AMENDED IN ASSEMBLY NOVEMBER 8, 2007

CALIFORNIA LEGISLATURE—2007–08 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL No. 8

Introduced by Assembly Member Villines
(Coauthors: Assembly Members Benoit, Blakeslee, Emmerson, Gaines, Garrick, Keene, Nakanishi, Niello, Smyth, and Strickland)

November 6, 2007

An act *to amend Section 3523 of the Business and Professions Code,* to add Sections 22869.5 and 22917 to the Government Code, to amend Section 1399.72 of, ~~and~~ to add Sections 1349.3 and 1367.08 to, *and to add Article 6 (commencing with Section 128559) to Chapter 5 of Part 3 of Division 107 of,* the Health and Safety Code, to add Sections 699.6 and 10119.3 to, and to add Part 6.6 (commencing with Section 12739.10) to Division 2 of, the Insurance Code, to amend Sections 17072, 17215, and 19184 of, to amend and repeal Sections 17131.4, 17131.5, 17215.1, and 17215.4 of, to add Sections 17053.102, 17138.5, 17138.6, 17204, and 17216 to, and to add and repeal Sections 17053.77 and 23677 of, the Revenue and Taxation Code, and to add Section 14078.5 to, and to add Article 2.93 (commencing with Section 14091.50) to Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 8, as amended, Villines. Health care.

(1) Existing law, the Physician Assistant Practice Act, establishes the Physician Assistant Committee of the Medical Board of California. Under existing law, the committee licenses physician assistants under the name of the board and regulates the practice of physician assistants.

Existing law requires the Office of Statewide Health Planning and Development to establish a nonprofit public benefit corporation known as the Health Professions Education Foundation to perform various duties with respect to implementing health professions scholarship and loan programs.

This bill would create the California Physician Assistant Scholarship and Loan Repayment Program within the foundation to provide scholarships to physician assistant students and to repay qualifying educational loans of physician assistants who practice in medically underserved areas of the state and in specified clinics. The bill would establish the California Physician Assistant Scholarship and Loan Repayment Program Fund in the State Treasury and would make its revenue available for expenditure for the program upon appropriation by the Legislature. The bill would direct the deposit of voluntary contributions made by a physician assistant upon renewal of his or her license into the fund. The bill would require the foundation to report to the Legislature on the program, as specified. The bill would make implementation of the program contingent upon sufficient revenue being available in the fund for those purposes.

~~(1)~~

(2) Under the Public Employees' Medical and Hospital Care Act, the Board of Administration of the Public Employees' Retirement System contracts for and administers health care benefit plans for public employees and annuitants. Existing state and federal income tax laws allow a deduction for contributions to a qualifying medical savings account by a taxpayer who is covered under a high deductible health plan, as defined. Money within this type of account may be used to pay for qualified medical expenses, as defined.

This bill would require the Board of Administration of the Public Employees' Retirement System to offer a high deductible health plan, as defined in the federal tax law, and a health savings account option to public employees and annuitants, as specified. The bill would establish the Public Employees' Health Savings Fund, a continuously appropriated trust fund within the State Treasury, for payment of qualified medical expenses of employees and annuitants who elect to enroll in the high deductible health plan and participate in the health savings account option, and would require those employees and annuitants, and their employers, to make specified contributions to that fund, thereby making an appropriation.

~~(2)~~

(3) The Knox-Keene Health Care Service Plan Act of 1975, the willful violation of which is a crime, 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 insurers by the Department of Insurance.

Existing law requires, subject to specified exceptions, that a health care service plan be licensed by the Department of Managed Health Care and provide basic health care services, as defined, unless exempted from that requirement by the director of the department. Existing law also requires, subject to specified exceptions, that an insurer obtain a certificate of authority from the Insurance Commissioner in order to transact business in this state and that the insurer operate in accordance with specified requirements. Under existing law, a plan and a health insurer are required to include or offer to include specified benefits in their plan contracts or policies.

This bill would allow a carrier domiciled in another state to offer, sell, or renew a health care service plan or a health insurance policy in this state without holding a license issued by the department or a certificate of authority issued by the commissioner. The bill would exempt the carrier's plan or policy from requirements otherwise applicable to plans and insurers providing health care coverage in this state if the plan or policy complies with the domiciliary state's requirements, and the carrier is lawfully authorized to issue the plan or policy in that state and to transact business there. The bill would also allow a health care service plan contract and a health insurance policy to be issued, renewed, or amended, on and after July 1, 2008, without certain of those specified benefits that the applicant, contractholder, or policyholder has waived. The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to prepare a disclosure form prior to July 1, 2008, summarizing the benefits a plan and insurer are required to include in their plan contracts or policies and those that may be waived. The bill would require the applicant, contractholder, or policyholder to designate in the disclosure form the benefits he or she is waiving and to acknowledge his or her understanding, as specified, of the disclosure's contents.

The Knox-Keene Health Care Service Plan Act of 1975 requires that a plan intending to convert from nonprofit to for-profit status, submit a conversion proposal to the director and, before approving the conversion, the director is required to find that the proposal sets aside the fair market value of the nonprofit plan and dedicates and transfers

it to a tax-exempt charitable organization with a charitable mission and grantmaking function of serving the health care needs of the people of California.

This bill would instead require that at least 90% of the money expended annually to fulfill the charitable mission and grantmaking function of the tax-exempt charitable organization receiving the set-aside be spent on health care services for Californians, as specified, who are not receiving health care services through a government program.

~~(3)~~

(4) Existing law creates the Managed Risk Medical Insurance Board, which administers various programs to arrange for the provision of health care coverage to persons meeting specified eligibility criteria.

This bill would establish the California Health Insurance Exchange, which would be administered by the board. The bill would, beginning September 1, 2008, allow an employer that sponsors a cafeteria plan in compliance with federal law and that has entered into an agreement with the board, to transmit premium payments for individual plan contracts and individual insurance policies obtained by its employees through the cafeteria plan to the exchange for remittance to the issuing plan or insurer that has agreed to participate in the exchange. The bill would create the California Health Insurance Exchange Fund, in which the premium payments would be deposited prior to remittance to the carrier. The bill would continuously appropriate the revenues in the California Health Insurance Exchange Fund to the board for purposes of operating the exchange. The bill would require the board to report certain information to the Governor and the Legislature relating to the exchange. The bill would authorize the board to charge a fee required in order to implement these provisions.

~~(4)~~

(5) The Personal Income Tax Law authorizes various deductions in computing income that is subject to tax under that law.

This bill would allow a deduction in computing adjusted gross income for the costs of health insurance, as provided. The bill would also allow a deduction in connection with health savings accounts in conformity with federal law, which would generally be an amount equal to the aggregate amount paid in cash during the taxable year by, or on behalf of, an eligible individual, as defined, to a health savings account of that individual, as provided. The bill would also provide related conformity to that federal law with respect to treatment of the account as a tax-exempt trust, the allowance of rollovers from Archer Medical

Savings Accounts, health flexible spending arrangements, or health reimbursement accounts to a health savings account, and penalties in connection therewith. The bill would additionally allow a physician a credit in an amount equal to 50% of the fair market value of uncompensated medical care, as specified, provided to an eligible individual, as defined.

The Personal Income Tax Law and the Corporation Tax Law authorize various credits against the taxes imposed by those laws.

This bill would authorize a credit against those taxes for each taxable year beginning on or after January 1, 2008, and before January 1, 2013, in an amount equal to 15% of the amount paid or incurred by a qualified taxpayer, as defined, during the taxable year for qualified health insurance, as defined, for specified employees of the taxpayer. This bill would also require the Franchise Tax Board and the Legislative Analyst to report on the usage and effectiveness of the credit, as specified.

~~(5)~~

(6) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons.

This bill would require the Director of Health Care Services to increase reimbursement rates for physician services and hospitals under the Medi-Cal program to a level that equals 80% of the Medicare reimbursement rate for those same services and would require the department to make specified determinations prior to a rate adjustment. It would specify that the adjustment does not apply to physician services for which reimbursement already equals or succeeds the 80% rate. The bill would also require the department to consider prescribed factors in making subsequent rate adjustments.

This bill would also require the State Department of Health Care Services to prepare and submit a proposal for a demonstration project by July 31, 2008, for participation in the federal Medicaid Demonstration Project for Health Opportunity Accounts and would specify the details of that demonstration project.

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

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

SECTION 1. Section 3523 of the Business and Professions Code is amended to read:

3523. *(a) (1)* All physician assistant licenses shall expire at 12 midnight of the last day of the birth month of the licensee during the second year of a two-year term if not renewed.

~~The~~

(2) The committee shall establish by regulation procedures for the administration of a birthdate renewal program, including, but not limited to, the establishment of a system of staggered license expiration dates and a pro rata formula for the payment of renewal fees by physician assistants affected by the implementation of the program.

~~To~~

(b) To renew an unexpired license, the licensee shall, on or before the date of expiration of the license, apply for renewal on a form provided by the committee, accompanied by the prescribed renewal fee.

(c) At the time of renewing a physician assistant license, the licensee may make a voluntary contribution of twenty-five dollars ($25) or more to the board for the sole purpose of funding the California Physician Assistant Scholarship and Loan Repayment Program established pursuant to Article 6 (commencing with Section 128559) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code. The board shall transmit the contribution submitted pursuant to this subdivision for deposit in the California Physician Assistant Scholarship and Loan Repayment Program Fund established pursuant to Section 128559.2 of the Health and Safety Code.

~~SECTION 1.~~

SEC. 2. Section 22869.5 is added to the Government Code, to read:

22869.5. (a) The Legislature hereby finds and declares all of the following:

(1) The Board of Administration of the Public Employees' Retirement System administers health benefits for employees and annuitants, and their family members, from state and local public agencies.

(2) Health savings accounts have been viewed as an alternative to the traditional health insurance market and give patients more control over their health care options and expenses.

(3) Health savings accounts are tax-exempt accounts that allow individuals to pay for health care expenses in conjunction with high-deductible catastrophic coverage.

(4) The benefits to patients who receive health insurance coverage through a health savings account include increased treatment options, access to specialty care, and strengthening of the patient-physician relationship.

(b) The board shall offer a health savings account option to all employees and annuitants beginning January 1, 2008. In addition to the basic health benefit plans described in Sections 22830 and 22850, and notwithstanding any other provision of this part, the board shall approve at least one high deductible health plan, as defined in Section 220(c)(2) of the Internal Revenue Code.

(c) The design and administration of the health savings account option shall comply with the standards provided in Section 220 of the Internal Revenue Code and any other applicable revenue procedures or provisions of the Internal Revenue Code and the Revenue and Taxation Code.

(d) (1) An employee or annuitant who elects to participate in the health savings account option shall enroll in a high deductible health plan offered by the board and shall contribute the total cost per month of the benefit coverage afforded him or her under that plan less the portion thereof to be contributed by the employer.

(2) The employee or annuitant shall also designate an additional amount to be deducted from his or her salary or retirement allowance for qualified medical expenses, which amount shall be deposited into the Public Employees' Health Savings Fund and shall be credited to a nominal account in the name of the employee or annuitant.

(3) For purposes of this section, "qualified medical expenses" means those expenses as defined in Section 220(d)(2) of the Internal Revenue Code.

(e) (1) The employer of an employee or annuitant who elects to participate in the health savings account option shall contribute a portion, pursuant to Article 7 (commencing with Section 22870) or Article 8 (commencing with Section 22890), of the cost of providing the benefit coverage under the high deductible health plan.

(2) The employer shall also contribute an amount equal to the difference between the amount contributed pursuant to paragraph

(1) and the weighted average of the health benefit plan premiums the employer would have paid if the employee or annuitant had enrolled in a plan other than the high deductible health plan, which amount shall be deposited into the Public Employees' Health Savings Fund and shall be credited to a nominal account in the name of the employee or annuitant.

(f) Moneys credited to the employee's or annuitant's nominal account in the Public Employees' Health Savings Fund shall be disbursed to pay qualified medical expenses incurred by the employee or annuitant, in accordance with Section 220 of the Internal Revenue Code.

(g) The board shall adopt regulations necessary to implement this section.

~~SEC. 2.~~

SEC. 3. Section 22917 is added to the Government Code, to read:

22917. (a) There is in the State Treasury a Public Employees' Health Savings Fund, the purpose of which is to pay the qualified medical expenses of health savings accountholders pursuant to Section 22869.5 and pursuant to Section 220 of the Internal Revenue Code. The board shall have the exclusive control of the administration and investment of the fund.

(b) The Public Employees' Health Savings Fund shall consist of moneys deducted from the salary or retirement allowance of an employee or annuitant, and moneys contributed by the employee's or annuitant's employer, for qualified medical expenses pursuant to Section 22869.5.

(c) The board may invest funds in the Public Employees' Health Savings Fund pursuant to the law governing its investment of the retirement fund, subject to the limitations contained in Section 220 of the Internal Revenue Code. Income, of whatever nature, earned on the fund during any fiscal year shall be credited to the fund.

(d) Notwithstanding Section 13340, the Public Employees' Health Savings Fund is continuously appropriated, without regard to fiscal years, to reimburse qualified medical expenses of health savings accountholders.

(e) The Legislature finds and declares that the Public Employees' Health Savings Fund is a trust fund held for the exclusive benefit of employees and annuitants who elect the health savings account option pursuant to Section 22869.5.

~~SEC. 3.~~

SEC. 4. Section 1349.3 is added to the Health and Safety Code, to read:

1349.3. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 1349, if it meets the following criteria:

(1) It offers, sells, or renews a health care service plan in this state that complies with all of the requirements of the domiciliary state applicable to the plan.

(2) It is authorized to issue the plan in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, a health care service plan offered, sold, or renewed by in this state a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this chapter.

~~SEC. 4.~~

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

1367.08. (a) Notwithstanding any other provision of law, on and after July 1, 2008, a health care service plan that covers hospital, medical, or surgical expenses on an individual or group basis may issue a plan contract that does not include one or more of the benefits described in subdivision (b) or may amend or renew a plan contract to delete one or more of those benefits, if the applicant or the contractholder waives the benefit pursuant to subdivision (d).

(b) The benefits that may be waived pursuant to subdivision (a) are those described in Sections 1367.06, 1367.18, 1367.19, 1367.2, 1367.21, 1367.22, 1367.25, 1367.3, 1367.35, 1367.4, 1367.45, 1367.51, 1367.54, 1367.6, 1367.61, 1367.62, 1367.63, 1367.635, 1367.64, 1367.65, 1367.66, 1367.665, 1367.67, 1367.68, 1367.69, 1367.7, 1367.71, 1367.8, 1367.9, 1367.11, 1367.215, 1367.22, 1367.24, 1368.2, 1368.5, 1370.6, 1373.4, 1374.17, 1374.55, 1374.56, and 1374.72.

(c) The director, in consultation with the Insurance Commissioner, shall prepare a disclosure form prior to July 1, 2008, that is easily understood and that summarizes the benefits a health care service plan is required to include in its plan contract under this chapter and the benefits that may be waived under this section.

(d) The applicant or the contractholder shall sign the disclosure described in subdivision (c), specifying the benefits he or she waives and indicating that the plan has explained the contents of the disclosure and that he or she understands them, before the plan contract may be issued, amended, or renewed without one or more of the benefits described in subdivision (b).

(e) This section and Section 10119.3 of the Insurance Code shall be known, and may be cited as, the Freedom to Choose Health Benefits Act of 2007.

~~SEC. 5.~~

SEC. 6. Section 1399.72 of the Health and Safety Code is amended to read:

1399.72. (a) A health care service plan that intends to convert from nonprofit to for-profit status, as defined in subdivision (b), shall, prior to the conversion, submit a conversion proposal to the director and secure approval from the director.

(b) For the purposes of this section, a "conversion" or "convert" by a nonprofit health care service plan means the transformation of the plan from nonprofit to for-profit status, as determined by the director.

(c) Prior to approving a conversion, the director shall find that the conversion proposal meets all of the following charitable trust requirements:

(1) The fair market value of the nonprofit plan is set aside for appropriate charitable purposes. In determining fair market value, the director shall consider, but not be bound by, any market-based information available concerning the plan.

(2) The set-aside shall be dedicated and transferred to one or more existing or new tax-exempt charitable organizations operating pursuant to Section 501(c)(3) (26 U.S.C. Sec. 501(c)(3)) of the Internal Revenue Code. The director shall consider requiring that a portion of the set-aside include equity ownership in the plan. Further, the director may authorize the use of an organization operating pursuant to Section 501(c)(4) of the Internal Revenue Code (26 U.S.C. Sec. 501(c)(4)) if, in the director's view, it is necessary to ensure effective management and monetization of equity ownership in the plan and if the plan agrees that the Section 501(c)(4) organization will be limited exclusively to these functions, that funds generated by the monetization shall be transferred to the Section 501(c)(3) organization except to the

extent necessary to fund the level of activity of the Section 501(c)(4) organization as may be necessary to preserve the organization's tax status, that no funds or other resources controlled by the Section 501(c)(4) organization shall be expended for campaign contributions, lobbying, or other political activities, and that the Section 501(c)(4) organization shall comply with reporting requirements that are applicable to Section 501(c)(3) organizations, and that the Section 501(c)(4) organization shall be subject to any other requirements imposed upon Section 501(c)(3) organizations that the director determines to be appropriate.

(3) Each Section 501(c)(3) or 501(c)(4) organization receiving a set-aside, its directors and officers, and its assets including any plan stock, shall be independent of any influence or control by the health care service plan and its directors, officers, subsidiaries, or affiliates.

(4) At least 90 percent of the money expended annually to fulfill the charitable mission and grantmaking functions of the charitable organization receiving any set-aside shall be spent on health care services for citizens who reside in California and who are not receiving health care services through a local, state, or federal program.

(5) Every Section 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall have in place procedures and policies to prohibit conflicts of interest, including those associated with grantmaking activities that may benefit the plan, including the directors, officers, subsidiaries, or affiliates of the plan.

(6) Every Section 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall demonstrate that its directors and officers have sufficient experience and judgment to administer grantmaking and other charitable activities to serve the state's health care needs.

(7) Every Section 501(c)(3) or 501(c)(4) organization that receives a set-aside under this section shall provide the director and the Attorney General with an annual report that includes a detailed description of its grantmaking and other charitable activities related to its use of the set-aside received from the health care service plan. The annual report shall be made available by the director and the Attorney General for public inspection, notwithstanding the California Public Records Act (Chapter 3.5

(commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Each organization shall submit the annual report for its immediately preceding fiscal year within 120 days after the close of that fiscal year. When requested by the director or the Attorney General, the organization shall promptly supplement the report to include any additional information that the director or the Attorney General deems necessary to ascertain compliance with this article.

(8) The plan has satisfied the requirements of this chapter, and a disciplinary action pursuant to Section 1386 is not warranted against the plan.

(d) The plan shall not file any forms or documents required by the Secretary of State in connection with any conversion or restructuring until the plan has received an order of the director approving the conversion or restructuring, or unless authorized to do so by the director.

SEC. 7. Article 6 (commencing with Section 128559) is added to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 6. California Physician Assistant Scholarship and Loan Repayment Program

128559. (a) There is hereby established, in the Health Professions Education Foundation, the California Physician Assistant Scholarship and Loan Repayment Program, referred to as the program for purposes of this article. The program shall provide scholarships to pay for the educational expenses of students enrolled in physician assistant schools and to repay qualifying educational loans of physician assistants who agree to practice in designated medically underserved areas as provided in this article.

(b) The Health Professions Education Foundation may also provide scholarships and loan repayments for physician assistants who practice in a clinic licensed pursuant to subdivision (a) of Section 1204.

128559.1. (a) The Health Professions Education Foundation shall administer the program utilizing the same general guidelines applicable to the federal National Health Service Corps Scholarship Program established pursuant to Section 254l of Title

42 of the United States Code and the National Health Service Corps Loan Repayment Program established pursuant to Section 254l-1 of Title 42 of the United States Code, with the following exceptions:

(1) A physician assistant student shall be eligible to participate in the program if he or she agrees to practice at a site located in an area of the state where unmet priority needs exist for primary care family physicians, as determined by the Health Workforce Policy Commission.

(2) No matching funds shall be required from an entity in the practice site area.

(b) The Office of Statewide Health Planning and Development shall adopt regulations regarding the implementation of the program, upon recommendations made by the Health Professions Education Foundation.

(c) In making recommendations regarding the implementation of the program and during the development of the program, the Health Professions Education Foundation shall solicit advice from representatives of the Physician Assistants Committee and the California Academy of Physician Assistants.

128559.2. (a) The California Physician Assistant Scholarship and Loan Repayment Program Fund is hereby established in the State Treasury.

(b) Revenues from the contributions made pursuant to Section 3523 of the Business and Professions Code, as well as any other private or public funds made available for purposes of the program, shall be deposited into the fund. Upon appropriation by the Legislature, moneys in the fund shall be available for expenditure by the Office of Statewide Health Planning and Development for purposes of implementing the program pursuant to this article.

(c) The Office of Statewide Health Planning and Development and the Health Professions Education Foundation shall be under no obligation to administer the program under this article until sufficient moneys have been accumulated in the fund and appropriated to the office by the Legislature.

128559.3. The Health Professions Education Foundation shall submit a report to the Legislature on or before January 1, 2009, and annually thereafter, that describes the experience of the program since its inception, evaluate its effectiveness in improving

access to health care for underserved populations, and make recommendations for maintaining or expanding its operation. The report shall also include the following data:

(a) The number of the participants in the program.

(b) The locations where the participants practice or attend school.

(c) The amount expended for the program's operation and the amount collected in donations for the program.

128559.4. This article shall be implemented only to the extent that sufficient moneys are available in the California Physician Assistant Scholarship and Loan Repayment Program Fund to administer the program.

~~SEC. 6.~~

SEC. 8. Section 699.6 is added to the Insurance Code, to read:

699.6. (a) Notwithstanding any other provision of law, a carrier domiciled in another state is exempt from Section 700, if it meets the following criteria:

(1) It offers, sells, or renews a health insurance policy in this state that complies with all of the requirements of the domiciliary state applicable to the policy.

(2) It is authorized to issue the policy in the state where it is domiciled and to transact business there.

(b) Notwithstanding any other provision of law, the health insurance policy offered, sold, or renewed in this state by a carrier that satisfies the criteria of subdivision (a) is exempt from all other provisions of this code.

~~SEC. 7.~~

SEC. 9. Section 10119.3 is added to the Insurance Code, to read:

10119.3. (a) Notwithstanding any other provision of law, on and after July 1, 2008, a health insurance policy that covers hospital, medical, or surgical expenses on an individual or group basis may issue a policy that does not include one or more of the benefits described in subdivision (b) or may amend or renew a policy to delete one or more of those benefits, if the applicant or policyholder waives the benefit pursuant to subdivision (d).

(b) The benefits that may be waived pursuant to subdivision (a) are those described in Sections 10119.6, 10119.8, 10119.9, 10122.1, 10123.10, 10123.141, 10123.15, 10123.18, 10123.184, 10123.185, 10123.195, 10123.196, 10123.2, 10123.21, 10123.5,

10123.55, 10123.6, 10123.7, 10123.8, 10123.81, 10123.82, 10123.83, 10123.86, 10123.87, 10123.88, 10123.89, 10123.9, 10125, 10126.6, 10127.3, 10145.2, and 10176.61.

(c) The commissioner, in consultation with the Director of the Department of Managed Health Care, shall prepare a disclosure form prior to July 1, 2008, that is easily understood and that summarizes the benefits a health insurer is required to include in its policy under this code and the benefits that may be waived under the section.

(d) The applicant or policyholder shall sign the disclosure described in subdivision (c), specifying the benefits he or she waives and indicating that the insurer has explained the contents of the disclosure and that he or she understands them, before the policy may be issued, amended, or renewed without one or more of the benefits described in subdivision (b).

(e) This section and Section 1367.08 of the Health and Safety Code shall be known, and may be cited as, the Freedom to Choose Health Benefits Act of 2007.

~~SEC. 8.~~

SEC. 10. Part 6.6 (commencing with Section 12739.10) is added to Division 2 of the Insurance Code, to read:

PART 6.6. THE CALIFORNIA HEALTH INSURANCE EXCHANGE

Chapter 1. General

12739.10. This part shall be known and may be cited as the California Health Insurance Exchange Act.

12739.11. The Legislature finds and declares the following:

(a) With the exception of a high deductible health plan coupled with a health savings account, federal tax law discourages individuals from purchasing health care coverage unless an individual's employer offers health care coverage and the individual is eligible for it and chooses to obtain that coverage.

(b) Though many employers, particularly small businesses, would like to provide health care coverage to their employees, existing regulations and increasing health care costs limit their options for directly offering health care coverage to their employees.

(c) Though high deductible health plans coupled with health savings accounts are gaining in popularity, these types of products do not meet the needs of every individual and every family.

(d) Government should not artificially limit choice in health care coverage products by offering tax preferences only to an individual who couples a high deductible health plan with a health savings account or to an employee whose employer offers, and whose employer's eligibility requirements allow the employee to obtain, health care coverage.

(e) Eighty-one percent of the population without health care coverage is employed by private employers who could establish affordable cafeteria plans under Section 125 of Title 26 of the United States Code to assist their employees' use of pretax income, as well as pretax employer contributions, to purchase health care coverage.

(f) Providing an equivalent tax benefit for the individual purchase of health care coverage that reduces the out-of-pocket premium cost of purchasing health care coverage is a vital component for extending health care coverage to those without it.

12739.12. The following definitions apply for the purposes of this part:

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

(b) "Carrier" means a health care service plan licensed by the Department of Managed Health Care or a health insurer holding a certificate of authority from the commissioner.

(c) "Employee" means an individual who has obtained either an individual plan contract or an individual health insurance policy from a carrier through a cafeteria plan established by his or her employer.

(d) "Employer" means an employer in this state who has established a cafeteria plan pursuant to Section 125 of Title 26 of the United States Code.

(e) "Exchange" means the California Health Insurance Exchange.

12739.13. The California Health Insurance Exchange is hereby established and shall be administered by the board. The purpose of the exchange is to administer the payment of premiums for health care coverage obtained by an employee pursuant to a cafeteria plan established by his or her employer.

Chapter 2. Administration

12739.20. The board shall have all of the following powers:

(a) To contract with professional service firms as may be necessary in its judgment and to fix their compensation.

(b) To contract with companies that provide third-party administrative and billing services.

(c) To contract with employers and carriers to administer the payment of premiums for health care coverage.

12739.21. The board shall maintain an accurate account of all of the activities, receipts, and expenditures of the exchange and shall annually report this information at the end of its fiscal year to the Governor and the Legislature. The exchange shall be subject to audits by the State Auditor.

12739.22. (a) No later than two years after the board begins operation of the exchange and annually thereafter, the board shall study the exchange and its enrollees and report in writing to the Governor and the Legislature on the status and activities of the exchange based on data collected in the study.

(b) The study shall review the following matters:

(1) The operation and administration of the exchange, including surveys and reports on the plan contracts and policies purchased by the employees and on the experience of the carriers that issued those plan contracts and policies.

(2) Any significant observations regarding utilization and adoption of the exchange.

Chapter 3. Operation

12739.30. On and after January 1, 2009, the exchange shall administer the payment of premiums for health care coverage obtained by an employee pursuant to a cafeteria plan established by his or her employer.

12739.31. The board shall develop a plan of operation for the exchange on or before June 31, 2008, that shall include, but not be limited to, the following components:

(a) Procedures for operation of the exchange.

(b) Procedures for contracting with employers and carriers.

(c) A system of collecting all premium payments made by, or on behalf of, employees and remitting those payments to carriers.

(d) A plan for publicizing the existence of the exchange.

(e) Procedures for resolving disputes arising from the operation of the exchange.

12739.32. (a) A carrier may apply to the board for participation in the exchange.

(b) To participate in the exchange, the carrier shall enter into an agreement with the board that all premiums for an individual plan contract or an individual policy that it issued to an employee shall be made to the carrier through the exchange.

(c) The board shall not impose on a carrier seeking to participate in the exchange any terms or conditions, including any requirements or agreements, with respect to rates or benefits.

12739.33. (a) An employer with employees in this state may apply to the board for participation in the exchange.

(b) The application shall contain the following information:

(1) The name of each employee who has obtained an individual plan contract or individual policy through the cafeteria plan.

(2) The name of the carrier who issued the plan contract or policy.

(3) The premium amount for each plan contract or policy.

(4) The amount of the premium paid by the employee and by the employer.

(c) To participate in the exchange, the employer shall enter into an agreement with the board containing the following provisions:

(1) The employer agrees to transmit to the exchange all premium payments for health care coverage issued to employees specified in the employer's application by a carrier participating in the exchange.

(2) The employer agrees to transmit the premium payments described in paragraph (1) to the exchange, at minimum, 15 days prior to the due date required by the carrier.

(3) The employer shall notify the board within 10 days of learning of any change in the information set forth in the application.

12739.34. (a) The board shall deposit all premium payments received pursuant to Section 12739.33 in the California Health Insurance Exchange Fund.

(b) The board shall remit the premium payments received for an employee's individual plan contract or individual policy to the

carrier that issued the plan contract or policy prior to the due date required by the carrier.

12739.35. The exchange shall operate in accordance with all requirements and restrictions set forth in this part and all other applicable federal and state laws and regulations.

Chapter 4. Revenue

12739.40. (a) It is the intent of the Legislature that the administration of the exchange be fully supported from fees collected for services provided by the board.

(b) The board is authorized to charge a fee necessary to implement this chapter.

(c) There is hereby created in the State Treasury the California Health Insurance Exchange Fund.

(d) Notwithstanding Section 13340 of the Government Code, revenue in the California Health Insurance Exchange Fund shall be continuously appropriated to the board for the purposes of this part.

~~SEC. 9.~~

SEC. 11. Section 17053.102 is added to the Revenue and Taxation Code, to read:

17053.102. (a) There shall be allowed a credit against the "net tax," as defined by Section 17039, an amount equal to 50 percent of the fair market value of uncompensated medical care provided by a physician during the taxable year to an eligible individual.

(b) For purposes of this section:

(1) "Eligible individual" means a resident of this state who is not covered by health insurance and is a member of a household whose combined household adjusted gross income for the taxable year is less than the federal poverty level for that household for the applicable taxable year.

(2) "Fair market value of uncompensated medical care" shall include only those medical procedures covered by Medicare and shall not exceed the reimbursement rate authorized under Medicare for any medical procedure for which a credit is allowed by this section.

(3) "Physician" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California.

(c) In the case where the credit allowed by this section exceeds the "net tax," the excess may be carried over to reduce the "net tax" in the following year, and succeeding years if necessary, until the credit is exhausted.

~~SEC. 10.~~

SEC. 12. Section 17053.77 is added to the Revenue and Taxation Code, to read:

17053.77. (a) For each taxable year beginning on or after January 1, 2008, and before January 1, 2013, there shall be allowed as a credit against the "net tax," as defined in Section 17039, an amount equal to 15 percent of the amount paid or incurred by a qualified taxpayer during the taxable year for qualified health insurance for employees of the taxpayer who perform services in this state and who pay income taxes to the state.

(b) For purposes of this section:

(1) "Qualified health insurance" means amounts paid on behalf of employees to a high deductible health plan, as defined by Section 223(c)(2) of the Internal Revenue Code, or to a health savings account, as defined by Section 223(d) of the Internal Revenue Code.

(2) "Qualified taxpayer" means any new small to medium size employer, or any existing small to medium size employer that, during any of the five taxable years immediately preceding the taxable year, has not provided health insurance to employees employed by the employer in this state.

(3) For purposes of this paragraph:

(A) "Small employer" means a person, as defined in Section 7701(a) of the Internal Revenue Code, or a private entity employing, for wages or salary, at least two but no more than 19 persons.

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

(C) "New small to medium employer" means a small employer or a medium employer that began doing business on or after October 1, 2008.

(c) The credit allowed by this section shall be in lieu of any deduction to which the taxpayer otherwise may be entitled for expenses on which a credit under this section is claimed.

(d) On or before December 1, 2011, the Franchise Tax Board shall report to the Legislature on the total number of employers using the credit under this section, the total number of employees who have enrolled in high deductible health plans since the inception of the credit, and the total cost of this credit to the state.

(e) In the case where the credit allowed by this section exceeds the "net tax," the excess may be carried over to reduce the "net tax" in the following year, and succeeding years if necessary, until the credit is exhausted.

(f) A qualified taxpayer is only eligible for the credit allowed by this section for the first year in which the credit is claimed and for each of the two consecutive taxable years following the taxable year in which the credit is first claimed.

(g) On or before March 1, 2012, the Legislative Analyst shall report to the Legislature on the effectiveness of the tax credits authorized by this section and Section 23677 upon employed Californians' ability to meet deductible medical expenses incurred under qualified health insurance plans.

(h) This section shall remain in effect only until December 1, 2013, and as of that date is repealed, unless a later enacted statute that is enacted before December 1, 2013, deletes or extends that date.

~~SEC. 11.~~

SEC. 13. Section 17072 of the Revenue and Taxation Code is amended to read:

17072. (a) Section 62 of the Internal Revenue Code, relating to adjusted gross income defined, shall apply, except as otherwise provided.

(b) Section 62(a)(2)(D) of the Internal Revenue Code, relating to certain expenses of elementary and secondary school teachers, shall not apply.

(c) The deduction allowed by Section 17204, relating to medical care shall be allowed in computing adjusted gross income.

(d) The deduction allowed by Section 17216, relating to health savings accounts, is allowed in computing adjusted gross income. This subdivision shall apply to taxable years beginning on or after January 1, 2008.

~~SEC. 12.~~

SEC. 14. Section 17131.4 of the Revenue and Taxation Code is amended to read:

17131.4. (a) Section 106(d) of the Internal Revenue Code, relating to contributions to health savings accounts, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2008. This section shall remain in effect only until January 1, 2013, and as of that date is repealed.

~~SEC. 13.~~

SEC. 15. Section 17131.5 of the Revenue and Taxation Code is amended to read:

17131.5. (a) Section 125(d)(2)(D) of the Internal Revenue Code, relating to the exception for health savings accounts, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2008. This section shall remain in effect only until January 1, 2013, and as of that date is repealed.

~~SEC. 14.~~

SEC. 16. Section 17138.5 is added to the Revenue and Taxation Code, to read:

17138.5. For taxable years beginning on or after January 1, 2008, Section 106 of the Internal Revenue Code, as amended by Section 302 of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-432), relating to health savings accounts, shall apply, except as otherwise provided.

~~SEC. 15.~~

SEC. 17. Section 17138.6 is added to the Revenue and Taxation Code, to read:

17138.6. For taxable years beginning on or after January 1, 2008, Section 125 of the Internal Revenue Code, as amended by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), relating to health savings accounts, shall apply, except as otherwise provided.

~~SEC. 16.~~

SEC. 18. Section 17204 is added to the Revenue and Taxation Code, to read:

17204. (a) There shall be allowed a deduction in an amount equal to the cost, not compensated by insurance or otherwise, paid or incurred during the taxable year by the taxpayer for medical care for the taxpayer, his or her spouse, his or her dependents, and, in the case of a married couple, any dependents of each spouse.

(b) For purposes of this section:

(1) "Taxpayer" means any person subject to the tax imposed by this part.

(2) "Dependent" has the same meaning as ascribed to that term by Section 17056.

(3) "Medical care" has the same meaning ascribed to that term by Section 213(d) of the Internal Revenue Code.

(c) The deduction allowed by this section shall be in lieu of any other deduction otherwise allowable by this part for the costs for which the deduction is allowed by this section.

~~SEC. 17.~~

SEC. 19. Section 17215 of the Revenue and Taxation Code is amended to read:

17215. (a) Section 220(a) of the Internal Revenue Code, relating to deduction allowed, is modified to provide that the amount allowed as a deduction shall be an amount equal to the amount allowed to that individual as a deduction under Section 220 of the Internal Revenue Code, relating to medical savings accounts, on the federal income tax return filed for the same taxable year by that individual.

(b) Section 220(f)(4) of the Internal Revenue Code, relating to additional tax on distributions not used for qualified medical expenses, is modified by substituting "10 percent" in lieu of "15 percent."

(c) Section 220(f)(5) of the Internal Revenue Code, as amended by Section 1201(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), relating to permitted rollovers from Archer Medical Savings Accounts, shall apply, except as otherwise provided. This subdivision shall apply to taxable years beginning on or after January 1, 2008.

~~SEC. 18.~~

SEC. 20. Section 17215.1 of the Revenue and Taxation Code is amended to read:

17215.1. (a) Section 220(f)(5) of the Internal Revenue Code, relating to rollover contributions, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2008. This section shall remain in effect only until January 1, 2013, and as of that date is repealed.

~~SEC. 19.~~

SEC. 21. Section 17215.4 of the Revenue and Taxation Code is amended to read:

17215.4. (a) Section 223 of the Internal Revenue Code, relating to health savings accounts, shall not apply.

(b) This section shall apply to taxable years beginning on or after January 1, 2005, and before January 1, 2008. This section shall remain in effect only until January 1, 2013, and as of that date is repealed.

~~SEC. 20.~~

SEC. 22. Section 17216 is added to the Revenue and Taxation Code, to read:

17216. For taxable years beginning on or after January 1, 2008, all of the following apply:

(a) Section 223 of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), and as amended by Title III of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-432), relating to health savings accounts, shall apply, except as otherwise provided.

(b) Section 223(e)(1) of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), shall be modified by substituting the phrase "Section 17651" for the phrase "Section 511 (relating to imposition of tax of unrelated business income of charitable, etc., organizations)," contained therein.

(c) Section 223(f)(4)(A) of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), shall be modified by substituting "2 ½ percent" for "10 percent," contained therein.

~~SEC. 21.~~

SEC. 23. Section 19184 of the Revenue and Taxation Code is amended to read:

19184. (a) A penalty of fifty dollars ($50) shall be imposed for each failure, unless it is shown that the failure is due to reasonable cause, by any person required to file who fails to file a report at the time and in the manner required by any of the following provisions:

(1) Subdivision (c) of Section 17507, relating to individual retirement accounts.

(2) Section 220(h) of the Internal Revenue Code, relating to medical savings accounts, for taxable years beginning on or after January 1, 1997.

(3) Section 223(h) of the Internal Revenue Code, as added by Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), relating to health savings accounts.

(4) Subdivision (b) of Section 17140.3 or subdivision (b) of Section 23711 relating to qualified tuition programs.

(5) Subdivision (e) of Section 23712, relating to Coverdell education savings accounts.

(b) (1) Any individual who:

(A) Is required to furnish information under Section 17508 as to the amount designated nondeductible contributions made for any taxable year, and

(B) Overstates the amount of those contributions made for that taxable year, shall pay a penalty of one hundred dollars ($100) for each overstatement unless it is shown that the overstatement is due to reasonable cause.

(2) Any individual who fails to file a form required to be filed by the Franchise Tax Board under Section 17508 shall pay a penalty of fifty dollars ($50) for each failure unless it is shown that the failure is due to reasonable cause.

(c) Article 3 (commencing with Section 19031) of this chapter (relating to deficiency assessments) shall not apply in respect of the assessment or collection of any penalty imposed under this section.

(d) The amendments made to this section by the act adding this subdivision shall apply to taxable years beginning on or after January 1, 2008.

~~SEC. 22.~~

SEC. 24. Section 23677 is added to the Revenue and Taxation Code, to read:

23677. (a) For each taxable year beginning on or after January 1, 2008, and before January 1, 2013, there shall be allowed as a credit against the "tax," as defined in Section 23036, an amount equal to 15 percent of the amount paid or incurred by a qualified taxpayer during the taxable year for qualified health insurance for

employees of the taxpayer who perform services in this state and who pay income taxes to the state.

(b) For purposes of this section:

(1) "Qualified health insurance" means amounts paid on behalf of employees to a high deductible health plan, as defined by Section 223(c)(2) of the Internal Revenue Code, or to a health savings account, as defined by Section 223(d) of the Internal Revenue Code.

(2) "Qualified taxpayer" means any new small to medium size employer, or any existing small to medium size employer that, during any of the five taxable years immediately preceding the taxable year, has not provided health insurance to employees employed by the employer in this state.

(3) For purposes of this paragraph:

(A) "Small employer" means a person, as defined in Section 7701(a) of the Internal Revenue Code, or a private entity employing, for wages or salary, at least two but no more than 19 persons.

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

(C) "New small to medium employer" means a small employer or a medium employer that began doing business on or after October 1, 2008.

(c) The credit allowed by this section shall be in lieu of any deduction to which the taxpayer otherwise may be entitled for expenses on which a credit under this section is claimed.

(d) On or before December 1, 2011, the Franchise Tax Board shall report to the Legislature on the total number of employers using the credit under this section, the total number of employees who have enrolled in high deductible health plans since the inception of the credit, and the total cost of this credit to the state.

(e) In the case where the credit allowed by this section exceeds the "tax," the excess may be carried over to reduce the "tax" in the following year, and succeeding years if necessary, until the credit is exhausted.

(f) A qualified taxpayer is only eligible for the credit allowed by this section for the first year in which the credit is claimed and

for each of the two consecutive taxable years following the taxable year in which the credit is first claimed.

(g) On or before March 1, 2012, the Legislative Analyst shall report to the Legislature on the effectiveness of the tax credits authorized by this section and Section 17053.77 upon employed Californians' ability to meet deductible medical expenses incurred under qualified health insurance plans.

(h) This section shall remain in effect only until December 1, 2013, and as of that date is repealed, unless a later enacted statute that is enacted before December 1, 2013, deletes or extends that date.

~~SEC. 23.~~

SEC. 25. Section 14078.5 is added to the Welfare and Institutions Code, to read:

14078.5. (a) Commencing January 1, 2009, the director shall increase reimbursement rates for physician services under the Medi-Cal program to a level that equals 80 percent of the Medicare reimbursement rate for those same services. This subdivision shall not apply to physician services currently reimbursed at or above 80 percent of the Medicare reimbursement rate.

(b) At the time of any future rate adjustment after January 1, 2009, the department shall consider the ability of Medi-Cal beneficiaries to access physician services by geography and specialty and shall request data from the Office of Statewide Health Planning and Development to allow the department to determine the extent of Medi-Cal physician shortages, if any, by geography and specialty.

~~SEC. 24.~~

SEC. 26. Article 2.93 (commencing with Section 14091.50) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.93. The Medi-Cal Empowerment Act

14091.50. This article shall be known, and may be cited, as the "Medi-Cal Empowerment Act."

14091.51. The Legislature finds and declares the following:

(a) Medi-Cal provides health coverage to approximately 6.6 million low-income, aged, and disabled beneficiaries at a total

projected cost for the 2006–07 fiscal year, of $35 billion, $13.7 billion from the General Fund.

(b) Since 2000, General Fund expenditures on Medi-Cal have risen by 44 percent.

(c) In 2000, Medi-Cal expenditures comprised 13 percent of the General Fund budget, but are projected to rise to 21 percent of the General Fund budget by 2015.

(d) Cost increases to the Medi-Cal program are unsustainable without reductions in eligibility or benefits.

(e) Medi-Cal is a large purchaser of health care services and should share in the responsibility of helping stabilize runaway health care costs that can contribute towards increasing the population of the uninsured.

(f) The federal Deficit Reduction Act of 2005 authorizes Medicaid Demonstration Projects for up to 10 states to implement Health Opportunity Accounts, that allow states to use federal matching dollars to deposit up to two thousand five hundred dollars ($2,500) per adult and one thousand dollars ($1,000) per child into an account accessible by a Medicaid enrollee that can be used to pay for out-of-pocket medical expenses to meet the deductible of an approved insurance product of the enrollee's choice. As a national leader, California should be one of these states.

14091.52. The State Department of Health Care Services shall prepare and submit a proposal to the federal government by July 31, 2008, for participation in the Medicaid Demonstration Project for Health Opportunity Accounts (HOA) in accordance with the federal Deficit Reduction Act of 2005.

14091.53. The program design shall achieve the following:

(a) Create patient awareness of the high cost of medical care.

(b) Provide incentives to patients to seek preventive care services, including one or more of the following:

(1) Additional account contributions for an individual demonstrating healthy prevention practices.

(2) Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.

(3) Routine prenatal and well-child care.

(4) Child and adult immunizations.

(5) Tobacco cessation programs.

(6) Obesity weight loss programs.

(7) Screening services.

(8) Other incentives as determined by the department and agreed to by the federal government under the demonstration project.

(c) Reduce inappropriate use of health care services.

(d) Enable patients to take responsibility for health outcomes.

(e) Provide enrollment counselors and ongoing education activities.

(f) Allow transactions involving HOAs to be conducted electronically and without cash.

(g) Provide access to negotiated provider payment rates.

14091.54. (a) The department shall select up to 10 counties in which to implement this demonstration project after considering the per enrollee Medi-Cal cost in each county as well as the overall Medi-Cal cost per county.

(b) An eligible individual shall be enrolled into the demonstration program only if the individual voluntarily enrolls.

(c) Enrollment shall be effective for a period of 12 months, and may be extended for additional periods of 12 months each with the consent of the individual.

(d) An individual who, for any reason, is disenrolled from the demonstration program under this section shall not be permitted to reenroll earlier than one year after disenrollment.

14091.55. (a) Insurance plans offered to enrollees who volunteer to participate in the demonstration shall encompass all standard Medi-Cal benefits.

(b) The amount of the annual deductible shall be at least 100 percent and no more than 110 percent of the amount of the contribution to the HOA.

(c) The number of individuals enrolled in any managed care organization that participate in this demonstration project shall not be either of the following:

(1) In excess of 5 percent of the total number of individuals enrolled in the organization.

(2) Significantly disproportionate to the proportion of similar enrollees in other participating managed care organizations.

(d) The state shall provide an adjustment in the per capita payments to a participating managed care organization to account for participation in the HOA. This shall take into account the difference in the likely use of health care services between managed

care enrollees who participate in the HOA and managed care enrollees who do not participate in the HOA.

14091.56. (a) The department may consider each participating enrollee's health to determine the state's contribution into an enrollee's HOA.

(b) Funds in an individual's HOA may be used for the purchase of medical services and private health care coverage authorized by the department or offered by the individual's employer.

(c) Charitable organizations may also contribute to an individual's HOA.

(d) After the individual has satisfied the annual deductible, alternative benefits for an eligible individual shall consist of at least the benefits that would otherwise be provided to the individual, including cost sharing relating to those benefits, if the individual was not enrolled in the demonstration project.

(e) After one year of participation in the program, an individual may apply the prior year's HOA funds for job training or tuition expenses.

(f) Any remaining funds in the individual's HOA shall carry over into subsequent years, provided that the individual is enrolled in an approved plan.

(g) If an individual disenrolls from the program, all of the following shall occur:

(1) The state shall cease all contributions.

(2) The HOA administrator shall remit 50 percent of the account to the General Fund.

(3) The remaining funds shall be used by the individual within three years to purchase health insurance coverage or on any other qualifying expenses, which may include job training or tuition expenses.

14091.57. The department shall coordinate administration of HOAs through the use of a third-party administrator and may implement appropriate policies and procedures for implementation of this demonstration project consistent with federal laws, regulations, and other guidance.

14091.58. The department shall annually report to the Governor and the Legislature on the results of this demonstration project.

14091.59. The department shall develop a strategic plan, including recommendations for maintaining the Medi-Cal program's current share of General Fund expenditures, and shall

submit the plan to the Legislature and the Governor on or before November 1, 2008, and annually thereafter.

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