Code and only with health care service plans that can demonstrate compliance with the requirements of Section 1357.23 of the Health and Safety Code.

2173. (a) The board shall develop and utilize appropriate cost containment measures to maximize the cost-effectiveness of health care coverage offered under the program. The board shall consider the findings of the California Health Care Quality Improvement and Cost Containment Commission.

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

## CHAPTER 8. ENROLLMENT AND COORDINATION WITH PUBLIC PROGRAMS

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

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

2190.1. (a) An enrollee or dependent who would qualify for Medi-Cal pursuant to Chapter 7 (commencing with Section

14000) of Part 3 of Division 6 of the Welfare and Institutions Code and who chooses to provide information about eligibility for the Medi-Cal program shall be enrolled in the Medi-Cal program if determined by the State Department of Health Services to be eligible for that program and shall be charged share-of-cost, copays, coinsurance, or deductibles in accordance with the requirements of that program.

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

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

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

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

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

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

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

2190.3. Nothing in this part shall be construed to diminish or otherwise change existing protections in law for persons eligible

for public programs, including, but not limited to, California Children's Services, Genetically Handicapped Persons Program, county mental health programs, programs administered by the Department of Alcohol and Drug Programs, or programs administered by local education agencies.

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

## CHAPTER 9. ADMINISTRATION

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

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

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

(c) Notwithstanding Section 2130.4, the board is authorized to obtain a loan from the General Fund for all necessary and reasonable expenses related to the establishment and administration of this part prior to the collection of the employer

fee. The proceeds of the loan are subject to appropriation in the annual Budget Act. The board shall repay principal and interest, using the rate of interest paid under the Pooled Money Investment Account, to the General Fund no later than five years after the first year of implementation of the employer fee.

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

Article 3.11. Insurance Market Reform

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

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

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

(2) For medium employers with 51 or more eligible employees, all requirements in that article shall apply, except that the health care service plan may develop health care coverage benefit plan designs to fairly and affirmatively market only to medium employer groups of 51 to 199 eligible employees, and apply a risk

adjustment factor of no more than 115 percent and no less than 85 percent of the standard employee risk rate.

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

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

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

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

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

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