AMENDED IN SENATE MARCH 29, 2017

SENATE BILL No. 562

Introduced by Senators Lara and Atkins
(Coauthors: Senators Allen, Galgiani, McGuire, and Skinner)
(Coauthors: Assembly Members Bonta, Chiu, Friedman, Nazarian, and Thurmond)

February 17, 2017

An act *to add Title 22.2 (commencing with Section 100600) to the Government Code,* relating to health care ~~coverage.~~ *coverage, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

SB 562, as amended, Lara. ~~Californians For A~~ *The* Healthy California Act.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. PPACA required each state, by January 1, 2014, to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing law, the Knox-Keene Health Care Service Plan Act of ~~1975,~~ *1975 (Knox-Keene),* provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of

Insurance. *Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.*

~~This bill would make findings and declarations with regard to the availability and affordability of health care coverage and would state the intent of the Legislature to enact legislation that would establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.~~

This bill, the Healthy California Act, would create the Healthy California program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that the program cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including, but not limited to, the state's Children's Health Insurance Program (CHIP), Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approval, and agreements to allow various existing federal health care payments to be paid to the Healthy California program, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would also provide for the participation of health care providers in the program, require care coordination for members, provide for payment for health care services and care coordination, and specify program standards. The bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the Healthy California program. The bill would create the Healthy California Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would create the Healthy California Board to govern the program, made up of 9 members with demonstrated and acknowledged expertise in health care, and appointed as provided. The bill would

provide the board with all the powers and duties necessary to establish the Healthy California program, including, but not limited to, determining when individuals may start enrolling into the program, employing necessary staff, and negotiating and entering into any necessary contracts. The bill would also require the Secretary of California Health and Human Services to establish a public advisory committee to advise the board on all matters of policy for the Healthy California program.

This bill would prohibit health care service plans and health insurers from offering health benefits or covering any service for which coverage is offered to individuals under the program, except as provided. The bill would authorize health care providers, as defined, to collectively negotiate rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies using a third-party representative, as provided.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

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

~~SECTION 1. This act shall be known, and may be cited, as the Californians for a Healthy California Act.~~

~~SEC. 2.~~

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

(1) All residents of this state have the right to health care. While the federal Patient Protection and Affordable Care Act *(PPACA)* brought many improvements in health care and health care coverage, it still leaves many Californians without coverage or with inadequate coverage.

(2) Californians, as individuals, employers, and taxpayers have experienced a rise in the cost of health care and health care coverage in recent years, including rising premiums, deductibles,

and copays, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan's economic needs rather than consumers' health care needs.

(5) To address the fiscal crisis facing the health care system and the state, and to ensure Californians can exercise their right to health care, comprehensive health care coverage needs to be provided.

~~(b)~~

(6) It is the intent of the Legislature to ~~enact legislation that would~~ establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.

(b) (1) It is further the intent of the Legislature to establish the Healthy California (HC) program to provide universal health coverage for every Californian based on his or her ability to pay and funded by broad-based revenue.

(2) It is the intent of the Legislature for the state to work to obtain waivers and other approvals relating to Medi-Cal, the state's Children's Health Insurance Program, Medicare, the PPACA, and any other federal programs so that any federal funds and other subsidies that would otherwise be paid to the State of California, Californians, and health care providers would be paid by the federal government to the State of California and deposited in the Healthy California Trust Fund.

(3) Under those waivers and approvals, those funds would be used for health coverage that provides health benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(4) Those programs would be replaced and merged into the HC program, which will operate as a true single-payer program.

(5) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan

amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally matched public health programs and federal health programs in the HC program.

(6) Thus, even if other programs such as Medi-Cal or Medicare may contribute to paying for care, it is the goal of this act that the coverage be delivered by the HC program, and, as much as possible, that the multiple sources of funding be pooled with other HC program funds and not be apparent to HC program members or participating providers.

(c) This act does not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.

(d) (1) It is the intent of the Legislature not to change or impact in any way the role or authority of any licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law, including, but not limited to, the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, as applicable.

(2) This act would in no way authorize the Healthy California Board, the Healthy California program, or the Secretary of California Health and Human Services to establish or revise licensure standards for health care providers.

(e) It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

(f) (1) It is the intent of the Legislature to prohibit the HC program, a state agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone, including, but not limited to, the federal government, any personally identifiable information obtained, including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(2) This act would also prohibit law enforcement agencies from using the HC program's funds, facilities, property, equipment, or

personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

(g) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

SEC. 2. Title 22.2 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 22.2. THE HEALTHY CALIFORNIA ACT

CHAPTER 1. GENERAL PROVISIONS

100600. This title shall be known, and may be cited, as the Healthy California Act.

100601. There is hereby established in state government the Healthy California program to be governed by the Healthy California Board pursuant to Chapter 2 (commencing with Section 100610).

100602. For the purposes of this title, the following definitions apply:

(a) "Affordable Care Act" or "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(b) "Allied health practitioner" means a group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat, and rehabilitate people of all ages and in all specialties. Together with a range of technical and support staff, they may deliver direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include, but are not limited to, audiologists, occupational therapists, social workers, and radiographers.

(c) "Board" means the Healthy California Board described in Section 100610.

(d) "Care coordination" means services provided by a care coordinator under Section 100637.

(e) "Care coordinator" means an individual or entity approved by the board to provide care coordination under Section 100637.

(f) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(g) "Committee" means the public advisory committee established pursuant to Section 100611.

(h) "Essential community providers" means persons or entities acting as safety net clinics, safety net health care providers, or rural hospitals.

(i) "Federally matched public health program" means the state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the state's Children's Health Insurance Program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(j) "Fund" means the Healthy California Trust Fund established under Section 100655.

(k) "Health care organization" means an entity that is approved by the board under Section 100640 to provide health care services to members under the program.

(l) "Health care service" means any health care service, including care coordination, that is included as a benefit under the program.

(m) "Healthy California" or "HC" means the Healthy California program established in Section 100601.

(n) "Implementation period" means the period under subdivision (f) of Section 100612 during which the program is subject to special eligibility and financing provisions until it is fully implemented under that section.

(o) "Integrated health care delivery system" means a provider organization that meets both of the following criteria:

(1) Is fully integrated operationally and clinically to provide a broad range of health care services, including preventative care, prenatal and well-baby care, immunizations, screening diagnostics,

emergency services, hospital and medical services, surgical services, and ancillary services.

(2) Is compensated by Healthy California using capitation or facility budgets for the provision of health care services.

(p) "Long-term care" means long-term care, treatment, maintenance, or services not covered under the state's Children's Health Insurance Program (CHIP), as appropriate, with the exception of short-term rehabilitation, and as defined by the board.

(q) "Medicaid" or "medical assistance" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The state's Children's Health Insurance Program (CHIP) under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(r) "Medicare" means Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(s) "Member" means an individual who is enrolled in the program.

(t) "Out-of-state health care service" means a health care service provided in person to a member while the member is physically located out of the state under either of the following circumstances:

(1) It is medically necessary that the health care service be provided while the member physically is out of the state.

(2) It is clinically appropriate and necessary, and cannot be provided in the state, because the health care service can only be provided by a particular health care provider physically located out of the state. However, any health care service provided to an HC member by a health care provider qualified under Section 100635 that is located outside the state shall not be considered an out-of-state service and shall be covered as otherwise provided in this title.

(u) "Participating provider" means any individual or entity that is a health care provider qualified under Section 100635 that provides health care services to members under the program, or a health care organization.

(v) "Prescription drugs" means prescription drugs as defined in subdivision (n) of Section 130501 of the Health and Safety Code.

(w) "Program" means the Healthy California program established in Section 100601.

(x) "Resident" means an individual whose primary place of abode is in the state, without regard to the individual's immigration status.

100603. This title does not preempt any city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this title.

100604. To the extent any provision of California law is inconsistent with this title or the legislative intent of the Healthy California Act, this title shall apply and prevail, except when explicitly provided otherwise by this title.

Chapter 2. Governance

100610. (a) The Healthy California Board shall be an independent public entity not affiliated with an agency or department. The board shall be governed by an executive board consisting of nine members who are residents of California. Of the members of the board, four shall be appointed by the Governor, two shall be appointed by the Senate Committee on Rules, and two shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or his or her designee shall serve as a voting, ex officio member of the board.

(b) Members of the board, other than an ex officio member, shall be appointed for a term of four years. Appointments by the Governor shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of his or her successor. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care.

(2) Appointing authorities shall also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care.

(3) Appointments to the board by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall be composed of:

(A) At least one representative of a labor organization representing registered nurses.

(B) At least one representative of the general public.

(C) At least one representative of a labor organization.

(D) At least one representative of the medical provider community.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this title, the Affordable Care Act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through the program, and to ensure the operational well-being and fiscal solvency of the program.

(e) In making appointments to the board, the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the board's composition reflects the communities of California.

(f) (1) A member of the board or of the staff of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a health care provider, a health care facility, or a health clinic while serving on the board or on the staff of the board. A member of the board or of the staff of the board shall not be a member, a board member, or an employee of a trade association of health facilities, health clinics, or health care providers while serving on the board or on the staff of the board. A member of the board or of the staff of the board shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a health care practice.

(2) A board member shall not receive compensation for his or her service on the board, but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(3) For purposes of this subdivision, "health care provider" means a person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions

Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act.

(g) A member of the board shall not make, participate in making, or in any way attempt to use his or her official position to influence the making of a decision that he or she knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(h) There shall not be liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this title or affairs related to this title.

(i) The board shall hire an executive director to organize, administer, and manage the operations of the board. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(j) The board shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(k) The board may adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

100611. (a) The Secretary of California Health and Human Services shall establish a public advisory committee to advise the board on all matters of policy for the program.

(b) The members of the committee shall include all of the following:

(1) Four physicians, all of whom shall be board certified in their fields, and at least one of whom shall be a psychiatrist. The Senate Committee on Rules and the Governor shall each appoint one member. The Speaker of the Assembly shall appoint two of these members, both of whom shall be primary care providers.

(2) Two registered nurses, to be appointed by the Senate Committee on Rules.

(3) One licensed allied health practitioner, to be appointed by the Speaker of the Assembly.

(4) One mental health care provider, to be appointed by the Senate Committee on Rules.

(5) One dentist, to be appointed by the Governor.

(6) One representative of private hospitals, to be appointed by the Governor.

(7) One representative of public hospitals, to be appointed by the Governor.

(8) One representative of an integrated health care delivery system, to be appointed by the Governor.

(9) Four consumers of health care. The Governor shall appoint two of these members, one of whom shall be a member of the disabled community. The Senate Committee on Rules shall appoint a member who is 65 years of age or older. The Speaker of the Assembly shall appoint the fourth member.

(10) One representative of organized labor, to be appointed by the Speaker of the Assembly.

(11) One representative of essential community providers, to be appointed by the Senate Committee on Rules.

(12) One member of organized labor, to be appointed by the Senate Committee on Rules.

(13) One representative of small business, which is a business that employs less than 25 people, to be appointed by the Governor.

(14) One representative of large business, which is a business that employs more than 250 people, to be appointed by the Speaker of the Assembly.

(15) One pharmacist, to be appointed by the Speaker of the Assembly.

(c) In making appointments pursuant to this section, the Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(d) Any member appointed by the Governor, the Senate Committee on Rules, or the Speaker of the Assembly shall serve a four-year term. These members may be reappointed for succeeding four-year terms.

(e) Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was initially selected or appointed. The Secretary of California Health and Human Services shall notify the appropriate appointing authority of any expected vacancies on the public advisory committee.

(f) Members of the committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive one hundred dollars ($100) for each full day of attending meetings of the committee. For purposes of this section, "full day of attending a meeting" means presence at, and participation in, not less than 75 percent of the total meeting time of the committee during any particular 24-hour period.

(g) The public advisory committee shall meet at least six times per year in a place convenient to the public. All meetings of the committee shall be open to the public, pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

(h) The public advisory committee shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

(i) Appointed committee members shall have worked in the field they represent on the committee for a period of at least two years prior to being appointed to the committee.

(j) It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any

information that is filed with, or obtained by, the committee and that is not generally available to the public.

100612. (a) The board shall have all powers and duties necessary to establish and implement Healthy California under this title. The program shall provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

(b) The board shall, to the maximum extent possible, organize, administer, and market the program and services as a single-payer program under the name "HC," "Healthy California," or any other name as the board determines, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. In implementing this title, the board shall avoid jeopardizing federal financial participation in the programs that are incorporated into Healthy California and shall take care to promote public understanding and awareness of available benefits and programs.

(c) The board shall consider any matter to effectuate the provisions and purposes of this title. The board shall have no executive, administrative, or appointive duties except as otherwise provided by law.

(d) The board shall employ necessary staff and authorize reasonable expenditures, as necessary, from the Healthy California Trust Fund to pay program expenses and to administer the program.

(e) The board may do all of the following:

(1) Negotiate and enter into any necessary contracts, including, but not limited to, contracts with health care providers, integrated health care delivery systems, and care coordinators.

(2) Sue and be sued.

(3) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state.

(4) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation.

(5) Share information with relevant state departments, consistent with the confidentiality provisions in this title, necessary for the administration of the program.

(f) The board shall determine when individuals may begin enrolling in the program. There shall be an implementation period that begins on the date that individuals may begin enrolling in the program and ends on a date determined by the board.

(g) A carrier may not offer benefits or cover any services for which coverage is offered to individuals under the program, but may, if otherwise authorized, offer benefits to cover health care services that are not offered to individuals under the program. However, this title does not prohibit a carrier from offering either of the following:

(1) Any benefits to or for individuals, including their families, who are employed or self-employed in the state but who are not residents of the state.

(2) Any benefits during the implementation period to individuals who enrolled or may enroll as members of the program.

(h) After the end of the implementation period, a person shall not be a board member unless he or she is a member of the program, except the ex officio member.

(i) No later than two years after the effective date of this section, the board shall develop the following proposals:

(1) The board shall develop a proposal, consistent with the principles of this title, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the principles of this title, for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties.

(2) The board shall develop proposals for both of the following:

(A) Accommodating employer retiree health benefits for people who have been members of HC but live as retirees out of the state.

(B) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state prior to the implementation of HC and live as retirees out of the state.

(3) The board shall develop a proposal for HC coverage of health care services currently covered under the workers' compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

100613. The board may contract with not-for-profit organizations to provide both of the following:

(a) Assistance to consumers with respect to selection of a care coordinator or health care organization, enrolling, obtaining health care services, disenrolling, and other matters relating to the program.

(b) Assistance to health care providers providing, seeking, or considering whether to provide health care services under the program, with respect to participating in a health care organization and interacting with a health care organization.

100614. The board shall provide grants from funds in the Healthy California Trust Fund or from funds otherwise appropriated for this purpose to health planning agencies established pursuant to Section 127155 of the Health and Safety Code to support the operation of those health planning agencies.

100615. The board shall provide funds from the Healthy California Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers for health care, whose jobs may be or have been ended as a result of the implementation of the program, consistent with otherwise applicable law.

100616. (a) The board shall provide for the collection and availability of all of the following data to promote transparency, assess adherence to patient care standards, compare patient outcomes, and review utilization of health care services paid for by the program:

(1) Inpatient discharge data, including acuity and risk of mortality.

(2) Emergency department and ambulatory surgery data, including charge data, length of stay, and patients' unit of observation.

(3) Hospital annual financial data, including all of the following:

(A) Community benefits by hospital in dollar value.

(B) Number of employees and classification by hospital unit.

(C) Number of hours worked by hospital unit.

(D) Employee wage information by job title and hospital unit.

(E) Number of registered nurses per staffed bed by hospital unit.

(F) Type and value of healthy information technology.

(G) Annual spending on health information technology, including purchases, upgrades, and maintenance.

(b) The board shall make all disclosed data collected under subdivision (a) publicly available and searchable through an Internet Web site and through the Office of Statewide Health Planning and Development public data sets.

(c) The board shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the Healthy California program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs of the Office of Statewide Health Planning and Development and the California Health and Human Services Agency, consistent with this title and otherwise applicable law.

(d) Prior to full implementation of the program, the board shall provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for all of the following categories of Office of Statewide Health Planning and Development data items:

(1) Patients receiving charity care.

(2) Contractual adjustments of county and indigent programs, including traditional and managed care.

(3) Bad debts.

100617. (a) Notwithstanding any other law, Healthy California, any state or local agency, or a public employee acting under color of law shall not provide or disclose to anyone, including, but not limited to, the federal government any personally identifiable information obtained, including, but not limited to, a person's religious beliefs, practices, or affiliation, national origin,

ethnicity, or immigration status for law enforcement or immigration purposes.

(b) Notwithstanding any other law, law enforcement agencies shall not use Healthy California moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.

Chapter 3. Eligibility and Enrollment

100620. (a) Every resident of the state shall be eligible and entitled to enroll as a member under the program.

(b) (1) A member shall not be required to pay any fee, payment, or other charge for enrolling in or being a member under the program.

(2) A member shall not be required to pay any premium, copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits.

(c) A college, university, or other institution of higher education in the state may purchase coverage under the program for a student, or a student's dependent, who is not a resident of the state.

Chapter 4. Benefits

100630. (a) Covered health care benefits under the program include all medical care determined to be medically appropriate by the member's health care provider.

(b) Covered health care benefits for members shall include, but are not limited to, all of the following:

(1) Licensed inpatient and licensed outpatient medical and health facility services.

(2) Inpatient and outpatient professional health care provider medical services.

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

(4) Medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for individual use.

(5) Inpatient and outpatient rehabilitative care.

(6) Emergency care services.

(7) Emergency transportation.

(8) Necessary transportation for health care services for persons with disabilities or who may qualify as low income.

(9) Child and adult immunizations and preventive care.

(10) Health and wellness education.

(11) Hospice care.

(12) Care in a skilled nursing facility.

(13) Home health care, including health care provided in an assisted living facility.

(14) Mental health services.

(15) Substance abuse treatment.

(16) Dental care.

(17) Vision care.

(18) Prescription drugs.

(19) Pediatric care.

(20) Prenatal and postnatal care.

(21) Podiatric care.

(22) Chiropractic care.

(23) Acupuncture.

(24) Therapies that are shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective.

(25) Blood and blood products.

(26) Dialysis.

(27) Adult day care.

(28) Rehabilitative and habilitative services.

(29) Ancillary health care or social services previously covered by county integrated health and human services programs pursuant to Chapter 12.96 (commencing with Section 18986.60) and Chapter 12.991 (commencing with Section 18986.86) of Part 6 of Division 9 of the Welfare and Institutions Code.

(30) Ancillary health care or social services previously covered by a regional center for persons with developmental disabilities pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(31) Case management and care coordination.

(32) Language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers.

(33) Health care and long-term supportive services currently covered under Medi-Cal or the state's Children's Health Insurance Program (CHIP).

(34) Covered benefits for members shall also include all health care services required to be covered under any of the following provisions, without regard to whether the member would otherwise be eligible for or covered by the program or source referred to:

(A) The state's Children's Health Insurance Program (CHIP) (Title XXI of the Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).

(B) Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(C) The federal Medicare program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(D) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) Division 2 of the Health and Safety Code).

(E) Health insurers, as defined in Section 106 of the Insurance Code, pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code.

(F) Any additional health care services authorized to be added to the program's benefits by the program.

(G) All essential health benefits mandated by the Affordable Care Act as of January 1, 2017.

CHAPTER 5. DELIVERY OF CARE

Article 1. Health Care Providers

100635. (a) (1) Any health care provider who is licensed to practice in California and is otherwise in good standing is qualified to participate in the program as long as the health care provider's services are performed within the State of California.

(2) The board shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under the program for

members who require out-of-state health care services while the member is temporarily located out-of-state.

(b) Any health care provider qualified to participate under this section may provide covered health care services under the program, as long as the health care provider is legally authorized to perform the health care service for the individual and under the circumstances involved.

(c) A member may choose to receive health care services under the program from any participating provider, consistent with provisions of this title, the willingness or availability of the provider, subject to provisions of this title relating to discrimination, and the appropriate clinically relevant circumstances.

(d) A person who chooses to enroll with an integrated health care delivery system, group medical practice, or essential community provider that offers comprehensive services, shall retain membership for at least one year after an initial three-month evaluation period during which time the person may withdraw for any reason.

(1) The three-month period shall commence on the date when a member first sees a primary care provider.

(2) A person who wants to withdraw after the initial three-month period shall request a withdrawal pursuant to the dispute resolution procedures established by the board and may request assistance from the patient advocate, which shall be provided for in the dispute resolution procedures, in resolving the dispute. The dispute shall be resolved in a timely fashion and shall not have an adverse effect on the care a patient receives.

Article 2. Care Coordination

100637. (a) Care coordination shall be provided to the member by his or her care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the board and with the statutory requirements and regulations of the care coordinator's licensure.

(b) Care coordination includes administrative tracking and medical recordkeeping services for members, except as otherwise specified for integrated health care delivery systems.

(c) Care coordination administrative tracking and medical recordkeeping services for members shall not be required to utilize a certified electronic health record, meet any other requirements of the federal Health Information Technology for Economic and Clinical Health, enacted under the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), or meet certification requirements of the federal Centers for Medicare & Medicaid Services' Electronic Health Records Incentive Programs, including meaningful use requirements.

(d) The care coordinator shall comply with all federal and state privacy laws, including, but not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1 of the Insurance Code), and Section 1798.81.5 of the Civil Code.

(e) Referrals from a care coordinator are not required for a member to see any eligible provider.

(f) A care coordinator may be an individual or entity that is approved by the program that is any of the following:

(1) A health care practitioner that is any of the following:

(A) The member's primary care provider.

(B) The member's provider of primary gynecological care.

(C) At the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition.

(2) An entity licensed pursuant to any of the following provisions:

(A) Health facility, Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(B) Health care service plan, Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) Division 2 of the Health and Safety Code).

(C) Long-term health care facility, as defined in Section 1418 of the Health and Safety Code, or a program developed pursuant to paragraph (1) of subdivision (i) of Section 100612, or a

long-term health care facility with respect to a member who receives mental health care services.

(D) County medical facility, Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(E) Residential care facility for persons with chronic, life-threatening illness, Chapter 3.01 (commencing with Section 1568.01) of Division 2 of the Health and Safety Code.

(F) Alzheimer's day care-resource center, Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code.

(G) Residential care facility for the elderly, Chapter 3.2 (commencing with Section 1569) of Division 2 of the Health and Safety Code.

(H) Home health agency, Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(I) Private duty nursing agency, Chapter 8.3 (commencing with Section 1743) of Division 2 of the Health and Safety Code.

(J) Hospice, Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(K) Pediatric day health and respite care facility, Chapter 8.6 (commencing with Section 1760) of Division 2 of the Health and Safety Code.

(L) Home care service, Chapter 13 (commencing with Section 1796.10) of Division 2 of the Health and Safety Code.

(M) Mental health care provider, pursuant to Division 4 (commencing with Section 4000 of the Welfare and Institutions Code).

(3) A health care organization.

(4) A Taft-Hartley health and welfare fund, with respect to its members and their family members. This provision does not preclude a Taft-Hartley health and welfare fund from becoming a care coordinator under paragraph (5) or a health care organization under Section 100640.

(5) Any not-for-profit or governmental entity approved by the program.

(g) (1) A health care provider shall only be reimbursed for services if the member is enrolled with a care coordinator at the time the health care service is provided.

(2) Every member shall be encouraged to enroll with a care coordinator that agrees to provide care coordination prior to

receiving health care services to be paid for under the program. If a member receives health care services before choosing a care coordinator, the program shall assist the member, when appropriate, with choosing a care coordinator.

(3) The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member. Members have the right to change their care coordinators on terms at least as permissive as Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) relating to an individual changing his or her primary care provider or managed care provider.

(h) A health care organization may establish rules relating to care coordination for members in the health care organization, different from this section but otherwise consistent with this title and other applicable laws.

(i) This section does not authorize any individual to engage in any act in violation of the provisions of Division 2 (commencing with Section 500) of the Business and Professions Code.

(j) An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual's professional scope of practice or the entity's legal authority.

(k) (1) The board shall develop and implement procedures and standards, by regulation, for an individual or entity to be approved as a care coordinator in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice, licensure standards, and regulations established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, as applicable.

(3) In developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health

care services, the board shall consult with the Mental Health Services Division of the State Department of Health Care Services and the Director of Developmental Services.

(l) To maintain approval under the program, a care coordinator shall do all of the following:

(1) Renew its status every three years pursuant to regulations adopted by the board.

(2) Provide to the program any data required by the Office of Statewide Health Planning and Development pursuant to Division 107 (commencing with Section 127000) of the Health and Safety Code that would enable the board to evaluate the impact of care coordinators on quality, outcomes, and cost of health care.

Article 3. Payment For Health Care Services and Care Coordination

100639. (a) The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

(b) Health care services provided to members under the program, except for care coordination, shall be paid for on a fee-for-service basis unless and until another payment methodology is established by the board.

(c) Notwithstanding subdivision (b), integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

(d) The program shall engage in good faith negotiations with health care providers' representatives under Chapter 8 (commencing with Section 100660), including, but not limited to, in relation to rates of payment for health care services, rates of

payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations shall be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

(e) (1) Payment for health care services established under this title shall be considered payment in full.

(2) A participating provider shall not charge any rate in excess of the payment established under this title for any health care service provided to a member under the program and shall not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program.

(3) However, this section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(f) The program may adopt, by regulation, payment methodologies for the payment of capital related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Any capital related expense generated by a capital expenditure that requires prior approval shall have received that approval in order to be paid by the program. That approval shall be based on achievement of the program standards described in Chapter 6 (commencing with Section 100645).

(g) Payment methodologies and payment rates shall include a distinct component of reimbursement for direct and indirect graduate medical education.

(h) The board shall adopt, by regulation, payment methodologies and procedures for paying for health care services provided to members while the member is located out-of-state.

Article 4. Health Care Organizations

100640. (a) A member may choose to enroll with and receive program care coordination and ancillary health care services from a health care organization.

(b) A health care organization shall be a not-for-profit or governmental entity that is approved by the board that is either of the following:

(1) A county integrated health and human services program under Chapter 12.96 (commencing with Section 18986.60) and Chapter 12.991 (commencing with Section 18986.86) of Part 6 of Division 9 of the Welfare and Institutions Code.

(2) A regional center for persons with developmental disabilities under Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(c) (1) The board shall develop and implement procedures and standards, by regulation, for an entity to be approved as a health care organization in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is incompetent to be a health care organization or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice and licensure standards established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code.

(3) In developing and implementing standards of approval of health care organizations, the board shall consult with the Mental Health Services Division of the State Department of Health Care Services and the Director of Developmental Services.

(d) To maintain approval under the program, a health care organization shall do both of the following:

(1) Renew its status at a frequency determined by the board.

(2) Provide data to the California Health and Human Services Agency, as required by the board, to enable the board to evaluate the health care organization in relation to the quality of health care services, health care outcomes, and cost.

(e) The board may adopt narrowly focused regulations relating solely to health care organizations for the sole and specific purpose of ensuring consistent compliance with this title.

(f) This title may not be construed to alter in any way the professional practice of health care providers or their licensure standards established pursuant to the Division 2 (commencing with Section 500) of the Business and Professions Code.

(g) Health care organizations shall not use health information technology or clinical practice guidelines that limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient's wishes.

CHAPTER 6. PROGRAM STANDARDS

100645. Healthy California shall establish a single standard of safe, therapeutic care for all residents of the state by the following means:

(a) The board shall establish requirements and standards, by regulation, for the program and for health care organizations, care coordinators, and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:

(1) The scope, quality, and accessibility of health care services.

(2) Relations between health care organizations or health care providers and members.

(3) Relations between health care organizations and health care providers, including credentialing and participation in the health care organization, and terms, methods, and rates of payment.

(b) The board shall establish requirements and standards, by regulation, under the program that include, but are not limited to, provisions to promote all of the following:

(1) Simplification, transparency, uniformity, and fairness in health care provider credentialing and participation in health care organization networks, referrals, payment procedures and rates, claims processing, and approval of health care services, as applicable.

(2) In-person primary and preventive care, care coordination, efficient and effective health care services, quality assurance, and promotion of public, environmental, and occupational health.

(3) Elimination of health care disparities.

(4) Consistent with the Unruh Civil Rights Act (Section 51 of the Civil Code), nondiscrimination with respect to members and health care providers on the basis of race, color, ancestry, national origin, religion, citizenship, immigration status, primary language, mental or physical disability, age, sex, gender, sexual orientation, gender identity or expression, medical condition, genetic information, marital status, familial status, military or veteran status, or source of income; however, health care services provided under the program shall be appropriate to the patient's clinically relevant circumstances.

(5) Accessibility of care coordination, health care organization services, and health care services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(6) Providing care coordination, health care organization services, and health care services in a culturally competent manner.

(c) The board shall establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with the Healthy California program health care services and ancillary services currently provided by other programs, including, but not limited to, Medicare, the Affordable Care Act, and federally matched public health programs.

(d) Any participating provider or care coordinator that is organized as a for-profit entity shall be required to meet the same requirements and standards as entities organized as not-for-profit entities, and payments under the program paid to those entities shall not be calculated to accommodate the generation of profit, revenue for dividends, or other return on investment or the payment of taxes that would not be paid by a not-for-profit entity.

(e) Every participating provider shall furnish information as required by the Office of Statewide Health Planning and Development pursuant to Division 107 (commencing with Section 127000) of the Health and Safety Code and permit examination of that information by the program as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

(f) In developing requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.

Chapter 7. Funding

Article 1. Federal Health Programs and Funding

100650. (a) The board shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate the program consistent with this title.

(b) (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs that provide federal funds for payment for health care services that are necessary to enable all Healthy California members to receive all benefits under the program through the program, to enable the state to implement this title, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the Healthy California Trust Fund, created pursuant to Section 100655, and to use those funds for the program and other provisions under this title.

(2) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to Healthy California in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

(3) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this title. Information provided by members to the board for the purposes of this subdivision shall not be used for any other purpose.

(4) The board may take any additional actions necessary to effectively implement Healthy California to the maximum extent possible as a single-payer program consistent with this title.

(c) The board may take actions consistent with this article to enable the program to administer Medicare in California, and the program shall be a provider of supplemental insurance coverage (Medicare Part B) and shall provide premium assistance drug coverage under Medicare Part D for eligible members of the program.

(d) The board may waive or modify the applicability of any provisions of this section relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to the program under this section, provided that the board, in consultation with the Director of Finance, determines that the waiver or modification is in the best interest of the state and members affected by the action.

(e) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare shall not cause any member to lose any health care service provided by the program or diminish any right the member would otherwise have.

(f) (1) Notwithstanding any other law, the board, by regulation, shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(2) The board may act under this subdivision, upon a finding approved by the Director of Finance and the board that the action does all of the following:

(A) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations

or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(B) Will not diminish any individual's access to any health care service or right the individual would otherwise have.

(C) Is in the interest of the program.

(D) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(3) Actions under this subdivision shall not apply to eligibility for payment for long-term care.

(g) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(h) As a condition of continued eligibility for health care services under the program, a member who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(i) The program shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage under Section 1860D of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(j) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member's eligibility for that subsidy; however, the board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(k) The program shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be

notified in writing that he or she has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member's coverage under the program may be terminated. Information provided by members to the board for the purposes of this section shall not be used for any other purpose.

(l) The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

Article 2. The Healthy California Trust Fund

100655. (a) The Healthy California Trust Fund is hereby created in the State Treasury for the purposes of this title. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

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

(c) The board shall establish and maintain a prudent reserve in the fund.

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

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

(f) The fund shall consist of all of the following:

(1) All moneys obtained pursuant to legislation enacted as proposed under Section 100657.

(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established

under Medicare, any federally matched public health program, or the Affordable Care Act.

(3) The amounts paid by the State Department of Health Care Services that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the Affordable Care Act for health benefits that are equivalent to health benefits covered under Healthy California.

(4) Federal and state funds for purposes of the provision of services authorized under Title XX of the Social Security Act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under Healthy California.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care services for services and benefits covered under Healthy California. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this title.

(g) All federal moneys shall be placed into the Healthy California Federal Funds Account, which is hereby created within the Healthy California Trust Fund.

(h) Moneys in the fund shall only be used for the purposes established in this title.

Article 3. Healthy California Financing

100657. (a) It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the program. In developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

(b) It is the intent of the Legislature to enact legislation that would require all state revenues from the program to be deposited in an account within the Healthy California Trust Fund to be established and known as the Healthy California Trust Fund Account.

Chapter 8. Collective Negotiation by Health Care Providers with Healthy California

Article 1. Definitions

100660. For purposes of this chapter, the following definitions apply:

(a) (1) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code and who is any of the following:

(A) An individual who practices that profession as a health care provider or as an independent contractor.

(B) An owner, officer, shareholder, or proprietor of a health care provider.

(C) An entity that employs or utilizes health care providers to provide health care services, including, but not limited to, a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A health care provider under Division 2 (commencing with Section 500) of the Business and Professions Code who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.

(b) "Health care providers' representative" means a third party that is authorized by health care providers to negotiate on their behalf with Healthy California over terms and conditions affecting those health care providers.

(c) "Healthy California" or "HC" means the Healthy California program established in Section 100601.

Article 2. Collective Negotiation Authorized

100662. (a) Health care providers may meet and communicate for the purpose of collectively negotiating with Healthy California on any matter relating to Healthy California, including, but not limited to, rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

(b) This chapter shall not be construed to allow or authorize an alteration of the terms of the internal and external review procedures set forth in law.

(c) This chapter shall not be construed to allow a strike of Healthy California by health care providers' related to the collective negotiations.

(d) This chapter shall not be construed to allow or authorize terms or conditions that would impede the ability of Healthy California to obtain or retain accreditation by the National Committee for Quality Assurance or a similar body, or to comply with applicable state or federal law.

Article 3. Collective Negotiation Requirements

100664. (a) Collective negotiation rights granted by this chapter shall meet all of the following requirements:

(1) Health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with HC.

(2) Health care providers may communicate with health care providers' representatives.

(3) A health care providers' representative is the only party authorized to negotiate with HC on behalf of the health care providers as a group.

(4) A health care provider can be bound by the terms and conditions negotiated by the health care providers' representatives.

(5) In communicating or negotiating with the health care providers' representative, HC is entitled to offer and provide different terms and conditions to individual competing health care providers.

(b) This chapter does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

(c) This chapter does not affect or limit collective action or collective bargaining on the part of a health care provider with his or her employer or any other lawful collective action or collective bargaining.

100666. (a) Before engaging in collective negotiations with HC on behalf of health care providers, a health care providers'

representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this chapter.

(b) Each person who acts as the representative of negotiating parties under this chapter shall pay a fee to the board to act as a representative. The board, by regulation, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this chapter.

Article 4. Prohibited Collective Action

100668. (a) This chapter does not authorize competing health care providers to act in concert in response to a health care providers' representative's discussions or negotiations with HC, except as authorized by other law.

(b) A health care providers' representative shall not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

SEC. 3. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Sections 100610 and 100617 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect private, confidential, and proprietary information, it is necessary for that information to remain confidential.

O