December 24, 2007

07 - 0103

RECEIVED

DEC 28 2007

INITIATIVE COORDINATOR
ATTORNEY GENERAL'S OFFICE

**VIA MESSENGER**

Office of the Attorney General
1300 "I" Street
Sacramento, CA 95814

Attention: Toni Melton

Re: *Secure and Affordable Health Care Act of 2008*

Dear Ms. Melton:

Pursuant to Elections Code section 9002, we request that the Attorney General prepare a title and summary of a measure entitled "Secure and Affordable Health Care Act of 2008." The text of the measure, a check for $200.00, the address at which we are registered to vote and the signed statement certifying that we will not willfully allow initiative signatures to be used for purposes other than qualification of the measure are enclosed.

Please direct all correspondence and inquiries regarding this measure to:

Robin B. Johansen
Karen Getman
Remcho, Johansen & Purcell, LLP
201 Dolores Avenue
San Leandro, CA 94577
Phone: (510) 346-6200
Fax: (510) 346-6201

Sincerely,

Arnold Schwarzenegger

Enclosures

December 24, 2007

07-0103

RECEIVED
DEC 28 2007
INITIATIVE COORDINATOR
ATTORNEY GENERAL'S OFFICE

**VIA MESSENGER**

Office of the Attorney General
1300 "I" Street
Sacramento, CA 95814

Attention: Toni Melton

Re: *Secure and Affordable Health Care Act of 2008*

Dear Ms. Melton:

Pursuant to Elections Code section 9002, we request that the Attorney General prepare a title and summary of a measure entitled "Secure and Affordable Health Care Act of 2008." The text of the measure, a check for $200.00, the address at which we are registered to vote and the signed statement certifying that we will not willfully allow initiative signatures to be used for purposes other than qualification of the measure are enclosed.

Please direct all correspondence and inquiries regarding this measure to:

Robin B. Johansen
Karen Getman
Remcho, Johansen & Purcell, LLP
201 Dolores Avenue
San Leandro, CA 94577
Phone: (510) 346-6200
Fax: (510) 346-6201

Sincerely,

Fabian Nuñez

Enclosures
(00046764)

## INITIATIVE MEASURE TO BE SUBMITTED DIRECTLY TO THE VOTERS

**SECTION 1. Title.**

This measure shall be known and may be cited as the Secure and Affordable Health Care Act of 2008.

**SECTION 2. Findings and declarations.**

The people find and declare as follows:

A. California's health care system is changing and not for the better. Costs are rising, hospitals and emergency rooms are closing, and more people are becoming uninsured. If we don't take action now, California's health care system will only get worse.

B. Thousands of Californians are denied the health care coverage they need or are dropped from their coverage when they get sick.

C. California's emergency rooms are overcrowded and facing closure because millions lack access to preventive and non-emergency care.

D. More than 5.1 million Californians have no health care insurance, including more than 800,000 children. The number of uninsured continues to grow as health care costs rise and employers drop employees' coverage or reduce benefits.

E. Basic health care coverage is becoming unaffordable for average working California families and for many employers that choose to provide coverage. That leaves more and more children, seniors and working families without access to care.

F. Health care costs and profits are skyrocketing and people are forced to pay more for their health care.

G. Many working families face financial ruin due to medical bills, sometimes losing their homes or declaring bankruptcy following a serious illness.

H. Health care resources are directed to treating people when they are ill or injured. Our system fails to emphasize preventive care and wellness programs that will keep people healthier and help hold down costs.

I. Premiums are increasing for Californians with insurance to cover the cost of the uninsured, and billions of dollars are spent to treat illnesses that may have been prevented with adequate care.

J. Consumers do not have access to the information they need to make informed choices about the best and most cost-effective health care providers and treatments.

K. Small business owners are being hurt by the lack of available health coverage for themselves and their employees, and many people who want to start small business can't do so because they would lose their health care.

L. Employers spending on health care for their employees have a competitive disadvantage when compared to employers not spending on health care for their employees.

M. It is in the State's interest to ensure that Californians have access to affordable health care coverage, that emergency rooms and doctor services are available to those who need them, that HMOs and insurers are held accountable, and that health care services are fully funded.

N. California has the lowest Medi-Cal rates in the country, and that hurts everyone – it's harder for Medi-Cal patients to access care; hospitals and doctors lose money and pass costs on to the rest of us; and taxpayers lose out on billions of dollars in federal matching funds.

**SECTION 3. Purpose and Intent.**

It is the intent of the People of California in enacting this measure to provide funding for and enable sweeping improvements in California's health care system which will:

A. Make health care more secure for everyone by making coverage available and affordable, and improving the quality of care.

B. Address the inefficiencies and waste in the current health care system that add on costs to employers and people with insurance.

C. Increase affordability and lower costs by providing working families and employers tax benefits.

D. Protect current funding for other vital state services such as education and public safety, while ensuring that moneys raised in this Act cannot be diverted for any other purpose.

E. Prohibit HMO's and insurers from offering bonuses to administrators for denying coverage to patients so people don't lose their coverage when they become ill.

F. Require HMO's and insurers to spend at least 85 percent of every health premium dollar on health care services, forcing them to reduce administrative overhead costs and bureaucratic red tape.

G. Hold health insurers, HMO's, doctors and hospitals more accountable to consumers by requiring them to disclose timely, accurate and meaningful information on the cost, quality and safety of health care services.

H. Keep everyone healthier and reduce costs by promoting access to primary and preventive care.

I. Provide affordable health insurance to 800,000 children and millions of uninsured Californians.

J. Ensure that every Californian who wants to buy insurance can do so regardless of their age or medical history.

K. Preserve and expand consumer choice, provide greater options for consumers and employers to access quality, affordable health care coverage, while ensuring that individuals who have insurance can keep it.

L. Promote prevention, wellness and personal responsibility to keep Californians healthier and health care costs lower.

M. Level the playing field among employers and businesses by providing a practical way for all employers to contribute to health care for their workers while ensuring small businesses are protected.

N. Protect employer choice to make health expenditures consistent with their business models.

O. Ensure long term sustainable funding for public and private health care providers and health care programs, and ensure California receives its fair share of federal funds for health care coverage.

P. Share responsibility for health care between individuals, government, hospitals and employers while protecting small businesses from the rising cost of health care.

**SECTION 4**. Section 14 is added to Article XIII B of the California Constitution, to read:

SEC. 14. Funds paid by an employer pursuant to Division 11 (commencing with Section 19001) of the Unemployment Insurance Code or Section 1356.2 of the Health and Safety Code, funds paid by enrollees pursuant to Part 6.45 (commencing with Section 12699.204) of the Insurance Code, funds paid by a county or a city and county pursuant to Section 14155 of the Welfare and Institutions Code, any federal matching funds, a tax on cigarettes pursuant to Article 4 (commencing with Section 30133) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code, and a coverage dividend contribution paid by a hospital pursuant to

Article 5.22 (commencing with Section 14167.31) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, or the successor provisions to these code sections, which are deposited into the California Health Trust Fund established by Section 12699.212 of the Insurance Code, or its successor, including any subaccounts, shall not be deemed to be General Fund proceeds of taxes for purposes of this article, or for purposes of Section 8 of Article XVI, and the appropriations from that fund or any of those proceeds shall not be deemed to be "appropriations subject to limitation" of the State or any entity of local government for purposes of this article.

**SECTION 5.** Section 13311 is added to the Government Code, to read:

13311. (a) Beginning in the year following implementation of the Health Care Security and Cost Reduction Act (hereafter the Act), the Director of Finance shall, not less than twice each fiscal year at times he or she deems to be appropriate, review the funds available and projected to be available to support the Act, review the information available through the evaluation of the Act as required in Section 12803.25 and other sources of information regarding the price and availability of health insurance and the impact of reforms established by the Act, and shall determine whether, based on reasonable financial projections, revenues generated to fund the Act, including but not limited to, federal funding, funding from employer contributions and funding from county contributions, are not sufficient to support the continued operation of the programs established by the Act, and the programs expanded by the Act, including, but not limited to, the programs established by Section 1399.844 of the Health and Safety Code, Section 17052.30 of the Revenue and Taxation Code and Section 14005.301 of the Welfare and Institutions Code, as well as to support the rate increases funded by the Act, in the current fiscal year or in either of the next two following fiscal years.

(b) If the Director of Finance determines that the circumstance identified in subdivision (a) has occurred, he or she shall:

(1) Notify the Governor, the Chief Clerk of the Assembly, and the Secretary of the Senate of that determination.

(2) Notify the Joint Legislative Budget Committee of that determination, and provide the committee with the information that serves as the basis for that determination.

(c) If the Legislature does not pass and send to the Governor a bill or bills that address the financial imbalance determined pursuant to this section by the 180th day following the notification pursuant to paragraph (1) of subdivision (b), both of the following shall occur:

(1) All of the following provisions shall become inoperative, and the provisions of law amended by the Act that were in effect and operative immediately prior to the implementation date of the Act shall again be operative, on the first January 1 that falls at least 270 days after the notification provided pursuant to paragraph (1) of subdivision (b):

(A) Section 8899.50 of the Government Code.

(B) Section 1399.829 of the Health and Safety Code and Section 10928 of the Insurance Code.

(C) Section 1399.844 of the Health and Safety Code.

(D) Section 17052.30 of the Revenue and Taxation Code.

(E) Section 12699.211.01 of the Insurance Code and Sections 14005.301, 14005.305 and 14005.333 of the Welfare and Institutions Code.

(2) Notwithstanding Article 5.21 (commencing with Section 14167.1) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, on the first January 1 that falls at least 270 days after the notification provided pursuant to paragraph (1) of subdivision (b), rates for

hospital services rendered to Medi-Cal beneficiaries shall be set in accordance with Section 14081.6 of the Welfare and Institutions Code.

(d) A bill addressing the financial imbalance passed pursuant to subdivision (c) shall contain a statement to that effect.

(e) The Legislative Analyst shall prepare and transmit to the Legislature and the Governor an analysis of any bill or bills passed by the Legislature and sent to the Governor pursuant to subdivision (c). The analysis shall consider the fiscal impact of the bill or bills and the anticipated effect of the proposed changes on the affordability of premiums in the individual market and on the financial imbalance identified by the Director of Finance.

**SECTION 6.** Section 12699.212 is added to the Insurance Code, to read:

12699.212. (a) The California Health Trust Fund is hereby created in the State Treasury. The moneys in the fund, upon appropriation by the Legislature, shall be available exclusively for providing affordable health care coverage to Californians; funding tax credits and tax benefits to make health insurance more affordable for working families and employers; increasing provider reimbursement rates; promoting prevention and wellness programs; administering and enforcing insurance market reforms; establishing and maintaining reinsurance to keep health care affordable; and administration and enforcement activities of the Health Care Security and Cost Reduction Act, including collection of revenues to support the Act. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year shall be carried forward to the next succeeding fiscal year.

(b) Moneys that have been deposited in the fund may be used to maximize federal funds, so long as all moneys are expended in a manner fully consistent with the purposes set forth in subdivision (a).

(c) The Managed Risk Medical Insurance Board shall establish and maintain a prudent reserve in the fund.

(d) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund.

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

(f) The Controller shall, on a biennial basis, conduct a financial audit of the fund to ensure that all moneys in the fund are expended consistent with the purposes set forth in (a) and shall report the findings of that audit to the Governor, the Chief Clerk of the Assembly, the Secretary of the Senate and the Joint Legislative Budget Committee.

**SECTION 7.** Article 4 (commencing with Section 30133) is added to Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code, to read:

Article 4. Tobacco Products Excise Tax

30133. (a) In addition to the taxes imposed upon the distribution of cigarettes by Article 1 (commencing with Section 30101), Article 2 (commencing with Section 30121), Article 3 (commencing with Section 30131), and any other taxes in this chapter, there shall be imposed an additional excise tax upon every distributor of cigarettes at the rate of eight and three- fourths mills ($0.0875) for each cigarette that is distributed on and after May 1, 2009.

(b) Consistent with subdivision (b) of Section 30123, there shall be imposed upon every distributor a tax upon the distribution of tobacco products as defined by subdivision (b) of Section 30121, based on the wholesale cost of these products, at a tax rate, as determined annually by the State Board of Equalization, which is equivalent to the combined rate of tax

imposed on cigarettes by subdivision (a) and the other provisions of this part.

(c) The wholesale cost used to calculate the amount of tax due under subdivision (b) does not include the wholesale cost of tobacco products that were returned by a customer during the same reporting period in which the tobacco products were distributed, when the distributor refunds the entire amount the customer paid for the tobacco products either in cash or credit. For purposes of this subdivision, refund or credit of the entire amount shall be deemed to be given when the purchase price less rehandling and restocking costs is refunded or credited to the customer. The amount withheld for rehandling and restocking costs may be a percentage of the sales price determined by the average cost of rehandling and restocking returned merchandise during the previous accounting cycle.

30134. (a) Every dealer and wholesaler, for the privilege of holding or storing cigarettes for sale, use, or consumption, shall pay a floor stock tax for each cigarette in his or her possession or under his or her control in this state at 12:01 a.m. on May 1, 2009, at the rate of eight and three-fourths mills ($0.0875) for each cigarette.

(b) Every dealer and wholesaler shall file a return with the board on or before June 16, 2009, on a form prescribed by the board, showing the number of cigarettes in his or her possession or under his or her control at 12:01 a.m. on May 1, 2009. The amount of tax shall be computed and shown on the return.

(c) Every licensed cigarette distributor, for the privilege of distributing cigarettes and for holding or storing cigarettes for sale, use, or consumption, shall pay a cigarette indicia adjustment tax for each California cigarette tax stamp that is affixed to any package of cigarettes and for each unaffixed California cigarette tax stamp in his or her possession or under his or her control at 12:01 a.m. on May 1, 2009, at the following rates:

(1) Two dollars and eighteen and three-quarters cents ($2.1875) for each stamp bearing the designation "25."

(2) One dollar and seventy five cents ($1.75) for each stamp bearing the designation "20."

(3) Eighty seven and one-half cents ($0.875) for each stamp bearing the designation "10."

(d) Every licensed cigarette distributor shall file a return with the board on or before June 16, 2009, on a form prescribed by the board, showing the number of stamps described in paragraphs (1), (2), and (3) of subdivision (c). The amount of tax shall be computed and shown on the return.

(e) The taxes required to be paid by this section are due and payable on or before June 16, 2009. Payments shall be made by remittances payable to the board and the payments shall accompany the forms required to be filed by this section.

(f) Any amount required to be paid by this section that is not timely paid shall bear interest at the rate and by the method established pursuant to Section 30202 from June 16, 2009, until paid, and shall be subject to determination, and redetermination, and any penalties provided with respect to determinations and redeterminations.

30135. (a) Except for payments of refunds made pursuant to Article 1 (commencing with Section 30361) of Chapter 6, and reimbursement of the State Board of Equalization for expenses incurred in the administration and collection of the taxes imposed by this article, all moneys raised pursuant to the taxes imposed by this article shall be transmitted by the board to the Treasurer for deposit in the California Health Trust Fund established pursuant to Section 12699.212 of the Insurance Code.

(b)(1) The State Board of Equalization shall determine within one and one-half years of the operative date of this article the effect that additional taxes imposed on cigarettes pursuant to this article has had on the consumption of cigarettes in this state. To the extent that a decrease in consumption is determined by the State Board of Equalization to be the direct result of additional taxes imposed by this article, the State Board of Equalization shall determine the fiscal effect that the decrease in consumption has had on state health-related education or research programs funded by the Cigarette and Tobacco Products Surtax Fund, established pursuant to Section 30122. This determination shall also include breast cancer early detection, asthma, cancer registry programs and state administrative support for tobacco programs funded by the Unallocated Account within the Cigarette and Tobacco Products Surtax Fund. The State Board of Equalization shall also determine the fiscal effect that the decrease in consumption has had on the Breast Cancer Fund, established pursuant to Section 30461.6 and the California Children and Families Trust Fund, established pursuant to Section 30131.

(2) For the 2009-10 fiscal year and each fiscal year thereafter, the State Board of Equalization shall determine the amount of the decrease in revenue available to each of the program funds described in paragraph (1) that is the direct result of the imposition of the tax under this article. These amounts shall be transferred from the California Health Trust Fund and deposited in the Health Education Account, the Unallocated Account and the Research Account of the Cigarette and Tobacco Products Surtax Fund, the Breast Cancer Fund, and the California Children and Families Trust Fund, as appropriate, at any time it is determined necessary by the State Board of Equalization to reimburse revenue losses that are a direct result of the imposition of the tax under this article.

For purposes of the transfer to the California Children and Families Trust Fund, the Board shall reduce the transfer by the amount allocated to health insurance for children in the 2007-08 fiscal year by the California Children and Families Commission and spent on health insurance for children in the 2007-08 fiscal year by the county children and families commissions, as determined by the Department of Finance, in consultation with the California Children and Families Commission, and as reported to the Board of Equalization.

**SECTION 8.** Division 11 (commencing with Section 19001) is added to the Unemployment Insurance Code, to read:

DIVISION 11. HEALTH CARE CONTRIBUTION

19001. The department shall have the power and duties necessary to administer the reporting, collection, refunds to employers, and enforcement of employer health care contributions required to be remitted by employers by this division.

19002. For purposes of this division, all of the following definitions apply:

(a) "Employer" means an employer as defined in Article 3 (commencing with Section 675) of Chapter 3 of Part 1 of Division 1, except for subdivision (a) of Section 683 and subdivision (a) of Section 685. An employer shall also include all of the members of a "controlled group of corporations," as defined in Section 1563 of the Internal Revenue Code, except that "more than 50 percent" shall be substituted for "at least 80 percent" each place it appears in Section 1563(a)(1) of the Internal Revenue Code, and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code.

(b) "Employing unit" means an employing unit as defined in Section 135.

(c) “Employment” means employment as defined in Article 1 (commencing with Section 601) of Chapter 3 of Part 1 of Division 1, but does not include services excluded under Section 632 and Sections 640, 641, 643, 644, and 644.5.

(d) “Health expenditures” means any amount paid by an employer subject to this division to, or on behalf of, its employees and, if applicable, their dependents to provide health care or health-related services, or to reimburse the costs of those services, excluding a payment made directly or indirectly for workers’ compensation, Medicare contributions, or any other health benefit cost, fees, or assessment that the employer is required to pay by state or federal law. “Health expenditures” may include any of the following:

(1) Programs to assist employees to attain and maintain healthy lifestyles, including, but not limited to, reimbursement for onsite wellness programs, offsite wellness programs, onsite health fairs and clinics, and financial incentives for participating in health screenings and other wellness activities.

(2) Disease management programs.

(3) Pharmacy benefit management programs.

(4) Care rendered to employees and their dependents by health care providers employed by or under contract to employers, such as employer-sponsored primary care clinics.

(5) Purchasing health care coverage from a health care service plan, a health insurer, or a multiple employee welfare arrangement which holds a valid certificate of compliance under section 742.23 of the Insurance Code.

(6) Contributions to a health savings account as defined by Section 223 of the Internal Revenue Code (Title 26 of the United States Code).

(7) Reimbursement by the employer to his or her employees, for incurred health care expenses for the employee, and if applicable, the employee's dependents, where those recipients have no entitlement to that reimbursement under any plan, fund, or program maintained by the employer. As used in this paragraph, "health care expenses" includes, but is not limited to, an expense for which payment is deductible from personal income under Section 213(d) of the Internal Revenue Code.

(8) Contributions for health expenditures made under a collective bargaining agreement pursuant to Section 302(c)(5) of the federal Labor Management Relations Act (29 U.S.C. sec. 186 (c)(5)).

(e) "Wages" means remuneration defined as wages by Section 13009.5 of the Unemployment Insurance Code, excluding any gratuity as defined in Section 350 of the Labor Code.

19003. (a) On and after January 1, 2010, each employer shall pay a health care contribution equal to a percentage of wages paid to its employees during the calendar year. Each employer shall be eligible for a credit to offset the contribution by the amount that the employer expends for health expenditures for employees and their dependents during that same period. The contribution shall be based on the total wages paid in the prior calendar year as follows:

(1) If the total amount of wages paid by an employer in the prior year was less than, or equal to, two hundred fifty thousand dollars ($250,000), the employer shall pay a contribution equal to 1 percent of wages paid to each employee not to exceed subdivision (b).

(2) If the total amount of wages paid by an employer in the prior year exceeded two hundred fifty thousand dollars ($250,000), but was less than, or equal to, one million dollars

($1,000,000), the employer shall pay a contribution equal to 4 percent of wages paid to each employee not to exceed subdivision (b).

(3) If the total amount of wages paid by an employer in the prior year exceeded one million dollars ($1,000,000), but was less than, or equal to, fifteen million dollars ($15,000,000), the employer shall pay a contribution equal to 6 percent of wages paid to each employee not to exceed subdivision (b).

(4) If the total amount of wages paid by an employer in the prior year exceeded fifteen million dollars ($15,000,000), the employer shall pay a contribution equal to 6.5 percent of wages paid to each employee not to exceed subdivision (b).

(b) For purposes of calculating health care contributions for each employee, "wages" shall not exceed the amount of the contribution and benefit base as established under Section 430 of Title 42 of the United States Code.

(c) The employer shall calculate the amount of any health care contributions required to be paid for each month of each calendar quarter and shall remit those contributions on or before the 15th day of the subsequent month.

(d)(1) If an employer is required by a collective bargaining agreement to make health expenditures on behalf of bargaining unit employees pursuant to Section 302(c)(5) of the federal Labor Management Relations Act (29 U.S.C. sec. 186(c)(5)) that, in the aggregate, equal or exceed the total amount of wages, as applicable, set forth in subdivision (a), for those bargaining unit employees, the employer shall be deemed to have satisfied the requirements of subdivision (a) with respect to those bargaining unit employees.

(2) For purposes of subdivision (a), the department shall not accept any employer contributions made to the California Health Trust Fund, as established by Section 12699.212 of

the Insurance Code, by an employer on behalf of bargaining unit employees represented by a labor organization for purposes of collective bargaining if notified by the labor organization that the health expenditures were made without express written mutual agreement of the employer and the labor organization representing such employees.

(3) An employer with employees represented by a labor organization for purposes of collective bargaining shall pay a contribution, as required by subdivision (a), separately for each bargaining unit, unless otherwise provided for in the collective bargaining agreement. For all employees who are not represented by a labor organization for purposes of collective bargaining, the employer shall pay a single contribution as required by subdivision (a).

(e) For employees of employers defined in subdivision (a) of Section 683 and subdivision (a) of Section 685 of the Unemployment Insurance Code, the health care contribution required under subdivision (a) of this section shall be met pursuant to Section 12302.2 of the Welfare and Institutions Code.

19004. (a) Health expenditures made by a loan-out corporation include actual health expenditures and any qualified health expenditures made on its behalf by another qualifying entity, as determined by the department, for services of the owner or sole shareholder to the extent that those expenditures, in the aggregate, do not exceed the amount of health care contributions required by Section 19003 on wages paid to the owner or sole shareholder by the loan-out corporation. Only those qualified health expenditures that the loan-out corporation is able to substantiate may be included.

(b) For purposes of this section, the following definitions apply:

(1) "Loan-out corporation" means an individual who operates through a corporation and is the sole shareholder.

(2) "Qualified health expenditures" means any contributions made pursuant to Section 302(c)(5) of the federal Labor Management Relations Act (29 U.S.C. sec. 186(c)(5)), under a collective bargaining agreement.

(c) Any qualified health expenditures made on behalf of a loan-out corporation by another qualifying entity, as determined by the department, shall not be included in that other entity's calculation of its allowable health expenditures as defined in subdivision (d) of Section 19002.

(d) The department may adopt regulations, as necessary, to implement this section.

19005. Each employer shall post and maintain in places readily accessible to individuals in its service printed statements concerning health expenditure information and other matters as may be prescribed by authorized regulations. The printed statements shall be supplied by the department without cost to each employer.

19006. (a) Except as otherwise specifically provided in this section, the information obtained in the administration of this division is confidential, not open to the public, and shall be for the exclusive use of the director in the discharge of his or her duties.

(b) The director shall release information obtained in the administration and enforcement of this division to the Managed Risk Medical Insurance Board and to the Department of Health Care Services, as needed, for the purpose of administering the Health Care Security and Cost Reduction Act.

(c) The information obtained in the administration of this division may be tabulated and published in statistical form for use by the state legislature, departments and agencies, and the public, except that the name or identity of the employer or of any employee shall not be divulged in the tabulation or publication.

19007. Revenue collected under the provisions of this division shall be deposited in the California Health Trust Fund established pursuant to Section 12699.212 of the Insurance Code.

19008. The department shall establish methods by which health care contributions due from employers are collected and shall use the existing authority of the department and procedures for adequate notice and other due process requirements to collect health care contributions owed to the state. The director shall adopt regulations to implement this section no later than January 1, 2010.

**SECTION 9.** Section 14155 is added to the Welfare and Institutions Code, to read:

14155. (a) The people of the State of California find and declare all of the following:

(1) Californians without private health care coverage frequently access the health care system through the services provided by local government.

(2) Pursuant to Section 17000, counties are responsible for the care of the poor and indigent who have no other means of support and are not eligible for state programs. Additionally, in 1982, the state transferred the responsibility for providing health care services for medically indigent adults to the counties. Over time, the state has provided funding for this responsibility through property tax reallocation, increased federal funding to public hospitals, and allocations from the Local Revenue Fund pursuant to the realignment provisions of Chapter 6 (commencing with Section 17600) of Part 5.

(3) Commencing in the 2010-11 fiscal year and continuing in subsequent fiscal years, the state's enactment of health care reform pursuant to the Health Care Security and Cost Reduction Act, including the expansion of eligibility for the Medi-Cal program and the Healthy Families Program, the establishment of the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) purchasing pool, and the provision of health care subsidies for low-income persons,

is estimated to significantly reduce the number of Californians without health care coverage who rely on local indigent health care services.

(4) The people find that counties will derive significant fiscal benefits from the health care reform provided by the Health Care Security and Cost Reduction Act, and that counties shall be fiscally responsible for a portion of the costs incurred by the state in providing health care coverage to those eligible and enrolled adults as identified in subdivision (b).

(b) Each county and city and county shall make payments, as specified in subdivision (c), to the state for the health care costs incurred by the state in providing health care coverage to those adults who meet any of the following criteria:

(1) Have an income less than or equal to 150 percent of the federal poverty level and are enrolled in the purchasing pool established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code, and are eligible for the pool pursuant to Section 12699.211.01 of the Insurance Code.

(2) Have an income greater than 100 percent of the federal poverty level, but less than or equal to 150 percent of the federal poverty level, are eligible for Medi-Cal benefits pursuant to Section 14005.301 or Section 14005.305, and, pursuant to Section 14005.306, are enrolled in the purchasing pool established pursuant to Part 6.45 (commencing with Section 12699.201) of Division 2 of the Insurance Code.

(3) Have an income less than or equal to 100 percent of the federal poverty level and are enrolled in the Medi-Cal program, and are eligible for Medi-Cal benefits pursuant to Section 14005.305 or Section 14005.333.

(c) Payments by each county or city and county pursuant to this section shall be 40 percent of the total costs paid by the state from all sources, for those eligible and enrolled

adults identified in subdivision (b), in accordance with payment schedules and methodologies which shall be established by statute, consistent with the requirements of this section. The obligation of each county or city and county shall be limited to payment for only those enrolled adults who reside within the county or city and county. For purposes of determining a county's or city and county's payment under this subdivision, an adult's enrollment and residency shall be determined semi-annually.

(d)(1) Notwithstanding subdivision (c), the counties' and city and county's maximum aggregate payment for the costs incurred by the state under this section for those adults identified in subdivision (b), except as may be adjusted annually in accordance with subdivision (e) and, as applicable, subdivision (j), shall not exceed one billion dollars ($1,000,000,000). Subject to the maximum aggregate payment established by this subdivision, as annually adjusted pursuant to subdivision (e), and, as applicable, subdivision (j), the amount of each county's or city and county's contribution toward the aggregate amount of one billion dollars ($1,000,000,000) shall be determined by statute. On or before April 1, 2009, the Department of Finance, in consultation with a statewide association representing all counties, shall provide a recommendation to the Legislature regarding the allocation methodology or formula to determine each county's or city and county's maximum aggregate payment amount.

(2) On or before April 1, 2015, the Department of Finance, in consultation with a statewide association representing all counties, may request legislation to modify the allocation methodology or formula determined pursuant to paragraph (1), to correct errors or omissions in the original methodology or formula. The allocation methodology or formula may be amended by statute, provided that the maximum statewide aggregate amount, as adjusted or modified by subdivision (e), and, as applicable, subdivision (j), shall not be increased.

(e)(1) The amount of the counties' and city and county's maximum aggregate payment under this section shall be adjusted annually, commencing with the 2010-11 fiscal year, by the percentage increase or decrease of the total statewide annual allocation from the Local Revenue Fund in accordance with Sections 17600 to 17609.10, inclusive. The adjustment shall be applied proportionately to the share of each county or city and county of the aggregate payment.

(2) In the event that the state reduces or eliminates eligibility for persons who are eligible for Medi-Cal under Sections 14005.305 or 14005.333, or for adults with an income at or below 150 percent of the federal poverty level who are eligible for health coverage under Section 12699.211.01 of the Insurance Code, the state shall correspondingly reduce the amount of the counties', and city and county's, maximum aggregate payment under this section, in an amount directly proportional to the health care coverage costs previously incurred by the state in the prior fiscal year for those individuals whose eligibility is reduced or eliminated. The amount of each county's or city and county's payment pursuant to subdivision (d), as adjusted or modified by this subdivision, and, as applicable, subdivision (j), shall also be reduced proportionately.

(f) Notwithstanding any other provision of law, funds currently used by, or available to, a county or city and county to pay for health care services may be used to make payments required by this section. A payment made by a county or city and county pursuant to this section shall be deemed an expenditure for indigent health care services pursuant to Section 17609.01.

(g) Payments by a county or city and county made pursuant to this section shall be deposited into the California Health Trust Fund, as established by Section 12699.212 of the Insurance Code.

(h) If, within 45 days after receiving written notification of the amount owed under this section, a county or city and county, fails to remit its payment, the state, to the extent permitted by law, may withhold the amount of the payment from either or both of the following sources:

(1) Allocations from the Health Subaccount of the Sales Tax Account of the Local Revenue Fund created pursuant to paragraph (3) of subdivision (b) of Section 17600.

(2) Any other revenue allocation to which the county or city and county would otherwise be entitled and to which access is not precluded by the California Constitution or federal law.

(i) During any period in which there is a dispute between a county or city and county and the state relating to the amount of any payment under this section, the amount in dispute shall be paid by the county or city and county, pending final resolution of the dispute in the manner provided by law. If the county or city and county is the prevailing party in the dispute, the county or city and county shall be entitled to interest on the disputed amount at the rate being earned by the Pooled Money Investment Account (PMIA) for the period between payment and final resolution. The state shall pay the disputed amount and interest to the county or city and county within 45 days of final resolution of the dispute.

(j)(1) A county or city and county may seek a modification of its share of cost, as determined pursuant to subdivision (d) and adjusted or modified under subdivision (e), for one fiscal year at a time, if the county or city and county experiences financial distress due to high demand for county-funded health care services by medically indigent persons and an actual level of savings attributable to implementation of the Health Care Security and Cost Reduction Act that is significantly below anticipated savings. A request for modification shall be made to the Department of Finance and shall be accompanied by an independent audit that reflects the level and extent of the county's or city and county's expenditures on health care costs for services

delivered to medically indigent persons in both the 2006-07 fiscal year and the fiscal year for which the request is made, adjusted for medical inflation and any change in eligibility and scope of services made by the county or city and county.

(2) The Department of Finance shall notify the Joint Legislative Budget Committee within 30 days of receipt of a request for modification under this subdivision. The notice shall be accompanied by a copy of the county's or city and county's request, including the required independent audit. The Department of Finance shall review the request and make a determination within 45 days, based on the factors identified in paragraph (1). At least 10 days prior to approving a temporary modification authorized by this subdivision, the Department of Finance shall provide written notification to the Joint Legislative Budget Committee of the amount of the modification and the fiscal year for which the modification is being made.

(3) If the Department of Finance grants a temporary modification, the counties' or city and county's maximum aggregate payment shall be reduced by the amount of the modification granted. A reduction to a county's or city and county's share of cost pursuant to this subdivision shall not result in any change or modification to another county's or city and county's share of cost.

(4) A permanent modification to an amount determined pursuant to subdivision (d), as adjusted or modified pursuant to subdivision (e), shall only be made pursuant to a subsequent statutory enactment.

**SECTION 10.** Section 14155.01 is added to the Welfare and Institutions Code, to read:

14155.01. The Department of Finance, in consultation with a statewide association representing all counties, the Department of Health Care Services, and the Managed Risk

Medical Insurance Board, shall establish a billing process for the payments required by Section 14155.

**SECTION 11.** Section 14155.02 is added to the Welfare and Institutions Code, to read:

14155.02. Notwithstanding any other provision of law, either the state or a county or city and county may seek to resolve a dispute arising under Section 14155 either through any appropriate judicial remedy or through a joint election to submit the dispute to arbitration. However, the state and the county or city and county shall first make good faith, reasonable efforts to resolve the dispute. The state and the county or city and county may jointly elect to submit the matter to arbitration. Upon this election, the parties shall agree upon an arbitrator designated by a recognized statewide arbitration association in accordance with the association's established rules and procedures. The arbitration hearing shall be set within 45 days of the parties' joint election, but not less than 28 days from the date of selection of an arbitrator. The arbitration hearing may be continued, as necessary, at the arbitrator's discretion. The decision of the arbitrator shall be based upon substantive law and shall be binding on all parties, subject to the following judicial review:

(1) Judicial review of the arbitrator's findings of fact shall be limited to whether there was substantial evidence to support the decision of the arbitrator;

(2) Judicial review of the arbitrator's conclusions of law shall be subject to de novo review.

**SECTION 12.** Article 5.22 (commencing with Section 14167.31) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.22. Coverage Dividend Contribution Act

14167.31. For purposes of this article, the following definitions shall apply:

(a) "General acute care hospital" shall have the meaning given in subdivision (a) of Section 1250 of the Health and Safety Code.

(b) "Net patient revenue" means net patient revenue as defined, as of July 1, 2007, for purposes of the Office of Statewide Health Planning and Development reporting by hospitals, provided that net patient revenue for a group of general acute care hospitals that receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans, that are operated as units of a coordinated group of health facilities under common management and that do not report net patient revenue to the Office of Statewide Health Planning and Development separately for each hospital, shall mean the amount of other operating revenue reported by the group to the Office of Statewide Health Planning and Development pursuant to Section 128735 of the Health and Safety Code.

(c) "Fee-for-service days" means fee-for-service days as defined, as of July 1, 2007, for purposes of the Office of Statewide Health Planning and Development reporting by hospitals.

(d) "Managed care days" means managed care days as defined, as of July 1, 2007, for purposes of the Office of Statewide Health Planning and Development reporting by hospitals.

(e) "Long-term care days" means long-term care days as defined, as of July 1, 2007, for purposes of the Office of Statewide Health Planning and Development reporting by hospitals.

(f) "Medicare days" means Medicare days as defined, as of July 1, 2007, for purposes of the Office of Statewide Health Planning and Development reporting by hospitals.

(g) "Prior fiscal year data" means data taken from sources that the department determines are the most accurate and reliable at the time the determination is made, or data that may be calculated from the most recent audited data using appropriate update factors.

(h) "Exempt facility" means a rural hospital of less than 50 licensed acute care beds or a hospital certified for participation in the Medicare Program as a long-term acute care hospital, so long as the exemption is acceptable to the federal government in conjunction with its approval of the contribution established pursuant to this article.

(i) "Hospital community" means a statewide organization representing a majority of California hospitals and any other hospital industry organization or system that represents children's hospitals, nondesignated public hospitals, designated public hospitals, private safety net hospitals, and other public or private hospitals.

(j) "Nondesignated public hospital" means a public hospital that is licensed under subdivision (a) of Section 1250 of the Health and Safety Code and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(k) "Private hospital" means a hospital licensed under subdivision (a) of Section 1250 of the Health and Safety Code that is a nonpublic hospital, nonpublic converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(l) "Designated public hospital" shall have the meaning given in subdivision (b) of Section 14167.1, as contained in the Medi-Cal Hospital Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)) as that section may be amended from time to time.

(m) "Aggregate hospital net patient revenue" means the sum of net patient revenue for all nonexempt hospitals.

14167.32. (a) Consistent with the principle of shared benefit and shared responsibility, beginning with patient days occurring on or after July 1, 2010, there shall be imposed on each general acute care hospital that is not an exempt facility a coverage dividend contribution, to be

calculated on an annual basis. The coverage dividend contribution shall be established prospectively by the department at 4 percent of the statewide aggregate net patient revenue of general acute care hospitals that are not exempt facilities.

(1) The department shall calculate the coverage dividend contribution based on the following two calculations:

(A) A fee on the general acute care hospital's fee-for-service days, excluding Medicare fee-for-service days and excluding long-term care fee-for-service days.

(B) A fee on the general acute care hospital's managed care days excluding Medicare managed care days and excluding long-term care managed care days.

(2) The contribution per patient day described in subparagraph (A) of paragraph (1) shall equal the contribution per patient day described in subparagraph (B) of paragraph (1) multiplied by 2.1.

(3) The department, in consultation with the hospital community and other stakeholders, shall calculate the contributions such that the total contributions will yield 4 percent of estimated aggregate hospital net patient revenue.

(b) The amount of the per patient day contributions described in paragraph (1) of subdivision (a) shall be determined prospectively prior to the beginning of the fiscal year to which the contributions apply. The estimate of net patient revenue used to calculate the coverage dividend contribution shall be based on the most recently published Office of Statewide Health Planning and Development Annual Disclosure Reports.

(c) Within 45 days following the end of each calendar quarter, each hospital that is subject to the coverage dividend contribution shall calculate and report to the department the

amount of the coverage dividend contribution that it owes for the particular quarter based on its qualifying days of care at the state-established coverage dividend contributions.

(d) In no case shall the aggregate coverage dividend contributions collected annually pursuant to this section exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the contribution that is prescribed under federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(e) The coverage dividend contribution, as calculated pursuant to subdivision (c), shall be paid by each hospital subject to the contribution, to the department for deposit in the Coverage Dividend Revenue Account as established in Section 14167.35 on a quarterly basis on or before the 45th day following the end of the quarter for which the contribution is calculated. Deposits may be accepted at any time and will be credited toward the fiscal year for which they were assessed.

(f) All general acute care hospitals subject to the coverage dividend contribution shall report all of the following data to the department in accordance with subdivisions (g) and (h), and other data the department may determine is necessary for the implementation of this article:

(1) The total number of fee-for-service patient days, Medicare fee-for-service patient days, and the number of long-term care fee-for-service patient days.

(2) The total number of managed care patient days, Medicare managed care patient days, and the number of long-term care managed care days.

(g) On or before the last day of each calendar quarter, each hospital subject to the coverage dividend contribution shall file a report with the department, in a prescribed form, which contains data as described in subdivision (f) for the previous calendar quarter and the amount of the contribution paid for patient days in that quarter. If it is determined that a lesser

amount was paid than was due as calculated on the prescribed form, the hospital shall pay the amount owed in the previous calendar quarter to the department with the report. Any amount determined to have been paid in excess during the calendar quarter shall be credited to the amount owed for the following quarter.

(h) On or before August 31 of each year, each hospital subject to the coverage dividend contribution shall file a report with the department, in a prescribed form, that contains the data as described in subdivision (f) for the preceding fiscal year and the amount of the contribution paid during that fiscal year. If it is determined that a lesser amount was paid than was due as calculated on the prescribed form, the hospital shall pay the amount owed in the preceding fiscal year to the department with the report. Any amount determined to have been paid in excess during the previous quarter shall be credited to the amount owed for the following quarter.

(i) A newly licensed hospital subject to the coverage dividend contribution shall complete all requirements of subdivision (g), commencing with the quarter in which it begins operations, and of subdivision (h), commencing with the year during which it begins operations.

(j) Interest shall be assessed on coverage dividend contributions not paid on the date due at the same rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and be deposited in the Coverage Dividend Interest Account as established in Section 14167.35.

(k)(1) When a hospital fails to pay all or part of the coverage dividend contribution within 60 days of the date that payment is due, the department may deduct the unpaid contribution and interest owed from any Medi-Cal payments to the hospital until the full amount is recovered. Any unpaid contribution deducted by the department under this subdivision shall

be deposited in the Coverage Dividend Revenue Account as established in Section 14167.35. Any interest deducted by the department under this subdivision shall be deposited in the Coverage Dividend Interest Account as established in Section 14167.35.

(2) Any deduction pursuant to this subdivision shall be made only after written notice to the hospital and may be taken over a period of time. The director may enter into an agreement with any hospital for the purpose of establishing the period of time during which the deduction shall be taken.

(l) In accordance with the provisions of the Medicaid state plan, the payment of the coverage dividend contribution shall be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(m) The department shall work in consultation with the hospital community to implement the coverage dividend contribution.

14167.35. (a) The Coverage Dividend Revenue Account and the Coverage Dividend Interest Account are hereby established as subaccounts in the California Health Trust Fund established in the State Treasury pursuant to Section 12699.212 of the Insurance Code. Interest earned on deposits in the Coverage Dividend Revenue Account and the Coverage Dividend Interest Account shall be retained in the respective accounts for purposes specified in subdivision (c).

(b) All contributions required to be paid to the state under this article shall be paid in the form of remittances payable to the department. The department shall directly transmit the contribution payments to the Treasurer to be deposited in the Coverage Dividend Revenue Account. All interest required to be paid to the state under this article shall be paid in the form

of remittances payable to the department. The department shall directly transmit the interest payments to the Treasurer to be deposited in the Coverage Dividend Interest Account.

(c) All moneys in the Coverage Dividend Revenue Account and all moneys in the Coverage Dividend Interest Account shall be used only for any of the following purposes in the following order of priority, subject to the requirements of subdivision (d):

(1) To make increased payments to hospitals pursuant to the Medi-Cal Hospital Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)).

(2) To make increased payments to managed health care plans pursuant to subdivision (a) of Section 14167.9 by an amount necessary to ensure that managed health care plans increase rates of payment to all hospitals subject to the coverage dividend contribution and to rural hospitals of less than 50 licensed acute care beds as defined in subdivision (h) of section 14167.31 under their contracts by the same percentage that Medi-Cal fee-for-service rates to these hospitals are increased pursuant to the Medi-Cal Hospital Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)), and subject to the limitations of federal law, if any.

(3) To increase payments to Medi-Cal managed health care plans which shall, in total, then be passed on as increased payments to all hospitals subject to the coverage dividend contribution and to rural hospitals of less than 50 licensed acute care beds as defined in subdivision (h) of section 14167.31, as limited in subdivision (d), and subject to the limitations of federal law, if any.

(4) To pay for the hospital component of the cost of coverage for individuals made eligible pursuant to Section 12699.211.01 of the Insurance Code and Sections 14005.301, 14005.305, and 14005.333 of the Welfare and Institutions Code.

(5) The balance remaining after making the payments pursuant to paragraphs (1) to (4), inclusive, shall be used to increase payments to Medi-Cal managed health care plans, which shall in total then be passed on as increased payments to all hospitals, subject to the coverage dividend contribution and to rural hospitals of less than 50 licensed acute care beds as defined in subdivision (h) of section 14167.31, and subject to the limitations of federal law, if any.

(6) Beginning on June 30, 2013, and at the end of each fiscal year thereafter, the department shall determine the average amount by which any undistributed funds, including interest, exceeded a percentage of the average annual contribution for the preceding two-year period. The percentage referred to in the preceding sentence shall be 20 percent for the 2013-14, 2014-15, 2015-16, and 2016-17 fiscal years, and 10 percent for each fiscal year thereafter. This paragraph shall only apply during those fiscal years in which this article remains operative. If the balance of undistributed funds at the end of the particular fiscal year is equal to or exceeds the amount determined by the department pursuant to the preceding sentence, the department shall return the amount determined pursuant to the preceding sentence to the hospitals that paid the contribution on a pro rata basis.

(d) The use of moneys in the Coverage Dividend Revenue Account shall be subject to all of the following:

(1) No less than 23.29 percent of the revenue derived from the coverage dividend contribution assessed on nondesignated public hospitals and private hospitals with respect to any fiscal year shall be made available for increased reimbursement rates to managed health care plans pursuant to paragraph (3) of subdivision (c). Managed health care plans shall pass on all of the increased payments resulting from the increased reimbursement rates to nondesignated public

hospitals and private hospitals under contract with the managed health care plans in return for the provision of services to Medi-Cal beneficiaries.

(2) The department, prior to each fiscal year, shall provide the hospital community with aggregate data, computations, and other information necessary to verify that the amount of the Coverage Dividend Revenue Account to be used for that fiscal year for the purpose described in paragraph (4) of subdivision (c) is solely the hospital component of the cost of coverage for the uninsured.

(3) The department, within 90 days after the close of the fiscal year, shall provide the hospital community with aggregate data, computations, and other information necessary to verify that the amount of the Coverage Dividend Revenue Account used for that fiscal year for the purpose described in paragraph (4) of subdivision (c) was used solely to pay for the hospital component of the cost of coverage for the uninsured.

(e) Upon the written request of the Director of Finance, the Controller shall transfer moneys to the purchasing pool established pursuant to Part 6.5 (commencing with Section 12699.201) of Division 2 of the Insurance Code to support the purchase of the hospital portion of health coverage as described in paragraph (4) of subdivision (c).

(f) No portion of the Coverage Dividend Revenue Account or of the Coverage Dividend Interest Account shall be used in support of the administration of the department, except that these moneys can be used in combination with federal funds to fund the actual cost of collecting the coverage dividend contribution.

(g) The moneys in the Coverage Dividend Revenue Account or the Coverage Dividend Interest Account shall be available for appropriation by the Legislature solely for the purposes of

this article and the Medi-Cal Hospital Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)).

(h) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt hospitals identified in this article as exempt facilities, including the submission, as may be necessary, of a request for waiver of the broad-based requirement, waiver of the uniform fee requirement, or both, pursuant to Section 433.68(e)(1) and (2) of Title 42 of the Code of Federal Regulations.

(i) Any methodology specified in this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval, provided those modifications do not violate the intent of this article and are not inconsistent with the conditions of implementation set forth in subdivisions (a) and (c) of Section 14167.36.

(j) The department, in consultation with the hospital community, shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 14167.32 to ensure compliance with the federal limits set forth in Section 433.68 of Title 42 of the Code of Federal Regulations, or elsewhere in federal law.

14167.36. (a) The coverage dividend contribution imposed by this article shall not be implemented unless all of the following conditions are met:

(1) A coverage dividend contribution consistent with this article is established.

(2) The coverage dividend contribution is limited to 4 percent of aggregate hospital net patient revenue.

(3) Segregated accounts apart from the General Fund are established for deposit of the coverage dividend contribution, and any interest, including any interest that may accrue on the balance of the accounts.

(4) The state receives federal approval of the coverage dividend contribution from the federal Centers for Medicare and Medicaid Services.

(b) This article shall be operative only whenever all of the following conditions are met:

(1) The state maintains federal approval from the federal Centers for Medicare and Medicaid Services of the coverage dividend contribution and the use of the coverage dividend contribution as set forth in this article.

(2) The Medi-Cal Hospital Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)) is enacted and remains in effect and hospitals are reimbursed the increased rates beginning on the implementation date, as defined in Section 14167.1.

(3) The full amount of the coverage dividend contribution assessed and collected pursuant to this article remains available for the purposes specified in this article.

(4) The state has continued its maintenance of effort for the level of state funding of hospital services for each fiscal year during which this article is implemented in a manner such that all of the following ends are achieved:

(A) Private hospitals and nondesignated public hospitals continue to receive payments pursuant to Sections 14167.2, 14167.3, 14167.6, and 14167.7 at the maximum amount that can be paid under federal Medicaid law.

(B) Managed care plans continue to be paid additional amounts pursuant to Section 14167.9.

(C) The state continues to provide health care coverage pursuant to Sections 14005.301, 14005.305, and 14005.333, and Section 12699.211.01 of the Insurance Code.

(D) Designated public hospitals continue to receive payments of the full rates pursuant to Section 14167.10.

(5) The proceeds of the coverage dividend contribution, including any interest and related federal reimbursement, are used for the purposes set forth in this article.

(c) If this article is implemented, and subsequently, any one of the conditions in subdivision (b) is not met, on and after the date that the department, in consultation with the hospital community and other stakeholders, makes that determination, this article shall become inoperative.

(d) Notwithstanding subdivisions (a) and (b), in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that the coverage dividend contribution assessed and collected pursuant to this article cannot be implemented, this article shall become inoperative.

(e) If this article becomes inoperative in accordance with subdivision (c), and the department subsequently determines that the conditions established in subdivision (b) are met, this article shall become operative by operation of law.

(f) This article shall become inoperative on July 1, 2015, and as of January 1, 2016 is repealed, unless a later enacted statute that is enacted on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

14167.37. (a) Prior to implementation of this article, the director shall seek federal approval of each element of this article. If after seeking federal approval, federal approval is not obtained, this article shall not be implemented.

(b) Every report or informational submission required from providers pursuant to this article shall contain a legal verification to be signed by the provider verifying under penalty of perjury that the information provided is true and correct, and that any information in supporting documents submitted by the provider is true and correct.

**SECTION 13.** On or before January 1, 2009, the Director of Finance shall authorize a one-time loan from the General Fund of up to twenty five million dollars ($25,000,000) to the Managed Risk Medical Insurance Board to provide funding to eligible counties operating a county health initiative. Funds shall be available to provide coverage to children under 19 years of age in families whose income is at or below 300 percent of the poverty level and may only be used to eliminate any caps on enrollment and waiting lists under a county health initiative. "County health initiative," for purposes of this section, means an entity that, as of July 1, 2007, was operational and actively providing for administration of coverage to children who do not qualify for either the Healthy Families Program or full-scope Medi-Cal with no share of cost. The Managed Risk Medical Insurance Board, in consultation with the director of the Department of Health Care Services and representatives of county health initiatives, shall develop an allocation formula for distribution of the funding. Notwithstanding section 12699.212 of the Insurance Code added by this act, the loan authorized under this section shall be repaid to the General Fund on or before June 30, 2009, from the proceeds of the tax on tobacco products provided in Article 4, commencing with Section 30133, Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code, as added by this act.

**SECTION 14.** Notwithstanding Section 13340 of the Government Code and subsection (1) of subdivision (f) of Section 17052.31 of the Revenue and Taxation Code, all funds determined to be necessary to implement the provisions of Section 17052.30 by the Managed Risk Medical Insurance Board, in consultation with the Department of Finance, are hereby continuously appropriated.

**SECTION 15.** Sections 7-11, and 14, inclusive, of this act may be amended by statute, passed in each house with the approval required by Article IV or Article XIII A of the California Constitution, as applicable. Sections 5 and 12 of this act may be amended by statute, passed in each house by a two-thirds vote of the membership. Nothing in this act is intended to limit the ability of the Legislature to amend Assembly Bill 1 of the 2007-08 First Extraordinary Session after this act is passed by the voters.

**SECTION 16.** Statutory References. This initiative is enacted with the expectation that the Legislature passes and the Governor signs into law a statute that is essentially the same as Assembly Bill 1 of the 2007-08 First Extraordinary Session as of December 17, 2007. References in this act to statutes not contained in this act are to statutes as amended or added by Assembly Bill 1 of the 2007-08 First Extraordinary Session.

**SECTION 17.** Severability. If any provision of this act, or part thereof, is for any reason held to be invalid or unconstitutional, the remaining provisions shall not be affected, but shall remain in full force and effect, and to this end the provisions of this act are severable.

**SECTION 18.** Conflicting Measures. This measure is intended to be comprehensive. It is the intent of the People that in the event this measure and another initiative measure or measures relating to the same subject appear on the same statewide election ballot, the provisions of the other measure or measures shall be deemed to be in conflict with this measure. In the event that

this measure shall receive a greater number of affirmative votes, the provisions of this measure shall prevail in their entirety, and all provisions of the other measure or measures shall be null and void.

**SECTION 19.** Limitation on Actions. Any action brought to challenge the facial validity of this act must be filed in the Superior Court of Sacramento County within 60 days after passage of the act. Any action brought pursuant to this section shall be given calendar preference and shall be subject to expedited review.