CITY OF HAYWARD
AGENDA REPORT

AGENDA DATE 10/12/04
AGENDA ITEM _____
WORK SESSION ITEM WS #2

TO: Mayor and City Council

FROM: City Manager

SUBJECT: Proposition 72: Health Care Coverage Requirements. Referendum

This item appears on the agenda at the request of Councilmember Bill Quirk.

Last year, the Legislature adopted and the Governor signed legislation establishing certain health care coverage obligations on the part of certain employers. A valid referendum petition was submitted, thereby placing the legislation on hold pending a decision by the voters. Attached for the Council's information is background material about the proposition obtained from the Voter Information Guide published by the Secretary of State.

The staff seeks Council direction on whether a resolution in support of the proposition should be prepared for your consideration at a subsequent Council meeting. If the Council decides in the affirmative, it would be our intent to place the item on your October 19 agenda for action.

Jesús Armas
City Manager

PROPOSITION

72

HEALTH CARE COVERAGE REQUIREMENTS. REFERENDUM.

OFFICIAL TITLE AND SUMMARY

Prepared by the Attorney General

Health Care Coverage Requirements. Referendum.

A "Yes" vote approves, and a "No" vote rejects legislation that:

- Provides for individual and dependent health care coverage for employees, as specified, working for large and medium employers;
- Requires that employers pay at least 80% of coverage cost; maximum 20% employee contribution;
- Requires employers to pay for health coverage or pay fee to medical insurance board that purchases primarily private health coverage;
- Applies to employers with 200 or more employees beginning 1/1/06;
- Applies to employers with 50 to 199 employees beginning 1/1/07. Applies to employers with 20 to 49 employees if tax credit enacted.

Summary of Legislative Analyst's Estimate of Net State and Local Government Fiscal Impact:

- Expenditures fully offset by fee revenues paid mainly by employers, which could range from tens of millions to hundreds of millions of dollars annually, to fund a new state program primarily to purchase private health insurance coverage.
- Reduction in county health program costs potentially in the low hundreds of millions of dollars annually.
- Uncertain net fiscal impact on state-supported health programs.
- Increased costs potentially in the low hundreds of millions of dollars annually for state and local public agencies to provide additional health coverage for their employees.
- Net reduction in state tax revenues potentially in the low hundreds of millions of dollars.
- In summary, unknown net savings or costs to state and local government.

ANALYSIS BY THE LEGISLATIVE ANALYST

BACKGROUND

Health Coverage in California

A majority of Californians under age 65 receive health insurance through their employer or the employer of a family member. Most Californians age 65 and over are covered by the federal Medicare Program. Others purchase health insurance for themselves. Many individuals receiving coverage share in the cost of the premiums paid for their health insurance.

Many low-income persons obtain health care services through the Medi-Cal Program, the Healthy Families Program, or other public programs operated by the state and county governments. Medi-Cal is administered by the state Department of Health Services (DHS), while the Healthy Families Program is administered by the state Managed Risk Medical Insurance Board (MRMIB). However, based upon a 2001 survey, an estimated 6.3 million nonelderly Californians lacked health coverage at some point during the year. These individuals are likely to receive medical assistance from county indigent health care programs or through the charitable activities of health care providers or pay for it themselves. Surveys indicate that of the nonelderly uninsured individuals, more than four out of five are either employed or are family members of someone who is working.

Some of the medical costs incurred by uninsured persons are indirectly shifted by health care providers to others who have health coverage, in effect adding to the cost of their health insurance. There are also indications that the number of employees who are uninsured may be adding to the costs of workers' compensation insurance, which includes medical coverage for on-the-job injuries.

Recent Legislation

In 2003, the Legislature approved and the Governor signed Senate Bill 2 (Chapter 673) to expand health insurance coverage beginning in 2006 for employees of certain employers and, in some cases, their dependents. The law also established a program to assist lower-income employees with paying their share of health care premiums.

The new law would have gone into effect January 1, 2004. However, Proposition 72, a referendum on this new law, subsequently qualified for the statewide ballot. As a result, SB 2 was put "on hold" and will take effect only if Proposition 72 is approved by the voters at the November 2004 election.

PROPOSAL

If approved, this proposition would allow the provisions of SB 2 to go into effect. Health care researchers have estimated that the provisions of SB 2 could eventually

ANALYSIS BY THE LEGISLATIVE ANALYST (CONT.)

result in more than 1 million uninsured employees and dependents receiving health coverage. The major provisions of SB 2 are described below.

"Pay or Play" Requirement for Employers

Senate Bill 2 enacts a "pay or play" system of health coverage for certain employers. Under the system, specified California employers would be required to pay a fee to the state to provide health insurance (in other words, "pay") for their employees and in some cases, for their dependents. Alternatively, the employer could choose to arrange directly with health insurance providers for coverage (in other words, "play") for these individuals.

Both "pay" and "play" employers are required to pay a fee to the state to support a state health insurance purchasing program. Employers choosing to arrange their own health coverage (in some cases by continuing or modifying the coverage now provided to their employees) would receive a credit that would fully offset their fee. In order for an employer to qualify for a fee offset, the employer would have to provide specified types of coverage. Employers would be responsible for at least 80 percent of the cost of the fee, with the balance borne by their employees. The fee would be collected from employers and the fee requirements enforced by the Employment Development Department (EDD).

Senate Bill 2 would generally apply to both private and public employers, including state government, counties, cities, special districts, and school districts.

Federal law, known as the Employee Retirement Income Security Act, has been interpreted by the courts to generally prohibit states from requiring certain employers to provide health insurance coverage to their employees. As a result, it is possible that the "pay or play" provisions of SB 2 could be challenged in court. Our analysis assumes that the "pay or play" provisions would go into effect.

Who Would Provide and Receive Coverage?

Figure 1 summarizes which employers are affected by the "pay or play" requirements, when they would be subject to the requirements of SB 2, and who would receive health coverage. These requirements depend upon the number of employees an employer has in California. Senate Bill 2 also provides that employers with 20 to 49 employees would be subject to the "pay or play" provisions only if state law were changed to establish a tax credit for those employers equal to 20 percent of their state fee for health coverage. To date, no such tax credit legislation has been enacted, and these employers are currently exempt from the provisions of SB 2. Employers with 19 or fewer employees within California would not be subject to its requirements.

Any employee who worked more than 100 hours per month for the same employer for three months would qualify for health coverage. Senate Bill 2 defines the list of dependents who could be eligible for coverage to be spouses, minor children, older children who are dependent upon the employee for support, and domestic partners.

Senate Bill 2 imposes penalties on any employer who reduces an employee's hours of work or takes other steps to avoid having to comply with its "pay or play" requirements.

Contributions by Employees

Employees would generally be required to make a contribution of up to 20 percent of the amount of the fee charged by the state to their employer. Contributions paid by employees would be collected by their employer and transferred to the state.

Low-income employees would have their contributions capped at 5 percent of their wages. Senate Bill 2 defines a low-income employee as an individual who earned wages of less than 200 percent of the federal poverty guidelines—currently about $19,000 a year in the case of an individual, and about $31,000 a year in the case of an employee and his or her family.

In addition to these contributions, employees could also be charged part of the additional costs for their coverage in the form of deductibles, copayments, or coinsurance payments in amounts determined by the state. These charges would have to be set at a level that took into account whether the persons would be deterred from obtaining appropriate and timely health care.

State Health Purchasing Program

Senate Bill 2 creates the State Health Purchasing Program to purchase health care coverage for eligible California employees (and their dependents) of employers who opt to pay a fee instead of arranging for health insurance. The purchasing program would be administered by MRMIB. The MRMIB would negotiate contracts with health insurers, primarily private health plans, who agreed to provide health care coverage. The coverage would have to meet existing state standards for health insurance, such as the inclusion of hospital and primary care, and would also include coverage for prescription drugs. The cost of health coverage purchased under the

FIGURE 1

WHICH EMPLOYERS ARE AFFECTED BY THIS MEASURE?

Employers Who Employ ...	... Must Provide Health Coverage to ...	Starting
200 or more employees in the state	Employees and dependents	1/1/06
50 to 199 employees in the state	Employees only	1/1/07
20 to 49 employees in the state	Employees only, if a specified tax credit is enacted	Undetermined
19 or fewer employees in the state	No requirement	Not applicable

For text of Proposition 72 see page 155.

PROP 72

HEALTH CARE COVERAGE REQUIREMENTS. REFERENDUM.

ANALYSIS BY THE LEGISLATIVE ANALYST (CONT.)

program, as well as MRMIB's and EDD's administrative costs for the implementation of the program, would be supported with the funds collected from employers and employees under SB 2.

State Premium Assistance

Senate Bill 2 establishes a program to pay the premiums for health coverage provided through the workplace for low-income employees who are eligible for Medi-Cal or the Healthy Families Program. This provision applies to eligible employees for all California employers, and not just those employees of employers affected by the "pay or play" requirements of SB 2. So, for example, eligible employees of employers that provide health coverage and that have fewer than 20 employees would qualify for premium assistance.

Under the premium assistance program, the state and employers would notify employees of the availability of premium assistance and employees may voluntarily provide information to the state that would indicate if they and their families were eligible for coverage under Medi-Cal or the Healthy Families Program. If these persons were subsequently enrolled in either public program, the state could require them to also enroll in any coverage available from their employer, if that were determined by the state to be cost-effective. The state would reimburse these employees for any premiums they paid for the coverage provided by their employer. However, these employees would remain subject to paying any premiums and copayments required under Medi-Cal or the Healthy Families Program.

Employees and their families receiving premium assistance would also receive what is known as "wraparound" coverage from the state. In this case, this means that the state would provide and pay for any additional medical services for an employee or their family that were included in either the Medi-Cal or Healthy Families benefit package (such as dental coverage), but that were not included in the health coverage provided by the employer.

The implementation of the state premium assistance provisions would be the responsibility of MRMIB and DHS, and would be subject to approval by the federal government.

Health Insurance Marketing Provisions

Senate Bill 2 expands to medium-sized employers a series of provisions now in state law that are intended to make it easier and more affordable for small employer groups to purchase health coverage. For example, if a health plan or insurer offered and sold an insurance product to one medium-sized employer, they would be required to offer and sell the same product to other employers of similar size. Senate Bill 2 provides that, should its "pay or play" requirements be invalidated in court, these provisions affecting health coverage purchases by medium-sized employers would also become inoperative.

General Fund Loan

Senate Bill 2 authorizes loans from the state General Fund, subject to appropriation in the annual budget act, for costs incurred by MRMIB and EDD for the establishment and administration of the State Health Purchasing Fund. The loans are to be repaid with interest within five years after the state begins the collection of fees from employers.

FISCAL EFFECTS

The health coverage requirements of SB 2 would have a number of significant fiscal effects on state and local governments, including counties, cities, special districts, and school districts. In addition, they could have significant effects on individuals and businesses. These effects are complex, uncertain, and difficult to predict over time. Among the factors that could cause savings and costs to vary significantly are:

- How some provisions of SB 2 were eventually implemented by state and local officials and interpreted by the courts.
- The proportion of employers who chose to participate in the State Health Purchasing Program.
- How the health insurance marketplace responded to the new law in the products and prices it offered to public and private purchasers of care.

Given these uncertainties, we believe that the net savings or costs to the state and local governments are unknown. Our estimates assume that SB 2 affects employers with 50 or more employees. The more significant identifiable savings and costs to state and local governments that could result from this SB 2 are summarized below.

Purchasing Program Revenues and Expenditures

The "pay or play" requirements of SB 2 would generate significant revenues to the state from fees paid by employers that chose to "pay" for health coverage rather than to "play" by directly arranging their own health coverage. Also, the state would receive additional revenues from contributions for coverage paid by the employees of the firms choosing to "pay."

The state revenues received from these employers and employees would, in turn, be used to fully offset the costs of the State Health Purchasing Program. The most significant program costs would be for the purchase of health insurance coverage, primarily from private insurers, for employees of these employers (and, in the case of some employers, the dependents of these employees). These state revenues would also be used to fully offset administrative and other costs related to the State Health Purchasing Program.

The proportion of employers who would choose to "pay" the fee to the state, thereby obtaining health coverage from the State Health Purchasing Program, rather than to "play" by arranging health coverage on their own, is a major unknown factor. The choices ultimately made by employers on whether to "pay or play" would have a significant impact on the amount of fee revenue paid to the state as well as the size of the State Health Purchasing Program. We estimate that the amount of fees collected from employers and employees and spent for the purchasing program could range from the tens of millions of dollars to the hundreds of millions of dollars annually, depending on the participation level of employers. This

ANALYSIS BY THE LEGISLATIVE ANALYST (CONT.)

estimate assumes that the state collects the fee only from firms that choose to "pay" and not from firms that "play" by arranging health coverage on their own and therefore receive a credit that fully offsets their fee.

Effect on Other Publicly Funded Health Programs

State. The net effect of SB 2 on state-funded health programs is uncertain. Some provisions are likely to result in state savings while other provisions are likely to result in costs, as discussed below.

On the one hand, the "pay or play" requirement for employers to either pay a fee to the state or provide health coverage would generally have the effect of reducing state costs for Medi-Cal and Healthy Families benefits. This is because costs for these state-supported health coverage programs would likely decrease as additional employees and dependents received coverage from the State Health Purchasing Program or through coverage arranged by employers.

On the other hand, the premium assistance and wraparound coverage components of SB 2 would generally have the effect of increasing state costs for Medi-Cal and Healthy Families benefits. These provisions would result in the enrollment of additional employees and dependents in the two programs, additional state expenditures to reimburse employees for the premiums they paid for employer-based coverage, and additional state expenditures for wraparound coverage.

Taking all of these provisions and their fiscal effects into account, we estimate that the fiscal impact on Medi-Cal benefits would eventually be a net savings to the state amounting to tens of millions of dollars annually. However, we estimate that SB 2 would result in a net cost to the state for Healthy Families Program benefits of roughly the same magnitude. Given the uncertainties associated with SB 2, it is not clear at this time whether it would ultimately result in a net cost or savings to the state for state-supported health benefits.

Local. County costs for providing health care for indigents are likely to decrease significantly as more employees and dependents receive health coverage that is paid for by employers, Medi-Cal, and the Healthy Families Program. We estimate that the implementation of SB 2 would eventually result in savings to county governments on a statewide basis, potentially in the low hundreds of millions of dollars annually.

State Administrative Costs

Senate Bill 2 specifies that part of the fees collected from employers would be used by MRMIB and EDD to offset their costs for administering the new State Health Purchasing Program. However, under the terms of SB 2, administrative costs incurred by DHS and MRMIB for the premium assistance program are not included among those that would be offset from fee revenue, and thus would probably be supported from the state General Fund and federal funds. We estimate that MRMIB, EDD, and DHS would incur significant administrative costs, probably amounting collectively in the low tens of millions of dollars annually, to implement SB 2.

Costs to Public Employers

The "pay or play" requirements of SB 2 generally apply to public employers, including the state, counties, cities, special districts, and school districts. Although full-time employees of public agencies in California usually have health coverage, some seasonal, temporary, and part-time employees and their dependents currently lack health coverage. We estimate that the additional cost to the state and local agencies to comply with SB 2 could potentially amount to the low hundreds of millions of dollars annually beginning in 2006–07.

These additional costs could be partially offset by savings to public agencies in certain circumstances. For example, some spouses of public agency employees would receive coverage from their own employers as a result of SB 2. Because these spouses would no longer receive coverage as dependents of employees of those public agencies, such agencies could realize some savings on their health coverage costs. The amount of the offsetting savings from this and other factors is unknown.

Effects on State Revenues

Senate Bill 2 would impact state revenues in two major ways.

First, some businesses would face increased operating costs to pay for employees' health insurance. To the extent that businesses absorb these costs, their taxable income would be less and, thus, income tax revenues would decline. Many employers would act to avoid absorbing these costs, however, such as by "passing them along" to consumers through higher product prices or to employees by cutting back on hours or wages. These steps could reduce overall economic activity, causing declines in personal income taxes and sales taxes. Revenue losses also would occur if California lost economic activity to other states.

Partially offsetting the above factors would be potential revenue gains due to any reduction in the health premiums that otherwise would have been paid by certain employers, as well as expanded economic activity in the health care sector. Current premiums paid by employers for health insurance and workers' compensation insurance may reflect some "cost-shifting" to cover health care costs of the uninsured. To the extent that SB 2 reduces the number of uninsured persons, it could reduce cost-shifting and could lower premiums paid by employers, thus increasing taxable income. In addition, employers' costs for complying with SB 2 may be reduced if the State Health Purchasing Program negotiates lower insurance rates, or the health care marketplace itself responds to SB 2 with reduced rates. Finally, the significant expansion of health coverage could increase state tax revenues paid by health plans and insurers.

Taking these and other factors into consideration, SB 2 would likely result in a net reduction in state tax revenues, potentially in the low hundreds of millions of dollars, with the actual magnitude depending on the behavioral responses of employers and the health care marketplace.

For text of Proposition 72 see page 155.

PROP 72 HEALTH CARE COVERAGE REQUIREMENTS. REFERENDUM.

ARGUMENT in Favor of Proposition 72

Across California, millions of people are working harder and harder to pay their bills. Worst of all is the skyrocketing cost they pay for health care.

Many companies are forcing employees to pay more for health care through higher premiums or cuts in coverage. For employees, higher insurance costs compete with their mortgage or rent, food, and transportation. Many employees are going without the medical care and prescription drugs their families need, creating a health care crisis in California.

It is simply wrong when employees can't afford health insurance for themselves and their children. 72 makes sure that private health insurance remains within reach.

72 WILL LIMIT WHAT EMPLOYEES PAY FOR HEALTH CARE

- PROBLEM: Employees are paying more—not just because of rising health care costs, but also because businesses are shifting a greater share of the burden to their workers. *The amount California families pay for premiums has increased 70% in the last three years.* Last year, employee premiums increased at *twice* the rate of business premiums. Unless something is done, more and more will be passed on to you.
- SOLUTION: Under 72, large and medium-sized companies must pay *at least* 80% of the cost of employees' premiums for health insurance.

72 WILL PROVIDE HEALTH INSURANCE TO 1.1 MILLION WORKING PEOPLE AND CHILDREN CURRENTLY UNINSURED

- PROBLEM: Some employers do not offer their employees insurance. The number of working people without insurance is increasing.
- SOLUTION: 72 requires large and mid-sized employers to pay for health insurance for employees, extending *coverage to an additional 1.1 million working people and their children.*

72 ENSURES COVERAGE YOU NEED

- PROBLEM: Already 30% of businesses say they plan to cut benefits. More will follow.
- SOLUTION: Under 72, coverage includes *prescription drugs, preventive care, and major medical.*

72 PROTECTS TAXPAYERS

- PROBLEM: California taxpayers pay $4.6 billion annually to cover emergency room and health care bills for the uninsured. Taxpayers will pay even more unless something changes.
- SOLUTION: 72 protects taxpayers by providing health care coverage to an additional 1.1 million workers and their children, taking them out of emergency rooms and *placing them in the care of their own doctors.*

72 LEVELS THE PLAYING FIELD FOR RESPONSIBLE COMPANIES

- PROBLEM: Companies that *don't* provide affordable health care to their employees have an advantage over companies that *do.*
- SOLUTION: *72 protects responsible companies from unfair competition* by requiring all large and mid-sized companies to pay for health care for employees.

Consumers Union, nonprofit publisher of Consumer Reports, says, "After studying Proposition 72, we conclude it is a necessary step forward that protects health coverage for working Californians."

By capping employees' health care premiums, 72 will keep private health insurance within reach of working families.

If nothing changes, workers will continue to pay more and more for health insurance—or lose their coverage. 72 provides an answer. It's a good first step in protecting employer-based health insurance—and the 19 million Californians who depend on it. Visit www.saveyourhealthcare.com.

RICHARD HOLOBER, *Executive Director*
Consumer Federation of California
DEBORAH BURGER, RN, *President*
California Nurses Association
RICHARD F. CORLIN, M.D., *Past President*
California Medical Association & American Medical Association

REBUTTAL to Argument in Favor of Proposition 72

PROPOSITION 72 WILL NOT CONTROL HEALTH COSTS

Health costs are skyrocketing but Proposition 72 WILL NOT control these costs. Proposition 72 makes the problem worse by creating a huge bureaucracy to administer a government-run health care scheme COSTING EMPLOYERS AND WORKERS an estimated $7 BILLION by 2007.

PROPOSITION 72 CREATES A GOVERNMENT-RUN HEALTH CARE SYSTEM

The backers of 72 are hiding the fact it creates a government-run system. Read it for yourself!—"Chapter 3. State Health Purchasing Program." Many people may lose their existing private coverage and end up in the state plan.

The former head of the state board charged with implementing 72 says it won't work:

"Proposition 72 is fatally flawed and poorly structured. It mandates coverage without controlling costs and forces workers and employers to pay whether they can afford to or not. Proposition 72 just doesn't work."

John Ramey, Former Executive Director
Managed Risk Medical Insurance Board

PROPOSITION 72 DOES NOT HELP THE UNINSURED OR TAXPAYERS

We all want to help the uninsured, but Proposition 72 isn't the solution. Up to 500,000 workers' jobs will be at risk if Proposition 72 becomes law. These people could end up unemployed AND uninsured.

THREATENS ACCESS TO YOUR DOCTORS

Under Proposition 72's state plan, you could lose access to your doctors and hospitals and have to be treated by government-approved providers.

Proposition 72 is not the kind of reform we need! PLEASE JOIN DOCTORS, CHARITIES, EDUCATORS, AND TAXPAYERS—VOTE NO ON 72!

THOMAS LAGRELIUS, M.D., *President*
California Chapter, Association of American Physicians and Surgeons
GLORIA RIOS, *Director*
California Association of School Business Officials
JON COUPAL, *President*
Howard Jarvis Taxpayers Association

Arguments printed on this page are the opinions of the authors and have not been checked for accuracy by any official agency.

HEALTH CARE COVERAGE REQUIREMENTS. REFERENDUM.

PROP 72

ARGUMENT Against Proposition 72

Real health care reform should control costs and cover more people, but Proposition 72 fails that test. Passed by the Legislature with no meaningful hearings and signed by Governor Davis just days before he was recalled, Proposition 72 creates a huge government-run health care system funded by an estimated $7 billion in new taxes by 2007 on employers and workers.

WORKERS MAY LOSE PRIVATE COVERAGE

Proposition 72 may hurt people who already have health coverage through their employer. You could get forced out of your current plan and into the government-run system! Under Proposition 72 you could lose access to your personal doctor and hospital and end up with a high deductible policy that requires you to pay thousands out of your pocket before getting coverage.

BUREAUCRATS GIVEN TOO MUCH POWER

Under Prop. 72, bureaucrats determine what medical services and providers are covered by the state-run health system and how much you'll pay to support the government-run plan. There are no caps on the administrative fees they can charge. The Orange County Register called it health care with, "the bedside manner of the DMV."

PAY WHETHER YOU WANT IT OR NOT

Proposition 72 is poorly written. You can't decline coverage even if you don't want it or can't afford your share of costs! Employees will pay up to 20% of the cost!

KILLS JOBS/ECONOMY

Proposition 72 will damage California's economy and mean MORE PEOPLE WITHOUT INSURANCE because thousands will lose their jobs as companies close or move out of state. California businesses already struggling with high workers' comp and energy costs just can't afford billions in new health care costs.

COSTS WORKERS $1,700 PER FAMILY

Covered workers will be forced to pay up to 20% of the premiums. The Los Angeles Economic Development Corporation estimates family coverage will cost workers up to $1,700 per year.

Employers must pay 80% of the cost. Many must also pay for dependent coverage, costing over $6,800 per worker each year.

COSTS SCHOOLS AND NONPROFITS MILLIONS

The Association of California School Administrators says Proposition 72 will cost school districts hundreds of millions annually—money urgently needed in classrooms! Nonprofit organizations like Easter Seals and the Goodwill of Long Beach and South Bay oppose Prop. 72 because it makes it harder to provide services to people in need.

Here's how Proposition 72 damages Californians:

"At Easter Seals, the high costs and mandates of Proposition 72 will force us to stop creating new and needed services for people with disabilities."

Gary Kasai, President, Easter Seals Superior California

"Proposition 72 will mandate the worst kind of managed health care we have. This means there will be more and more patients with terrible insurance."

Thomas LaGrelius, M.D., President, California Chapter, Association of American Physicians and Surgeons

"Prop. 72 will discourage those of us who have worked so hard to fulfill the American dream from growing their business and providing more jobs in our communities. Some will simply have to close shop."

C.C. Yin, Restaurant Owner

JOIN EMPLOYERS, EDUCATORS, DOCTORS, NONPROFITS, AND TAXPAYERS: VOTE NO ON PROPOSITION 72!

ALLAN ZAREMBERG, *President*
California Chamber of Commerce
SANDRA CARSTEN, *President*
Association of California School Administrators
JAMES G. KNIGHT, M.D., *2003 President*
San Diego Medical Society

REBUTTAL to Argument Against Proposition 72

Opponents are using scare tactics so voters will be afraid to approve protections for employees. Their claims are false.

SCARE TACTIC: GOVERNMENT HEALTH CARE REPLACES PRIVATE COVERAGE

Prop. 72 sets standards for health coverage and the share of costs employers must pay—just like the minimum wage sets standards for wages.

"Prop. 72 is the opposite of government-run health care. It strengthens private employer health insurance." John Garamendi, California Insurance Commissioner

If you already get health insurance from your employer, your employer can keep that same coverage under 72 and can continue to pay up to 100% of premiums. You get the security of knowing your employer cannot pay less than 80% of premiums and must maintain preventive care, prescription drugs, and major medical.

SCARE TACTIC: 72 COSTS MORE

Opponents claim premiums could be $1,700 under 72.

But the average California family ALREADY pays $2,452 in premiums (*Sacramento Bee*, 3/17/04).

Under 72, the average California family will *save money.*

SCARE TACTIC: JOB KILLER

- Corporate lobbyists always complain about California's business climate, but California is the world's 6th largest economy.
- 93% of California's restaurants and retailers are exempt.
- Businesses will benefit from a healthier, more productive workforce.

IF WE DO NOTHING:

- Employee premiums will keep rising.
- More working families will be uninsured.
- Taxpayers will continue paying health care costs for employees of big companies like Wal-Mart and McDonalds.

Don't be confused by scare tactics. 72 keeps private health care within the reach of California families.

PAUL KIVELA, M.D., *President*
California Chapter American College of Emergency Physicians
BARBARA E. KERR, *President*
California Teachers Association
TOM PORTER, *California State Director*
AARP

Proposition 71 *(cont.)*

(b) "State service," solely for purposes of qualification for benefits and retirement allowances under this system, shall also include service rendered as an officer or employee of a county if the salary for the service constitutes compensation earnable by a member of this system under Section 20638.

SEC. 7. Severability

If any provision of this act, or part thereof, is for any reason held to be invalid or unconstitutional, the remaining provisions shall not be affected, but shall remain in full force and effect, and to this end the provisions of this act are severable.

SEC. 8. Amendments

The statutory provisions of this measure, except the bond provisions, may be amended to enhance the ability of the institute to further the purposes of the grant and loan programs created by the measure, by a bill introduced and passed no earlier than the third full calendar year following adoption, by 70 percent of the membership of both houses of the Legislature and signed by the Governor, provided that at least 14 days prior to passage in each house, copies of the bill in final form shall be made available by the clerk of each house to the public and news media.

Proposition 72

This law proposed by Senate Bill 2 of the 2003–2004 Regular Session (Chapter 673, Statutes of 2003) is submitted to the people as a referendum in accordance with the provisions of Section 9 of Article II of the California Constitution.

This proposed law amends and adds sections to various codes; therefore, new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. The Legislature finds and declares all of the following:

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

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

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

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

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

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

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

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

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

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

(k) It is therefore the intent of the Legislature to assure that working Californians and their families have health benefits and that employers pay a user fee to the State of California so that the state may serve as a purchasing agent to pool those fees to purchase coverage for all working Californians and their families that is not tied to employment with an individual employer. However, consistent with this act, if the employer voluntarily provides proof of health care coverage, that employer is to be exempted from payment of the fee.

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

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

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

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

PART 8.7. EMPLOYEE HEALTH INSURANCE

CHAPTER 1. TITLE AND PURPOSE

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

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

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

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

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

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CHAPTER 2. DEFINITIONS

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

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

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

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

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

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

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

2122.7. "Principal employer" means the employer for whom an enrollee works the greatest number of hours in any month.

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

2122.9. "Fund" means the State Health Purchasing Fund created pursuant to Section 2210.

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

2122.11. "Board" means the Managed Risk Medical Insurance Board.

2122.12. "Fee" means the fee as determined in Chapter 4 (commencing with Section 2140).

CHAPTER 3. STATE HEALTH PURCHASING PROGRAM

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

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

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

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

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

CHAPTER 4. EMPLOYER FEE

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

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

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

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

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

2140.5. The fee paid by employers shall be based on the cost of coverage for all enrollees, and, if applicable, their dependents. The fee to be paid by each employer shall be based on the number of potential enrollees, and if applicable, dependents, using the employer's own workforce on a date specified by the board as the basis for the allocation and such other factors as the board may determine in order to provide coverage that meets the standards of this part. To assist the board in determining the fee, each employer shall provide to the board information as specified by the board regarding potential enrollees, and, if applicable, dependents. To the extent feasible, the board shall work with the Employment Development Department to facilitate the provision of information regarding the number of potential enrollees and dependents.

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

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

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

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

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

CHAPTER 5. ENROLLEE CONTRIBUTION

2150. The applicable enrollee contribution, not to exceed 20 percent of the fee assessed to the employer, shall be collected by the employer and paid concurrently with the employer fee. The employer may agree to pay more than 80 percent of the fee, resulting in an enrollee, and, if applicable, dependent contribution of less than 20 percent. For enrollees making a contribution for family coverage and whose wages are less than 200 percent of the federal poverty guidelines for a family of three, as specified annually by the United States Department of Health and Human Services, the applicable enrollee contribution shall not exceed 5 percent of wages. For enrollees making a contribution for individual coverage and whose wages are less than 200 percent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed 5 percent of wages.

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

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

(c) In determining the required enrollee and dependent deductibles, coinsurance, and copayments, the board shall consider whether the proposed copayments, coinsurance, and deductibles deter enrollees and dependents from receiving appropriate and timely care, including those enrollees with low or moderate family incomes. The board shall also consider the impact of out-of-pocket costs on the ability of employers to pay the fee. This section shall apply to coverage provided through the program only and is not intended to apply coverage that is not provided through the program.

2150.2. In the event that the employer fails to collect or transmit the enrollee contribution provided for under this part in a timely manner, the employer shall become liable for a penalty of 200 percent of the amount that the employer has failed to collect or transmit, and the employee shall be relieved of all liability for that failure. In no event shall the employer's failure to collect or transmit the required enrollee's contribution or to provide enrollment information about an employee affect the employee's coverage arranged pursuant to Chapter 3 (commencing with Section 2130), nor may an employer withhold or collect any amount that is not withheld and transmitted in the manner and at such times as specified by the Employment Development Department pursuant to this part. An employee for whom enrollment information is not otherwise received by the board may demonstrate eligibility for coverage by any reliable means of demonstrating employment as provided for in regulation. To the extent feasible, the board shall work with the Employment Development Department to facilitate the provision of information regarding the eligibility of enrollees and to provide information regarding any failure of an employer to collect or transmit employee contributions as required by this part.

CHAPTER 6. EMPLOYER CREDIT AGAINST THE FEE

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

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

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

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

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

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

(e) A multiple employer welfare arrangement established pursuant to Section 742.20 of the Insurance Code, provided that its benefits have not changed after January 1, 2004, or that it meets the benefits required under subdivision (a) or (b) of this section.

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

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

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

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

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

2160.5. The Employment Development Department shall adopt regulations to ensure that employers abide by the provisions of this chapter. The regulations may initially 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 of the Government Code, but those emergency regulations shall be in effect only from the effective date of this part until after the requirements of this program are in effect for large and medium employers as provided in Section 2120.1.

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

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

CHAPTER 7. PARTICIPATING HEALTH PLANS

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

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

2173. (a) The board shall develop and utilize appropriate cost containment measures to maximize the cost-effectiveness of health care

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coverage offered under the program. The board shall consider the findings of the California Health Care Quality Improvement and Cost Containment Commission.

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

CHAPTER 8. ENROLLMENT AND COORDINATION WITH PUBLIC PROGRAMS

2190. (a) Employers shall provide information to the board regarding potential enrollees, and, if applicable, dependents as prescribed by the board to assist the board in obtaining information necessary for enrollment. In no case shall the board require the employer to obtain from the potential enrollee information about the family income or other eligibility requirements for Medi-Cal, Healthy Families, or other public programs other than that information about the enrollee's employment status otherwise known to the employer consistent with existing state and federal law and regulation.

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 9. ADMINISTRATION

2200. A contract entered into by the board pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on the projected or actual enrollee enrollments to a total amount not to exceed the amount appropriate for the program including applicable contributions.

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

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

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

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

Article 3.11. Insurance Market Reform

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

1357.21. (a) Notwithstanding any other provision of law, on and after January 1, 2006, except as specified in subdivision (b), all requirements in Article 3.1 (commencing with Section 1357) applicable to offering, marketing, and selling health care service plan contracts to small employers as defined in that article, including, but not limited to, the obligation to fairly and affirmatively offer, market, and sell all of the plan's contracts to all employers, guaranteed renewal of all health care service plan contracts, use of the risk adjustment factor, and the restriction of risk categories to age, geographic region, and family composition as described in that article, shall be applicable to all health care service plan contracts offered to all small and medium employers providing coverage to employees pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, except as follows:

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

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

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

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

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

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

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

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

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

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

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

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

1357.23. On and after January 1, 2006, all health care service plans contracting with employers consistent with Section 1357.22 or with the State Health Purchasing Program shall make reasonable efforts to contract with county hospital systems and clinics, including providers or networks of providers that refer enrollees to such hospitals and clinics, as well as community clinics and other safety net providers. This section shall not prohibit a plan from applying appropriate credentialing requirements consistent with this chapter. This section shall not apply to a nonprofit health care service plan that provides hospital services to its enrollees primarily through a nonprofit hospital corporation with which the health care service plan shares an identical board of directors.

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

CHAPTER 8.1. INSURANCE MARKET REFORM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) If an employer, as defined in Section 2022.6 of the Labor Code, chooses to purchase more than one means of coverage, the employer may require a higher level of contribution from potential enrollees so long as one means of coverage meets the standards of this section.

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

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

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

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

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

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

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

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

(2) Organizations that represent persons with disabilities.

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

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

(5) Employer organizations.

(b) The board shall develop a Healthy Families premium assistance program for eligible individuals as permitted under federal law to reduce state costs and maximize federal financial participation by providing health care coverage to eligible individuals through a combination of available employer-based coverage and a wraparound benefit that covers any gap between the employer-based coverage and the benefits required by this part.

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

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

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

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

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

131. "Contributions" means the money payments to the Unemployment Fund, Employment Training Fund, *State Health Purchasing Fund,* or Unemployment Compensation Disability Fund which are required by this division.

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

976.7. (a) In addition to other contributions required by this division and consistent with the requirements of Chapter 6 (commencing with Section 2160) of Part 8.7 of Division 2 of the Labor Code, an employer shall pay to the department for deposit into the State Health Purchasing Fund a fee in the amount set by the Managed Risk Medical Insurance Board for the State Health Purchasing Program in accordance with Chapter 4 (commencing with Section 2140) of Part 8.7 of Division 2 of the Labor Code. The fees shall be collected in the same manner and at the same time as any contributions required under Sections 976 and 1088.

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

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

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

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

(b) If Medi-Cal fee-for-service utilization or Medi-Cal fee-for-service payments to county-owned hospitals and clinics, community clinics, and other vital institutional safety net providers eligible for Medi-Cal payments under Section 14105.98 have been reduced, then the department shall review statute, regulations, policies and procedures, payment arrangements or other mechanisms to determine what changes may be necessary to protect Medi-Cal funding and maximize federal financial participation to protect the financial stability of county-owned hospitals and clinics, community clinics, and other vital institutional safety net providers. The department shall consult with representatives of county-owned hospital systems, community clinics, vital institutional safety net providers eligible for Medi-Cal payments under Section 14105.98, legal services advocates, and recognized collective bargaining agents for the specified providers.

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

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

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

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(c) The department in implementing the premium assistance program shall promptly reimburse an applicant for Medi-Cal for his or her share of premium, minus any share of cost required pursuant to this part. Once enrolled in both the premium assistance program and employer-based health care coverage repayment to Medi-Cal covered enrollees of any share of premium shall coincide with the payment by the enrollee of the premium for the available employer-based health care coverage. Where the applicant or beneficiary avails himself or herself of the wraparound benefit, Medi-Cal shall pay for any copayments, deductibles, and other allowable out-of-pocket medical costs under the employer-based coverage.

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

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

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

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

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

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

(1) The Managed Risk Medical Insurance Board.

(2) Representatives of county welfare departments.

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

(4) Organizations that represent persons with disabilities.

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

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

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

(1) Provide that enrollees and, if applicable, dependents who receive coverage consistent with the Health Insurance Act of 2003 and who are enrolled in Medi-Cal retain the same amount, duration, and scope of benefits to which those beneficiaries currently are entitled.

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

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

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

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

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

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

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

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

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

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

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

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

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

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

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

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

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

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

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

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be withheld at the victim's request, or at the request of the

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victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code, except that the address of the victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph shall not be used directly or indirectly to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury.

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

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

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

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

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

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

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

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

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

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

(q) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

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

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

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

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

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

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

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

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

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

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

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

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

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

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

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

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

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

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

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 13. (a) 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, except as provided in subdivision (b) or (c).

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

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

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

SEC. 15. 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.