within 30 days of the receipt of the application
10 for review and supporting documentation, *including, but not limited*
11 *to, information from the good faith examination conducted*
12 *pursuant to subdivision (a)*, or within less time as prescribed by
13 the director. If the disputed health care service has not been
14 provided and the enrollee's provider or the department certifies in
15 writing that an imminent and serious threat to the health of the
16 enrollee may exist, including, but not limited to, serious pain, the
17 potential loss of life, limb, or major bodily function, or the
18 immediate and serious deterioration of the health of the enrollee,
19 the analyses and determinations of the reviewers shall be expedited
20 and rendered within three days of the receipt of the information,
21 *including, but not limited to, information from the good faith*
22 *examination conducted pursuant to subdivision (a)*. Subject to the
23 approval of the department, the deadlines for analyses and
24 determinations involving both regular and expedited reviews may
25 be extended by the director for up to three days in extraordinary
26 circumstances or for good cause.

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

38 (e) The independent medical review organization shall provide
39 the director, the plan, the enrollee, and the enrollee's provider with
40 the analyses and determinations of the medical professionals

1 reviewing the case, and a description of the qualifications of the
2 medical professionals. The independent medical review
3 organization shall keep the names of the reviewers confidential in
4 all communications with entities or individuals outside the
5 independent medical review organization, except in cases where
6 the reviewer is called to testify and in response to court orders. If
7 more than one medical professional reviewed the case and the
8 result was differing determinations, the independent medical review
9 organization shall provide each of the separate reviewer's analyses
10 and determinations.

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

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

23 SEC. 17. Section 1374.58 of the Health and Safety Code is
24 amended to read:

25 1374.58. (a) A group health care service plan that provides
26 hospital, medical, or surgical expense benefits shall provide equal
27 coverage to employers~~—or~~, guaranteed associations, *or eligible*
28 *associations*, as defined in Section 1357, for the registered domestic
29 partner of an employee or subscriber to the same extent, and subject
30 to the same terms and conditions, as provided to a spouse of the
31 employee or subscriber, and shall inform employers~~—and~~,
32 guaranteed associations, *and eligible associations* of this coverage.
33 A plan may not offer or provide coverage for a registered domestic
34 partner that is not equal to the coverage provided to the spouse of
35 an employee or subscriber.

36 (b) If an employer~~—or~~, guaranteed association, *or eligible*
37 *association* has purchased coverage for spouses and registered
38 domestic partners pursuant to subdivision (a), a health care service
39 plan that provides hospital, medical, or surgical expense benefits
40 for employees or subscribers and their spouses shall enroll, upon

1 application by the employer or group administrator, a registered
2 domestic partner of an employee or subscriber in accordance with
3 the terms and conditions of the group contract that apply generally
4 to all spouses under the plan, including coordination of benefits.

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

8 (d) (1) A health care service plan may require that the employee
9 or subscriber verify the status of the domestic partnership by
10 providing to the plan a copy of a valid Declaration of Domestic
11 Partnership filed with the Secretary of State pursuant to Section
12 298 of the Family Code or an equivalent document issued by a
13 local agency of this state, another state, or a local agency of another
14 state under which the partnership was created. The plan may also
15 require that the employee or subscriber notify the plan upon the
16 termination of the domestic partnership.

17 (2) Notwithstanding paragraph (1), a health care service plan
18 may require the information described in that paragraph only if it
19 also requests from the employee or subscriber whose spouse is
20 provided coverage, verification of marital status and notification
21 of dissolution of the marriage.

22 (e) Nothing in this section shall be construed to expand the
23 requirements of Section 4980B of Title 26 of the United States
24 Code, Section 1161, and following, of Title 29 of the United States
25 Code, or Section 300bb-1, and following, of Title 42 of the United
26 States Code, as added by the Consolidated Omnibus Budget
27 Reconciliation Act of 1985 (Public Law 99-272), and as those
28 provisions may be later amended.

29 (f) A plan subject to this section that is issued, amended,
30 delivered, or renewed in this state on or after January 2, 2005, shall
31 be deemed to provide coverage for registered domestic partners
32 that is equal to the coverage provided to a spouse of an employee
33 or subscriber.

34 SEC. 18. Article 12 (commencing with Section 1399.830) is
35 added to Chapter 2.2 of Division 2 of the Health and Safety Code,
36 to read:

1 Article 12. Mandate-Free Individual Coverage

2
3 1399.830. (a) Notwithstanding any other provision of this
4 chapter, on and after January 1, 2011, a health care service plan
5 may offer, market, and sell an individual health care service plan
6 contract that does not include all of the health benefits mandated
7 under this chapter to an individual if all of the following
8 requirements are met:

9 (1) The individual has an income below 350 percent of the
10 federal poverty level.

11 (2) The individual waives the benefits pursuant to subdivision
12 (c).

13 (3) The plan contract is approved by the director.

14 (b) The director, in consultation with the Insurance
15 Commissioner, shall prepare a disclosure form prior to July 1,
16 2010, that is easily understood and that summarizes the benefits
17 a health care service plan is required to include in its health care
18 service plan contract under this chapter.

19 (c) Before a health care service plan contract described in
20 subdivision (a) may be issued, the individual shall sign the
21 disclosure form described in subdivision (b), specifying the benefits
22 he or she is waiving and indicating that the plan has explained the
23 contents of the disclosure and that he or she understands those
24 contents.

25 SEC. 19. Section 699.6 is added to the Insurance Code, to read:

26 699.6. (a) Notwithstanding any other provision of law, a carrier
27 domiciled in another state is exempt from Section 700, if it meets
28 the following criteria:

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

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

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

38 SEC. 20. Section 10121.7 of the Insurance Code is amended
39 to read:

1 10121.7. (a) A policy of group health insurance that provides
2 hospital, medical, or surgical expense benefits shall provide equal
3 coverage to employers~~or~~, guaranteed associations, *or eligible*
4 *associations*, as defined in Section 10700, for the registered
5 domestic partner of an employee, insured, or policyholder to the
6 same extent, and subject to the same terms and conditions, as
7 provided to a spouse of the employee, insured, or policyholder,
8 and shall inform employers~~and~~, guaranteed associations, *and*
9 *eligible associations* of this coverage. A policy may not offer or
10 provide coverage for a registered domestic partner that is not equal
11 to the coverage provided to the spouse of an employee, insured,
12 or policyholder.

13 (b) If an employer~~or~~, guaranteed association, *or eligible*
14 *association* has purchased coverage for spouses and registered
15 domestic partners pursuant to subdivision (a), a health insurer that
16 provides hospital, medical, or surgical expense benefits for
17 employees, insureds, or policyholders and their spouses shall enroll,
18 upon application by the employer or group administrator, a
19 registered domestic partner of the employee, insured, or
20 policyholder in accordance with the terms and conditions of the
21 group contract that apply generally to all spouses under the policy,
22 including coordination of benefits.

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

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

36 (2) Notwithstanding paragraph (1), a policy may require the
37 information described in that paragraph only if it also requests
38 from the employee, insured, or policyholder whose spouse is
39 provided coverage, verification of marital status and notification
40 of dissolution of the marriage.

1 (e) Nothing in this section shall be construed to expand the
2 requirements of Section 4980B of Title 26 of the United States
3 Code, Section 1161, and following, of Title 29 of the United States
4 Code, or Section 300bb-1, and following, of Title 42 of the United
5 States Code, as added by the Consolidated Omnibus Budget
6 Reconciliation Act of 1985 (Public Law 99-272), and as those
7 provisions may be later amended.

8 (f) A group health insurance policy subject to this section that
9 is issued, amended, delivered, or renewed in this state on or after
10 January 2, 2005, shall be deemed to provide coverage for registered
11 domestic partners that is equal to the coverage provided to a spouse
12 of an employee, insured, or policyholder.

13 SEC. 21. Section 10123.56 is added to the Insurance Code, to
14 read:

15 10123.56. (a) Every policy of health insurance, except for a
16 Medicare supplement policy, that covers hospital, medical, or
17 surgical expenses on a group basis may offer to include a Healthy
18 Action Incentives and Rewards Program, as described in
19 subdivision (b), to be implemented in connection with a health
20 insurance policy, under such terms and conditions as may be agreed
21 upon between the group policyholder and the health insurer. Every
22 insurer that offers a Healthy Action Incentives and Rewards
23 Program shall communicate the availability of that program to all
24 prospective group policyholders with whom it is negotiating and
25 to existing group policyholders upon renewal.

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

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

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

39 (3) Incentives or rewards for policyholders to become more
40 engaged in their health care and to make appropriate choices that

1 support good health, including obtaining health risk appraisals,
2 screening services, immunizations, or participating in healthy
3 lifestyle programs and practices. These programs and practices
4 may include, but need not be limited to, smoking cessation,
5 physical activity, or nutrition. Incentives may include, but need
6 not be limited to, health premium reductions, differential
7 copayment or coinsurance amounts, and cash payments. Rewards
8 may include, but need not be limited to, nonprescription pharmacy
9 products or services not otherwise covered under a policyholder's
10 health insurance policy, exercise classes, gym memberships, and
11 weight management programs.

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

16 SEC. 22. Section 10123.135 of the Insurance Code is amended
17 to read:

18 10123.135. (a) Every disability insurer, or an entity with which
19 it contracts for services that include utilization review or utilization
20 management functions, that covers hospital, medical, or surgical
21 expenses and that prospectively, retrospectively, or concurrently
22 reviews and approves, modifies, delays, or denies, based in whole
23 or in part on medical necessity, requests by providers prior to,
24 retrospectively, or concurrent with the provision of health care
25 services to insureds, or that delegates these functions to medical
26 groups or independent practice associations or to other contracting
27 providers, shall comply with this section.

28 (b) A disability insurer that is subject to this section, or any
29 entity with which an insurer contracts for services that include
30 utilization review or utilization management functions, shall have
31 written policies and procedures establishing the process by which
32 the insurer prospectively, retrospectively, or concurrently reviews
33 and approves, modifies, delays, or denies, based in whole or in
34 part on medical necessity, requests by providers of health care
35 services for insureds. These policies and procedures shall ensure
36 that decisions based on the medical necessity of proposed health
37 care services are consistent with criteria or guidelines that are
38 supported by clinical principles and processes. These criteria and
39 guidelines shall be developed pursuant to subdivision (f). These
40 policies and procedures, and a description of the process by which

1 an insurer, or an entity with which an insurer contracts for services
2 that include utilization review or utilization management functions,
3 reviews and approves, modifies, delays, or denies requests by
4 providers prior to, retrospectively, or concurrent with the provision
5 of health care services to insureds, shall be filed with the
6 commissioner, and shall be disclosed by the insurer to insureds
7 and providers upon request, and by the insurer to the public upon
8 request.

9 (c) If the number of insureds covered under health benefit plans
10 in this state that are issued by an insurer subject to this section
11 constitute at least 50 percent of the number of insureds covered
12 under health benefit plans issued nationwide by that insurer, the
13 insurer shall employ or designate a medical director who holds an
14 unrestricted license to practice medicine in this state issued
15 pursuant to Section 2050 of the Business and Professions Code or
16 the Osteopathic Initiative Act, or the insurer may employ a clinical
17 director licensed in California whose scope of practice under
18 California law includes the right to independently perform all those
19 services covered by the insurer. The medical director or clinical
20 director shall ensure that the process by which the insurer reviews
21 and approves, modifies, delays, or denies, based in whole or in
22 part on medical necessity, requests by providers prior to,
23 retrospectively, or concurrent with the provision of health care
24 services to insureds, complies with the requirements of this section.
25 Nothing in this subdivision shall be construed as restricting the
26 existing authority of the Medical Board of California.

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

31 (e) *(1)* An individual, other than a ~~licensed physician or a~~
32 ~~licensed health care professional who is competent to evaluate the~~
33 ~~specific clinical issues involved in the health care services~~
34 ~~requested by the provider~~ *person licensed to practice medicine*
35 *pursuant to Section 2050 of the Business and Professions Code*
36 *or pursuant to the Osteopathic Act, or a licensed health care*
37 *professional acting within the limitations of paragraph (2), may*
38 not deny or modify requests for authorization of health care
39 services for an insured for reasons of medical necessity. ~~The~~

1 (2) *A licensed health care professional, other than a person*
2 *licensed to practice medicine pursuant to Section 2050 of the*
3 *Business and Professions Code or pursuant to the Osteopathic*
4 *Act, may deny or modify requests for authorization of health care*
5 *services for an insured for reasons of medical necessity only with*
6 *respect to services that fall within his or her scope of practice.*
7 *That professional's review shall also be subject to standardized*
8 *protocol limitations or supervision requirements applicable under*
9 *his or her license.*

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

17 (4) *The decision of the physician or other health care provider*
18 *described in this subdivision shall be communicated to the provider*
19 *and the insured pursuant to subdivision (h).*

20 (f) (1) *An insurer shall disclose, or provide for the disclosure,*
21 *to the commissioner and to network providers, the process the*
22 *insurer, its contracting provider groups, or any entity with which*
23 *it contracts for services that include utilization review or utilization*
24 *management functions, uses to authorize, delay, modify, or deny*
25 *health care services under the benefits provided by the insurance*
26 *contract, including coverage for subacute care, transitional inpatient*
27 *care, or care provided in skilled nursing facilities. An insurer shall*
28 *also disclose those processes to policyholders or persons designated*
29 *by a policyholder, or to any other person or organization, upon*
30 *request.*

31 (2) *The criteria or guidelines used by an insurer, or an entity*
32 *with which an insurer contracts for utilization review or utilization*
33 *management functions, to determine whether to authorize, modify,*
34 *delay, or deny health care services, shall comply with all of the*
35 *following:*

36 (A) *Be developed with involvement from actively practicing*
37 *health care providers.*

38 (B) *Be consistent with sound clinical principles and processes.*

39 (C) *Be evaluated, and updated if necessary, at least annually.*

1 (D) If used as the basis of a decision to modify, delay, or deny
2 services in a specified case under review, be disclosed to the
3 provider and the policyholder in that specified case.

4 (E) Be available to the public upon request. An insurer shall
5 only be required to disclose the criteria or guidelines for the
6 specific procedures or conditions requested. An insurer may charge
7 reasonable fees to cover administrative expenses related to
8 disclosing criteria or guidelines pursuant to this paragraph that are
9 limited to copying and postage costs. The insurer may also make
10 the criteria or guidelines available through electronic
11 communication means.

12 (3) The disclosure required by subparagraph (E) of paragraph
13 (2) shall be accompanied by the following notice: “The materials
14 provided to you are guidelines used by this insurer to authorize,
15 modify, or deny health care benefits for persons with similar
16 illnesses or conditions. Specific care and treatment may vary
17 depending on individual need and the benefits covered under your
18 insurance contract.”

19 (g) If an insurer subject to this section requests medical
20 information from providers in order to determine whether to
21 approve, modify, or deny requests for authorization, the insurer
22 shall request only the information reasonably necessary to make
23 the determination.

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

29 (1) Decisions to approve, modify, or deny, based on medical
30 necessity, requests by providers prior to, or concurrent with, the
31 provision of health care services to insureds that do not meet the
32 requirements for the 72-hour review required by paragraph (2),
33 shall be made in a timely fashion appropriate for the nature of the
34 insured’s condition, not to exceed five business days from the
35 insurer’s receipt of the information reasonably necessary and
36 requested by the insurer to make the determination, *including, but*
37 *not limited to, information from the good faith examination*
38 *conducted pursuant to subdivision (e)*. In cases where the review
39 is retrospective, the decision shall be communicated to the
40 individual who received services, or to the individual’s designee,

1 within 30 days of the receipt of information that is reasonably
2 necessary to make this determination, *including, but not limited*
3 *to, information from the good faith examination conducted*
4 *pursuant to subdivision (e)*, and shall be communicated to the
5 provider in a manner that is consistent with current law. For
6 purposes of this section, retrospective reviews shall be for care
7 rendered on or after January 1, 2000.

8 (2) When the insured's condition is such that the insured faces
9 an imminent and serious threat to his or her health, including, but
10 not limited to, the potential loss of life, limb, or other major bodily
11 function, or the normal timeframe for the decisionmaking process,
12 as described in paragraph (1), would be detrimental to the insured's
13 life or health or could jeopardize the insured's ability to regain
14 maximum function, decisions to approve, modify, or deny requests
15 by providers prior to, or concurrent with, the provision of health
16 care services to insureds shall be made in a timely fashion,
17 appropriate for the nature of the insured's condition, but not to
18 exceed 72 hours after the insurer's receipt of the information
19 reasonably necessary and requested by the insurer to make the
20 determination, *including, but not limited to, information from the*
21 *good faith examination conducted pursuant to subdivision (e)*.

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

36 (4) Communications regarding decisions to approve requests
37 by providers prior to, retrospectively, or concurrent with the
38 provision of health care services to insureds shall specify the
39 specific health care service approved. Responses regarding
40 decisions to deny, delay, or modify health care services requested

1 by providers prior to, retrospectively, or concurrent with the
2 provision of health care services to insureds shall be communicated
3 to insureds in writing, and to providers initially by telephone or
4 facsimile, except with regard to decisions rendered retrospectively,
5 and then in writing, and shall include a clear and concise
6 explanation of the reasons for the insurer's decision, a description
7 of the criteria or guidelines used, and the clinical reasons for the
8 decisions regarding medical necessity. Any written communication
9 to a physician or other health care provider of a denial, delay, or
10 modification or a request shall include the name and telephone
11 number of the health care professional responsible for the denial,
12 delay, or modification. The telephone number provided shall be a
13 direct number or an extension, to allow the physician or health
14 care provider easily to contact the professional responsible for the
15 denial, delay, or modification. Responses shall also include
16 information as to how the provider or the insured may file an appeal
17 with the insurer or seek department review under the unfair
18 practices provisions of Article 6.5 (commencing with Section 790)
19 of Chapter 1 of Part 2 of Division 1 and the regulations adopted
20 thereunder.

21 (5) If the insurer cannot make a decision to approve, modify,
22 or deny the request for authorization within the timeframes
23 specified in paragraph (1) or (2) because the insurer is not in receipt
24 of all of the information reasonably necessary and requested,
25 *including, but not limited to, information from the good faith*
26 *examination conducted pursuant to subdivision (e)*, or because the
27 insurer requires consultation by an expert reviewer, or because the
28 insurer has asked that an additional examination or test be
29 performed upon the insured, provided that the examination or test
30 is reasonable and consistent with good medical practice, the insurer
31 shall, immediately upon the expiration of the timeframe specified
32 in paragraph (1) or (2), or as soon as the insurer becomes aware
33 that it will not meet the timeframe, whichever occurs first, notify
34 the provider and the insured, in writing, that the insurer cannot
35 make a decision to approve, modify, or deny the request for
36 authorization within the required timeframe, and specify the
37 information requested but not received, or the expert reviewer to
38 be consulted, or the additional examinations or tests required. The
39 insurer shall also notify the provider and enrollee of the anticipated
40 date on which a decision may be rendered. Upon receipt of all

1 information reasonably necessary and requested by the insurer,
2 the insurer shall approve, modify, or deny the request for
3 authorization within the timeframes specified in paragraph (1) or
4 (2), whichever applies.

5 (6) If the commissioner determines that an insurer has failed to
6 meet any of the timeframes in this section, or has failed to meet
7 any other requirement of this section, the commissioner may assess,
8 by order, administrative penalties for each failure. A proceeding
9 for the issuance of an order assessing administrative penalties shall
10 be subject to appropriate notice to, and an opportunity for a hearing
11 with regard to, the person affected. The administrative penalties
12 shall not be deemed an exclusive remedy for the commissioner.
13 These penalties shall be paid to the Insurance Fund.

14 (i) Every insurer subject to this section shall maintain telephone
15 access for providers to request authorization for health care
16 services.

17 (j) Nothing in this section shall cause a disability insurer to be
18 defined as a health care provider for purposes of any provision of
19 law, including, but not limited to, Section 6146 of the Business
20 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
21 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
22 Code of Civil Procedure.

23 SEC. 23. Section 10169.2 of the Insurance Code is amended
24 to read:

25 10169.2. (a) ~~By January 1, 2001, the~~ *The* department shall
26 contract with one or more independent medical review
27 organizations in the state to conduct reviews for purposes of this
28 article. The independent medical review organizations shall be
29 independent of any disability insurer doing business in this state.
30 The commissioner may establish additional requirements, including
31 conflict-of-interest standards, consistent with the purposes of this
32 article, that an organization shall be required to meet in order to
33 qualify for participation in the Independent Medical Review System
34 and to assist the department in carrying out its responsibilities.

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

39 (c) The independent medical review organization, any experts
40 it designates to conduct a review, or any officer, director, or

1 employee of the independent medical review organization shall
2 not have any material professional, familial, or financial affiliation,
3 as determined by the commissioner, with any of the following:

4 (1) The insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (C) Ensures that the method of selecting medical professionals
38 for individual cases achieves a fair and impartial panel of medical
39 professionals who are qualified to render recommendations

1 regarding the clinical conditions and the medical necessity of
2 treatments or therapies in question.

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

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

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

14 (A) The medical professional shall be a clinician knowledgeable
15 in the treatment of the insured's medical condition, knowledgeable
16 about the proposed treatment, and familiar with guidelines and
17 protocols in the area of treatment under review. *Review by a*
18 *medical professional, other than a physician licensed to practice*
19 *medicine pursuant to Section 2050 of the Business and Professions*
20 *Code or pursuant to the Osteopathic Act, shall be limited to*
21 *services that fall within that professional's scope of practice and*
22 *shall be subject to standardized protocol limitations or supervision*
23 *requirements applicable under his or her license.*

24 (B) Notwithstanding any other provision of law, the medical
25 professional shall hold a nonrestricted *California* license ~~in the~~
26 ~~any state of the United States,~~ and for physicians, a current
27 ~~certification by a recognized American medical specialty board in~~
28 ~~the area or areas appropriate to the condition or treatment under~~
29 ~~review. The independent medical review organization shall give~~
30 ~~preference to the use of a physician licensed in California as the~~
31 ~~reviewer, except when training and experience with the issue under~~
32 ~~review reasonably requires the use of an out-of-state reviewer~~
33 *license to practice medicine pursuant to Section 2050 of the*
34 *Business and Professions Code or pursuant to the Osteopathic*
35 *Act.*

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

1 (5) Neither the expert reviewer, nor the independent medical
2 review organization, shall have any material professional, material
3 familial, or material financial affiliation with any of the following:
4 (A) The disability insurer or a provider group of the insurer,
5 except that an academic medical center under contract to the insurer
6 to provide services to insureds may qualify as an independent
7 medical review organization provided it will not provide the service
8 and provided the center is not the developer or manufacturer of
9 the proposed treatment.
10 (B) Any officer, director, or management employee of the
11 insurer.
12 (C) The physician, the physician’s medical group, or the
13 independent practice association (IPA) proposing the treatment.
14 (D) The institution at which the treatment would be provided.
15 (E) The development or manufacture of the treatment proposed
16 for the insured whose condition is under review.
17 (F) The insured or the insured’s immediate family.
18 (6) For purposes of this section, the following terms shall have
19 the following meanings:
20 (A) “Material familial affiliation” means any relationship as a
21 spouse, child, parent, sibling, spouse’s parent, or child’s spouse.
22 (B) “Material professional affiliation” means any
23 physician-patient relationship, any partnership or employment
24 relationship, a shareholder or similar ownership interest in a
25 professional corporation, or any independent contractor
26 arrangement that constitutes a material financial affiliation with
27 any expert or any officer or director of the independent medical
28 review organization. “Material professional affiliation” does not
29 include affiliations that are limited to staff privileges at a health
30 facility.
31 (C) “Material financial affiliation” means any financial interest
32 of more than 5 percent of total annual revenue or total annual
33 income of an independent medical review organization or
34 individual to which this subdivision applies. “Material financial
35 affiliation” does not include payment by the insurer to the
36 independent medical review organization for the services required
37 by this section, nor does “material financial affiliation” include an
38 expert’s participation as a contracting provider where the expert
39 is affiliated with an academic medical center or a National Cancer
40 Institute-designated clinical cancer research center.

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

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

10 SEC. 24. Section 10169.3 of the Insurance Code is amended
11 to read:

12 10169.3. (a) Upon receipt of information and documents
13 related to a case, the medical professional reviewer or reviewers
14 selected to conduct the review by the independent medical review
15 organization shall promptly review all pertinent medical records
16 of the insured, provider reports, as well as any other information
17 submitted to the organization as authorized by the department or
18 requested from any of the parties to the dispute by the reviewers.
19 If reviewers request information from any of the parties, a copy
20 of the request and the response shall be provided to all of the
21 parties. The reviewer or reviewers shall also review relevant
22 information related to the criteria set forth in subdivision (b). *In*
23 *addition, at least one medical professional reviewer selected to*
24 *conduct the review shall conduct a good faith examination of the*
25 *insured. This good faith examination shall not be required if the*
26 *insured's policy explicitly excludes coverage of the disputed health*
27 *care service.*

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

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

34 (B) Nationally recognized professional standards.

35 (C) Expert opinion.

36 (D) Generally accepted standards of medical practice.

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

1 (c) The organization shall complete its review and make its
2 determination in writing, and in layperson's terms to the maximum
3 extent practicable, within 30 days of the receipt of the application
4 for review and supporting documentation, *including, but not limited*
5 *to, information from the good faith examination conducted*
6 *pursuant to subdivision (a)*, or within less time as prescribed by
7 the commissioner. If the disputed health care service has not been
8 provided and the insured's provider or the department certifies in
9 writing that an imminent and serious threat to the health of the
10 insured may exist, including, but not limited to, serious pain, the
11 potential loss of life, limb, or major bodily function, or the
12 immediate and serious deterioration of the health of the insured,
13 the analyses and determinations of the reviewers shall be expedited
14 and rendered within three days of the receipt of the information,
15 *including, but not limited to, information from the good faith*
16 *examination conducted pursuant to subdivision (a)*. Subject to the
17 approval of the department, the deadlines for analyses and
18 determinations involving both regular and expedited reviews may
19 be extended by the commissioner for up to three days in
20 extraordinary circumstances or for good cause.

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

32 (e) The independent medical review organization shall provide
33 the director, the insurer, the insured, and the insured's provider
34 with the analyses and determinations of the medical professionals
35 reviewing the case, and a description of the qualifications of the
36 medical professionals. The independent medical review
37 organization shall keep the names of the reviewers confidential in
38 all communications with entities or individuals outside the
39 independent medical review organization, except in cases where
40 the reviewer is called to testify and in response to court orders. If

1 more than one medical professional reviewed the case and the
2 result was differing determinations, the independent medical review
3 organization shall provide each of the separate reviewer’s analyses
4 and determinations.

5 (f) The commissioner shall immediately adopt the determination
6 of the independent medical review organization, and shall promptly
7 issue a written decision to the parties that shall be binding on the
8 insurer.

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

17 SEC. 25. Section 10700 of the Insurance Code is amended to
18 read:

19 10700. As used in this chapter:

20 (a) “Agent or broker” means a person or entity licensed under
21 Chapter 5 (commencing with Section 1621) of Part 2 of Division
22 1.

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

34 (c) “Board” means the Major Risk Medical Insurance Board.

35 (d) “Carrier” means any disability insurance company or any
36 other entity that writes, issues, or administers health benefit plans
37 that cover the employees of small employers, regardless of the
38 situs of the contract or master policyholder. For the purposes of
39 Articles 3 (commencing with Section 10719) and 4 (commencing

1 with Section 10730), “carrier” also includes health care service
2 plans.

3 (e) “Dependent” means the spouse or child of an eligible
4 employee, subject to applicable terms of the health benefit plan
5 covering the employee, and includes dependents of guaranteed
6 association members *and dependents of eligible association*
7 *members* if the association elects to include dependents under its
8 health coverage at the same time it determines its membership
9 composition pursuant to subdivision (z).

10 (f) “Eligible employee” means either of the following:

11 (1) Any permanent employee who is actively engaged on a
12 full-time basis in the conduct of the business of the small employer
13 with a normal workweek of at least 30 hours, in the small
14 employer’s regular place of business, who has met any statutorily
15 authorized applicable waiting period requirements. The term
16 includes sole proprietors or partners of a partnership, if they are
17 actively engaged on a full-time basis in the small employer’s
18 business, and they are included as employees under a health benefit
19 plan of a small employer, but does not include employees who
20 work on a part-time, temporary, or substitute basis. It includes any
21 eligible employee as defined in this paragraph who obtains
22 coverage through a guaranteed association *or an eligible*
23 *association*. Employees of employers purchasing through a
24 guaranteed association *or an eligible association* shall be deemed
25 to be eligible employees if they would otherwise meet the definition
26 except for the number of persons employed by the employer. A
27 permanent employee who works at least 20 hours but not more
28 than 29 hours is deemed to be an eligible employee if all four of
29 the following apply:

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

32 (B) The employer offers the employee health coverage under a
33 health benefit plan.

34 (C) All similarly situated individuals are offered coverage under
35 the health benefit plan.

36 (D) The employee must have worked at least 20 hours per
37 normal workweek for at least 50 percent of the weeks in the
38 previous calendar quarter. The insurer may request any necessary
39 information to document the hours and time period in question,

1 including, but not limited to, payroll records and employee wage
2 and tax filings.

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

5 (g) “Enrollee” means an eligible employee or dependent who
6 receives health coverage through the program from a participating
7 carrier.

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

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

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

15 (i) “Fund” means the California Small Group Reinsurance Fund.

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

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

30 (l) “Late enrollee” means an eligible employee or dependent
31 who has declined health coverage under a health benefit plan
32 offered by a small employer at the time of the initial enrollment
33 period provided under the terms of the health benefit plan, and
34 who subsequently requests enrollment in a health benefit plan of
35 that small employer, provided that the initial enrollment period
36 shall be a period of at least 30 days. It also means any member of
37 an association that is a guaranteed association *or an eligible*
38 *association* as well as any other person eligible to purchase through
39 the guaranteed association *or eligible association* when that person
40 has failed to purchase coverage during the initial enrollment period

1 provided under the terms of the guaranteed association's *or eligible*
2 *association's* health benefit plan and who subsequently requests
3 enrollment in the plan, provided that the initial enrollment period
4 shall be a period of at least 30 days. However, an eligible
5 employee, another person eligible for coverage through a
6 guaranteed association *or an eligible association* pursuant to
7 subdivision (z), or an eligible dependent shall not be considered
8 a late enrollee if any of the following is applicable:

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

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

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

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

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

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

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

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

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

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

38 (5) The individual is an employee or dependent who meets the
39 criteria described in paragraph (1) and was under a COBRA
40 continuation provision and the coverage under that provision has

1 been exhausted. For purposes of this section, the definition of
2 “COBRA” set forth in subdivision (e) of Section ~~1373.62~~ 10116.5
3 shall apply.

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

10 (7) The individual is an eligible employee who previously
11 declined coverage under an employer health benefit plan and who
12 has subsequently acquired a dependent who would be eligible for
13 coverage as a dependent of the employee through marriage, birth,
14 adoption, or placement for adoption, and who enrolls for coverage
15 under that employer health benefit plan on his or her behalf, and
16 on behalf of his or her dependent within 30 days following the
17 date of marriage, birth, adoption, or placement for adoption, in
18 which case the effective date of coverage shall be the first day of
19 the month following the date the completed request for enrollment
20 is received in the case of marriage, or the date of birth, or the date
21 of adoption or placement for adoption, whichever applies. Notice
22 of the special enrollment rights contained in this paragraph shall
23 be provided by the employer to an employee at or before the time
24 the employee is offered an opportunity to enroll in plan coverage.

25 (8) The individual is an eligible employee who has declined
26 coverage for himself or herself or his or her dependents during a
27 previous enrollment period because his or her dependents were
28 covered by another employer health benefit plan at the time of the
29 previous enrollment period. That individual may enroll himself or
30 herself or his or her dependents for plan coverage during a special
31 open enrollment opportunity if his or her dependents have lost or
32 will lose coverage under that other employer health benefit plan.
33 The special open enrollment opportunity shall be requested by the
34 employee not more than 30 days after the date that the other health
35 coverage is exhausted or terminated. Upon enrollment, coverage
36 shall be effective not later than the first day of the first calendar
37 month beginning after the date the request for enrollment is
38 received. Notice of the special enrollment rights contained in this
39 paragraph shall be provided by the employer to an employee at or

1 before the time the employee is offered an opportunity to enroll
2 in plan coverage.

3 (m) “New business” means a health benefit plan issued to a
4 small employer that is not the carrier’s in force business.

5 (n) “Participating carrier” means a carrier that has entered into
6 a contract with the program to provide health benefits coverage
7 under this part.

8 (o) “Plan of operation” means the plan of operation of the fund,
9 including articles, bylaws and operating rules adopted by the fund
10 pursuant to Article 3 (commencing with Section 10719).

11 (p) “Program” means the Health Insurance Plan of California.

12 (q) “Preexisting condition provision” means a policy provision
13 that excludes coverage for charges or expenses incurred during a
14 specified period following the insured’s effective date of coverage,
15 as to a condition for which medical advice, diagnosis, care, or
16 treatment was recommended or received during a specified period
17 immediately preceding the effective date of coverage.

18 (r) “Creditable coverage” means:

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

34 (2) The federal Medicare ~~program~~ *Program* pursuant to Title
35 XVIII of the Social Security Act.

36 (3) The ~~medicaid~~ *Medicaid* program pursuant to Title XIX of
37 the Social Security Act.

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

1 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
2 (Civilian Health and Medical Program of the Uniformed Services
3 (CHAMPUS)).

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

6 (7) A state health benefits risk pool.

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

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

14 (10) A health benefit plan under Section 5(e) of the Peace Corps
15 Act (22 U.S.C. Sec. 2504(e)).

16 (11) Any other creditable coverage as defined by subdivision
17 (c) of Section 2701 of Title XXVII of the federal Public Health
18 Services Act (42 U.S.C. Sec. 300gg(c)).

19 (s) "Rating period" means the period for which premium rates
20 established by a carrier are in effect and shall be no less than six
21 months.

22 (t) "Risk adjusted employee risk rate" means the rate determined
23 for an eligible employee of a small employer in a particular risk
24 category after applying the risk adjustment factor.

25 (u) "Risk adjustment factor" means the percent adjustment to
26 be applied equally to each standard employee risk rate for a
27 particular small employer, based upon any expected deviations
28 from standard claims. This factor may not be more than 120 percent
29 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
30 this factor may not be more than 110 percent or less than 90
31 percent.

32 (v) "Risk category" means the following characteristics of an
33 eligible employee: age, geographic region, and family size of the
34 employee, plus the benefit plan design selected by the small
35 employer.

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

38 Under 30

39 30-39

40 40-49

- 1 50–54
- 2 55–59
- 3 60–64
- 4 65 and over

5 However, for the 65 and over age category, separate premium
6 rates may be specified depending upon whether coverage under
7 the health benefit plan will be primary or secondary to benefits
8 provided by the federal Medicare ~~program~~ *Program* pursuant to
9 Title XVIII of the federal Social Security Act.

10 (2) Small employer carriers shall base rates to small employers
11 using no more than the following family size categories:

- 12 (A) Single.
- 13 (B) Married couple.
- 14 (C) One adult and child or children.
- 15 (D) Married couple and child or children.

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

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

1 regions may be noncontiguous. No carrier shall have less than one
2 geographic area.

3 (w) “Small employer” means ~~either~~ any of the following:

4 (1) Any person, proprietary or nonprofit firm, corporation,
5 partnership, public agency, or association that is actively engaged
6 in business or service that, on at least 50 percent of its working
7 days during the preceding calendar quarter, or preceding calendar
8 year, employed at least two, but not more than 50, eligible
9 employees, the majority of whom were employed within this state,
10 that was not formed primarily for purposes of buying health
11 insurance and in which a bona fide employer-employee relationship
12 exists. In determining whether to apply the calendar quarter or
13 calendar year test, the insurer shall use the test that ensures
14 eligibility if only one test would establish eligibility. However,
15 for purposes of subdivisions (b) and (h) of Section 10705, the
16 definition shall include employers with at least three eligible
17 employees until July 1, 1997, and two eligible employees
18 thereafter. In determining the number of eligible employees,
19 companies that are affiliated companies and that are eligible to file
20 a combined income tax return for purposes of state taxation shall
21 be considered one employer. Subsequent to the issuance of a health
22 benefit plan to a small employer pursuant to this chapter, and for
23 the purpose of determining eligibility, the size of a small employer
24 shall be determined annually. Except as otherwise specifically
25 provided, provisions of this chapter that apply to a small employer
26 shall continue to apply until the health benefit plan anniversary
27 following the date the employer no longer meets the requirements
28 of this definition. It includes any small employer as defined in this
29 paragraph who purchases coverage through a guaranteed
30 association *or an eligible association*, and any employer purchasing
31 coverage for employees through a guaranteed association *or an*
32 *eligible association*.

33 (2) Any guaranteed association, as defined in subdivision (y),
34 that purchases health coverage for members of the association.

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

37 (x) “Standard employee risk rate” means the rate applicable to
38 an eligible employee in a particular risk category in a small
39 employer group.

1 (y) “Guaranteed association” means a nonprofit organization
2 comprised of a group of individuals or employers who associate
3 based solely on participation in a specified profession or industry,
4 accepting for membership any individual or employer meeting its
5 membership criteria ~~which, and that~~ (1) includes one or more small
6 employers as defined in paragraph (1) of subdivision (w), (2) does
7 not condition membership directly or indirectly on the health or
8 claims history of any person, (3) uses membership dues solely for
9 and in consideration of the membership and membership benefits,
10 except that the amount of the dues shall not depend on whether
11 the member applies for or purchases insurance offered by the
12 association, (4) is organized and maintained in good faith for
13 purposes unrelated to insurance, ~~(5) has been in active existence~~
14 ~~on January 1, 1992, and for at least five years prior to that date,~~
15 ~~(6) has been offering health insurance to its members for at least~~
16 ~~five years prior to January 1, 1992,~~ (7) has a constitution and
17 bylaws, or other analogous governing documents that provide for
18 election of the governing board of the association by its members,
19 ~~(8) (6) offers any benefit plan design that is purchased to all~~
20 ~~individual members and employer members in this state,~~ ~~(9) (7)~~
21 ~~includes any member choosing to enroll in the benefit plan design~~
22 ~~offered to the association provided that the member has agreed to~~
23 ~~make the required premium payments, and~~ ~~(10) (8) covers at least~~
24 ~~1,000 100 persons with the carrier with which it contracts. The~~
25 ~~requirement of 1,000 100 persons may be met if component~~
26 ~~chapters of a statewide association contracting separately with the~~
27 ~~same carrier cover at least 1,000 100 persons in the aggregate.~~

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

32 ~~For purposes of this subdivision, an association formed by a~~
33 ~~merger of two or more associations after January 1, 1992, and~~
34 ~~otherwise meeting the criteria of this subdivision shall be deemed~~
35 ~~to have been in active existence on January 1, 1992, if its~~
36 ~~predecessor organizations had been in active existence on January~~
37 ~~1, 1992, and for at least five years prior to that date and otherwise~~
38 ~~met the criteria of this subdivision.~~

39 (z) “Members of a guaranteed association” or “members of an
40 eligible association” means any individual or employer meeting

1 the association’s membership criteria if that person is a member
2 of the association and chooses to purchase health coverage through
3 the association. At the association’s discretion, it may also include
4 employees of association members, association staff, retired
5 members, retired employees of members, and surviving spouses
6 and dependents of deceased members. However, if an association
7 chooses to include those persons as members of the guaranteed
8 association *or members of the eligible association*, the association
9 must so elect in advance of purchasing coverage from a plan.
10 Health plans may require an association to adhere to the
11 membership composition it selects for up to 12 months.

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

15 (ab) “Eligible association” means a community or civic group
16 or a charitable or religious organization.

17 SEC. 26. Section 10705 of the Insurance Code is amended to
18 read:

19 ~~10705. Upon the effective date of this act:~~

20 10705. (a) No group or individual policy or contract or
21 certificate of group insurance or statement of group coverage
22 providing benefits to employees of small employers as defined in
23 this chapter shall be issued or delivered by a carrier subject to the
24 jurisdiction of the commissioner regardless of the situs of the
25 contract or master policyholder or of the domicile of the carrier
26 nor, except as otherwise provided in Sections 10270.91 and
27 10270.92, shall a carrier provide coverage subject to this chapter
28 until a copy of the form of the policy, contract, certificate, or
29 statement of coverage is filed with and approved by the
30 commissioner in accordance with Sections 10290 and 10291, and
31 the carrier has complied with the requirements of Section 10717.

32 (b) Each carrier, except a self-funded employer, shall fairly and
33 affirmatively offer, market, and sell all of the carrier’s benefit plan
34 designs that are sold to, offered through, or sponsored by, small
35 employers or associations that include small employers to all small
36 employers in each geographic region in which the carrier makes
37 coverage available or provides benefits, *regardless of the*
38 *employer’s implementation of, or intent to implement, any form*
39 *of claim or benefit support to covered employees.* A carrier
40 contracting to participate in the Voluntary Alliance Uniting

1 Employers Purchasing Program shall be deemed to be in
2 compliance with this requirement for a benefit plan design offered
3 through the program in those geographic regions in which the
4 carrier participates in the program and the benefit plan design is
5 offered exclusively through the program.

6 (1) Nothing in this section shall be construed to require an
7 association, or a trust established and maintained by an association
8 to receive a master insurance policy issued by an admitted insurer
9 and to administer the benefits thereof solely for association
10 members, to offer, market or sell a benefit plan design to those
11 who are not members of the association. However, if the
12 association markets, offers or sells a benefit plan design to those
13 who are not members of the association it is subject to the
14 requirements of this section. This shall apply to an association that
15 otherwise meets the requirements of paragraph (5) ~~formed by~~
16 ~~merger of two or more associations after January 1, 1992, if the~~
17 ~~predecessor organizations had been in active existence on January~~
18 ~~1, 1992, and for at least five years prior to that date and met the~~
19 ~~requirements of paragraph (5).~~

20 (2) A carrier which (A) effective January 1, 1992, and at least
21 20 years prior to that date, markets, offers, or sells benefit plan
22 designs only to all members of one association and (B) does not
23 market, offer or sell any other individual, selected group, or group
24 policy or contract providing medical, hospital and surgical benefits
25 shall not be required to market, offer, or sell to those who are not
26 members of the association. However, if the carrier markets, offers
27 or sells any benefit plan design or any other individual, selected
28 group, or group policy or contract providing medical, hospital and
29 surgical benefits to those who are not members of the association
30 it is subject to the requirements of this section.

31 (3) Each carrier that sells health benefit plans to members of
32 one association pursuant to paragraph (2) shall submit an annual
33 statement to the commissioner which states that the carrier is selling
34 health benefit plans pursuant to paragraph (2) and which, for the
35 one association, lists all the information required by paragraph (4).

36 (4) Each carrier that sells health benefit plans to members of
37 any association shall submit an annual statement to the
38 commissioner which lists each association to which the carrier
39 sells health benefit plans, the industry-~~or~~, profession, *community*
40 *or civic group, or charitable or religious organization* which is

1 served by the association, the association's membership criteria,
2 a list of officers, the state in which the association is organized,
3 and the site of its principal office.

4 (5) For purposes of paragraphs (1) and (2), an association is a
5 *one of the following:*

6 (A) A nonprofit organization comprised of a group of individuals
7 or employers who associate based solely on participation in a
8 specified profession or industry, accepting for membership any
9 individual or small employer meeting its membership criteria,
10 which do not condition membership directly or indirectly on the
11 health or claims history of any person, which uses membership
12 dues solely for and in consideration of the membership and
13 membership benefits, except that the amount of the dues shall not
14 depend on whether the member applies for or purchases insurance
15 offered by the association, which is organized and maintained in
16 good faith for purposes unrelated to insurance, ~~which has been in~~
17 ~~active existence on January 1, 1992, and at least five years prior~~
18 ~~to that date~~, which has a constitution and bylaws, or other
19 analogous governing documents which provide for election of the
20 governing board of the association by its members, which has
21 contracted with one or more carriers to offer one or more health
22 benefit plans to all individual members and small employer
23 members in this state.

24 (B) *A community or civic group or a charitable or religious*
25 *organization that has contracted with one or more carriers to offer*
26 *one or more health benefit plans to all individual members and*
27 *small employer members in this state.*

28 (c) Each carrier shall make available to each small employer
29 all benefit plan designs that the carrier offers or sells to small
30 employers or to associations that include small employers
31 *regardless of the employer's implementation of, or intent to*
32 *implement, any form of claim or benefit support to covered*
33 *employees.* Notwithstanding subdivision (d) of Section 10700, for
34 purposes of this subdivision, companies that are affiliated
35 companies or that are eligible to file a consolidated income tax
36 return shall be treated as one carrier.

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

38 (1) Prepare a brochure that summarizes all of its benefit plan
39 designs and make this summary available to small employers,
40 agents and brokers upon request. The summary shall include for

1 each benefit plan design information on benefits provided, a generic
2 description of the manner in which services are provided, such as
3 how access to providers is limited, benefit limitations, required
4 copayments and deductibles, standard employee risk rates, an
5 explanation of how creditable coverage is calculated if a preexisting
6 condition or affiliation period is imposed, and a telephone number
7 that can be called for more detailed benefit information. Carriers
8 are required to keep the information contained in the brochure
9 accurate and up to date, and, upon updating the brochure, send
10 copies to agents and brokers representing the carrier. Any entity
11 that provides administrative services only with regard to a benefit
12 plan design written or issued by another carrier shall not be
13 required to prepare a summary brochure which includes that benefit
14 plan design.

15 (2) For each benefit plan design, prepare a more detailed
16 evidence of coverage and make it available to small employers,
17 agents and brokers upon request. The evidence of coverage shall
18 contain all information that a prudent buyer would need to be aware
19 of in making selections of benefit plan designs. An entity that
20 provides administrative services only with regard to a benefit plan
21 design written or issued by another carrier shall not be required to
22 prepare an evidence of coverage for that benefit plan design.

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

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

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

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

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

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

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

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

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

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

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

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

37 (C) Notify the small employer that, ~~from July 1, 1993 to July~~
38 ~~1, 1996, actual rates may be 20 percent higher or lower than the~~
39 ~~sum of the standard employee risk rates, and from July 1, 1996,~~
40 ~~and thereafter, actual rates may be 10 percent higher or lower than~~

1 the sum of the standard employee risk rates depending on how the
2 carrier assesses the risk of the small employer's group.

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

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

10 (f) No carrier, agent, or broker shall induce or otherwise
11 encourage a small employer to separate or otherwise exclude an
12 eligible employee from a health benefit plan which, in the case of
13 an eligible employee meeting the definition in paragraph (1) of
14 subdivision (f) of Section 10700, is provided in connection with
15 the employee's employment or which, in the case of an eligible
16 employee as defined in paragraph (2) of subdivision (f) of Section
17 ~~17000~~ 10700, is provided in connection with a guaranteed
18 association *or an eligible association*.

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

21 (1) The small employer as defined by paragraph (1) of
22 subdivision (w) of Section 10700 offers health benefits to 100
23 percent of its eligible employees as defined in paragraph (1) of
24 subdivision (f) of Section 10700. Employees who waive coverage
25 on the grounds that they have other group coverage shall not be
26 counted as eligible employees.

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

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

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

34 (A) *The health status, claims experience, industry, occupation,*
35 *or geographic location within the carrier's approved service area*
36 *of the small employer or the small employer's employees.*

37 (B) *The small employer's implementation of, or intent to*
38 *implement, any form of claim or benefit support for its covered*
39 *employees through a health reimbursement arrangement, a medical*
40 *expense reimbursement plan, a limited purpose flexible spending*

1 *account, or any other form of wraparound plan or payment for*
2 *any portion of claims that apply to the health plan deductible or*
3 *other benefits.*

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

7 (A) *The health status, claims experience, industry, occupation,*
8 *or geographic location within the carrier's approved service area*
9 *of the small employer or the small employer's employees.*

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

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

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

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

32 (2) *This subdivision shall not apply with respect to a*
33 *compensation arrangement that provides compensation to an agent*
34 *or broker on the basis of percentage of premium, provided that the*
35 *percentage shall not vary because of the ~~health status, claims~~*
36 *~~experience, industry, occupation, or geographic area of the small~~*
37 *~~employer factors described in subparagraph (A) or (B) of~~*
38 *paragraph (1).*

39 (j) Except in the case of a late insured, or for satisfaction of a
40 preexisting condition clause in the case of initial coverage of an

1 eligible employee, a disability insurer may not exclude any eligible
2 employee or dependent who would otherwise be entitled to health
3 care services on the basis of any of the following: the health status,
4 the medical condition, including both physical and mental illnesses,
5 the claims experience, the medical history, the genetic information,
6 or the disability or evidence of insurability, including conditions
7 arising out of acts of domestic violence of that employee or
8 dependent. No health benefit plan may limit or exclude coverage
9 for a specific eligible employee or dependent by type of illness,
10 treatment, medical condition, or accident, except for preexisting
11 conditions as permitted by Section 10198.7 or 10708.

12 (k) If a carrier enters into a contract, agreement, or other
13 arrangement with a third-party administrator or other entity to
14 provide administrative, marketing, or other services related to the
15 offering of health benefit plans to small employers in this state,
16 the third-party administrator shall be subject to this chapter.

17 (l) (1) With respect to the obligation to provide coverage newly
18 issued under subdivision (d), the carrier may cease enrolling new
19 small employer groups and new eligible employees as defined by
20 paragraph (2) of subdivision (f) of Section 10700 if it certifies to
21 the commissioner that the number of eligible employees and
22 dependents, of the employers newly enrolled or insured during the
23 current calendar year by the carrier equals or exceeds: (A) in the
24 case of a carrier that administers any self-funded health benefits
25 arrangement in California, 10 percent of the total number of eligible
26 employees, or eligible employees and dependents, respectively,
27 enrolled or insured in California by that carrier as of December
28 31 of the preceding year, or (B) in the case of a carrier that does
29 not administer any self-funded health benefit arrangements in
30 California, 8 percent of the total number of eligible employees, or
31 eligible employees and dependents, respectively, enrolled or
32 insured by the carrier in California as of December 31 of the
33 preceding year.

34 (2) Certification shall be deemed approved if not disapproved
35 within 45 days after submission to the commissioner. If that
36 certification is approved, the small employer carrier shall not offer
37 coverage to any small employers under any health benefit plans
38 during the remainder of the current year. If the certification is not
39 approved, the carrier shall continue to issue coverage as required

1 by subdivision (d) and be subject to administrative penalties as
2 established in Section 10718.

3 SEC. 27. Section 10706 of the Insurance Code is amended to
4 read:

5 10706. Every carrier shall file with the commissioner the
6 reasonable participation requirements and employer contribution
7 requirements that are to be included in its health benefit plans.
8 Participation requirements shall be applied uniformly among all
9 small employer groups, except that a carrier may vary application
10 of minimum employer participation requirements by the size of
11 the small employer group and whether the employer contributes
12 100 percent of the eligible employee's premium. Employer
13 contribution requirements shall not vary by employer size. A carrier
14 shall not establish a participation requirement that (1) requires a
15 person who meets the definition of a dependent in subdivision (e)
16 of Section 10700 to enroll as a dependent if he or she is otherwise
17 eligible for coverage and wishes to enroll as an eligible employee
18 and (2) allows a carrier to reject an otherwise eligible small
19 employer because of the number of persons that waive coverage
20 due to coverage through another employer. Members of an
21 association eligible for health coverage eligible under subdivision
22 (z) of Section 10700 but not electing any health coverage through
23 the association shall not be counted as eligible employees for
24 purposes of determining whether the guaranteed association *or the*
25 *eligible association* meets a carrier's reasonable participation
26 standards.

27 SEC. 28. Section 10708 of the Insurance Code is amended to
28 read:

29 10708. (a) Preexisting condition provisions of health benefit
30 plans shall not exclude coverage for a period beyond six months
31 following the individual's effective date of coverage and may only
32 relate to conditions for which medical advice, diagnosis, care, or
33 treatment, including the use of prescription medications, was
34 recommended by or received from a licensed health practitioner
35 during the six months immediately preceding the effective date of
36 coverage.

37 (b) A carrier that does not utilize a preexisting condition
38 provision may impose a waiting or affiliation period, not to exceed
39 60 days, before the coverage issued subject to this chapter shall
40 become effective. During the waiting or affiliation period, the

1 carrier is not required to provide health care benefits and no
2 premiums shall be charged to the subscriber or enrollee.

3 (c) In determining whether a preexisting condition provision or
4 a waiting period applies to any person, a plan shall credit the time
5 the person was covered under creditable coverage, provided the
6 person becomes eligible for coverage under the succeeding plan
7 contract within 62 days of termination of prior coverage, exclusive
8 of any waiting or affiliation period, and applies for coverage with
9 the succeeding health benefit plan contract within the applicable
10 enrollment period. A plan shall also credit any time an eligible
11 employee must wait before enrolling in the health benefit plan,
12 including any postenrollment or employer-imposed waiting or
13 affiliation period. However, if a person's employment has ended,
14 the availability of health coverage offered through employment
15 or sponsored by an employer has terminated, or an employer's
16 contribution toward health coverage has terminated, a plan shall
17 credit the time the person was covered under creditable coverage
18 if the person becomes eligible for health coverage offered through
19 employment or sponsored by an employer within 180 days,
20 exclusive of any waiting or affiliation period, and applies for
21 coverage under the succeeding health benefit plan within the
22 applicable enrollment period.

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

25 (1) To a newborn individual, who, as of the last day of the
26 30-day period beginning with the date of birth, applied for coverage
27 through the employer-sponsored plan.

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

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

37 (e) A carrier providing aggregate or specific stop loss coverage
38 or any other assumption of risk with reference to a health benefit
39 plan shall provide that the plan meets all requirements of this

1 section concerning preexisting condition provisions and waiting
2 or affiliation periods.

3 (f) In addition to the preexisting condition exclusions authorized
4 by subdivision (a) and the waiting or affiliation period authorized
5 by subdivision (b), carriers providing coverage to a guaranteed
6 association *or an eligible association* may impose on employers
7 or individuals purchasing coverage who would not be eligible for
8 guaranteed coverage if they were not purchasing through the
9 association a waiting or affiliation period, not to exceed 60 days,
10 before the coverage issued subject to this chapter shall become
11 effective. During the waiting or affiliation period, the carrier is
12 not required to provide health care benefits and no premiums shall
13 be charged to the insured.

14 SEC. 29. Chapter 9.7 (commencing with Section 10920) is
15 added to Part 2 of Division 2 of the Insurance Code, to read:

16

17 CHAPTER 9.7. MANDATE-FREE INDIVIDUAL COVERAGE

18

19 10920. (a) Notwithstanding any other provision of this code,
20 on and after January 1, 2011, a health insurer may offer, market,
21 and sell an individual health insurance policy that does not include
22 all of the health benefits mandated under this code to an individual
23 if all of the following requirements are met:

24 (1) The individual has an income below 350 percent of the
25 federal poverty level.

26 (2) The individual waives the benefits pursuant to subdivision
27 (c).

28 (3) The insurance policy is approved by the commissioner.

29 (b) The commissioner, in consultation with the Director of the
30 Department of Managed Health Care, shall prepare a disclosure
31 form prior to July 1, 2010, that is easily understood and that
32 summarizes the benefits a health insurer is required to include in
33 its health insurance policy under this code.

34 (c) Before a health insurance policy described in subdivision
35 (a) may be issued, the individual shall sign the disclosure form
36 described in subdivision (b), specifying the benefits he or she is
37 waiving and indicating that the insurer has explained the contents
38 of the disclosure and that he or she understands those contents.

39 SEC. 30. Article 7 (commencing with Section 11885) is added
40 to Chapter 4 of Part 3 of Division 2 of the Insurance Code, to read:

Article 7. 24-Hour Care Policies

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

SEC. 31. Section 12938.1 is added to the Insurance Code, to read:

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

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

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

(2) The commissioner shall also report to the chair and to the vice chairs of the committees listed in paragraph (1), prior to December 31, 2011, on the increase in the number of persons insured by a health insurance policy as a result of the requirements described in subdivisions (a) and (b).

SEC. 32. Section 96.8 is added to the Labor Code, to read:

96.8. (a) Notwithstanding any other provision in this chapter, an employer may provide health coverage that includes a Healthy Action Incentives and Rewards Program that meets the requirements of Section 1367.38 of the Health and Safety Code,

1 or Section 10123.56 of the Insurance Code, to the employer's
2 employees.

3 (b) A Healthy Action Incentives and Rewards Program offered
4 pursuant to this section may include, but need not be limited to,
5 monetary incentives and health coverage premium cost reductions
6 for employees for nonsmokers and smoking cessation.

7 SEC. 33. Section 511 of the Labor Code is amended to read:

8 511. (a) Upon the proposal of an employer, the employees of
9 an employer may adopt a regularly scheduled alternative workweek
10 that authorizes work by the affected employees for no longer than
11 10 hours per day within a 40-hour workweek without the payment
12 to the affected employees of an overtime rate of compensation
13 pursuant to this section. A proposal to adopt an alternative
14 workweek schedule shall be deemed adopted only if it receives
15 approval in a secret ballot election by at least two-thirds of affected
16 employees in a work unit. The regularly scheduled alternative
17 workweek proposed by an employer for adoption by employees
18 may be a single work schedule that would become the standard
19 schedule for workers in the work unit, or a menu of work schedule
20 options, from which each employee in the unit would be entitled
21 to choose.

22 (b) *This subdivision shall be known as the "Small Business*
23 *Family Scheduling Option."* Notwithstanding subdivision (a), an
24 *employer with 50 or fewer employees that offers health care*
25 *coverage benefits to its employees may approve a written request*
26 *of an employee to work an alternative workweek schedule for no*
27 *longer than 10 hours per day within a 40-hour workweek without*
28 *the payment to the affected employee of an overtime rate of*
29 *compensation pursuant to this section. An employee shall provide*
30 *a voluntary, signed written request that includes the start date of*
31 *the alternative workweek schedule and the days and the number*
32 *of hours per day for the alternative workweek schedule. If agreed,*
33 *the employer and employee shall execute a written agreement that*
34 *includes the start date of the alternative workweek schedule and*
35 *the days and the number of hours per day for the alternative*
36 *workweek schedule. The employer shall maintain the written*
37 *agreement as a record for three years beyond the termination of*
38 *the alternative workweek agreement. The employee or employer*
39 *may terminate the agreement at any time upon seven days' advance*
40 *written notice.*

1 ~~(b)~~

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

17 ~~(e)~~

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

21 ~~(d)~~

22 (e) An employer shall make a reasonable effort to find a work
23 schedule not to exceed eight hours in a workday, in order to
24 accommodate any affected employee who was eligible to vote in
25 an election authorized by ~~this section~~ *subdivision (a)* and who is
26 unable to work the alternative schedule hours established as the
27 result of that election. An employer shall be permitted to provide
28 a work schedule not to exceed eight hours in a workday to
29 accommodate any employee who was hired after the date of the
30 election and who is unable to work the alternative schedule
31 established as the result of that election. An employer shall explore
32 any available reasonable alternative means of accommodating the
33 religious belief or observance of an affected employee that conflicts
34 with an adopted alternative workweek schedule, in the manner
35 provided by ~~subdivision (j)~~ *(i)* of Section 12940 of the Government
36 Code.

37 ~~(e)~~

38 (f) The results of any election conducted pursuant to ~~this section~~
39 *subdivision (a)* shall be reported by an employer to the Division

1 of Labor Statistics and Research within 30 days after the results
2 are final.

3 ~~(f)~~

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

16 ~~(g)~~

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

29 ~~(h)~~

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

38 SEC. 34. Section 515 of the Labor Code is amended to read:

39 515. (a) The Industrial Welfare Commission may establish
40 exemptions from the requirement that an overtime rate of

1 compensation be paid pursuant to Sections 510 and 511 for
2 executive, administrative, and professional employees, provided
3 that the employee is primarily engaged in the duties that meet the
4 test of the exemption, customarily and regularly exercises
5 discretion and independent judgment in performing those duties,
6 and earns a monthly salary equivalent to no less than two times
7 the state minimum wage for full-time employment. The
8 commission shall conduct a review of the duties that meet the test
9 of the exemption. The commission may, based upon this review,
10 convene a public hearing to adopt or modify regulations at that
11 hearing pertaining to duties that meet the test of the exemption
12 without convening wage boards. Any hearing conducted pursuant
13 to this subdivision shall be concluded not later than July 1, 2000.

14 ~~(b) (1) The commission may establish additional exemptions~~
15 ~~to hours of work requirements under this division where it finds~~
16 ~~that hours or conditions of labor may be prejudicial to the health~~
17 ~~or welfare of employees in any occupation, trade, or industry. This~~
18 ~~paragraph shall become inoperative on January 1, 2005.~~

19 ~~(2)~~

20 (b) Except as otherwise provided in this section and in
21 subdivision ~~(g)~~ (h) of Section 511, nothing in this section requires
22 the commission to alter any exemption from provisions regulating
23 hours of work that was contained in any valid wage order in effect
24 in 1997. Except as otherwise provided in this division, the
25 commission may review, retain, or eliminate any exemption from
26 provisions regulating hours of work that was contained in any valid
27 wage order in effect in 1997.

28 (c) For ~~the~~ purposes of this section, “full-time employment”
29 means employment in which an employee is employed for 40 hours
30 per week.

31 (d) For the purpose of computing the overtime rate of
32 compensation required to be paid to a nonexempt full-time salaried
33 employee, the employee’s regular hourly rate shall be $\frac{1}{40}$ th of the
34 employee’s weekly salary.

35 (e) For ~~the~~ purposes of this section, “primarily” means more
36 than one-half of the employee’s worktime.

37 (f) (1) In addition to the requirements of subdivision (a),
38 registered nurses employed to engage in the practice of nursing
39 shall not be exempted from coverage under any part of the orders
40 of the Industrial Welfare Commission, unless they individually

1 meet the criteria for exemptions established for executive or
2 administrative employees.

3 (2) This subdivision does not apply to any of the following:

4 (A) A certified nurse midwife who is primarily engaged in
5 performing duties for which certification is required pursuant to
6 Article 2.5 (commencing with Section 2746) of Chapter 6 of
7 Division 2 of the Business and Professions Code.

8 (B) A certified nurse anesthetist who is primarily engaged in
9 performing duties for which certification is required pursuant to
10 Article 7 (commencing with Section 2825) of Chapter 6 of Division
11 2 of the Business and Professions Code.

12 (C) A certified nurse practitioner who is primarily engaged in
13 performing duties for which certification is required pursuant to
14 Article 8 (commencing with Section 2834) of Chapter 6 of Division
15 2 of the Business and Professions Code.

16 (D) Nothing in this paragraph shall exempt the occupations set
17 forth in subparagraphs (A), (B), and (C) from meeting the
18 requirements of subdivision (a).

19 SEC. 35. Section 17053.58 is added to the Revenue and
20 Taxation Code, to read:

21 17053.58. (a) For each taxable year beginning on or after
22 January 1, 2010, and before January 1, 2015, there shall be allowed
23 as a credit against the “net tax,” as defined in Section 17039, an
24 amount equal to the amount paid or incurred by the taxpayer during
25 the taxable year for qualified health expenses. The credit shall not
26 exceed any of the following for the taxable year:

27 (1) Seven and one-half percent of the taxpayer gross income.

28 (2) Two thousand five hundred dollars (\$2,500) per each
29 individual covered by the plan.

30 (3) Five thousand dollars (\$5,000) for all individuals covered
31 by the plan.

32 (b) For purposes of this section, “qualified health expenses”
33 means the total amount the taxpayer paid or incurred during the
34 taxable year for health insurance and health care service plans for
35 the taxpayer and his or her spouse and dependents.

36 (c) No other credit or deduction shall be allowed under other
37 provisions of this part for qualified health expenses for which a
38 credit is taken under this section.

39 (d) This section shall remain in effect only until December 1,
40 2015, and as of that date is repealed.

1 SEC. 36. Section 17053.77 is added to the Revenue and
2 Taxation Code, to read:

3 17053.77. (a) For each taxable year beginning on or after
4 January 1, 2009, and before January 1, 2015, there shall be allowed
5 as a credit against the “net tax,” as defined in Section 17039, an
6 amount equal to 15 percent of the amount paid or incurred by a
7 qualified taxpayer during the taxable year for qualified health
8 insurance for employees of the taxpayer who perform services in
9 this state.

10 (b) For purposes of this section:

11 (1) “Qualified health insurance” means amounts paid on behalf
12 of employees to a high deductible health plan, as defined by Section
13 223(c)(2) of the Internal Revenue Code, or to a Health Savings
14 Account, as defined by Section 223(d) of the Internal Revenue
15 Code.

16 (2) “Qualified taxpayer” means any small or medium employer,
17 or any small or medium employer that, during the five taxable
18 years immediately preceding the taxable year, has not provided
19 health insurance to employees employed by the employer in this
20 state.

21 (3) For purposes of this paragraph:

22 (A) “Small employer” means a person, as defined in Section
23 7701(a) of the Internal Revenue Code, employing, for wages or
24 salary, at least two but no more than 50 persons.

25 (B) “Medium employer” means a person, as defined in Section
26 7701(a) of the Internal Revenue Code, employing, for wages or
27 salary, at least 51 but no more than 250 persons.

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

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

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

38 (f) This section shall remain in effect only until December 1,
39 2015, and as of that date is repealed, unless a later enacted statute,

1 that is enacted before December 1, 2015, deletes or extends that
2 date.

3 SEC. 37. Section 17053.91 is added to the Revenue and
4 Taxation Code, to read:

5 17053.91. (a) For each taxable year beginning on or after
6 January 1, 2009, there shall be allowed as a credit against the “net
7 tax,” as defined in Section 17039, an amount equal to 25 percent
8 of the “net tax,” of an individual who is a qualified medical care
9 professional.

10 (b) For purposes of this section:

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

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

26 (c) In the case where the credit allowed by this section exceeds
27 the “net tax,” the excess may be carried over to reduce the “net
28 tax” in the following year, and succeeding years if necessary, until
29 the credit is exhausted.

30 SEC. 38. Section 17053.102 is added to the Revenue and
31 Taxation Code, to read:

32 17053.102. (a) There shall be allowed as a credit against the
33 “net tax,” as defined by Section 17039, an amount equal to 50
34 percent of the fair market value of uncompensated medical care
35 provided by a physician during the taxable year to an eligible
36 individual.

37 (b) For purposes of this section:

38 (1) “Physician” means a physician and surgeon licensed by the
39 Medical Board of California or the Osteopathic Medical Board of
40 California.

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

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

11 (c) In the case where the credit allowed by this section exceeds
12 the “net tax,” the excess may be carried over to reduce the “net
13 tax” in the following year, and succeeding years if necessary, until
14 the credit is exhausted.

15 SEC. 39. Section 17053.103 is added to the Revenue and
16 Taxation Code, to read:

17 17053.103. (a) There shall be allowed a credit against the “net
18 tax,” as defined by Section 17039, an amount equal to 10 percent
19 of the “net tax” for the taxable year to a primary care provider who
20 provides primary care for patients in this state during the taxable
21 year.

22 (b) For purposes of this section, “primary care provider” means
23 a physician and surgeon, a nurse practitioner, or a physician’s
24 assistant.

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

28 (d) The credit shall be allowed by this section only for the first
29 10 taxable years for which the primary care provider provides
30 primary care services in this state.

31 (e) In the case of a primary care provider who is a physician
32 and surgeon who changes his or her practice from primary care to
33 specialty care, any credit previously allowed by this section shall
34 be recaptured by adding the amount of the credit to the “net tax”
35 for the taxable year in which the change of practice occurs.

36 (f) In the case where the credit allowed by this section exceeds
37 the “net tax,” the excess may be carried over to reduce the “net
38 tax” in the following year, and succeeding years if necessary, until
39 the credit is exhausted.

1 SEC. 40. Section 17072 of the Revenue and Taxation Code is
2 amended to read:

3 17072. (a) Section 62 of the Internal Revenue Code, relating
4 to adjusted gross income defined, shall apply, except as otherwise
5 provided.

6 (b) Section 62(a)(2)(D) of the Internal Revenue Code, relating
7 to certain expenses of elementary and secondary school teachers,
8 shall not apply.

9 (c) *The deduction allowed by Section 17204, relating to medical
10 care, shall be allowed in computing adjusted gross incomes.*

11 (d) *The deduction allowed by Section 17216, relating to Health
12 Savings Accounts, shall be allowed in computing adjusted gross
13 income. This subdivision shall apply only to each taxable year
14 beginning on or after January 1, 2009.*

15 SEC. 41. Section 17138.5 is added to the Revenue and Taxation
16 Code, to read:

17 17138.5. For each taxable year beginning on or after January
18 1, 2009, Section 106 of the Internal Revenue Code, as amended
19 by Section 1201 of the Medicare Prescription Drug, Improvement,
20 and Modernization Act of 2003 (Public Law 108-173), relating to
21 Health Savings Accounts, shall apply, except as otherwise
22 provided.

23 SEC. 42. Section 17138.6 is added to the Revenue and Taxation
24 Code, to read:

25 17138.6. For each taxable year beginning on or after January
26 1, 2009, Section 125 of the Internal Revenue Code, as amended
27 by Section 1201 of the Medicare Prescription Drug, Improvement,
28 and Modernization Act of 2003 (Public Law 108-173), relating to
29 Health Savings Accounts, shall apply, except as otherwise
30 provided.

31 SEC. 43. Section 17204 is added to the Revenue and Taxation
32 Code, to read:

33 17204. (a) For each taxable year beginning on or after January
34 1, 2010, and before January 1, 2015, there shall be allowed a
35 deduction in an amount equal to the cost, not compensated by
36 insurance or otherwise, paid or incurred during the taxable year
37 by the taxpayer for medical care for the taxpayer, his or her spouse,
38 his or her dependents, and, in the case of a married couple, any
39 dependents of each spouse. The deduction shall not exceed any of
40 the following for the taxable year:

- 1 (1) Seven and one-half percent of the taxpayer's gross income.
- 2 (2) Two thousand dollars (\$2,000) per person.
- 3 (3) Five thousand dollars (\$5,000) per family.

4 (b) For purposes of this section:

5 (1) "Taxpayer" means any person subject to the tax imposed
6 by this part.

7 (2) "Dependent" has the same meaning ascribed to that term by
8 Section 17056.

9 (3) "Medical care" has the same meaning ascribed to that term
10 by Section 213(d) of the Internal Revenue Code.

11 (c) The deduction allowed by this section shall be in lieu of any
12 other deduction otherwise allowable by this part for the costs for
13 which the deduction is allowed by this section.

14 (d) This section shall remain in effect only until December 1,
15 2015, and as of that date is repealed.

16 SEC. 44. Section 17215 of the Revenue and Taxation Code is
17 amended to read:

18 17215. (a) Section 220(a) of the Internal Revenue Code,
19 relating to deduction allowed, is modified to provide that the
20 amount allowed as a deduction shall be an amount equal to the
21 amount allowed to that individual as a deduction under Section
22 220 of the Internal Revenue Code, relating to medical savings
23 accounts, on the federal income tax return filed for the same taxable
24 year by that individual.

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

29 (c) *Section 220(f)(5) of the Internal Revenue Code, as amended*
30 *by Section 1201(c) of the Medicare Prescription Drug,*
31 *Improvement, and Modernization Act of 2003 (Public Law*
32 *108-173), relating to rollovers from Archer MSAs permitted, shall*
33 *apply, except as otherwise provided.*

34 (d) *The amendments made to this section by the act adding this*
35 *subdivision shall apply only to each taxable year beginning on or*
36 *after January 1, 2009.*

37 SEC. 45. Section 17216 is added to the Revenue and Taxation
38 Code, to read:

39 17216. For each taxable year beginning on or after January 1,
40 2009, all of the following apply:

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

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

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

17 SEC. 46. Section 19184 of the Revenue and Taxation Code is
18 amended to read:

19 19184. (a) A penalty of fifty dollars (\$50) shall be imposed
20 for each failure, unless it is shown that the failure is due to
21 reasonable cause, by any person required to file who fails to file
22 a report at the time and in the manner required by any of the
23 following provisions:

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

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

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

33 ~~(3)~~

34 (4) Subdivision (b) of Section 17140.3 or subdivision (b) of
35 Section 23711 relating to qualified tuition programs.

36 ~~(4)~~

37 (5) Subdivision (e) of Section 23712, relating to Coverdell
38 education savings accounts.

39 (b) (1) Any individual who:

1 (A) Is required to furnish information under Section 17508 as
2 to the amount designated nondeductible contributions made for
3 any taxable year, and

4 (B) Overstates the amount of those contributions made for that
5 taxable year, shall pay a penalty of one hundred dollars (\$100) for
6 each overstatement unless it is shown that the overstatement is due
7 to reasonable cause.

8 (2) Any individual who fails to file a form required to be filed
9 by the Franchise Tax Board under Section 17508 shall pay a
10 penalty of fifty dollars (\$50) for each failure unless it is shown
11 that the failure is due to reasonable cause.

12 (c) Article 3 (commencing with Section 19031) of this chapter
13 (relating to deficiency assessments) shall not apply in respect of
14 the assessment or collection of any penalty imposed under this
15 section.

16 (d) *The amendments made to this section by the act adding this*
17 *subdivision shall apply only to each taxable year beginning on or*
18 *after January 1, 2009.*

19 SEC. 47. Section 23658 is added to the Revenue and Taxation
20 Code, to read:

21 23658. (a) For each taxable year beginning on or after January
22 1, 2010, and before January 1, 2015, there shall be allowed as a
23 credit against the “tax,” as defined in Section 23036, an amount
24 equal to the amount paid or incurred by the taxpayer during the
25 taxable year for qualified health expenses. The credit shall not
26 exceed any of the following for the taxable year:

27 (1) Seven and one-half percent of the taxpayer’s gross income.

28 (2) Two thousand five hundred dollars (\$2,500) per each
29 individual covered by the plan.

30 (3) Five thousand dollars (\$5,000) for all individuals covered
31 by the plan.

32 (b) For purposes of this section “qualified health expenses”
33 means the total amount the taxpayer paid or incurred during the
34 taxable year for health insurance and health care service plans for
35 the taxpayer and his or her spouse and dependents.

36 (c) No other credit or deduction shall be allowed under other
37 provisions of this part for qualified health expenses for which a
38 credit is taken under this section.

39 (d) This section shall remain in effect only until December 1,
40 2015, and as of that date is repealed.

1 SEC. 48. Section 23677 is added to the Revenue and Taxation
2 Code, to read:

3 23677. (a) For each taxable year beginning on or after January
4 1, 2009, and before January 1, 2015, there shall be allowed as a
5 credit against the “tax,” as defined in Section 23036, an amount
6 equal to 15 percent of the amount paid or incurred by a qualified
7 taxpayer during the taxable year for qualified health insurance for
8 employees of the taxpayer who perform services in this state.

9 (b) For purposes of this section:

10 (1) “Qualified health insurance” means amounts paid on behalf
11 of employees to a high deductible health plan, as defined by Section
12 223(c)(2) of the Internal Revenue Code, or to a Health Savings
13 Account, as defined by Section 223(d) of the Internal Revenue
14 Code.

15 (2) “Qualified taxpayer” means any small or medium employer,
16 or any small or medium employer that, during the five taxable
17 years immediately preceding the taxable year, has not provided
18 health insurance to employees employed by the employer in this
19 state.

20 (3) For purposes of this paragraph:

21 (A) “Small employer” means a person, as defined in Section
22 7701(a) of the Internal Revenue Code, employing, for wages or
23 salary, at least two but no more than 50 persons.

24 (B) “Medium employer” means a person, as defined in Section
25 7701(a) of the Internal Revenue Code, employing, for wages or
26 salary, at least 51 but no more than 250 persons.

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

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

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

37 (f) This section shall remain in effect only until December 1,
38 2015, and as of that date is repealed, unless a later enacted statute,
39 that is enacted before December 1, 2015, deletes or extends that
40 date.

1 SEC. 49. Section 14026.7 is added to the Welfare and
2 Institutions Code, to read:

3 14026.7. (a) The State Department of Health Care Services
4 shall establish a computer modeling program to be used to prevent
5 and identify Medi-Cal fraud. The computer modeling program
6 shall alert the department when a provider does any of the
7 following:

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

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

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

17 (b) When the department receives an alert from the computer
18 modeling program established pursuant to subdivision (a), the
19 department shall conduct a Medi-Cal fraud investigation if the
20 department determines an investigation is appropriate under the
21 circumstances.

22 SEC. 50. Section 14029.7 is added to the Welfare and
23 Institutions Code, to read:

24 14029.7. The State Department of Health Care Services shall
25 ensure the existence and operation of a single searchable Internet
26 Web site, accessible by the public at no cost, that specifies
27 Medi-Cal expenditures, including a line item breakdown of
28 administrative overhead and provider and health care expenses.

29 SEC. 51. Section 14043.26 of the Welfare and Institutions
30 Code is amended to read:

31 14043.26. (a) (1) On and after January 1, 2004, an applicant
32 that currently is not enrolled in the Medi-Cal program, or a provider
33 applying for continued enrollment, upon written notification from
34 the department that enrollment for continued participation of all
35 providers in a specific provider of service category or subgroup
36 of that category to which the provider belongs will occur, or, except
37 as provided in subdivisions (b) and (e), a provider not currently
38 enrolled at a location where the provider intends to provide
39 services, goods, supplies, or merchandise to a Medi-Cal
40 beneficiary, shall submit a complete application package for

1 enrollment, continuing enrollment, or enrollment at a new location
2 or a change in location.

3 (2) Clinics licensed by the department pursuant to Chapter 1
4 (commencing with Section 1200) of Division 2 of the Health and
5 Safety Code and certified by the department to participate in the
6 Medi-Cal program shall not be subject to this section.

7 (3) Health facilities licensed by the department pursuant to
8 Chapter 2 (commencing with Section 1250) of Division 2 of the
9 Health and Safety Code and certified by the department to
10 participate in the Medi-Cal program shall not be subject to this
11 section.

12 (4) Adult day health care providers licensed pursuant to Chapter
13 3.3 (commencing with Section 1570) of Division 2 of the Health
14 and Safety Code and certified by the department to participate in
15 the Medi-Cal program shall not be subject to this section.

16 (5) Home health agencies licensed pursuant to Chapter 8
17 (commencing with Section 1725) of Division 2 of the Health and
18 Safety Code and certified by the department to participate in the
19 Medi-Cal program shall not be subject to this section.

20 (6) Hospices licensed pursuant to Chapter 8.5 (commencing
21 with Section 1745) of Division 2 of the Health and Safety Code
22 and certified by the department to participate in the Medi-Cal
23 program shall not be subject to this section.

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

35 (c) (1) Except as provided in paragraph (2), within 30 days
36 after receiving an application package submitted pursuant to
37 subdivision (a), the department shall provide written notice that
38 the application package has been received and, if applicable, that
39 there is a moratorium on the enrollment of providers in the specific
40 provider of service category or subgroup of the category to which

1 the applicant or provider belongs. This moratorium shall bar further
2 processing of the application package.

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

9 (d) (1) ~~Except as provided in paragraph (4),~~ if the application
10 package submitted pursuant to subdivision (a) is from an applicant
11 or provider who meets the criteria listed in paragraph (2), the
12 applicant or provider shall be considered a preferred provider and
13 shall be granted preferred provisional provider status pursuant to
14 this section and for a period of no longer than 18 months, effective
15 from the date on the notice from the department. The ability to
16 request consideration as a preferred provider and the criteria
17 necessary for the consideration shall be publicized to all applicants
18 and providers. An applicant or provider who desires consideration
19 as a preferred provider pursuant to this subdivision shall request
20 consideration from the department by making a notation to that
21 effect on the application package, by cover letter, or by other means
22 identified by the department in a provider bulletin. Request for
23 consideration as a preferred provider shall be made with each
24 application package submitted in order for the department to grant
25 the consideration. An applicant or provider who requests
26 consideration as a preferred provider shall be notified within 60
27 days whether the applicant or provider meets or does not meet the
28 criteria listed in paragraph (2). If an applicant or provider is notified
29 that the applicant or provider does not meet the criteria for a
30 preferred provider, the application package submitted shall be
31 processed in accordance with the remainder of this section.

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

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

1 (B) Be a current faculty member of a teaching hospital or a
2 children’s hospital, as defined in Section 10727, accredited by the
3 Joint Commission or the American Osteopathic Association, or
4 be credentialed by a health care service plan that is licensed under
5 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
6 2.2 (commencing with Section 1340) of Division 2 of the Health
7 and Safety Code) or county organized health system, or be a current
8 member in good standing of a group that is credentialed by a health
9 care service plan that is licensed under the Knox-Keene Act.

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

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

15 (3) The department may recognize other providers as qualifying
16 as preferred providers if criteria similar to those set forth in
17 paragraph (2) are identified for the other providers. The department
18 shall consult with interested parties and appropriate stakeholders
19 to identify similar criteria for other providers so that they may be
20 considered as preferred providers.

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

23 (i) *Dentists.*

24 (ii) *Physicians and surgeons.*

25 (iii) *Osteopathic physicians and surgeons.*

26 (iv) *Nurse anesthetists.*

27 (v) *Nurse practitioners.*

28 (vi) *Physician assistants.*

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

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

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

38 (C) *In order for the department to determine if the applicant*
39 *satisfies the conditions specified in subparagraph (B), the*
40 *application package shall include the applicant’s National*

1 *Provider Identifier issued pursuant to Subpart D of Part 162 of*
2 *Title 42 of the Code of Federal Regulations and state professional*
3 *license number.*

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

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

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

17 *(e) (1) If a Medi-Cal applicant meets the criteria listed in*
18 *paragraph (2), the applicant shall be enrolled in the Medi-Cal*
19 *program after submission and review of a short form application*
20 *to be developed by the department. The form shall comply with*
21 *all minimum federal requirements related to Medicaid provider*
22 *enrollment. The department shall notify the applicant that the*
23 *department has received the application within 15 days of receipt*
24 *of the application. The department shall issue the applicant a*
25 *provider number or notify the applicant that the applicant does not*
26 *meet the criteria listed in paragraph (2) within 90 days of receipt*
27 *of the application.*

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

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

38 *(B) The applicant or provider holds a current, unrevoked, or*
39 *unsuspended license as a physician and surgeon issued by the*
40 *Medical Board of California or the Osteopathic Medical Board of*

1 California. An applicant or provider shall not be in compliance
2 with this subparagraph if a license revocation has been stayed, the
3 licensee has been placed on probation, or the license is subject to
4 any other limitation.

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

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

9 (f) Except as provided in subdivision (g), within 180 days after
10 receiving an application package submitted pursuant to subdivision
11 (a), or from the date of the notice to an applicant or provider that
12 the applicant or provider does not qualify as a preferred provider
13 under subdivision (d), the department shall give written notice to
14 the applicant or provider that any of the following applies, or shall
15 on the 181st day grant the applicant or provider provisional
16 provider status pursuant to this section for a period no longer than
17 12 months, effective from the 181st day:

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

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

24 (3) The department is exercising its authority under Section
25 14043.37, 14043.4, or 14043.7, and is conducting background
26 checks, preenrollment inspections, or unannounced visits.

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

29 (A) Pursuant to Section 14043.2 or 14043.36.

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

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

36 (D) For other stated reasons authorized by law.

37 (g) Notwithstanding subdivision (f), within 90 days after
38 receiving an application package submitted pursuant to subdivision
39 (a) from a physician or physician group licensed by the Medical
40 Board of California or the Osteopathic Medical Board of California,

1 or from the date of the notice to that physician or physician group
2 that does not qualify as a preferred provider under subdivision (d),
3 or within 90 days after receiving a change of location form
4 submitted pursuant to subdivision (b), the department shall give
5 written notice to the applicant or provider that either paragraph
6 (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st
7 day grant the applicant or provider provisional provider status
8 pursuant to this section for a period no longer than 12 months,
9 effective from the 91st day.

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

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

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

21 (C) The department is exercising its authority under Section
22 14043.37, 14043.4, or 14043.7 to conduct background checks,
23 preenrollment inspections, or unannounced visits.

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

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

36 (C) Notwithstanding subparagraph (A), if the notice of an
37 incomplete application package included a request for information
38 or documentation related to grounds for denial under Section
39 14043.2 or 14043.36, the applicant or provider shall not reapply
40 for enrollment or continued enrollment in the Medi-Cal program

1 or for participation in any health care program administered by
2 the department or its agents or contractors for a period of three
3 years.

4 (i) (1) If the department exercises its authority under Section
5 14043.37, 14043.4, or 14043.7 to conduct background checks,
6 preenrollment inspections, or unannounced visits, the applicant or
7 provider shall receive notice, from the department, after the
8 conclusion of the background check, preenrollment inspection, or
9 unannounced visit of either of the following:

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

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

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

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

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

34 (j) If provisional provider status or preferred provisional provider
35 status is granted pursuant to this section, a provider number shall
36 be used by the provider for each business address for which an
37 application package has been approved. This provider number
38 shall be used exclusively for the locations for which it is issued,
39 unless the practice of the provider's profession or delivery of
40 services, goods, supplies, or merchandise is such that services,

1 goods, supplies, or merchandise are rendered or delivered at
2 locations other than the provider's business address and this
3 practice or delivery of services, goods, supplies, or merchandise
4 has been disclosed in the application package approved by the
5 department when the provisional provider status or preferred
6 provisional provider status was granted.

7 (k) Except for providers subject to subdivision (c) of Section
8 14043.47, a provider currently enrolled in the Medi-Cal program
9 at one or more locations who has submitted an application package
10 for enrollment at a new location or a change in location pursuant
11 to subdivision (a), or filed a change of location form pursuant to
12 subdivision (b), may submit claims for services, goods, supplies,
13 or merchandise rendered at the new location until the application
14 package or change of location form is approved or denied under
15 this section, and shall not be subject, during that period, to
16 deactivation, or be subject to any delay or nonpayment of claims
17 as a result of billing for services rendered at the new location as
18 herein authorized. However, the provider shall be considered during
19 that period to have been granted provisional provider status or
20 preferred provisional provider status and be subject to termination
21 of that status pursuant to Section 14043.27. A provider that is
22 subject to subdivision (c) of Section 14043.47 may come within
23 the scope of this subdivision upon submitting documentation in
24 the application package that identifies the physician providing
25 supervision for every three locations. If a provider submits claims
26 for services rendered at a new location before the application for
27 that location is received by the department, the department may
28 deny the claim.

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

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

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

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

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

12 SEC. 52. Section 14079.7 is added to the Welfare and
13 Institutions Code, to read:

14 14079.7. (a) (1) Notwithstanding any other provision of this
15 chapter, on January 1, 2010, the reimbursement levels for
16 fee-for-service physician services under Medi-Cal shall be
17 increased to 80 percent of the amount that the federal Medicare
18 Program reimburses for these same services in Area 9 (Santa Clara
19 County). This reimbursement change shall apply only to services
20 reimbursed at rates below 80 percent of the amount that the federal
21 Medicare Program reimburses for these same services in Area 9.

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

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

28 SEC. 53. Article 2.94 (commencing with Section 14091.50)
29 is added to Chapter 7 of Part 3 of Division 9 of the Welfare and
30 Institutions Code, to read:

31

32 Article 2.94. The Medi-Cal Empowerment Act

33

34 14091.50. This article shall be known, and may be cited, as
35 the “Medi-Cal Empowerment Act.”

36 14091.51. The Legislature finds and declares the following:

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

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

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

6 (d) Including federal funds, Medi-Cal expended about three
7 thousand seven hundred dollars (\$3,700) per enrollee in the
8 2006–07 fiscal year.

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

11 (f) Medi-Cal is a large purchaser of health care services and
12 should share in the responsibility of helping stabilize runaway
13 health care costs that can contribute towards increasing the
14 population of the uninsured.

15 (g) Empowering Medi-Cal beneficiaries to become more active
16 participants in their utilization of health care services will help
17 reduce the perceived or actual stigma associated with receiving
18 government assistance.

19 (h) The federal Deficit Reduction Act of 2005 authorizes
20 Medicaid Demonstration Projects for up to 10 states to implement
21 Health Opportunity Accounts, that allow states to use federal
22 matching dollars to deposit up to two thousand five hundred dollars
23 (\$2,500) per adult and one thousand dollars (\$1,000) per child into
24 an account accessible by a Medicaid enrollee that can be used to
25 pay for out-of-pocket medical expenses to meet the deductible of
26 an approved insurance product of the enrollee’s choice. As a
27 national leader, California should be one of these states.

28 14091.52. The State Department of Health Care Services shall
29 prepare and submit a proposal to the federal government by July
30 31, 2010, for participation in the Medicaid Demonstration Project
31 for Health Opportunity Accounts (HOA) in accordance with the
32 federal Deficit Reduction Act of 2005.

33 14091.53. The program design shall achieve the following:

34 (a) Create patient awareness of the high cost of medical care.

35 (b) Provide incentives to patients to seek preventive care
36 services, including one or more of the following:

37 (1) Additional account contributions for an individual
38 demonstrating healthy prevention practices.

- 1 (2) Periodic health evaluations, including tests and diagnostic
2 procedures ordered in connection with routine examinations, such
3 as annual physicals.
- 4 (3) Routine prenatal and well-child care.
- 5 (4) Child and adult immunizations.
- 6 (5) Tobacco cessation programs.
- 7 (6) Obesity weight loss programs.
- 8 (7) Screening services.
- 9 (8) Other incentives as determined by the department and agreed
10 to by the federal government under the demonstration project.
- 11 (c) Reduce inappropriate use of health care services.
- 12 (d) Enable patients to take responsibility for health outcomes.
- 13 (e) Provide enrollment counselors and ongoing education
14 activities.
- 15 (f) Allow transactions involving HOAs to be conducted
16 electronically and without cash.
- 17 (g) Provide access to negotiated provider payment rates.
- 18 14091.54. (a) The department shall select up to 10 counties
19 in which to implement this demonstration project after considering
20 the per enrollee Medi-Cal cost in each county as well as the overall
21 Medi-Cal cost per county.
- 22 (b) An eligible individual shall be enrolled into the
23 demonstration program only if the individual voluntarily enrolls.
- 24 (c) Enrollment shall be effective for a period of 12 months, and
25 may be extended for additional periods of 12 months each with
26 the consent of the individual.
- 27 (d) An individual who, for any reason, is disenrolled from the
28 demonstration program under this section shall not be permitted
29 to reenroll earlier than one year after disenrollment.
- 30 14091.55. (a) Insurance plans offered to enrollees who
31 volunteer to participate in the demonstration shall encompass all
32 standard Medi-Cal benefits.
- 33 (b) The amount of the annual deductible shall be at least 100
34 percent and no more than 110 percent of the amount of the
35 contribution to the HOA.
- 36 (c) The number of individuals enrolled in any managed care
37 organization that participate in this demonstration project shall not
38 be either of the following:
- 39 (1) In excess of 5 percent of the total number of individuals
40 enrolled in the organization.

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

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

9 14091.56. (a) The department may consider each participating
10 enrollee's health to determine the state's contribution into an
11 enrollee's HOA.

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

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

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

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

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

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

29 (1) The state shall cease all contributions.

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

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

36 14091.57. (a) The following individuals shall not be enrolled
37 in the demonstration project during the first five years after it is
38 approved:

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

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

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

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

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

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

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

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

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

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

34 (6) The individual is medically frail or otherwise an individual
35 with special medical needs as defined in Section 438.50(d) of Title
36 42 of the Code of Federal Regulations.

37 (7) The individual qualifies based on medical condition for
38 medical assistance for long-term care services described in Section
39 1917(c)(I)(C) of the federal Social Security Act (42 U.S.C. Sec.
40 1396p(c)(I)(C)).

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

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

14 (10) The individual is a woman who is receiving medical
15 assistance by virtue of the application of Section
16 1902(a)(10)(ii)(XVIII) of the federal Social Security Act (42 U.S.C.
17 1396a(a)(10)(ii)(XVIII)), and Section 1902(aa) of the federal Social
18 Security Act (42 U.S.C. Sec. 1396a(aa)).

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

27 14091.58. The department shall coordinate administration of
28 HOAs through the use of a third-party administrator and may
29 implement appropriate policies and procedures for implementation
30 of this demonstration project consistent with federal laws,
31 regulations, and other guidance.

32 14091.59. The department shall annually report to the Governor
33 and the Legislature on the results of this demonstration project.

34 SEC. 54. Section 14132.104 is added to the Welfare and
35 Institutions Code, to read:

36 14132.104. (a) On or before January 1, 2011, the department
37 shall provide or arrange for the provision of an electronic personal
38 health record (PHR) and an electronic personal benefits record
39 (PBR) for beneficiaries under the Medi-Cal program. The records
40 shall be provided for the purpose of providing beneficiaries with

1 information to assist them in understanding their coverage benefits
2 and managing their health care.

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

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

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

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

20 SEC. 55. Section 14132.105 is added to the Welfare and
21 Institutions Code, to read:

22 14132.105. (a) (1) The department may establish a Healthy
23 Action Incentives and Rewards Program to be provided as a
24 covered benefit under the Medi-Cal program.

25 (2) The benefits described in this section shall only be provided
26 under the terms and conditions determined by the department.

27 (b) For purposes of this section, the Healthy Action Incentives
28 and Rewards Program may include, but need not be limited to, all
29 of the following:

30 (1) Health risk appraisals that collect information from eligible
31 beneficiaries to assess overall health status and identify risk factors,
32 including, but not limited to, smoking and smokeless tobacco use,
33 alcohol abuse, drug use, nutrition, and physical activity practices.

34 (2) A followup appointment with a licensed health care
35 professional acting within his or her scope of practice to review
36 the results of the health risk appraisal and discuss any
37 recommended actions.

38 (3) Incentives or rewards or both for eligible beneficiaries to
39 become more engaged in their health care and to make appropriate
40 choices that support good health, including obtaining health risk

1 appraisals, screening services, immunizations, or participating in
2 healthy lifestyle programs or practices. These programs or practices
3 may include, but need not be limited to, smoking cessation,
4 physical activity, or nutrition. Incentives may include, but need
5 not be limited to, nonmedical pharmacy products or services not
6 otherwise covered under this chapter, gym memberships, and
7 weight management programs.

8 (c) The department shall seek and obtain federal financial
9 participation and secure all federal approvals, including all required
10 state plan amendments or waivers, necessary to implement and
11 fund the services authorized under this section.

12 (d) This section shall be implemented only if and to the extent
13 that federal financial participation is available and has been
14 obtained.

15 SEC. 56. Section 14133 of the Welfare and Institutions Code
16 is amended to read:

17 14133. Utilization controls that may be applied to the services
18 set forth in Section 14132 which are subject to utilization controls
19 shall be limited to:

20 (a) Prior authorization, which is approval by a department
21 consultant, of a specified service in advance of the rendering of
22 that service based upon a determination of medical necessity. ~~Prior
23 authorization includes authorization for multiple services which
24 are requested and granted on the basis of an extended treatment
25 plan where there is a need for continuity in the treatment of a
26 chronic or extended condition that the service is covered under
27 Medi-Cal.~~

28 (b) Postservice prepayment audit, which is review for ~~medical
29 necessity and~~ program coverage after service was rendered but
30 before payment is made. Payment may be withheld or reduced if
31 the service rendered was not a covered benefit, ~~deemed medically
32 unnecessary or inappropriate.~~ Nothing in this subdivision shall
33 supersede the claims processing deadlines provided by Section
34 14104.3.

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

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

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

7 SEC. 57. Section 14164.5 is added to the Welfare and
8 Institutions Code, to read:

9 14164.5. Before making any adjustment to Medi-Cal
10 reimbursement rates, the State Department of Health Care Services
11 shall consider the extent to which Medi-Cal beneficiaries have the
12 ability to access physician services by geography and specialty
13 and shall also request data from the Office of Statewide Health
14 Planning and Development to allow the department to determine
15 the extent of Medi-Cal physician shortages, if any, by geography
16 and specialty.

17 SEC. 58. Division 23 (commencing with Section 23000) is
18 added to the Welfare and Institutions Code, to read:

19

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

23

24 23000. (a) For purposes of this division, the following
25 definitions shall apply:

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

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

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

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

37 (5) "Health care provider" means any person licensed or certified
38 pursuant to Division 2 (commencing with Section 500) of the
39 Business and Professions Code, or licensed pursuant to the
40 Osteopathic Initiative Act or the Chiropractic Initiative Act, or

1 certified pursuant to Chapter 2.5 (commencing with Section 1440)
2 of Division 2 of the Health and Safety Code, and any clinic, health
3 dispensary, or health facility licensed pursuant to Division 2
4 (commencing with Section 1200) of the Health and Safety Code.

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

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

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

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

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

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

20 (A) The identity of the debtor.

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

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

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

32 (1) Identity of the debtor.

33 (2) Amount of money owed to the claimant.

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

36 (g) Upon receiving a certification of debt pursuant to this
37 section, the Franchise Tax Board and the California Lottery
38 Commission shall, respectively, determine if the debtor is owed a
39 tax refund or lottery prize money. If the debtor is owed a tax refund
40 or lottery prize money, the Franchise Tax Board or the California

1 Lottery Commission, as appropriate, shall notify the debtor by
2 certified mail of the following:

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

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

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

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

13 (1) If the tax refund or lottery prize money is more than the debt
14 owed to the claimant, the debtor shall receive the remaining
15 difference within a reasonable time after the excess amount is
16 determined.

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

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

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

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

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

1 circumstances shall the administrative expenses exceed 20 percent
2 of the collected amount.

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

6 SEC. 59. On or before March 1, 2014, the Legislative Analyst
7 shall report to the Legislature on the effectiveness of the tax credits
8 provided by Sections 17053.77 and 23677 of the Revenue and
9 Taxation Code, as added by this act, upon employed Californians’
10 ability to meet deductible medical expenses incurred under
11 qualified health insurance plans.

12 SEC. 60. (a) The amendments made by this act to Sections
13 17072, 17215, and 19184 of the Revenue and Taxation Code
14 incorporate, by reference, the provisions of Section 1201 of the
15 Medicare Prescription Drug, Improvement, and Modernization
16 Act of 2003 (Public Law 108-173), which added Section 223 of
17 the Internal Revenue Code to Part VII of Subchapter B of Chapter
18 1 of Subtitle A of the Internal Revenue Code and amended Sections
19 62, 106, 125, and 220 of the Internal Revenue Code, and shall
20 apply retroactively to taxable years beginning on or after January
21 1, 2009.

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

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

35 (c) If, by the operation of any law or rule of law, including res
36 judicata, a refund or credit of any overpayment of tax resulting
37 from the retroactive application of the amendments made to
38 Sections 17072, 17215, and 19184 of the Revenue and Taxation
39 Code by this act is prevented at any time before the close of the
40 two-year period beginning on the effective date of this act, that

1 refund or credit may nonetheless be made or allowed, provided
2 that the claim for refund or credit is filed before the close of that
3 period.

4 SEC. 61. (a) The Legislature finds and declares all of the
5 following:

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

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

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

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

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

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

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

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

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

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

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

13 SEC. 62. It is the intent of the Legislature to enact legislation
14 that would realign Medi-Cal benefits to more closely resemble
15 benefits offered through private health care coverage.

16 SEC. 63. It is the intent of the Legislature to enact legislation
17 that would establish a pilot project in which Medi-Cal managed
18 care is used as a platform to transition from a defined-benefit
19 system, where the state pays for services used based on a defined
20 set of benefits, to a defined-contribution system, where Medi-Cal
21 enrollees would be assigned a risk-adjusted amount to purchase
22 private health care coverage.

23 SEC. 64. It is the intent of the Legislature to enact legislation
24 that would establish a pilot project that utilizes a self-directed “cash
25 and counseling” model for providing Medi-Cal services to disabled
26 Medi-Cal enrollees. Under a “cash and counseling” model, disabled
27 Medi-Cal enrollees, with assistance from family members and
28 Medi-Cal case managers, would be given an individual budget to
29 manage and direct payment for their personal care services and
30 enable them to determine which supportive services they want and
31 from whom they wish to have these services delivered.

32 SEC. 65. The Legislature hereby finds and declares all of the
33 following:

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

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

39 (c) The Legislature hereby memorializes the Congress and
40 President of the United States to enact legislation that would

1 provide full reimbursement for the costs of providing federally
2 mandated health care services to anyone, regardless of immigration
3 status.

4 SEC. 66. It is the intent of the Legislature to enact legislation
5 that would relieve the overutilization of hospital emergency rooms
6 by allowing hospitals to offer preventative medical services
7 delivered through the hospital's primary care or community-based
8 clinic.

9 SEC. 67. It is the intent of the Legislature to enact legislation
10 that would impose consequences on attorneys and litigants who
11 do either of the following:

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

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

18 SEC. 68. It is the intent of the Legislature to enact legislation
19 that would provide incentives to employers who offer health
20 insurance, flex-time work schedules, and other benefits agreed
21 upon by employers and employees.

22 SEC. 69. No reimbursement is required by this act pursuant to
23 Section 6 of Article XIII B of the California Constitution because
24 the only costs that may be incurred by a local agency or school
25 district will be incurred because this act creates a new crime or
26 infraction, eliminates a crime or infraction, or changes the penalty
27 for a crime or infraction, within the meaning of Section 17556 of
28 the Government Code, or changes the definition of a crime within
29 the meaning of Section 6 of Article XIII B of the California
30 Constitution.