AMENDED IN SENATE JUNE 18, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 78

Introduced by ~~Assembly Member Ting~~ *Committee on Budget (Assembly Members Ting (Chair), Arambula, Bloom, Chiu, Cooper, Frazier, Cristina Garcia, Jones-Sawyer, Limón, McCarty, Medina, Mullin, Muratsuchi, Nazarian, O'Donnell, Ramos, Reyes, Luz Rivas, Blanca Rubio, Mark Stone, Weber, Wicks, and Wood)*

December 3, 2018

~~An act relating to the Budget Act of 2019.~~ *An act to amend Sections 100502, 100506, 100506.1, 100506.2, 100506.4, 100506.5, and 100520 of, to amend, repeal, and add Section 12803 of, to add Title 24 (commencing with Section 100700) to, and to add and repeal Title 25 (commencing with Section 100800) of, the Government Code, to amend Sections 1272, 1365, 1399.849, 124130, and 130062 of, to add Sections 1345.5, 1367.0085, 120511, 120512, 120780.5, 120780.6, 122440, and 122441 to, to add Part 1.5 (commencing with Section 438) to Division 1 of, to add Chapter 6.2 (commencing with Section 120973) to Part 4 of Division 105 of, and to repeal and add Section 120525 of, the Health and Safety Code, to amend Sections 10273.6 and 10965.3 of, and to add Section 10112.296 to, the Insurance Code, to amend Sections 3208.3 and 3351 of, and to add Sections 3370.1 and 3371.1 to, the Labor Code, to amend Sections 19254, 19291, 19521, and 19533 of, to add Sections 17141.1 and 19548.8 to, and to add Part 32 (commencing with Section 61000) to Division 2 of, the Revenue and Taxation Code, to amend Sections 4316 and 14131.10 of, to add Sections 4317.5, 7281.1, 14021.37, 14104.36, 14105.36, and 14190 to, and to add Article 5.8 (commencing with Section 14188) and Article 6.8 (commencing with Section 14199.60) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, and to amend Section 52 of Chapter 18 of the*

Statutes of 2015, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

LEGISLATIVE COUNSEL'S DIGEST

AB 78, as amended, ~~Ting~~ *Committee on Budget*. ~~Budget Act of 2019.~~ *Health.*

(1) Existing law requires the State Department of Public Health to approve or deny an application submitted by a general acute care hospital or an acute psychiatric hospital to the department's centralized applications unit within specified deadlines and further requires the department to develop a centralized applications advice program and an automated application system. Existing law provides that the resources necessary to implement these requirements be made available, upon appropriation by the Legislature, from the Internal Departmental Quality Improvement Account.

This bill would delete the provision specifying that the resources necessary to implement these requirements be made available, upon appropriation by the Legislature, from the Internal Departmental Quality Improvement Account.

(2) Existing law establishes the Office of AIDS in the State Department of Public Health as the lead agency within the state responsible for coordinating state programs, services, and activities relating to the human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), and AIDS related conditions (ARC), including the CARE Services Program and the AIDS Drug Assistance Program (ADAP). Existing law, to the extent that state and federal funds are appropriated in the annual Budget Act for these purposes, authorizes the Director of Public Health to administer the ADAP to provide drug treatments to persons infected with HIV and AIDS, and to establish uniform standards of financial eligibility for the drugs under the program, in accordance with applicable federal law.

This bill would rename the CARE Services Program the HIV Care Program. The bill would, commencing April 1, 2020, require the State Department of Public Health to apply the same financial eligibility requirements for the purposes of administering the HIV Care Program as those set forth for the ADAP.

(3) Existing law, the Childhood Lead Poisoning Prevention Act of 1991, requires the State Department of Public Health to adopt regulations establishing a standard of care at least as stringent as the

most recent federal Centers for Disease Control and Prevention screening guidelines, whereby all children are evaluated for risk of lead poisoning by health care providers during each child's periodic health assessment. Existing law requires a laboratory that performs a blood lead analysis on a specimen of human blood drawn in California to report specified information to the State Department of Public Health for each analysis on every person tested. Existing law requires that all information reported be confidential, except that the department is authorized to share the information for the purpose of surveillance, case management, investigation, environmental assessment, environmental remediation, or abatement with the local health department, environmental health agency, or building department, so long as the entity receiving the information otherwise maintains the confidentiality of the information, as specified.

This bill would allow the State Department of Public Health to also share the information with the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services. The bill would allow the State Department of Health Care Services to further disclose this information to a managed health care plan in which the beneficiary who is the subject of the information is enrolled, who the bill would also allow to share the information with the beneficiary's health care provider.

(4) Existing law establishes the patients' personal deposit fund at each institution under the jurisdiction of the State Department of State Hospitals for the deposit of patient funds. Whenever the sum in the fund belonging to any one patient exceeds $500, existing law allows the excess to be applied to the payment of care, support, maintenance, and medical attention of the patient.

This bill would prohibit a patient of an institution under the jurisdiction of the State Department of State Hospitals who participates in a sheltered workshop or vocational rehabilitation program from being required to return or remit their earnings to the institution for these purposes.

(5) Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes a program of seismic safety building standards for certain hospitals. Existing law requires all hospitals with buildings subject to a seismic compliance deadline of January 1, 2020, and that are seeking an extension for their buildings to submit an application to the Office of Statewide Health Planning and Development

by April 1, 2019, that specifies the seismic compliance method each building will use.

This bill would instead make the application due by September 1, 2019, for Providence Tarzana Medical Center in the City of Los Angeles and UCSF Benioff Children's Hospital in the City of Oakland.

(6) Existing law requires a hospital granted an extension to provide a quarterly status report to the office, with the first report due on July 1, 2019, until seismic compliance is achieved.

This bill would instead make the first report due on October 1, 2019, for the above-described 2 facilities if they are granted an extension based on an application submitted on or after April 1, 2019.

This bill would make legislative findings and declarations as to the necessity of a special statute for those 2 facilities.

(7) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the California Health Benefit Exchange (Exchange), also known as Covered California. Existing law specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers. Existing law establishes the California Health Trust Fund and continuously appropriates moneys in the fund for these purposes.

Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms as of January 1, 2014. PPACA generally requires an individual, and any dependents of the individual, to maintain minimum essential coverage, as defined, and, if an individual fails to maintain minimum essential coverage, PPACA imposes on the individual taxpayer a penalty. This provision is referred to as the individual mandate.

This bill would create the Minimum Essential Coverage Individual Mandate to require an individual who is a California resident to ensure that the individual, and any spouse or dependent of the individual, is enrolled in and maintains minimum essential coverage for each month

beginning on and after January 1, 2020, except as specified. The bill would require the Exchange to grant exemptions from the mandate for reason of hardship or religious conscience, and would require the Exchange to establish a process for determining eligibility for an exemption. The bill would impose the Individual Shared Responsibility Penalty for the failure to maintain minimum essential coverage, as determined and collected by the Franchise Tax Board, in collaboration with the Exchange, as specified. The bill would require the Franchise Tax Board to provide specified information to the Exchange regarding individuals who do not maintain minimum essential coverage, and would require the Exchange to conduct annual outreach and enrollment efforts with those individuals. The bill would require an applicable entity, as defined, that provides minimum essential coverage to an individual to file specified returns to the Franchise Tax Board regarding that coverage, as prescribed.

Until January 1, 2023, the bill would create Individual Market Assistance, which would be authorized to provide health care coverage financial assistance to California residents with household incomes at or below 600% of the federal poverty level, including advanced premium assistance subsidies. The bill would authorize a health care service plan or health insurer to cancel a contract or policy for nonpayment after a 3-month grace period if the individual receives that advanced premium assistance subsidy or advance payments of the federal premium tax credit, but would require a plan or insurer to provide health care coverage for the first month of the grace period and to return the subsidy and tax credit for the 2nd and 3rd months of the grace period if the outstanding premiums are not paid. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also expand the purposes of the California Health Trust Fund to include the Exchange's operational costs of the Minimum Essential Coverage Individual Mandate and Individual Market Assistance. By expanding the purposes of a continuously appropriated fund, the bill would make an appropriation.

(8) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes specified outpatient services, including, among others, chiropractic services and audiology services, subject to utilization controls. Notwithstanding this provision, existing law excludes certain optional Medi-Cal benefits, including, among others, audiology services and speech therapy services, podiatric

services, psychology services, and incontinence creams and washes, from coverage under the Medi-Cal program, except for specified beneficiaries. Existing law provides for the restoration of optometric and optician services, as described.

This bill would require the coverage of optometric and optician services to be suspended on December 31, 2021, unless specified circumstances apply. This bill would restore coverage of optional benefits for audiology services and speech therapy services, podiatric services, psychology services, and incontinence creams and washes no sooner than January 1, 2020, and would require these services to be suspended on December 31, 2021, unless specified circumstances apply.

(9) Existing law creates the California Health and Human Services Agency for the implementation and oversight of human services and health care programs.

This bill would, within the California Health and Human Services Agency, establish the Office of the Surgeon General to raise public awareness, coordinate policies, and advise policymakers on topics of health, including toxic stress and adverse childhood events. The bill would establish the Surgeon General as the director of the office, to be appointed by the Governor with the confirmation of the Senate for appointments after July 1, 2019.

(10) Existing law establishes the Office of AIDS in the State Department of Public Health. That office, among other functions, provides funding for AIDS prevention and education.

This bill would authorize the department, contingent upon a specific appropriation in the annual Budget Act, to award grant funding to specified entities on a competitive basis to provide comprehensive HIV prevention and control activities, as described.

(11) Existing law established a 3-year demonstration pilot project for the 2015–16 to 2018–19 fiscal years, inclusive, that required the State Department of Public Health to award funding, on a competitive basis, for innovative, evidence-based approaches to provide outreach, hepatitis C screening, and linkage to and retention in quality health care for the most vulnerable and underserved individuals living with, or at high risk for, hepatitis C viral infection (HCV).

This bill would, contingent upon a specific appropriation in the annual Budget Act, require the department to allocate funds to local health jurisdictions to provide HCV activities, including monitoring, prevention, testing, and linkage to and retention in care activities for

the most vulnerable and underserved individuals living with, or at high risk for, HCV.

(12) Existing law requires the State Department of Public Health to develop and review plans and participate in a program for the prevention and control of venereal disease.

This bill would also require the department, contingent upon a specific appropriation in the annual Budget Act, to allocate grants to local health jurisdictions for sexually transmitted disease control and prevention activities, as prescribed.

This bill would suspend the above programs as of December 31, 2021, unless projected General Fund revenues exceed the projected annual General Fund expenditures in the 2021–22 and 2022–23 fiscal years by a specified amount.

(13) Existing law authorizes the State Department of Public Health to establish, maintain, and subsidize clinics, dispensaries, and prophylactic stations for the diagnosis, treatment, and prevention of venereal disease, and authorizes the department to provide medical, advisory, financial, or other assistance to those clinics, dispensaries, and stations, as may be approved by the department.

The bill would delete this authority to establish, maintain, and subsidize clinics, dispensaries, and prophylactic stations and, instead, would authorize the department to provide medical, advisory, financial, or other assistance to organizations, funded by the sexually transmitted disease control and prevention program.

(14) Existing federal law, the PPACA, established annual limits on deductibles and defining bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, which provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime, and similar provisions of the Insurance Code, which provide for the regulation of health insurers by the Department of Insurance, prohibit the actuarial value for a nongrandfathered individual or small employer health plan or health insurance policy from varying by more than plus or minus 2%.

This bill would instead authorize the actuarial value for a nongrandfathered bronze level high deductible health plan or health insurance policy to range from plus 4% to minus 2%. Because a willful violation of the bill's requirements relative to health care service plans

would be a crime, the bill would impose a state-mandated local program.

(15) Existing law vests the State Department of State Hospitals with jurisdiction over state hospitals, and defines state hospital to include, among others, the Atascadero State Hospital, Napa State Hospital, and county jail treatment facilities under contract with the department to provide competency restoration services.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law provides that each inmate of a state penal or correctional institution is entitled to workers' compensation benefits for injury arising out of, and in the course of, assigned employment, and for the death of the inmate if the injury proximately causes the death. Existing law provides counsel to an inmate under the workers' compensation system for an appeal and generally provides that an employee who is an inmate, or their family on behalf of that inmate, is not entitled to compensation for psychiatric injury, except with respect to an injury sustained prior to incarceration. With respect to temporary disability payments, existing law requires the deposit of those payments into the Uninsured Employers Benefits Trust Fund, a continuously appropriated fund, for the payment of nonadministrative expenses of the workers' compensation program, if the inmate has no dependents.

This bill would similarly provide that each patient in a State Department of State Hospitals facility is entitled to workers' compensation benefits for injury arising out of, and in the course of, a vocational rehabilitation work assignment, and for the death of the patient if the injury proximately causes the death. The bill would provide counsel to a patient under the workers' compensation system for an appeal and provide that an employee who is a patient committed to a state hospital facility under the State Department of State Hospitals, or their family on behalf of the patient, is not entitled to compensation for psychiatric injury while working in a vocational rehabilitation program, except as specified with respect to an injury sustained prior to commitment. With respect to any temporary disability payments incurred prior to commitment under that provision, if the patient has no dependents, the bill would require the deposit of those payments into

the Uninsured Employers Benefits Trust Fund, a continuously appropriated fund, thereby making an appropriation.

(16) Subject to rules and regulations adopted by the State Department of State Hospitals, a hospital director is authorized to establish sheltered workshops at a state hospital to provide patients with remunerative work.

This bill would similarly authorize a hospital director to establish other vocational rehabilitation programs for state hospital patients, and would specify that patients who participate in a sheltered workshop or other vocational rehabilitation program under these provisions are not employees for purposes of state civil service, minimum wage, and contracts of employment.

(17) Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law imposes a managed care organization provider tax, which is administered by the State Department of Health Care Services, on licensed health care service plans, managed care plans contracted with the department to provide Medi-Cal services, and alternate health care service plans, as defined. Existing law terminates that tax on July 1, 2019.

This bill would declare the intent of the Legislature to enact a managed care organization provider tax in California. The bill would make collection of the tax and the associated revenue contingent upon receipt of approval from the federal Centers for Medicare and Medicaid Services.

(18) Existing law requires the Director of Health Care Services to develop and implement standards, for purposes of the Medi-Cal program, for the timely processing and payment of each claim type. Existing law authorizes the State Department of Health Care Services to enter into various contracts with fiscal intermediaries to provide claims processing services.

This bill would authorize the department to make a contingency payment, as part of the claims processing services, which is also referred to as the Medi-Cal Checkwrite Schedule, to an identified provider during an identified service period to ensure continued access to healthcare services, subject to approval of the Department of Finance. The bill would authorize the department to implement these provisions without taking regulatory action, and would require the department to implement these provisions only to the extent that necessary federal approvals are obtained and federal financial participation is not jeopardized.

(19) Existing law requires the State Department of Health Care Services to license and regulate alcoholism or drug abuse recovery or treatment facilities serving adults.

This bill would require the State Department of Health Care Services to seek federal approval, to the extent it deems necessary, to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for misuse of opioids and other illicit drugs. The bill would suspend implementation of these provisions on December 31, 2021, unless specified circumstances apply.

(20) Existing law authorizes the State Department of Health Care Services, among other things, to enter into contracts with certain drug manufacturers that provide for state rebates for purposes of the Medi-Cal program. Under existing law, the department is entitled to various drug rebates, including federal rebates in accordance with certain conditions, and drug manufacturers are required to calculate and pay interest on late or unpaid rebates.

This bill would establish the Medi-Cal Drug Rebate Fund in the State Treasury, and would provide that nonfederal moneys collected by the department and deposited into the account be continuously appropriated for purposes of funding the nonfederal share of health care services provided under the Medi-Cal program. The bill would authorize the Controller to use any money in the fund for cashflow loans to the General Fund, as specified. By establishing a continuously appropriated fund, the bill would make an appropriation.

(21) Existing law requires the State Department of Health Care Services to consult with the Medi-Cal Contract Drug Advisory Committee regarding contract drugs under the Medi-Cal program.

This bill would require the department to convene an advisory group to receive feedback on the changes, modifications, and operational timeframes regarding the implementation of pharmacy benefits offered in the Medi-Cal program.

(22) Existing law, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, or Proposition 56, which was approved by voters at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and allocates a specified percentage of those revenues to the department to increase funding for the Medi-Cal program, in a manner that, among other things, ensures timely access, limits specific

geographic shortages of services, or ensures quality care. Existing law establishes the Healthcare Treatment Fund for this purpose.

This bill would require the State Department of Health Care Services to develop value-based payment (VBP) programs that would require designated Medi-Cal managed care plans to make incentive payments to qualified network providers, aimed at improving behavioral health integration, prenatal and postpartum care, chronic disease management, and quality and outcomes for children, for the purpose of improving care for some of the most vulnerable or at-risk populations in the Medi-Cal managed care delivery system. The bill would require the department to implement the VBP programs for a period no shorter than 3 fiscal years, effective no earlier than July 1, 2019.

The bill would condition program implementation on receipt of any necessary federal approvals, availability of federal financial participation, and an appropriation of moneys to the department in the annual Budget Act from the Healthcare Treatment Fund in accordance with Proposition 56.

The bill would authorize the department to implement these provisions by means of plan letters or other similar instructions, and by entering into exclusive or nonexclusive contracts, or amending existing contracts, on a bid or negotiated basis.

(23) Existing law authorizes the State Department of Health Care Services, subject to federal approval, to create the Health Home Program (program) for enrollees with chronic conditions, as authorized under federal law.

Existing law creates the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds, to be expended, upon appropriation by the Legislature, for the purposes of implementing the program. Existing law appropriates $50,000,000 from the account to the department for the purposes of implementing the program. Under existing law, the appropriation is available for encumbrance or expenditure until June 30, 2020.

This bill would extend the availability of those funds for encumbrance or expenditure to June 30, 2024, and would also specify state administration as a component of the program implementation for which those funds may be expended, thereby making an appropriation.

(24) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state.

Statutory provisions establish procedures for making that reimbursement.

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

(25) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2019.~~

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

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

SECTION 1. Section 12803 of the Government Code is amended to read:

12803. (a) The California Health and Human Services Agency consists of the following departments: Aging; Community Services and Development; Developmental Services; Health Care Services; Managed Health Care; Public Health; Rehabilitation; Social Services; and State Hospitals.

(b) The agency also includes the Emergency Medical Services Authority, ~~the Managed Risk Medical Insurance Board,~~ the Office of Health Information Integrity, the Office of Patient Advocate, the Office of Statewide Health Planning and Development, the Office of Systems Integration, the Office of Law Enforcement Support, *the Office of the Surgeon General,* and the State Council on Developmental Disabilities.

(c) The Department of Child Support Services is hereby created within the agency ~~commencing January 1, 2000,~~ and ~~shall be~~ *is* the single organizational unit designated as the state's Title IV-D agency with the responsibility for administering the state plan and providing services relating to the establishment of paternity or the establishment, modification, or enforcement of child support obligations as required by Section 654 of Title 42 of the United States Code. State plan functions shall be performed by other agencies as required by law, by delegation of the department, or by cooperative agreements.

(d) This section shall become inoperative on July 1, 2020, and, as of January 1, 2021, is repealed.

SEC. 2. Section 12803 is added to the Government Code, to read:

12803. (a) The California Health and Human Services Agency consists of the California Department of Aging, the Department of Community Services and Development, the State Department of Developmental Services, the State Department of Health Care Services, the Department of Managed Health Care, the State Department of Public Health, the Department of Rehabilitation, the State Department of Social Services, the State Department of State Hospitals, and the Department of Youth and Community Restoration.

(b) The agency also includes the Emergency Medical Services Authority, the Office of Health Information Integrity, the Office of Patient Advocate, the Office of Statewide Health Planning and Development, the Office of Systems Integration, the Office of Law Enforcement Support, the Office of the Surgeon General, and the State Council on Developmental Disabilities.

(c) The agency also includes the Department of Child Support Services, which is the single organizational unit designated as the state's Title IV-D agency with the responsibility for administering the state plan and providing services relating to the establishment of paternity or the establishment, modification, or enforcement of child support obligations as required by Section 654 of Title 42 of the United States Code. State plan functions shall be performed by other agencies as required by law, by delegation of the department, or by cooperative agreements.

(d) This section shall become operative July 1, 2020.

SEC. 3. Section 100502 of the Government Code is amended to read:

100502. The board shall, at a minimum, do all of the following to implement Section 1311 of the federal act:

(a) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the United States Secretary of Health and Human Services, of health plans as qualified health plans. The board shall require health plans seeking certification as qualified health plans to do all of the following:

(1) Submit a justification for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their ~~Internet Web sites.~~ *internet websites.* The

board shall take this information, and the information and the recommendations provided to the board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

(2) (A) Make available to the public and submit to the board, the United States Secretary of Health and Human Services, and the Insurance Commissioner or the Department of Managed Health Care, as applicable, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under Title I of the federal act.

(ix) Other information as determined appropriate by the United States Secretary of Health and Human Services.

(B) The information required under subparagraph (A) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an ~~Internet Web site~~ *internet website* and through other means for individuals without access to the ~~Internet.~~ *internet.*

(b) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(c) Maintain an ~~Internet Web site~~ *internet website* through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(d) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the United States Secretary of Health and Human Services.

(e) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(f) Inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program.

(g) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of ~~1986 and~~ *1986,* any cost-sharing reduction under Section 1402 of the federal ~~act.~~ *act, and any state financial assistance under Title 25.*

(h) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that section because of either of the following:

(1) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(i) Transfer to the Secretary of the Treasury all of the following:

(1) A list of the individuals who are issued a certification under subdivision (h), including the name and taxpayer identification number of each individual.

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was

determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because of either of the following:

(A) The employer did not provide minimum essential coverage.

(B) The employer provided the minimum essential coverage but it was determined under subparagraph (C) of paragraph (2) of subsection (c) of Section 36B of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(3) The name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subsection (b) of Section 1411 of the federal act that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(j) Provide to each employer the name of each employee of the employer described in paragraph (2) of subdivision (i) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(k) Perform duties required of, or delegated to, the Exchange by the United States Secretary of Health and Human Services or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions.

(*l*) Establish the navigator program in accordance with subdivision (i) of Section 1311 of the federal act. Any entity chosen by the Exchange as a navigator shall do all of the following:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans.

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B of the Internal Revenue Code of ~~1986 and~~ *1986,* cost-sharing reductions under Section 1402 of the federal ~~act.~~ *act, and state financial assistance under Title 25.*

(3) Facilitate enrollment in qualified health plans.

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee

with a grievance, complaint, or question regarding ~~his or her~~ *the enrollee's* health plan, coverage, or a determination under that plan or coverage.

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(m) Establish the Small Business Health Options Program, separate from the activities of the board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market in a manner consistent with paragraph (2) of subdivision (a) of Section 1312 of the federal act.

SEC. 4. Section 100506 of the Government Code is amended to read:

100506. (a) The board shall establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal act concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations. ~~In no event shall the scope of those appeals be construed to be broader than the requirements of the federal act.~~ Once the federal regulations concerning appeals have been issued in final form by the United States Secretary of Health and Human Services, the board may establish additional requirements related to appeals, provided that the board determines, prior to adoption, that any additional requirement results in no cost to the General Fund and no increase in the charge imposed under subdivision (n) of Section 100503.

(b) The board shall not be required to provide an appeal if the subject of the appeal is within the jurisdiction of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and its implementing regulations, or within the jurisdiction of the Department of Insurance pursuant to the Insurance Code and its implementing regulations.

SEC. 5. Section 100506.1 of the Government Code is amended to read:

100506.1. An applicant or enrollee has the right to appeal any of the following:

(a) Any action or inaction related to the individual's eligibility for or enrollment in an insurance affordability program, or for advance payment of premium tax credits and cost-sharing reductions, or the amount of the advance payment of the premium tax credit and level of cost sharing, or eligibility for affordable plan ~~options.~~ *options, or eligibility for state financial assistance, or the amount of the advanced premium assistance subsidy.*

(b) An eligibility determination for an exemption from the individual responsibility penalty pursuant to Section 1311(d)(4)(H) of the federal ~~act.~~ *act or an eligibility determination for an exemption from the Minimum Essential Coverage Individual Mandate, as specified in Section 100715.*

(c) A failure to provide timely or adequate notice of an eligibility determination or redetermination or an enrollment-related determination.

SEC. 6. Section 100506.2 of the Government Code is amended to read:

100506.2. (a) The entity making an eligibility or enrollment determination described in Section 100506.1 shall provide notice of the appeals process at the time of application and at the time of eligibility or enrollment determination or redetermination.

(b) The entity making an eligibility or enrollment determination described in Section 100506.1 shall also issue a combined eligibility notice after the Director of Health Care Services determines in writing that the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) has been programmed for the implementation of this section, but no later than July 1, 2017. The combined eligibility notice shall contain all of the following:

(1) Information about eligibility or ineligibility for Medi-Cal, premium tax credits and cost-sharing reductions, *state financial assistance,* and, if applicable, for the Medi-Cal Access Program, for each individual, or multiple family members of a household, that has applied, including all of the following:

(A) An explanation of the action reflected in the notice, including the effective date of the action.

(B) Any factual bases upon which the decision is made.

(C) Citations to, or identification of, the legal authority supporting the action.

(D) Contact information for available customer service resources, including local legal aid and welfare rights offices.

(E) The effective date of eligibility and enrollment.

(2) Information regarding the bases of eligibility for non-modified adjusted gross income (MAGI) Medi-Cal and the benefits and services afforded to individuals eligible on those bases, sufficient to enable the individual to make an informed choice as to whether to appeal the eligibility determination or the date of enrollment, which may be included with the notice in a separate document.

(3) An explanation that the applicant or enrollee may appeal any action or inaction related to an individual's eligibility for or enrollment in an insurance affordability program *or state financial assistance* with which the applicant or enrollee is dissatisfied by requesting a state fair hearing consistent with this title and the provisions of Chapter 7 (commencing with Section 10950) of Part 2 of Division 9 of the Welfare and Institutions Code.

(4) Information on the applicant or enrollee's right to represent ~~himself or herself~~ *themselves* or to be represented by legal counsel or an authorized representative as provided in subdivision (f) of Section 100506.4.

(5) An explanation of the circumstances under which the applicant's or enrollee's eligibility shall be maintained or reinstated pending an appeal decision, pursuant to Section 100506.5.

(c) This section shall be implemented only to the extent it does not conflict with federal law.

SEC. 7. Section 100506.4 of the Government Code is amended to read:

100506.4. (a) (1) Except as provided in paragraph (2), the State Department of Social Services, acting as the appeals entity, shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of an eligibility or enrollment determination, or exemption determination within the Exchange's jurisdiction, unless there is good cause as provided in Section 10951 of the Welfare and Institutions Code.

(2) The appeals entity shall establish and maintain a process for an applicant or enrollee to request an expedited appeals process where there is immediate need for health services because a standard appeal could seriously jeopardize the appellant's life, health, or the ability to attain, maintain, or regain maximum

function. If an expedited appeal is granted, the decision shall be issued as expeditiously as possible, but no later than five working days after the hearing, unless the appellant agrees to a delay to submit additional documents for the appeals record. If an expedited appeal is denied, the appeals entity shall notify the appellant within three days by telephone or through other commonly available secure electronic means, to be followed by a notice in writing, within five working days of the denial of an expedited appeal. If an expedited appeal is denied, the appeal shall be handled through the standard appeal process.

(b) Appeal requests may be submitted to the appeals entity by telephone, by mail, in person, through the ~~Internet,~~ *internet,* through other commonly available electronic means, or by facsimile.

(c) The staff of the Exchange, the county, or the State Department of Health Care Services or its designee shall assist the applicant or enrollee in making the appeal request.

(d) (1) Upon receipt of an appeal, the appeals entity shall send timely acknowledgment to the appellant that the appeal has been received. The acknowledgment shall include information relating to the appellant's eligibility for benefits while the appeal is pending, an explanation that advance payments of the premium tax credit *and advanced premium assistance subsidy* while the appeal is pending may be subject to reconciliation if the appeal is unsuccessful, an explanation that the appellant may participate in informal resolution pursuant to subdivision (g), information regarding how to initiate informal resolution, and an explanation that the appellant shall have the opportunity to review ~~his or her~~ *the appellant's* entire eligibility file, including information on how an income determination was made and all papers, requests, documents, and relevant information in the possession of the entity that made the decision that is the subject of the appeal at any time from the date on which an appeal request is filed to the date on which the appeal decision is issued.

(2) Upon receipt of an appeal request, the appeals entity shall send, via secure electronic means, timely notice of the appeal to the Exchange and the county, and the State Department of Health Care Services or its designee if applicable.

(3) Upon receipt of the notice of appeal from the appeals entity, the entity that made the determination of eligibility or enrollment being appealed shall transmit, either as a hardcopy or electronically,

the appellant's eligibility and enrollment records for use in the adjudication of the appeal to the appeals entity.

(e) A member of the board, employee of the Exchange, a county, the State Department of Health Care Services or its designee, or the appeals entity shall not limit or interfere with an applicant's or enrollee's right to make an appeal or attempt to direct the individual's decisions regarding the appeal.

(f) An applicant or enrollee may be represented by counsel or designate an authorized representative to act on ~~his or her~~ *the applicant's or enrollee's* behalf, including, but not limited to, when making an appeal request and participating in the informal resolution process provided in subdivision (g).

(g) An applicant or enrollee who files an appeal shall have the opportunity for informal resolution, prior to a hearing, that conforms ~~with~~ *to* all of the following:

(1) A representative of the entity that made the eligibility or enrollment determination shall contact the appellant or the appellant's appropriately authorized representative and offer to discuss the determination with the appellant if ~~he or she~~ *the appellant* agrees.

(2) The appellant's right to a hearing shall be preserved if the appellant is dissatisfied with the outcome of the informal resolution process. The appellant or the authorized representative may withdraw the hearing request voluntarily or may agree to a conditional withdrawal that shall list the agreed-upon conditions that the appellant and the Exchange, county, or the State Department of Health Care Services or its designee shall meet.

(3) If the appeal advances to a hearing, the appellant shall not be required to provide duplicative information or documentation that ~~he or she~~ *the appellant* previously provided during the application, redetermination, enrollment, or informal resolution processes.

(4) The informal resolution process shall not delay the timeline for a provision of a hearing.

(5) The informal resolution process is voluntary and neither an appellant's participation nor nonparticipation in the informal resolution process shall affect the right to a hearing under this section.

(6) For eligibility or enrollment determinations for insurance affordability programs based on modified adjusted gross income

~~(MAGI),~~ *(MAGI) or state financial assistance under Title 25,* the appellant or the appellant's appropriately authorized representative may initiate the informal resolution process with the entity that made the determination, except that all of the following shall apply:

(A) The Exchange shall conduct informal resolution involving issues related only to the Exchange, including, but not limited to, exemption from the individual responsibility penalty pursuant to Section 1311(d)(4)(H) of the federal act, offers of affordable employer coverage, special enrollment periods, and eligibility for affordable plan options.

(B) Counties shall conduct informal resolution involving issues related to non-MAGI Medi-Cal eligibility or enrollment decisions.

(C) The State Department of Health Care Services or its designee shall conduct informal resolution involving issues related to eligibility or enrollment determinations for programs when the State Department of Health Care Services is the entity making the determination.

(7) The staff involved in the informal resolution process shall try to resolve the issue through a review of case documents, in person or through electronic means as desired by the appellant, and shall give the appellant the opportunity to review case documents, verify the accuracy of submitted documents, and submit updated information or provide further explanation of previously submitted documents.

(8) The informal resolution process set forth by the State Department of Social Services for Medi-Cal fair hearings shall be used for the informal resolutions pursuant to this subdivision and shall require the Exchange, county representative, or the State Department of Health Care Services or its designee to do the following:

(A) Review the file to determine the appropriateness of the action and whether a hearing is needed.

(B) Attempt to resolve the matter if the action was incorrect.

(C) Determine whether a dual agency appeal is required to resolve the matter at hearing and notice the other agency if not already included.

(D) Determine whether interpretation services are necessary and arrange for those services accordingly.

(E) Inform appellants of other agencies that may also be available to resolve the controversy.

(h) (1) A position statement, as required by Section 10952.5 of the Welfare and Institutions Code, shall be made available at least two working days before the hearing on the appeal. The position statement shall be made available electronically by the entity that determined eligibility if the entity has the capacity to send information electronically in a secure manner.

(2) The appeals entity shall send written notice, electronically or in hard copy, to the appellant of the date, time, and location of the hearing no later than 15 days prior to the date of the hearing. If the date, time, and location of the hearing are prohibitive of participation by the appellant, the appeals entity shall make reasonable efforts to set a reasonable, mutually convenient date, time, and location. The notice shall explain what format the hearing shall be held in, via telephone or video conference or in person, and include the right of the appellant to request that the hearing be held via telephone or video conference or in person. The notice shall include instructions for submitting the request on the notice, by telephone or through other commonly available electronic means.

(3) The hearing format may be held via telephone or video conference, unless the appellant requests the hearing be held in person pursuant to paragraph (2).

(4) The hearing shall be an evidentiary hearing where the appellant may present evidence, bring witnesses, establish all relevant facts and circumstances, and question or refute any testimony or evidence, including, but not limited to, the opportunity to confront and cross-examine adverse witnesses, if any.

(5) The hearing shall be conducted by one or more impartial officials who have not been directly involved in the eligibility or enrollment determination or any prior appeal decision in the same matter.

(6) The appellant shall have the opportunity to review ~~his or her~~ *the appellant's* appeal record, case file, and all documents to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing.

(7) Cases and evidence shall be reviewed de novo by the appeals entity.

(i) Decisions shall be made within 90 days from the date the appeal is filed and shall be based exclusively on the application of the applicable laws and eligibility and enrollment rules to the

information used to make the eligibility or enrollment decision, as well as any other information provided by the appellant during the course of the appeal. The content of the decision of appeal shall include a decision with a plain language description of the effect of the decision on the appellant's eligibility or enrollment, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision, which may be retroactive at the election of the appellant if the appellant is otherwise eligible.

(j) Upon adjudication of the appeal, the appeals entity shall transmit the decision of appeal to the entity that made the eligibility or enrollment determination via a secure electronic means.

(k) If an appellant disagrees with the decision of the appeals entity, ~~he or she~~ *the appellant* may make an appeal request regarding coverage in a qualified health plan through the Exchange to the federal Department of Health and Human Services within 30 days of the notice of decision through any of the methods in subdivision (b).

(*l*) An appellant may also seek judicial review to the extent provided by law. Appeal to the federal Department of Health and Human Services is not a prerequisite for seeking judicial review, nor shall seeking an appeal to the federal Department of Health and Human Services preclude a judicial review.

(m) Upon final exhaustion of administrative or judicial review, whichever is later, that affects the amount of advance payment of the premium tax credit or the amount of advanced premium assistance subsidy, or both, for a taxable year that has been reconciled previously, the appellant shall file an amended return for that taxable year to reconcile the advanced premium assistance subsidy pursuant to subdivision (a) of Section 100810.

~~(m)~~

(n) Nothing in this section, or in Sections 100506.1 and 100506.2, shall limit or reduce an appellant's rights to notice, hearing, and appeal under Medi-Cal, county indigent programs, or any other public programs.

~~(n)~~

(o) This section shall be implemented only to the extent it does not conflict with federal law.

SEC. 8. Section 100506.5 of the Government Code is amended to read:

100506.5. For appeals of redetermination of Exchange advance premium tax ~~credits or~~ *credits,* cost-sharing reductions, *or state financial assistance,* upon receipt of notice from the appeals entity that it has received an appeal, the entity that made the redetermination shall continue to consider the applicant or enrollee eligible for the same level of advance premium tax ~~credits or~~ *credits,* cost-sharing ~~reductions~~ *reductions, or state financial assistance* while the appeal is pending in accordance with the level of eligibility immediately before the redetermination being appealed.

SEC. 9. Section 100520 of the Government Code is amended to read:

100520. (a) The California Health Trust Fund is hereby created in the State Treasury for the purpose of this ~~title.~~ *title, Title 24 (commencing with Section 100700), and Title 25 (commencing with Section 100800).* Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this ~~title.~~ *title, Title 24 (commencing with Section 100700), and Title 25 (commencing with Section 100800).* Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other provision of law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

(c) The board of the California Health Benefit Exchange shall establish and maintain a prudent reserve in the fund.

(d) The board or staff of the Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) Effective January 1, 2016, if at the end of any fiscal year, the fund has unencumbered funds in an amount that equals or is more than the board approved operating budget of the Exchange for the next fiscal year, the board shall reduce the charges imposed

under subdivision (n) of Section 100503 during the following fiscal year in an amount that will reduce any surplus funds of the Exchange to an amount that is equal to the agency's operating budget for the next fiscal year.

(g) Notwithstanding subdivision (a), moneys in the fund shall not be used to fund the minimum essential coverage individual mandate pursuant to Title 24 (commencing with Section 100700) or the financial assistance program authorized pursuant to Title 25 (commencing with Section 100800), except for the Exchange's operational costs necessary to administer the individual mandate and financial assistance program.

(h) The Legislature finds and declares that the Exchange's operations of the programs in Title 24 (commencing with Section 100700) and Title 25 (commencing with Section 100800) are necessary and directly related to furthering the Exchange's purposes pursuant to this title and the federal act.

SEC. 10. Title 24 (commencing with Section 100700) is added to the Government Code, to read:

TITLE 24. MINIMUM ESSENTIAL COVERAGE INDIVIDUAL MANDATE

100700. The Legislature finds and declares all of the following:

(a) The individual mandate imposed by this title, and the penalty imposed by Part 32 (commencing with Section 61000) of the Revenue and Taxation Code, are necessary to protect the compelling state interests of:

(1) Protecting the health and welfare of the state's residents.

(2) Ensuring access to affordable health care coverage in this state.

(3) Ensuring a stable and well-functioning health insurance market in this state.

(b) There is compelling evidence that, without an effective mandate on individuals to secure health coverage, there would be substantial instability in health insurance markets, including higher prices and the possibility of areas without any insurance available.

(c) Ensuring the health of insurance markets is a responsibility reserved for states under the federal McCarran-Ferguson Act (15 U.S.C. Sec. 1011 et seq.) and other federal law.

100705. (a) For each month beginning on or after January 1, 2020, a California resident shall be enrolled in and maintain minimum essential coverage for that month, except as provided in subdivision (c).

(b) For each month beginning on or after January 1, 2020, a California resident shall ensure and maintain minimum essential coverage for any person who qualifies as that California resident's applicable spouse or applicable dependent, except as provided in subdivision (c).

(c) The following individuals shall be exempt, with respect to any month, from the requirements imposed by subdivisions (a) and (b):

(1) An individual who has in effect a certificate of exemption for hardship or religious conscience issued by the Exchange under Section 100715 for that month.

(2) An individual who is a member of a health care sharing ministry for that month. "Health care sharing ministry" has the same meaning as the term was defined in Section 5000A(d)(2)(B) of the Internal Revenue Code on January 1, 2017.

(3) An individual who is incarcerated for that month, other than incarceration pending the disposition of charges.

(4) An individual who is not a citizen or national of the United States and is not lawfully present in the United States for that month.

(5) An individual who is a member of an Indian tribe, as defined in Section 45A(c)(6) of the Internal Revenue Code of 1986, during that month.

(6) An individual for whom that month occurs during a period described in subparagraph (A) or (B) of Section 911(d)(1) of the Internal Revenue Code of 1986 that is applicable to the individual.

(7) An individual who is a bona fide resident of a possession of the United States, as determined under Section 937(a) of the Internal Revenue Code of 1986, for that month.

(8) An individual who is a bona fide resident of another state for that month.

(9) An individual who is enrolled in limited or restricted scope coverage under the Medi-Cal program or another health care coverage program administered by and determined to be substantially similar to limited or restricted scope coverage by the State Department of Health Care Services for that month.

(d) The requirements of subdivisions (a) and (b) shall be referred to as the Minimum Essential Coverage Individual Mandate.

(e) An Individual Shared Responsibility Penalty shall be imposed for failure to meet the requirement of the Minimum Essential Coverage Individual Mandate pursuant to Part 32 (commencing with Section 61000) of the Revenue and Taxation Code.

100710. For the purposes of this title, the following definitions shall apply:

(a) "Applicable dependent" means a dependent, with respect to an applicable individual, who meets all of the following criteria:

(1) The dependent is an applicable individual.

(2) The dependent is generally eligible for enrollment for health care coverage purposes, including, but not limited to, because of the applicable individual's employment status or status as the head of household, parent, spouse, or domestic partner.

(3) With respect to a given month, the dependent is not covered by other minimum essential coverage for that month.

(b) "Applicable individual" means, with respect to any month, an individual who is subject to the Minimum Essential Coverage Individual Mandate, pursuant to Section 100705.

(c) "Applicable spouse" means a spouse or domestic partner of an applicable individual who meets all of the following criteria:

(1) The spouse or domestic partner is an applicable individual.

(2) The spouse or domestic partner is generally eligible for enrollment for health care coverage purposes, including, but not limited to, because of the applicable individual's employment status or status as the head of household, parent, spouse, or domestic partner.

(3) With respect to a given month, the spouse or domestic partner is not covered by other minimum essential coverage for that month.

(4) The spouse or domestic partner files a joint return with the individual under Chapter 2 (commencing with Section 18501) of Part 10.2 of the Revenue and Taxation Code.

(d) "California resident" has the same meaning as in Section 17014 of the Revenue and Taxation Code.

(e) "Dependent" has the same meaning as in Section 17056 of the Revenue and Taxation Code.

(f) "Exchange" means the California Health Benefit Exchange, also known as Covered California, established pursuant to Title 22 (commencing with Section 100500).

(g) "Minimum essential coverage" has the same meaning as defined in Section 1345.5 of the Health and Safety Code.

100715. (a) The Exchange shall grant an exemption for reason of hardship from the Minimum Essential Coverage Individual Mandate established in Section 100705 for a given month upon determining that an individual has suffered a hardship with respect to the capability to obtain minimum essential coverage.

(b) The Exchange shall grant an exemption for reason of religious conscience from the Minimum Essential Coverage Individual Mandate established in Section 100705 for a given month upon determining that an individual for that month is either of the following:

(1) A member of a recognized religious sect or division thereof, as described in Section 1402(g)(1) of the Internal Revenue Code of 1986, and is an adherent of established tenets or teachings of that sect or division.

(2) A member of a religious sect or division thereof that is not described in Section 1402(g)(1) of the Internal Revenue Code of 1986, who relies solely on a religious method of healing, for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual, and who includes an attestation that the individual has not received medical health services during the preceding taxable year. For purposes of this paragraph, the term "medical health services" does not include routine dental, vision, and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and other services as the Secretary of United States Department of Health and Human Services may provide in implementing Section 1311(d)(4)(H) of the federal Patient Protection and Affordable Care Act. An individual who claims this exemption, but received medical health services during the coverage year, shall lose eligibility for the religious conscience exemption, is liable for the cost of the care, and is liable for the Individual Shared Responsibility Penalty.

(c) The Exchange shall establish a process for determining whether an individual is entitled to an exemption pursuant to subdivisions (a) and (b), issuing a certificate of exemption to an

individual, and notifying the individual and the Franchise Tax Board of the determination in a time and manner as the Exchange, in consultation with the Franchise Tax Board, determines is feasible and prompt. The Exchange may contract with a third party or another entity, including a state or federal agency, to administer this section.

100720. (a) The Exchange shall annually conduct outreach and enrollment efforts to individuals who did not indicate on their individual income tax returns that they and their dependents were enrolled in and maintained minimum essential coverage for the preceding taxable year or who indicated that they or their dependents were exempt from the Minimum Essential Coverage Individual Mandate for that year.

(b) For purposes of the efforts required by subdivision (a), the Franchise Tax Board shall provide the Exchange with individual income tax return information, as authorized by Section 19548.8 of the Revenue and Taxation Code, in a form and manner determined by the Franchise Tax Board, in consultation with the Exchange.

100725. (a) The Exchange may, in consultation with the Franchise Tax Board, promulgate rules and regulations to implement this title.

(b) The Franchise Tax Board may, in consultation with the Exchange, promulgate rules and regulations to implement this title to the extent that those regulations do not conflict with regulations promulgated by the Exchange pursuant to subdivision (a).

(c) Until January 1, 2022, any rules and regulations necessary to implement this title may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2). The adoption of emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, including subdivisions (e) and (h) of Section 11346.1, an emergency regulation adopted pursuant to this section shall be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the board pursuant to Chapter 3.5 (commencing with Section

11340) of Part 1 of Division 3 of Title 2 within five years of the initial adoption of the emergency regulation. An emergency regulation adopted pursuant to this section shall be discussed by the board during at least one properly noticed board meeting before the board meeting at which the board adopts the regulation. Notwithstanding subdivision (h) of Section 11346.1, until January 1, 2027, the Office of Administrative Law may approve more than two readoptions of an emergency regulation adopted pursuant to this section.

(d) It is the intent of the Legislature that, in construing this title, the regulations promulgated under Section 5000A of the Internal Revenue Code as of December 15, 2017, shall apply to the extent that those regulations do not conflict with this title or regulations promulgated pursuant to subdivision (a) or (b).

SEC. 11. Title 25 (commencing with Section 100800) is added to the Government Code, to read:

TITLE 25. INDIVIDUAL MARKET ASSISTANCE

100800. (a) The Exchange shall administer a program of financial assistance to help low-income and middle-income Californians access affordable health care coverage through the Exchange.

(b) The program may provide financial assistance to California residents with household incomes at or below 600 percent of the federal poverty level, and may provide other appropriate subsidies designed to make health care coverage more accessible and affordable for individuals and households.

(c) The Exchange shall adopt, and may amend, an annual program design for each coverage year to implement this section by resolution of the board of the Exchange. The resolution shall be adopted at a duly noticed meeting.

(1) A resolution adopted pursuant to this section shall not take effect until approved by the Director of Finance following 10 days notification in writing to the Joint Legislative Budget Committee.

(2) The requirements of paragraph (1) may be waived by the joint written consent of the Director of Finance and the Chair of the Joint Legislative Budget Committee to adopt a resolution that is deemed urgent. A resolution adopted pursuant to this paragraph shall take immediate effect.

(3) Until January 1, 2022, the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall not apply to the program design or a resolution adopted pursuant to this section.

(d) The program design adopted for a coverage year shall be based on funds appropriated to the program for that coverage year. An appropriation made for the program shall contain provisional language directing the Exchange to provide a certain proportion of the funds to specified income ranges as determined by the Legislature and may provide other parameters guiding the design of the program.

(e) The Exchange shall provide appropriate opportunities for stakeholders and the public to consult in the design of the program.

100805. (a) A premium assistance subsidy provided by the program shall be able to be advanced to program participants and shall be remitted by the Exchange to a qualified health plan issuer, based on the program participant's projected household income, family size, and other factors determined pursuant to the program design and subject to reconciliation against actual household income, family size, and other factors determined pursuant to the program design as provided in Section 100810.

(b) A premium assistance subsidy provided by the program shall be provided only to a California resident who is eligible for the federal premium tax credit authorized under Section 36B of the Internal Revenue Code, except that premium assistance subsidy shall not be subject to the income requirements of that section.

(c) Gross income, as defined in Section 17071 of the Revenue and Taxation Code, does not include an amount received as a premium assistance subsidy provided by the program.

100810. (a) A responsible individual shall reconcile premium assistance subsidies advanced pursuant to subdivision (a) of Section 100805 to the responsible individual or the responsible individual's dependents with the premium assistance subsidies allowed based on actual household income, family size, and other factors determined pursuant to the program design for a coverage year during which the responsible individual or the responsible individual's dependents received an advanced premium assistance subsidy, as follows:

(1) If a program participant's allowed premium assistance subsidies for the taxable year exceed the program participant's advanced premium assistance subsidies, the program participant may receive the excess as a premium assistance subsidy reconciliation refund. The Franchise Tax Board shall remit the refund to the program participant, less any taxes, fees, and penalties the program participant owes to the state. If a program participant is a dependent, the Franchise Tax Board shall remit the refund to the responsible individual, less any taxes, fees, and penalties the responsible individual or program participant owes to the state.

(2) If a program participant's advanced premium assistance subsidies for the taxable year exceed the program participant's allowed premium assistance subsidies, the program participant shall have a liability in the amount equal to the excess of the advanced premium assistance subsidies over the program participant's allowed premium assistance subsidies as a reconciliation liability, up to a limit specified by the program design. The program design may vary that limit based on household income.

(3) The responsible individual shall reconcile premium assistance subsidies in accordance with this section, and shall include the liability imposed by this section or the premium assistance subsidy reconciliation refund on a return filed pursuant to Chapter 2 (commencing with Section 18501) of Part 10.2 of the Revenue and Taxation Code for the taxable year.

(4) If a program participant with a liability imposed by this section is a dependent, the responsible individual shall be solely liable for that liability of the dependent.

(5) If a responsible individual with a liability imposed by this section files a joint return for the taxable year, the responsible individual and the spouse or domestic partner of the responsible individual shall be jointly and severally liable for that liability.

(6) Notwithstanding the return filing thresholds requirements in Chapter 2 (commencing with Section 18501) of Part 10.2 of the Revenue and Taxation Code, a responsible individual shall file a California income tax return with the Franchise Tax Board for the purpose of reconciliation as required under this section.

(b) The Franchise Tax Board's civil authority and procedures for purposes of compliance with notice and other due process

requirements imposed by law to collect income taxes shall be applicable to the collection of the premium assistance subsidy reconciliation liability due pursuant to subdivision (a). The amount due shall be paid upon notice and demand by the Franchise Tax Board and shall be assessed and collected pursuant to Part 10.2 (commencing with Section 18401) of the Revenue and Taxation Code.

(c) The Franchise Tax Board shall integrate enforcement of the liability imposed pursuant to subdivision (a) into existing activities, protocols, and procedures, including audits, enforcement actions, and taxpayer education efforts.

100815. For purposes of this title:

(a) "Coverage year" means a calendar year in which a program participant, or the program participant's spouse, domestic partner, or dependent, received financial assistance pursuant to this title.

(b) "Dependent" means a dependent, as defined in Section 17056 of the Revenue and Taxation Code

(c) "Exchange" means the California Health Benefit Exchange, also known as Covered California, established pursuant to Title 22 (commencing with Section 100500).

(d) "Family size" shall be defined in the program design adopted pursuant to Section 100800.

(e) "Federal poverty level" shall be defined in the program design adopted pursuant to Section 100800.

(f) "Household income" shall be defined in the program design adopted pursuant to Section 100800.

(g) "Modified adjusted gross income" shall be defined in the program design adopted pursuant to Section 100800.

(h) "Program" means Individual Market Assistance established pursuant to Section 100800.

(i) "Program participant" means an individual eligible to receive financial assistance pursuant to this title.

(j) "Qualified health plan" has the same meaning as defined in Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(k) "Responsible individual" means a program participant or an individual with a dependent who is a program participant. With

respect to a dependent, "responsible individual" means the individual who claims the dependent as a dependent.

(l) With respect to a program participant's household income or size:

(1) "Actual" means the household income or family size determined to have applied for the coverage year in accordance with the program design adopted pursuant to Section 100800.

(2) "Projected" means the household income or family size projected for the coverage year in accordance with the program design adopted pursuant to Section 100800.

100820. (a) The Exchange may, in consultation with the Franchise Tax Board, promulgate rules and regulations as necessary to implement this title that are consistent with the program design adopted pursuant to Section 100800.

(b) The Franchise Tax Board may, in consultation with the Exchange, adopt regulations that are necessary and appropriate to implement Section 100810 and that are consistent with the program design adopted pursuant to Section 100800 and regulations adopted by the Exchange pursuant to this section.

(c) Until January 1, 2022, the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall not apply to a regulation, standard, criterion, procedure, determination, rule, notice, guideline, or any other guidance established or issued by the Exchange or Franchise Tax Board pursuant to this title.

(d) In construing this title, the regulations promulgated by the Exchange under Title 10 of the California Code of Regulations shall apply to the extent that those regulations do not conflict with this title, the program design adopted pursuant to Section 100800, regulations promulgated by the Exchange pursuant to this section, and regulations promulgated by the Franchise Tax Board pursuant to this section.

(e) It is the intent of the Legislature that, in construing this Title, the regulations promulgated under Section 36B of the Internal Revenue Code as of January 1, 2019, shall apply to the extent that those regulations do not conflict with this title or regulations promulgated by the Exchange pursuant to subdivision (a) or Franchise Tax Board pursuant to subdivision (b).

100825. (a) This title shall not be construed to create an entitlement program of any kind, to appropriate any funds, to

require the Legislature to appropriate any funds, or to increase or decrease taxes owed by a taxpayer.

(b) (1) This title shall remain in effect only until January 1, 2023, and as of that date is repealed.

(2) New financial assistance or other subsidies shall not be provided for periods after coverage year 2022.

SEC. 12. Part 1.5 (commencing with Section 438) is added to Division 1 of the Health and Safety Code, to read:

PART 1.5. OFFICE OF THE SURGEON GENERAL

438. The Office of the Surgeon General is hereby established within the California Health and Human Services Agency. The office shall be responsible for all of the following:

(a) Raising public awareness on and coordinating policies governing scientific screening and treatment for toxic stress and adverse childhood events.

(b) Advising the Governor, the Secretary of the California Health and Human Services Agency, and policymakers on a comprehensive approach to address health issues and challenges, including toxic stress and adverse childhood events, as effectively and early as possible.

(c) Marshalling the insights and energy of medical professionals, scientists, and other academic experts, public health experts, public servants, and everyday Californians to solve our most pressing health challenges, including toxic stress and adverse childhood events.

439. (a) The Surgeon General shall be appointed by the Governor and shall be the director of the Office of the Surgeon General.

(b) On and after July 1, 2019, the appointment of the Surgeon General shall be subject to confirmation by the Senate.

(c) The salary of the Surgeon General shall be fixed in accordance with state law.

SEC. 13. Section 1272 of the Health and Safety Code is amended to read:

1272. (a) If a general acute care hospital or an acute psychiatric hospital submits a written application to the department's centralized applications unit, the department shall do both of the following:

(1) Complete its evaluation and approve or deny the application within 100 days of receiving it, including completing any activities pursuant to paragraph (2).

(2) Once the written application is approved, the district office of the department shall, within 30 business days from the date of approval, complete any additional review, including an onsite visit, if applicable, and submit its findings to the department. If the hospital's application is approved, the department shall add it to the hospital's license and issue a new or revised license on the 31st business day following approval of the written application.

(b) Notwithstanding subdivision (a), if a general acute care hospital or an acute psychiatric hospital submits a written application to expand a service that it currently provides and that is currently approved by the department, the department shall, within 30 business days of receipt of the completed application, approve the expansion, add it to the hospital license, and issue a revised license, unless the hospital is out of compliance with existing laws governing the service to be expanded. A service approved pursuant to this subdivision shall remain licensed for not more than 18 months, unless the department approves the license for a longer period. The department shall not be required to conduct an onsite inspection of the service to approve the expansion. This subdivision does not preclude the department from conducting an onsite inspection of a hospital at any time or denying an application in accordance with this subdivision.

(c) A general acute care hospital or an acute psychiatric hospital that receives a license to modify, add, or expand a service or program pursuant to this section shall comply with all laws related to that service or program.

(d) The department shall develop a centralized applications advice program to assist hospitals in identifying and completing the correct paperwork and other requirements necessary to modify, add, or expand a service or program.

(e) On or before December 31, 2019, the department shall develop an automated application system to process applications submitted pursuant to this section.

~~(f) The resources necessary to implement this section shall, upon appropriation by the Legislature, be made available from the Internal Departmental Quality Improvement Account, established pursuant to subdivision (f) of Section 1280.15.~~

SEC. 14. Section 1345.5 is added to the Health and Safety Code, to read:

1345.5. (a) "Minimum essential coverage" means any of the following:

(1) Coverage under any of the following government-sponsored programs:

(A) The Medicare program under Part A or Part C of Title XVIII of the federal Social Security Act.

(B) Full scope coverage under the Medi-Cal program, including the Medi-Cal Access Program and Medi-Cal for Pregnant Women, and other full scope health coverage programs administered and determined to be minimum essential coverage by the State Department of Health Care Services.

(C) The Medicaid program under Title XIX of the federal Social Security Act.

(D) The CHIP program under Title XXI of the federal Social Security Act or under a qualified CHIP look-alike program, as defined in Section 2107(g) of the federal Social Security Act.

(E) Medical coverage under Chapter 55 of Title 10 of the United States Code, including coverage under the TRICARE program.

(F) A health care program under Chapter 17 or Chapter 18 of Title 38 of the United States Code.

(G) A health plan under Section 2504(e) of Title 22 of the United States Code, relating to Peace Corps volunteers.

(H) The Nonappropriated Fund health benefits program of the Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(I) Refugee Medical Assistance, supported by the Administration for Children and Families, which is authorized under Section 412(e)(7)(A) of The Immigration and Nationality Act.

(J) A successor program to one of the above programs, as determined by the department or, pursuant to subparagraph (B), by the State Department of Health Care Services.

(2) The University of California Student Health Insurance Plan and the University of California Voluntary Dependent Plan.

(3) Coverage under an eligible employer-sponsored plan, including grandfathered plans and policies. "Eligible employer-sponsored plan" means a group health plan offered in connection with employment to an employee or related individuals, including a governmental plan within the meaning of Section

2791(d)(8) of the federal Public Health Service Act (42 U.S.C. Sec. 201 et seq.) or any other plan, group health care service plan contract, or group health insurance policy offered in the small or large group market within the state.

(4) Coverage under an individual health care service plan contract or individual health insurance policy, including grandfathered contracts and policies, or student health coverage that substantially meets all the requirements of Title I of the Affordable Care Act pertaining to nongrandfathered, individual health insurance coverage.

(5) Any other health benefits coverage similar in form and substance to the benefits described in this subdivision that is determined by the department to constitute minimum essential coverage pursuant to this section.

(b) "Minimum essential coverage" does not include health coverage as follows:

(1) Coverage of the following excepted benefits:

(A) Coverage only for accident or disability income insurance, or a combination of the two.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar health coverage, under which benefits for medical care are secondary or incidental to other health benefits.

(2) Coverage of the following excepted benefits, if offered separately:

(A) Limited scope dental or vision benefits, or benefits limited to any other single specialized area of health care.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits.

(3) Coverage of the following excepted benefits if offered as independent, noncoordinated benefits.

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Coverage of the following excepted benefits if offered as a separate contract for health care coverage:

(A) Medicare supplemental health insurance, as defined under Section 1395ss(g)(1) of Title 42 of the United States Code.

(B) Coverage supplemental to the coverage provided under Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, or the State Department of Health Care Services, may implement, interpret, or make specific this section by means of guidance or instructions, without taking regulatory action.

SEC. 15. Section 1365 of the Health and Safety Code is amended to read:

1365. (a) An enrollment or a subscription shall not be canceled or not renewed except for the following reasons:

(1) (A) ~~For~~ *Except as otherwise specified in subparagraph (C), for* nonpayment of the required premiums by the individual, employer, or contractholder if the individual, employer, or contractholder has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

(B) Pursuant to subparagraph (A), a health care service plan shall continue to provide coverage as required by the individual's, employer's, or contractholder's health care service plan contract during the *30-day* period described in subparagraph (A).

(C) (i) For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 36B of the Internal Revenue Code or advanced premium assistance subsidy authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

(ii) During the first month of the three-month grace period described in clause (i), a health care service plan shall continue to do both of the following:

(I) Collect advance payments of the federal premium tax credit or state advanced premium assistance subsidy, or both, on behalf of the enrollee.

(II) Provide coverage as required by the individual's health care service plan contract.

(iii) If the individual exhausts the three-month grace period described in clause (i) without paying all outstanding premiums due, the health care service plan shall return both of the following:

(I) Advance payments of the premium tax credit paid on behalf of the individual for the second and third months of the three-month grace period described in clause (i), pursuant to Section 156.270(e)(2) of Title 45 of the Code of Federal Regulations.

(II) The advanced premium assistance subsidy paid on behalf of the individual for the second and third months of the three-month grace period described in clause (i), pursuant to subdivision (a) of Section 100805 of the Government Code.

(iv) A health care service plan shall comply with all federal and state laws and regulations relating to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of the federal premium tax credit or state advanced premium assistance subsidy. For a health care service plan contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advanced premium assistance subsidy authorized by Section 100800 of the Government Code.

(2) The plan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract by the individual contractholder or employer.

(3) In the case of an individual health care service plan contract, the individual subscriber no longer resides, lives, or works in the plan's service area, but only if the coverage is terminated uniformly

without regard to any health status-related factor of covered individuals.

(4) In the case of a group health care service plan contract, violation of a material contract provision relating to employer contribution or group participation rates by the contractholder or employer.

(5) If the plan ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the individual or group market, or all markets, in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the individual or group contractholder or employer, and the enrollees covered under those contracts, at least 180 days prior to discontinuation of those contracts.

(B) Health benefit plans shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and, for that business of a plan that remains in force, any plan that ceases to offer for sale new health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(C) Except as authorized under subdivision (b) of Section 1357.09 and Section 1357.10, a plan that ceases to write new health benefit plans in the individual or group market, or all markets, in this state shall be prohibited from offering for sale health benefit plans in that market or markets in this state for a period of five years from the date of the discontinuation of the last coverage not so renewed.

(6) If the plan withdraws a health benefit plan from the market, provided that all of the following conditions are satisfied:

(A) The plan notifies all affected subscribers, contractholders, employers, and enrollees and the director at least 90 days prior to the discontinuation of the plan.

(B) The plan makes available to the individual or group contractholder or employer all health benefit plans that it makes available to new individual or group business, respectively.

(C) In exercising the option to discontinue a health benefit plan under this paragraph and in offering the option of coverage under subparagraph (B), the plan acts uniformly without regard to the claims experience of the individual or contractholder or employer,

or any health status-related factor relating to enrollees or potential enrollees.

(D) For small employer health care service plan contracts offered under Article 3.1 (commencing with Section 1357), the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12. This subparagraph shall not apply after December 31, 2013.

(7) In the case of a group health benefit plan, if an individual or employer ceases to be a member of a guaranteed association, as defined in subdivision (n) of Section 1357, but only if that coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any enrollee.

(b) (1) An enrollee or subscriber who alleges that an enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed may request a review by the director pursuant to Section 1368.

(2) If the director determines that a proper complaint exists, the director shall notify the plan and the enrollee or subscriber who requested the review.

(3) If, after review, the director determines that the cancellation, rescission, or failure to renew is contrary to existing law, the director shall order the plan to reinstate the enrollee or subscriber. Within 15 days after receipt of that order, the health care service plan shall request a hearing or reinstate the enrollee or subscriber.

(4) If an enrollee or subscriber requests a review of the health care service plan's determination to cancel or rescind or failure to renew the enrollee's or subscriber's health care service plan contract pursuant to this section, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the contract until a final determination of the enrollee's or subscriber's request for review has been made by the director. This paragraph shall not apply if the health care service plan cancels or does not renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a).

(5) A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation, rescission, or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation, rescission, or nonrenewal to and including

the date of reinstatement. The health care service plan shall reimburse the enrollee or subscriber for any expenses incurred pursuant to this paragraph within 30 days of receipt of the completed claim.

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and a health care service plan or a specialized health care service plan, including, but not limited to, the financial liability of the plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under those preexisting contracts to conform them to existing law.

(d) As used in this section, "health benefit plan" means any individual or group insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, or disability income coverage, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, dental or vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) On or before July 1, 2011, the director may issue guidance to health care service plans regarding compliance with this section and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall only be effective through December 31, 2013, or until the director adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first.

SEC. 16. Section 1367.0085 is added to the Health and Safety Code, to read:

1367.0085. Notwithstanding paragraph (1) of subdivision (b) of Section 1367.008 and paragraph (1) of subdivision (b) of Section 1367.009, the actuarial value for a nongrandfathered bronze level high deductible health plan, as defined in Section 223(c)(2) of Title

26 of the United States Code, may range from plus 4 percent to minus 2 percent.

SEC. 17. Section 1399.849 of the Health and Safety Code is amended to read:

1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A plan shall allow the subscriber of an individual health benefit plan to add a dependent to the subscriber's plan at the option of the subscriber, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) With respect to individual health benefit plans offered outside of the Exchange, a plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, annual enrollment periods for policy years beginning on or after January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from October 15, of the preceding calendar year, to January 15 of the benefit year, inclusive.

(2) With respect to individual health benefit plans offered through the Exchange, a plan shall provide an annual enrollment period for the policy years beginning on January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after

January 1, 2019, from November 1 to December 15 of the preceding calendar year, inclusive.

(3) With respect to individual health benefit plans offered through the Exchange, for policy years beginning on or after January 1, 2019, a plan shall provide a special enrollment period for all individuals selecting an individual health benefit plan through the Exchange from October 15 to October 31 of the preceding calendar year, inclusive, and from December 16, of the preceding calendar year, to January 15 of the benefit year, inclusive. An application for a health benefit plan submitted during these two special enrollment periods shall be treated the same as an application submitted during the annual open enrollment period. The effective date of coverage for plan selections made between October 15 and October 31, inclusive, shall be January 1 of the benefit year, and for plan selections made from December 16 to January 15, inclusive, shall be no later than February 1 of the benefit year.

(4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) ~~He or she or his or her~~ *The individual or the individual's* dependent loses minimum essential coverage. For purposes of this paragraph, the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in *Section 1345.5 or* subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay

premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 1389.7 and 1389.21.

(B) ~~He or she~~ *The individual* gains a dependent or becomes a dependent.

(C) ~~He or she~~ *The individual* is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) ~~He or she~~ *The individual* has been released from incarceration.

(E) ~~His or her~~ *The individual's* health coverage issuer substantially violated a material provision of the health coverage contract.

(F) ~~He or she~~ *The individual* gains access to new health benefit plans as a result of a permanent move.

(G) ~~He or she~~ *The individual* was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 of this code or Section 10965 of the Insurance Code, for one of the conditions described in subdivision (c) of Section 1373.96 of this code and that provider is no longer participating in the health benefit plan.

(H) ~~He or she~~ *The individual* demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that ~~he or she~~ *the individual* did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because ~~he or she~~ *the individual* was misinformed that ~~he or she~~ *the individual* was covered under minimum essential coverage.

(I) ~~He or she~~ *The individual* is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(J) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the

Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in paragraph (1) of subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, to December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in paragraph (1) of subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs

later, by December 15 of the preceding calendar year, coverage shall become effective on January 1 of the benefit year. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 to December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the plan receives the request for special enrollment.

(g) (1) A health care service plan shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (Public Law 78-410).

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an individual applicant or ~~his or her~~ *the applicant's* dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or ~~his or her~~ *the applicant's* dependent or any other source prior to enrollment of the individual.

(h) (1) A health care service plan shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and all enrollees in all nongrandfathered individual health benefit plans offered by that health care service plan in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside of the Exchange. Student health insurance coverage, as that coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health care service plan's single risk pool for individual coverage.

(2) Each calendar year, a health care service plan shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment program established for the state pursuant to Section 1343 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after that repeal or amendment.

SEC. 18. Section 120511 is added to the Health and Safety Code, to read:

120511. (a) The department shall allocate funds to local health jurisdictions for sexually transmitted disease prevention and control activities in accordance, to the extent possible, with the following:

(1) Local health jurisdictions shall be prioritized based on population and incidence of sexually transmitted diseases.

(2) Funds shall be allocated to prioritized local health jurisdictions in a manner that balances the need to spread funding to as many local health jurisdictions and community-based

organizations as possible and the need to provide meaningful activities to each recipient. No less than 50 percent of the funds allocated to local health jurisdictions shall be provided to community-based organizations for purposes consistent with this section, provided that there are community-based organizations in the jurisdiction that provide these activities.

(3) Each local health jurisdiction shall demonstrate to the department that the community-based organization recipient has done all of the following:

(A) Identified priority target populations.

(B) Satisfactorily described its outreach protocols.

(C) Included community resources for prevention and control activities.

(4) The department shall develop measures for each local health jurisdiction funded pursuant to this section to demonstrate accountability.

(b) In awarding funds pursuant to subdivision (a), the department shall authorize local health jurisdictions to include innovative and impactful prevention and control activities, including, but not limited to, the following:

(1) Voluntary screening for sexually transmitted diseases among inmates and wards of county adult and juvenile correctional facilities. The department may provide assistance or guidance to the local health jurisdiction if necessary to secure participation by other county agencies.

(2) Technology, telehealth, and digital platforms and applications to enhance immediate access to screening, testing, and treatment, as well as partner activities in order to speed activities and to reduce administrative costs.

(3) State-of-the-art testing modalities that ensure swift and accurate screening for, and diagnosis of, sexually transmitted diseases.

(4) Community-based testing and disease investigation.

(c) The department shall monitor activities in funded local health jurisdictions, based on the accountability measures required under paragraph (4) of subdivision (a), in order to assess the effectiveness of prevention and control activities efforts.

(d) It is the intent of the Legislature that the activities identified in this section are to enhance the activities that are already provided. Therefore, nothing in this section shall be construed to

require the department to replace existing activities with the activities provided for in subdivision (a) or to prevent the department from adding new activities as may be appropriate.

(e) This section shall be operative only if funds are explicitly appropriated in the annual Budget Act specifically for purposes of this section.

SEC. 19. Section 120512 is added to the Health and Safety Code, to read:

120512. Section 120511 shall be suspended on December 31, 2021. If the estimates of General Fund revenues and expenditures determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code, contain projected annual General Fund revenues that exceed projected annual General Fund revenues expenditures in the 2021–22 fiscal year and the 2022–23 fiscal year by the sum total of General Fund revenues appropriated for all programs suspended pursuant to the Budget Act of 2019 and all related trailer bill legislation implementing the provisions of the Budget Act of 2019, then the suspension shall not take effect. It is the intent of the Legislature to consider alternative solutions to restore this program, should the suspension take effect.

SEC. 20. Section 120525 of the Health and Safety Code is repealed.

~~120525. The department may establish, maintain, and subsidize clinics, dispensaries, and prophylactic stations for the diagnosis, treatment, and prevention of venereal diseases, and may provide medical, advisory, financial, or other assistance to the clinics, dispensaries, and stations as may be approved by it. No clinic, dispensary, or prophylactic station shall be approved unless it meets the requirements of the board and complies with its regulations.~~

SEC. 21. Section 120525 is added to the Health and Safety Code, to read:

120525. The department may provide medical, advisory, financial, or other assistance to organizations funded pursuant to Section 120511.

SEC. 22. Section 120780.5 is added to the Health and Safety Code, to read:

120780.5. (a) Upon an appropriation in the annual Budget Act, the State Department of Public Health shall award funding, on a competitive basis, to community-based organizations or local health jurisdictions to provide comprehensive HIV prevention and control activities for the most vulnerable and underserved individuals living with, or at high risk for, HIV infection. Applicants may include individual community-based organizations and local health jurisdictions, as well as collaborations between community-based organizations and local health jurisdictions.

(b) Entities located in any county are eligible to receive grant funding.

(c) Comprehensive HIV prevention and control activities may include, but are not limited to, any of the following:

(1) HIV testing, including the purchase of HIV test kits.

(2) Linkage to and retention in care for people living with HIV.

(3) Pre-exposure prophylaxis (PrEP)-related and post-exposure prophylaxis (PEP)-related activities.

(4) Syringe services programs.

(d) The department shall determine the funding levels of each award based on scope and geographic area. Priority for grants shall be given to community-based organizations or local health jurisdictions that, through their applications, demonstrate expertise, history, and credibility at working successfully in engaging the most vulnerable and underserved individuals living with, or at high risk for, HIV infection.

(e) Funds shall be allocated in a manner that balances the need to spread funding to as many local health jurisdictions and community-based organizations as possible and the need to provide meaningful activities to each recipient. Not less than 50 percent of the funds allocated shall be provided to community-based organizations, for purposes consistent with this section.

(f) The department shall determine the application process, selection criteria, and any reporting requirements for the grant, consistent with this section.

(g) The department shall develop measures for each local health jurisdiction and community-based organization funded pursuant to this section to demonstrate accountability.

(h) This section shall be operative only if funds are explicitly appropriated in the annual Budget Act specifically for purposes of this section.

SEC. 23. Section 120780.6 is added to the Health and Safety Code, to read:

120780.6. Section 120780.5 shall be suspended on December 31, 2021. If the estimates of General Fund revenues and expenditures determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code, contain projected annual General Fund revenues that exceed projected annual General Fund expenditures in the 2021–22 fiscal year and the 2022–23 fiscal year by the sum total of General Fund revenues appropriated for all programs suspended pursuant to the Budget Act of 2019 and all related trailer bill legislation implementing the provisions of the Budget Act of 2019, then the suspension shall not take effect. It is the intent of the Legislature to consider alternative solutions to restore this program, should the suspension take effect.

SEC. 24. Chapter 6.2 (commencing with Section 120973) is added to Part 4 of Division 105 of the Health and Safety Code, to read:

CHAPTER 6.2. HIV CARE PROGRAM

120973. The following definitions apply for purposes of this chapter:

(a) "ADAP" means the AIDS Drug Assistance Program.

(b) "HIV Care Program" means the CARE Services Program referenced in subparagraph (C) of paragraph (1) of subdivision (a) of Section 131051. Any reference to the CARE Services Program is deemed a reference to the HIV Care Program.

(c) The HIV Care Program provides primary medical care and support services pursuant to the federal Ryan White CARE Act (42 U.S.C. Sec. 300ff), and is administered by the Office of AIDS in the State Department of Public Health in accordance with Sections 131019 and 131051.

120973.5 The State Department of Public Health shall apply the same financial eligibility requirements for the purposes of administering the HIV Care Program as those set forth for the ADAP in Section 120960.

120974. This chapter shall become operative on April 1, 2020.

SEC. 25. Section 122440 is added to the Health and Safety Code, to read:

122440. (a) The State Department of Public Health shall allocate funds to local health jurisdictions to provide hepatitis C virus (HCV) activities, including, but not limited to, monitoring, prevention, testing, and linkage to and retention in care activities for the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

(b) Local health jurisdictions shall be prioritized based on factors that indicate a need for HCV monitoring, prevention, testing, and linkage to and retention in care activities.

(c) Funds shall be allocated to prioritized local health jurisdictions in a manner that balances the need to spread funding to as many local health jurisdictions and community-based organizations as possible and the need to provide meaningful activities to each recipient. No less than 50 percent of the funds allocated to local health jurisdictions shall be provided to community-based organizations for purposes consistent with this section, provided that there are community-based organizations in the jurisdiction that are able to provide these activities and demonstrate expertise, history, and credibility working successfully in engaging the most vulnerable and underserved individuals living with, or at high risk for, HCV infection.

(d) The department shall develop measures for each local health jurisdiction funded pursuant to this section to demonstrate accountability.

(e) This section shall not be construed to require the department to replace existing activities with the activities provided for in subdivision (a) or to prevent the department from adding new activities as appropriate.

(f) This section shall be operative only if funds are explicitly appropriated in the annual Budget Act specifically for purposes of this section.

SEC. 26. Section 122441 is added to the Health and Safety Code, to read:

122441. Section 122440 shall be suspended on December 31, 2021. If the estimates of General Fund revenues and expenditures determined pursuant to section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the

Government Code, contain projected annual General Fund revenues that exceed projected annual General Fund expenditures in the 2021–22 fiscal year and the 2022–23 fiscal year by the sum total of General Fund revenues appropriated for all programs suspended pursuant to the Budget Act of 2019 and all related trailer bill legislation implementing the provisions of the Budget Act of 2019, then the suspension shall not take effect. It is the intent of the Legislature to consider alternative solutions to restore this program, should the suspension take effect.

SEC. 27. Section 124130 of the Health and Safety Code is amended to read:

124130. (a) A laboratory that performs a blood lead analysis on a specimen of human blood drawn in California shall report the information specified in this section to the department for each analysis on every person tested.

(b) The analyzing laboratory shall report all of the following:

(1) The test results in micrograms of lead per deciliter.

(2) The name of the person tested.

(3) The person's birth date if the analyzing laboratory has that information, or if not, the person's age.

(4) The person's address, including the ZIP Code, if the analyzing laboratory has that information, or if not, a telephone number by which the person may be contacted.

(5) The name, address, and telephone number of the health care provider that ordered the analysis.

(6) The name, address, and telephone number of the analyzing laboratory.

(7) The accession number of the specimen.

(8) The date the analysis was performed.

(c) The analyzing laboratory shall report all of the following information that it possesses:

(1) The person's gender.

(2) The name, address, and telephone number of the person's employer, if any.

(3) The date the specimen was drawn.

(4) The source of the specimen, specified as venous, capillary, arterial, cord blood, or other.

(d) The analyzing laboratory may report to the department other information that directly relates to the blood lead analysis or to

the identity, location, medical management, or environmental management of the person tested.

(e) If the result of the blood lead analysis is a blood lead level equal to or greater than 10 micrograms of lead per deciliter of blood, the report required by this section shall be submitted within three working days of the analysis. If the result is less than 10 micrograms per deciliter, the report required by this section shall be submitted within 30 calendar days.

(f) A report required by this section shall be submitted by electronic transfer.

(g) All information reported pursuant to this section shall be confidential, as provided in Section 100330, except that the department may share the information for the purpose of surveillance, case management, investigation, environmental assessment, environmental remediation, or abatement with the local health department, environmental health agency authorized pursuant to Section 101275, or building ~~department.~~ *department, and with the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services. The Department of Health Care Services may further disclose the information to a managed health care plan in which a beneficiary who is the subject of the information is enrolled, who may further disclose this information to the beneficiary's health care provider to proactively offer and coordinate care and treatment services and administer payment programs.* The local health department, environmental health agency, or building department shall otherwise maintain the confidentiality of the information in the manner provided in Section 100330. *The State Department of Health Care Services shall use, disclose, and maintain the confidentiality of information shared with it pursuant to this subdivision in accordance with the federal Health Insurance Portability and Accountability Act of 1996, as may be amended, and pursuant to regulations promulgated thereto, and other laws applicable to information in possession of the State Department of Health Care Services. The Legislature finds and declares that under existing law this information is not subject to public disclosure.*

(h) The director may assess a fine up to five hundred dollars ($500) against any laboratory that knowingly fails to meet the reporting requirements of this section.

(i) A laboratory shall not be fined or otherwise penalized for failure to provide the patient's birth date, age, address, or telephone number if the result of the blood lead analysis is a blood lead level less than 25 micrograms of lead per deciliter of blood, and if all of the following circumstances exist:

(1) The test sample was sent to the laboratory by another medical care provider.

(2) The laboratory requested the information from the medical care provider who obtained the sample.

(3) The medical care provider that obtained the sample and sent it to the laboratory failed to provide the patient's birth date, age, address, or telephone number.

SEC. 28. Section 130062 of the Health and Safety Code is amended to read:

130062. (a) For the purposes of this section, the following terms have the following meanings:

(1) "Rebuild plan" means a plan to meet seismic standards primarily by constructing a new conforming SPC-5 building for use in lieu of an SPC-1 building.

(2) "Removal plan" means a plan to meet seismic standards primarily by removing acute care services or beds from the hospital's license.

(3) "Replacement plan" means a plan to meet seismic standards primarily by relocating acute care services or beds from nonconforming buildings into a conforming building.

(4) "Retrofit plan" means a plan to meet seismic standards primarily by modifying the building in a manner that brings the building up to SPC-2, SPC-4D, or SPC-5 standards.

(b) ~~All~~ *(1) Except as specified in paragraph (2), all* hospitals seeking an extension for their SPC-1 buildings shall submit to the office an application, in a manner acceptable to the office, by April 1, 2019.~~At~~

(2) If Providence Tarzana Medical Center in the City of Los Angeles or UCSF Benioff Children's Hospital in the City of Oakland seeks an extension for its SPC-1 buildings, it shall submit to the office an application, in a manner acceptable to the office, by September 1, 2019.

(3) At a minimum, ~~the~~ *an* application *described in paragraph (1) or (2)* shall state which of the seismic compliance methods described in subdivision (a) will be used for each SPC-1 building.

(c) A hospital owner that has been granted an extension pursuant to subdivision (g) of Section 130060 or subdivision (b) of Section 130061.5 may request, and the office shall grant, an additional extension of time as set forth in this section.

(d) (1) For a hospital that seeks an extension for compliance based on a replacement plan or retrofit plan, the owner shall submit a construction schedule, obtain a building permit, and begin construction by April 1, 2020.

(2) Using the construction schedule submitted pursuant to paragraph (1), the hospital and the office shall identify at least two major milestones relating to the compliance plan that will be used as the basis for determining whether the hospital is making adequate progress toward meeting the seismic compliance deadline.

(3) Failure to comply with the requirements described in paragraph (1) or (2), or to meet any milestone agreed to pursuant to paragraph (2), shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the requirements or milestones, respectively, are met.

(4) Final seismic compliance shall be achieved by July 1, 2022.

(e) (1) For a hospital that seeks an extension for compliance based on a rebuild plan, the office shall grant an extension of up to five years. The owner shall submit, in a manner acceptable to the office, no later than July 1, 2020, the rebuild plan, deemed ready for review, and shall submit a construction schedule, obtain a building permit, and begin construction no later than January 1, 2022.

(2) The hospital and the office shall identify at least two major milestones, agreed upon by the hospital and the office, that will be used as the basis for determining whether the hospital is making adequate progress toward meeting the seismic compliance deadline.

(3) Failure to comply with the requirements described in paragraph (1) or (4), or to meet any milestone agreed to pursuant to paragraph (2) or (4), shall result in the assessment of a fine of five thousand dollars ($5,000) per calendar day until the requirements or milestones, respectively, are met.

(4) For a hospital that has previously submitted to the office a rebuild project under construction, the office may accept

certification from the hospital that it has obtained appropriate building permits consistent with an approved incremental plan review and that construction thereunder has commenced and is continuing. The previously approved construction schedule shall be amended to reflect the extension being requested, and at least two new major milestones shall be identified. The owner shall not be required to resubmit construction plans previously submitted to the office, and the office may not impose new or different requirements for any increment already approved or building permit already issued by the office as a condition for granting an extension.

(5) Final seismic compliance shall be achieved, and a certificate of occupancy shall be obtained, by January 1, 2025.

(f) The office may grant an adjustment to the requirements described in paragraph (1) or (2) of subdivision (d) or paragraph (1) or (4) of subdivision (e), or the milestones agreed to pursuant to paragraph (2) of subdivision (d) or paragraph (2) or (4) of subdivision (e), as necessary to deal with contractor, labor, or material delays, or with acts of God, or with governmental entitlements, experienced by the hospital. If that adjustment is granted, the hospital shall submit a revised construction schedule, and the hospital and the office shall identify at least two new major milestones consistent with the adjustment. Failure to comply with the revised construction schedule or meet any of the major milestones shall result in penalties as specified in paragraph (3) of subdivision (d) and paragraph (3) of subdivision (e). The adjustment shall not exceed the corresponding final seismic compliance date specified in paragraph (4) of subdivision (d) or paragraph (5) of subdivision (e).

(g) The duration of an extension granted by the office pursuant to this section shall not exceed the maximums permitted by this section. Moreover, within that limit, the office shall not grant an extension that exceeds the amount of time needed by the owner to come into compliance. The determination by the office regarding the length of the extension to be granted shall be based upon a showing by the owner of the facts necessitating the additional time. It shall include a review of the plan and all the documentation submitted in the application for the extension, and shall permit only that additional time necessary to allow the owner to deal with

compliance plan issues that cannot be fully met without the extension.

(h) No extension shall be granted pursuant to this section for SPC-1 buildings unless the owner has submitted to the office, by January 1, 2018, a seismic compliance plan.

(i) An extension shall not be granted pursuant to this section for seismic compliance based upon a removal plan.

(j) ~~In~~ *(1) Except as specified in paragraph (2), in* lieu of the reporting requirements described in Section 130061, a hospital granted an extension pursuant to this section shall provide a quarterly status report to the office, with the first report due on July 1, 2019, and every October 1, January 1, April 1, and July 1 thereafter, until seismic compliance is achieved. ~~The~~

(2) In lieu of the reporting requirements described in Section 130061, if Providence Tarzana Medical Center in the City of Los Angeles or UCSF Benioff Children's Hospital in the City of Oakland is granted an extension pursuant to this section based on an application submitted on or after April 1, 2019, the first quarterly status report shall be due on October 1, 2019, and every January 1, April 1, July 1, and October 1 thereafter, until seismic compliance is achieved.

(3) The office shall post the status reports ~~on its Internet Web site.~~ *described in paragraphs (1) and (2) on its internet website.*

(k) Before June 1, 2019, the office shall provide the Legislature with an inventory of the SPC category of each hospital building. A report submitted to the Legislature pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(*l*) (1) The office may revoke an extension granted pursuant to this section for a hospital building where the assessment for a penalty exceeds 60 days.

(2) Notwithstanding any other law, any penalties assessed pursuant to this section shall be deposited into the General Fund within 45 days of assessment or within 45 days following a determination on appeal, if any. A hospital assessed a penalty pursuant to this section may appeal the assessment to the Hospital Building Safety Board, provided the hospital posts the funds for any penalties with the office, to be held pending the resolution of the appeal.

(3) The office shall not issue a construction final or certificate of occupancy for the building until all assessed penalties accrued pursuant to this section have been paid in full or, if an appeal is pending, have been posted subject to resolution of the appeal. Penalties deposited by the hospital pursuant to paragraph (2) shall be considered paid in full for purposes of issuing a construction final or certificate of occupancy. This paragraph is in addition to, and is not intended to supersede, any other requirements that must be met by the hospital for issuance of a construction final or certificate of occupancy.

(m) The office may promulgate emergency regulations as necessary to implement this section.

SEC. 29. Section 10112.296 is added to the Insurance Code, to read:

10112.296. Notwithstanding paragraph (1) of subdivision (b) of Section 10112.295 and paragraph (1) of subdivision (b) of Section 10112.297, the actuarial value for a nongrandfathered bronze level high deductible health insurance policy that is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 4 percent to minus 2 percent.

SEC. 30. Section 10273.6 of the Insurance Code is amended to read:

10273.6. All individual health benefit plans shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) (1) ~~For~~ *Except as otherwise specified in paragraph (3), for* nonpayment of the required premiums by the individual if the individual has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(3) For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 36B of the Internal Revenue Code or advanced premium assistance subsidy authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

(A) During the first month of the three-month grace period described in paragraph (3), an insurer shall continue to do both of the following:

(i) Collect advance payments of the federal premium tax credit or state advanced premium assistance subsidy, or both, on behalf of the insured.

(ii) Provide coverage as required by the individual's policy.

(B) If the individual exhausts the three-month grace period described in paragraph (3) without paying all outstanding premiums due, the insurer shall return both of the following:

(i) Advance payments of the premium tax credit paid on behalf of the individual for the second and third months of the three-month grace period described in paragraph (3), pursuant to Section 156.270(e)(2) of Title 45 of the Code of Federal Regulations.

(ii) The advanced premium assistance subsidy paid on behalf of the individual for the second and third months of the three-month grace period described in paragraph (3), pursuant to subdivision (a) of Section 100805 of the Government Code.

(C) An insurer shall comply with all federal and state laws and regulations relating to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of the federal premium tax credit or state advanced premium assistance subsidy. For a health insurance contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive premium assistance subsidy authorized by Section 100800 of the Government Code.

(b) The insurer demonstrates fraud or intentional misrepresentation of material fact under the terms of the policy by the individual.

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

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state, as long as the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days before discontinuation of that coverage.

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

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market, as long as the disability insurer notifies all affected individuals and the commissioner at least 90 days before the discontinuation of these plans, and the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(f) If coverage is made available in the individual market through a bona fide association, and the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if that coverage is terminated under this subdivision uniformly without regard to a health status-related factor of covered individuals.

SEC. 31. Section 10965.3 of the Insurance Code is amended to read:

10965.3. (a) (1) On and after October 1, 2013, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services. A health insurer shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer shall allow the policyholder of an individual health benefit plan to add a dependent to the policyholder's health benefit plan at the option of the policyholder, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) (1) With respect to individual health benefit plans offered outside of the Exchange, a health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive, annual enrollment periods for policy years beginning on or after January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from October 15 of the preceding calendar year, to January 15 of the benefit year, inclusive.

(2) With respect to individual health benefit plans offered through the Exchange, a health insurer shall provide an annual enrollment period for the policy years beginning on January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from November 1 to December 15 of the preceding calendar year, inclusive.

(3) With respect to individual health benefit plans offered through the Exchange, for policy years beginning on or after January 1, 2019, a health insurer shall provide a special enrollment

period for all individuals selecting an individual health benefit plan through the Exchange from October 15 to October 31 of the preceding calendar year, inclusive, and from December 16, of the preceding calendar year, to January 15 of the benefit year, inclusive. An application for a health benefit plan submitted during these two special enrollment periods shall be treated the same as an application submitted during the annual open enrollment period. The effective date of coverage for plan selections made between October 15 and October 31, inclusive, shall be January 1 of the benefit year, and for plan selections made from December 16 to January 15, inclusive, shall be no later than February 1 of the benefit year.

(4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a health insurer shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(A) ~~He or she or his or her~~ *The individual or the individual's* dependent loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(i) "Minimum essential coverage" has the same meaning as that term is defined in *Section 1345.5 of the Health and Safety Code or* subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 10119.2 and 10384.17.

(B) ~~He or she~~ *The individual* gains a dependent or becomes a dependent.

(C) ~~He or she~~ *The individual* is mandated to be covered as a dependent pursuant to a valid state or federal court order.

(D) ~~He or she~~ *The individual* has been released from incarceration.

(E) ~~His or her~~ *The individual's* health coverage issuer substantially violated a material provision of the health coverage contract.

(F) ~~He or she~~ *The individual* gains access to new health benefit plans as a result of a permanent move.

(G) ~~He or she~~ *The individual* was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 of this code or Section 1399.845 of the Health and Safety Code, for one of the conditions described in subdivision (a) of Section 10133.56 of this code and that provider is no longer participating in the health benefit plan.

(H) ~~He or she~~ *The individual* demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that ~~he or she~~ *the individual* did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because ~~he or she~~ *the individual* was misinformed that ~~he or she~~ *the individual* was covered under minimum essential coverage.

(I) ~~He or she~~ *The individual* is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

(J) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered

through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to an individual health benefit plan offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in paragraph (1) of subdivision (c), when the policyholder submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, to December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in paragraph (1) of subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15 of the preceding calendar year, coverage shall become effective on January 1 of the benefit year. When that

payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 to December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (Public Law 78-410).

(2) Notwithstanding subdivision (c) of Section 10291.5, a health insurer shall not require an individual applicant or ~~his or her~~ *the applicant's* dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health insurer shall not acquire or request information that relates to a health status-related factor from the applicant or ~~his or her~~ *the applicant's* dependent or any other source prior to enrollment of the individual.

(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds and enrollees who enroll in individual coverage through the Exchange and insureds and enrollees who enroll in individual coverage outside the Exchange. Student health insurance coverage, as such coverage is defined in Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.

(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment program established for the state pursuant to Section 1343 of PPACA and Exchange user fees, as described in subdivision (d) of Section 156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after the date of that repeal or amendment and individual health care benefit plans shall thereafter be subject to Sections 10901.2, 10951, and 10953.

SEC. 32. Section 3208.3 of the Labor Code is amended to read:

3208.3. (a) A psychiatric injury shall be compensable if it is a mental disorder which causes disability or need for medical treatment, and it is diagnosed pursuant to procedures promulgated under paragraph (4) of subdivision (j) of Section 139.2 or, until these procedures are promulgated, it is diagnosed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(b) (1) In order to establish that a psychiatric injury is compensable, an employee shall demonstrate by a preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury.

(2) Notwithstanding paragraph (1), in the case of employees whose injuries resulted from being a victim of a violent act or from direct exposure to a significant violent act, the employee shall be required to demonstrate by a preponderance of the evidence that actual events of employment were a substantial cause of the injury.

(3) For the purposes of this section, "substantial cause" means at least 35 to 40 percent of the causation from all sources combined.

(c) It is the intent of the Legislature in enacting this section to establish a new and higher threshold of compensability for psychiatric injury under this division.

(d) Notwithstanding any other provision of this division, no compensation shall be paid pursuant to this division for a psychiatric injury related to a claim against an employer unless the employee has been employed by that employer for at least six months. The six months of employment need not be continuous. This subdivision shall not apply if the psychiatric injury is caused by a sudden and extraordinary employment condition. Nothing in this subdivision shall be construed to authorize an employee, or ~~his or her~~ *the employee's* dependents, to bring an action at law or equity for damages against the employer for a psychiatric injury, where those rights would not exist pursuant to the exclusive remedy doctrine set forth in Section 3602 in the absence of the amendment of this section by the act adding this subdivision.

(e) Where the claim for compensation is filed after notice of termination of employment or layoff, including voluntary layoff, and the claim is for an injury occurring prior to the time of notice of termination or layoff, no compensation shall be paid unless the employee demonstrates by a preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury and one or more of the following conditions exist:

(1) Sudden and extraordinary events of employment were the cause of the injury.

(2) The employer has notice of the psychiatric injury under Chapter 2 (commencing with Section 5400) prior to the notice of termination or layoff.

(3) The employee's medical records existing prior to notice of termination or layoff contain evidence of treatment of the psychiatric injury.

(4) Upon a finding of sexual or racial harassment by any trier of fact, whether contractual, administrative, regulatory, or judicial.

(5) Evidence that the date of injury, as specified in Section 5411 or 5412, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.

(f) For purposes of this section, an employee provided notice pursuant to Sections 44948.5, 44949, 44951, 44955, 44955.6, 72411, 87740, and 87743 of the Education Code shall be considered to have been provided a notice of termination or layoff only upon a district's final decision not to reemploy that person.

(g) A notice of termination or layoff that is not followed within 60 days by that termination or layoff shall not be subject to the provisions of this subdivision, and this subdivision shall not apply until receipt of a later notice of termination or layoff. The issuance of frequent notices of termination or layoff to an employee shall be considered a bad faith personnel action and shall make this subdivision inapplicable to the employee.

(h) No compensation under this division shall be paid by an employer for a psychiatric injury if the injury was substantially caused by a lawful, nondiscriminatory, good faith personnel action. The burden of proof shall rest with the party asserting the issue.

(i) When a psychiatric injury claim is filed against an employer, and an application for adjudication of claim is filed by an employer or employee, the division shall provide the employer with information concerning psychiatric injury prevention programs.

(j) An employee who is an inmate, as defined in subdivision (e) of Section 3351, or ~~his or her~~ *their* family on behalf of an inmate, shall not be entitled to compensation for a psychiatric injury except as provided in subdivision (d) of Section 3370.

(k) An employee who is a patient, as defined in subdivision (h) of Section 3351, or their family on behalf of a patient, shall not be entitled to compensation for a psychiatric injury except as provided in subdivision (d) of Section 3370.1.

SEC. 33. Section 3351 of the Labor Code is amended to read:

3351. "Employee" means every person in the service of an employer under any appointment or contract of hire or

apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes:

(a) Aliens and minors.

(b) All elected and appointed paid public officers.

(c) All officers and members of boards of directors of quasi-public or private corporations while rendering actual service for the corporations for pay. An officer or member of a board of directors may elect to be excluded from coverage in accordance with paragraph (16), (18), or (19) of subdivision (a) of Section 3352.

(d) Except as provided in paragraph (8) of subdivision (a) of Section 3352, any person employed by the owner or occupant of a residential dwelling whose duties are incidental to the ownership, maintenance, or use of the dwelling, including the care and supervision of children, or whose duties are personal and not in the course of the trade, business, profession, or occupation of the owner or occupant.

(e) All persons incarcerated in a state penal or correctional institution while engaged in assigned work or employment as defined in paragraph (1) of subdivision (a) of Section 10021 of Title 8 of the California Code of Regulations, or engaged in work performed under contract.

(f) All working members of a partnership or limited liability company receiving wages irrespective of profits from the partnership or limited liability company. A general partner of a partnership or a managing member of a limited liability company may elect to be excluded from coverage in accordance with paragraph (17) of subdivision (a) of Section 3352.

(g) A person who holds the power to revoke a trust, with respect to shares of a private corporation held in trust or general partnership or limited liability company interests held in trust. To the extent that this person is deemed to be an employee described in subdivision (c) or (f), as applicable, the person may also elect to be excluded from coverage as described in subdivision (c) or (f), as applicable, if that person otherwise meets the criteria for exclusion, as described in Section 3352.

~~(h) This section shall become operative on July 1, 2018.~~

(h) A person committed to a state hospital facility under the State Department of State Hospitals, as defined in Section 4100 of the Welfare and Institutions Code, while engaged in and

assigned work in a vocation rehabilitation program, including a sheltered workshop.

SEC. 34. Section 3370.1 is added to the Labor Code, to read:

3370.1. (a) Each patient in a State Department of State Hospital facility shall be entitled to the workers' compensation benefits provided by this division for injury arising out of and in the course of a vocational rehabilitation program work assignment, including a sheltered workshop work assignment, and for the death of the patient if the injury proximately causes death, subject to all of the following conditions:

(1) The patient was not injured as the result of an assault in which the patient was the initial aggressor, or as the result of the intentional act of the patient injuring themselves.

(2) The patient shall not be entitled to any temporary disability indemnity benefits while committed in a state hospital facility or reincarcerated in a city or county jail or state penal or correctional institution.

(3) Benefits shall not be paid to a patient while the patient is committed in a state hospital facility. The period of benefit payment shall instead commence upon release from a state hospital. If a patient who has been released from a state hospital facility, and has been receiving benefits under this section, is recommitted to a state hospital facility, a jail-based competency treatment program, an Admission, Evaluation, and Stabilization (AES) Center, or any other program considered to be a facility of the State Department of State Hospitals under Section 4100 of the Welfare and Institutions Code, or if the patient is reincarcerated in a city or county jail or state penal or correctional institution, the benefits shall cease immediately upon the patient's recommitment or reincarceration and shall not be paid for the duration of the recommitment or reincarceration.

(4) This section shall not be construed to provide for the payment to a patient, upon release from a state hospital facility, a jail-based competency treatment program, an Admission, Evaluation, and Stabilization (AES) Center, or any other program considered to be a facility of the State Department of State Hospitals under Section 4100 of the Welfare and Institutions Code, or upon release from incarceration, of temporary disability benefits that were not paid due to the prohibition of paragraph (2).

(5) In determining temporary and permanent disability indemnity benefits for the patient, the average weekly earnings shall be taken at not more than the minimum amount set forth in Section 4453.

(6) If a dispute exists respecting a patient's rights to the workers' compensation benefits provided herein, the patient may file an application with the workers' compensation appeals board to resolve the dispute. The application may be filed at any time during the patient's commitment at a state hospital facility.

(7) After release or discharge from a state hospital facility, the former patient shall have one year in which to file an original application with the workers' compensation appeals board, unless the time of injury is such that it would allow more time under Section 5804.

(8) The percentage of disability to total disability shall be determined as for the occupation of a laborer of like age by applying the schedule for the determination of the percentages of permanent disabilities prepared and adopted by the administrative director.

(9) This division shall be the exclusive remedy against the state for injuries occurring while engaged in a vocational rehabilitation program. Nothing in this division shall affect any other right or remedy of an injured patient resulting from injuries not compensated by this division.

(b) The State Department of State Hospitals shall present to each patient worker, prior to their first vocational rehabilitation assignment, a printed statement of their rights under this division, and a description of procedures to be followed in filing for benefits under this section. The statement shall be approved by the Director of State Hospitals or their designee and shall be posted in various conspicuous locations where patients work or reside.

(c) Notwithstanding any other provision of this division, the State Department of State Hospitals shall provide medical care for its patients, which may include medical services at an outside facility.

(d) (1) Paragraphs (2), (3), and (4) of subdivision (a) shall also be applicable to a patient who would otherwise be entitled to receive workers' compensation benefits based on an injury sustained prior to their commitment to a state hospital facility. However, temporary and permanent disability benefits which,

except for this subdivision, would otherwise be payable to a patient based on an injury sustained prior to commitment to a state hospital facility, a jail-based competency treatment program, an Admission, Evaluation, and Stabilization (AES) Center, or any other program considered to be a facility of the State Department of State Hospitals under Section 4100 of the Welfare and Institutions Code, shall be paid to the dependents of the patient. If the patient has no dependents, the temporary disability benefits which, except for this subdivision, would otherwise be payable during the patient's commitment shall be paid to the State Treasury to the credit of the Uninsured Employers Benefits Trust Fund, and the permanent disability benefits that would otherwise be payable during the patient's commitment shall be held in trust for the patient by the State Department of State Hospitals during the period of commitment.

(2) For purposes of this subdivision, "dependents" means the patient's spouse or children, including a patient's former spouse due to divorce and the patient's children from that marriage.

(e) Notwithstanding any other provision of this division, a patient who is an employee, as defined in subdivision (h) of Section 3351, is eligible for supplemental job displacement benefits as defined in Section 4658.7.

SEC. 35. Section 3371.1 is added to the Labor Code, to read:

3371.1. If the issues are complex or if the patient applicant requests, the State Department of State Hospitals shall furnish a list of qualified workers' compensation attorneys to permit the patient applicant to choose an attorney to represent them before the workers' compensation appeals board.

SEC. 36. Section 17141.1 is added to the Revenue and Taxation Code, to read:

17141.1. Gross income does not include any amounts received as a premium assistance subsidy under Title 25 (commencing with Section 100800) of the Government Code.

SEC. 37. Section 19254 of the Revenue and Taxation Code is amended to read:

19254. (a) (1) If any person, other than an organization exempt from taxation under Section 23701, fails to pay any amount of tax, penalty, addition to tax, interest, or other liability imposed and delinquent under Part 10 (commencing with Section 17001), Part 11 (commencing with Section 23001), *Part 32 (commencing with*

Section 61000), Title 25 (commencing with Section 100800) of the Government Code, or this part, a collection cost recovery fee shall be imposed if the Franchise Tax Board has mailed notice to that person for payment that advises that continued failure to pay the amount due may result in collection action, including the imposition of a collection cost recovery fee. The collection cost recovery fee shall be in the amount of:

(A) In the case of an individual, partnership, limited liability company classified as a partnership for California income tax purposes, or fiduciary, eighty-eight dollars ($88) or an amount as adjusted under subdivision (b).

(B) In the case of a corporation or limited liability company classified as a corporation for California income tax purposes, one hundred sixty-six dollars ($166) or an amount as adjusted under subdivision (b).

(2) If any person, other than an organization exempt from taxation under Section 23701, fails or refuses to make and file a tax return required by Part 10 (commencing with Section 17001), Part 11 (commencing with Section 23001), or this part, within 25 days after formal legal demand to file the tax return is mailed to that person by the Franchise Tax Board, the Franchise Tax Board shall impose a filing enforcement cost recovery fee in the amount of:

(A) In the case of an individual, partnership, limited liability company classified as a partnership for California income tax purposes, or fiduciary, fifty-one dollars ($51) or an amount as adjusted under subdivision (b).

(B) In the case of a corporation or limited liability company classified as a corporation for California income tax purposes, one hundred nineteen dollars ($119) or an amount as adjusted under subdivision (b).

(b) For fees imposed under this section during the fiscal year 1993–94 and fiscal years thereafter, the amount of those fees shall be set to reflect actual costs and shall be specified in the annual Budget Act.

(c) Interest shall not accrue with respect to the cost recovery fees provided by this section.

(d) The amounts provided by this section are obligations imposed by this part and may be collected in any manner provided under this part for the collection of a tax.

(e) Subdivision (a) is operative with respect to the notices for payment or formal legal demands to file, either of which is mailed on or after September 15, 1992.

(f) The Franchise Tax Board shall determine the total amount of the cost recovery fees collected or accrued through June 30, 1993, and shall notify the Controller of that amount. The Controller shall transfer that amount to the Franchise Tax Board, and that amount is hereby appropriated to the board for the 1992–93 fiscal year for reimbursement of its collection and filing enforcement efforts.

SEC. 38. Section 19291 of the Revenue and Taxation Code is amended to read:

19291. (a) The Franchise Tax Board may enter into an agreement to collect any delinquent tax debt due to the Internal Revenue Service or any other state imposing an income tax or tax measured by income if, pursuant to Section 19377.5, the Internal Revenue Service or that state has entered into an agreement to collect delinquent tax debts due the Franchise Tax Board.

(b) Upon written notice to the debtor from the Franchise Tax Board, any amount referred to the Franchise Tax Board under subdivision (a) shall be treated as final and due and payable to the State of California, and shall be collected from the debtor by the Franchise Tax Board in any manner authorized under the law for collection of a delinquent income tax liability, including, but not limited to, the recording of a notice of state tax lien under Article 2 (commencing with Section 7170) of Chapter 14 of Division 7 of Title 1 of the Government Code, and the issuance of an order and levy under Article 4 (commencing with Section 706.070) of Chapter 5 of Division 2 of Title 9 of Part 2 of the Code of Civil Procedure in the manner provided for earnings withholding orders for taxes.

(c) Part 10 (commencing with Section 17001), this part, Part 10.7 (commencing with Section 21001), and Part 11 (commencing with Section 23001) shall apply to amounts referred under this section in the same manner and with the same force and effect and to the full extent as if the language of those laws had been incorporated in full into this section, except to the extent that any provision is either inconsistent with this section or is not relevant to this section.

(d) The activities required to implement and administer this section shall not interfere with the primary mission of the Franchise Tax Board to administer Part 10 (commencing with Section 17001) and Part 11 (commencing with Section 23001).

(e) In no event shall a collection under this section be construed as a payment of income taxes imposed under Part 10 (commencing with Section 17001) or Part 11 (commencing with Section ~~23001).~~ *23001), a penalty imposed under Part 32 (commencing with Section 61000), or a premium assistance subsidy under Title 25 (commencing with Section 100800) of the Government Code.*

SEC. 39. Section 19521 of the Revenue and Taxation Code is amended to read:

19521. (a) The rate established under this section (referred to in other code sections as "the adjusted annual rate") shall be determined in accordance with Section 6621 of the Internal Revenue Code, except that:

(1) (A) For taxpayers other than corporations, the overpayment rate specified in Section 6621(a)(1) of the Internal Revenue Code shall be modified to be equal to the underpayment rate determined under Section 6621(a)(2) of the Internal Revenue Code.

(B) In the case of any corporation, for purposes of determining interest on overpayments for periods beginning before July 1, 2002, the overpayment rate specified in Section 6621(a)(1) of the Internal Revenue Code shall be modified to be equal to the underpayment rate determined under Section 6621(a)(2) of the Internal Revenue Code.

(C) In the case of any corporation, for purposes of determining interest on overpayments for periods beginning on or after July 1, 2002, the overpayment rate specified in Section 6621(a)(1) of the Internal Revenue Code shall be modified to be the lesser of 5 percent or the bond equivalent rate of 13-week United States Treasury bills, determined as follows:

(i) The bond equivalent rate of 13-week United States Treasury bills established at the first auction held during the month of January shall be utilized in determining the appropriate rate for the following July 1 to December 31, inclusive. Any such rate shall be rounded to the nearest full percent (or, if a multiple of one-half of 1 percent, that rate shall be increased to the next highest full percent).

(ii) The bond equivalent rate of 13-week United States Treasury bills established at the first auction held during the month of July shall be utilized in determining the appropriate rate for the following January 1 to June 30, inclusive. Any such rate shall be rounded to the nearest full percent (or, if a multiple of one-half of 1 percent, that rate shall be increased to the next highest full percent).

(2) The determination specified in Section 6621(b) of the Internal Revenue Code shall be modified to be determined semiannually as follows:

(A) The rate for January shall apply during the following July through December, and

(B) The rate for July shall apply during the following January through June.

(b) (1) For purposes of this part, Part 10 (commencing with Section 17001), Part 11 (commencing with Section 23001), *Part 32 (commencing with Section 61000), Title 25 (commencing with Section 100800) of the Government Code*, and any other provision of law referencing this method of computation, in computing the amount of any interest required to be paid by the state or by the taxpayer, or any other amount determined by reference to that amount of interest, that interest and that amount shall be compounded daily.

(2) Paragraph (1) shall not apply for purposes of computing the amount of any addition to tax under Section 19136 or 19142.

(c) Section 6621(c) of the Internal Revenue Code, relating to increase in underpayment rate for large corporate underpayments, is modified as follows:

(1) The applicable date shall be the 30th day after the earlier of either of the following:

(A) The date on which the proposed deficiency assessment is issued.

(B) The date on which the notice and demand is sent.

(2) This subdivision shall apply for purposes of determining interest for periods after December 31, 1991.

(3) Section 6621(c)(2)(B)(iii) of the Internal Revenue Code shall apply for purposes of determining interest for periods after December 31, 1998.

(d) Section 6621(d) of the Internal Revenue Code, relating to the elimination of interest on overlapping periods of tax overpayments and underpayments, shall not apply.

SEC. 40. Section 19533 of the Revenue and Taxation Code is amended to read:

19533. (a) In the event the debtor has more than one debt being collected by the Franchise Tax Board and the amount collected by the Franchise Tax Board is insufficient to satisfy the total amount owing, the amount collected shall be applied in the following priority:

(1) Payment of any taxes, additions to tax, penalties, interest, fees, or other amounts due and payable under Part 7.5 (commencing with Section 13201), Part 10 (commencing with Section 17001), Part 11 (commencing with Section 23001), or this part, and amounts authorized to be collected under Section 19722.

(2) Payment of delinquencies collected under Section 10878.

(3) Payment of any amounts due that are referred for collection under Article 5.5 (commencing with Section 19280) of Chapter 5.

(4) Payment of any delinquencies referred for collection under Article 7 (commencing with Section 19291) of Chapter 5.

(5) Payment of any penalty due and payable under Part 32 (commencing with Section 61000).

(6) Payment of any advanced premium subsidies in excess of the program participant's allowed premium assistance subsidy under Title 25 (commencing with Section 100800) of the Government Code.

(b) Notwithstanding the payment priority established by this section, voluntary payments designated by the taxpayer as payment for a personal income tax liability or as a payment on amounts authorized to be collected under Section 19722, shall not be applied pursuant to this priority, but shall instead be applied as designated.

SEC. 41. Section 19548.8 is added to the Revenue and Taxation Code, to read:

19548.8. (a) (1) The Franchise Tax Board shall disclose to the California Health Benefit Exchange individual income tax return information described in paragraph (2) and other information related to the income tax return in the records of the Franchise Tax Board, through information sharing agreements

or data interfaces, for purposes of providing the notification required under Section 100720 of the Government Code.

(2) Individual income tax return information that may be disclosed to the California Health Benefit Exchange pursuant to this section is limited to the following information from the individual income tax return of a taxpayer who fails to report minimum essential coverage, as required by Section 100705 of the Government Code, or fails to reconcile the advanced premium assistance subsidy, as required by Section 100810 of the Government Code:

(A) Taxpayer name or, in the case of taxpayers filing a joint return, the names of both spouses or domestic partners.

(B) Full mailing address listed on the return.

(C) Number and age of household dependents.

(D) Gross income.

(E) Number of months the applicable individual, as defined in Section 61000, and the applicable individual's applicable spouse and applicable dependents, if any, as defined in Section 61000, were covered by minimum essential coverage.

(F) The amount of the penalty paid or owed by a taxpayer.

(G) Whether the taxpayer or any of the taxpayer's dependents claimed an exemption from the Minimum Essential Coverage Individual Mandate established pursuant to Title 24 (commencing with Section 100700) of the Government Code and the Individual Shared Responsibility Penalty assessed pursuant to Part 32 (commencing with Section 61000), and which exemption or exemptions were claimed.

(H) Whether the taxpayer reconciled the premium assistance subsidy advanced pursuant to Title 25 (commencing with Section 100800) of the Government Code with the premium assistance subsidy granted.

(b) The Franchise Tax Board may require reimbursement from the California Health Benefit Exchange for costs incurred in providing the information specified in this section.

SEC. 42. Part 32 (commencing with Section 61000) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 32. INDIVIDUAL SHARED RESPONSIBILITY PENALTY

61000. For the purposes of this part, the following definitions shall apply:

(a) "Applicable entity" means the following:

(1) A carrier licensed or otherwise authorized to offer health coverage with respect to minimum essential coverage, including coverage in a catastrophic plan, that is not described in paragraph (3) or (4).

(2) An employer or other sponsor of an employment-based health plan with respect to employment-based minimum essential coverage

(3) The State Department of Health Care Services and county welfare departments with respect to coverage under a state program.

(4) The Exchange with respect to individual health plans, except catastrophic plans, on the Exchange.

(5) Any other provider of minimum essential coverage, including the University of California with respect to coverage under a student health insurance program.

(b) "Applicable dependent" has the same meaning as defined in Section 100710 of the Government Code.

(c) "Applicable household income" means, with respect to a responsible individual for a taxable year, an amount equal to the sum of the modified adjusted gross income of all applicable household members who were required to file a tax return under Chapter 2 (commencing with Section 18501) of Part 10.2 for the taxable year.

(d) "Applicable household members" means, with respect to a responsible individual, all of the following persons:

(1) The responsible individual.

(2) The responsible individual's applicable spouse.

(3) The responsible individual's applicable dependents.

(e) "Applicable individual" has the same meaning as defined in Section 100710 of the Government Code.

(f) "Applicable spouse" has the same meaning as defined in Section 100710 of the Government Code.

(g) "Dependent" has the same meaning as defined in Section 17056 of the Revenue and Taxation Code.

(h) "Exchange" means the California Health Benefit Exchange, also known as Covered California, established pursuant to Title 22 (commencing with Section 100500).

(i) "Household size" means, with respect to a responsible individual, the number of applicable household members.

(j) "Modified adjusted gross income" means adjusted gross income, as defined in Section 17072, increased by both of the following:

(1) The amount of interest received or accrued by the individual during the taxable year that is exempt from tax, unless the interest is exempt from tax under the United States Constitution or the California Constitution.

(2) Foreign-earned income, foreign housing exclusion, or foreign housing deduction under Section 911 of the Internal Revenue Code.

(k) "Premium assistance" means the amount of credit allowable under Section 36B of the Internal Revenue Code of 1986 and any premium assistance subsidies administered pursuant to Title 25 (commencing with Section 100800) of the Government Code.

(l) "Qualified health plan" has the same meaning as defined in Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(m) (1) Except as provided in paragraphs (2) and (3), "responsible individual" means an applicable individual who is required to file a return under Chapter 2 (commencing with Section 18501) of Part 10.2 and who is either of the following:

(A) An applicable individual required to be enrolled in and maintain minimum essential coverage, pursuant to subdivision (a) of Section 100705 of the Government Code.

(B) An applicable individual required to ensure that a person who qualifies as the applicable individual's applicable spouse or applicable dependent is enrolled in and maintains minimum essential coverage for that month, pursuant to subdivision (b) of Section 100705 of the Government Code.

(2) If two applicable individuals file a joint return, only one shall be considered the responsible individual for purposes of calculating the penalty as determined by the Franchise Tax Board.

(3) If a dependent files a return, only the dependent or the individual claiming the dependent, but not both, shall be considered the responsible individual for purposes of calculating the penalty as determined by the Franchise Tax Board.

61005. (a) The Legislature finds and declares both of the following:

(1) The reporting requirement provided for in this section is necessary for the successful implementation of the penalty imposed by Section 61010. In particular, this requirement provides the only widespread source of third-party reporting to help applicable individuals and the Franchise Tax Board verify whether an applicable individual maintains minimum essential coverage. There is compelling evidence that third-party reporting is crucial for ensuring compliance with those tax provisions.

(2) The reporting requirement in this section has been narrowly tailored to support compliance with the penalty imposed by Section 61010, while imposing only an incidental burden on reporting entities. In particular, the information required to be reported under this section is limited to the information already required to be reported under a similar federal reporting requirement under Section 6055 of the Internal Revenue Code of 1986. In addition, this section provides that its reporting requirement may be satisfied by providing the same information that is currently reported under that federal requirement.

(b) For purposes of administering the penalty imposed by this part on applicable individuals who fail to maintain minimum essential coverage as required by Title 24 of the Government Code:

(1) An applicable entity that provides minimum essential coverage to an individual during a calendar year shall, at the time the Franchise Tax Board prescribes, make a return to the Franchise Tax Board in the form and manner described in subdivision (c) or (d) on or before March 31 of the year following the calendar year for which the return is required.

(2) An applicable entity described in paragraph (2) of subdivision (a) of Section 61000 shall not be required to make the return specified in paragraph (1) if the applicable entity that is described in paragraph (1) of subdivision (a) of Section 61000 makes that return.

(c) Except as provided in subdivision (d), an applicable entity shall make a return that complies with all of the following:

(1) Is in the form as the Franchise Tax Board prescribes.

(2) Contains the name, address, and taxpayer identification number of the applicable individual and the name and taxpayer identification number of each other individual who receives coverage under the policy.

(3) Contains the dates during which the individuals specified in paragraph (2) were covered under minimum essential coverage during the calendar year.

(4) Contains any other information as the Franchise Tax Board may require.

(d) Notwithstanding the requirements of subdivision (c), a return complies with the requirements of this section if it is in the form of, and includes the information contained in, a return described in Section 6055 of the Internal Revenue Code of 1986, as that section is in effect on December 15, 2017.

(e) Except as provided in subdivision (g), an applicable entity required to make a return under subdivision (b) shall provide to each primary subscriber, primary policyholder, primary insured, employee, former employee, uniformed services sponsor, parent, or other related person named on an application who enrolls one or more individuals, including themselves, in minimum essential coverage a written statement in the form and manner described in subdivision (f) on or before January 31 of the year following the calendar year for which the return is required under subdivision (b).

(f) The written statement required by subdivision (e) shall include both of the following:

(1) The name and address of the person required to make the return and the telephone number of the contact information for that person.

(2) The information required to be shown on the return, as specified in subdivision (c).

(g) Notwithstanding subdivisions (e) and (f), the requirements of this section may be satisfied by a written statement provided to an individual under Section 6055 of the Internal Revenue Code of 1986, as that section is in effect and interpreted on December 15, 2017.

(h) In the case of coverage provided by an applicable entity that is a governmental unit or an agency or instrumentality of that unit, the officer or employee who enters into the agreement to provide

the coverage, or the person appropriately designated for purposes of this section, shall be responsible for the returns and statements required by this section.

(i) An applicable entity may contract with third-party service providers, including insurance carriers, to provide the returns and statements required by this section.

(j) Except for the applicable entities described in paragraphs (3) and (4) of subdivision (a) of Section 61000, a penalty shall be imposed on an applicable entity that fails to make a return as required by subdivision (b) in an amount of fifty dollars ($50) per applicable individual covered by the applicable entity for a taxable year in which the failure occurs.

61010. (a) A penalty in the amount determined under Section 61015 shall be imposed on a responsible individual for a failure by the responsible individual, the applicable spouse, or an applicable dependent to enroll in and maintain minimum essential coverage pursuant to Section 100705 of the Government Code for one or more months, except as provided in Section 61020 and 61023. This penalty shall be referred to as the Individual Shared Responsibility Penalty.

(b) A penalty imposed by this section with respect to any month shall be included with a responsible individual's return under Chapter 2 (commencing with Section 18501) of Part 10.2 for the taxable year that includes that month.

(c) If an individual with respect to whom a penalty is imposed by this section for any month is a dependent of another individual for the other individual's taxable year, including that month, the other individual shall be solely liable for that penalty.

(d) If a responsible individual with respect to whom a penalty is imposed pursuant to this section for any month files a joint return for the taxable year, including that month, that responsible individual and the spouse or domestic partner of the individual shall be jointly and severally liable for the penalty imposed.

61015. (a) The amount of the Individual Shared Responsibility Penalty imposed on a responsible individual for a taxable year with respect to the failures described in Section 61010 shall be equal to the lesser of either of the following amounts:

(1) The sum of the monthly penalty amounts determined under subdivision (b) for months in the taxable year during which one or more of the failures described in Section 61010 occurred.

(2) An amount equal to one-twelfth of the state average premium for qualified health plans that have a bronze level of coverage for the applicable household size involved, and are offered through the Exchange for plan years beginning in the calendar year with or within which the taxable year ends, multiplied by the number of months in which a failure described in Section 61010 occurred.

(b) For purposes of subdivision (a), the monthly penalty amount with respect to a responsible individual for any month during which a failure described in Section 61010 occurred is an amount equal to one-twelfth of the greater of either of the following amounts:

(1) An amount equal to the lesser of either of the following:

(A) The sum of the applicable dollar amounts for all applicable household members who failed to enroll in and maintain minimum essential coverage pursuant to Section 100705 of the Government Code during the month, except as provided by Section 61023.

(B) Three hundred percent of the applicable dollar amount determined for the calendar year during which the taxable year ends.

(2) An amount equal to 2.5 percent of the excess of the responsible individual's applicable household income for the taxable year over the amount of gross income that would trigger the responsible individual's requirement to file a state income tax return under Section 18501, also referred to as the applicable filing threshold, for the taxable year.

(c) For purposes of subdivisions (a) and (b):

(1) Except as provided in paragraph (2) and subdivision (d), the applicable dollar amount is six hundred ninety-five dollars ($695).

(2) If an applicable individual has not attained 18 years of age as of the beginning of a month, the applicable dollar amount with respect to that individual for that month shall be equal to one-half of the applicable dollar amount as provided in paragraph (1) or subdivision (d).

(d) In the case of a calendar year beginning after 2019, the applicable dollar amount shall be equal to six hundred ninety-five dollars ($695) and increased as follows:

(1) An amount equal to six hundred ninety-five dollars ($695) multiplied by the cost-of-living adjustment determined pursuant to paragraph (2).

(2) A cost-of-living adjustment for a calendar year is an amount equal to the percentage by which the California Consumer Price Index for all items in the preceding calendar year exceeds the California Consumer Price Index for all items for the 2016 calendar year.

(3) If the amount of an increase under paragraph (1) is not a multiple of fifty dollars ($50), that increase shall be rounded down to the next multiple of fifty dollars ($50).

(4) No later than August 1 of each year, the Department of Industrial Relations shall annually transmit to the Franchise Tax Board the percentage change in the California Consumer Price Index for all items from June of the prior calendar year to June of the current calendar year, inclusive.

(e) For taxable years during which the Franchise Tax Board determines that a federal shared responsibility penalty applies, the Individual Shared Responsibility Penalty shall be reduced, but not below zero, by the amount of the federal penalty imposed on the responsible individual for each month of the taxable year during which the Individual Shared Responsibility Penalty is imposed.

61020. An Individual Shared Responsibility Penalty shall not be imposed on a responsible individual for a month in which any of the following circumstances apply:

(a) If the responsible individual's required contribution, determined on an annual basis, for coverage for the month exceeds 8.3 percent of that responsible individual's applicable household income for the taxable year.

(1) For purposes of applying this subdivision, an individual's applicable household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(2) For purposes of this subdivision, the term "required contribution" means either of the following:

(A) In the case of a responsible individual eligible to purchase minimum essential coverage consisting of coverage through an eligible employer-sponsored plan, the portion of the annual premium that would be paid by the responsible individual, without regard to whether paid through salary reduction or otherwise, for self-only coverage.

(B) In the case of a responsible individual eligible only to purchase minimum essential coverage in the individual market, the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the rating area in which the individual resides, reduced by any premium assistance for the taxable year determined as if the responsible individual was covered by a qualified health plan offered through the Exchange for the entire taxable year.

(3) For purposes of subparagraph (A) of paragraph (2), if a responsible individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under paragraph (1) shall be made by reference to the portion of the premium required to be paid by the employee for family coverage.

(4) In the case of plan years beginning in any calendar year after 2019, this subdivision shall be applied by substituting for "8.3 percent" an amount equal to 8 percent increased by the amount the United States Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for that period. If the United States Secretary of Health and Human Services fails to determine this percentage for a calendar year, the Exchange shall determine the percentage.

(b) If the responsible individual's applicable household income for the taxable year containing the month is less than the amount of adjusted gross income specified in paragraph (1) or (2) of subdivision (a) of Section 18501 for that taxable year.

(c) If the responsible individual's gross income for the taxable year containing the month is less than the amount specified in paragraph (3) of subdivision (a) of Section 18501.

61023. An Individual Shared Responsibility Penalty shall not be imposed with respect to an applicable household member for a month if the last day of the month occurred during a period in which the applicable household member did not maintain minimum essential coverage for a continuous period of three months or less.

(a) The length of a continuous period shall be determined without regard to the calendar years in which months in that period occur.

(b) If a continuous period is greater than the period allowed under this subdivision, an exception shall not be provided under this subdivision for any month in the period.

(c) If there is more than one continuous period described in this subdivision covering months in a calendar year, the exception provided by this subdivision shall only apply to months in the first of those periods.

(d) The Franchise Tax Board may prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than one taxable year.

61025. (a) The Franchise Tax Board's civil authority and procedures for purposes of compliance with notice and other due process requirements imposed by law to collect income taxes shall be applicable to the collection of the Individual Shared Responsibility Penalty.

(b) The Individual Shared Responsibility Penalty shall be paid upon notice and demand by the Franchise Tax Board, and shall be assessed and collected pursuant to Part 10.2 (commencing with Section 18401), except as follows:

(1) If an applicable individual fails to timely pay the Individual Shared Responsibility Penalty, the applicable individual shall not be subject to a criminal prosecution or penalty with respect to that failure.

(2) The Franchise Tax Board shall not file a notice of lien with respect to any real property of an applicable individual by reason of any failure to pay the Individual Shared Responsibility Penalty, or levy any real property with respect to that failure.

(3) For the purpose of collecting the Individual Shared Responsibility Penalty, Article 1 (commencing with Section 19201) of Chapter 5 of Part 10.2 shall not apply.

(c) The Franchise Tax Board shall integrate enforcement of the Individual Shared Responsibility Penalty into existing activities, protocols, and procedures, including audits, enforcement actions, and taxpayer education efforts.

61030. (a) The Franchise Tax Board may, in consultation with the Exchange, adopt regulations that are necessary and appropriate to implement this part.

(b) It is the intent of the Legislature that, in construing this part, the regulations promulgated by under Section 5000A of the Internal Revenue Code as of December 15, 2017, notwithstanding the

specified date in paragraph (1) of subdivision (a) of Section 17024.5, shall apply to the extent that those regulations do not conflict with this part or regulations promulgated by the Franchise Tax Board pursuant to subdivision (a) in consultation with the Exchange.

(c) Until January 1, 2022, the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall not apply to any standard, criterion, procedure, determination, rule, notice, guideline, or any other guidance established or issued by the Franchise Tax Board pursuant to this part.

61035. Moneys collected from the Individual Shared Responsibility Penalty shall be deposited into the General Fund.

61040. The provisions of this part are severable. If any provision of this part or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

61045. The Franchise Tax Board shall annually publish on its internet website all of the following information:

(a) The number of applicable households paying the penalty and the average penalty amount by applicable household income level.

(b) The number of applicable households paying the penalty in each county and statewide.

(c) The total penalty amount collected.

(d) The number and type of most commonly claimed exemptions.

(e) The number and total penalty amounts collected under subdivision (j) of Section 61005.

SEC. 43. Section 4316 of the Welfare and Institutions Code is amended to read:

4316. *(a)* Subject to rules and regulations adopted by the department, the hospital director may establish a sheltered workshop at a state hospital to provide patients with remunerative work performed in a setting which simulates that of industry and is performed in such a manner as to meet standards of industrial quality. The workshop shall be so operated as to provide the treatment staff with a realistic atmosphere for assessing patients' capabilities in work settings, and to provide opportunities to strengthen and expand patient interests and aptitudes.

(b) Notwithstanding any payment schedule approved by the department, state hospital patients who participate in sheltered workshops established under this section are not "employees" within the meaning of Sections 18526 and 18529 of the Government Code and Sections 1182.12, 1191.5, and 2750 of the Labor Code.

SEC. 44. Section 4317.5 is added to the Welfare and Institutions Code, to read:

4317.5. The hospital director, subject to rules and regulations adopted by the department, may in addition to establishing a sheltered workshop, provide other vocational rehabilitation programs for state hospital patients. Notwithstanding any payment schedule approved by the department, state hospital patients who participate in a vocational rehabilitation program established under this section are not "employees" within the meaning of Sections 18526 and 18529 of the Government Code and Sections 1182.12, 1191.5, and 2750 of the Labor Code.

SEC. 45. Section 7281.1 is added to the Welfare and Institutions Code, to read:

7281.1. A patient of an institution under the jurisdiction of the State Department of State Hospitals who participates in a sheltered workshop or vocational rehabilitation program shall not be required to return or remit any earnings received during the patient's participation to the institution for the cost of care, support, maintenance, and medical attention pursuant to Section 7281.

SEC. 46. Section 14021.37 is added to the Welfare and Institutions Code, to read:

14021.37. (a) The State Department of Health Care Services shall seek federal approval, to the extent it deems necessary, to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for misuse of opioids and other illicit drugs, in order to strengthen linkages and referral pathways between primary care and specialty substance use disorder treatment. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement,

interpret, or make specific this section by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking regulatory action.

(c) This section shall be suspended on December 31, 2021. If the estimates of General Fund revenues and expenditures determined pursuant to section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code, contain projected annual General Fund revenues that exceed projected annual General Fund expenditures in the 2021–22 fiscal year and the 2022–23 fiscal year by the sum total of General Fund appropriated for all programs suspended pursuant to the Budget Act of 2019 and all related trailer bill legislation implementing the provisions of the Budget Act of 2019, then the suspension shall not take effect. It is the intent of the Legislature to consider alternative solutions to restore this program, should the suspension take effect.

SEC. 47. Section 14104.36 is added to the Welfare and Institutions Code, to read:

14104.36. (a) The following definitions apply for purposes of this section:

(1) "Identified provider" means either a fee-for-service Medi-Cal provider or any other provider participating in a program administered by the department, in good standing, identified by the department for an identified service period.

(2) "Identified service period" means the service dates involving a Medi-Cal Checkwrite contingency as identified by the department.

(3) "Medi-Cal Checkwrite contingency" means any situation involving a delay, nonfunctionality, or system error in the Medi-Cal Checkwrite Schedule provider claims processing system as identified by the department.

(b) (1) Notwithstanding any other law, if there is a Medi-Cal Checkwrite contingency, the department may make a contingency payment to an identified provider during an identified service period to ensure continued access to healthcare services, subject to approval of the Department of Finance.

(2) The department shall calculate a contingency payment based upon the previous payment claims history of the identified provider as identified in departmental records.

(c) The department shall reconcile the contingency payment for an identified provider against the actual claims for service dates during the identified service period. The department shall subsequently make payment adjustments to the identified provider in accordance with the departmental standards for provider claims processing.

(d) Any provider grievance or complaint arising from either a contingency payment or the reconciliation of a contingency payment shall be governed by Section 14104.5.

(e) This section does not alter the amount of reimbursement due to an identified provider for eligible claims or otherwise change any billing requirement or condition of program participation for a provider subject to this section.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by provider manual, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

(g) The department shall seek any necessary approvals from the federal Centers for Medicare and Medicaid Services to implement this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations, and only to the extent that the necessary approvals are obtained and federal financial participation is not jeopardized.

SEC. 48. Section 14105.36 is added to the Welfare and Institutions Code, to read:

14105.36. (a) (1) The Medi-Cal Drug Rebate Fund is hereby created in the State Treasury.

(2) Nonfederal moneys collected by the department pursuant to Sections 14105.33, 14105.332, 14105.436 and 14105.86 and Section 1396r-8 of Title 42 of the United States Code, as part of the state's share of state and federal supplemental Medi-Cal drug rebates, shall be deposited in the Medi-Cal Drug Rebate Fund.

(b) Notwithstanding Section 13340 of the Government Code, the funds deposited in the Medi-Cal Drug Rebate Fund shall be continuously appropriated, without regard to fiscal year, to the department for purposes of funding the nonfederal share of health care services for children, adults, seniors, and persons with disabilities enrolled in the Medi-Cal program.

(c) Notwithstanding Section 16305.7 of the Government Code, the Medi-Cal Drug Rebate Fund shall contain all interest and dividends earned on moneys in the fund and shall be used only for the purpose identified in subdivision (b).

(d) Notwithstanding any other law, the Controller may use the funds in the Medi-Cal Drug Rebate Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

SEC. 49. Section 14131.10 of the Welfare and Institutions Code is amended to read:

14131.10. (a) Notwithstanding any other provision of this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591), in order to implement changes in the level of funding for health care services, specific optional benefits are excluded from coverage under the Medi-Cal program.

(b) (1) The following optional benefits are excluded from coverage under the Medi-Cal program:

(A) Adult dental services, except as specified in paragraph (2).

(i) This exclusion shall be in effect only through December 31, 2017, and adult dental services shall be covered under the Medi-Cal program as of January 1, 2018, or the effective date of any necessary federal approvals, whichever is later.

(ii) The restoration of adult dental services pursuant to clause (i) shall be effective only to the extent any necessary federal approvals are obtained as required by subdivision (f).

(B) Audiology services and speech therapy services.

(C) Chiropractic services.

(D) Optometric and optician services, including services provided by a fabricating optical laboratory, except as provided in subdivision (g).

(E) Podiatric services.

~~(F) Psychology services.~~

~~(G)~~

(F) Incontinence creams and washes.

(2) (A) Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state, are covered.

(B) Emergency procedures are also covered in the categories of service specified in subparagraph (A). The director may adopt regulations for any of the services specified in subparagraph (A).

(C) Effective May 1, 2014, or the effective date of any necessary federal approvals as required by subdivision (f), whichever is later, for persons 21 years of age or older, adult dental benefits, subject to utilization controls, are limited to all the following medically necessary services:

(i) Examinations, radiographs/photographic images, prophylaxis, and fluoride treatments.

(ii) Amalgam and composite restorations.

(iii) Stainless steel, resin, and resin window crowns.

(iv) Anterior root canal therapy.

(v) Complete dentures, including immediate dentures.

(vi) Complete denture adjustments, repairs, and relines.

(D) Services specified in this paragraph shall be included as a covered medical benefit under the Medi-Cal program pursuant to Section 14132.89.

(3) Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy are not excluded from coverage under this section.

(c) The optional benefit exclusions do not apply to either of the following:

(1) Beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program.

(2) Beneficiaries receiving long-term care in a nursing facility that is both:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c) and (d) of Section 1250 of the Health and Safety Code.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(d) This section shall only be implemented to the extent permitted by federal law.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the provisions of this section by means of all-county letters, provider bulletins, or similar instructions, without taking further regulatory action.

(f) This section shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

(g) (1) Effective no sooner than January 1, 2020, or January 1 of the subsequent calendar year following the legislative action pursuant to paragraph (2), whichever is later, and subject to paragraph (2) and subdivision (f), optometric and optician services, including services provided by a fabricating optical laboratory, shall be covered benefits under the Medi-Cal program.

(2) The restoration of optometric and optician services pursuant to this subdivision is contingent upon the Legislature including funding for these services in the state budget process.

(3) The optional benefits covered under the Medi-Cal program in this subdivision shall be suspended on December 31, 2021, unless the condition of paragraph (4) applies.

(4) The optional benefits covered under the Medi-Cal program pursuant to this subdivision shall not be suspended pursuant to paragraph (3) if the estimates of General Fund revenues and expenditures for the 2021–22 and 2022–23 fiscal years, as determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code contain estimated annual General Fund revenues that exceed estimated annual General Fund expenditures for the 2021–22 and 2022–23 fiscal years, by an amount equal to or greater than the sum total of all General Fund appropriations for all programs subject to suspension pursuant to the 2019 Budget Act and all bills providing for appropriations related to that act.

(5) It is the intent of the Legislature to consider alternative solutions to restore these optional benefits if the suspension takes effect.

(h) (1) Effective no sooner than January 1, 2020, the following optional benefits, shall be covered benefits under the Medi-Cal program.

(A) Audiology services and speech therapy services.

(B) Podiatric services.

(C) Incontinence creams and washes.

(2) The optional benefits covered under the Medi-Cal program in this subdivision shall be suspended on December 31, 2021, unless the condition of paragraph (3) applies.

(3) The optional benefits covered under the Medi-Cal program pursuant to this subdivision shall not be suspended pursuant to paragraph (2) if the estimates of General Fund revenues and expenditures for the 2021–22 and 2022–23 fiscal years, as determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code contain estimated annual General Fund revenues that exceed estimated annual General Fund expenditures for the 2021–22 and 2022–23 fiscal years, by an amount equal to or greater than the sum total of all General Fund appropriations for all programs subject to suspension pursuant to the 2019 Budget Act and all bills providing for appropriations related to that act.

(4) It is the intent of the Legislature to consider alternative solutions to restore these optional benefits if the suspension takes effect.

SEC. 50. Article 5.8 (commencing with Section 14188) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.8. Value-Based Incentives in Medi-Cal Managed Care

14188. (a) The Legislature finds and declares both of the following:

(1) Value-based payment (VBP) strategies offer financial incentives to health care providers that improve their performance on predetermined measures or meet specified targets that focus on quality and efficiency of care.

(2) Funding pursuant to the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, or Proposition 56, which was approved by voters at the November 8, 2016, statewide general election, is intended, in part, to supplement payments to Medi-Cal providers to ensure quality care in the Medi-Cal program.

(b) In accordance with Proposition 56 and subject to an appropriation by the Legislature, Proposition 56 funding may be used, pursuant to Section 14188.2, for directed payment programs in Medi-Cal managed care, including VBPs required of Medi-Cal managed care plans as designated by the department and as described in this article. The purpose of the VBPs shall be to help

improve care for some of the most vulnerable or at-risk populations in the Medi-Cal managed care delivery system.

(c) Effective no earlier than July 1, 2019, and for a period no shorter than three fiscal years, the department shall implement the VBP programs described in Section 14188.1, only to the extent that federal financial participation is available and that any necessary federal approvals have been obtained. The department shall develop the structure and parameters of the VBP programs, including designation of those Medi-Cal managed care plans that are required to participate in VBP programs. The department may modify the VBP programs to the extent it deems necessary to obtain or maintain federal approval, if needed to target spending in a manner that furthers the purpose of the programs, or based on evaluation of the programs.

(d) (1) The department shall require the designated Medi-Cal managed care plans to make VBPs to network providers that meet the requirements of the VBP programs implemented pursuant to Section 14188.1, in the amounts, form, and manner as directed by the department.

(2) The department shall not require a county mental health plan contracted with the department pursuant to Chapter 8.9 (commencing with Section 14700), or a county Drug Medi-Cal organized delivery system authorized in the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver as applicable, to participate in any VBP program described in Section 14188.1.

(3) VBPs made pursuant to this article shall be in addition to any other payments made by the designated Medi-Cal managed care plans to applicable network providers for services or other performance-based incentives.

(e) For purposes of this article, "VBP" means value-based payment.

14188.1. Subject to Section 14188, the department shall develop all of the following VBP programs:

(a) A VBP program that is aimed at improving behavioral health integration in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that adopt a

team-based care approach for individuals with serious mental health conditions or other chronic health conditions.

(2) Qualified network providers may be eligible for different levels of incentive payments, depending on the level of integration, using either a coordination or collocation approach. The qualified network providers may be eligible for partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(b) A VBP program that is aimed at improving prenatal and postpartum care in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network primary care or appropriate specialist providers that meet achievement levels on selected prenatal and postpartum care measures, as determined by the department.

(2) Qualified network primary care or appropriate specialist providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(c) A VBP program that is aimed at improving chronic disease management in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that meet achievement levels on selected chronic disease care measures, as determined by the department. The measures shall be in chronic disease care areas, including, but not limited to, diabetes care and control of hypertension, using measures currently recognized for those areas in the Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally recognized measures that the department deems appropriate.

(2) Qualified network providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

(d) A VBP program that is aimed at improving quality and outcomes for children in Medi-Cal managed care.

(1) Designated Medi-Cal managed care plans shall make incentive payments to qualified network providers that meet achievement levels on selected childhood health care quality measures, as determined by the department. The measures shall be developed using measures currently recognized for those areas in HEDIS or other nationally recognized measures that the department deems appropriate.

(2) Qualified network providers may be eligible for maximum incentive payments if they meet the designated high-performance standards, and partial incentive payments for meeting above-minimum standards.

(3) The requirements for receiving an incentive payment and the methodology for determining the value of the payment shall be determined by the department, in accordance with this article.

14188.2. (a) The VBP programs described in Section 14188.1 shall be funded using moneys appropriated to the department for purposes of those programs in the Budget Act of 2019, or a Budget Act in a subsequent fiscal year, from the Healthcare Treatment Fund established pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(b) The Legislature finds and declares that the expenditures authorized by this article are all of the following:

(1) Made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Article 2.5 (commencing with Section 30130.50) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code).

(2) Based on criteria developed and periodically updated as part of the annual state budget process, in accordance with subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

(3) Consistent with the purposes and conditions of expenditures described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.

14188.3. (a) To implement this article, the department may enter into exclusive or nonexclusive contracts, or amend existing

contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article, in whole or in part, by means of plan letters or other similar instructions, without taking regulatory action.

14188.4. Value-based payments pursuant to this article shall be suspended on December 31, 2021. If the estimates of General Fund revenues and expenditures determined pursuant to Section 12.5 of Article IV of the California Constitution that accompany the May Revision required to be released by May 14, 2021, pursuant to Section 13308 of the Government Code, contain projected annual General Fund revenues that exceed projected annual General Fund expenditures in the 2021–22 fiscal year and the 2022–23 fiscal year by the sum total of General Fund revenues appropriated for all programs suspended pursuant to the Budget Act of 2019 and all related trailer bill legislation implementing the provisions of the Budget Act of 2019, then the suspension shall not take effect. It is the intent of the Legislature to consider alternative solutions to restore this program, should the suspension take effect.

SEC. 51. Section 14190 is added to the Welfare and Institutions Code, to read:

14190. (a) The department shall convene an advisory group to receive feedback on the changes, modifications, and operational timeframes regarding the implementation of pharmacy benefits offered in the Medi-Cal program. This advisory group shall be composed of organizations and entities such as hospitals, clinics, health plans, and consumer advocates.

(b) The department, through this advisory group as well as through other existing stakeholder meetings, shall provide regular updates on the pharmacy transition that include the following:

(1) A description of the changes in the division of responsibilities between the department and managed care plans as a result of a transition of the outpatient pharmacy benefit to fee-for-service.

(2) A description of anticipated changes, if any, to beneficiary access to prescription medications.

(c) The department shall include in the Governor's proposed budget the fiscal assumptions for the transition of the outpatient pharmacy benefit to a fee-for-service benefit.

SEC. 52. Article 6.8 (commencing with Section 14199.60) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.8. Managed Care Organization Provider Tax

14199.60. It is the intent of the Legislature to enact a managed care organization provider tax in California. The collection of the tax and the associated revenue shall be contingent upon receipt of approval from the federal Centers for Medicare and Medicaid Services.

SEC. 53. Section 52 of Chapter 18 of the Statutes of 2015 is amended to read:

Sec. 52. The sum of fifty million dollars ($50,000,000) is hereby appropriated from the Health Home Program Account to the State Department of Health Care Services for the purposes of implementing the Health Home ~~Program~~ *Program, including state administration,* established pursuant to Article 3.9 (commencing with Section 14127) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. Notwithstanding Section 16304 of the Government Code, this appropriation shall be available for encumbrance or expenditure until June 30, ~~2020.~~ *2024.*

SEC. 54. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution due to the following:

(a) It is the intent of the Legislature in enacting this act to offer a specific one-time exception to Providence Tarzana Medical Center in the City of Los Angeles and UCSF Benioff Children's Hospital in the City of Oakland, which missed a clerical submission deadline with the Office of Statewide Health Planning and

Development, to allow them to submit an application pursuant to subdivision (b) of Section 130062 of the Health and Safety Code.

(b) The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 established seismic safety building standards for hospitals, which are intended to keep patients, workers, hospital visitors, and all Californians safe during and after a major seismic event. As a result of that act, a majority of hospitals will remain seismically safe after a major earthquake.

(c) California hospitals have been granted extensions to seismic safety building standard timelines since the enactment of these laws in 1983 due to construction delays. Furthermore, Providence Tarzana Medical Center specifically received an extension for its facility from the Legislature in 2017 pursuant to Assembly Bill 908 (Chapter 350 of the Statutes of 2017), to extend its construction completion deadline to October 1, 2022. Finally, in 2018, the Legislature granted hospitals an extension of seismic safety building timelines, allowing them until 2025 to complete construction pursuant to Assembly Bill 2190 (Chapter 673 of the Statutes of 2018). The two hospitals described in this act are seeking an extension to an application deadline specified in Assembly Bill 2190.

(d) In this specific situation, it is in the best interest of the public that these two hospitals be granted time to submit the application, with the understanding that it is a priority for these hospitals to maintain access to services while balancing the safety of patients and workers in and after a disaster.

(e) It is not the intent of the Legislature in enacting this act to authorize or provide additional extensions to the requirements described in Section 130062 of the Health and Safety Code for Providence Tarzana Medical Center or UCSF Benioff Children's Hospital in the City of Oakland.

SEC. 55. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 56. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 57. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

~~SECTION 1. It is the intent of the Legislature to enact statutory changes relating to the Budget Act of 2019.~~

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