

# CALIFORNIA HEALTH SECURITY ACT

The Attorney General of California has prepared the following title and summary of the chief purpose and points of the proposed measure:

HEALTH SERVICES. TAXES. INITIATIVE CONSTITUTIONAL AMENDMENT AND STATUTE. Establishes health services system with defined medical, prescription drug, long-term, mental health, dental, emergency, other benefits, available to California residents. Establishes Health Security Fund. Elected Health Commissioner to administer Fund and system. Imposes tax upon employers, individuals, with stated exemptions; surtax upon cigarettes, tobacco products. Requires tax proceeds, existing federal, state, county health funds, if authorized, be paid into Fund. Requires health benefit providers, authorized costs, be paid from Fund. Requires Commissioner coordinate with federal law. Limits annual expenditures to prior year expenditures, as adjusted. Creates advisory Policy Board, Consumer Council. Summary of estimate by Legislative analyst and Director of Finance of fiscal impact on state and local governments. Additional revenues to the state in the range of \$40 billion annually would result from new revenue sources to fund universal health care services. Expenditures, including those to replace existing employer and employee costs for health care services, could be higher or lower than new revenue amount, depending on a number of factors. Fiscal impact on state and local governments as providers of health care is unknown, but could result in long run savings, potentially in the hundreds of millions of dollars annually, to the extent that expenditures for health care programs are limited to a specified rate of increase.

TO THE HONORABLE SECRETARY OF STATE OF CALIFORNIA:

We, the undersigned, registered, qualified voters of California, residents of \_\_\_\_\_ County (or City and County), hereby propose amendments to the Constitution of California, to the California Health and Safety Code, to the California Revenue and Taxation Code, and to the California Welfare and Institutions Code, relating to health care, and petition the Secretary of State to submit the same to the voters of California for their adoption or rejection at the next succeeding general election or at any special state-wide election held prior to that general election or otherwise provided by law. The proposed constitutional and statutory amendments, entitled the "California Health Security Act", read as follows:

SECTION 1. This initiative establishes a California Health Security System that will protect California consumers, taxpayers and employers from the skyrocketing cost of health care. Savings will be achieved by limiting health care costs, eliminating waste, and emphasizing disease prevention. Under the time-tested single-payer system established by this Act and administered by an elected Health Commissioner, the practice of medicine will remain private. Under the Health Security System, all Californians will

have free choice of health care provider, regardless of employment, and access to comprehensive health care including long term care. The Health Security System will provide these services for the same or less money in real dollars than is spent on health care in California today.

SECTION 2. Division 13 (commencing with Section 25000) is added to the Welfare and Institutions Code, to read:

#### CHAPTER 1. FINDINGS AND INTENT

25000. This act shall be known and may be cited as the California Health Security Act.

25001. Findings and Declarations.

The people of the State of California find and declare as follows:

(a) Californians have a right not to be financially ruined when they or their loved ones becomes sick or ill.

(b) California employers have a right not to be driven into insolvency by the spiraling cost of employee medical benefits.

(c) Californians have a right to high quality health care.

(d) Californians should be guaranteed the freedom to choose their own doctor or other health care provider.

(e) Californians should not be at risk of losing their health benefits if they change or lose their jobs.

(f) California taxpayers are bearing enormous financial cost because many Californians do not have a regular health care provider. This lack of primary care leads to expensive overuse of emergency facilities resulting in exorbitant financial costs that are ultimately borne by the taxpayers.

(g) Because health care costs are rising faster than wages and prices, the number of uninsured and under-insured Californians is growing at an alarming rate. Over five million Californians presently have no health insurance. Children, low-income working and unemployed individuals, and individuals with disabilities and chronic conditions, in particular, are having a harder and harder time getting all types of medical care.

(h) In spite of the fact that employers and individuals spend huge

amounts of money purchasing health insurance from insurance companies, the insurance they purchase often does not provide adequate medical care or real protection from financial ruin, especially if a loved one develops a catastrophic illness or needs long term care.

(i) Enormous savings will be achieved in California upon institution of a single-payer for health care. Savings will be achieved by decreasing wasteful administrative overhead, bargaining for the best possible prescription drug prices, providing more cost-effective primary care, and by providing long term care at home. The current health care system is so wasteful that the savings will be enough to fund universal coverage for all medical care services and extend benefits to include long term care, mental health care, and some dental services, and increase the resources available to prevent disease, all for the same amount of money currently spent on health care in California.

(j) The quality of health care can be improved in California upon institution of a single-payer for health care. Quality can be improved by changing those features of the health care system that underserve consumers and which subject some to the risks of unnecessary medical treatments.

(k) Since people always need health care services, prices for those services often do not respond to normal supply-and-demand market forces. As a result, health care costs much more than it should to provide for the health care needs of Californians. Any health care delivery system relying on price competition is unlikely to keep costs in check or provide universal health services to the population. Price control is therefore necessary to achieve cost containment and to make quality health care accessible to all.

(l) Because the best way to control health care costs in the long run is to prevent disease, funding for public health measures, and for research directed at the causes and prevention of disease, should be directly related to the overall cost of illness to society.

(m) Health care consumers need to participate in developing and reviewing public policies affecting the quality, accessibility and the accountability of health care service providers. Health care consumers therefore have the right voluntarily to join and support a democratically-controlled Health Care Consumer Council that will represent their interests before administrative, judicial and legislative bodies, and that will have an efficient and honest system for funding.

(n) Safeguarding the quality and accountability of the health care system requires that there be a Health Commissioner who is elected by a direct vote of the people of California.

25002. Purpose and intent.

The people enact this Act to accomplish the following purposes:

- (a) To replace the current hodgepodge of government programs, private health insurance and health care expenditures by individuals, with a comprehensive and sensible Health Security System that will provide all medically appropriate care specific to individual needs, including preventive, mental health and long-term care as well as prescription drug coverage and some dental care, for all Californians.
- (b) To control health care costs without compromising quality, primarily by eliminating wasteful overhead and excessive expenditures that do not contribute to the quality of health care.
- (c) To finance the Health Security System in a manner that is fair, and spend no more money per individual in real dollars than is now being spent on health care in California.
- (d) To provide incentives by which competition can improve quality and service in the health care system. When consumers have freedom of choice of health care providers, instead of a restricted choice of health plans based on what they can afford, providers have an incentive to provide the best quality care and service, in order to attract patients. When providers have freedom of mode of reimbursement, such as a choice of fee-for-service, capitation, or salary, under an overall budget, they can focus on taking the best possible care of their patients, without bureaucratic intrusion into the relationship between individual providers and their patients.
- (e) To allocate Health Security System funds effectively in order to make the highest standards of care available for all Californians.
- (f) To address the current and future health care needs of all Californians through emphasis on public health measures, changes in training and distribution of health care workers, and an intensive program of research into the causes of disease and most effective means of preventing illness.
- (g) To convert the current health care delivery system from one focused on emergency care to one focused on primary health care services and the promotion, restoration and maintenance of health. These reforms will integrate all health care services and emphasize preventive services, early intervention, vigorous rehabilitation and restorative care in order to make health care a more vital part of individual and community life.
- (h) To establish a governance structure for the Health Security System that is democratic and accountable while assuring the quality, reliability,

efficiency and effectiveness of the System.

(i) To ensure effective representation of the interests of the state's health care consumers before all administrative, judicial and legislative bodies by establishing a Health Care Consumer Council funded only by voluntary contributions and grants and controlled by a democratically-elected board of directors.

(j) To provide initial benefits under the Health Security System as of January 1, of the second year following passage of the Act, with full benefits provided no more than four years later.

(k) To have a neutral effect on the spending limit in California Constitution Article XIII B so that spending under this Act neither increases nor decreases the amount of appropriations available for non-health related spending by state and local government entities.

(l) To give the elected Health Commissioner the maximum authority permitted by law to determine budgeting needs and appropriations for the Health Security System.

(m) To achieve compliance with federal health care reform legislation and to obtain the maximum amount of federal revenues possible to fund the Health Security System.

25003. Construction.

This Act shall be liberally construed to accomplish its purposes.

## CHAPTER 2. DEFINITIONS

25004. The definitions contained in this section shall govern the construction of this Division, unless the context requires otherwise.

(a) "Academic medical center" means a health facility associated with a degree granting health professional training program and with major resource commitments to research.

(b) "Advisory Board" means the Health Care Policy Advisory Board appointed by the Commissioner to make expert recommendations on all aspects of health care policy.

(c) "Base year" means the twelve months prior to the passage of the Act.

(d) "Base fiscal year" means the fiscal year of passage of the Act.

(e) "Capitation" means allocation of System funds to a professional provider or integrated professional provider network based on the number of individuals whose health care must be covered, with respect to all benefits available under the Health Security System, for the calendar year, or part thereof, by that professional provider or professional provider network.

(f) "Clinic" means a facility licensed pursuant to Chapter 1, Division 2, of the Health and Safety Code commencing at Section 1200, subject to standards and criteria.

(g) "Clinical case manager" means a licensed professional provider who provides case management of an individual's health care. A case manager shall be a primary care professional provider, except in the case of individuals with particular chronic medical conditions requiring a specialist to be the case manager. An individual may select a specialist as a case manager if his or her primary health care needs are served within that specialty and the specialist is able and willing to provide individual case management.

(h) "Clinical case management" means a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs through communications and available resources to promote quality, cost-effective outcomes.

(i) "Commissioner" means the California State Health Commissioner whose office is established by this Act.

(j) "Complementary medicine" means those medical and health practices based upon empirical healing benefits and cultural traditions that do not rely on prevailing allopathic pharmaceuticals and techniques.

(k) "Consumer Council" means the Health Care Consumer Council established by this Act.

(l) "Effective date" means the day after passage of this Act.

(m) "Elective care" means health care services that are not emergency care or urgent care, as determined by the Commissioner based on recommendation of the Advisory Board.

(n) "Employee" means a resident of California who works for an employer, is listed on the employer's payroll records, and is under the employer's control.

(o) "Employer" means any person, partnership, corporation, association, joint venture, or public or private entity employing for wages, salary, or other compensation, one or more employees at any one time to work in this state. "Employer" does not include self-employed persons with respect to earnings from self-employment.

(p) "Emergency care" means health care services required for alleviation of severe pain or distress or for immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to disability or death, as defined in Section 16953 of the Welfare and Institutions Code.

(q) "Health facility" means a facility licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code commencing at Section 1250 and Chapter 8 of Division 2 of the Health and Safety Code commencing at Section 1725, subject to standards and criteria.

(r) "Health Security System" means the program of comprehensive health services administered by the Commissioner as set out in this Act and all policies and directives of the Commissioner.

(s) "Medical care" means all health care items and services, except for items and services not reasonable and necessary for the diagnosis, treatment or prevention of illness or injury or to improve the functioning of a malformed or injured body member, according to guidelines established by the Commissioner based on recommendation of the Advisory Board.

(t) "Medical indication" means the set of medical conditions for which there is evidence that a particular service improves the overall health outcome of patients receiving that service.

(u) "Medically appropriate" means all health care services and procedures chosen by the patient's health care professional provider subject to the guidelines established by the Commissioner based on recommendation of the Advisory Board.

(v) "Mental health care" means health care services provided for the prevention, diagnosis or treatment, or one or more mental disorders, including substance dependence and abuse and including diseases of the brain.

(w) "Mode of reimbursement" means the way in which a professional provider is paid including, but not necessarily limited to, any of the following: 1) a fee for each service provided, 2) capitation or 3) salary.

(x) "Primary care" means comprehensive longitudinal individual clinical prevention and treatment services, provided by a professional provider acting within the scope of his or her practice, subject to standards and criteria.

(y) "Primary care provider " means a professional provider delivering primary care.

(z) "Professional provider" means a individual licensed to provide health care services pursuant to Division 2 of the Business and Professions Code, subject to standards and criteria.

(aa) "Provider" means a professional provider, health facility or clinic, subject to standards and criteria.

(bb) "Regional Administrator" means the individual appointed by the Commissioner to coordinate Health Security System activities in a System Region.

(cc) "Regional Consumer Advocate" means the individual appointed for each System Region by the Commissioner to serve as the ombudsperson and liaison between health care consumers and the Health Security System.

(dd) "Resident" means a resident of California as determined pursuant to Section 244 of the Government Code, or as otherwise defined by the Legislature.

(ee) "Secondary care" means both of the following:

(1) Outpatient health care services other than those that constitute primary care, and

(2) Inpatient health care services other than those that constitute tertiary care.

(ff) "Specialist" means those professional providers who are specialty board certified or eligible for certification, or who currently provide specialized health care services in the state of California, who provide specialized health care services and accept referrals from primary care providers, case managers and other specialists, subject to standards and criteria.

(gg) "State gross domestic product" means the sum total of value of all goods sold, and services provided, in the State of California for any given year as determined by the U.S. Department of Commerce.

(hh) "Standards and criteria" mean standards and criteria as promulgated by the Commissioner.

(ii) "System" means the Health Security System established by this Act.

(jj) "System budget" means the amount of money projected to be spent in the state on health care in any given year under the Health Security System pursuant to Chapter 6 (commencing with Section 25150)

(kk) "System formulary" means the list of drugs that are covered for payment by the Health Security System when prescribed by a professional provider acting within the scope of his or her practice according to standards and criteria.

(ll) "System Region" means a region of the state composed of geographically contiguous counties grouped on the basis of common economic or demographic characteristics, for administrative and other purposes of the Health Security System.

(mm) "Tertiary care" means the specialized diagnostic and treatment services for which regional referral centers have been designated by the Commissioner.

### CHAPTER 3. ELIGIBILITY

25006. (a) All Californians who meet residency requirements defined by the Legislature and certified by the Commissioner are eligible for covered benefits specified in Chapter 4 of this Division commencing with Section 25010, other than long term care benefits as provided in Article 4 of that Chapter.

(b) A California resident eligible for benefits under subdivision (a) is further eligible for long term care benefits as provided in Article 4 of Chapter 4 upon showing any of the following:

(1) That he or she has been employed full time for not less than 24 months, or a correspondingly greater number of months of part-time employment, by an employer who, for the entire time,

(A) Made payments into the Health Security Fund pursuant to Section 25115, less any credit allowed under Section 33003 of the Revenue and Taxation Code; or

(B) Was exempt from making payments pursuant to Section 25136.

(2) That he or she has, for a period of two years, made individual payments by way of taxes or otherwise into the Health Security Fund pursuant to Section 25120, less any credit allowed under Section 33003(b) of the Revenue and Taxation Code.

(3) That he or she was, for the period specified, a dependent and member of the household of a person qualifying under paragraph (1) or (2).

(4) That he or she is entitled under federal law to such benefits.

(c) Until such time as the Legislature establishes residency requirements for purposes of this Act, residency shall be determined according to Government Code Section 244.

(d) Any individual who is not eligible for long term care under subdivision (b) shall be eligible for care to the same extent and under the same conditions as he or she would have been eligible under programs existing prior to the effective date of this Act, including but not limited to, the Medical Assistance Program (Medi-Cal) and California Children's Services.

#### 25007. Eligibility cards.

(a) The Regional Administrator for each System Region shall certify the eligibility of each individual within the region, pursuant to Section 25006, and shall provide each eligible individual with a card with an identifying number listing any limitations of the services for which the individual is eligible. The card shall be in such form and manner as determined by the Commissioner, or as required by federal law.

(b) (1) In the case of minors under the age of 18, the Regional Administrator shall issue the card to a person having legal custody of the minor. More than one minor may be listed on a single card.

(2) Any eligible minor who is legally capable of giving consent to health care may apply to the Regional Administrator for a separate card. The card shall be limited to the types of care for which the minor may lawfully consent.

(c) (1) Within 30 days of receipt of a completed application, the Regional Administrator shall issue an eligibility card, or provide a written explanation for its denial or any restrictions placed thereon.

(2) If good cause exists to believe that the applicant may not meet the eligibility requirements of Section 25006, the Regional Administrator may extend the period under paragraph (1) up to an additional 30 days to permit further investigation.

(3) Where necessary to avoid an interruption in care, the Regional Administrator may issue a temporary eligibility card.

25008. Presumptive eligibility.

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

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

25009. Nothing in the California Health Security Act shall relieve the counties of their obligation under Division 9, Part 5 of this Code, commencing with Section 17000.

## CHAPTER 4. BENEFITS

### Article 1. General.

25010. (a) Any eligible individual may choose to receive services under this Division from any willing professional provider participating in the Health Security System.

(b) No eligible individual shall be required to meet a deductible or co-payment as a condition for receiving health care services by any health facility or clinic or professional provider reimbursed by the Health Security System except as follows:

(1) As authorized by the Commissioner under provisions for implementing phase-in of the Health Security System, as provided in Chapter 10 (commencing with Section 25305);

(2) For out-patient prescription drugs as specified in Chapter 4, Article 3, (commencing with Section 25020);

(3) For room and board charges as specified in Chapter 4, Article 4 (commencing with Section 25025) and Article 5 (commencing with

Section 25030); and

(4) For cost control purposes as specified in Chapter 7, Article 8, (commencing with Section 25240).

#### Article 2. Medical Benefits.

25015. Covered benefits in this chapter shall include all medical care determined to be medically appropriate by the patient's health care provider except as excluded under Section 25045, including but not limited to all of the following:

(a) Inpatient and outpatient health facility or clinic services other than long term care services as defined in Section 25025 (a).

(b) Inpatient and outpatient professional provider services, including eye care and home health care.

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

(d) Prenatal, perinatal and maternity care.

(e) Durable medical equipment and appliances including prosthetics, eyeglasses and hearing aids, as determined by the Commissioner.

(f) Podiatry.

(g) Chiropractic.

(h) Dialysis.

(i) Emergency transportation and necessary transportation for health care services for the disabled, as determined by the Commissioner.

(j) Rehabilitative care.

(k) Language interpretation for health care services, including sign language, for those unable to speak, hear or understand English, and for the hearing impaired.

(l) Blood.

25016. Covered benefits in this chapter shall include outreach, education and screening services, including but not limited to:

(a) Children's preventive care, well-child care, immunizations, screening, outreach and education.

(b) Adult preventive care including mammograms, Pap smears and other screening, outreach and educational services.

### Article 3. Prescription Drugs.

25020. (a) Covered benefits in this chapter shall include pharmacological products of proven pharmaceutical effectiveness pursuant to a System formulary composed of the best-priced prescription drugs of proven efficacy for particular conditions as set out in Section 25216. In establishing the formulary, and achieving the lowest possible prices for formulary drugs, the Commissioner shall not be considered to be the dispenser or distributor of formulary drugs.

(b) Only those prescription drugs on the System formulary shall be reimbursed under the Health Security System, except where special standards and criteria are met.

(c) The Health Security System shall cover the full cost of all drugs provided during hospitalizations and during emergency care.

(d) Except as otherwise provided in this subdivision, a co-payment of not more than five dollars (\$5) per prescription shall be charged for out-patient prescription drugs.

(1) Standards and criteria for application of, adjustment of, and a ceiling on, out-patient prescription drug co-payments shall be established.

(2) A list of drugs available without co-payments, including but not limited to, antineoplastic agents, drugs to combat infectious diseases including tuberculosis, blood derivatives and immune serum globulins, vaccines and sera, shall be established and may be modified at the discretion of the Commissioner.

(3) A mechanism for waiving the prescription drug co-payment requirement in the case of individuals whose financial resources are insufficient to meet any co-payment shall be established by the Commissioner.

(e) A mechanism for daily drug dispensing for those individuals who are eligible for drugs without co-payment pursuant to paragraphs (2) and (3) of subdivision (f), but who are deemed unable to manage their own drugs on the basis of repeated loss of prescribed drugs provided without co-payment,

shall be established according to standards and criteria.

#### Article 4. Long-Term Services.

25025. (a) Long-term services necessary for the physical health, mental health, social, and personal needs of individuals with limited self-care capabilities are covered benefits under this Division as provided in this section.

(b) Long-term services shall include all of the following:

- (1) Institutional and residential care including Alzheimer's Disease units.
- (2) Home health care.
- (3) Hospice care.
- (4) Home- and community-based services, including personal assistance and attendant care.
- (5) Appropriate access to specialty consultation within long term care settings.
- (6) Reassessment of an individual's need for long term services, conducted at appropriate intervals, but not less than once a year.

(c) Individual needs for long term care shall be determined through a standardized assessment of the individual's abilities for self-care and need for a particular level of care. This assessment shall occur at the time of discharge planning, if applicable, and otherwise shall occur before provision of long term care services under this Section, and shall include all of the following, unless otherwise specified by the Commissioner:

- (1) Medical examinations necessary to determine what level of medical care is required.
- (2) Environmental and psycho-social evaluations to determine what the individual can and cannot do for himself or herself physically, as well as mentally.
- (3) Services, service coordination, or case management, to ensure that necessary services are provided to enable the individual to remain safely in the least restrictive setting.
- (4) Early intervention services and individualized family

services for the developmentally disabled pursuant to Part H of the Independent Disability Education Act, 20 U.S.C. Section 51417 et seq. and Government Code Section 95000 et seq.

(d) Services may be provided in the individual's home, or through community-based, residential, or institutional programs, pursuant to standards and criteria.

(e) In providing long-term services under this section, the Commissioner shall encourage and reimburse non-institutional long-term services where appropriate, as determined pursuant to the assessment and reassessment process. At the discretion of the Commissioner, up to 100% of the cost to the Health Security System of institutional care may be expended in order to allow persons needing long-term services to remain safely in their homes to the maximum extent possible.

(f) The Health Security System shall not cover that portion of long term care expenses incurred for room and board, unless an individual has no resources for payment as determined by the Commissioner. Persons with low income and assets shall be charged for basic room and board at a reduced rate corresponding to a percentage of Social Security or other income, as determined by the Commissioner. Additional amenities for room and board may be purchased at individual expense.

#### Article 5. Mental Health Care Benefits.

25030. (a) Mental health care services that are medically appropriate, including, but not limited to, treatment for substance abuse and treatment for diseases of the brain, are covered benefits under this Division.

(b) Covered mental health care benefits in this chapter shall include, but not be limited to, the following when determined to be medically appropriate by the Commissioner:

(1) Crisis intervention, including assessment, diagnosis, brief emergency treatment, and referral.

(2) Outpatient services, including, but not limited to, adult day care, detoxification services, home health care, psycho-social rehabilitation and professionally sponsored and professionally supervised self-help and peer-support programs which are approved by the Commissioner.

(3) Intermediate-level care, including, but not limited to, intensive day and evening programs and institutional and residential services. The Health Security System shall not cover that portion of intermediate-level care expenses incurred for room and board in excess of one meal per day,

unless an individual has no resources for payment. Persons with low income and assets shall be charged for basic room and board at a reduced rate, as determined by the Commissioner. The reduced rate charged to individuals with low income for room and board shall be a percentage of Social Security or other income, to be determined by the Commissioner. Additional amenities for room and board may be purchased at individual expense.

(4) Inpatient health facility services as approved by the Commissioner based on the recommendations of the Advisory Board.

(5) Professional provider services at outpatient, intermediate and inpatient levels of care, including, but not limited to, individual, family, and group psychotherapy, medical management, psychological testing and mental health case management and coordination of care.

(6) Diagnostic imaging, laboratory services and other diagnostic and evaluative services, as provided in Article 2 (commencing with Section 25015).

(7) Prescription drugs, as provided in Article 4 (commencing with Section 25020).

(c) Services under subdivision (b) (3) of this Section may be integrated with long term care services described under Article 5 of this Chapter (commencing with section 25025) at the discretion of the Commissioner.

(d) During the first year that benefits are available under the Health Security System, a patient co-payment may apply to certain outpatient mental health care services, as provided in Article 3 of Chapter 10 (commencing with Section 25305).

#### Article 6. Dental Benefits.

25035. Dental services are a covered benefit under this chapter as specified by the Commissioner. To the extent funding permits, dental benefits shall include the following, in the priority listed:

(1) Emergency dental services.

(2) Dental care for individuals, to the same extent and under the same conditions as they would have been eligible for, under programs existing prior to the effective date of this Act, including, but not limited to, Medi-Cal.

(3) Preventive dental services and non-cosmetic orthodontia for individuals under the age of 18.

(4) Preventive dental services for individuals over the age of 18 and restorative care.

#### Article 7. Expansion of Covered Benefits.

25040. (a) The Commissioner may expand benefits beyond the minimum benefits described in this Chapter when expansion meets the intent of this Division and there are sufficient funds to cover the expansion.

(b) Coverage for any service or benefit not previously covered by the Health Security System may be instituted without expansion of benefits, provided that the Commissioner determines it is of equivalent therapeutic value or is a less costly treatment alternative to a listed service, and if the service or benefit is provided by a professional provider acting within the scope of his or her practice, according to standards and criteria.

#### Article 8. Excluded Benefits.

25045. (a) Services determined to have no medical indication by the Advisory Board shall be excluded from coverage under the Health Security System.

(b) Elective services may be restricted or excluded from coverage under the cost containment provisions of Section 25240.

#### Article 9. Coverage for Californians While Out-of-State.

25055. (a) The Health Security System shall cover all eligible California residents travelling out of state for up to 90 days in each twelve month period.

(1) Coverage for emergency care shall be at prevailing local rates;

(2) Coverage for non emergency care shall be according to rates and conditions established by the Commissioner. The Commissioner may require transport back to California for further treatment when the patient is medically stable.

(b) The Commissioner may make arrangements for reciprocal coverage with other states or countries, provided that the programs provided by the other states or countries are comparable to those available in California in coverage, cost and quality.

Article 10. Emergency Benefits.

25059. (a) Emergency care and health care services necessary to safeguard the health of the population shall be readily available through the Health Security System to all individuals.

(b) The Commissioner shall provide funding to public fire agencies for delivery of emergency medical services and emergency transportation.

CHAPTER 5. GOVERNANCE AND ADMINISTRATION

Article 1. California State Health Commissioner.

25060. (a) There is a California State Health Commissioner. The Office of State Health Commissioner is an agency of the State of California.

(b) The Commissioner shall administer the California Health Security System.

(c) The first Commissioner shall be appointed by the Governor not less than 75 nor more than 100 days following passage of this Act, and shall be confirmed by the Legislature within 30 days of nomination.

(d) The Commissioner shall stand for election at the same time and in the same manner as the Governor.

(e) At any time that the Commissioner is unable to perform the duties of the office, the Deputy Health Commissioner may perform those duties for a period of up to 90 days.

(f) The Commissioner may be impeached for malfeasance of office.

(g) In the event of vacancy, or inability of the Commissioner to perform the duties of office for a period of more than 90 days, an acting Commissioner shall be appointed by the Governor and confirmed by the Legislature, for the balance of the Commissioner's term.

(h) Compensation and benefits of the Commissioner shall be determined pursuant to Article 3, Section 8 of the California Constitution.

(i) The Commissioner shall appoint a Deputy Health Commissioner.

(j) Neither the Commissioner nor the Deputy Health Commissioner, nor either's spouse or children, shall be an employee, director or stockholder

of any company researching, developing or marketing products or services which would have a financial interest in the outcome of deliberations in which that member would participate as a result of their appointment, during the time of appointment and for a period of three years after completion of the appointment.

## Article 2. Health Commissioner Powers and Duties.

25063. The Commissioner's powers include any and all powers necessary and proper to implement this Act, and to promote its underlying aims and purposes. These broad powers include, but are not limited to, the power to set rates and promulgate generally binding regulations on any and all matters relating to the implementation of this Act and its purposes.

25065. The Commissioner shall do all of the following:

(a) Establish and maintain a system of universal access to medical care for all Californians, as required by this Division, including:

(1) Implement statutory eligibility standards.

(2) Adopt annually a benefits package for consumers which meets or exceeds the minimums required by law.

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

(4) Develop and implement separate formulae for determining budgets pursuant to Chapter 7, Article 3, commencing with Section 25155.

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

(6) Provide for timely payments to professional providers and health facilities and clinics through a structure that is efficient to administer and which eliminates unnecessary administrative costs. The cost of administration of the Health Security System shall not exceed the limits set in Article 3 of Chapter 7 (commencing with Section 25175).

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

(8) Establish an enrollment system that will ensure that all eligible Californians, including those who travel frequently, those who cannot

read, and those who do not speak English, are aware of their right to health care, and are formally enrolled.

(9) Determine the number and precise county-by-county composition of the System Regions, based on criteria of common economic and demographic features and geographic contiguity.

(10) Bid for prescription drug contracts in order to achieve the lowest possible cost for drugs available under the System formulary.

(11) Negotiate for, or set, rates, fees and prices involving any aspect of the Health Security System, and establish procedures relating thereto.

(b) (1) Administer the revenues of the Health Security System in accordance with Chapter 6 of this Division (commencing with Section 25100).

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

(c) Establish, appoint, and fund, as part of the administration of the Health Security System, the following:

(1) A Health Policy Advisory Board pursuant to Section 25068.

(2) A Regional Administrator with appropriate staff for each System Region pursuant to Section 25074.

(3) A Regional Consumer Advocate with appropriate staff for each System Region pursuant to Section 25075.

(d) Administer all aspects of the Health Security System that include, but are not limited to, all of the following:

(1) Establish standards and criteria for allocation of operating funds and funds from Named Accounts as described in Section 25250 to System Regions.

(2) Meet regularly with the Regional Administrators and Advocates to review the impact of the Health Security System and its policies on the System Regions.

(3) Budget the Public Health and Prevention Account, Innovations Account, Capital Improvement Account, Health Worker Training Account, and Reserve Accounts for each System Region in a manner determined by the Commissioner to most equitably meet the health care

needs of the population of the state as a whole and the population within each region pursuant to the specific purposes for which those accounts have been established as described in Article 10 of Chapter 7 (commencing with Section 25250).

(4) Achieve the best pharmaceutical drug prices for the Health Security System pursuant to Section 25216.

(e) Gather and analyze data necessary for the efficient and equitable functioning of the Health Security System pursuant to Section 25095.

(f) In addition to all other powers conferred under this Division, the Commissioner may:

(1) Employ appropriate staff as necessary to implement this Division.

(2) Delegate to appointed staff any aspect of the Health Security System that is the responsibility of the Commissioner. Individuals employed by the Commissioner or by any Department or state agency that is made a part of the Health Security System shall perform their duties as the Commissioner assigns them.

(3) Employ and direct attorneys on staff or as outside counsel in the defense or implementation of any provision of this Act.

(4) Sue and be sued to enforce any provision of this Act.

(5) Seek, at his or her discretion, legal advice or counsel from the Attorney General.

(6) Incur travelling expenses as are necessary for the performance of his or her duties.

(7) Issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the administration of the Health Security System.

(g) Promulgate procedures and standards for competitive bidding which shall govern the contracts authorized by this section. Notwithstanding any other provision of law, the contracts shall be subject to the competitive bidding requirements so promulgated, and no others.

(h) Assure all existing statutes regarding confidentiality of medical records shall continue to apply to the Health Security System. No policy, directive, or study by the Commissioner may be taken which compromises confidentiality of medical records as established by law.

25066. Nothing contained in this Act shall prevent the Legislature from transferring to the Health Security System programs for health care, including mental health care for patients in state hospitals and other health care facilities owned by the state, and facilities located in state prisons.

25067. (a) The Commissioner shall not set any rate, fee, or price, that is confiscatory.

(b) Any provider, vendor, or other person aggrieved by a rate, fee, or price set by the Commissioner, upon the production of credible evidence that the rate, fee, or price is confiscatory, shall be entitled to a timely hearing.

(c) This Section shall not apply to any rate, fee, or price that is negotiated with the Commissioner.

### Article 3. Health Care Policy Advisory Board.

25068. (a) The Commissioner shall establish and appoint a Health Care Policy Advisory Board consisting of health care and public health professionals and other experts, including the Director of the California Department of Health Services.

(b) Members of the Advisory Board, other than the Director of the Department of Health Services, and any committee or task force established by the Commissioner,

(1) Shall serve for a period determined by the Commissioner and shall be exempt from civil service pursuant to Art. VII, Section 4(d) of the California Constitution;

(2) Shall receive a salary and other compensation as determined by the Commissioner;

(3) Shall not be an employee, director or stockholder of any for-profit company researching, developing, marketing or providing health care products or services during the time of appointment and for a period of three years after completion of service on the Advisory Board, task force or committee. No individual shall be appointed to the Advisory Board, task force or committee whose spouse or child is an employee, director or stockholder of any for-profit company researching, developing, marketing or providing health care products or services.

(c) The Director of the Department of Health Services shall be a

member of the Advisory Board and shall serve without additional compensation.

25070. The Advisory Board shall do all of the following:

(a) Make policy recommendations on medical issues, population-based public health issues, research priorities, scope of services, and expanding access to care and Health Security System evaluation.

(b) Review proposals for innovative approaches to health promotion, disease and injury prevention, education, research, and health care delivery.

(c) Be consulted by the Commissioner regarding any matter involving practice or quality under the Health Security System.

(d) Recommend expert task forces, including an expert formulary committee, to be appointed by the Commissioner to study and make recommendations on specialized areas of medical policy and effectiveness.

(e) Identify medical services for which there is no credible evidence of significant benefit.

(f) Establish standards and criteria by which requests by health facilities for capital improvements shall be evaluated.

25071. The responsibilities of the formulary committee shall include, but need not be limited to, all of the following:

(a) Prepare, and update as required, a formulary that shall contain drugs covered under the Health Security System.

(b) Make recommendations to the Commissioner as to which drugs are of proven efficacy for particular conditions.

(c) Identify those prescription drugs that are of comparable efficacy or that lack distinguishing features that would justify their independent inclusion in a Health Security System formulary.

25073. The Commissioner shall establish a mechanism to allow the Consumer Council and any organization or advocacy groups with special health care-related interests, including those representing complementary medicine, to provide input to the Advisory Board on a regular basis.

Article 4. Regional Administration.

25074. (a) There shall be a Regional Administrator in each System Region whose duties shall include, but are not limited to, negotiating service contracts, preparing budgets, approving and funding of capital expense projects of health facilities and clinics in the region, following guidelines and formula determined by the Commissioner.

(b) Each Regional Administrator shall be exempt from civil service pursuant to Article VII, Section 4(d) of the California Constitution.

(c) The Regional Administrator shall not be an employee, director or stockholder of any for-profit company researching, developing, marketing or providing health care products or services during the time of appointment and for a period of three years after completion of service. No individual shall be appointed as Regional Administrator whose spouse or child is an employee, director or stockholder of any for-profit company researching, developing, marketing or providing health care products or services.

25075. Regional Consumer Advocates

(a) There shall be a Consumer Advocate in each System Region, appointed by the Commissioner.

(b) The Regional Consumer Advocate shall monitor the effectiveness of the Health Security System within a System Region including but not limited to examining:

- (1) Complaints and suggestions from the public;
- (2) Proposals to be considered by the Commissioner in the future;
- (3) The Commissioner's plans for changes in resource allocation;
- (4) The extent to which individual health facilities and clinics in a System Region meet the needs of the community in which they are located; and
- (5) Any other factor bearing on the effectiveness of the Health Security System.

(c) The Regional Consumer Advocate shall receive, investigate and respond to complaints from any source about any aspect of the Health Security System, referring the results of investigations to the appropriate

professional provider or facility licensing boards or law enforcement agencies, as appropriate.

(d) The Regional Consumer Advocate shall publish an annual report to the public containing an evaluation of the Health Security System in that System Region, including, but not limited to, the items described in subdivision (b).

(e) The Regional Consumer Advocate shall hold public hearings no less than yearly on, but not limited to, the items listed in subdivision (b).

(f) In the pursuit of his or her duties, the Regional Consumer Advocate shall have unlimited access to all non-confidential and non-privileged documents in the custody and control of the Commissioner, Regional Administrator, and Health Security System staff.

(g) The Regional Consumer Advocate shall not be an employee, director or stockholder of any for-profit company researching, developing, marketing or providing health care products or services during the time of appointment and for a period of three years after completion of service. No individual shall be appointed as Regional Consumer Advocate whose spouse or child is an employee, director or stockholder of any for-profit company researching, developing, marketing or providing health care products or services.

#### Article 5. Health Care Consumer Council.

25080. (a) There is established a Health Care Consumer Council as an agency to:

(1) Advise the Commissioner on behalf of health care consumers of the State regarding policies and practices in the provision and delivery of health care services and supplemental health insurance;

(2) Educate health care consumers about preparation and submission of claims or disputes to the Commissioner or any other entity in regard to provision and delivery of health care services and supplemental health insurance;

(3) Represent and promote the interests of health care consumers as a class before the Commissioner, or any administrative or judicial body, and initiate, maintain, intervene, or participate in any proceeding related to health care or supplemental health insurance which affects the interests of health care consumers, except that the Consumer Council shall not represent any person in any action for compensation for injury or damages arising from any provision of health care services or supplemental

health insurance;

(4) Appear before local, state, and federal legislative or policy making bodies to advocate and lobby on behalf of the interests of health care consumers;

(5) Conduct and support research, surveys, conferences and public information activities concerning health care and supplemental health insurance matters;

(6) Develop proposals to improve the delivery and quality of health care services;

(7) Perform all acts necessary or expedient for the administration of its affairs and the attainment of its purposes.

(b) The membership of the Consumer Council shall consist of all individual health care consumers sixteen (16) years of age or older residing in the state who have contributed to the Consumer Council the appropriate annual membership fee. The Board of Directors shall establish an annual membership fee of not less than \$10.00, to be adjusted every three years for inflation, and provide for reduced fee membership for low income individuals.

(c) Within 90 days of the effective date of this Act, the Governor shall appoint five individuals to the interim Board of Directors, and the Rules Committee of the Senate and the Speaker of the Assembly shall each appoint ten individuals to the interim board of directors.

(d) The interim Board of Directors shall, prior to the date benefits are first provided under this Act, organize the Consumer Council; inform health care consumers of and solicit their membership in the Consumer Council; elect officers; employ such staff as are necessary; solicit funds; determine the Consumer Council electoral districts, each of which shall consist of two state senatorial districts; establish procedures for democratic election of twenty members of the Board of Directors; oversee the election campaign, tally the votes and install the elected and appointed directors; and carry out all other duties and exercise all other powers necessary to establish the first elected board, including establishing procedures for the first election of the board of directors regarding conflicts of interest, contribution limitations, nomination procedures, requirements of candidates to submit statements of financial interest, background and positions, and regarding reimbursement of actual, reasonable expenses of interim directors. The agency shall not participate in any representation of health care consumers before any administrative, judicial or legislative body before such time as the first elected board of directors is installed.

(e) The Consumer Council Board of Directors shall consist of twenty-

five members, of which one shall be appointed by the Governor, two shall be appointed by the Rules Committee of the Senate and two shall be appointed by the Speaker of the Assembly, subject to the requirements of subdivisions (b) and (f) of this Article regarding qualifications for directors. The remaining twenty shall be elected by the membership. The term for all appointed directors shall be two years. Each elected Director shall represent a Consumer Council electoral district. One-third of the directors first elected shall serve for a one-year term, one-third of such directors shall serve for a two-year term, and one-third of such directors shall serve a full three-year term. The directors shall draw lots upon their installation to determine the length of their terms. Once each year, the board shall elect its officers. All directors shall serve without compensation, but may be reimbursed for actual, reasonable expenses incurred by them in the performance of their duties.

(f) No present employee, director, consultant, attorney, or accountant of any private health insurance provider, the Commissioner, any health care provider, or spouse or child of any such individual, shall be eligible to be appointed or elected to either the interim or subsequent Consumer Council Boards of Directors, and no candidate for such office may accept any campaign contributions or gifts, either monetary or in kind, from any such person. No elected member of the Consumer Council Board of Directors shall serve more than two consecutive terms and no appointed member shall serve more than one term. No Consumer Council Board of Directors member or candidate may hold any other elective public office or be a candidate for elective public office or be appointed to hold state or local office.

(g) Not more than 60 days after the membership of the Consumer Council reaches 25,000 persons with at least one hundred members in each Consumer Council district, the interim Board of Directors shall set a date for the first general election of directors and shall so notify every member. The date set for elections shall be not less than four months nor more than eight months after such notification. The date of subsequent elections shall be fixed by the Board of Directors at least four months in advance of the date chosen for the election.

(h) The Board of Directors shall have the following duties:

(1) To prescribe rules for the conduct of elections and election campaigns for the Board of Directors not inconsistent with this Act;

(2) To establish policies and procedures regarding conflicts of interest; campaign contribution limitations; nomination of candidates for directors; requirements of candidates to submit statements of financial interest, background and position; and regarding reimbursement of actual, reasonable expenses of directors;

(3) To establish the policies of the Council regarding

appearances before the Commissioner, administrative, judicial and legislative bodies, and regarding other activities which the Council has the authority to perform under this Act;

(4) To maintain up-to-date membership rolls;

(5) To keep minutes, books and records which shall reflect all the acts and transactions of the board of directors which shall be open to examination by any member during regular business hours;

(6) To maintain and make all reports and studies compiled by the Consumer Council pursuant to this Article available for public inspection during regular business hours;

(7) To maintain for inspection by the membership quarterly statements of the financial and substantive operations of the Consumer Council;

(8) To cause the Consumer Council's books to be audited by an independent certified public accountant at least once each fiscal year, and to make the audit available to the general public;

(9) To prepare, as soon as practicable after the close of the Consumer Council's fiscal year, an annual report of the Consumer Council's financial and substantive operations to be made available for public inspection;

(10) To conduct an annual membership meeting and therein report to the membership on the past and projected activities and policies of the Consumer Council. In addition, the Consumer Council shall sponsor on behalf of each director at least one meeting per year in each Consumer Council electoral district;

(11) To employ an executive director and staff;

(12) To hold regular meetings, including meetings by telephone conference, at least once every four months on such dates and at such places as it may determine. Special meetings may be called by the president of the board or by at least one-quarter of the directors upon at least five days' notice. One-half of the directors plus one shall constitute a quorum. All meetings of the board of directors shall be open to the public. Complete minutes of the meetings shall be kept; and

(13) To carry out all other duties and responsibilities imposed upon the Consumer Council and the board of directors and to exercise all powers necessary to accomplish the purposes of this Article.

(i) The executive director hired by the Board of Directors shall be subject to the conflict of interest provisions in subdivision (f) of this Section. The executive director may not be a candidate for the Board of Directors while serving as executive director. All candidates for executive director must submit a statement of financial interest as defined by the board and the executive director shall be required to file such a statement annually. The executive director shall be exempt from civil service and shall serve at the pleasure of the Board of Directors.

(j) The Consumer Council shall be funded by voluntary donations from its members and through other grants or donations, including intervenor compensation funds for which it might be eligible, except that no gift, loan or other aid shall be accepted from any insurance company, health care industry company or member, director, employee or agent thereof.

(k) A "Health Consumer Representation Fund," ("Fund") shall hereby be created and shall be maintained as a trust fund by the State Treasurer under California Government Code 16429.1. Membership fees and all other monies received by the Consumer Council shall be deposited in the Fund. Monies in the Fund shall be solely and continuously appropriated for expenditure by the Consumer Council Board of Directors to cover all actual and necessary expenses incurred in carrying out the provisions of this section. The Legislature shall have no right of appropriation of monies in the Fund.

(l) The Consumer Council shall prepare and furnish any state agency an enclosure soliciting voluntary membership contributions which shall be included, upon the request of the Consumer Council, in any mailing by that agency to at least 1,000 individuals.

(m) The Consumer Council shall:

(1) Upon furnishing any state agency the enclosure permitted by this Article, certify that the enclosure is neither false nor misleading. Upon request by the Commissioner or any state agency the Commissioner shall review the enclosure within 30 days, and may disapprove the enclosure if it is false or misleading.

(2) Reimburse the Health Security Fund or state agency for all reasonable incremental costs incurred as a result of compliance with this subdivision above the total postage and handling costs which otherwise would have been incurred without the enclosure, provided that an itemized accounting of such additional costs shall be provided first.

(n) The Consumer Council shall not sponsor, endorse, or otherwise support or oppose any political party or the candidacy of any individual for elective office.

(o) The Consumer Council may employ and direct attorneys on staff or as outside counsel in the defense or implementation of any of its powers. The Consumer Council may sue and be sued.

(p) Nothing in this Article shall be construed to limit the right of any individual or group or class of individuals to initiate, intervene in, or otherwise participate in any proceeding before any administrative, judicial or legislative bodies; nor to require any petition or notification to the Consumer Council as a condition precedent to such right; nor to relieve any agency, court or other public body of any obligation, or affect its discretion to permit intervention or participation by a consumer or group of consumers in any proceeding or activity; nor to limit the right of any individual or individuals to obtain administrative or judicial review.

#### Article 6. Public Hearings.

25090. The Commissioner, Regional Consumer Advocates and Consumer Council shall jointly sponsor public hearings, no less than yearly in each System Region, at which testimony shall be taken regarding all of the following:

(a) The Commissioner's proposals for resource allocation, revenue generation, and other substantive policy changes for the coming year.

(b) The responsiveness of health facilities and clinics in a region to the health care needs of the local communities and populations they serve.

#### Article 7. Monitoring and Data Gathering.

25095. (a) The Commissioner shall guarantee that the data gathering and analysis necessary for the functioning of the Health Security System, including, but not limited to review of access to care, quality, efficiency and appropriateness of care and services, professional provider participation, population-based health outcomes and geographic distribution of health care resources, are carried out.

(b) The Commissioner, in consultation with the Advisory Board, shall establish a standard set of indicators and methods to be used to assess the effectiveness of the Health Security System in implementing and fulfilling the intents and purposes of this Act. This should include, but is not limited to, the current federal Centers for Disease Control and Prevention's consensus list of population health outcome indicators, indicators of child health, maternal health, safety and cost of births, promptness and appropriateness of treatment for cancer and other diseases, surgical survival and success rates

for common procedures, functional status in the elderly, communicable disease rates, and monitoring of out-of-pocket expenditures, availability of services including geographic proximity and waiting times, the number and types of staff employed by professional providers, and the number of each category of professional provider giving hands-on care.

(c) As a condition of reimbursement, professional providers and health facilities and clinics shall be required to report to the Commissioner a certain amount of clinical data to be used to assist in the Health Security System's health outcome monitoring effort and for the purposes of improving the effectiveness of practice by professional providers and health facilities and clinics.

(d) Clinical data provided by individual professional providers shall be confidential and used only for statistical and System-wide purposes, and for improving the quality of care.

(e) The Commissioner shall make the non-confidential data and analysis generated pursuant to this section available to the Consumer Council, State and local health departments, and the public in a timely manner.

(f) The Commissioner shall establish uniform fiscal and medical reporting requirements for all health care professional providers. Health facilities and clinics and professional providers, including those in integrated delivery systems, shall provide information to the Commissioner about financial relationships with other Health facilities and clinics and professional providers. Such information shall be available for public disclosure in order to assure that Health facilities, clinics, and professional providers do not collude to increase prices or evade cost controls.

(g) The Commissioner shall make available to the Consumer Council all available information regarding administration and any other aspects of the Health Security System that they might request for the purpose of compiling reports and recommendations and other activities.

(h) None of the data disclosure activities of the Health Security System shall infringe on the confidentiality of Health Security System information on individuals and their medical records.

## CHAPTER 6. FUNDING

### Article 1. Funding of the Health Security System.

25100. There is established a special fund in the State Treasury, to be

called the Health Security Fund, for the purpose of implementing this Act.

25101. (a) All monies collected, received and transferred pursuant to this Act shall be transmitted to the State Treasury to be deposited to the credit of the Health Security Fund for the purpose of financing the Health Security System.

(b) The money in the Health Security Fund shall not be considered State revenues or State money or proceeds of tax for purposes of Sections 3 and 8 of Article XVI of the California Constitution.

25102. (a) If, for each of two consecutive years, the balance remaining in the Health Security Fund at the end of the fiscal year is greater than 1% of the System Budget, and the Reserve Account is fully funded, the Commissioner shall request the Legislature to reduce the tax rates under this Chapter.

(b) subdivision (a) shall apply only after full phase-in of benefits as set forth in Section 25305.

## Article 2. Sources of Funding.

### 25105. Federal contributions to the Health Security Fund.

The Commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current federal payments for health care shall be paid directly to the Health Security System, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the Commissioner shall seek from the federal government a contribution for health care services in California that shall not decrease in relation to the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

### 25108. State contributions to the Health Security Fund.

(a) The Commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current state payments for health care shall be paid directly to the Health Security System, which shall then assume responsibility for all benefits and services previously paid for by state government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the Commissioner shall seek from the Legislature a contribution for health care services that shall not decrease in relation to

state government expenditures for health care services in the year of passage of the Act, corrected for change in state gross domestic product and population.

(b) (1) It is the intent of the people that the Legislature cooperate with the Commissioner in transferring funding for state programs for health services to the Health Security System.

(2) Funds transferred from the Cigarette and Tobacco Products Surtax Fund shall be used only to the extent authorized by Article 2 (commencing with section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code.

25110. County and local contributions to the Health Security Fund.

The Commissioner shall seek all necessary waivers, exemptions, agreements, or legislation, so that all current county or other local agency payments for health care, including employee health benefits and health benefits for retired employees, shall be paid directly to the Health Security System, which shall then assume responsibility for all benefits and services previously paid for by county or other local agency or local government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the Commissioner shall seek contributions for health care services that shall not decrease in relation to expenditures for health care services in the year of passage of the Act, corrected for change in state gross domestic product and population.

25112. The Health Security System's responsibility for providing care shall be secondary to existing federal, state or local governmental programs for health care services to the extent that funding for these program are not transferred to the Health Security Fund or that such transfer is delayed beyond the date on which initial benefits are provided under the Health Security System.

25113. In order to diminish the administrative burden of maintaining eligibility records for programs transferred to the Health Security System, the Commissioner shall strive to reach an agreement with federal, state and local governments in which their contributions to the Health Security Fund shall be fixed to the rate of change of the state gross domestic product and population.

25115. Employer contributions to funding the Health Security System.

All employers shall pay a Health Security payroll tax commencing January 1 of the second year following passage of this Act, as provided in Revenue and Taxation Code Section 33001.

25120. Individual contributions to funding the Health Security System.

All individuals shall pay a Health Security Fund income tax commencing January 1 of the second year following passage of this Act, as provided in Revenue and Taxation Code Section 33004 through 33007, inclusive.

25126. Medicare Part B.

(a) (1) If and to the extent the Legislature transfers Medi-Cal funding, the Commissioner shall pay all premiums, deductibles, and co-insurance for qualified Medicare beneficiaries who are receiving SSI benefits.

(2) In the event and to the extent that the Commissioner obtains authorization to fold-in Medicare funds in California, this subdivision shall lapse and be replaced by subdivision (b).

(b) Medicare part B payments which previously were made by individuals or the Commissioner shall, commencing in the second year following passage of this Act, be paid by the Health Security System for all individuals eligible for both the Health Security System and the Medicare program, provided arrangements have been made to pay Medicare revenues into the Health Security Fund, pursuant to Section 25105.

(c) Until appropriate waivers have been obtained, the Health Commissioner shall make the Part B Medicare premiums for all persons who would have been eligible to have Medi-Cal pay their Medicare Part B premium prior to the effective date of this Act.

25130. Cigarette and Tobacco Products Surtax.

All distributors of cigarettes and tobacco products shall pay a Health Security Fund tobacco tax commencing January 1 of the second year following passage of this Act, as provided in Revenue and Taxation Code Section 30123.5.

25134. The Legislature may provide for the collection and administration of the taxes imposed by this Act consistent with the collection of other similar taxes.

25135. Nothing in this Act shall be construed to affect or diminish the benefits that an individual may have under a collective bargaining agreement.

Article 3. Federal Preemption.

25136. Exempt employers.

(a) (1) An employer is exempt from the payroll tax requirements of Section 25115 of this Code and Section 33001 to 33003, inclusive, of the Revenue and Taxation Code if it has established an employee benefit plan subject to federal law which preempts the funding provisions of this Chapter.

(2) Notwithstanding paragraph (1), an exempt employer shall comply with the reporting requirements of Section 33001(b) of the Revenue and Taxation Code, to the extent permitted by federal law.

(b) An employer is exempt from any other provisions of this Act to the extent compliance with the provision would be preempted by federal law. It is the intent of the people that the provisions of this Act be construed to be consistent with federal law.

25137. Waiver.

(a) The Commissioner shall pursue all reasonable means to secure repeal or waiver of any provision of federal law which preempts any provision of this Act.

(b) In the event repeal or waiver cannot be secured, the Commissioner shall exercise his or her powers to promulgate rules and regulations, or seek conforming state legislation, that are consistent with federal law in an effort to best fulfill the purposes of this Act.

25138. Employees covered by health plan subject to preemption.

(a) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan which, under federal law, preempts provisions of this Act, shall first seek benefits under that contract or plan before receiving benefits under this Act.

(1) No benefits shall be denied under this Act unless the employee has failed to take reasonable steps to secure like benefits from the contract or plan, if such benefits are available.

(2) Nothing in this Section shall preclude an employee from receiving benefits under this Act which are superior to benefits available to the employee under the contract or plan.

(3) Nothing in this Act is intended, nor shall this Act be construed, to discourage recourse to contracts or plans which are protected by federal law.

(b) Any physician or health care provider, including a hospital, may render services pursuant to a contract or plan subject to federal preemption without regard to the limitations on professional provider fees contained in Section 25180.

(1) To the extent permitted by federal law, the provider shall first seek payment from the contract or plan, before submitting bills to the Health Security System.

(2) Any fee charged by the provider in excess of the rate set or negotiated by the Commissioner shall not serve to increase the amount of funding available to the provider from the Health Security System in the current or subsequent years.

#### Article 4. Subrogation.

25139. (a) It is the intent of the people to establish a single public payer for all health care in the State of California. However, until such time as the role of all other payers for health care have been terminated, it is the intent of the people to recover health care costs from collateral sources whenever medical services are provided to an individual that are or may be covered services under a policy of insurance, health benefits plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(b) As used in this Article, the term collateral source includes all of the following:

(1) Insurance companies and carriers, as defined in Section 14124.7 including the medical components of automobile, homeowners and other forms of insurance;

(2) Health care and pension plans;

(3) Employers;

(4) Employee benefits contracts;

(5) Government benefits programs including but not limited to Workers' Compensation;

(6) A judgment for damages for personal injury;

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

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

(1) A contract or plan subject to federal preemption as described in Article 3 of Chapter 6 commencing with Section 25136.

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

(d) It is the further intent of the people that the Commissioner and the Legislature make every attempt to negotiate waivers, seek federal legislation or make other arrangements to incorporate collateral sources in California into the Health Security System.

25140. Whenever an individual receives health care services under the Health Security System for which he or she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and the Commissioner and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information as requested by the Commissioner.

25141. Use of an eligibility card for, or receipt of, health care services under this Act for which an individual is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, shall be deemed an assignment by the individual to the Health Security System of his or her rights from or against the collateral source, to the extent of services provided under the Act. Any provision or agreement between the individual and the collateral source prohibiting assignment of rights shall not be applicable to an assignment under this Section. Except as specified in this Article, nothing contained in this Act affects any person's right to benefits, money, or right of action from or against, a collateral source.

25142. (a) The Health Security System shall seek reimbursement

from the collateral source for services provided to the individual, and may institute appropriate action, including suit, to recover same. Upon demand, the collateral source shall pay to the Health Security Fund such sums as it would have paid or expended on behalf of the individual for the health care services provided by the Health Security System.

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

25143. If a collateral source is exempt from subrogation or the obligation to reimburse the Health Security System as provided in Sections 25136 and 25139, the Commissioner may require that an individual who is entitled to medical services from the source first seek those services from that source.

25144. To the extent permitted by federal law, contractual retiree health benefits provided by employers shall be subject to the same subrogation as other contracts, allowing the Health Security System to recover the cost of services provided to individuals covered by such retiree benefits, unless and until arrangements are made to transfer the revenues of such benefits directly to the Health Security System.

25145. Upon integration of worker's compensation health benefits into the Health Security System, the cost of workplace related medical claims that are found to result from unsafe work place conditions or negligence on the part of the employer shall be borne by the employer rather than the Health Security System.

#### Article 5. Other Considerations.

25147. (a) Revenue to operate the Health Security System shall be generated in a manner intended to coincide in the aggregate with financial responsibility for health care expenditures in the base year, and not exceed the limits described in Article 1 (commencing with Section 25150) of Chapter 7.

(b) In the event of unanticipated expenditures in excess of the Reserve Account, or if cost control mechanisms indicated under Article 8 (commencing with Section 25225) of Chapter 7, are unable to lower expenditures without endangering the health of Californians, the

Commissioner may request the Legislature to increase Health Security System funding either by increasing tax rates on the sources described in this Chapter or from other revenue sources.

(c) In the event that federal health care reform legislation is passed prior to or subsequent to passage of this Act, the Commissioner shall take all steps necessary to ensure that all funds available to California for benefits and services covered under the federal Health Security System are paid to the Health Security Fund.

(d) In the event of federal health care reform legislation including payroll, individual income or cigarette and tobacco products taxation, and to the extent that agreements are reached to transfer those revenues into the Health Security Fund, the Legislature may enact a proportional decrease in the payroll, individual and cigarette and tobacco taxes established by this Act pursuant to Revenue and Taxation Code Sections 30123.5 and 30001 to 30007 inclusive, in order that revenues to the Health Security Fund be maintained within the limits established by Section 25102 (a) and 25150 (a).

25148. (a) Default, underpayment or late payment of any tax or other obligation imposed by this Act shall result in the remedies and penalties provided by law except as provided in this Section.

(b) Eligibility for benefits under Chapter 4, except for those benefits provided by Article 4, relating to long-term care, shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by this Chapter.

(c) (1) Eligibility for benefits provided by Article 4 of Chapter 4, relating to long-term care, shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed on employers by Section 25115.

(2) Eligibility for benefits provided by Article 4 of Chapter 4, relating to long-term care, may not be established pursuant to Section 25006(b)(2) except upon payment of the taxes or other contributions stated in that Section.

25149. Actions taken by the Commissioner, including, but not limited to, the negotiating or setting of rates, fees, or prices, and the promulgation of any and all regulations, shall be completely exempt from any review by the Office of Administrative Law, except for Government Code Section 11344, subdivisions (a), (b) (1) and (2), (c), and (d), and Sections 11344.1, 11344.2, 11344.3 and 11344.6 addressing the publication of regulations. This exemption from Office of Administrative Law review includes, but is not limited

to, exemptions from Government Code Sections 11340, 11340.1, 11340.15, 11342, 11346.1 as that statute provides for action by the Office of Administrative Law, and Sections 11345.53 (b), 11346.2 (d), 11346.7, 11349, 11349.1, 11349.3, 11349.4, 11349.5, 11349.10, and 11349.11.

## CHAPTER 7. APPROPRIATIONS, BUDGETING, AND EXPENDITURES

### Article 1. Expenditure Limit.

25150. (a) It is the intent of the people that expenditures under this Act not exceed in any year expenditures for the prior year adjusted for changes in the state's gross domestic product and population.

(b) (1) If the Reserve Account is not fully funded, mandatory cost control measures as described in Section 25240 shall be triggered when the cumulative expenditures of the Health Security System on an annualized basis exceed 95% of the Health Security System budget exclusive of the Reserve Account, except during the last month of the fiscal year.

(2) If the Reserve Account is fully funded, and during the last month of the fiscal year, mandatory cost control measures as described in Section 25240 shall be triggered only when cumulative expenditures of the Health Security System on an annualized basis exceed 100% of the Health Security System budget exclusive of the Reserve Account.

### Article 2. Appropriations.

25151. (a) It is the intent of the people that all monies in the Health Security Fund be appropriated to the Health Security System to support the implementation of this Act.

(b) On July 1 of any year, all monies in the Reserve Account are appropriated to the Commissioner for the purpose of implementing the Health Security System if a Budget Act for the fiscal year beginning on that July 1 has not been enacted by that date. The authority to spend funds from the Reserve Account for that fiscal year, pursuant to this subdivision, shall be terminated upon enactment of the Budget Act, unless the Budget Act continues that authority.

(c) The Legislature may appropriate additional money from the General Fund or from other sources to support the implementation of this Act.

### Article 3. Health Security System Budgets.

25155. Preparation of Budgets.

(a) The Commissioner shall prepare an annual budget in the manner prescribed by law. The budget shall include all of the following:

(1) A System Budget which includes all expenditures for the Health Security System.

(2) Regional Budgets, which include all expenditures for the Health Security System within each System Region.

(3) Global Budgets for each of the two principal mechanisms of professional provider reimbursement (fee-for-service and integrated health delivery system), and for individual health facilities and their associated clinics. The Global Budgets shall be part of the Regional Budget for each System Region.

(4) A Capital Expenditure Budget, as described in Section 25215.

(b) The Commissioner shall prepare the System Budget for the Health Security System to be submitted to the Legislature as part of the Governor's budget.

25156. System Budget.

(a) The cost of the Health Security System, including the cost of all services and benefits provided, administration, data gathering and other activities, and revenues deposited within the named Accounts pursuant to Section 25250, shall comprise the System Budget.

(b) Monies in the Reserve Account shall not be considered as available revenues for purposes of preparing the System Budget.

25157. Regional Budgets.

(a) The Commissioner, in consultation with the Regional Administrator, shall propose a Regional Budget for each System Region.

(b) The cost of all functions of the Health Security System within the System Region, including the cost of all services and other benefits provided, administration, data gathering and other activities, and allocations to the System Region from the named Accounts, shall comprise the Regional Budget.

(c) Funds available for System Regions shall be equally allocated

among the System Regions, on a per capita basis, adjusted for variations in population, demographics, incidence of disease, quality and availability of providers, reimbursement rates, and any other factor relevant to a particular System Region, as determined by the Commissioner.

25158. Global Budgets.

(a) The Commissioner, in consultation with the Regional Administrator, shall prepare a Regional Budget for each System Region. That Budget shall include allocations for each of the following:

(1) fee-for-service providers;

(2) capitated providers; and

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

(b) The allocations in subdivision (a) shall consider the relative usage of fee-for-service providers, capitated providers, and health facilities and associated clinics that are not part of a capitated provider network within the System Region. The Global Budgets shall be adjusted from year to year to reflect changes in the utilization of services, changes in co-payment for covered services, and the addition or exclusion of covered services made by the Commissioner upon recommendation of the Advisory Board.

(c) The Global Budget for fee-for-service providers in each System Region shall be further divided among categories of licensed professional providers, thus establishing a total annual budget for each category within each region. Each of these category budgets shall be sufficient to cover all included services anticipated to be required by eligible individuals choosing fee-for-service within the region, at the rates negotiated or set by the Commissioner, except as necessary for cost containment purposes under Chapter 7, Article 8, commencing with Section 25225.

(d) The Global Budget for capitated providers shall be sufficient to cover all eligible individuals choosing an integrated health delivery system within the System Region, at the capitation rates negotiated or set by the Commissioner, except as necessary for cost containment purposes under Chapter 7, Article 8, commencing with Section 25225.

(e) Each health facility and clinic in a System Region, apart from those that are part of capitated integrated delivery systems, shall have a Facility Budget that encompasses all operating expenses for the health facility or clinic. In establishing a Facility Budget, the Commissioner shall develop and utilize separate formulae that reflect the differences in cost of primary,

secondary and tertiary care services and health care services provided by academic medical centers.

25162. In preparing the budgets under this Article, the Commissioner shall consider anticipated increased expenditures and savings including, but not limited to, all of the following:

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

(b) Projected administrative savings under the single-payer mechanism.

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

(d) Projected saving in health facility and clinic costs due to decreased acuity of hospitalization in some cases, and appropriate availability of long term care facilities in other cases.

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

(f) Projected savings from termination of reimbursement of procedures of no documented benefit or for which appropriate indications are not present.

(g) Projected savings from diminished reimbursement for procedures and services of marginal benefit, as determined by the Advisory Board.

(h) Projected savings from decreased reimbursement of specialty care relative to primary care.

(i) Projected savings due to regionalization of high-technology and experimental services.

25165. In preparing the System Budget the Commissioner shall also consider, in addition to changes in the state gross domestic product and population from year to year, anticipated additional expenditures due to medically appropriate increases in utilization due to changes in disease incidence and prevalence among the population, and technological advances allowing better diagnosis and treatment of disease.

25175. (a) Commencing with the second budget year, the administrative costs of the Health Security System incurred by the Health Commissioner shall be 4 percent or less of the total funds appropriated for the

Health Security System. If administrative costs exceed this target, the Commissioner shall report to the Legislature the reasons for excess administrative costs.

(b) That amount of the System Budget remaining after funds are allocated for administration, data gathering, and the named Accounts pursuant to Section 25250, shall be budgeted for the System Regions, in the manner described commencing with Section 25157, to provide benefits pursuant to Chapter 4 of this Division.

#### Article 4. Provider Reimbursement.

25180. (a) Professional providers registered for reimbursement with the System shall, with respect to all covered services under Chapter 4 of this Division (commencing with Section 25010) provided to an eligible individual:

(1) Submit all bills to the Regional Administrator pursuant to procedures established by the Commissioner.

(2) Not charge the System an amount in excess of rates negotiated or set by the Commissioner.

(3) Not charge the patient any additional amount or co-payment except as specified under Sections 25020, 25030, 25040, and 25305.

(b) Professional providers registered for reimbursement under the System, who have submitted bills for covered services in accordance with the guidelines established by the Commissioner, shall be paid promptly. Interest shall accrue on all bills 45 days past due at the rate of 1% per month.

25185. (a) Health facilities and clinics registered with the Health Security System may choose to be reimbursed on the basis of either a Facility Budget for all covered services rendered under the Health Security System based on standards and criteria pursuant to Section 25158, or as a capitated integrated professional provider network pursuant to subdivision (c) of Section 25190.

(b) The budget specified in paragraph (a) shall be negotiated with each participating health facility or clinic on an annual basis, with adjustments during the year made for epidemics and other unforeseen catastrophic changes in the general health status of a patient population, at the discretion of the Commissioner.

(c) Surplus generated from the operating section of a health facility or

clinic's Facility Budget shall not be used for the payment or reimbursement of any capital cost, except in accordance with the provisions of Sections 25213 and 25215.

(d) Such surplus as a health facility and clinic may be able to generate through increased efficiency of operation may be used to develop new and innovative programs, as approved by the Commissioner, or shall be returned to the Health Security System.

(e) Health facilities and clinics shall inform the Commissioner as soon as evidence suggests that operating expenses will exceed the Facility Budget provided.

(f) (1) Any real or projected operating deficit as a result of a health facility or clinic exceeding the Facility Budget shall be investigated by the Commissioner. If it is determined that the deficit reflects appropriate increased utilization of services, the Facility Budget for the health facility or clinic shall be adjusted and appropriately revised in the current or subsequent year, or both, to cover the anticipated shortfall.

(2) To the extent that it is determined that the operating deficit was not justifiable under the policies and terms of the Health Security System, such adjustments in the Facility Budget shall not be made. Instead, recommendations for improved efficiency or other changes necessary to bring costs within the health facility or clinic's Facility Budget, or other changes, may be made by the Regional Administrator. Implementation of these recommendations may be a precondition for funding in the next Health Security System year.

(g) (1) Every health facility or clinic Facility Budget shall allow for care of individuals who are not enrolled in the Health Security System or are not eligible for services, at the same rates as for enrolled individuals, as necessary to provide emergency care and to protect the health and safety of the population as a whole.

(2) Any health facility or clinic which fails to provide full access to all individuals pursuant to section (1) shall be investigated by the Commissioner and may be barred from receiving Health Security System funds in subsequent years, at the discretion of the Commissioner, subject to the review procedures in Section 25200.

25190. (a) Physicians, advanced practice nurses and other independent professional providers may choose from a variety of payment mechanisms for reimbursement. These payment methods may include, but need not be restricted to, fee-for-service, capitation, or a salary from a globally budgeted health facility or clinic for a defined level of service.

Nothing in this Act shall be construed to permit discrimination in eligibility for reimbursement against a class of professional providers who are providing services within the scope of practice permitted by law.

(b) The Commissioner may require that all care under fee-for-service payment be coordinated by a designated primary care provider, and that all individuals select such a primary care provider. The primary care provider may be an individual professional provider or a group of professional providers. Under such arrangements, care provided by specialists without referral from a designated primary provider shall be reimbursed at the primary care rate rather than that for specialty care.

(c) (1) An individual professional provider or a group of professional providers may elect to be paid a prospective payment on a capitated basis for all individuals enrolling for care from that professional provider or group of professional providers. Providers accepting payment on a capitated basis cannot also be paid on a fee-for-service basis. All patients receiving care from professional providers participating under prepaid arrangement must do so on a capitated basis. A formal enrollment process shall be adopted whereby individuals voluntarily designate the individual professional provider or group of professional providers for prepaid care. Individuals enrolling under prepaid arrangements must receive their care from the designated prepaid practice or professional providers authorized by the prepaid practice.

(2) The fee level for capitated reimbursement shall be negotiated annually by professional provider organizations and the Commissioner, or set by the Commissioner, and shall apply uniformly to all professional providers in the System Region. The capitated fee level shall be adjusted based on health risk of enrollees, scope of ambulatory services provided by the professional provider, and any other relevant factors. At a minimum, the scope of services covered by the capitated payment shall include all primary care services. Capitated contracts may include stop-loss measures for catastrophic expenses and such other measures as necessary to maintain fairness and fiscal stability.

(d) Compensation for professional providers who provide services as employees of, or under contract to, health facilities or clinics, shall be covered under the Facility Budget of those health facilities or clinics.

25195. (a) The Commissioner shall recognize professional associations to represent licensed professional providers in each System Region in negotiations with the Commissioner on reimbursement and other professional issues.

(b) It is the intent of the people that the Legislature establish procedures allowing each category of professional provider in a System

Region to choose, by majority vote of that category of professional provider, the organization or association in each region which shall be their representative in all negotiations with the Commissioner.

(c) All professional provider organizations may participate in annual negotiations. All professional providers within a category shall be bound by the results of the negotiations between the Commissioner and the organization representing that category of professional provider.

(d) In the event that negotiations with professional providers and others are not concluded in a timely manner, the Commissioner may set rates, fees and prices for services reimbursed by the Health Security System.

25196. (a) Notwithstanding Section 25195, the Commissioner shall establish a limit on the aggregate annual payments to an individual professional provider, or discounts on reimbursements above a specified amount of aggregate billing, as negotiated with the professional associations.

(b) An individual professional provider whose billing volume or distribution suggests the possibility of impropriety may be subject to investigation by the Commissioner through either the Regional Administrator or the Regional Consumer Advocate and may be subject to exclusion or other penalties pursuant to Chapter 9, commencing with Section 25282.

25200. (a) (1) A health facility or clinic and a group of physicians and other professional providers may organize as an integrated delivery system providing the full spectrum of health care services to a defined population of enrollees. Such integrated systems may be paid by the Health Security System on a capitated basis to provide the full spectrum of benefits covered by the Health Security System. Nothing in this Act shall prevent an integrated delivery system from offering benefits beyond those set forth in Chapter 4 (commencing with Section 25010) of this Division. The fee level for capitated reimbursement shall be negotiated on a regional basis by professional provider organizations and the Commissioner, based on health risk of enrollees, and any other relevant factors, and shall apply uniformly to all professional providers in the region.

(2) Health facilities and clinics participating under this capitated arrangement as part of an integrated delivery system are exempt from negotiating separate operating budgets with the Health Security System. However they are not exempt from regulation of capital investment as specified in Article 5 (commencing with Section 25213).

(b) (1) Health facilities, clinics and professional providers organizing as integrated delivery systems that are for-profit shall have their

profits restricted to a fair rate of return to be negotiated with the Commissioner and are subject to the same restrictions on capital expansion that apply to all other health facilities, clinics and professional providers.

(2) Health facilities, clinics and providers organizing as an integrated delivery system that are for-profit shall be capitated or Facility Budgeted by the same criteria and at the same rates as non-profit entities.

(c) If any professional provider involved in such an integrated system has an existing collective bargaining agreement or agreements, those collective bargaining agreement(s) may be extended to the employees of all of the professional providers in the integrated system, unless otherwise prohibited by law.

(d) Nothing in this Act shall prevent the Commissioner, after public hearings, from termination of the participation of a health facility or clinic in the Health Security System, should credible evidence lead the Commissioner to conclude either of the following:

(1) That the health facility or clinic is unable to meet minimum requirements relating to the number and type of professional providers on the staff, the type of equipment available to the facility or the range of specialty services provided by the facility, or other standards and criteria.

(2) That the health facility or clinic provides care significantly below the standard for facilities in the region.

(e) The Commissioner shall develop different standards and criteria pursuant to subdivision (d) for urban and rural health facilities. Under the circumstances of subdivision (d), the Commissioner may authorize conversion of such facilities to meet health care needs in such areas as long term care.

25205. (a) The Commissioner shall provide clear and well-publicized procedures whereby individuals eligible for benefits under the Health Security System may voluntarily enroll under capitated payment arrangements with a specified professional provider, group of professional providers, or integrated delivery system. Individuals shall be entitled to disenroll from such capitated practices as specified in subdivision (b). Enrollment and disenrollment shall be administered by the Health Security System and not delegated to professional providers or professional provider organizations for the purposes of processing or otherwise administering enrollment and disenrollment procedures.

(b) Every six months, individuals enrolled in a capitated practice shall be entitled to an open enrollment period of not less than two weeks, pursuant

to regulations promulgated by the Commissioner.

(c) During the open enrollment period, an individual may enroll in another capitated practice or choose a primary care provider in the fee-for-service sector.

(d) A individual who has selected a primary care provider in the fee-for-service sector may choose to switch to enrollment in a capitated practice at any time.

(e) Any professional provider accepting payment from the Health Security System on a prepaid basis shall allow any eligible individual to enroll in the order of application, up to a reasonable limit determined by the capacity of the capitated practice to provide services.

(f) Providers accepting payment from the Health Security System on a prepaid basis, as a condition of approval to participate in the provision of benefits under this Division, shall demonstrate they will provide, or arrange and pay for, all of the benefits required for the capitation payment negotiated or set by the Commissioner.

(g) Nothing in this Division shall prohibit an integrated delivery system or other capitated practice from offering additional benefits beyond those set forth in Chapter 4. The additional benefits shall be clearly set forth in disclosure and practice description materials provided to individuals eligible for services under this Division.

25210. (a) The Commissioner shall incorporate into the reimbursement policies specific financial incentives for professional providers to perform community outreach and preventive services. As a condition of receiving such incentives, professional providers shall coordinate their efforts with those of the state Department of Health Services, local health departments and other agencies funded from the Public Health and Prevention Account, in a manner specified by the Commissioner.

(b) (1) The Commissioner shall reimburse collaborative practice costs to meet the objectives of community oriented primary care including the costs of visiting health workers and public health nurses working with primary care providers including physicians, advanced degree nurses and physician assistants.

(2) The Commissioner may institute reimbursement mechanisms which have as their purpose improving the availability of health care services to underserved areas and populations.

(c) The Commissioner shall consider the special needs and

requirements of rural hospitals in California that are financially distressed and in danger of closure. The Commissioner may provide technical assistance with respect to the reimbursement and other requirements and procedures of the Health Security System to financially distressed rural hospitals, when appropriate in order to preserve the availability of health care services.

Article 5. Capital Expenditures.

25213. (a) (1) The purpose of this Article is to assure that health care facilities which are reimbursed by the Health Security System do not engage in unnecessary capital expenditures and thereby contribute to health care cost inflation.

(2) Commencing on the operative date of this Article, no licensed health care facility or any individual acting on behalf of a licensed health care facility shall incur a capital expenditure as defined herein, and no health facility can receive Health Facility Construction Loans, pursuant to Division 1, Part 1, Chapter 4, of the Health and Safety Code, commencing with Section 436, without obtaining the prior approval of the Commissioner.

(3) The Commissioner shall exclude from any reimbursement under this Division amounts for capital expenditures, operating expenses for capital improvements, and the cost of services provided by those capital improvements, made or incurred by a health facility, clinic or provider after the date of passage of this Act, unless that capital expenditure was approved by the Commissioner.

(4) As used herein the term "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which does any of the following:

(A) exceeds \$500,000;

(B) changes the bed capacity of the facility with respect to which such expenditure is made; or

(C) adds a new service or license category.

(5) For purposes of this section, the cost of studies, surveys, design plans and working drawings, specifications and other activities essential to the acquisition, improvement, expansion or replacement of the plant and equipment with respect to which such expenditures are made shall be included in determining whether such expenditure exceeds the dollar amount specified in this section.

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

(b) The Commissioner shall only approve a capital expenditure if it is in conformity with standards, criteria and plans developed by the Commissioner to accomplish one or more of the following:

(1) fill unmet needs;

(2) eliminate duplicative, inappropriate or unnecessary services by regionalizing tertiary care services in appropriate facilities;

(3) encourage the expansion of those facilities with superior records of consumer satisfaction and operating efficiency;

(4) convert to non-acute care uses general acute care hospitals of less than 150 licensed beds within Standard Metropolitan Statistical Areas;

(5) assure that health care facilities are accessible to all parts of the community including the disabled and populations with special medical needs;

(6) promote joint, cooperative or shared health care resources;

(7) assure the development of new technologies in appropriate facilities; or

(8) meet the special needs of rural hospitals.

(c) (1) The Commissioner shall establish procedures for the review of capital expenditures.

(2) The procedures may provide that all capital expenditures in a particular region or for one or more particular purposes submitted over a period of time of up to one year, may be reviewed together at the same hearing.

(d) Notwithstanding the provisions of subdivision (b), the Commissioner may approve capital expenditures:

(1) If necessary to meet parking, seismic safety, fire safety, physical accessibility for the disabled, energy or water conservation or other public health and safety requirements of federal, state or local government; or

(2) if necessary to replace physical plant and equipment damaged or destroyed by fire, earthquake or other natural disaster.

(e) Notwithstanding any other provision of law, the Commissioner may approve the temporary or permanent conversion of general acute care beds to skilled nursing beds or the addition of skilled nursing beds to any general acute care hospital.

#### Article 6. Capital Allocation.

25215. (a) Funds appropriated for capital expenditures pursuant to the Capital Expenditures Budget shall be placed in the Capital Improvement Account, pursuant to this Section and Section 25155.

(b) Once a capital expenditure request has been approved by the Commissioner, it may be funded either from the Capital Improvements Account or from other sources. All capital improvements made from the Capital Improvement Account shall remain the property of the state of California under the Health Security System.

(c) No later than January 1 of the second year following passage of this Act, the Commissioner shall report on the capital needs of health facilities and clinics in each System Region. In addition to any other matter deemed relevant by the Commissioner, the report shall identify the capital needs of all of the following:

(1) County health facilities and clinics;

(2) Underserved geographic areas with per capita investment in health facilities and clinics substantially different from the state average.

(3) Geographic areas where the distance to health facilities and clinics imposes a barrier to care.

#### Article 7. Formulary.

25216. (a) In order to achieve the lowest possible cost for prescription drugs the Commissioner shall do all of the following:

(1) Establish a Health Security System formulary composed of the best-priced prescription drugs of proven efficacy for a particular condition. The formulary may include in whole or in part the List of Contract Drugs established pursuant to Welfare and Institutions Code Sections 14105.3 (a) through 14105.35, inclusive, and Section 14105.405. The Commissioner shall have the authority to enter into purchase contracts for prescription drugs

pursuant to these sections.

(2) Use his or her bidding power to negotiate directly from the manufacturer the lowest possible prices for drugs provided under the Health Security System.

(3) Establish standards and criteria as needed to ensure that only those prescription drugs on the formulary shall be reimbursed under the Health Security System.

(4) Establish standards and criteria as needed to ensure that formulary drugs are substituted for prescriptions written for comparable non-formulary drugs, with the approval of the prescribing provider.

(5) Establish standards and criteria by which certain non-prescription, over-the-counter, investigational, and other exceptional drugs, and nutritional supplements, that are of particular benefit for the treatment of specific medical conditions, or that are cost-effective compared to prescription drugs, may be reimbursed when prescribed by a licensed provider acting in the scope of his or her practice.

(6) Use his or her express or implied powers to reduce the direct cost of prescription drugs.

(7) Encourage the rational use of prescription drugs through educational, outreach and other programs.

(b) In establishing the formulary and standards and criteria for purposes of this Section, the Commissioner shall seek the advice of the Advisory Board.

(c) Formulary drugs, reimbursable under the Health Security System, shall be substituted for prescriptions written for comparable non-formulary drugs, with the approval of the prescribing provider, pursuant to standards and criteria.

#### Article 8. Cost control measures.

25225. The Commissioner shall not carry out any cost control measure that limits access to care that is needed on an emergent or urgent basis, or that is medically appropriate for treatment of a patient's medical condition.

25226. (a) In order to control costs the Commissioner shall strive at all times to do all of the following:

(1) Eliminate administrative and other costs that do not contribute to health care.

(2) Identify and eliminate wasteful and unnecessary care that is of no benefit to patients receiving that care.

(3) Identify and foster those measures that prevent disease and maintain health.

(b) (1) In the event that the measures taken pursuant to subdivision (a) are insufficient to maintain the fiscal integrity of the Health Security System, the Commissioner shall study the contribution of inappropriately provided services to escalating costs. The Commissioner shall adjust the next year's budgets, pursuant to Sections 25155 and 25162, to correct for the degree of over utilization identified for particular services or particular categories of licensed providers, under particular modes of reimbursement.

(2) Restrictions in budgets under Paragraph (1), may be employed only to the extent necessary to correct for the proportion of cost increase in excess of that resulting from appropriate utilization, based on incidence of illness in the population, that is due to the particular services, category of provider or mode of reimbursement being restricted, as determined by the Commissioner.

25240. (a) In the event that cost control is required by Section 25150, subdivision (b), the Commissioner may request that the Legislature increase appropriations for the Health Security System. Any such request shall be accompanied by a report on the causes of the increase in expenditures beyond the increase in gross domestic product, adjusted for population, and measures taken to control costs pursuant to Section 25226.

(b) In the event the actions taken pursuant to subdivision (a) and Section 25226 are insufficient to contain costs or increase revenues, the Commissioner may, as necessary, defer funding of the Reserve Account and reduce funding of the named Accounts for a period not to exceed one year, and establish restrictions or co-payments on elective services.

(c) Restrictions on, and co-payments for elective services, as necessary to balance the System Budget, shall be applied by the Commissioner in order of increasing efficacy, as determined by the Advisory Board, in order that those elective services which are clearly beneficial for treatment of a patient's condition be the last services to be restricted or to have a co-payment applied.

(d) Measures taken under subdivision (b) and Section 25226 shall not be used to restrict coverage of a specific diagnosis, unless the Commissioner finds both of the following:

(1) that the diagnosis or the available treatments are often inappropriate, and

(2) that a means of distinguishing appropriate from inappropriate utilization of services for the diagnosis is established based on recommendations of the Advisory Board.

#### Article 9. Named Accounts in the Health Security Fund.

25250. There are in the Health Security Fund a number of named Accounts. The Commissioner shall propose budgets that fully fund these Accounts as provided for in this Act except under circumstances described in Section 25240:

- (a) The Public Health and Prevention Account.
- (b) The Innovations Account.
- (c) The Capital Improvements Account.
- (d) The Reserve Account
- (e) The Health Worker Training Account

25251. (a) There is in the Health Security Fund the Public Health and Prevention Account. Funds in the Public Health and Prevention Account shall be budgeted for programs designed to prevent disease, including, but not limited to, community-based disease prevention and health promotion programs, training programs and research as described in Chapter 8 (commencing with Section 25260).

(b) The programs funded by the Public Health and Prevention Account shall give priority to meeting the population-based health care needs of population groups with the greatest unmet needs, to provide public health outreach to underserved populations, and research designed to better understand, reduce or eliminate the causes of illnesses in the population as a whole and enhance quality of life.

(c) All existing population-based public health programs of the Department of Health Services and the county departments of health, shall be funded from the Public Health and Prevention Account. Nothing in this Act

shall be construed to require any decrease in funding for population-based programs of the Department of Health Services and the county departments of health.

(d) The Public Health and Prevention Account shall be used to provide additional funding for existing programs of the state Department of Health Services and funding for new programs designed to improve health outcomes of the population by addressing the educational, social, economic, basic biological, and other causes of ill health.

(1) To develop new programs for funding by the Public Health and Prevention Account, the Commissioner may consult with the Director of the Department of Health Services, Local Health Officers, directors of county health departments, the State Superintendent of Schools, directors of other state and local human services programs, and the deans of health professional training programs, academic medical centers, and schools of public health in the state, in order to determine the areas of investment likely to have the greatest impact on future improvement of health outcomes for the population in each System Region.

(2) New programs shall be coordinated with existing public health and human services programs and may be funded by grants to any state, local or private non-profit human services agencies, or may be established by the Commissioner directly.

(e) The Public Health and Prevention Account may be used to provide funding for school-based nurses to provide such services as immunizations and health education, as deemed appropriate by the Commissioner.

(f) (1) In the first four budget years under this Act, the Commissioner's proposed budget shall include funding of the Public Health and Prevention Account at a level not less than the sum of all population-based public health expenditures of the State and local health departments in the base year, supplemented by an additional one percent (1%) of anticipated total annual Health Security System revenues for the first year, and such amounts in the second through fourth years as will achieve the level of funding specified in paragraph (2).

(2) In the fifth year and subsequent budget years under this Act, the Commissioner's proposed budget shall include funding of the Public Health and Prevention account at a level not less than five percent (5%) of total annual Health Security System revenues.

25252. (a) There is in the Health Security Fund the Innovations Account. Funds in this Account shall be expended for research and development of new strategies for disease treatment and cure. These funds

shall also be used to guarantee that new technologies, approaches and insights into disease treatment and cure are developed in order that they be available to all Californians at regional tertiary care referral centers.

(b) The Commissioner's proposed budget shall include funding of the Innovations Account at a level not less than one percent (1%) of total annual Health Security System revenues.

25253. (a) There is in the Health Security Fund the Capital Improvements Account. The Commissioner, in consultation with the Advisory Board, shall propose the amount to be included in each Regional Budget for capital improvements to be funded out of the Capital Improvements Account.

(b) To ensure survival and transition for state, county or municipally operated facilities, the funds in the Capital Improvements Account shall be disbursed, for a period of at least 3 years, in a manner proposed by the Commissioner, to give priority to the capital needs of those facilities.

(c) Allocation of funds for capital expenditures in each System Region shall require approval of the Commissioner and shall be funded from the Capital Improvements Account.

(d) Notwithstanding any other provision of law, it is the intent of the people that no funds shall be appropriated for any health facility or clinic-related capital improvements above \$500,000 per health facility or clinic in any year, unless that capital improvement is approved by the Commissioner.

25254. (a) There is in the Health Security Fund the Reserve Account. The Reserve Account shall be considered to be fully funded when it contains an amount no less than five percent (5%) of total Health Security System revenues in a given year.

(b) The Commissioner shall retain the Reserve Account for budgetary shortfalls, epidemics or other extraordinary circumstances as defined by the Commissioner and as set forth in Section 25151. The Commissioner's proposed budget shall contain funding for the Reserve Account equal to one percent (1%) of the System Budget, unless the Commissioner determines that a different amount is needed for prudent operation of the Health Security System.

25255. (a) There is in the Health Security Fund, for a period of at least three years after benefits are first provided, a Health Worker Training Account.

(1) The Commissioner's proposed budget shall contain funding for the Health Worker Account equal to one percent (1%) of the System Budget, unless the Commissioner determines that a different amount is needed for prudent operation of the Health Security System.

(2) Funds in the Health Worker Training Account may be used to allow health workers displaced by transition to the Health Security System to be retrained and placed in jobs that meet the new needs of the System.

(3) It is the intent of the people that the Legislature, in consultation with the Commissioner, establish job retraining or apprenticeship training programs in each System Region, pursuant to this Section, to be funded from the Health Worker Training Account.

(b) After three years, the Commissioner may do either of the following:

(1) propose termination of the Health Worker Training Account;  
or

(2) continue the Health Worker Training Account, and its inclusion in the Commissioner's proposed budgets, for the purpose of providing career education and training assistance which will enhance the delivery of health care to California communities which are underserved either in the quality of health care or in accessibility to health care providers.

#### Article 10. Transfer of Other State Programs.

25257. (a) Programs for individual clinical prevention and treatment, previously administered by the state Department of Health Services, the Department of Mental Health, the Department of Rehabilitation, the Department of Aging, the Department of Developmental Disabilities and the Department of Social Services, and any other state or county entity which provide individual clinical prevention and treatment services, shall be administered by the Commissioner to the extent that those programs are transferred to the Health Security System.

(b) Local health departments shall continue to provide clinical services when needed to reach special or underserved populations and to fulfill the counties' responsibility to provide health care services pursuant to Section 17000 of the Health and Welfare Code. However, to the greatest extent possible, such facilities shall be funded for these services from the Health Security Fund under the same overall operating expense budgets according to formulae applied to all health facilities and clinics.

(c) Those programs concerned with population-based public health activities and core public health functions shall remain the responsibility of the state Department of Health Services and shall be funded from the Public Health and Prevention Account pursuant to Section 25251.

(d) It is the intent of the people that the Legislature take steps to consolidate the administration of residual programs in those state departments whose functions have been significantly appropriated to the Health Security System, in order to maintain administrative efficiency and to effectively carry out the goals for which any such residual programs were established.

## CHAPTER 8. PRIMARY CARE, TERTIARY CARE, PUBLIC HEALTH, RESEARCH, AND HEALTH CARE WORKER TRAINING AND DISTRIBUTION

### Article 1. Primary Care.

25260. The people find that quality and efficiency in the delivery of health care services can best be achieved when the ratio of primary care to specialist physicians is one-to-one. Accordingly, the Commissioner shall develop and implement appropriate policies which are intended to achieve this ratio.

### Article 2. Tertiary Care.

25265. (a) The Commissioner shall designate one or more tertiary care referral centers for each Health Security System Region, where particular specialized, experimental, high-technology and high-expense procedures and services shall be performed based on the expertise available, and outcomes demonstrated at those centers.

(1) The Commissioner shall guarantee that specialized, high-technology, and high-expense procedures and services are performed at the highest level of competency possible and are fully available to all Californians with conditions whose effective treatment requires such care.

(2) The Commissioner shall guarantee that the specialized services available in tertiary care referral centers are not in oversupply or otherwise available in ways that are likely to foster their inappropriate utilization.

(3) Tertiary care referral centers shall include, but need not be limited to, academic medical centers and county hospitals in the region,

unless the Commissioner finds compelling reasons to designate otherwise.

(b) The services whose reimbursement is restricted to such designated tertiary care referral centers shall be determined and specified no less than yearly by the Commissioner on recommendation of the Advisory Board.

(c) The Commissioner shall take such measures as are necessary to insure that regionalization of specialized services does not result in barriers to appropriate and reasonable access to those services.

### Article 3. Public Health.

25270. (a) The Advisory Board shall make recommendations to the Commissioner on technology assessment, cost-effectiveness, practice guidelines and standards, and promotion of population-based health strategies with an emphasis on prevention. Funding to carry out these recommendations, and to carry out public health research to promote disease prevention strategies shall be budgeted from the Public Health and Prevention Account in the form of grants for specific programs of the state Department of Health Services, county health departments, state Department of Education, or other state or local government or private non-profit human services agencies, or to programs established directly by the Commissioner.

(b) It is the intent of the people that the Legislature not use funding by the Commissioner of new programs under the auspices of the state Department of Health Services, county health departments, state Department of Education, or other state or local government or private non-profit human services agencies as a basis for diminishing existing funding of these Departments and agencies.

### Article 4. Academic Medical Centers.

25275. (a) The Commissioner shall acknowledge the special role of academic medical centers in providing individual health care services delivery, public health and basic research affecting health care outcomes and costs, and health worker education and training, by establishing special formulae by which Facility Budgets for academic centers are established.

(b) The Commissioner shall meet with representatives of academic medical centers no less than yearly to promote the needs of the Health Security System and better coordinate health worker supply, distribution and demand to fulfill the objectives of this Act. These objectives include:

- (1) Achieving the targeted ratio of primary care to specialist

physician providers specified in Section 25260.

(2) Achieving the number, geographic, discipline and specialty distribution of professional providers to that needed by the state as a whole.

(3) Adjusting, over a period of years to be determined by the Commissioner, the number, geographic and specialty distribution of professional providers as needed to staff underserved areas and communities.

(c) Actions of the Commissioner with respect to academic medical centers shall be limited to filling those needs resulting from the replacement of multiple third party providers by a single payer for health care services.

#### Article 5. Research.

25280. (a) The Commissioner may provide competitive grants to academic medical centers and other health professional schools in the state and to local health care experts in the regions to improve the effectiveness of the Health Security System at a level of funding recommended by the Advisory Board. Such funding shall be for the following purposes:

(1) (A) To determine, and periodically review, the medical conditions which are effectively treated by particular new and currently practiced procedures and services:

(B) The outcome of such studies shall be provided to the Advisory Board for use in establishing recommendations regarding medical indications for new and currently practiced services and procedures and to the Commissioner and professional provider representatives for the purposes of negotiating rate and fee schedules for professional provider reimbursement and Health facility or clinic Facility Budgets, and in decisions regarding capital expansion.

(2) To carry out basic biomedical and clinical research whose eventual outcome may prevent disease or allow it to be treated with greater efficacy and cost-effectiveness than is the case now.

(3) To carry out research into all aspects of health care services, organization, delivery, and population-based public health.

(b) Specific funding for these and other activities which explore new and innovative approaches to the current and future health care needs of California shall, upon appropriation of the Legislature, come from, but need not be limited to funds from, the Public Health and Prevention Account and the Innovations Account and shall be calculated separately from the Facility

Budget for provision of services and health worker training of academic medical centers or the budget for local health departments.

Article 6. Miscellaneous.

25281. The Commissioner may establish standards and criteria regarding any aspect of primary care, tertiary care, public health, health worker training and research not specified in this chapter.

CHAPTER 9. ENFORCEMENT

25282. (a) No provider that receives funds or provides care pursuant to this Division, shall discriminate against a person seeking care on the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, medical condition, marital status, sex, sexual orientation, age, wealth, or any other basis prohibited by the civil rights laws of this state; provided that nothing in this Act shall require a professional provider or health facility or clinic to perform a particular service where:

(1) the particular service is outside its scope of practice which is bona fide limited to certain medical specialties, services or age groups; or

(2) the professional provider or health facility or clinic asserts a religious or conscientious objection to providing the particular service.

(b) Any person who is eligible for health care services under this Division has the right to equitable access to medically appropriate health care, and shall have standing to enforce this Section.

25283. (a) Standards and criteria shall be established to assure that health care providers shall not have a financial interest in laboratory and diagnostic facilities to which they refer patients for tests, procedures or services.

(b) Standards and criteria shall be established regarding financial disclosure by any health facility, clinic, or professional provider reimbursed under the Health Security System, in order to safeguard patient care and the integrity of the System.

25284. The Commissioner shall exclude the following providers from participation in any program under this Act:

(a) Any provider that has been convicted, under either state or federal law, of a criminal offense relating to any of the following:

(1) The delivery of an item or service under the Act or any other federal or state health care program.

(2) The neglect or abuse of a patient in connection with the delivery of health care.

(3) Fraud, theft, embezzlement, breach of financial responsibility or other financial misconduct in connection with the delivery of health care or with respect to any act or omission in a program operated by or financed in whole or in part by any federal, state or local government agency.

(4) The interference with or obstruction of any act of the Commissioner.

(5) The unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(b) Any provider whose license to provide health care has been revoked or suspended by any state licensing agency or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance or financial integrity.

(c) Any provider which has been suspended or excluded from participation in any federal or state program involving the provision of health care, including but not limited to Medicare, Medi-Cal, and programs of the Department of Defense and the Veterans Administration.

(d) Any provider that the Commissioner determines:

(1) Has submitted or caused to be submitted to the Commissioner bills or requests for payment for items or services furnished, where the bills or requests are based on charges or costs in excess of permitted charges or costs, unless the Commissioner finds there is good cause for the bills or requests;

(2) Has furnished or caused to be furnished items or services to patients substantially in excess of the needs of such patients or of a quality which fails to meet professional recognized standards of health care; or

(3) Is a health maintenance organization or other capitated program and has failed substantially to provide medically necessary items and services that are required under this Act to be provided to eligible individuals if the failure has adversely affected or has had a substantial

likelihood of adversely affecting those individuals.

(e) Any provider that did not fully or accurately make any disclosure required to be made by a health care facility or other provider under this Act.

(f) Any provider that fails to grant the Commissioner access upon reasonable request of the Commissioner, pursuant to regulations promulgated by the Commissioner, to enable the Commissioner:

(1) to review data and records relating to compliance with conditions for participation and payment;

(2) to perform the reviews and surveys required by this Act; or

(3) to review records, documents, and other data necessary to the performance of the statutory functions of the Commissioner.

25285. The Commissioner may exclude the following providers from participation in any program under this Act :

(a) Any provider found to violate Sections 25282 or 25283.

(b) Any person, including an organization, agency or other entity, but excluding a covered individual, that presents or causes to be presented to an officer, employee or agent of the Commissioner a claim or request for payment that the Commissioner determines:

(1) is for a service or item that the person knows or should know was not provided as claimed;

(2) is for a service or item and the person knows or should know the claim is false or fraudulent;

(3) is presented for a physician's service or an item or service incident to a physician's service by a person who knows or should know that the individual who furnished or supervised the furnishing of the service was not licensed as a physician or was not certified in a medical specialty by a medical specialty board when the individual was represented as certified or the individual had been previously excluded from participation; or

(4) is in violation of this Act or any regulation issued thereunder.

(c) Any person, including an organization, agency or other entity, but excluding a covered individual that:

(1) makes a payment or provides an item or service, directly or

indirectly to any other provider, as an inducement to reduce or limit the service provided to a covered individual under this Act; or

(2) offers to pay or solicits or receives any remuneration (including but not limited to any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment is made under this Act; or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any good, facility, service or time for which payment may be made in whole or in part under this Act;

(d) subdivision (c) shall not apply to:

(1) any discount or other reduction in price obtained by a provider of service or other entity if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this Act;

(2) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items and services; or

(3) any other agreement or payment practices that the Commissioner determines, pursuant to regulations promulgated by the Commissioner, are not primarily intended to induce or influence the quantity or quality of services provided under this Act.

(e) (1) Any provider found to provide substandard care or engage in unprofessional conduct.

(2) Standards and criteria shall be established to review the care provided by providers to detect potential and actual quality of care problems and to prevent over-utilization or under-utilization of services paid for by the Health Security System.

25286. In addition to any other penalties prescribed by law, the Commissioner may impose a civil money penalty of not more than \$5,000 for each violation of this Chapter. In addition, such a person shall be subject to an assessment of not more than twice the amount of unlawful payment or damages sustained by the State of California resulting from the violation. In addition, the Commissioner may make a determination in the same

proceeding to exclude the person from participation in the Health Security System.

25289. The Commissioner shall establish regulations and procedures for the review of any action which may result in exclusion or penalties under this Chapter.

(a) In the case of exclusion or limitation under Section 25285 (e), the review procedures shall be consistent with those required by Business and Professions Code Sections 809 through 809.9 inclusive. The Commissioner and all other individuals participating in the review procedures shall have all the immunities provided to a hospital by Civil Code Sections 43.7, 43.8, 43.9, 47 and Business and Professions Code section 2318. The review procedures shall be protected from discovery by Evidence Code Sections 1156, 1156.1, 1157, 1157.5.

(b) In the case of exclusion, limitation or penalty for any other reason permitted by this Chapter, the review procedures shall be consistent with Section 25405.

25290. (a) An exclusion shall be effective at such time and upon such conditions as the Commissioner determines.

(b) An exclusion may be terminated at such time and upon such conditions as the Commissioner determines.

25291. (a) The Commissioner shall provide notice to the public of all exclusions in accordance with regulations promulgated by the Commissioner.

(b) The Commissioner shall file a report pursuant to Business and Professions Code Section 805 with respect to any professional provider whose participation in the Health Security System has been limited in any way or who has been excluded from participation.

## CHAPTER 10. IMPLEMENTATION

### Article 1. Initial Health Security System Budget.

25300. (a) The Health Commissioner shall seek from the Legislature sufficient appropriation for start up expenditures and transition costs.

(b) Any money appropriated under subdivision (a) shall be repaid with

interest to the General Fund from the Health Security Fund within two years, unless a longer period is authorized by the Legislature.

### Article 3. Phase-in of Benefits.

25305. (a) Benefits under Chapter 4, Articles 2 (medical benefits), 3 (prescription drugs), and 5 (mental health benefits), shall be available to eligible individuals commencing January 1 of the second year following passage of this Act.

(b) During the first year of benefits under this Act, the Commissioner may establish co-payments as follows:

(1) For any elective service or prescription drug not to exceed \$5 for each procedure or prescription; and

(2) For outpatient mental health care services, after the 26th service rendered in the year, not to exceed:

(A) In the case of services rendered by fee-for-service providers, 50% of the fee charged for each visit or rendered service.

(B) In the case of services rendered by capitated providers, \$25 per visit or rendered service.

(3) Individuals who receive benefits under the federal Medicare program, the CHAMPUS Program or the Federal Employee's Health Benefit Plan, or who are exempt from co-payments under federal law, shall not be required to pay the co-payments specified in this section.

(c) After the first year of benefits under this Act, no co-payment shall be required for any covered benefit, other than as established by the Commissioner pursuant to Sections 25020 and 25240, provided that the Commissioner may extend the period of co-payment under subdivision (b) for up to one additional year upon making a finding that the Health Security System is not yet capable of absorbing the full cost of the benefits.

(d) Benefits under Chapter 4, Article 6 (dental benefits) shall be available to eligible individuals commencing January 1 of the third year following passage of this Act.

(e) Benefits under Chapter 4, Article 4 (long-term care) shall be available to eligible individuals commencing January 1 of the fourth year following passage of this Act.

#### Article 4. Health Worker Staffing Ratio Changes.

25310. (a) Commencing on the effective date of this Act, no health facility, clinic or professional provider shall increase the ratio of patients to licensed or registered nurses without the approval of the Commissioner. Petitions for such waivers shall be made public and may not be approved without 60 days public notice.

(b) Prior to the date benefits are first available under this Act, the Commissioner shall establish minimum safe staffing standards for all settings in which health care is provided including minimum public health staffing standards.

#### Article 5. Transition of Capitated Integrated Health Delivery Systems.

25311. (a) Individuals enrolled in a capitated integrated health delivery system on December 31 of the first year following passage of this Act, shall be considered enrolled in that integrated health delivery system for the purposes of initial benefits effective January 1 of the second year following passage of this Act, unless the particular integrated delivery system in which they are enrolled has not been registered by the Health Security System or has selected a non-capitated mode of reimbursement under the Health Security System.

(b) The Commissioner shall meet with representatives of registered integrated health care delivery systems in each System Region no less than 4 months prior to providing initial benefits under this Act, for the purposes of coordinating their transition to the Health Security System.

(c) The Commissioner shall consider the special needs and requirements of capitated integrated health care delivery systems in California. The Commissioner may provide technical assistance or promulgate regulations with respect to the reimbursement and other requirements and procedures of the Health Security System to ease the transition of capitated integrated health care delivery systems in order to preserve the availability of health care services in California.

### CHAPTER 11. MISCELLANEOUS

#### Article 1. Hearings and Judicial Review.

25400. (a) Any person aggrieved by a decision, order, rate, rule, regulation, action or failure to act, of or by the Commissioner, a Regional Administrator, or a Regional Consumer Advocate, may seek judicial review.

(1) A decision that is required by law to be made following a quasi-adjudicatory hearing shall be set aside only if it is not supported by substantial evidence. Any other decision, order, rate, rule, regulation, action or failure to act, shall be set aside only if it is arbitrary and capricious.

(2) In suits brought by one or more individuals contesting an action of the Commissioner restricting coverage afforded them under this program, a prevailing plaintiff shall be awarded costs of suit and reasonable attorney's fees.

(b) In any action or proceeding challenging a Legislative Amendment to this Act.

(1) The party or parties asserting the validity of the amendment shall have the burden of proof by clear and convincing evidence that the amendment is consistent with the purposes of this Act. The purposes of this Act include not only those intents, findings and declarations set forth in Sections 25001 and 25002 of this Division, but also the means the Act employs to achieve its stated aims.

(2) A Legislative amendment inconsistent with the purposes of this Act shall be declared invalid, and the prevailing plaintiff, other than the Commissioner, an officer, or a member of a department, board or agency established by this Act, shall be awarded cost of suit and reasonable attorney's fees.

25405. (a) Any quasi-adjudicatory hearing required by law shall be conducted in accordance with Chapter 5 commencing with Section 11500 of Part 1 of Division 3 of Title 2 of the Government Code, except as provided in this Act or in regulations promulgated by the Commissioner.

(b) The hearing shall be conducted by a hearing officer assigned by the Commissioner who shall rule on the admission and the exclusion of evidence and may exercise all other powers relating to the conduct of the hearing.

## Article 2. Insurance and Practice Outside the Health Security System.

25415. (a) Any person providing or offering health care or insurance to any individual for a fee or other consideration which covers benefits available under the Health Security System shall inform these individuals, including prospective customers, in writing of the benefits for which they may be eligible under the Health Security System.

(b) The Commissioner may establish a uniform notice, specifying both content and print size, to be included in any place of business, advertisement, policy of insurance, or offer to insure, as described in subdivision (a). The notice shall be limited to an advisement of rights under this Act and the name and phone number of a person or office that can provide further information.

(c) Failure to provide the notice required by this section shall constitute an unfair business practice, entitling the individual to rescission, restitution, damages, and other remedies as provided by law and result in such other action by the Commissioner as authorized by law.

25420. Any health facility, clinic or professional provider may elect to participate in the Health Security System, unless excluded by the Commissioner.

25421. (a) Except as provided in Section 25138, a participating health facility, clinic, or professional provider may not charge any person, including individuals not eligible for benefits under this Act, for services or procedures that are covered benefits under this Act, other than for a co-payment as permitted by this Act.

(b) Except as provided in Chapter 6, Article 4, commencing with Section 25180, a participating health facility, clinic, or professional provider may provide to any person services or procedures that are not covered benefits under this Act.

(1) A provider may require a patient to pay for services or procedures which the Commissioner has determined are not covered by this Act. Fees or reimbursement for such service or procedure is a matter between the provider and the patient. The Health Security System is not liable for these charges and shall not be billed.

(2) No provider shall require a patient to pay for or obtain a service not covered by this Act as a condition of obtaining covered services.

(3) The Commissioner may monitor the provision, frequency, and cost of services under this subdivision to determine their efficacy and possible inclusion as covered benefits, and to safeguard against abuse of the Health Security System.

### Article 3. Coordination with Other Laws.

25520. Exemption from state and federal antitrust laws.

(a) Actions taken by or on behalf of the Health Commissioner, or by any person as authorized by this Act, shall not be considered a violation of California antitrust laws, including but not limited to Division 7, Part 2, Chapter 2 of the Business and Professions Code.

(b) It is the intent of the people to ensure that all Californians receive high-quality health care coverage in the most efficient and cost-effective manner possible.

(1) In furtherance of this intent, the people find and declare that it is in the public interest to enhance the ability of professional providers, health facilities and clinics to form bargaining units for the purpose of contracting for the delivery of health care services, and that it is in the public interest for the Health Security System to contract with vendors, professional providers, health facilities and clinics to further the purposes of this Act.

(2) The people further find and declare that the existing marketplace for health care services, relying on contracts between individual providers, both institutional and professional, and individual insurers and purchasers, has not proven effective, and has been unable to provide quality and efficient health care to all Californians.

(3) The people further find and declare that the efficient operation of the Health Security System, including its salient purpose of providing universal, comprehensive, accessible, portable and publicly administered health care, providing the greatest freedom of choice to the health care consumer, requires the displacement of competition among providers, insurers and purchasers of health care services.

(4) The California Legislature has previously demonstrated a similar intent and public purpose in Section 16770 of the Business and Professions Code, Sections 1342.6 and 1797.6 of the Health and Safety Code, Section 10133.6 of the Insurance Code, and Section 14087.26 of the Welfare and Institutions Code.

(5) It is the intent of the people therefore, that the formation of groups and combinations of providers and health facilities and the concentration of purchasing power and regulatory authority in the Health Security System, be exempt from federal antitrust restraints.

(c) The people find and declare that:

(1) there is a compelling state public interest in each action undertaken by or on behalf of the Commissioner, and every other state and local agency, board, council, and officer acting under and in furtherance of this Act, including but not limited to those actions otherwise considered in restraint of trade; and

(2) this Act prescribes and exercises the degree of state direction and supervision over health care services as shall provide for state action immunity under federal antitrust laws for activities undertaken by local governmental entities in carrying out their prescribed functions under this Act.

(d) This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the above-described groups or combinations, any person who is lawfully qualified to perform the services to be performed by the members of the group or combination, where the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the group or combination.

#### 25525. Compliance with federal health care reform legislation.

(a) The Commissioner shall determine which provisions of this Act, and which actions taken pursuant to this Act, must be modified to achieve compliance with requirements for state health plans as specified by federal laws or regulations including those enacted after submission of this ballot initiative, or other federal laws and regulations.

(1) If any statutory provision of this Act must be modified to achieve compliance with federal health care reform legislation, the Commissioner shall seek appropriate amendment by the Legislature, preserving the goals of this Act, including, but not limited to, providing universal and comprehensive coverage, cost control, fiscal soundness and progressive financing.

(2) The Commissioner shall construe or modify any regulation promulgated under this Act as necessary to achieve compliance with federal health care reform legislation.

(b) Provisions of federal laws and regulations covered by this Section include, but are not limited to, certifying health plans, financing and financial solvency, cost control, protection for health care providers and enrollees, health benefits, enrollment, and provider reimbursement.

#### 25530. Federal Waivers.

(a) The Commissioner shall seek all appropriate federal waivers, exemptions, agreements or legislation that shall allow all federal payments for medical, mental health and long-term care made in this state to be paid directly to the Commissioner for the purposes of the Health Security System, and for the assumption, by the Health Security System, of the responsibility for all benefits previously paid for by the federal government.

(b) The Commissioner shall, in all cases, seek to maximize federal contributions and payments for medical, mental health, and long-term care services provided in this state and, in obtaining the waivers, exemptions, agreements, or legislation required by subdivision (a), the Commissioner shall seek to ensure that the contributions of the federal government for medical, mental health, and long-term care services in California shall not decrease in relation to other states as a result of the waivers, exemptions, agreements or legislation.

#### 25535. Construction.

This Act shall be construed as necessary to comply with federal health care legislation, consistent with the intent of the Act to establish a single payer for health care with freedom of choice of professional provider and a single standard of care for all Californians eligible for particular services under the Health Security System.

SECTION 3. Section 13 is hereby added to Article XIII B of the California Constitution to read as follows:

Section 13 (a) "Appropriations subject to limitation" for each entity of government do not include appropriations for purposes of the California Health Security Act.

(b) "Appropriations subject to limitation" for each entity of government shall be lowered in any year by the amount excluded from limitation under Section (a) of this Section, to the extent such amount was subject to limitation in the prior year.

SECTION 4. Section 20 is hereby added to Article XVI of the California Constitution to read as follows:

Section 20. (a) There is established a special fund in the State Treasury, to be called the Health Security Fund, for the purpose of implementing the California Health Security Act.

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

(c) The money in the Health Security Fund shall not be considered State revenues or State money or proceeds of tax for purposes of Sections 3

and 8 of this Article.

SECTION 5. Unless expressly provided for in this Act, the provisions of Division 2, Part 2, commencing with Section 10110, of the Insurance Code, shall not be applicable to this Act.

SECTION 6. Welfare and Institutions Code Sections 5750, 10720, 10721, 10722, 10723 and 10724 are hereby adopted to read as follows:

5750. Administrative duties; standards; rules and regulations.

(a) The Health Commissioner shall administer this Part 2. Notwithstanding any other provision of law, standards and regulations for mental health services shall be adopted in the manner set out in Chapter 4 of Division 13 of this Code (California Health Security Act) for the adoption of standards and regulations for other benefits provided under this Act consistent with Sections 5751 and 5751.1.

(b) Notwithstanding any other provision of law, the duties, purposes, responsibilities, functions and jurisdiction of the Citizen Advisory Council and the California Conference of Local Mental Health Directors under this Part 2 are transferred to the Advisory Board as defined in Section 25004 (b), unless the Health Commissioner determines otherwise by regulation.

(c) The transfer of the purposes, responsibilities, functions, property, officers and employees of the Director of Mental Health to the Health Commissioner shall occur as provided in Sections 10720, 10721, 10722 of the Welfare and Institutions Code, amended by this Act.

(d) All regulations heretofore adopted by the Director of the Department of Mental Health which relate to the Director of Mental Health's duties, purposes, responsibilities, functions and jurisdiction as well as payment, accounting, auditing and collection of funds under Part 2, and that are in effect on the date of passage of this Act, shall remain in effect and shall be fully enforceable unless and until re-adopted, amended or repealed by the Health Commissioner.

10720. Duties of the Health Commissioner. The Health Commissioner shall administer the chapters and Part referred to in Section 10721, below, as well as any other law in this Division pertaining to the administration of health care services and medical assistance. As used in the chapters and parts referred to in Section 10721, below, the term "directors" and "department" mean the Health Commissioner.

10721. Transfer of functions; effective date; impairment of contracts.

(a) The Health Commissioner succeeds to and is vested with the duties, purposes, responsibilities, functions and jurisdiction exercised by the State Department of Health Services pursuant to Chapter 6.5 (commencing with Section 13900), Chapter 7, (commencing with Section 14000), chapter 8 (commencing with section 14200), chapter 8.5 (commencing with Section 14500), Chapter 8.7 (commencing with Section 14520), Chapter 8.8 (commencing with section 14600), Chapter 9 (commencing with Section 15000), Chapter 9.5 (commencing with Section 15300) of this part, Chapter 11 (commencing with Section 15600), and Chapter 12 (commencing with Section 15710) and Part 4 (commencing with Section 16000), Part 4.5 (commencing with Section 16700), Part 4.6 (commencing with Section 16800), Part 4.7 (commencing with Section 16900), Part 5 (commencing with Section 17000), Part 5.5 (commencing with Section 17770) and Part 6 (commencing with Section 18000) of this Division the date immediately prior to the date this Section becomes effective.

(b) Functions transferred pursuant to this section include the management and administration of the Health Care Deposit Fund and the audit and recovery of amounts due as the result of payments made under the California Medical Assistance Program (Medi-Cal).

(c) Transfer to the Health Commissioner of the above duties, purposes, responsibilities, functions and jurisdiction shall not impair any contract between the State Department of Health Services and any third party and such transfer shall neither create nor vest any right or obligation in either party. In no case shall the substitution of the Health Commissioner for the State Department of Health Services be considered a breach of contract or failure of performance, nor shall it disturb the legal relationship of the two parties.

10722. Transfer of property. The Health Commissioner shall have possession and control of all records, papers, offices, equipment, supplies, monies, funds, appropriations, land and other property real or personnel held for the benefit or use of the Director of Health Services in the performance of his or her duties, powers, purposes, responsibilities and jurisdiction that are vested in the State Department of Health Services for the purposes of carrying out Chapters and Parts referred to in Section 10721.

10723. Transfer of officers and employees. All officers and employees of the Director of Health Services who on the effective date of this Act are serving in the state civil service, other than temporary employees, and engaged in the performance of a function vested in the Health Commissioner by Section 10721 shall be transferred to the Health Commissioner. The

status, positions, and rights of such individuals shall not be affected by the transfer and shall be retained by them as officers and employees of the Health Commissioner, pursuant to the State Civil Service Act except as to positions exempt from civil service.

10724. Regulations; continued effectiveness; re-adoption, amendment or repeal. All regulations heretofore adopted by the Director of the Department of Health Services which relate to payment, accounting, auditing and collections functions vested in the state Department of Health Services, or by any predecessor department which relate to health care services or medical assistance functions vested in the State Department of Health Services, and which are in effect immediately preceding the effective date of this Section, shall remain in effect and shall be fully enforceable unless and until re-adopted, amended or repealed by the Health Commissioner.

SECTION 7. Health and Safety Code Sections 443.20, 446, and 446.35 are adopted to read as follows:

443.20. The California Health Policy and Data Advisory Commission is abolished. The Health Commissioner succeeds to and is vested with all the duties, powers, purposes, responsibilities and jurisdiction of the California Health Policy and Data Advisory Commission including but not limited to those functions and responsibilities performed pursuant to Division 1 of this Code.

446. The Office of State-wide Health Planning and Development is abolished. The Health Commissioner succeeds to and is vested with all the duties, powers, purposes, responsibilities and jurisdiction of the Office of State-wide Health Planning and Development including but not limited to those functions and responsibilities performed pursuant to Division 1 of this Code.

446.35. All regulations heretofore adopted by the Office of State-wide Health Planning and Development and which are in effect immediately preceding the operative date of this Section, shall remain in effect and shall be fully enforceable unless and until re-adopted, amended or repealed by the Health Commissioner.

SECTION 8. Section 30123.5 and Part 14.5 of Division 2, commencing with Section 33000, are hereby added to the Revenue and Taxation Code to read as follows:

30123.5. Health Security System Cigarette and Tobacco Products Surtax.

(a) In addition to the tax imposed upon the distribution of cigarettes by this chapter, there shall be imposed on every distributor a tax upon the distribution of cigarettes at the rate of 50 mills (\$.05) for each cigarette distributed.

(b) There shall be imposed on every distributor of tobacco products based on the wholesale cost of these products, at a tax rate, as determined annually by the State Board of Equalization, which is equivalent to the combined rate of tax imposed on cigarettes by subdivision (a).

(c) The rate specified in subdivisions (a) and (b) shall be reduced by an amount equal to any tax imposed on like cigarette and tobacco products pursuant to federal health security legislation, to the extent that the federal tax revenues are contributed to the Health Security Fund.

(d) The revenues generated pursuant to this Section shall be deposited in the Health Security Fund.

Part 14.5. Health Security Fund.

33000. Definitions

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

(a) "Act" means the California Health Security Act, Division 13, commencing with Section 25000, of the Welfare and Institutions Code.

(b) "Base year" means the twelve months prior to the passage of the California Health Security Act.

(c) "Commissioner" or "Health Commissioner" means the California State Health Commissioner.

(d) "Employee" means a resident of California who works for an employer, is listed on the employer's payroll records, and is under the employer's control.

(e) "Employer" means any person, partnership, corporation, association, joint venture, or public or private entity employing for wages, salary, or other compensation, one or more employees at any one time to work in this state. "Employer" does not include self-employed persons with respect to self-employed earnings.

33001. Employer Health Security System Payroll Tax.

(a) All employers shall pay a Health Security payroll tax commencing January 1 of the second year following passage of the California Health Security Act.

(b) (1) Not later than April 15 of the year following passage of the Act, each employer shall report to the Health Commissioner, by means and formulae determined by the Commissioner, the number of employees and the amount paid for employee health insurance and benefits, both in absolute dollars and as a percentage of overall payroll, for the base year.

(2) An employer without a base year payroll shall estimate the items in paragraph (1) for its first full year of operation after the base year and report them to the Commissioner. Within 90 days of completing the first full year of doing business in the State, the employer shall file a corrected report with the Commissioner. The first full year of doing business in the State shall serve as the employer's base year for the purposes of this Section.

(3) In addition to any penalties provided by law, an employer who fails to file the report required by this subdivision, or misstates any material fact, shall be assessed the maximum rate permitted under this Section or Section 33002, plus an additional 1% tax on payroll, until a valid report is filed.

(c) Except as provided in Section 33002, the payroll tax rate shall be:

(1) In the case of employers with fewer than 10 employees, 4.4% of payroll.

(2) In the case of employers with 10 or more but fewer than 25 employees, 6.0 % of payroll.

(3) In the case of employers with 25 or more but fewer than 50 employees, 7.0 % of payroll.

(4) In the case of employers with 50 or more employees, 8.9 % of payroll.

(5) In the event that federal law requires a different payroll tax rate, that rate shall apply.

(d) The payroll tax rate specified in this section shall be inclusive of, but not in addition to, any payroll tax mandated by federal health care reform legislation.

(e) For purposes of determining the tax rates under subdivision (c),

(1) the number of employees means the number of full-time equivalent employees;

(2) the number of employees shall be the greater of the number in the current year or the base year.

(f) Nothing in the California Health Security Act shall be construed to prevent an employer from providing health benefits in excess of those available under the Health Security System.

(g) The Commissioner may seek assistance from any appropriate State agency in obtaining the data necessary to carry out this Section.

(h) The earnings of a self-employed individual resulting from self-employment shall not be considered payroll for the purposes of this Section.

#### 33002. Phase-in of Employer Health Security Payroll Tax

(a) For the first year in which benefits are provided under this Act, the payroll tax rate shall be the amount specified in Section 33001, adjusted as follows:

(1) By adding, in the case of an employer whose base-year health insurance and benefit payments, expressed as a percentage of payroll, was greater than the rate specified in Section 33001(c), two-thirds of the difference between these two rates.

(2) By subtracting, in the case of an employer whose base-year health insurance and benefit payments expressed as a percentage of payroll, was less than the rate specified in Section 33001(c), two-thirds of the difference between these two rates.

(b) For the second year in which benefits are provided under this Act, the payroll tax rate shall equal the amount calculated in subdivision (a), replacing the fraction two-thirds in paragraphs (1) and (2) with the fraction one-third.

#### 33003. Credit Against Employer Health Security Payroll Tax.

(a) With respect to each employee affected, an employer who, on the date of passage of this Act, was under a contractual or legal obligation to provide the employee with health care benefits, that are covered benefits

under this Act, or to pay for such benefits through a policy of insurance or otherwise, shall receive a credit against its payroll tax obligation in a tax period equal to the amount it pays during that period for such benefits or insurance pursuant to the contract or legal obligation.

(1) Entitlement to the credit shall lapse upon the expiration of the contractual or legal obligation. No credit may be claimed for any obligation arising on or after the effective date of this Act.

(2) This subdivision shall not apply to obligations subject to federal preemption as described in Chapter 6 Article 3, commencing with Section 25136, of the Welfare and Institutions Code.

(b) (1) In the event that the amount of a credit provided by this Section exceeds the employer's payroll tax obligation for any affected employee, the excess shall be credited against the employee's tax obligation imposed by Section 33004.

(2) In the case of an employer exempt from the payroll tax obligation pursuant to section 25136 of the Welfare and Institutions Code, the amount of credit to be applied to the employee's tax obligation shall be determined in the same manner as in the case of a non-exempt employer.

(c) No credit may be carried over from year to year or transferred among employees.

#### 33004. Individual Health Security Income Tax.

(a) All heads of households and persons subject to California income tax shall pay a Health Security income tax commencing January 1 of the second year following passage of the California Health Security Act.

(b) The tax rate shall be 2.5% of taxable income as defined in Revenue and Taxation Code 17073, but not less than \$50 per household per year.

(c) In the case of households where no member files a California State income tax return, the Health Commissioner shall establish mechanisms or coordinate with other State agencies to establish mechanisms, for the collection of the minimum tax, including but not limited to deduction of the tax from transfer payments or entitlements at their source.

#### 33005. Credit Against Individual Health Security Income Tax.

(a) Individuals shall receive a credit against their individual Health

Security income tax obligation for either or both of the following:

(1) any credit arising under Section 33003(b);

(2) any premium or tax paid by the individual required by federal health care reform legislation, to the extent that such payments are mandatory and no election is allowed for a single-payer system.

(b) In no case shall the amount of a credit provided under this Section exceed the individual's health security income tax obligation in any year. No credit may be carried over from year to year.

33006. (a) Nothing in the California Health Security Act shall be construed to interfere with an employer choosing to pay, in part or in full, the individual Health Security income tax for an employee.

(b) If an employer chooses to pay the Health Security income tax on behalf of an employee, such payments shall not substitute for any obligation of the employer pursuant to Section 33000.

33007. Individual Health Security Income Surtax.

(a) Persons filing a California income tax return shall pay a Health Security income surtax of 2.5% on net taxable income in excess of \$250,000.

(b) Notwithstanding subdivision (a), married couples filing a California joint income tax return shall pay a Health Security income surtax of 2.5% on net taxable income in excess of \$500,000.

(c) The surtax described in this subdivision shall be in addition to the individual Health Security income tax imposed by Section 33004.

SECTION 9. Legislative Amendment.

(a) The provisions of this Act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(b) The two-thirds vote requirement of subdivision (a) shall not apply to any provision of this Act which:

(1) specifically mentions and authorizes action by the Legislature, in which case a majority of the membership in each house shall be sufficient for amendment;

(2) specifically states a different method for amendment, in which case that method shall control; or

(3) must be amended to achieve compliance with federal health care reform legislation, pursuant to Welfare and Institutions Code Sections 25525 and 25530, in which case a majority of the membership in each house shall be sufficient for amendment.

#### SECTION 10. Severability.

If any provisions of this Act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable. Towards this end, it is the intent of the people that any invalid section, subdivision, paragraph, sentence or clause shall be severed from the remainder of the Act to preserve its remaining provisions.

SECTION 11. Repeal of Welfare and Institutions Code Sections 5750, 10720, 10721, 10722, 10723, 10724, 10725 and 10726, and Health and Safety Code Sections 443.20, 443.21, 446, 446.1, 446.2, 446.3, and 446.35.

Welfare and Institutions Code Section 5750 is hereby repealed.

~~5750. Administrative duties; standards; rules and regulations; exception for psychiatric health facilities~~

~~(a) The State Department of Mental Health shall administer this part and shall adopt standards for approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the California Council on Mental Health and the California Conference of Local Mental Health Directors. Adoption of these standards, rules, and regulations shall require approval by the California Conference of Local Mental Health Directors by majority vote of those present at an official session except for regulations pertaining to psychiatric health facilities. For regulations pertaining to psychiatric health facilities, the vote by the conference, following consultation, shall be only advisory to the State Department of Mental Health.~~

~~(b) If the conference refuses or fails to approve standards, rules, or regulations submitted to it by the State Department of Mental Health for its approval, the State Department of Mental Health may submit these standards, rules, or regulations to the conference at its next meeting, and if the conference again refuses to approve them, the matter shall be referred for~~

~~decision to a committee composed of the Secretary of the Health and Welfare Agency, the Director of Mental Health, the President of the California Conference of Local Mental Health Directors, the Chairman of the California Council on Mental Health, and a member designated by the State Advisory Health Council.~~

~~(c) (1) From July 1, 1991, to June 30, 1993, inclusive, the conference shall not approve regulations of the State Department of Mental Health. The impact on this subdivision of regulatory timing shall be included in the department's report to the Legislature on September 30, 1992.~~

~~(2) The department shall continue during that period to involve the conference in the development of all regulations which affect local mental health programs, prior to the promulgation of those regulations pursuant to the Administrative Procedure Act.~~

Welfare and Institutions Code Section 10720 is hereby repealed.

~~10720. Department and director defined~~

~~As used in this chapter, "department" means the State Department of Health Services, and "director" means the State Director of Health Services.~~

Welfare and Institutions Code Section 10721 is hereby repealed.

~~10721. Duties of director~~

~~The director shall administer Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of this division and any other law pertaining to the administration of health care services and medical assistance. He shall perform such other duties as may be prescribed by law and shall observe and report to the Secretary of Health and Welfare and the Governor on the condition of health care services and medical assistance throughout the state.~~

Welfare and Institutions Code Section 10722 is hereby repealed.

~~10722. Transfer of functions; operative date; impairment of contracts~~

~~The State Department of Health Services succeeds to and is vested with the duties, purposes, responsibilities, and jurisdiction exercised by the State Department of Health or the State Department of Benefit Payments pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), Chapter 8.5 (commencing with Section 14500), and Chapter~~

~~8.7 (commencing with Section 14520) of this part on the date immediately prior to the date this section becomes operative. Functions transferred pursuant to this section include the management and administration of the Health Care Deposit Fund and the audit and recovery of amounts due as the result of payments made under the California Medical Assistance Program (Medi-Cal).~~

~~Transfer to the State Department of Health Services of the above functions shall not impair any contract between the State Department of Health or the State Department of Benefit Payments and any third party and such transfer shall neither create nor vest any right or obligation in either party. In no case shall the substitution of the State Department of Health Services for the State Department of Health or the State Department of Benefit Payments be considered a breach of contract or failure of performance, nor shall it disturb the legal relationships of the parties.~~

Welfare and Institutions Code Section 10723 is hereby repealed.

~~10723. Transfer of property~~

~~The State Department of Health Services shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, and other property real or personal held for the benefit or use of the Director of Health or the Director of Benefit Payments in the performance of his duties, powers, purposes, responsibilities, and jurisdiction that are vested in the State Department of Health Services by Section 10722.~~

Welfare and Institutions Code Section 10724 is hereby repealed.

~~10724. Transfer of officers and employees~~

~~All officers and employees of the Director of Health and the Director of Benefit Payments who on the operative date of this section are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the State Department of Health Services by Section 10722 shall be transferred to the State Department of Health Services. The status, positions, and rights of such persons shall not be affected by the transfer and shall be retained by them as officers and employees of the State Department of Health Services pursuant to the State Civil Service Act, [FN1] except as to positions exempt from civil service.~~

Welfare and Institutions Code Section 10725 is hereby repealed.

~~10725. Director; adoption of regulations, orders and standards~~

~~The director may adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law enforced by the department, and such regulations, orders, and standards shall be adopted, amended, or repealed by the director only in accordance with the provisions of Chapter 4.5 (commencing with Section 11371), Part 1, Division 3, Title 2 of the Government Code, [FN1] provided that regulations relating to services need not be printed in the California Administrative Code or California Administrative Register if they are included in the publications of the department. Such authority also may be exercised by the director's designee. In adopting regulations the director shall strive for clarity of language which may be readily understood by those administering services or subject to such regulations.~~

~~The rules of the department need not specify or include the detail of forms, reports or records, but shall include the essential authority by which any person, agency, organization, association or institution subject to the supervision or investigation of the department is required to use, submit or maintain such forms, reports or records.~~

Welfare and Institutions Code Section 10726 is hereby repealed.

~~10726. Regulations; continued effectiveness; readoption, amendment or repeal~~

~~All regulations heretofore adopted by the Director of the State Department of Benefit Payments which relate to payment, accounting, auditing and collection functions vested in the State Department of Health Services, or by the State Department of Health or any predecessor department which relate to health care services or medical assistance functions vested in the State Department of Health Services, and which are in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended or repealed by the State Director of Health Services.~~

Health and Safety Code Section 443.20 is hereby repealed.

~~443.20. California health policy and data advisory commission; creation; membership; terms~~

~~There is hereby created the California Health Policy and Data Advisory Commission to be composed of 11 members.~~

~~The Governor shall appoint seven members, one of whom shall be a hospital chief executive officer, one of whom shall be a long term care facility chief~~

~~executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment health care service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member.~~

~~The chairperson shall be designated by the Governor. The Governor shall designate four original appointments which will be for four year terms. The Governor shall designate three original appointments which shall be for two year terms. The Speaker of the Assembly shall designate one original appointment which will be for two years and one original appointment which will be for four years. The Senate Rules Committee shall designate one original appointment which will be for two years and one original appointment which will be four years. Thereafter, all appointments shall be for four year terms.~~

~~In addition to the 11 original appointees to the commission, the chairperson of the Advisory Health Council on December 31, 1985, and the chairperson of the California Health Facilities Commission on December 31, 1985, shall also serve four year terms. During their terms when the commission shall have 13 members, they shall be full voting representatives.~~

Health and Safety Code Section 443.21 is hereby repealed.

#### ~~443.21. Definitions~~

~~As used in this part, the following terms mean:~~

~~(a) "Commission" means the California Health Policy and Data Advisory Commission.~~

~~(b) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.~~

~~(c) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.~~

~~(d) "Office" means the Office of Statewide Health Planning and Development.~~

~~(e) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures which have been adjusted for demographic and clinical factors.~~

Health and Safety Code Section 446 is hereby repealed.

~~446. Existence of office~~

~~There is in the state government, in the Health and Welfare Agency, an Office of Statewide Health Planning and Development.~~

Health and Safety Code Section 446.1 is hereby repealed.

~~446.1. Director~~

~~The Office of Statewide Health Planning and Development is under the control of an executive officer known as the Director of Statewide Health Planning and Development, who shall be appointed by the Governor, subject to confirmation by the Senate, and hold office at the pleasure of the Governor. He shall receive the annual salary provided by Article 1 (commencing with Section 11550) of Chapter 6 of Part 1 of Division 3 of Title 2 of the Government Code.~~

Health and Safety Code Section 446.2 is hereby repealed.

~~446.2. Powers of director~~

~~The Director of Statewide Health Planning and Development shall have the powers of a head of the department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code.~~

Health and Safety Code Section 446.3 is hereby repealed.

~~446.3. Succession to powers, etc.~~

~~The Office of Statewide Health Planning and Development succeeds to and is vested with all the duties, powers, purposes, responsibilities, and jurisdiction of the State Department of Health relating to health planning and research development. The office shall assume the functions and responsibilities of the Facilities Construction Unit of the former State Department of Health, including, but not limited to, those functions and responsibilities performed pursuant to the following provisions of law:~~

~~Article 5.5 (commencing with Section 380) of Chapter 2 of Part 1 of Division 1; Article 18 (commencing with Section 429.70) and Article 19 (commencing with Section 429.94) of Chapter 2.5 of Part 1 of Division 1; Chapter 3 (commencing with Section 430) and Chapter 4 (commencing with Section 436) of Part 1 of Division 1; Part 1.5 (commencing with Section 437) of Division 1; Section 1260; Chapter 10 (commencing with Section 1770) of~~

~~Division 2; Section 13113; and Division 12.5 (commencing with Section 15000).~~

Health and Safety Code Section 446.35 is hereby repealed.

#### ~~446.35. Regulations~~

~~All regulations heretofore adopted by the State Department of Health which relate to functions vested in the Office of Statewide Health Planning and Development and which are in effect immediately preceding the operative date of this section, shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the Office of Statewide Health Planning and Development.~~

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