

PROPOSED CONFERENCE REPORT NO. 1  
SEPTEMBER 9, 2003

AMENDED IN ASSEMBLY JUNE 23, 2003

AMENDED IN SENATE JUNE 3, 2003

AMENDED IN SENATE MARCH 18, 2003

**SENATE BILL**

**No. 2**

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**Introduced by Senators Burton and Speier**  
*(Principal coauthor: Assembly Member Frommer)*  
*(Coauthor: Assembly Member Cohn)*

December 2, 2002

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~~An act to add Part 8.5 (commencing with Section 2020) to Division 2 of the Labor Code, relating to health care coverage. An act to amend Section 6254 of the Government Code, to add Article 3.11 (commencing with Section 1357.20) to Chapter 2.2 of Division 2 of the Health and Safety Code, to add Section 12693.55 to, and to add Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, the Insurance Code, to add Part 8.7 (commencing with Section 2120) to Division 2 of the Labor Code, to amend Section 131 of, and to add Section 976.7 to, the Unemployment Insurance Code, and to amend Section 14124.91 of, and to add Sections 14105.981, 14124.915, and 14124.916 to, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 2, as amended, Burton. Health care coverage.

Existing law does not provide a system of health care coverage for all California residents and does not require employers to provide health

care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program administered by the State Department of Health Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

~~This bill would declare the intent of the Legislature to ensure health care coverage for working Californians and their families.~~

*This bill would create the State Health Purchasing Program, which would be administered by the Managed Risk Medical Insurance Board. The bill would require specified health benefits to be provided directly by employers or through the program. The bill would require the board to arrange health plan coverage for certain employers, who would be required to pay a fee for employee health coverage, except that employers who provide health care coverage directly would receive a credit against the fee. The bill would require employees and dependents of large employers to be covered beginning January 1, 2006, while it would require employees of medium employers to be covered beginning January 1, 2007, subject to certain conditions. Small employers would be exempt from the requirement to provide coverage and from the fee. The bill would require the board to determine the fee to be paid by employers, and would provide that the associated employee contributions, which employers would be required to collect from employees, may not exceed 20% of the employer fee. The fees, including the employee contributions, would be collected by the Employment Development Department and would be deposited in the newly created State Health Purchasing Fund. The moneys in the fund would be continuously appropriated to the board for the purposes of the program. The bill would authorize the board to coordinate coverage under the program with coverage available under the Medi-Cal program, the Healthy Families Program, and other public programs, and would impose various requirements on the board and the State Department of Health Services in that regard. The bill would authorize a loan from the General Fund to the board for startup costs related to the State Health*



*Purchasing Program, subject to appropriation by the Legislature. The bill would enact other related provisions.*

*Existing law requires health care service plans and health insurers to comply with various requirements relating to health care coverage for small employers. A willful violation of provisions governing health care service plans is a crime.*

*This bill would extend the application of these requirements to health care coverage provided directly by employers under the bill, and would impose various other requirements. Because a willful violation of these provisions by health care service plans would be a crime, the bill would impose a state-mandated local program.*

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

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

*This bill would provide that it shall not become operative unless AB 1528 is also enacted and becomes operative.*

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

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

- 1 ~~SECTION 1.—The Legislature finds and declares all of the~~
- 2 *SECTION 1. The Legislature finds and declares all of the*
- 3 *following:*
- 4 *(a) The Legislature finds and declares that working*
- 5 *Californians and their families should have health insurance*
- 6 *coverage.*
- 7 *(b) The Legislature further finds and declares that most*
- 8 *working Californians obtain their health insurance coverage*
- 9 *through their employment.*
- 10 *(c) The Legislature finds and declares that in 2001, more than*
- 11 *6,000,000 Californians lacked health insurance coverage at some*
- 12 *time and 3,600,000 Californians had no health insurance*
- 13 *coverage at any time.*
- 14 *(d) The Legislature finds and declares that more than 80*
- 15 *percent of Californians without health insurance coverage are*
- 16 *working people or their families. Most of these working*



1 Californians without health insurance coverage work for  
2 employers who do not offer health benefits.

3 (e) The Legislature finds and declares that employment-based  
4 health insurance coverage provides access for millions of  
5 Californians to the latest advances in medical science, including  
6 diagnostic procedures, surgical interventions, and  
7 pharmaceutical therapies.

8 (f) The Legislature finds and declares that people who are  
9 covered by health insurance have better health outcomes than  
10 those who lack coverage. Persons without health insurance are  
11 more likely to be in poor health, more likely to have missed needed  
12 medications and treatment, and more likely to have chronic  
13 conditions that are not properly managed.

14 (g) The Legislature finds and declares that persons without  
15 health insurance are at risk of financial ruin and that medical debt  
16 is the second most common cause of personal bankruptcy in the  
17 United States.

18 (h) The Legislature further finds and declares that the State of  
19 California provides health insurance to low- and  
20 moderate-income working parents and their children through the  
21 Medi-Cal and Healthy Families programs and pays the cost of  
22 coverage for those working people who are not provided health  
23 coverage through employment. The Legislature further finds and  
24 declares that the State of California and local governments fund  
25 county hospitals and clinics, community clinics, and other safety  
26 net providers that provide care to those working people whose  
27 employers fail to provide affordable health coverage to workers  
28 and their families as well as to other uninsured persons.

29 (i) The Legislature further finds and declares that controlling  
30 health care costs can be more readily achieved if a greater share  
31 of working people and their families have health benefits so that  
32 cost shifting is minimized.

33 (j) The Legislature finds and declares that the social and  
34 economic burden created by the lack of health coverage for some  
35 workers and their dependents creates a burden on other employers,  
36 the State of California, affected workers, and the families of  
37 affected workers who suffer ill health and risk financial ruin.

38 (k) It is therefore the intent of the Legislature to assure that  
39 working Californians and their families have health benefits and  
40 that employers pay a user fee to the State of California so that the



1 state may serve as a purchasing agent to pool those fees to  
2 purchase coverage for all working Californians and their families  
3 that is not tied to employment with an individual employer.  
4 However, consistent with this act, if the employer voluntarily  
5 provides proof of health care coverage, that employer is to be  
6 exempted from payment of the fee.

7 (l) It is further the intent of the Legislature that workers who  
8 work on a seasonal basis, for multiple employers, or who work  
9 multiple jobs for the same employer should be afforded the  
10 opportunity to have health coverage in the same manner as those  
11 who work full-time for a single employer.

12 (m) The Legislature recognizes the vital role played by the  
13 health care safety net and the potential impact this act may have  
14 on the resources available to county hospital systems and clinics,  
15 including physicians or networks of physicians that refer patients  
16 to such hospitals and clinics, as well as community clinics and  
17 other safety net providers. It is the intent of the Legislature to  
18 preserve the viability of this important health care resource.

19 (n) Nothing in this act shall be construed to diminish or  
20 otherwise change existing protections in law for persons eligible  
21 for public programs including, but not limited to, Medi-Cal,  
22 Healthy Families, California Children’s Services, Genetically  
23 Handicapped Persons Program, county mental health programs,  
24 programs administered by the Department of Alcohol and Drug  
25 programs, or programs administered by local education agencies.  
26 It is further the intent of the Legislature to preserve benefits  
27 available to the recipients of these programs, including dental,  
28 vision, and mental health benefits.

29 SEC. 2. Part 8.7 (commencing with Section 2120) is added to  
30 Division 2 of the Labor Code, to read:

31  
32 PART 8.7. EMPLOYEE HEALTH INSURANCE

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34  
35 CHAPTER 1. TITLE AND PURPOSE

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37 2120. This part shall be known and may be cited as the Health  
38 Insurance Act of 2003.



1 2120.1. (a) Large employers, as defined in Section 2122.3,  
2 shall comply with the provisions of this part applicable to large  
3 employers commencing on January 1, 2006.

4 (b) Medium employers, as defined in Section 2122.4, shall  
5 comply with the provisions of this part applicable to medium  
6 employers commencing on January 1, 2007, except that those  
7 employers with at least 20 employees but no more than 49  
8 employees are not required to comply with the provisions of this  
9 part unless a tax credit is enacted that is available to those  
10 employers with at least 20 employees but no more than 49  
11 employees. The tax credit shall be 20 percent of net cost to the  
12 employer of the fee owed under Chapter 4 (commencing with  
13 Section 2140). "Net cost" means the dollar amount of the  
14 employer fee or the credit consistent with Section 2160.1 reduced  
15 by the employee share of that fee or credit and further reduced by  
16 the value of state and federal tax deductions.

17 2120.2. It is the purpose of this part to ensure that working  
18 Californians and their families are provided health care coverage.

19 2120.3. This part shall not be construed to diminish any  
20 protection already provided pursuant to collective bargaining  
21 agreements or employer-sponsored plans that are more favorable  
22 to the employees than the health care coverage required by this  
23 part.

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## 25 CHAPTER 2. DEFINITIONS

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27 2122. Unless the context requires otherwise, the definitions  
28 set forth in this chapter shall govern the construction and meaning  
29 of the terms and phrases used in this part.

30 2122.1. "Dependent" means the spouse, domestic partner,  
31 minor child of a covered enrollee, or child 18 years of age and over  
32 who is dependent on the enrollee, as specified by the board.  
33 "Dependent" does not include a dependent who is provided  
34 coverage by another employer or who is an eligible enrollee as a  
35 consequence of that dependent's employment status.

36 2122.2. "Enrollee" means a person who works at least 100  
37 hours per month for any individual employer and has worked for  
38 that employer for three months. The term includes sole proprietors  
39 or partners of a partnership, if they are actively engaged at least  
40 100 hours per month in that business.



1 2122.3. “Large employer” means a person, as defined in  
2 Section 7701(a) of the Internal Revenue Code, or public or private  
3 entity employing for wages or salary 200 or more persons to work  
4 in this state.

5 2122.4. “Medium employer” means a person, as defined in  
6 Section 7701(a) of the Internal Revenue Code, or public or private  
7 entity employing for wages or salary at least 20 but no more than  
8 199 persons to work in this state.

9 2122.5. “Small employer” means a person, as defined in  
10 Section 7701(a) of the Internal Revenue Code, or public or private  
11 entity employing for wages or salary at least 2 but no more than  
12 19 persons to work in this state.

13 2122.6. “Employer” means an employing unit as defined in  
14 Section 135 of the Unemployment Insurance Code, that is either  
15 a large employer or medium employer, as defined in Sections  
16 2122.3 and 2122.4. For purposes of this part, an employer shall  
17 include all of the members of a controlled group of corporations.  
18 A “controlled group of corporations” means controlled group of  
19 corporations as defined in Section 1563(a) of the Internal Revenue  
20 Code, except that “more than 50 percent” shall be substituted for  
21 “at least 80 percent” each place it appears in Section 1563(a)(1)  
22 of the Internal Revenue Code and the determination shall be made  
23 without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the  
24 Internal Revenue Code.

25 2122.7. “Principal employer” means the employer for whom  
26 an enrollee works the greatest number of hours in any month.

27 2122.8. “Wages” means wages as defined in subdivision (a)  
28 of Section 200 paid directly to an individual by his or her employer.

29 2122.9. “Fund” means the State Health Purchasing Fund  
30 created pursuant to Section 2210.

31 2122.10. “Program” means the State Health Purchasing  
32 Program, which includes a purchasing pool providing health care  
33 coverage for enrollees, and, if applicable, their dependents, which  
34 will be financed by fees paid by employers and contributions by  
35 enrollees.

36 2122.11. “Board” means the Managed Risk Medical  
37 Insurance Board.

38 2122.12. “Fee” means the fee as determined in Chapter 4  
39 (commencing with Section 2140).

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## 1           CHAPTER 3.   STATE HEALTH PURCHASING PROGRAM

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3       2130. The State Health Purchasing Program is hereby  
4 created. The program shall be managed by the Managed Risk  
5 Medical Insurance Board, which shall have those powers granted  
6 to the board with respect to the Healthy Families Program under  
7 Section 12693.21 of the Insurance Code, except that the  
8 emergency regulation authority referenced in subdivision (o) of  
9 that section shall only be in effect for this program from the  
10 effective date of this part until three years after the requirements  
11 of this program are in effect for large and medium employers as  
12 provided in Section 2120.1.

13       2130.1. Notwithstanding any other provisions of law to the  
14 contrary, the board shall have authority and fiduciary  
15 responsibility for the administration of the program, including sole  
16 and exclusive fiduciary responsibility over the assets of the fund.  
17 The board shall also have sole and exclusive responsibility to  
18 administer the program in a manner that will assure prompt  
19 delivery of benefits and related services to the enrollees, and, if  
20 applicable, dependents, including sole and exclusive  
21 responsibility over contract, budget, and personnel matters.  
22 Nothing in this section shall preclude legislative or state auditor  
23 oversight over the program.

24       2130.2. The board shall arrange coverage for enrollees, and,  
25 if applicable, dependents eligible under this part by establishing  
26 and maintaining a purchasing pool. The board shall negotiate  
27 contracts with those health care service plans and health insurers  
28 that choose to participate for the benefit package described in this  
29 part and shall not self-insure or partially self-insure the health  
30 care benefits under this part.

31       2130.3. The health care benefits coverage provided to  
32 enrollees, and, if applicable, dependents, shall be equivalent to the  
33 coverage required under subdivision (a) or (b) of Section 2160.1.

34       2130.4. The program shall be funded by employer fees and  
35 enrollee contributions as described in this part. The board shall  
36 administer the program in a manner that assures that the fees and  
37 enrollee contributions collected pursuant to this part are sufficient  
38 to fund the program, including administrative costs.

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CHAPTER 4. EMPLOYER FEE

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2140. Except as otherwise provided in this part, every large employer and every medium employer shall pay a fee as specified in this chapter.

2140.1. The board shall establish the level of the fee by determining the total amount necessary to pay for health care for all enrollees, and, if applicable, their dependents eligible for the program. In setting the fee the board may include costs associated with the administration of the fund, including those costs associated with collection of the fee and its enforcement by the Employment Development Department. The program implemented pursuant to this part shall be fully supported by the fees and enrollee contributions collected pursuant to this part. The fees and enrollee contributions collected pursuant to this part shall not be used for any purpose other than providing health coverage for enrollees and, if applicable, their dependents, as well as costs associated with the administration of the fund and with collection of the fee and its enforcement by the Employment Development Department.

2140.2. The board shall provide notice to the Employment Development Department of the amount of the fee in a time and manner that permits the Employment Development Department to provide notice to all employers of the estimated fee for the budget year pursuant to Section 976.7 of the Unemployment Insurance Code.

2140.3. The Employment Development Department shall waive the fee of any employer that is entitled to a credit under the terms of this part. The Employment Development Department shall specify the manner and means by which that credit may be claimed by an employer.

2140.4. Revenue from the fee and from the enrollee contributions specified in this part shall be deposited into the fund.

2140.5. The fee paid by employers shall be based on the cost of coverage for all enrollees, and, if applicable, their dependents. The fee to be paid by each employer shall be based on the number of potential enrollees, and if applicable, dependents, using the employer's own workforce on a date specified by the board as the basis for the allocation and such other factors as the board may determine in order to provide coverage that meets the standards of



1 *this part. To assist the board in determining the fee, each employer*  
2 *shall provide to the board information as specified by the board*  
3 *regarding potential enrollees, and, if applicable, dependents. To*  
4 *the extent feasible, the board shall work with the Employment*  
5 *Development Department to facilitate the provision of information*  
6 *regarding the number of potential enrollees and dependents.*

7 2140.6. *A large employer shall pay a fee to the fund for the*  
8 *purpose of providing health care coverage pursuant to this part.*  
9 *The fee paid by a large employer shall be based on the number of*  
10 *enrollees and dependents.*

11 2140.7. *A medium employer shall pay a fee to the fund for the*  
12 *purpose of providing health care coverage pursuant to this part.*  
13 *The fee paid by a medium employer shall be based on the number*  
14 *of enrollees.*

15 2140.8. *Coverage of an enrollee or, if applicable, dependents*  
16 *shall not be contingent upon payment of the fee required pursuant*  
17 *to this part by the employer of that enrollee or, if applicable,*  
18 *dependents. If an employer fails to pay the required fee, for*  
19 *whatever reason, the employer shall be responsible to the fund for*  
20 *payment of a penalty of 200 percent of the amount of any fee that*  
21 *would have otherwise been paid by the employer including for the*  
22 *period that the enrollee and, if applicable, dependents should have*  
23 *received coverage but for the employer's conduct in violation of*  
24 *this section.*

25 2140.9. *All amounts due and unpaid under this part,*  
26 *including unpaid penalties, shall bear interest in accordance with*  
27 *Section 1129 of the Unemployment Insurance Code.*

28 2140.10. *Nothing in this part shall preclude an employer from*  
29 *purchasing additional benefits or coverage, in addition to paying*  
30 *the fee.*

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#### CHAPTER 5. ENROLLEE CONTRIBUTION

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34 2150. *The applicable enrollee contribution, not to exceed 20*  
35 *percent of the fee assessed to the employer, shall be collected by the*  
36 *employer and paid concurrently with the employer fee. The*  
37 *employer may agree to pay more than 80 percent of the fee,*  
38 *resulting in an enrollee, and, if applicable, dependent contribution*  
39 *of less than 20 percent. For enrollees making a contribution for*  
40 *family coverage and whose wages are less than 200 percent of the*



1 *federal poverty guidelines for a family of three, as specified*  
2 *annually by the United States Department of Health and Human*  
3 *Services, the applicable enrollee contribution shall not exceed 5*  
4 *percent of wages. For enrollees making a contribution for*  
5 *individual coverage and whose wages are less than 200 percent of*  
6 *the federal poverty guidelines for an individual, the applicable*  
7 *enrollee contribution shall not exceed 5 percent of wages.*

8 2150.1. (a) *The board shall establish the required enrollee*  
9 *and dependent deductibles, coinsurance or copayment levels for*  
10 *specific benefits, including total annual out-of-pocket cost.*

11 (b) *No out-of-pocket costs other than copayments,*  
12 *coinsurance, and deductibles in accordance with this section shall*  
13 *be charged to enrollees and dependents for health benefits.*

14 (c) *In determining the required enrollee and dependent*  
15 *deductibles, coinsurance, and copayments, the board shall*  
16 *consider whether the proposed copayments, coinsurance, and*  
17 *deductibles deter enrollees and dependents from receiving*  
18 *appropriate and timely care, including those enrollees with low-or*  
19 *moderate-family incomes. The board shall also consider the*  
20 *impact of out-of-pocket costs on the ability of employers to pay the*  
21 *fee.*

22 *This section shall apply to coverage provided through the*  
23 *program only and is not intended to apply coverage that is not*  
24 *provided through the program.*

25 2150.2. *In the event that the employer fails to collect or*  
26 *transmit the enrollee contribution provided for under this part in*  
27 *a timely manner, the employer shall become liable for a penalty of*  
28 *200 percent of the amount that the employer has failed to collect*  
29 *or transmit, and the employee shall be relieved of all liability for*  
30 *that failure. In no event shall the employer's failure to collect or*  
31 *transmit the required enrollee's contribution or to provide*  
32 *enrollment information about an employee affect the employee's*  
33 *coverage arranged pursuant to Chapter 3 (commencing with*  
34 *Section 2130), nor may an employer withhold or collect any*  
35 *amount that is not withheld and transmitted in the manner and at*  
36 *such times as specified by the Employment Development*  
37 *Department pursuant to this part. An employee for whom*  
38 *enrollment information is not otherwise received by the board may*  
39 *demonstrate eligibility for coverage by any reliable means of*  
40 *demonstrating employment as provided for in regulation. To the*



1 *extent feasible, the board shall work with the Employment*  
2 *Development Department to facilitate the provision of information*  
3 *regarding the eligibility of enrollees and to provide information*  
4 *regarding any failure of an employer to collect or transmit*  
5 *employee contributions as required by this part.*

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CHAPTER 6. EMPLOYER CREDIT AGAINST THE FEE

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9 *2160. An employer required to pay a fee to the fund may apply*  
10 *to the Employment Development Department for a credit against*  
11 *the fee by providing proof of coverage for eligible enrollees and*  
12 *their dependents, if applicable, consistent with Section 2140.3.*

13 *2160.1. Proof of coverage shall be demonstrated by any of the*  
14 *following:*

15 *(a) Any health care coverage that meets the minimum*  
16 *requirements set forth in Chapter 2.2 (commencing with Section*  
17 *1340) of Division 2 of the Health and Safety Code.*

18 *(b) A group health insurance policy, as defined in subdivision*  
19 *(b) of Section 106 of the Insurance Code, that covers hospital,*  
20 *surgical, and medical care expenses, provided the maximum*  
21 *out-of-pocket costs for insureds do not exceed the maximum*  
22 *out-of-pocket costs for enrollees of health care service plans*  
23 *providing benefits under a preferred provider organization policy.*  
24 *For the purposes of this section, a group health insurance policy*  
25 *shall not include Medicare supplement, vision-only, dental-only,*  
26 *and Champus-supplement insurance. For purposes of this section,*  
27 *a group health insurance policy shall not include hospital*  
28 *indemnity, accident-only, and specified disease insurance that*  
29 *pays benefits on a fixed benefit, cash-payment-only basis.*

30 *(c) Any Taft-Hartley health and welfare fund or any other*  
31 *lawful collective bargaining agreement which provides for health*  
32 *and welfare coverage for collective bargaining unit or other*  
33 *employees thereby covered.*

34 *(d) Any employer sponsored group health plan meeting the*  
35 *requirements of the federal Employee Retirement Income Security*  
36 *Act of 1974, provided it meets the benefits required under*  
37 *subdivision (a) or (b) of this section.*

38 *(e) A multiple employer welfare arrangement established*  
39 *pursuant to Section 742.20 of the Insurance Code, provided that*



1 *its benefits have not changed after January 1, 2004, or that it meets*  
2 *the benefits required under subdivision (a) or (b) of this section.*

3 *(f) Coverage provided under the Public Employees' Medical*  
4 *and Hospital Care Act (Part 5 (commencing with Section 22850)*  
5 *of Division 5 of Title 2 of the Government Code, provided it meets*  
6 *the benefits required under subdivision (a) or (b) of this section or*  
7 *is otherwise collectively bargained.*

8 *(g) Health coverage provided by the University of California to*  
9 *students of the University of California who are also employed by*  
10 *the University of California.*

11 *2160.2. Nothing in this part shall preclude an employer from*  
12 *providing additional benefits or coverage.*

13 *2160.3. It shall be unlawful for an employer to designate an*  
14 *employee as an independent contractor or temporary employee,*  
15 *reduce an employee's hours of work, or terminate and rehire an*  
16 *employee if a purpose of which is to avoid the employer's*  
17 *obligations under this part. An employer that violates this section*  
18 *shall be responsible to the fund for a penalty of 200 percent of the*  
19 *amount of any fee that would have otherwise been paid by the*  
20 *employer including for the period that the enrollee, and, if*  
21 *applicable, dependents should have received coverage but for the*  
22 *employer's conduct in violation of this section. The rights*  
23 *established under this section shall not reduce any other rights*  
24 *established under any other provision of law.*

25 *2160.4. An employer shall not request or otherwise seek to*  
26 *obtain information concerning income or other eligibility*  
27 *requirements for public health benefit programs regarding an*  
28 *employee, dependent, or other family member of an employee,*  
29 *other than that information about the employee's employment*  
30 *status otherwise known to the employer consistent with existing*  
31 *state and federal law and regulation. For these purposes, public*  
32 *health benefit programs include, but are not limited to, the*  
33 *Medi-Cal program, Healthy Families Program, Major Risk*  
34 *Medical Insurance Program, and Access for Infants and Mothers*  
35 *program.*

36 *2160.5. The Employment Development Department shall*  
37 *adopt regulations to ensure that employers abide by the provisions*  
38 *of this chapter. The regulations may initially be adopted as*  
39 *emergency regulations in accordance with the Administrative*  
40 *Procedure Act (Chapter 3.5 (commencing with Section 11340) of*



1 *Part 1 of Division 3 of Title 2 of the Government Code, but those*  
 2 *emergency regulations shall be in effect only from the effective date*  
 3 *of this part until after the requirements of this program are in effect*  
 4 *for large and medium employers as provided in Section 2120.1.*

5 2160.7. (a) *Any new employer or existing employer that*  
 6 *previously was not subject to this part shall begin complying with*  
 7 *all applicable provisions of this part within one month of the date*  
 8 *it became subject to this part.*

9 (b) *Any existing employer previously subject to this part but no*  
 10 *longer subject to this part shall notify the Employment*  
 11 *Development Department in a manner prescribed by that*  
 12 *department within 15 days of this change before discontinuing to*  
 13 *comply with the provisions of this part.*

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#### 15 CHAPTER 7. PARTICIPATING HEALTH PLANS

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17 2170. *Notwithstanding any other provision of law, the board*  
 18 *shall not be subject to licensure or regulation by the Department*  
 19 *of Insurance or the Department of Managed Health Care.*

20 2171. *The board shall contract only with insurers that can*  
 21 *demonstrate compliance with Section 10761.2 of the Insurance*  
 22 *Code and only with health care service plans that can demonstrate*  
 23 *compliance with the requirements of Section 1357.23 of the Health*  
 24 *and Safety Code.*

25 2173. (a) *The board shall develop and utilize appropriate*  
 26 *cost containment measures to maximize the cost-effectiveness of*  
 27 *health care coverage offered under the program. The board shall*  
 28 *consider the findings of the California Health Care Quality*  
 29 *Improvement and Cost Containment Commission.*

30 (b) *Health care service plans, health insurers, and providers*  
 31 *are encouraged to develop innovative approaches, services, and*  
 32 *programs that may have the potential to deliver health care that is*  
 33 *both cost-effective and responsive to the needs of enrollees.*

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#### 35 CHAPTER 8. ENROLLMENT AND COORDINATION WITH PUBLIC 36 PROGRAMS

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38 2190. (a) *Employers shall provide information to the board*  
 39 *regarding potential enrollees, and, if applicable, dependents as*  
 40 *prescribed by the board to assist the board in obtaining*



1 *information necessary for enrollment. In no case shall the board*  
2 *require the employer to obtain from the potential enrollee*  
3 *information about the family income or other eligibility*  
4 *requirements for Medi-Cal, Healthy Families, or other public*  
5 *programs other than that information about the enrollee's*  
6 *employment status otherwise known to the employer consistent*  
7 *with existing state and federal law and regulation.*

8 *(b) The board shall obtain enrollment information from*  
9 *potential enrollees and, if applicable, dependents to be covered by*  
10 *the program. The enrollee may voluntarily provide information*  
11 *sufficient to determine whether the enrollee or dependents may be*  
12 *eligible for coverage under Medi-Cal, Healthy Families, or other*  
13 *public programs if the enrollee chooses to seek enrollment in those*  
14 *programs. The board shall use a uniform enrollment form for*  
15 *obtaining that information. The board shall provide information*  
16 *to enrollees covered by the program regarding the coverage*  
17 *available under the program and other programs, including*  
18 *Medi-Cal and Healthy Families, for which enrollees or*  
19 *dependents may be eligible.*

20 *2190.1. (a) An enrollee or dependent who would qualify for*  
21 *Medi-Cal pursuant to Chapter 7 (commencing with Section*  
22 *14000) of Part 3 of Division 6 of the Welfare and Institutions Code*  
23 *and who chooses to provide information about eligibility for the*  
24 *Medi-Cal program shall be enrolled in the Medi-Cal program if*  
25 *determined by the State Department of Health Services to be*  
26 *eligible for that program and shall be charged share of cost,*  
27 *copays, coinsurance, or deductibles in accordance with the*  
28 *requirements of that program.*

29 *(b) An enrollee or dependent who would qualify for the Healthy*  
30 *Families Program pursuant to Part 6.2 (commencing with Section*  
31 *12693) of the Insurance Code and who chooses to provide*  
32 *information about eligibility for the Healthy Families Program*  
33 *shall be enrolled in the Healthy Families Program if determined*  
34 *eligible for that program and shall be charged share of premium,*  
35 *copays, coinsurance, or deductibles in accordance with the*  
36 *requirements of that program.*

37 *2190.2. (a) The board shall provide to the State Department*  
38 *of Health Services information concerning the potential or*  
39 *continuing eligibility of enrollees and dependents in the program*  
40 *for Medi-Cal.*



1 (b) (1) For those enrollees and dependents of the program who  
2 are determined to be eligible for Medi-Cal, the board shall provide  
3 the state share of financial participation for the cost of Medi-Cal  
4 coverage provided through the program.

5 (2) For those enrollees and dependents of the program who are  
6 determined to be eligible for Healthy Families, the board shall  
7 provide the state share of financial participation for the cost of  
8 Healthy Families coverage provided through the program.

9 (c) Nothing in this part shall affect the authority of the State  
10 Department of Health Services or the board to verify eligibility as  
11 required by federal law.

12 (d) The board shall have authority to make any necessary  
13 repayments of enrollee contributions to persons whose coverage  
14 is provided under this section, and may also delegate to the State  
15 Department of Health Services the authority to repay those  
16 contributions.

17 (e) The State Department of Health Services shall seek all state  
18 plan amendments and federal approvals as necessary to maximize  
19 the amount of any federal financial participation available.

20 2190.3. Nothing in this part shall be construed to diminish or  
21 otherwise change existing protections in law for persons eligible  
22 for public programs, including, but not limited to, California  
23 Children's Services, Genetically Handicapped Persons Program,  
24 county mental health programs, programs administered by the  
25 Department of Alcohol and Drug programs, or programs  
26 administered by local education agencies.

27 2190.4. In implementing this part, the board shall consult  
28 with organizations representing the interests of enrollees,  
29 particularly those who may be covered by public programs as well  
30 as family members, providers, advocacy organizations, and plans  
31 providing coverage under public programs.

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#### CHAPTER 9. ADMINISTRATION

34

35 2200. A contract entered into by the board pursuant to this  
36 part shall be exempt from any provision of law relating to  
37 competitive bidding, and shall be exempt from the review or  
38 approval of any division of the Department of General Services.  
39 The board shall not be required to specify the amounts encumbered  
40 for each contract, but may allocate funds to each contract based



1 on the projected or actual enrollee enrollments to a total amount  
2 not to exceed the amount appropriate for the program including  
3 applicable contributions.

4 2210. (a) The State Health Purchasing Fund is hereby  
5 created in the State Treasury and, notwithstanding Section 13340  
6 of the Government Code, is continuously appropriated to the  
7 board for the purposes specified in this part.

8 (b) The board shall authorize the expenditure from the fund of  
9 applicable employer fees and enrollee contributions that are  
10 deposited into the fund. This shall include the authority for the  
11 board to transfer funds to two separate special deposit funds to be  
12 established by the board pursuant to this part, and administered  
13 respectively by the State Department of Health Services and the  
14 board, to be used as the state’s share of financial participation for  
15 the respective costs of Medi-Cal or Healthy Families coverage  
16 provided to enrollees, and, if applicable, dependents, who enroll  
17 in Medi-Cal or Healthy Families.

18 (c) Notwithstanding Section 2130.4, the board is authorized to  
19 obtain a loan from the General Fund for all necessary and  
20 reasonable expenses related to the establishment and  
21 administration of this part prior to the collection of the employer  
22 fee. The proceeds of the loan are subject to appropriation in the  
23 annual Budget Act. The board shall repay principal and interest,  
24 using the rate of interest paid under the Pooled Money Investment  
25 Account, to the General Fund no later than five years after the first  
26 year of implementation of the employer fee.

27 SEC. 3. Article 3.11 (commencing with Section 1357.20) is  
28 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
29 to read:

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Article 3.11. Insurance Market Reform

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1357.20. If the provisions of Part 8.7 (commencing with  
Section 2120) of Division 2 of the Labor Code are held invalid,  
then the provisions of this article shall become inoperative.

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1357.21. (a) Notwithstanding any other provision of law, on  
and after January 1, 2006, except as specified in subdivision (b),  
all requirements in Article 3.1 (commencing with Section 1357)  
applicable to offering, marketing, and selling health care service  
plan contracts to small employers as defined in that article,



1 including, but not limited to, the obligation to fairly and  
2 affirmatively offer, market, and sell all of the plan's contracts to all  
3 employers, guaranteed renewal of all health care service plan  
4 contracts, use of the risk adjustment factor, and the restriction of  
5 risk categories to age, geographic region, and family composition  
6 as described in that article, shall be applicable to all health care  
7 service plan contracts offered to all small and medium employers  
8 providing coverage to employees pursuant to Part 8.7  
9 (commencing with Section 2120) of Division 2 of the Labor Code,  
10 except as follows:

11 (1) For small and medium employers with two to 50 eligible  
12 employees, all requirements in that article shall apply. As used in  
13 this article, "small employer" shall have the meaning as defined  
14 in Section 2122.5 of the Labor Code and "medium employer"  
15 shall have the meaning as defined in Section 2122.4 of the Labor  
16 Code, unless the context otherwise requires.

17 (2) For medium employers with 51 or more eligible employees,  
18 all requirements in that article shall apply, except that the health  
19 care service plan may develop health care coverage benefit plan  
20 designs to fairly and affirmatively market only to medium  
21 employer groups of 51 to 199 eligible employees, and apply a risk  
22 adjustment factor of no more than 115 percent and no less than 85  
23 percent of the standard employee risk rate.

24 (b) Health care service plans shall be required to comply with  
25 this section only beginning with the date when coverage begins to  
26 be offered through the State Health Purchasing Program pursuant  
27 to Part 8.7 (commencing with Section 2120 of Division 2 of the  
28 Labor Code.

29 1357.22. On and after January 1, 2006, a health care service  
30 plan contract with an employer as defined in Section 2122.6 of the  
31 Labor Code providing health coverage to enrollees or subscribers  
32 shall meet all of the following requirements:

33 (a) The employer shall be responsible for the cost of health care  
34 coverage except as provided in this section.

35 (b) An employer may require a potential enrollee to pay up to  
36 20 percent of the cost of the coverage, proof of which is provided  
37 by the employer in lieu of paying the fee required by Part 8.7  
38 (commencing with Section 2120) of Division 2 of the Labor Code,  
39 unless the wages of the potential enrollee are less than 200 percent  
40 of the federal poverty guidelines, as specified annually by the



1 *United States Department of Health and Human Services. For*  
2 *enrollees making a contribution for family coverage and whose*  
3 *wages are less than 200 percent of the federal poverty guidelines*  
4 *for a family of three, the applicable enrollee contribution shall not*  
5 *exceed 5 percent of wages. For enrollees making a contribution for*  
6 *individual coverage and whose wages are less than 200 percent of*  
7 *the federal poverty guidelines for an individual, the applicable*  
8 *enrollee contribution shall not exceed 5 percent of wages of the*  
9 *individual.*

10 (c) *If an employer, as defined in Section 2122.6 of the Labor*  
11 *Code, chooses to purchase more than one means of coverage for*  
12 *potential enrollees and, if applicable, dependents, the employer*  
13 *may require a higher level of contribution from potential enrollees*  
14 *as long as one means of coverage meets the standards of this*  
15 *section.*

16 (d) *An employer, as defined in Section 2122.6 of the Labor*  
17 *Code, may purchase health care coverage that includes additional*  
18 *out-of-pocket expenses, such as copayments, coinsurance, or*  
19 *deductibles. In reviewing subscriber or enrollee share of premium,*  
20 *deductibles, copayments, and other out-of-pocket costs, the*  
21 *department shall consider those permitted by the board under Part*  
22 *8.7 (commencing with Section 2120) of Division 2 of the Labor*  
23 *Code.*

24 (e) *Notwithstanding subdivision (b), a medium employer may*  
25 *require an enrollee to contribute more than 20 percent of the cost*  
26 *of coverage if both of the following apply:*

27 (1) *The coverage provided by the employer includes coverage*  
28 *for dependents.*

29 (2) *The employer contributes an amount that exceeds 80*  
30 *percent of the cost of the coverage for an individual employee.*

31 (f) *The contract includes prescription drug coverage with*  
32 *out-of-pocket costs for enrollees consistent with subdivision (d).*

33 1357.23. *On and after January 1, 2006, all health care service*  
34 *plans contracting with employers consistent with Section 1357.22*  
35 *or with the State Health Purchasing Program shall make*  
36 *reasonable efforts to contract with county hospital systems and*  
37 *clinics, including providers or networks of providers that refer*  
38 *enrollees to such hospitals and clinics, as well as community*  
39 *clinics and other safety net providers. This section shall not*  
40 *prohibit a plan from applying appropriate credentialing*



1 requirements consistent with this chapter. This section shall not  
2 apply to a nonprofit health care service plan that provides hospital  
3 services to its enrollees primarily through a nonprofit hospital  
4 corporation with which the health care service plan shares an  
5 identical board of directors.

6 SEC. 4. Chapter 8.1 (commencing with Section 10760) is  
7 added to Part 2 of Division 2 of the Insurance Code, to read:

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9

CHAPTER 8.1. INSURANCE MARKET REFORM

10

11 10760. If the provisions of Part 8.7 (commencing with Section  
12 2120) of Division 2 of the Labor Code are held invalid, then the  
13 provisions of this chapter shall become inoperative.

14 10761. (a) Notwithstanding any other provision of law, on  
15 and after January 1, 2006, except as specified in subdivision (b),  
16 all requirements in Chapter 8 (commencing with Section 10700)  
17 applicable to offering, marketing, and selling health benefit plans  
18 to small employers as defined in that chapter, including, but not  
19 limited to, the obligation to fairly and affirmatively offer, market,  
20 and sell all of the insurer's health benefit plans to all employers,  
21 guaranteed renewal of all health benefit plans, use of the risk  
22 adjustment factor, and the restriction of risk categories to age,  
23 geographic region, and family composition as described in that  
24 chapter, shall be applicable to all health benefit plans offered to  
25 all small and medium employers providing coverage to employees  
26 pursuant to Part 8.7 (commencing with Section 2120) of Division  
27 2 of the Labor Code, except as follows:

28 (1) For small and medium employers with two to 50 eligible  
29 employees, all requirements in that chapter shall apply. As used in  
30 this chapter, "small employer" shall have the meaning as defined  
31 in Section 2122.5 of the Labor Code and "medium employer"  
32 shall have the meaning as defined in Section 2122.4 of the Labor  
33 Code, unless the context otherwise requires.

34 (2) For medium employers with 51 or more eligible employees,  
35 all requirements in that chapter shall apply, except that the health  
36 insurers may develop health care coverage benefit plan designs to  
37 fairly and affirmatively market only to medium employer groups  
38 of 51 to 199 eligible employees, and apply a risk adjustment factor  
39 of no more than 115 percent and no less than 85 percent of the  
40 standard employee risk rate.



1 (b) Insurers shall be required to comply with this section only  
2 beginning with the date when coverage begins to be offered  
3 through the State Health Purchasing Program pursuant to Part 8.7  
4 (commencing with Section 2120) of Division 2 of the Labor Code.

5 10762. On and after January 1, 2006, a health insurer selling  
6 a policy to an employer, as defined in Section 2122.6 of the Labor  
7 Code, providing health coverage to insureds pursuant to Part 8.7  
8 (commencing with Section 2120) of Division 2 of the Labor Code  
9 shall meet all of the following requirements:

10 (a) The employer shall be responsible for the cost of health care  
11 coverage except as provided in this section.

12 (b) An employer may require a potential enrollee to pay up to  
13 20 percent of the cost of the coverage, proof of which is provided  
14 by the employer in lieu of paying the fee required by Part 8.7  
15 (commencing with Section 2120) of Division 2 of the Labor Code,  
16 unless the wages of the potential enrollee are less than 200 percent  
17 of the federal poverty guidelines, as specified annually by the  
18 United States Department of Health and Human Services. For  
19 enrollees making a contribution for family coverage and whose  
20 wages are less than 200 percent of the federal poverty guidelines  
21 for a family of three, the applicable enrollee contribution shall not  
22 exceed 5 percent of wages. For enrollees making a contribution for  
23 individual coverage and whose wages are less than 200 percent of  
24 the federal poverty guidelines for an individual, the applicable  
25 enrollee contribution shall not exceed 5 percent of wages of the  
26 individual.

27 (c) If an employer, as defined in Section 2122.6 of the Labor  
28 Code, chooses to purchase more than one means of coverage for  
29 potential enrollees and, if applicable, dependents, the employer  
30 may require a higher level of contribution from potential enrollees  
31 as long as one means of coverage meets the standards of this  
32 section.

33 (d) An employer, as defined in Section 2122.6 of the Labor  
34 Code, may purchase health care coverage that includes additional  
35 out-of-pocket expenses, such as copayments, coinsurance, or  
36 deductibles. In reviewing enrollee share of premium, deductibles,  
37 copayments, and other out-of-pocket costs, the department shall  
38 consider those permitted by the board under Part 8.7 (commencing  
39 with Section 2120) of Division 2 of the Labor Code.



1 (e) Notwithstanding subdivision (b), a medium employer may  
2 require an enrollee to contribute more than 20 percent of the cost  
3 of coverage if both of the following apply:

4 (1) The coverage provided by the employer includes coverage  
5 for dependents.

6 (2) The employer contributes an amount that exceeds 80  
7 percent of the cost of the coverage for an individual employee.

8 (f) The contract includes prescription drug coverage with  
9 out-of-pocket costs for enrollees consistent with subdivision (d).

10 10763. On and after January 1, 2006, all insurers that sell  
11 insurance policies to employers consistent with Section 10762 or  
12 to the State Health Purchasing Program shall make reasonable  
13 efforts to include as preferred providers county hospital systems  
14 and clinics, including providers or networks of providers that refer  
15 enrollees to those hospitals and clinics, as well as community  
16 clinics and other safety net providers. This section shall not  
17 prohibit a plan from applying appropriate credentialing  
18 requirements consistent with this chapter. This section shall not  
19 apply to a nonprofit health care service plan that provides hospital  
20 services to its enrollees primarily through a nonprofit hospital  
21 corporation with which the plan shares an identical board of  
22 directors.

23 10764. (a) On and after January 1, 2006, except as provided  
24 in subdivision (b), health insurers shall not offer or sell the  
25 following insurance policies to employers providing coverage to  
26 employees pursuant to Part 8.7 (commencing with Section 2120)  
27 of Division 2 of the Labor Code:

28 (1) A Medicare supplement, vision-only, dental-only, or  
29 Champus-supplement insurance policy.

30 (2) A hospital indemnity, accident-only, or specified disease  
31 insurance policy that pays benefits on a fixed benefit,  
32 cash-payment-only basis.

33 (b) However, an insurer may sell one or more of the types of  
34 policies listed in paragraph (1) or (2) of subdivision (a) if the  
35 employer has purchased or purchases concurrently health care  
36 coverage meeting the standards of Part 8.7 (commencing with  
37 Section 2120) of Division 2 of the Labor Code.

38 (c) If an employer, as defined in Section 2022.6 of the Labor  
39 Code, chooses to purchase more than one means of coverage, the  
40 employer may require a higher level of contribution from potential



1 enrollees so long as one means of coverage meets the standards of  
2 this section.

3 (d) An employer, as defined in Section 2122.6 of the Labor  
4 Code, may purchase health care coverage that includes additional  
5 out-of-pocket expenses, such as coinsurance or deductibles. In  
6 reviewing the share of premium, deductibles, copayments, and  
7 other out-of-pocket costs paid by insureds, the department shall  
8 consider those permitted by the board under Part 8.7 (commencing  
9 with Section 2120) of Division 2 of the Labor Code.

10 (e) Notwithstanding subdivision (b), a medium employer, as  
11 defined in Section 2122.4 of the Labor Code, may require an  
12 enrollee to contribute more than 20 percent of the cost of coverage  
13 if both of the following apply:

14 (1) The coverage provided by the employer includes coverage  
15 for dependents.

16 (2) The employer contributes an amount that exceeds 80  
17 percent of the cost of the coverage for an individual employee

18 (f) The policy includes prescription drug coverage, which shall  
19 be subject to coinsurance, deductibles, and other out-of-pocket  
20 costs consistent with (d).

21 SEC. 5. Section 12693.55 is added to the Insurance Code, to  
22 read:

23 12693.55. (a) Prior to implementation of the Health  
24 Insurance Act of 2003, the board shall to the maximum extent  
25 permitted by federal law ensure that persons who are either  
26 covered or eligible for Healthy Families will retain the same  
27 amount, duration, and scope of benefits that they currently receive  
28 or are currently eligible to receive, including dental, vision and  
29 mental benefits. The board shall consult with a stakeholder group  
30 that shall include all of the following:

31 (1) Consumer advocate groups that represent persons eligible  
32 for Healthy Families.

33 (2) Organizations that represent persons with disabilities.

34 (3) Representatives of public hospitals, clinics, safety net  
35 providers, and other providers.

36 (4) Labor organizations that represent employees whose  
37 families include persons likely to be eligible for Healthy Families.

38 (5) Employer organizations.

39 (b) The board shall develop a Healthy Families premium  
40 assistance program for eligible individuals as permitted under



1 *federal law to reduce state costs and maximize federal financial*  
2 *participation by providing health care coverage to eligible*  
3 *individuals through a combination of available employer-based*  
4 *coverage and a wraparound benefit that covers any gap between*  
5 *the employer-based coverage and the benefits required by this*  
6 *part.*

7 *(c) The board shall do all of the following in implementing the*  
8 *premium assistance program:*

9 *(1) Require eligible individuals with access to employer-based*  
10 *coverage to enroll themselves or their family or both in the*  
11 *available employer-based coverage if the board finds that*  
12 *enrollment in that coverage is cost-effective.*

13 *(2) Promptly reimburse an eligible individual for his or her*  
14 *share of premium cost under the employer-based coverage, minus*  
15 *any contribution that an individual would be required to pay*  
16 *pursuant to Section 12693.43.*

17 *(d) If federal approval of a premium assistance program cannot*  
18 *be obtained, the board in consultation with the stakeholder group*  
19 *shall explore alternatives that provide that persons who are either*  
20 *covered or eligible for Healthy Families retain the same amount,*  
21 *duration and scope of benefits that they currently receive or are*  
22 *currently eligible to receive, including vision, dental and mental*  
23 *health benefits.*

24 *SEC. 6. Section 131 of the Unemployment Insurance Code is*  
25 *amended to read:*

26 131. “Contributions” means the money payments to the  
27 Unemployment Fund, Employment Training Fund, *State Health*  
28 *Purchasing Fund*, or Unemployment Compensation Disability  
29 Fund which are required by this division.

30 *SEC. 7. Section 976.7 is added to the Unemployment*  
31 *Insurance Code, to read:*

32 976.7. (a) *In addition to other contributions required by this*  
33 *division and consistent with the requirements of Chapter 6*  
34 *(commencing with Section 2160) of Part 8.7 of Division 2 of the*  
35 *Labor Code, an employer shall pay to the department for deposit*  
36 *into the State Health Purchasing Fund a fee in the amount set by*  
37 *the Managed Risk Medical Insurance Board for the State Health*  
38 *Purchasing Program in accordance with Chapter 4 (commencing*  
39 *with Section 2140) of Part 8.7 of Division 2 of the Labor Code. The*



1 *fees shall be collected in the same manner and at the same time as*  
2 *any contributions required under Sections 976 and 1088.*

3 *(b) In notifying employers of the contributions required under*  
4 *this section, the department shall also provide notice of required*  
5 *employee contribution amounts consistent with Section 2150 of the*  
6 *Labor Code.*

7 *(c) An employer shall provide information to all newly hired*  
8 *and existing employees regarding the availability of Medi-Cal*  
9 *coverage for low- and moderate-income employees, including the*  
10 *availability of Medi-Cal premium assistance as well as Medi-Cal*  
11 *coverage for persons receiving coverage through the State Health*  
12 *Purchasing Fund. The Employment Development Department, in*  
13 *consultation with the State Department of Health Services and the*  
14 *Managed Risk Medical Insurance Board shall develop a simple,*  
15 *uniform notice containing that information.*

16 *SEC. 8. Section 14105.981 is added to the Welfare and*  
17 *Institutions Code, to read:*

18 *14105.981. (a) Prior to the implementation of the Health*  
19 *Insurance Act of 2003, annually for five years after its*  
20 *implementation, and every five years thereafter, the department*  
21 *shall report to the Legislature and the Managed Risk Medical*  
22 *Insurance Board regarding utilization patterns for Medi-Cal*  
23 *pursuant to Chapter 7 (commencing with Section 14000) of Part*  
24 *3 of Division 6 at county-owned hospitals and clinics, community*  
25 *clinics, and vital institutional safety net providers eligible for*  
26 *Medi-Cal payments under Section 14105.98, including*  
27 *determining the number of Medi-Cal inpatient days and outpatient*  
28 *visits as well as the nature and cost of care provided to Medi-Cal*  
29 *patients.*

30 *(b) If Medi-Cal fee-for-service utilization or Medi-Cal*  
31 *fee-for-service payments to county-owned hospitals and clinics,*  
32 *community clinics, and other vital institutional safety net*  
33 *providers eligible for Medi-Cal payments under Section 14105.98*  
34 *have been reduced, then the department shall review statute,*  
35 *regulations, policies and procedures, payment arrangements or*  
36 *other mechanisms to determine what changes may be necessary to*  
37 *protect Medi-Cal funding and maximize federal financial*  
38 *participation to protect the financial stability of county-owned*  
39 *hospitals and clinics, community clinics, and other vital*  
40 *institutional safety net providers. The department shall consult*



1 *with representatives of county-owned hospital systems, community*  
2 *clinics, vital institutional safety net providers eligible for*  
3 *Medi-Cal payments under Section 14105.98, legal services*  
4 *advocates, and recognized collective bargaining agents for the*  
5 *specified providers.*

6 *SEC. 9. Section 14124.91 of the Welfare and Institutions Code*  
7 *is amended to read:*

8 14124.91. (a) The State Department of Health Services shall,  
9 whenever it is cost-effective, pay the premium for third-party  
10 health coverage for beneficiaries under this chapter. The State  
11 Department of Health Services shall, when a beneficiary's  
12 third-party health coverage would lapse due to loss of employment  
13 or change in health status, lack of sufficient income or financial  
14 resources, or any other reason, continue the health coverage by  
15 paying the costs of continuation of group coverage pursuant to  
16 federal law or converting from a group to an individual plan,  
17 whenever it is cost-effective. Notwithstanding any other provision  
18 of a contract or of law, the time period for the department to  
19 exercise either of these options shall be 60 days from the date of  
20 lapse of the policy.

21 (b) *In addition, contingent on federal financial participation,*  
22 *the department shall implement a Medi-Cal premium assistance*  
23 *program to reduce state costs and maximize allowable federal*  
24 *financial participation by paying the premium for employer-based*  
25 *health care coverage available to persons who are eligible for*  
26 *Medi-Cal, and in combination with employer-based health care*  
27 *coverage providing a wraparound benefit that covers any gap*  
28 *between the employer-based health care coverage and the benefits*  
29 *provided by the Medi-Cal program.*

30 (c) *The department in implementing the premium assistance*  
31 *program shall promptly reimburse an applicant for Medi-Cal for*  
32 *his or her share of premium, minus any share of cost required*  
33 *pursuant to this part. Once enrolled in both the premium assistance*  
34 *program and employer-based health care coverage repayment to*  
35 *Medi-Cal covered enrollees of any share of premium shall coincide*  
36 *with the payment by the enrollee of the premium for the available*  
37 *employer-based health care coverage. Where the applicant or*  
38 *beneficiary avails himself or herself of the wraparound benefit,*  
39 *Medi-Cal shall pay for any copayments, deductibles, and other*



1 allowable out-of-pocket medical costs under the employer-based  
2 coverage.

3 (d) The department shall seek all state plan amendments and  
4 federal approvals as necessary to maximize the amount of any  
5 federal financial participation available.

6 SEC. 10. Section 14124.915 is added to the Welfare and  
7 Institutions Code, to read:

8 14124.915. (a) Six months prior to implementation of Part  
9 8.7 (commencing with Section 2120) of Division 2 of the Labor  
10 Code, the department shall notify Medi-Cal enrollees of the  
11 implementation of the Health Insurance Act of 2003, the  
12 categories of enrollees covered, the requirements of the program,  
13 the availability of Medi-Cal coverage for those persons, including  
14 the availability of a premium assistance program for those persons  
15 eligible for Medi-Cal who are also covered by employer-based  
16 coverage.

17 (b) Three months prior to the implementation of each phase of  
18 the program created by the Health Insurance Act of 2003, those  
19 persons enrolled in Medi-Cal shall be offered the opportunity to  
20 enroll in a Medi-Cal premium assistance program.

21 SEC. 11. Section 14124.916 is added to the Welfare and  
22 Institutions Code, to read:

23 14124.916. (a) Prior to the implementation of the Health  
24 Insurance Act of 2003, the department shall convene a stakeholder  
25 group that includes, but is not limited to, the following members:

26 (1) The Managed Risk Medical Insurance Board.

27 (2) Representatives of county welfare departments.

28 (3) Consumer advocacy groups that represent persons enrolled  
29 in or eligible to be enrolled in the Medi-Cal program.

30 (4) Organizations that represent persons with disabilities.

31 (5) Labor organizations that represent employees and their  
32 dependents who are likely to be eligible for enrollment in  
33 Medi-Cal.

34 (6) Representatives of public hospitals, clinics, provider  
35 groups, and safety net providers.

36 (b) The department in consultation with the stakeholder group  
37 shall develop a plan to accomplish the following objectives:

38 (1) Provide that enrollees and, if applicable, dependents who  
39 receive coverage consistent with the Health Insurance Act of 2003  
40 and who are enrolled in Medi-Cal retain the same amount,



1 duration, and scope of benefits to which those beneficiaries  
2 currently are entitled.

3 (2) Provide that enrollees and, if applicable, dependents who  
4 receive coverage consistent with the Health Insurance Act of 2003  
5 and who are enrolled in Medi-Cal do not incur greater  
6 cost-sharing, including premiums, deductibles, and copays, than  
7 currently allowed under federal Medicaid law.

8 (3) Maximize continuity of care for enrollees and, if applicable,  
9 dependents who receive coverage consistent with the Health  
10 Insurance Act of 2003 and who are enrolled in Medi-Cal.

11 (4) Streamline and simplify eligibility and enrollment  
12 requirements for Medi-Cal beneficiaries who also have other  
13 coverage.

14 (c) The department shall report to the Legislature every six  
15 months and shall submit its final plan to the Legislature three  
16 months prior to initial implementation of the Health Insurance Act  
17 of 2003.

18 (d) The department shall seek all state plan amendments and  
19 federal approvals as necessary to maximize the amount of any  
20 federal financial participation available.

21 SEC. 12. Section 6254 of the Government Code is amended to  
22 read:

23 6254. Except as provided in Sections 6254.7 and 6254.13,  
24 nothing in this chapter shall be construed to require disclosure of  
25 records that are any of the following:

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

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

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

37 (d) Contained in or related to any of the following:

38 (1) Applications filed with any state agency responsible for the  
39 regulation or supervision of the issuance of securities or of  
40 financial institutions, including, but not limited to, banks, savings



1 and loan associations, industrial loan companies, credit unions,  
2 and insurance companies.

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

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

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

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

15 (f) Records of complaints to, or investigations conducted by, or  
16 records of intelligence information or security procedures of, the  
17 office of the Attorney General and the Department of Justice, and  
18 any state or local police agency, or any investigatory or security  
19 files compiled by any other state or local police agency, or any  
20 investigatory or security files compiled by any other state or local  
21 agency for correctional, law enforcement, or licensing purposes,  
22 except that state and local law enforcement agencies shall disclose  
23 the names and addresses of persons involved in, or witnesses other  
24 than confidential informants to, the incident, the description of any  
25 property involved, the date, time, and location of the incident, all  
26 diagrams, statements of the parties involved in the incident, the  
27 statements of all witnesses, other than confidential informants, to  
28 the victims of an incident, or an authorized representative thereof,  
29 an insurance carrier against which a claim has been or might be  
30 made, and any person suffering bodily injury or property damage  
31 or loss, as the result of the incident caused by arson, burglary, fire,  
32 explosion, larceny, robbery, carjacking, vandalism, vehicle theft,  
33 or a crime as defined by subdivision (c) of Section 13960, unless  
34 the disclosure would endanger the safety of a witness or other  
35 person involved in the investigation, or unless disclosure would  
36 endanger the successful completion of the investigation or a  
37 related investigation. However, nothing in this division shall  
38 require the disclosure of that portion of those investigative files  
39 that reflect the analysis or conclusions of the investigating officer.



1 Notwithstanding any other provision of this subdivision, state  
2 and local law enforcement agencies shall make public the  
3 following information, except to the extent that disclosure of a  
4 particular item of information would endanger the safety of a  
5 person involved in an investigation or would endanger the  
6 successful completion of the investigation or a related  
7 investigation:

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

17 (2) Subject to the restrictions imposed by Section 841.5 of the  
18 Penal Code, the time, substance, and location of all complaints or  
19 requests for assistance received by the agency and the time and  
20 nature of the response thereto, including, to the extent the  
21 information regarding crimes alleged or committed or any other  
22 incident investigated is recorded, the time, date, and location of  
23 occurrence, the time and date of the report, the name and age of the  
24 victim, the factual circumstances surrounding the crime or  
25 incident, and a general description of any injuries, property, or  
26 weapons involved. The name of a victim of any crime defined by  
27 Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286,  
28 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code  
29 may be withheld at the victim's request, or at the request of the  
30 victim's parent or guardian if the victim is a minor. When a person  
31 is the victim of more than one crime, information disclosing that  
32 the person is a victim of a crime defined by Section 220, 261,  
33 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6,  
34 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the  
35 request of the victim, or the victim's parent or guardian if the  
36 victim is a minor, in making the report of the crime, or of any crime  
37 or incident accompanying the crime, available to the public in  
38 compliance with the requirements of this paragraph.

39 (3) Subject to the restrictions of Section 841.5 of the Penal  
40 Code and this subdivision, the current address of every individual



1 arrested by the agency and the current address of the victim of a  
2 crime, where the requester declares under penalty of perjury that  
3 the request is made for a scholarly, journalistic, political, or  
4 governmental purpose, or that the request is made for investigation  
5 purposes by a licensed private investigator as described in Chapter  
6 11.3 (commencing with Section 7512) of Division 3 of the  
7 Business and Professions Code, except that the address of the  
8 victim of any crime defined by Section 220, 261, 261.5, 262, 264,  
9 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7,  
10 422.75, or 646.9 of the Penal Code shall remain confidential.  
11 Address information obtained pursuant to this paragraph shall not  
12 be used directly or indirectly to sell a product or service to any  
13 individual or group of individuals, and the requester shall execute  
14 a declaration to that effect under penalty of perjury.

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

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

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

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

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



1 (l) Correspondence of and to the Governor or employees of the  
2 Governor's office or in the custody of or maintained by the  
3 Governor's legal affairs secretary, provided that public records  
4 shall not be transferred to the custody of the Governor's Legal  
5 Affairs Secretary to evade the disclosure provisions of this chapter.

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

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

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

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

37 (q) Records of state agencies related to activities governed by  
38 Article 2.6 (commencing with Section 14081), Article 2.8  
39 (commencing with Section 14087.5), and Article 2.91  
40 (commencing with Section 14089) of Chapter 7 of Part 3 of



1 Division 9 of the Welfare and Institutions Code, that reveal the  
2 special negotiator's deliberative processes, discussions,  
3 communications, or any other portion of the negotiations with  
4 providers of health care services, impressions, opinions,  
5 recommendations, meeting minutes, research, work product,  
6 theories, or strategy, or that provide instruction, advice, or training  
7 to employees.

8 Except for the portion of a contract containing the rates of  
9 payment, contracts for inpatient services entered into pursuant to  
10 these articles, on or after April 1, 1984, shall be open to inspection  
11 one year after they are fully executed. In the event that a contract  
12 for inpatient services that is entered into prior to April 1, 1984, is  
13 amended on or after April 1, 1984, the amendment, except for any  
14 portion containing the rates of payment, shall be open to inspection  
15 one year after it is fully executed. If the California Medical  
16 Assistance Commission enters into contracts with health care  
17 providers for other than inpatient hospital services, those contracts  
18 shall be open to inspection one year after they are fully executed.

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

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

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

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

33 (t) Records of a local hospital district, formed pursuant to  
34 Division 23 (commencing with Section 32000) of the Health and  
35 Safety Code, or the records of a municipal hospital, formed  
36 pursuant to Article 7 (commencing with Section 37600) or Article  
37 8 (commencing with Section 37650) of Chapter 5 of Division 3 of  
38 Title 4 of this code, that relate to any contract with an insurer or  
39 nonprofit hospital service plan for inpatient or outpatient services  
40 for alternative rates pursuant to Section 10133 or 11512 of the



1 Insurance Code. However, the record shall be open to inspection  
2 within one year after the contract is fully executed.

3 (u) (1) Information contained in applications for licenses to  
4 carry firearms issued pursuant to Section 12050 of the Penal Code  
5 by the sheriff of a county or the chief or other head of a municipal  
6 police department that indicates when or where the applicant is  
7 vulnerable to attack or that concerns the applicant's medical or  
8 psychological history or that of members of his or her family.

9 (2) The home address and telephone number of peace officers,  
10 judges, court commissioners, and magistrates that are set forth in  
11 applications for licenses to carry firearms issued pursuant to  
12 Section 12050 of the Penal Code by the sheriff of a county or the  
13 chief or other head of a municipal police department.

14 (3) The home address and telephone number of peace officers,  
15 judges, court commissioners, and magistrates that are set forth in  
16 licenses to carry firearms issued pursuant to Section 12050 of the  
17 Penal Code by the sheriff of a county or the chief or other head of  
18 a municipal police department.

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

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

34 (B) In the event that a contract for health coverage that is  
35 entered into prior to July 1, 1991, is amended on or after July 1,  
36 1991, the amendment, except for any portion containing the rates  
37 of payment, shall be open to inspection one year after the  
38 amendment has been fully executed.

39 (3) Three years after a contract or amendment is open to  
40 inspection pursuant to this subdivision, the portion of the contract



1 or amendment containing the rates of payment shall be open to  
2 inspection.

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

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

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

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

29 (x) Financial data contained in applications for registration, or  
30 registration renewal, as a service contractor filed with the Director  
31 of the Department of Consumer Affairs pursuant to Chapter 20  
32 (commencing with Section 9800) of Division 3 of the Business and  
33 Professions Code, for the purpose of establishing the service  
34 contractor's net worth, or financial data regarding the funded  
35 accounts held in escrow for service contracts held in force in this  
36 state by a service contractor.

37 (y) (1) Records of the Managed Risk Medical Insurance Board  
38 related to activities governed by Part 6.2 (commencing with  
39 Section 12693) or Part 6.4 (commencing with Section 12699.50)  
40 of Division 2 of the Insurance Code, and that reveal the



1 deliberative processes, discussions, communications, or any other  
2 portion of the negotiations with health plans, or the impressions,  
3 opinions, recommendations, meeting minutes, research, work  
4 product, theories, or strategy of the board or its staff, or records  
5 that provide instructions, advice, or training to employees.

6 (2) (A) Except for the portion of a contract that contains the  
7 rates of payment, contracts entered into pursuant to Part 6.2  
8 (commencing with Section 12693) or Part 6.4 (commencing with  
9 Section 12699.50) of Division 2 of the Insurance Code, on or after  
10 January 1, 1998, shall be open to inspection one year after they  
11 have been fully executed.

12 (B) In the event that a contract entered into pursuant to Part 6.2  
13 (commencing with Section 12693) or Part 6.4 (commencing with  
14 Section 12699.50) of Division 2 of the Insurance Code is amended,  
15 the amendment shall be open to inspection one year after the  
16 amendment has been fully executed.

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

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

27 (5) The exemption from disclosure provided pursuant to this  
28 subdivision for the contracts, deliberative processes, discussions,  
29 communications, negotiations with health plans, impressions,  
30 opinions, recommendations, meeting minutes, research, work  
31 product, theories, or strategy of the board or its staff shall also  
32 apply to the contracts, deliberative processes, discussions,  
33 communications, negotiations with health plans, impressions,  
34 opinions, recommendations, meeting minutes, research, work  
35 product, theories, or strategy of applicants pursuant to Part 6.4  
36 (commencing with Section 12699.50) of Division 2 of the  
37 Insurance Code.

38 (z) Records obtained pursuant to paragraph (2) of subdivision  
39 (c) of Section 2891.1 of the Public Utilities Code.



1 (aa) A document prepared by a local agency that assesses its  
2 vulnerability to terrorist attack or other criminal acts intended to  
3 disrupt the public agency’s operations and that is for distribution  
4 or consideration in a closed session.

5 (bb) (1) *Records of the Managed Risk Medical Insurance*  
6 *Board related to activities governed by Part 8.7 (commencing with*  
7 *Section 2120) of Division 2 of the Labor Code, and that reveal the*  
8 *deliberative processes, discussions, communications, or any other*  
9 *portion of the negotiations with entities contracting or seeking to*  
10 *contract with the board, or the impressions, opinions,*  
11 *recommendations, meeting minutes, research, work product,*  
12 *theories, or strategy of the board or its staff, or records that provide*  
13 *instructions, advice, or training to employees.*

14 (2) (A) *Except for the portion of a contract that contains the*  
15 *rates of payment, contracts entered into pursuant to Part 8.7*  
16 *(commencing with Section 2120) of Division 2 of the Labor Code*  
17 *on or after January 1, 2004, shall be open to inspection one year*  
18 *after they have been fully executed.*

19 (B) *In the event that a contract entered into pursuant to Part 8.7*  
20 *(commencing with Section 2120) of Division 2 of the Labor Code*  
21 *is amended, the amendment shall be open to inspection one year*  
22 *after the amendment has been fully executed.*

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

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

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

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



1 SEC. 13. (a) *The provisions of this act are severable. If any*  
2 *provision of this act or its application is held invalid, that*  
3 *invalidity shall not affect other provisions or applications that can*  
4 *be given effect without the invalid provision or application, except*  
5 *as provided in subdivision (b) or (c).*

6 (b) *In the event that the provisions of Section 2160.1 of the*  
7 *Labor Code are held invalid and this action is affirmed on final*  
8 *appeal, an employer may qualify for a full credit for those amounts*  
9 *spent for providing or reimbursing health care benefits, allowable*  
10 *by state law as a deductible business expense if the amount spent*  
11 *equals or exceeds the lower of the cost for Healthy Families or 150*  
12 *percent of the cost for Medi-Cal 1931(b) coverage. In no instance*  
13 *shall the amount of the credit exceed the amount of the fee that*  
14 *would otherwise have been paid. The Employment Development*  
15 *Department shall specify the manner and means of submitting*  
16 *proof to obtain the credit.*

17 (c) *In the event that Chapter 8.7 (commencing with Sec. 2120)*  
18 *of Division 2 of the Labor Code is held invalid, Article 3.11*  
19 *(commencing with Section 1357.20) of Chapter 2.2 of Division 2*  
20 *of the Health and Safety Code and Chapter 8.1 (commencing with*  
21 *Section 11760) of Part 2 of Division 2 of the Insurance Code shall*  
22 *become inoperative.*

23 SEC. 14. *This act shall not become operative unless AB 1528*  
24 *of the 2003–04 Regular Session is also enacted and becomes*  
25 *operative.*

26 SEC. 15. *No reimbursement is required by this act pursuant*  
27 *to Section 6 of Article XIII B of the California Constitution*  
28 *because the only costs that may be incurred by a local agency or*  
29 *school district will be incurred because this act creates a new crime*  
30 *or infraction, eliminates a crime or infraction, or changes the*  
31 *penalty for a crime or infraction, within the meaning of Section*  
32 *17556 of the Government Code, or changes the definition of a*  
33 *crime within the meaning of Section 6 of Article XIII B of the*  
34 *California Constitution.*

35 ~~following:~~

36 ~~(a) The Legislature finds and declares that working~~  
37 ~~Californians and their families should have health insurance~~  
38 ~~coverage.~~



1 ~~(b) The Legislature further finds and declares that most~~  
2 ~~working Californians obtain their health insurance coverage~~  
3 ~~through their employment.~~

4 ~~(c) The Legislature finds and declares that in 2001, more than~~  
5 ~~6,000,000 Californians lacked health insurance coverage at some~~  
6 ~~time and 3,600,000 Californians had no health insurance coverage~~  
7 ~~at any time.~~

8 ~~(d) The Legislature finds and declares that more than 80~~  
9 ~~percent of Californians without health insurance coverage are~~  
10 ~~working people or their families. Most of these working~~  
11 ~~Californians without health insurance coverage work for~~  
12 ~~employers who do not offer health benefits.~~

13 ~~(e) The Legislature finds and declares that people who are~~  
14 ~~covered by health insurance have better health outcomes than~~  
15 ~~those who lack coverage. Persons without health insurance are~~  
16 ~~more likely to be in poor health, more likely to have missed needed~~  
17 ~~medications and treatment, and more likely to have chronic health~~  
18 ~~conditions that are not properly managed.~~

19 ~~(f) The Legislature finds and declares that employers who do~~  
20 ~~not provide health benefits to their workers have an unfair~~  
21 ~~competitive advantage over those employers who provide health~~  
22 ~~benefits. Employers who provide health benefits often pay directly~~  
23 ~~for the failure of other employers to provide health benefits by~~  
24 ~~providing health benefits to spouses and other dependents who~~  
25 ~~should be covered by the spouse's or dependent's employer.~~  
26 ~~Employers who provide health benefits also pay directly when a~~  
27 ~~previously uninsured person becomes an employee and the~~  
28 ~~accumulated health costs due to lack of insurance burden the~~  
29 ~~employer providing health benefits.~~

30 ~~(g) The Legislature further finds and declares that health~~  
31 ~~benefit costs in California generally are lower than costs in other~~  
32 ~~states but employers generally are less likely to offer coverage.~~

33 ~~(h) The Legislature further finds and declares that controlling~~  
34 ~~health care costs can be more readily achieved if all working~~  
35 ~~people and their families have health benefits so that cost shifting~~  
36 ~~is minimized.~~

37 ~~(i) It is therefore the intent of the Legislature to assure that~~  
38 ~~working Californians and their families have health benefits and~~  
39 ~~that their employers shall either provide those benefits or pay a~~  
40 ~~user fee to the State of California so that the state may serve as a~~



1 ~~purchasing agent to pool those fees to purchase coverage that~~  
2 ~~would otherwise have been purchased directly by employers.~~

3 ~~(j) The Legislature further finds and declares that, while~~  
4 ~~covering all working people and their families will substantially~~  
5 ~~reduce the number of Californians without health insurance~~  
6 ~~coverage, several million Californians will still lack coverage.~~

7 ~~(k) It is therefore not the intent of the Legislature to reduce or~~  
8 ~~eliminate funding for safety net programs that provide access to~~  
9 ~~care for those who remain uninsured.~~

10 ~~SEC. 2. Part 8.5 (commencing with Section 2020) is added to~~  
11 ~~Division 2 of the Labor Code, to read:~~

12  
13 ~~PART 8.5.—EMPLOYEE HEALTH INSURANCE~~

14  
15 ~~CHAPTER 1.—GENERAL PROVISIONS~~

16  
17 ~~Article 1.—Title and Purpose~~

18  
19 ~~2020.—This part shall be known and may be cited as the Health~~  
20 ~~Insurance Act of 2003.~~

21 ~~2020.5.—It is the purpose of this part to ensure that all working~~  
22 ~~Californians and their families are provided health care coverage.~~

23 ~~2021.—This part shall not be construed to diminish any~~  
24 ~~protection already provided pursuant to collective bargaining~~  
25 ~~agreements or employer-sponsored plans that are more favorable~~  
26 ~~to the employees than the health care coverage required by this~~  
27 ~~part.~~

