AMENDED IN SENATE MAY 16, 2007

AMENDED IN SENATE MAY 1, 2007

AMENDED IN SENATE APRIL 18, 2007

SENATE BILL No. 48

Introduced by Senator Perata
(~~Coauthor: Senator Kuehl~~ *Coauthors: Senators Alquist and Kuehl*)

January 3, 2007

An act to add Section 12803.2 to the Government Code, to add Section 1367.08 to, and to add Article 3.11 (commencing with Section 1357.20) and Article 4.1 (commencing with Section 1366.10) to Chapter 2.2 of Division 2 of, the Health and Safety Code, to amend Sections 12693.43, 12693.70, 12693.73, and 12693.755 of, to add Section 10127.19 to, to add Article 14.9 (commencing with Section 1069) to Chapter 1 of Part 2 of Division 1 of, to add Chapter 1.6 (commencing with Section 10199.10) and Chapter 8.1 (commencing with Section 10760) to Part 2 of Division 2 of, and to add Part 6.45 (commencing with Section 12699.201) to Division 2 of, the Insurance Code, to add Part 8.8 (commencing with Section 2200) to Division 2 of the Labor Code, to amend Section 19552 of, to add Section 17054.2 to, and to add Chapter 11 (commencing with Section 19901) to Part 10.2 of Division 2 of, the Revenue and Taxation Code, to amend Section 131 of, and to add Division 1.2 (commencing with Section 4800) to, the Unemployment Insurance Code, and to amend Sections 14005.23, 14005.30, and 14008.85 of, to add Sections 14005.335 and 14005.34 to, and to add Article 7 (commencing with Section 14199.10) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 48, as amended, Perata. Health care coverage: employers and employees.

Existing law does not provide a system of health care coverage for all California residents. Existing law does not require employers to provide health care coverage for employees and dependents, other than coverage provided as part of the workers' compensation system for work-related employee injuries, and does not require individuals to maintain health care coverage. Existing law provides for the creation of various programs to provide health care coverage to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program, administered by the State Department of Health Care Services. 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, on and after January 1, 2011, would require each employer to spend a ~~designated amount~~ *minimum of 7.5% of the employer's social security wages*, adjusted annually by the board , on health care expenditures for its full-time or part-time employees, or both, and their dependents or, alternatively, would allow employers to elect to pay an employer health care fee in an equivalent *minimum* amount to the Health Care Connector (Connector) created by the bill as a purchasing pool for health care coverage for eligible employees. The Connector would be administered by the Managed Risk Medical Insurance Board. The bill would require employers electing to pay the fee to also collect an employee health care contribution, as determined by the board, from each employee. Revenues from the employer health care fees and employee health care contributions would be collected by the Employment Development Department for deposit in the Health Insurance Trust Fund created by the bill, and moneys in the fund would be continuously appropriated to the board for the purposes of the bill. The bill would require the board to offer eligible employees a choice of various health plans through the Connector, and would require the board to establish standards to cap administrative costs and profits of participating health plans and determine standards for plans to control growing health care costs. The bill would provide for health care subsidies under the Connector to eligible employees who are also

eligible for the Healthy Families Program or the Medi-Cal program. The bill, on and after January 1, 2011, would generally require individuals who are employed to maintain a minimum policy of health care coverage for themselves and their dependents, as determined by the board, but would exempt individuals whose family income is less than 400% of the federal poverty level, individuals whose only source of income is from qualified retirement income, and individuals for whom the minimum policy cost would exceed 5% of the individual's family income.

The bill, subject to future appropriation of funds, would expand the number of children eligible for coverage under the Healthy Families Program. The bill would also expand the number of persons eligible for the Medi-Cal program. The bill would delete as an eligibility requirement for a child under the Healthy Families Program and the Medi-Cal program that the child must meet citizen and immigration status requirements applicable to the programs under federal law, thereby creating a state-only element of the program. The bill would require the State Department of Health Care Services to seek any necessary federal waiver to enable the state to receive federal Medicaid funds for specified persons who could otherwise be made eligible for Medi-Cal benefits, with the state share of funds to be provided from the Health Insurance Trust Fund. The bill would enact other related provisions. Because each county would be required to determine eligibility for the Medi-Cal program, expansion of program eligibility would impose a state-mandated local program.

The bill would enact various health insurance market reforms relative to small employers. The bill would prohibit health care service plans and health insurers from spending less than 85% of premiums or fees from enrollees or insureds on health care services. The bill would require health care service plans and health insurers to offer individual health benefit plans on a guaranteed issue basis beginning January 1, 2011, as specified, and would create a reinsurance mechanism in that regard. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

Existing law creates the California Health and Human Services Agency.

This bill would require the secretary of the agency to seek partnership and contract with independent, nonprofit groups or foundations, and

other organizations to track and assess the effectiveness of health care reforms in this act.

Existing law authorizes a taxpayer under the Personal Income Tax Law to claim personal exemption credits against income taxes due for the taxpayer and dependents of the taxpayer.

This bill would provide that a taxpayer under that law may not claim these exemption credits if the taxpayer fails to comply in a tax year with the requirement for employed individuals to maintain a policy of health care coverage, unless exempt from the requirement. The bill would require the Franchise Tax Board, based on estimates, to correspondingly increase the exemption credits for the remaining taxpayers in a manner that the estimated revenue gain in a tax year from denying the exemption credits under the bill is equal to the estimated revenue loss in that tax year from increasing the exemption credits under the bill.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

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

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. This act shall be known and may be cited as the California Health Care Coverage and Cost Control Act.

SEC. 2. Section 12803.2 is added to the Government Code, to read:

12803.2. (a) The Secretary of the Health and Human Services Agency shall seek partnership and contract with independent, nonprofit groups or foundations, academic institutions, or governmental entities providing grants for health-related activities, to establish and administer a program to track and assess the effects of health care reform as contained in the California Health Care Coverage and Cost Control Act.

(b) The assessment of health care reform shall be guided by an advisory body chaired by the Secretary of Health and Human Services Agency. The Governor shall make five appointments to the advisory body, the Senate President pro Tempore shall make two appointments, and the Speaker of the Assembly shall make two appointments.

(c) To the extent possible, this assessment shall maximize the use of current surveys and databases and the secretary shall seek partnerships with independent, nonprofit groups or foundations, or academic institutions that administer or provide grants for health-related surveys and data collection activities to build on these current surveys and databases.

(d) This assessment shall include at least the following components:

(1) An assessment of the compliance rates of the individual health insurance mandate.

(2) An assessment of the sustainability and solvency of the Health Insurance Connector (Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code). This assessment shall include the number of persons purchasing health insurance through the pool by income bracket and size and type of employer.

(3) An assessment of the cost and affordability of health care in California. This assessment shall include the cost of health insurance products for individuals and families obtained through employers, city and county governments, Medi-Cal, the state CALPERS program, Medicare Advantage Plans, and the individual market.

(4) An assessment of the health insurance market in California, including a review of the various insurers and health plans, their offering and underwriting practices, their efficiency in providing health care services, and their financial conditions including their medical loss ratios. This assessment shall also include an assessment of the risk selection.

(5) An assessment of the effect on employers and employment. This assessment shall include the effect on the types of employers and firm size, employer administrative costs, and employee turnover rate, and the effect on wages.

(6) An assessment of employer-based health insurance including the numbers of employers providing insurance and the number paying into the purchasing pool by employer characteristic.

(7) An assessment of the change in access and availability of health care throughout the state, including tracking the availability of health insurance products in rural and other underserved areas of the state and assessing the adequacy of the health care delivery infrastructure to meet the need for health care services. This assessment shall include a more in-depth review of areas of the state that were determined to be medically underserved in 2007.

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

(9) An assessment of the economic effect of the individual mandate on Californians including tracking the amount of out-of-pocket health care expenditures by individuals and families and the rates of personal bankruptcy due to health costs.

(10) An assessment of health insurance coverage as compiled in the California Health Interview Survey, or other applicable surveys.

(11) An assessment of the wellness and health status of Californians as compiled in the California Health Interview Survey, or other applicable surveys.

(12) An assessment of the capacity related to numbers and location of the various health professions to provide care to the populations included in health care reform.

(13) An assessment of the quality of the health care services, as determined by recognized measures, provided in California.

(14) An assessment of the availability and potential for increasing federal funding for health care services and coverage in California.

(15) Any other assessments as determined necessary by the advisory board.

(e) To the extent feasible, in order to track the effect of health care reform on ongoing trends in the health care field, the assessments shall include data from years prior to the introduction of health care reform.

(f) The Secretary of the Health and Human Services Agency and the advisory body shall establish a timeline for reporting information to the appropriate policy and fiscal committees of the Legislature. At a minimum, the reporting timeline shall include the release of annual data that will serve as benchmarks for the program. These annual benchmarks shall include the individual

mandate compliance rate, the employer compliance rate, and the cost of health care coverage in the state. In addition, the timeline shall include more in-depth reports addressing the items listed under subdivision (d).

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

Article 3.11. Insurance Market Reform

1357.20. Notwithstanding any other provision of law, on and after January 1, 2008, 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, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan's contracts to all of those employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health care service plan contracts offered to all employers with 199 or fewer employees, except that for employers with 51 to 199 eligible employees, the health care service plan may develop health care coverage benefit plan designs to fairly and affirmatively market only to medium employer groups of 51 to 199 eligible employees, and apply a risk adjustment factor of no more than 110 percent and no less than 90 percent of the standard employee risk rate. However, on and after January 1, 2011, no risk adjustment factor will be permitted for contracts offered to employers with two to 199 employees.

SEC. 4. Article 4.1 (commencing with Section 1366.10) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.1. California Individual Coverage Guarantee Issue

1366.10. It is the intent of the Legislature to do all of the following:

(a) To guarantee the availability and renewability of qualifying health coverage through the private health insurance market to individuals.

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

(c) To provide for an appropriate transition period before full implementation of guaranteed issue, assuring that individuals currently in the individual market do not experience a sudden increase in rates, and that the individual market remains viable.

1366.101. (a) On and after January 1, 2011, every health care service plan and health insurer issuing individual health benefit plans in this state shall be required to guarantee issue at least one baseline plan. The baseline plan shall be the minimum policy of health care coverage determined by the Managed Risk Medical Insurance Board pursuant to Section 2203 of the Labor Code.

(b) Consistent with subdivision (a), the ~~director~~ *Director of the Department of Managed Health Care* and the Insurance Commissioner shall jointly adopt regulations defining a baseline ~~HMO~~ *health maintenance organization (HMO)* benefit plan and a baseline ~~PPO~~ *preferred provider organization (PPO)* benefit plan.

(c) Beginning 180 days following the adoption of regulations defining baseline plans pursuant to subdivision (b), every health care service plan and health insurer providing or arranging for the provision of health care services to individuals shall fairly and affirmatively offer, market, and sell, on a guarantee issue basis, in each service area in which the plan or insurer operates, an approved baseline health benefit plan to all individuals who apply for individual coverage.

(d) If a health care service plan or health insurer elects to offer more than one individual product in the individual market, it shall offer a baseline health benefit plan for each product. For purposes of this subdivision, a health benefit plan offered in the Connector pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code shall not be deemed a separate individual product.

1366.102. During the transition period, a health care service plan or health insurer may offer other health benefit plans in the individual market not subject to guaranteed issue. A health care

service plan or health insurer may continue to develop and submit individual health care benefit plans to the director or Insurance Commissioner, as applicable, for approval and to offer and issue such plans. A health care service plan's or health insurer's lowest class baseline health benefit plan for each provider network shall be offered on a guarantee issue basis and shall be its lowest priced plan for that network.

1366.103. Upon a finding by the Managed Risk Medical Insurance Board that ____ percent of California residents have qualifying health coverage pursuant to Section 2203 of the Labor Code, the requirements in Sections 1366.104 to 1366.116, inclusive, shall become operative.

1366.104. (a) Within 90 days of the finding in Section 1366.103, the director and the Insurance Commissioner shall jointly adopt regulations governing five classes of individual health benefit plans that health care service plans and health insurers shall make available.

(b) Within 90 days of the adoption of the regulations required by subdivision (a), the director and the Insurance Commissioner shall jointly approve five classes of individual health benefit plans for each health care service plan and health insurer participating in the individual market, with each class having an increased level of benefits beginning with the lowest class. Within each class, the director and the Insurance Commissioner shall jointly approve one baseline HMO and one baseline PPO, to be issued by health care service plans and health insurers in the individual market. The classes of benefits jointly approved by the director and the Insurance Commissioner shall reflect a reasonable continuum between the class with the lowest level of benefits and the class with the highest level of benefits, shall permit reasonable benefit variation that will allow for a diverse market within each class, and shall be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(c) In approving the five classes of plans filed by health care service plans and health insurers, the director and the Insurance Commissioner shall do both of the following:

(1) Jointly determine that the plans provide reasonable benefit variation, allowing a diverse market.

(2) Jointly require either (A) that benefits within each class are standard and uniform across all plans and insurers, or (B) that benefits offered in each class are actuarially equivalent across all plans and insurers.

(d) The lowest class of benefit plan shall provide exclusively those benefits specified by the Managed Risk Medical Insurance Board pursuant to Section 2203 of the Labor Code.

1366.105. At the same time that health care service plans and health insurers participating in the individual market are required to guarantee issue the five classes of approved health benefit plans, health care service plans and health insurers shall discontinue offering and selling health benefit plans other than those within the five approved classes of benefit plans in the individual market.

1366.106. Individuals who are required to purchase qualifying health coverage may purchase a health benefit plan from one of the five classes of approved plans. After selecting and purchasing a health benefit plan within a class of benefits, an individual may change plans only as set forth in this section. For individuals enrolled as a family, the subscriber may change classes for himself or herself, or for all dependents:

(a) Annually in the month of the subscriber's birth, an individual may select a different individual plan from another health care service plan or insurer, within the same class of benefits or the next higher class of benefits.

(b) Annually in the month of the subscriber's birth, an individual may move up one class of benefits offered by the same health care service plan or health insurer.

(c) At any time a subscriber may move to a lower class of benefits.

(d) At significant life events, the subscriber may move up to a higher class of benefits as follows:

(1) Upon marriage or entering into a domestic partnership.

(2) Upon divorce.

(3) Upon the death of spouse or domestic partner, on whose qualifying health coverage an individual was a dependent.

(4) Upon the birth or adoption of a child.

(e) A dependent child may terminate coverage under a parent's plan, and select his or her own account, within the same class of benefits following his or her 18th birthday.

(f) If a subscriber becomes eligible for group benefits, Medicare, or other benefits that meet the minimum requirements of the individual mandate, and selects those benefits in lieu of his or her individual coverage, the dependent spouse or domestic partner may become the subscriber. If there is no dependent spouse or domestic partner enrolled in the plan, the oldest child may become the subscriber.

1366.107. At the time an individual applies for qualifying health coverage from a health care service plan or health insurer participating in the individual market, an individual shall provide information as required by a standardized health status questionnaire to assist plans and insurers in identifying (a) persons in need of disease management; and (b) high risk applicants whose risk a health care service plan or health insurer may elect to cede to the reinsurance mechanism as provided by Article 14.9 (commencing with Section 1069) of Chapter 1 of Part 2 of Division 1 of the Insurance Code. All health care service plans and health insurers participating in the individual market shall use the standardized health status questionnaire adopted jointly by the director and the Insurance Commissioner. Health care service plans and health insurers may not use information provided on the questionnaire to decline coverage or to limit an individual's choice of health care benefit plan.

1366.108. Health benefit plans shall become effective within 31 days of receipt of the individual's application, standardized health status questionnaire, and premium payment.

1366.109. Health care service plans and health insurers may reject an application for health care benefits where the individual does not reside or work in a plan's or insurer's approved service area.

1366.110. The director or the Insurance Commissioner, as applicable, may require a health care service plan or health insurer to discontinue the offering of health care benefits, or acceptance of applications from individuals, upon a determination by the director or commissioner that the plan or insurer does not have sufficient financial viability, or organizational and administrative capacity, to assure the delivery of health care benefits to its enrollees or insureds.

1366.111. All health care benefits offered to individuals shall be renewable with respect to all individuals and dependents at the option of the subscriber, except:

(a) For nonpayment of the required premiums by the subscriber.

(b) When the plan or insurer withdraws from the individual health care market, subject to rules and requirements jointly approved by the director and the Insurance Commissioner.

1366.112. No health care service plan or health insurer shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract or health insurance policy to be varied because of the health status, claims experience, occupation, or geographic location of the individual, provided the geographic location is within the plan's or insurer's approved service area.

1366.113. This article shall not apply to individual health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Family contracts with the Managed Risk Medical Insurance Board, high risk pool contracts with the Major Risk Medical Insurance Program, Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure subsidized individual coverage from the Connector.

1366.114. (a) A health care service plan or health insurer may rate its entire portfolio of health benefit plans in accord with expected costs or other market considerations, but the rate for each plan or insurer shall be set in relation to the balance of the portfolio as certified by an actuary. Each benefit plan shall be priced as determined by each health care service plan or health insurer to reflect the difference in benefit variation, or the effectiveness of a provider network, but may not adjust the rate for a specific plan for risk selection. A health care service plan's or health insurer's rates shall use the same rating factors for age, family size, and geographic location for each individual health care benefit plan it issues. Rates for health care benefits may vary from applicant to applicant only by:

(1) Age of the subscriber, as determined by the director and the Insurance Commissioner.

(2) Family size in categories determined by the director and the Insurance Commissioner.

(3) Geographic rate regions as determined by the director and the Insurance Commissioner.

(4) Health improvement discounts. A health care service plan or health insurer may reduce copayments or offer premium discounts for nonsmokers, individuals demonstrating weight loss through a measurable health improvement program, or individuals actively participating in a disease management program, provided discounts are approved by the director and the Insurance Commissioner.

(b) The director and Insurance Commissioner shall take into consideration the age, family size, and geographic region rating categories applicable to small group coverage contracts pursuant to Section 1357 of this code and Section 10700 of the Insurance Code in implementing this section.

1366.115. The first term of each health benefit plan contract or policy issued shall be from the effective date through the last day of the month immediately preceding the subscriber's next birthday. Contracts or policies may be renewed by the subscriber as set forth in this article.

1366.116. Health care service plans and health insurers participating in the individual market may participate in the California Individual Market Reinsurance Fund and cede risk to the fund in accordance with Article 14.9 (commencing with Section 1069) of Chapter 1 of Part 2 of Division 1 of the Insurance Code.

SEC. 5. Section 1367.08 is added to the Health and Safety Code, to read:

1367.08. (a) No health care service plan shall expend on patient care less than 85 percent of the aggregate dues, fees, and other periodic payments received by the plan for providing health care services to its enrollees.

(b) This action shall not preclude a plan from expending additional sums of money for nonpatient care costs if the money is not derived from revenue obtained from its subscribers or enrollees.

(c) The department shall adopt regulations to implement this section and submit the regulations to the Office of Administrative Law no later than January 15, 2008.

SEC. 6. Article 14.9 (commencing with Section 1069) is added to Chapter 1 of Part 2 of Division 1 of the Insurance Code, to read:

Article 14.9. Individual Market Reinsurance Fund

1069. The California Individual Market Reinsurance Fund is hereby created to allow health care service plans and health insurers in the individual market to equitably share the burden of financing the cost of covering high-risk individuals across the entire state.

SEC. 7. Section 10127.19 is added to the Insurance Code, to read:

10127.19. (a) No health insurer shall expend on patient care less than 85 percent of the aggregate premiums received by the insurer for providing health care services to its insureds.

(b) This section shall not preclude a health insurer from expending additional sums of money for nonpatient care costs if the money is not derived from revenue obtained from its insureds.

(c) The commissioner shall adopt regulations to implement this section and submit the regulations to the Office of Administrative Law no later than January 15, 2008.

SEC. 8. Chapter 1.6 (commencing with Section 10199.10) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 1.6. California Individual Coverage Guarantee Issue

10199.10. It is the intent of the Legislature to do all of the following:

(a) To guarantee the availability and renewability of qualifying health coverage through the private health insurance market to individuals.

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

(c) To provide for an appropriate transition period before full implementation of guaranteed issue, assuring that individuals currently in the individual market do not experience a sudden increase in rates, and that the individual market remains viable.

10199.101. (a) On and after January 1, 2011, every health care service plan and health insurer issuing individual health benefit

plans in this state shall be required to guarantee issue at least one baseline plan. The baseline plan shall be the minimum policy of health care coverage determined by the Managed Risk Medical Insurance Board pursuant to Section 2203 of the Labor Code.

(b) Consistent with subdivision (a), the commissioner and the Director of the Department of Managed Health Care shall jointly adopt regulations defining a baseline HMO benefit plan and a baseline PPO benefit plan.

(c) Beginning 180 days following the adoption of regulations defining baseline plans pursuant to subdivision (b), every health care service plan and health insurer providing or arranging for the provision of health care services to individuals shall fairly and affirmatively offer, market, and sell, on a guarantee issue basis, in each service area in which the plan or insurer operates, an approved baseline health benefit plan to all individuals who apply for individual coverage.

(d) If a health care service plan or health insurer elects to offer more than one individual product in the individual market, it shall offer a baseline health benefit plan for each product. For purposes of this subdivision, a health benefit plan offered in the Connector pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 shall not be deemed a separate individual product.

10199.102. During the transition period, a health care service plan or health insurer may offer other health benefit plans in the individual market not subject to guaranteed issue. A health care service plan or health insurer may continue to develop and submit individual health care benefit plans to the commissioner or the Director of Managed Health Care, as applicable, for approval and to offer and issue such plans. A health care service plan's or health insurer's lowest class baseline health benefit plan for each provider network shall be offered on a guarantee issue basis and shall be its lowest priced plan for that network.

10199.103. Upon a finding by the Managed Risk Medical Insurance Board that ____ percent of California residents have qualifying health coverage pursuant to Section 2203 of the Labor Code, the requirements in Sections 10199.104 to 10199.116, inclusive, shall become operative.

10199.104. (a) Within 90 days of the finding in Section 10199.103, the commissioner and the Director of the Department of Managed Health Care shall jointly adopt regulations governing

five classes of individual health benefit plans that health care service plans and health insurers shall make available.

(b) Within 90 days of the adoption of the regulations required by subdivision (a), the commissioner and the Director of Managed Health Care shall jointly approve five classes of individual health benefit plans for each health care service plan and health insurer participating in the individual market, with each class having an increased level of benefits beginning with the lowest class. Within each class, the commissioner and the Director of the Department of Managed Health Care shall jointly approve one baseline HMO and one baseline PPO, to be issued by health care service plans and health insurers in the individual market. The classes of benefits jointly approved by the commissioner and the Director of the Department of Managed Health Care shall reflect a reasonable continuum between the class with the lowest level of benefits and the class with the highest level of benefits, shall permit reasonable benefit variation that will allow for a diverse market within each class, and shall be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(c) In approving the five classes of plans filed by health care service plans and health insurers, the commissioner and the Director of the Department of Managed Health Care shall do both of the following:

(1) Jointly determine that the plans provide reasonable benefit variation, allowing a diverse market.

(2) Jointly require either (A) that benefits within each class are standard and uniform across all plans and insurers, or (B) that benefits offered in each class are actuarially equivalent across all plans and insurers.

(d) The lowest class of benefit plan shall provide exclusively those benefits specified by the Managed Risk Medical Insurance Board pursuant to Section 2203 of the Labor Code.

10199.105. At the same time that health care service plans and health insurers participating in the individual market are required to guarantee issue the five classes of approved health benefit plans, health care service plans and health insurers shall discontinue offering and selling health benefit plans other than those within the five approved classes of benefit plans in the individual market.

10199.106. Individuals who are required to purchase qualifying health coverage may purchase a health benefit plan from one of the five classes of approved plans. After selecting and purchasing a health benefit plan within a class of benefits, an individual may change plans only as set forth in this section. For individuals enrolled as a family, the subscriber may change classes for himself or herself, or for all dependents:

(a) Annually in the month of the subscriber's birth, an individual may select a different individual plan from another health care service plan or insurer, within the same class of benefits or the next higher level of benefits.

(b) Annually in the month of the subscriber's birth, an individual may move up one class of benefits offered by the same health care service plan or health insurer.

(c) At any time a subscriber may move to a lower class of benefits.

(d) At significant life events, the subscriber may move up to a higher class of benefits as follows:

(1) Upon marriage or entering into a domestic partnership.

(2) Upon divorce.

(3) Upon the death of spouse or domestic partner, on whose qualifying health coverage an individual was a dependent.

(4) Upon the birth or adoption of a child.

(e) A dependent child may terminate coverage under a parent's plan, and select his or her own account, within the same class of benefits following his or her 18th birthday.

(f) If a subscriber becomes eligible for group benefits, Medicare, or other benefits that meet the minimum requirements of the individual mandate, and selects those benefits in lieu of his or her individual coverage, the dependent spouse or domestic partner may become the subscriber. If there is no dependent spouse or domestic partner enrolled in the plan, the oldest child may become the subscriber.

10199.107. At the time an individual applies for qualifying health coverage from a health care service plan or health insurer participating in the individual market, an individual shall provide information as required by a standardized health status questionnaire to assist plans and insurers in identifying (a) persons in need of disease management; and (b) high risk applicants whose risk a health care service plan or health insurer may elect to cede

to the reinsurance mechanism as provided by Article 14.9 (commencing with Section 1069) of Chapter 1 of Part 2 of Division 1. All health care service plans and health insurers participating in the individual market shall use the standardized health status questionnaire adopted jointly by the commissioner and the Director of the Department of Managed Health Care. Health care service plans and health insurers may not use information provided on the questionnaire to decline coverage, or to limit an individual's choice of health care benefit plan.

10199.108. Health benefit plans shall become effective within 31 days of receipt of the individual's application, standardized health status questionnaire, and premium payment.

10199.109. Health care service plans and health insurers may reject an application for health care benefits where the individual does not reside or work in a plan's or insurer's approved service area.

10199.110. The commissioner or the Director of the Department of Managed Health Care, as applicable, may require a health care service plan or health insurer to discontinue the offering of health care benefits, or acceptance of applications from individuals, upon a determination by the director or commissioner that the plan or insurer does not have sufficient financial viability, or organizational and administrative capacity, to assure the delivery of health care benefits to its enrollees or insureds.

10199.111. All health care benefits offered to individuals shall be renewable with respect to all individuals and dependents at the option of the subscriber, except:

(a) For nonpayment of the required premiums by the subscriber.

(b) When the plan or insurer withdraws from the individual health care market, subject to rules and requirements jointly approved by the director and the Insurance Commissioner.

10199.112. No health care service plan or health insurer shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract or health insurance policy to be varied because of the health status, claims experience, occupation, or geographic location of the individual, provided the geographic location is within the plan's or insurer's approved service area.

10199.113. This chapter shall not apply to individual health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Family contracts with the Managed Risk Medical Insurance Board, high risk pool contracts with the Major Risk Medical Insurance Program, Medicare supplement policies, long-term care policies, specialized health plan contracts, or contracts issued to individuals who secure subsidized individual coverage from the Connector.

10199.114. (a) A health care service plan or health insurer may rate its entire portfolio of health benefit plans in accord with expected costs or other market considerations, but the rate for each plan or insurer shall be set in relation to the balance of the portfolio as certified by an actuary. Each benefit plan shall be priced as determined by each health care service plan or health insurer to reflect the difference in benefit variation, or the effectiveness of a provider network, but may not adjust the rate for a specific plan for risk selection. A health care service plan's or health insurer's rates shall use the same rating factors for age, family size, and geographic location for each individual health care benefit plan it issues. Rates for health care benefits may vary from applicant to applicant only by:

(1) Age of the subscriber, as determined by the commissioner and the Director of the Department of Managed Health Care.

(2) Family size in categories determined by the commissioner and the Director of the Department of Managed Health Care.

(3) Geographic rate regions as determined by the commissioner and the Director of the Department of Managed Health Care.

(4) Health improvement discounts. A health care service plan or health insurer may reduce copayments or offer premium discounts for nonsmokers, individuals demonstrating weight loss through a measurable health improvement program, or individuals actively participating in a disease management program, provided discounts are approved by the commissioner and the Director of the Department of Managed Health Care.

(b) The commissioner and the Director of the Department of Managed Health Care shall take into consideration the age, family size, and geographic region rating categories applicable to small group coverage contracts pursuant to Section 1357 of the Health

and Safety Code and Section 10700 of this code in implementing this section.

10199.115. The first term of each health benefit plan contract or policy issued shall be from the effective date through the last day of the month immediately preceding the subscriber's next birthday. Contracts or policies may be renewed by the subscriber as set forth in this chapter.

10199.116. Health care service plans and health insurers participating in the individual market may participate in the California Individual Market Reinsurance Fund and cede risk to the fund in accordance with Article 14.9 (commencing with Section 1069) of Chapter 1 of Part 2 of Division 1.

SEC. 9. Chapter 8.1 (commencing with Section 10760) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 8.1. Insurance Market Reform

10760. Notwithstanding any other provision of law, on and after January 1, 2008, all requirements in Chapter 8 (commencing with Section 10700) applicable to offering, marketing, and selling health benefit plans to small employers as defined in that chapter, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans to all of those employers, guaranteed renewal of all health benefit plans, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that chapter, shall be applicable to all health benefit plans offered to all employers with 199 or fewer employees providing coverage to employees pursuant to Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code, except that for employers with 51 to 199 eligible employees, health insurers may develop health care coverage benefit plan designs to fairly and affirmatively market only to employer groups of 51 to 199 eligible employees, and apply a risk adjustment factor of no more than 110 percent and no less than 90 percent of the standard employee risk rate. However, on and after January 1, 2011, no risk adjustment factor shall be permitted for contracts offered to employees with two to 199 employees.

SEC. 10. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost family value package in a given geographic area.

(b) In each geographic area, the board shall designate one or more family value packages for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that

subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-five dollars ($25) per child with a maximum required contribution of seventy-five dollars ($75) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost family value package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost family value package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this paragraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable

to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this paragraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(4) On and after July 1, 2008, twenty-two dollars ($22) per child with a maximum required contribution of sixty-six dollars ($66) per month per family for applicants with annual household incomes greater than 250 percent and up to and including 300 percent of the federal poverty level.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purposes of subdivision (e) of Section 11346.1 of the Government Code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative Law, is hereby extended to 180 days.

SEC. 11. Section 12693.70 of the Insurance Code is amended to read:

12693.70. To be eligible to participate in the program, an applicant shall meet all of the following requirements:

(a) Be an applicant applying on behalf of an eligible child, which means a child who is all of the following:

(1) Less than 19 years of age. An application may be made on behalf of a child not yet born up to three months prior to the expected date of delivery. Coverage shall begin as soon as administratively feasible, as determined by the board, after the board receives notification of the birth. However, no child less than 12 months of age shall be eligible for coverage until 90 days after the enactment of the Budget Act of 1999.

(2) Not eligible for no-cost full-scope Medi-Cal or Medicare coverage at the time of application.

(3) In compliance with Sections 12693.71 and 12693.72.

(4) [Reserved].

(5) A resident of the State of California pursuant to Section 244 of the Government Code; or, if not a resident pursuant to Section 244 of the Government Code, is physically present in California and entered the state with a job commitment or to seek employment, whether or not employed at the time of application to or after acceptance in, the program.

(6) (A) In either of the following:

(i) In a family with an annual or monthly household income equal to or less than 200 percent of the federal poverty level.

(ii) When implemented by the board, subject to subdivision (b) of Section 12693.765 and pursuant to this section, a child under the age of two years who was delivered by a mother enrolled in the Access for Infants and Mothers Program as described in Part 6.3 (commencing with Section 12695). Commencing July 1, 2007, eligibility under this subparagraph shall not include infants during any time they are enrolled in employer-sponsored health insurance or are subject to an exclusion pursuant to Section 12693.71 or 12693.72, or are enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. For purposes of this clause, any infant born to a woman whose enrollment in the Access for Infants and Mothers Program begins after June 30, 2004, shall be automatically enrolled in the Healthy Families Program, except during any time on or after July 1, 2007, that the infant is enrolled

in employer-sponsored health insurance or is subject to an exclusion pursuant to Section 12693.71 or 12693.72, or is enrolled in the full scope of benefits under the Medi-Cal program at no share of cost. Except as otherwise specified in this section, this enrollment shall cover the first 12 months of the infant's life. At the end of the 12 months, as a condition of continued eligibility, the applicant shall provide income information. The infant shall be disenrolled if the gross annual household income exceeds the income eligibility standard that was in effect in the Access for Infants and Mothers Program at the time the infant's mother became eligible, or following the two-month period established in Section 12693.981 if the infant is eligible for Medi-Cal with no share of cost. At the end of the second year, infants shall again be screened for program eligibility pursuant to this section, with income eligibility evaluated pursuant to clause (i), subparagraphs (B) and (C), and paragraph (2) of subdivision (a).

(B) All income over 200 percent of the federal poverty level but less than or equal to 300 percent of the federal poverty level shall be disregarded in calculating annual or monthly household income.

(C) In a family with an annual or monthly household income greater than 300 percent of the federal poverty level, any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income. If the income deductions reduce the annual or monthly household income to 300 percent or less of the federal poverty level, subparagraph (B) shall be applied.

(b) The applicant shall agree to remain in the program for six months, unless other coverage is obtained and proof of the coverage is provided to the program.

(c) An applicant shall enroll all of the applicant's eligible children in the program.

(d) In filing documentation to meet program eligibility requirements, if the applicant's income documentation cannot be provided, as defined in regulations promulgated by the board, the applicant's signed statement as to the value or amount of income shall be deemed to constitute verification.

(e) An applicant shall pay in full any family contributions owed in arrears for any health, dental, or vision coverage provided by the program within the prior 12 months.

(f) By January 2008, the board, in consultation with stakeholders, shall implement processes by which applicants for subscribers may certify income at the time of annual eligibility review, including rules concerning which applicants shall be permitted to certify income and the circumstances in which supplemental information or documentation may be required. The board may terminate using these processes not sooner than 90 days after providing notification to the Chair of the Joint Legislative Budget Committee. This notification shall articulate the specific reasons for the termination and shall include all relevant data elements that are applicable to document the reasons for the termination. Upon the request of the Chair of the Joint Legislative Budget Committee, the board shall promptly provide any additional clarifying information regarding implementation of the processes required by this subdivision.

(g) Notwithstanding any other provision of law, the changes to this section made by the act adding this subdivision in the 2007–08 Regular Session of the Legislature may only be implemented on or after July 1, 2008, and only to the extent funds are appropriated for those purposes in another statute.

SEC. 12. Section 12693.73 of the Insurance Code is amended to read:

12693.73. Notwithstanding any other provision of law, children excluded from coverage under Title XXI of the Social Security Act are not eligible for coverage under the program, except as specified in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70 and Section 12693.76, or except children who otherwise meet eligibility requirements for the program but for their immigration status.

SEC. 13. Section 12693.755 of the Insurance Code is amended to read:

12693.755. (a) Subject to subdivision (b), but no later than July 1, 2008, the board shall expand eligibility under this part to uninsured parents of, and as defined by the board, adults responsible for, children enrolled to receive coverage under this part whose income does not exceed 300 percent of the federal poverty level, before applying the income disregard provided for in subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70.

(b) (1) The board shall implement a program to provide coverage under this part to any uninsured parent or responsible adult who is eligible pursuant to subdivision (a), pursuant to the waiver or approval identified in paragraph (2).

(2) The program shall be implemented only in accordance with a State Child Health Insurance Program waiver or other federal approval pursuant to Section 1397gg(e)(2)(A) of Title 42 of the United States Code, or pursuant to the Deficit Reduction Act of 2005, Section 6044 of Public Law 109-171, to provide coverage to uninsured parents and responsible adults, and shall be subject to the terms, conditions, and duration of the waiver or other federal approval. The services shall be provided under the program only if the waiver or other federal approval is approved by the federal Centers for Medicare and Medicaid Services, and, except as provided under the terms and conditions of the waiver or other federal approval, only to the extent that federal financial participation is available and funds are appropriated specifically for this purpose.

SEC. 14. Part 6.45 (commencing with Section 12699.201) is added to Division 2 of the Insurance Code, to read:

PART 6.45. THE HEALTH INSURANCE CONNECTOR

12699.201. For the purposes of this part, the following terms have the following meanings:

(a) "Board" means the Managed Risk Medical Insurance Board.

(b) "Health Insurance Connector" or "Connector" means the health care coverage purchasing pool for employees and dependents of employers electing to pay an employer health care fee instead of making health care expenditures for the employees and dependents as provided in Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code.

12699.202. The board shall be responsible for establishing the Connector and administering this part.

12699.203. (a) The board shall develop standards for high quality coverage for the Connector and negotiate favorable rates and contract with health plans by leveraging its purchasing power. Employees of participating employers shall be offered a choice of health plans that provide comprehensive health care coverage that

meets the requirements of the Knox-Keene Health Care Service Plan Act of 1975, plus prescription drug benefits.

(b) The board shall offer three tiers of health plans to eligible employees. Plans offered in the first tier may require appropriate enrollee copayments, consistent with utilization management practices that improve health outcomes and encourage cost-effective use of services. Plans in the higher level tiers would provide a higher level of benefits or greater provider choices with additional costs borne by the enrollee. The board may limit access to some plans to employees who contribute on a sliding scale basis pursuant to subdivision (c) of Section 2201 of the Labor Code.

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

12699.2035. Notwithstanding any other provisions of law to the contrary, the board shall have authority and fiduciary responsibility for the administration of the program, including sole and exclusive fiduciary responsibility over the assets of the Health Care Trust Fund. The board shall also have sole and exclusive responsibility to administer the Connector in a manner that will assure prompt delivery of benefits and related services to the enrollees, and, if applicable, dependents, including sole and exclusive responsibility over contract, budget, and personnel matters. Nothing in this section shall preclude legislative or State Auditor oversight over the Connector.

12699.204. The board shall establish standards to cap administrative costs and profits of participating health plans. At a minimum, these standards shall ensure that no participating health plan shall expend on patient care less than 85 percent of the aggregate dues, fees, and other periodic payments received by the insurer or plan for providing health care services to its enrollees. This section shall not preclude a health plan from expending additional sums of money for nonpatient care cost if the money is not derived from revenue obtained from its enrollees.

12699.2041. The board shall also determine standards to ensure that plans utilize efficient practices to improve and control costs.

These practices shall include, but need not be limited to, the following:

(a) Preventive care.

(b) Care management for chronic diseases.

(c) Promotion of health information technology.

(d) Standardized billing practices.

(e) Reduction of medical errors.

(f) Incentives for healthy lifestyles.

(g) Patient cost sharing to encourage use of preventive and appropriate care.

(h) Rational use of new technology.

12699.205. The board shall collect and disseminate, as appropriate and to the extent possible, information on health plan quality and cost-effectiveness to provide information to the pool and enrollees for their decisionmaking.

12699.206. The board shall negotiate with Medi-Cal managed care plans to obtain affordable, first-tier coverage for eligible employees.

12699.207. The Health Insurance Trust Fund is hereby created in the State Treasury. The moneys in the fund shall be continuously appropriated to the board for the purposes of providing health care coverage pursuant to this part.

12699.208. The board shall pay the nonfederal share of cost from the Health Insurance Trust Fund for employees and dependents eligible under the Medi-Cal program or the Healthy Families Program.

12699.209. It is the intent of the Legislature that the Connector should pay from the Health Insurance Trust Fund the nonfederal share of funds necessary to match federal funds made available for individuals that are enrolled in the Connector and that are eligible for the Healthy Families Program or the Medi-Cal program or benefit plans. The board shall adopt regulations in that regard to facilitate the enrollment of those eligible individuals in the Healthy Families Program or the Medi-Cal program in a manner that maximizes federal funds available to the state, provides convenient enrollment and access to care for families, and efficiently provides for coordination of coverage.

12699.210. The board shall establish a working group for the purpose of developing recommendations to the Legislature designed to broaden access to the Connector to all self-employed

individuals. A report containing the recommendations shall be submitted to the Legislature on or before January 1, 2009.

SEC. 15. Part 8.8 (commencing with Section 2200) is added to Division 2 of the Labor Code, to read:

PART 8.8. EMPLOYEE HEALTH CARE

2200. (a) (1) Beginning January 1, 2011, each employer shall elect to either (A) make health expenditures as provided in paragraph (2) for its full-time or part-time employees, or both, and their dependents, or (B) pay an equivalent amount in either or both cases, as applicable, to the Health Insurance Trust Fund, created pursuant to Section 12699.207 of the Insurance Code, as required by Section 4805 of the Unemployment Insurance Code.

(2) (A) An employer's cumulative amount of health care expenditures for the employer's full-time employees working 30 or more hours per week shall be equivalent ~~to ____~~, *at a minimum, to 7.5* percent of social security wages paid by the employer to full-time employees. ~~However, the amount of social security wages exceeding ____ dollars ($____) for any employee shall be excluded from this computation.~~

(B) An employer's cumulative amount of health care expenditures for the employer's part-time employees working less than 30 hours per week shall be equivalent ~~to ____~~, *at a minimum, to 7.5* percent of social security wages paid by the employer. ~~However, the amount of social security wages exceeding ____ dollars ($____) for any employee shall be excluded from this computation.~~

(b) The Employment Development Department, in consultation with the board, shall ensure that funds are deposited in the Health Insurance Trust Fund pursuant to this section and are available to ensure the timely enrollment of eligible employees in the Connector.

(c) The Employment Development Department, in consultation with the board, shall adopt regulations determining the minimum number of hours per week a part-time employee must work in order to be subject to subparagraph (B) of paragraph (2) of subdivision (a) for purposes of the employer election in this section. The regulations shall exempt employers of part-time employees

not working the required minimum number of hours from the requirements of this part.

(d) It shall be unlawful for an employer to designate an employee as an independent contractor or temporary employee, to reduce an employee's hours of work, or to terminate and rehire an employee if a purpose for the action is to avoid the employer's obligations under this part.

(e) "Health care expenditures" means any amount paid by an employer subject to this section to or on behalf of its employees and their dependents to provide health care or health-related services or to reimburse the costs of those services, including, but not limited to, any of the following:

(1) Contributions to a health savings account as defined by Section 223 of the Internal Revenue Code.

(2) Reimbursement by the employer to its employees and their dependents for incurred health care expenses, where those recipients have no entitlement to that reimbursement under any plan, fund, or program maintained by the employer. As used in this paragraph, "health care expenses" includes, but ~~it~~ *is* not limited to, an expense for which payment is deductible from personal income under Section 213(d) of the Internal Revenue Code.

(3) Programs to assist employees attain and maintain health and healthy lifestyles, including, but not limited to, onsite wellness programs, reimbursement for attending offsite wellness programs, onsite health fairs and clinics for flu shots and similar matters, and financial incentives for participating in health screenings and other wellness activities.

(4) Disease management programs.

(5) Pharmacy benefit management programs.

(6) Care rendered to employees and dependents by health care providers employed by or under contract to employers, such as employer-sponsored primary care clinics.

(7) Purchasing health care coverage from a health care service plan or a health insurer.

(f) Health care expenditures do not include any payment made directly or indirectly for workers' compensation, Medicare benefits, or any other health benefit costs, taxes, or assessments that the employer is required to pay by state or federal law.

(g) Notwithstanding subparagraphs (A) and (B) of paragraph (2) of subdivision (a), the amounts in those subparagraphs may be

adjusted by the board to ensure that the revenues in the Health Care Trust Fund derived from employer health care fees are sufficient to pay for the cost of health coverage provided through the Connector when combined with the resources available pursuant to Section 2201 and federal funds received pursuant to Section 1499.10 of the Welfare and Institutions Code. On or before October 31 of each year, the board shall prepare a statement, which shall be a public record, containing the applicable fee amounts for the coming calendar year and shall promptly notify the Employment Development Department in that regard.

2201. (a) The employees of employers electing to pay the employer health care fee shall be required to pay a health coverage contribution to the Employment Development Department for deposit in the Health Insurance Trust Fund. The employee health coverage contribution shall be adjusted based on the type of plan that the employee selects and the number of dependents that would be covered.

(b) An individual employee's minimum contribution shall be determined by the board. On or before October 31 of each year, the board shall prepare a schedule, which shall be a public record, indicating the employee health coverage contribution amounts for the coming calendar year.

(c) The board shall also establish a schedule of employee health coverage contributions, based on a sliding scale, for employees who have a family income that is less than 300 percent of the federal poverty level.

(d) The board may adjust the schedule to ensure that the revenues in the Health Insurance Trust Fund derived from employee health coverage contributions are sufficient to pay for the cost of health coverage provided through the Connector when combined with the resources available pursuant to subdivision (b) of Section 2200, except that the maximum amount that employees referred to in subdivision (c) shall be required to pay in employee health coverage contributions shall be limited to a threshold that shall range from zero to 5 percent of family income, depending on family income level, after taking into account the tax savings the employee is able to realize by using the cafeteria plan made available by the employee's employer pursuant to Chapter 11 (commencing with Section 19901) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

2203. (a) Except as provided in subdivision (c), beginning January 1, 2011, every individual in this state who receives income subject to tax under Part 10 (commencing with Section 17001) of Division 2 of the Revenue and Taxation Code during a calendar year shall be required to maintain a minimum policy of health care coverage, as determined by the Managed Risk Medical Insurance Board, for himself or herself and his or her dependents.

(b) An individual is not subject to the requirements of subdivision (a) if any of the following apply:

(1) The individual's family income is less than 400 percent of the federal poverty level.

(2) The individual's only source of income is qualified retirement income, as defined in subdivision (b) of Section 17952.5 of the Revenue and Taxation Code.

(3) The cost of the minimum policy of health care coverage exceeds 5 percent of his or her family income.

(c) For purposes of this section, the term "dependents" has the same meaning as that term is defined by Section 152 of the Internal Revenue Code, as applicable for purposes of Part 10 of Division 2 of the Revenue and Taxation Code (commencing with Section 17001).

(d) The minimum policy of health care coverage shall provide basic benefits as defined in Section 1345 of the Health and Safety Code, plus prescription drugs. In establishing the minimum policy of health care coverage, the board shall consider all of the following:

(1) The affordability of the minimum policy for individuals who are subject to the requirements of subdivision (a), taking into account premiums, deductibles, coinsurance, copayments, and total out-of-pocket costs.

(2) The degree to which the minimum policy protects individuals who are subject to the requirements of subdivision (a) from catastrophic medical costs.

(3) The importance of encouraging periodic health evaluation and the use of services that have be shown to been effective in detecting or preventing serious illness.

SEC. 16. Section 17054.2 is added to the Revenue and Taxation Code, to read:

17054.2. (a) (1) Personal income tax return forms for individuals filed for taxable years beginning on or after January

1, 2011, shall be revised to require taxpayers to indicate on the form, in a manner prescribed by the Franchise Tax Board, whether, for the period of time during the calendar year ending with or within the taxable year for which the return is filed, every individual identified as a taxpayer or dependent on that return had health care coverage as required by Section 2203 of the Labor Code or was exempt pursuant to that section.

(2) Notwithstanding Section 17054 or any other provision of law, a personal exemption credit pursuant to Section 17054 shall only be allowed with respect to an individual for whom there was health care coverage as required by Section 2203 of the Labor Code. In the case of a joint return where only one spouse has health care coverage as required by Section 2203 of the Labor Code, the personal exemption credit pursuant to subdivision (b) of Section 17054 shall be reduced by one-half.

(3) A denial or reduction of a personal exemption credit pursuant to this section on the basis of information disclosed by the return may be assessed in the same manner as is provided by Section 19051 in the case of a mathematical error appearing on the return.

(b) The Franchise Tax Board shall annually estimate the revenue gain from subdivision (a) for each tax year. Based on this estimate, notwithstanding Section 17054 or any other provision of law, the Franchise Tax Board shall proportionately increase the amounts of the personal exemption credits for that tax year for all taxpayers that demonstrate compliance with Section 2203 of the Labor Code, in a manner that the estimate of revenue lost from that action equals the estimated revenue gain from subdivision (a).

(c) The Franchise Tax Board may prescribe those regulations as may be appropriate to carry out the purposes of this section and ensure compliance with the purposes of the California Health Care Coverage and Cost Control Act.

SEC. 17. Section 19552 of the Revenue and Taxation Code is amended to read:

19552. (a) Except as otherwise provided by this article, the information furnished or secured pursuant to either this article or the express provisions of law, shall be used solely for the purpose of administering the tax laws or other laws administered by the person or agency obtaining it. Any unwarranted disclosure or use of the information by the person or agency, or the employees and officers thereof, is a misdemeanor.

(b) Subject to limitations under federal law as prescribed under Section 6103(d) of the Internal Revenue Code, the information furnished or secured by the Franchise Tax Board for purposes of tax administration may be used to facilitate the administration of the health care coverage mandate as prescribed under Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code.

SEC. 18. Chapter 11 (commencing with Section 19901) is added to Part 10.2 of Division 2 of the Revenue and Taxation Code, to read:

CHAPTER 11. CAFETERIA PLANS

19901. Unless federal law or the law of this state provides otherwise, each employer in this state that elects to pay the employer health care fee pursuant to Section 2200 of the Labor Code during a taxable year shall adopt and maintain a cafeteria plan, within the meaning of Section 125 of the Internal Revenue Code, to provide accident or health plan coverage to the extent amounts for that coverage are excludable from the gross income of the employee under Section 106 of the Internal Revenue Code. The plan shall at a minimum include premium-only products for health insurance purposes.

SEC. 19. Section 131 of the Unemployment Insurance Code is amended to read:

131. "Contributions" means the money payments to the Unemployment Fund, Employment Training Fund, Health Insurance Trust Fund, or Unemployment Compensation Disability Fund that are required by this division.

~~SEC. 21.~~

SEC. 20. Division 1.2 (commencing with Section 4800) is added to the Unemployment Insurance Code, to read:

DIVISION 1.2. HEALTH INSURANCE CONNECTOR

4800. The department shall have the powers and duties necessary to administer the reporting, collection, refunding to the employer, and enforcement of employer health care fees required to be paid, and employee contributions required to be withheld by employers, pursuant to this division.

4801. The following provisions of this code shall apply to any amount required to be deducted, reported, and paid to the department under this division:

(a) Sections 301, 305, 306, 310, 311, 312, 317, and 318, relating to general administrative powers of the department.

(b) Sections 403 to 413, inclusive of Section 1336, and Chapter 8 (commencing with Section 1951) of Part 1 of Division 1, relating to appeals and hearing procedures.

(c) Article 8 (commencing with Section 1126) of Chapter 4 of Part 1 of Division 1, relating to assessments.

(d) Article 9 (commencing with Section 1176), except Section 1176, of Chapter 4 of Part 1 of Division 1, relating to refunds and overpayments.

(e) Article 10 (commencing with Section 1206) of Chapter 4 of Part 1 of Division 1, relating to notice.

(f) Article 11 (commencing with Section 1221) of Chapter 4 of Part 1 of Division 1, relating to administrative appellate review.

(g) Article 12 (commencing with Section 1241) of Chapter 4 of Part 1 of Division 1, relating to judicial review.

(h) Chapter 7 (commencing with Section 1701) of Part 1 of Division 1, relating to collections.

(i) Chapter 10 (commencing with Section 2101) of Part 1 of Division 1, relating to violations.

(j) Sections 1110.6, 1111, 1111.5, 1112, 1113, 1113.1, 1114, 1115, 1116, and 1117 relating to the making of returns or the payment of reported contributions.

4802. For the purposes of this division, the following definitions apply:

(a) "Board" means the Managed Risk Medical Insurance Board.

(b) "Contribution" means employer health care fees and employee health care contributions required by Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code.

(c) "Employer" has the same meaning as set forth in Article 3 (commencing with Section 675) of Chapter 3 of Part 1 of Division 1.

(d) "Health Insurance Connector" or "Connector" means the health care coverage purchasing pool for employees of employers electing to pay the employer health care fee instead of making health care expenditures for employees and dependents as provided

in Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code.

(e) "Wages" means all remuneration as defined in Article ~~H~~ *2* (commencing with Section 926) of Chapter 4 of Division 1. As used in this subdivision, "wages" does not include the provisions referred to in Sections 930, 930.1, and 930.5.

(f) The definitions set forth in Sections 126, 127, 129, 133, and 134 shall apply to this division.

4805. Commencing January 1, 2011, in addition to other payments required by this code and consistent with the requirements of Part 8.8 (commencing with Section 2200) of Division 2 of the Labor Code, an employer electing to pay the employer health care fee shall pay to the department for deposit into the Health Insurance Trust Fund the amounts required by Sections 2200 and 2201 of the Labor Code. These contributions shall be collected in the same manner and at the same time as any contributions required under Part 1 (commencing with Section 100) of Division 1 and Division 6 (commencing with Section 13000). The department shall deposit these payments in the Health Insurance Trust Fund.

4805.5. The employees and dependents of an employer that elects to pay the employer health care fee to the Health Care Trust Fund pursuant to Section 2200 of the Labor Code are eligible for health care coverage provided through the Connector.

4806. An employer electing to pay the employer health care fee shall do all of the following:

(a) Notify the department of that intention by September 15th of the calendar year prior to the date the obligation to pay the employer health care fee would arise.

(b) Notify the department by September 15th of the intention to terminate its decision to cease payment of the employer health care fee for the following year.

(c) Continue to elect to pay the employer health care fee for not less than two calendar years. An employer electing to cease paying the employer health care fee shall not be eligible to again elect to pay the employer health care fee for a minimum of two calendar years.

(d) Advise all employees of the requirement that they participate in a health plan offered by the board and that they have the option to cover their spouses, domestic partners, and dependents.

(e) Report to the department on the hiring of any employee who works in this state and to whom the employer anticipates paying wages.

(1) The report shall contain information on the name, address, and social security number of the employee; the employer's name, address, and state employer identification number; and the first date the employee worked.

(2) Employers shall submit this report within 20 days of hiring or rehiring any employee.

(3) The department may assess a penalty against an employer for failure to report the hiring or rehiring of an employee within 20 days, unless the failure is due to good cause. The director shall promulgate regulations establishing a schedule of penalties to be imposed depending upon the frequency of violations, the history of previous violations, if any, and the gravity of the violation. The schedule shall provide for a penalty of up to one hundred dollars ($100) for an initial violation and for the imposition of penalties in progressively higher amounts for the most serious types of violations to be set at up to five thousand dollars ($5,000) per violation.

(f) Report to the department on the termination of any employee who works in this state within 20 days of the last day of work.

(g) Establish a cafeteria plan pursuant to Chapter 11 (commencing with Section 19901) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(h) Remit both employer fees and employee contributions required by Sections 2200 and 2201 of the Labor Code to the department.

4808. The employer shall do both of the following:

(a) Advise the employee of the employee's choice to decline coverage for himself or herself offered by the board if the employee certifies that he or she has health care coverage through his or her spouse or domestic partner, or that he or she has health care coverage as a dependent of another person.

(b) Advise the employee of the right to apply to the board to determine eligibility for a subsidy if the employee's family income is less than 300 percent of the federal poverty level.

4810. The board shall annually publish a packet of information about health plan choices for the department to disseminate to all participating employers.

4820. (a) Notwithstanding any other provision of this code, an employer electing to pay the employer health care fee who fails to file or remit the employer health care fee and employee health care contributions under this division, within the time required, shall become liable for a penalty of ____ dollars ($____) and interest on those contributions at ____ annual rate from and after the date of delinquency until paid.

(b) Coverage of an enrollee, and, if applicable, dependents, shall not be contingent upon payment of the employer health care fee by the employer of that enrollee.

(c) Nothing in this division shall preclude an employer from paying some or all of the employee health care contribution required by Section 2201 of the Labor Code.

4825. The department shall deposit all contributions in the Health Insurance Trust Fund created pursuant to Section 12699.207 of the Insurance Code, and forward any necessary identifying information about who is receiving health care coverage to the Connector.

4830. The department shall promulgate rules and regulations to implement the provisions of this division.

4835. The department is authorized to obtain a loan from the General Fund for all necessary and reasonable expenses related to the establishment and administration of this division prior to January 1, 2011. The proceeds of the loan are subject to appropriation in the annual Budget Act. The department shall repay principal and interest, using the rate of interest at an amount of ____, to the General Fund no later than January 1, 2016.

~~SEC. 22.~~

SEC. 21. Section 14005.23 of the Welfare and Institutions Code is amended to read:

14005.23. (a) To the extent federal financial participation is available, the department shall, when determining eligibility for children under Section 1396a(*l*)(1)(D) of Title 42 of the United States Code, designate a birth date by which all children who have not attained the age of 19 years will meet the age requirement of Section 1396a(*l*)(1)(D) of Title 42 of the United States Code.

(b) Commencing July 1, 2008, to the extent federal financial participation is available, the department shall apply a less restrictive income deduction described in Section 1396a(r) of Title 42 of the United States Code when determining eligibility for the

children identified in subdivision (a). The amount of this deduction shall be the difference between 133 percent and 100 percent of the federal poverty level applicable to the size of the family.

~~SEC. 23.~~

SEC. 22. Section 14005.30 of the Welfare and Institutions Code is amended to read:

14005.30. (a) (1) To the extent that federal financial participation is available, Medi-Cal benefits under this chapter shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt less restrictive income and resource eligibility standards and methodologies to the extent necessary to allow all recipients of benefits under Chapter 2 (commencing with Section 11200) to be eligible for Medi-Cal under paragraph (1).

(3) To the extent federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code authorizing the state to disregard all changes in income or assets of a beneficiary until the next annual redetermination under Section 14012. The department shall implement this paragraph only if, and to the extent that the State Child Health Insurance Program waiver described in Section 12693.755 of the Insurance Code extending Healthy Families Program eligibility to parents and certain other adults is approved and implemented.

(b) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to simplify eligibility for Medi-Cal under subdivision (a) by exempting all resources for applicants and recipients.

(c) To the extent federal financial participation is available, the department shall, commencing March 1, 2000, adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1) and the amount equal to 100 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled

to the same disregard, but only to the extent it is more beneficial than, and is substituted for, the earned income disregard available to recipients.

(d) Commencing July 1, 2008, the department shall adopt an income disregard for applicants equal to the difference between the income standard under the program adopted pursuant to Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1(b)) and the amount equal to 133 percent of the federal poverty level applicable to the size of the family. A recipient shall be entitled to the same disregard, but only to the extent it is more generous than, and is substituted for, the earned income disregard available to recipients. Implementation of this subdivision is contingent upon federal financial participation. Upon implementation of this subdivision, the income disregard described in subdivision (c) shall no longer apply.

(e) For purposes of calculating income under this section during any calendar year, increases in social security benefit payments under Title II of the federal Social Security Act (42 U.S.C. Sec. 401 and following) arising from cost-of-living adjustments shall be disregarded commencing in the month that these social security benefit payments are increased by the cost-of-living adjustment through the month before the month in which a change in the federal poverty level requires the department to modify the income disregard pursuant to subdivision (c) and in which new income limits for the program established by this section are adopted by the department.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking regulatory action, subdivisions (a) and (b) of this section by means of an all county letter or similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of this section, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

~~SEC. 24.~~

SEC. 23. Section 14005.335 is added to the Welfare and Institutions Code, to read:

14005.335. (a) (1) Notwithstanding Section 14005.30, to the extent that federal financial participation is available, Medi-Cal benefits under a benchmark plan as permitted under Section 6044 of the federal Deficit Reduction Act of 2005 (42 U.S.C. Sec. 1396u-7) shall be provided to individuals eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) of Title 42 of the United ~~State~~ *States* Code made available to and exercised by the state.

(2) The department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code to adopt an income disregard in an amount that is the difference between the Medi-Cal income eligibility established under subdivision (d) of Section 14005.30 and 300 percent of the federal poverty level applicable to the size of the family.

(b) The benchmark benefit plan referenced in subdivision (a) shall be equivalent to the coverage established under Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(c) To the extent that federal financial participation is available, the department shall exercise its option under Section 1396u-1(b)(2)(C) of Title 42 of the United States Code as necessary to simplify eligibility for Medi-Cal under subdivision (a) by exempting all resources for applicants and recipients.

~~SEC. 25.~~

SEC. 24. Section 14005.34 is added to the Welfare and Institutions Code, to read:

14005.34. Notwithstanding any other provision of law, all children under 19 years of age who meet the state residency requirements of the Medi-Cal program shall be eligible for full scope benefits under this chapter if they either (a) live in families with countable household income at or below 133 percent of the federal poverty level, (b) are infants less than one year of age living in families at or below 200 percent of the federal poverty level, or (c) meet the income and resource requirements of Section 14005.7 or 14005.30, including those children for whom federal financial participation is not available under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.), or under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

~~SEC. 26.~~

SEC. 25. Section 14008.85 of the Welfare and Institutions Code is amended to read:

14008.85. (a) To the extent federal financial participation is available, a parent who is the principal wage earner shall be considered an unemployed parent for purposes of establishing eligibility based upon deprivation of a child where any of the following applies:

(1) The parent works less than 100 hours per month as determined pursuant to the rules of the Aid to Families with Dependent Children program as it existed on July 16, 1996, including the rule allowing a temporary excess of hours due to intermittent work.

(2) The total net nonexempt earned income for the family is not more than 100 percent of the federal poverty level as most recently calculated by the federal government. The department may adopt additional deductions to be taken from a family's income.

(3) The parent is considered unemployed under the terms of an existing federal waiver of the 100-hour rule for recipients under the program established by Section 1931(b) of the federal Social Security Act (42 U.S.C. Sec. 1396u-1).

(4) The parent is eligible for services under Section 1396u-1 of Title 42 of the United States Code, including any options under Section 1396u-1(b)(2)(C) made available and exercised by the state.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of an all county letter or similar instruction without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

~~SEC. 27.~~

SEC. 26. Article 7 (commencing with Section 14199.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 7. Coordination with the California Health Care Coverage and Cost Control Act

14199.10. The department shall seek any necessary federal waiver to enable the state to receive federal funds for coverage provided through the Connector to persons who would be eligible for Medi-Cal if the state adopted an additional income disregard as allowed by Section 1931(b) of the Social Security Act (42 U.S.C. Sec. 1396u-1) sufficient to make persons with income up to 300 percent of the federal poverty level eligible for coverage under that section. Revenues in the Health Insurance Trust Fund created pursuant to Section 12699.207 of the Insurance Code shall be used as state matching funds for receipt of federal funds resulting from the implementation of this section. All federal funds received pursuant to that waiver shall be deposited in the Health Insurance Trust Fund.

~~SEC. 28.~~

SEC. 27. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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