SA2005RF0139,
ADMT. #1-NS

December 16, 2005

Ms. Tricia Knight
Initiative Coordinator
Office of the Attorney General
State of California
PO Box 994255
Sacramento, CA 94244-25550

Re: Amendment to the Tobacco Tax Act of 2006 (SA2005RF0139)

Dear Ms. Knight:

Please find enclosed an amendment to the Tobacco Tax Act of 2006 (SA2005RF0139). This amendment adds the word "Healthcare" to Section 8 of the proposed initiative to make it clear that the initiative refers to the existing California Healthcare Workforce Policy Commission.

You have indicated that this amendment is technical and non-substantive.

Thank you for your assistance in this matter.

Sincerely,

Paul Knepprath
Coalition for a Healthy California

SA2005RF0139, AMDT. #1 - NS

INITIATIVE MEASURE TO BE SUBMITTED TO VOTERS

THE TOBACCO TAX ACT OF 2006

SECTION 1. Statement of Findings

(a) Cigarette smoking and other uses of tobacco are leading causes of many serious health problems, including cancer, heart disease and respiratory diseases. The treatment of tobacco-related diseases imposes a significant burden upon California's already overstressed health care system. Prior efforts to curb the use of tobacco have not sufficiently eased the health care burden on the taxpayers of California.

(b) Tobacco use costs Californians billions of dollars a year in medical expenses and lost productivity.

(c) Currently, the state imposes a tax on cigarettes and tobacco products. Funds from that tax are used in part by the state to fund programs to offset the adverse health consequences of tobacco use. The tobacco tax is an appropriate source to fund prevention, research and treatment of chronic diseases, including improved access to health care for children and adults.

(d) The tax on tobacco products in California has not been raised since 1998. As a consequence, the total tax levied on tobacco products is much less than in many other states. Yet the health consequences to our citizens, particularly children and young adults, and the corresponding burden on our state's health care system continue.

(e) The deterioration of the state's hospital emergency services network has left many communities unable to adequately cope with the normal flow of emergency services. This emergency services crisis imposes a significant burden on our community clinics and keeps them from fulfilling their important health care function for low income children and adults.

(f) Funds which could be used to provide pioneering research into the prevention and treatment of chronic diseases, and health insurance for our most vulnerable children, are increasingly diverted to address the health care crisis caused, in part, by tobacco-related illnesses.

(g) Almost 80% of adult smokers become addicted to tobacco before age 18. Increasing the cost of cigarettes and other tobacco products and providing a comprehensive tobacco control program have proven to be two of the most effective ways to reduce smoking among youth and the associated health problems and economic costs.

(h) The establishment of programs designed to (1) reduce the consumption of tobacco in the first instance, (2) fund research, early detection and treatment of chronic diseases, and (3) preserve access to emergency hospital services performed by well-trained doctors and nurses, is vital to the public's interest.

SECTION 2. Statement of Purpose

(a) The people of California hereby increase the tax on tobacco to reduce the economic costs of tobacco use in California and to provide supplemental funding to:

(1) promote medical research into chronic diseases, particularly cancer;

(2) reduce the impact of chronic diseases through prevention, early detection, treatment and comprehensive health insurance; and

(3) improve access to and delivery of health care, particularly emergency health services.

SECTION 3. Tobacco Tax

Article 4 of Chapter 2 of Part 13 of Division 2 (commencing with Section 30132) of the Revenue and Taxation Code is added to read:

Article 4. The Tobacco Tax of 2006 Trust Fund

§ 30132 The Tobacco Tax of 2006 Trust Fund ("Tobacco Trust Fund") is hereby created in the State Treasury. The fund shall consist of all revenues deposited therein pursuant to this Article, including interest and investment income. Moneys deposited into the Tobacco Tax of 2006 Trust Fund shall be allocated and are continuously appropriated for the exclusive purpose of funding the programs and services in Section 30132.3 and shall be available for expenditure without regard to fiscal years.

§ 30132.1(a) In addition to the taxes imposed upon the distribution of cigarettes by Article 1 (commencing with Section 30101) and Article 2 (commencing with Section 30121) and Article 3 (commencing with Section 30131) and any other taxes in this Chapter, there shall be imposed an additional tax upon every distributor of cigarettes at the rate of one hundred thirty mills ($0.130) for each cigarette distributed.

(b) For purposes of this Article, the term "cigarette" has the same meaning as in Section 30003, as it read on January 1, 2005.

(c) The tax imposed by this Section, and the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, shall be imposed on every cigarette and on all tobacco products in the possession or under the control of every dealer, wholesaler, and distributor on and after 12:01 a.m. on January 1, 2007, pursuant to rules and regulations promulgated by the State Board of Equalization.

§ 30132.2 The State Board of Equalization shall determine within one year of the passage of this Act, and annually thereafter, the effect that the additional tax imposed on cigarettes by this Act, and the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, have on the consumption of cigarettes and tobacco products in this state. To the extent that a decrease in consumption is determined by the State Board of Equalization to be a

direct result of the additional tax imposed by this Act, or the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, the State Board of Equalization shall determine the fiscal effect the decrease in consumption has on the California Children and Families First Trust Fund created by Proposition 10 (1998). Funds shall be transferred from the Tobacco Trust Fund to the California Children and Families First Trust Fund as necessary to offset the revenue decrease directly resulting from imposition of the additional tax imposed by this Act, and the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123. The reimbursements shall occur, and at such times, as determined necessary to further the intent of this Section.

§ 30132.3 Except for payments of refunds made pursuant to Article 1 (commencing with Section 30361) of Chapter 6, reimbursement of the State Board of Equalization for expenses incurred in the administration and collection of the tax imposed by Section 30132.1 and the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, and transfers of funds in accordance with Section 30132.2, all moneys raised pursuant to the tax imposed by Section 30132.1, and the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, shall be deposited in the Tobacco Trust Fund. Moneys shall be allocated and appropriated from the Tobacco Trust Fund, as follows:

(a) To the Health and Disease Research Account, which is hereby created, five percent (5%), allocated to the following Sub-Accounts for the purposes stated therein:

(1) Thirty-four percent (34%) shall be deposited in a Tobacco Control Research Sub-Account, which is hereby created. All funds in the Tobacco Control Research Sub-Account shall be continuously appropriated to the University of California to be used solely to supplement the Tobacco Related Disease Research Program described in Article 2 (commencing with Section 104500) of Chapter 1 of Part 3 of Division 103 of the Health and Safety Code. The research funded by the Tobacco-Related Disease Research Program with these supplementary funds shall include, but not be limited to:

(A) Research to improve the effectiveness of tobacco control efforts in California, including programs and strategies for governmental and other organizations to reduce tobacco use and exposure to secondhand smoke; and

(B) Research on the prevention, causes, and treatment of tobacco-related diseases, including, but not limited to coronary heart disease, cerebrovascular disease, chronic obstructive lung disease, and cancer.

(2) Fourteen and one-half percent (14.50%) shall be deposited in a Cancer Registry Sub-Account, which is hereby created. All funds in the Cancer Registry Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for a statewide population-based cancer surveillance system as provided for in Chapter 2 (commencing with Section 103875) of Part 2 of Division 102 of the Health and Safety Code.

(3) Twenty-five and three-fourths percent (25.75%) shall be deposited in a Breast Cancer Research Sub-Account, which is hereby created. All funds in the Breast Cancer Research Sub-

Account shall be continuously appropriated to the University of California to be used solely for the Breast Cancer Research Program provided for in Article 1 (commencing with Section 104145) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(4) Fourteen and three-fourths percent (14.75%) shall be deposited in a Cancer Research Sub-Account, which is hereby created. All funds in the Cancer Research Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for the Cancer Research Program described in Section 104181 of the Health and Safety Code, with a focus on applied research, which includes but is not limited to, research that is geared towards the accelerated transfer of recent laboratory and clinical technologic advances into primary care, public health and community settings so that the majority of California's population may benefit. This research should be focused on converting recent discoveries into interventions and technologies, proving that they work, and learning how best to apply them.

(5) Eleven percent (11%) shall be deposited in the Lung Cancer and Lung Disease Research Sub-Account, which is hereby created. All funds deposited in the Lung Cancer and Lung Disease Research Sub-Account shall be continuously appropriated to the University of California to be used solely to provide research grants to develop and advance the understanding, causes, techniques, and modalities effective in the prevention, care, treatment, and cure of lung disease. For purposes of this Section, the lung disease research areas shall include, but not be limited to lung cancer, asthma, tuberculosis, and chronic obstructive pulmonary disease, which includes chronic bronchitis and emphysema.

(b) To the Health Maintenance and Disease Prevention Account, which is hereby created, forty-two and one-fourth of one percent (42.25%), allocated to the following Sub-Accounts for the purposes stated therein:

(1) Six and three-fourths percent (6.75%) shall be deposited in the Tobacco Control Media Campaign Sub-Account, which is hereby created. All funds in the Tobacco Control Media Campaign Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for media advertisements and public relations programs to prevent and reduce the use of tobacco products as described in paragraph (1) of subdivision (e) of Section 104375 of the Health and Safety Code.

(2) Four and one-half percent (4.50%) shall be deposited in a Tobacco Control Competitive Grants Sub-Account, which is hereby created. All funds in the Tobacco Control Competitive Grants Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for the competitive grants program directed at the prevention of tobacco-related diseases as described in Section 104385 of the Health and Safety Code.

(3) Four and one-fourths percent (4.25%) shall be deposited in a Local Health Department Tobacco Prevention Sub-Account, which is hereby created. All funds in the Local Health Department Tobacco Prevention Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for local-health-department-based programs to prevent tobacco use as described in Section 104400 of the Health and Safety Code. Notwithstanding Section 104380 of the Health and Safety Code, funds from the Local Health

Department Tobacco Prevention Sub-Account shall be appropriated to local lead agencies based on each county's proportion of the statewide population.

(4) One half percent (0.50%) shall be deposited in a Tobacco Control Evaluation Sub-Account, which is hereby created. All funds in the Tobacco Control Evaluation Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for evaluation of tobacco control programs as required by subdivisions (b) and (c) of Section 104375 of the Health and Safety Code.

(5) Three and one-half percent (3.50%) shall be deposited in a Tobacco Education Sub-Account, which is hereby created. All funds in the Tobacco Education Sub-Account shall be continuously appropriated to the Department of Education to be used solely for programs to prevent or reduce the use of tobacco products as described in Section 104420 of the Health and Safety Code. Any program receiving funds pursuant to this section must participate in program evaluations conducted by the Department of Health Services pursuant to Article 1 (commencing with Section 104350) of Chapter 1 of Part 3 of Division 103 of the Health and Safety Code. At least two percent (2%) of the money in the Tobacco Education Sub-Account shall be used solely for administration of the department's tobacco prevention education program as described in Sections 104420 and 104425 of the Health and Safety Code.

(6) Two and one-fourths percent (2.25%) shall be deposited in the Tobacco Control Enforcement Sub-Account, which is hereby created. All funds in the Tobacco Control Enforcement Sub-Account shall be used solely for programs to enforce tobacco-related statutes and policies, to enforce legal settlement provisions and to conduct law enforcement training and technical assistance activities, and shall be appropriated as follows:

(A) Fifty percent (50%) of the funds in the Tobacco Control Enforcement Sub-Account is continuously appropriated to the Department of Health Services to be used to support programs, including, but not limited to: providing grants to local law enforcement agencies to provide training and funding for the enforcement of state and local tobacco-related laws and policies, including, but not limited to the illegal sales of tobacco to minors, tobacco retailer licensing and exposure to secondhand smoke; and increasing investigative activities, compliance checks and other appropriate activities to reduce illegal sales of tobacco products to minors under the Stop Tobacco Access to Kids Enforcement (STAKE) Act, pursuant to Section 22952 of the Business and Professions Code.

(B) Twenty five percent (25%) of the funds in the Tobacco Control Enforcement Sub-Account is continuously appropriated to the California Office of the Attorney General to be used for activities including, but not limited to: enforcing laws that regulate the distribution and sale of cigarettes and other tobacco products, such as laws that prohibit cigarette smuggling, counterfeiting, selling untaxed tobacco, selling tobacco without a proper license and selling tobacco to minors; enforcing tobacco-related laws, court judgments and settlements, such as the Tobacco Master Settlement Agreement and the Smokeless Tobacco Master Settlement Agreement, entered into on November 23, 1998, by the State of California and leading United States tobacco product manufacturers, including tracking tobacco industry advertising, marketing, and promotional activities in California, and bringing actions against violators; and

assisting local law enforcement agencies in the enforcement of tobacco related statutes and local ordinances through technical assistance and training activities.

(C) Twenty five percent (25%) of the funds in the Tobacco Control Enforcement Sub-Account is continuously appropriated to the State Board of Equalization to be used to enforce laws that regulate the distribution and sale of cigarettes and other tobacco products, such as laws that prohibit cigarette smuggling, counterfeiting, selling untaxed tobacco, and selling tobacco without a proper license.

(7) Eight percent (8%) shall be deposited in a Breast and Cervical Cancer Early Detection Sub-Account, which is hereby created. All funds in the Breast and Cervical Cancer Early Detection Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for breast and cervical cancer prevention and early detection services that result in the reduction of breast and cervical cancer morbidity and mortality in California. These early detection services shall be part of a program that includes a significant quality assurance and improvement component, including patient and provider education, community outreach, and program evaluation.

(8) Eight and one-half percent (8.50%) shall be deposited in a Heart Disease and Stroke Prevention Sub-Account, which is hereby created. All funds in the Heart Disease and Stroke Prevention Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for the California Heart Disease and Stroke Prevention Program provided for in Section 104142 of the Health and Safety Code. The intent of this program is to reduce the risk, disability and death from heart disease and stroke.

(9) Seven and three-fourths percent (7.75%) shall be deposited in an Obesity Prevention, Nutrition and Physical Activity Promotion Sub-Account, which is hereby created. All funds in the Obesity Prevention, Nutrition and Physical Activity Promotion Sub-Account shall be appropriated as follows:

(A) Seventy percent (70%) shall be continuously appropriated to the Department of Health Services to support programs and activities to be used solely to prevent obesity, diabetes and chronic diseases through the promotion of community norm change, healthy eating and physical activity. The department shall design, develop and enhance a comprehensive program that includes, but need not be limited to: media advertisements and public relations programs; competitive grants to community based organizations and agencies; grants to local health departments; research and evaluation of program effectiveness; and those provisions contained in Section 104650 of the Health and Safety Code.

(B) Thirty percent (30%) shall be continuously appropriated to the Department of Education to be used solely to design, develop and support programs and activities to prevent obesity, diabetes and chronic diseases through the promotion of, and access to, healthy eating and physical activity for children and their families within the context of coordinated school health. Such programs and activities shall include but need not be limited to, promotion of, and access to, fruits, vegetables and other healthy foods; promotion of moderate and vigorous physical activity; promotion of health education and physical education; research, surveillance and evaluation of program effectiveness; professional development for teachers and other

appropriate staff in health education and physical education; and monitoring local educational agencies' compliance with state laws for nutrition and physical education.

(C) The Department of Health Services, in consultation with the Department of Education, shall establish an Oversight Committee composed of 13 members selected for their expertise in nutrition, physical activity and education, and related disciplines pertinent to the purposes of this Sub-Account. Membership shall include, but need not be limited to, representation from the following: health and education organizations, public health and local education agencies, advocacy groups, and healthcare professionals and organizations.

The Oversight Committee shall advise the Department of Health Services and the State Department of Education with respect to policy development and evaluation and provide guidance on strategic priorities, coordination, and collaboration among State agencies with regard to the programs funded by the Obesity Prevention and Nutrition and Physical Activity Promotion Sub-Account.

(10) Four and one-fourths percent (4.25%) shall be deposited in an Asthma Prevention and Control Sub-Account, which is hereby created. All funds in the Asthma Prevention and Control Sub-Account shall be used solely to support asthma assessment, community intervention strategies, training and technical assistance, surveillance, evaluation of asthma prevention and control activities, translational research to implement effective interventions, and school-based asthma education, training and coordination activities. These funds shall be appropriated as follows:

(A) Sixty percent (60%) of the funds in the Asthma Prevention and Control Sub-Account is continuously appropriated to the Department of Health Services to fund programs and services including, but not limited to those described in Chapter 6.5 (commencing with Section 104316) of Part 1 of Division 103 of the Health and Safety Code, including community childhood asthma programs within the California Asthma Public Health Initiative and asthma surveillance within the Environmental Health Investigations Branch, and to support media advertisements, public relations and other public education activities. Areas in the state that have the highest asthma prevalence, and areas with low socioeconomic status populations shall receive priority consideration in the expenditure of these funds.

(B) Forty percent (40%) of the funds in the Asthma Prevention and Control Sub-Account is continuously appropriated to the Department of Education to improve the management of asthma within the school setting. Funds shall be for activities and programs, including, but not limited to: statewide coordination of asthma programs and services, the development or purchase and dissemination of educational and training materials, delivery of asthma education and training to school personnel, and the reduction of asthma triggers in the indoor and outdoor school environments. Schools in areas of the state that have the highest asthma prevalence, schools serving low socioeconomic status students and school districts that do not have school nurses shall receive priority consideration in the expenditure of these funds.

(11) Four and one-fourths percent (4.25%) shall be deposited in a Colorectal Cancer Sub-Account, which is hereby created. All funds in the Colorectal Cancer Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely for the

Colorectal Cancer Prevention, Detection and Treatment Program described in Article 2.7 (commencing with Section 104195) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code. The intent of this program is to reduce the incidence, morbidity, and mortality due to colorectal cancer. This program shall include various public health components, including a significant quality assurance and improvement component, patient and provider education, community outreach, and program evaluation. No less than forty percent (40%) of the funds for this program shall be used for those non-clinical public health components.

(12) Forty-five and one-half percent (45.50%) of the Fund shall be deposited in the California Healthy Kids Sub-Account, which is hereby created to ensure that every child in California is eligible for comprehensive, affordable health insurance and has access to needed health care. All moneys in the California Healthy Kids Sub-Account shall be continuously appropriated to the California Health and Human Services Agency only for implementation by the Department of Health Services and the Managed Risk Medical Insurance Board of Chapter 17 (commencing with Section 12693.99) of Part 6.2 of Division 2 of the Insurance Code pursuant to the provisions and restrictions thereof. No less than ninety percent (90%) of the funds appropriated from this Sub-Account shall be used for implementation of Section 12693.99 of the Insurance Code. No more than ten percent (10%) of the funds appropriated from this Sub-Account shall be used for implementation of Section 12693.991 of the Insurance Code.

(c) To the Health Treatment and Services Account, which is hereby created, fifty-two and three-fourths percent (52.75%), allocated to the following Sub-Accounts for the purposes stated therein:

(1) One and three-fourths percent (1.75%) shall be deposited in a Tobacco Cessation Services Sub-Account, which is hereby created. All funds in the Tobacco Cessation Services Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely to provide tobacco cessation programs and services to assist adult and minor tobacco users to quit tobacco. It is the intent of this Act that this appropriation supports programs and services including, but not limited to counseling, referral and support services, pharmaceutical tobacco cessation products, and training and technical assistance activities.

(2) One and three-fourths percent (1.75%) shall be deposited in a Prostate Cancer Treatment Sub-Account, which is hereby created. All funds in the Prostate Cancer Treatment Sub-Account shall be continuously appropriated to the Department of Health Services to be used solely to provide for prostate cancer prevention and treatment for low income and uninsured men.

(3) Five and three-fourths percent (5.75%) shall be deposited in the Community Clinics Uninsured Sub-Account, which is hereby created to fund nonprofit clinic corporations providing vital health care service to the uninsured in accordance with Article 6 (commencing with Section 1246) of Chapter 1 of Division 2 of the Health and Safety Code. All funds in the Community Clinics Uninsured Sub-Account shall be continuously appropriated to the Department of Health Services solely for implementation of Article 6 (commencing with Section 1246) of Chapter 1 of Division 2 of the Health and Safety Code.

(4)(i) Five and three-fourths percent (5.75%) to the Emergency Care Physician Services Sub-Account, which is hereby created. All funds in the Emergency Care Physician Services Sub-Account shall be continuously appropriated to the Department of Health Services to be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP), Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(ii) Three-fourths percent (0.75%) to the Rural Emergency Care Physician Services Sub-Account, which is hereby created. All funds in the Rural Emergency Care Physician Services Sub-Account shall be continuously appropriated to the Department of Health Services to be administered and allocated for distribution through the Rural Health Services Program (RHSP), Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(iii) Funds allocated to the Emergency Care Physician Services Sub-Account and Rural Emergency Care Physician Services Sub-Account shall be used only for reimbursement of physicians for losses incurred in providing uncompensated emergency services in general acute care hospitals providing basic, comprehensive or standby emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred annually by the Department to the Physician Services Accounts in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code, and shall be paid only to physicians who directly provide emergency medical services to patients, based on claims submitted or a subsequent reconciliation of claims. Payments shall be made as provided in Sections 16951 to 16599, inclusive, of the Welfare and Institutions Code, and payments shall be made on an equitable basis, without preference to any particular physician or group of physicians. Funds allocated by this Section to counties that have not established an Emergency Medical Services Fund pursuant to Section 16951 shall be deposited into the Department of Health Services EMSA Contract Back Program, to be used only for the reimbursement of uncompensated emergency services, as defined in Section 16953, and payments made, based on claims submitted, in accordance with the procedures and policies established in Sections 16952 through 16959 of the Welfare and Institutions Code.

(5) Three-fourths percent (0.75%) to the Medically Underserved Account created by Business and Professions Code section 2154.4. All funds in the Medically Underserved Account shall be continuously appropriated to the Medical Board of California to promote the practice of medicine in areas of the state underserved by physicians to low-income patients pursuant to the Steven M. Thompson Physician Corps Loan Repayment Program set forth in Article 7.7 (commencing with Section 2154) of Chapter 5, Division 2 of the Business and Professions Code.

(6) Nine percent (9%) to the Nursing Workforce Education Sub-Account, which is hereby created. All funds in the Nursing Workforce Education Sub-Account shall be continuously appropriated to the Office of Statewide Health Planning and Development to be used solely to expand nursing education opportunities and capabilities to meet nursing workforce demands pursuant to Section 128225.5 of the Health and Safety Code. Expenditures from the Nursing Workforce Education Sub-Account shall be made according to the following formula:

(A) Eighty-six percent (86%) shall be used to support the expansion of California Board of Registered Nursing ("BRN") -approved registered nurse education pre-licensure programs in the California Community Colleges, the California State University and the University of California, and to support the expansion of graduate nursing education programs (MSN, DNSc/PhD), and to support California Advanced Practice Registered Nurse Programs at the California State University and the University of California.

(B) Fourteen percent (14%) shall be used to support the expansion of BRN-approved privately operated registered nurse education pre-licensure programs, the expansion of privately operated graduate nursing education programs (MSN, DNSc/Ph.D.), and to support the expansion of privately operated California Advanced Practice Registered Nurse Programs.

(7) Seventy-four and one-half percent (74.50%) to the Emergency and Trauma Hospital Services Sub-Account, which is hereby created. All funds in the Emergency and Trauma Hospital Services Sub-Account shall be continuously appropriated to the Department of Health Services to further the provision of hospital and medical services to emergency patients in California pursuant to Chapter 4.5 (commencing with Section 1797.300) of Division 2.5 of the Health and Safety Code.

§ 30132.4 All moneys allocated to and deposited in the specific Accounts and Sub-Accounts of the Tobacco Tax of 2006 Trust Fund shall be expended as set forth pursuant to the requirements specific to each Account or Sub-Account as set forth in Section 30132.3. Notwithstanding Government Code section 13340, any moneys allocated and appropriated to any of the Accounts or Sub-Accounts of the Tobacco Tax of 2006 Trust Fund that are not encumbered or expended within any applicable period prescribed by law shall, together with the accrued interest on the amount, revert to and remain in the same Account or Sub-Account for encumbrance and expenditure for the next fiscal period.

§ 30132.5(a) All moneys raised pursuant to the tax imposed by Section 30132.1, and all moneys raised by the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, shall be appropriated and expended only for the purposes expressed in this Act. Funds appropriated pursuant to this Act shall be used only to supplement existing levels of service and not to supplant funding for existing levels of service. Funds may be used to match available state, federal, or local funds. Except as specified in subdivision (b), no moneys in the Tobacco Tax of 2006 Trust Fund shall be used to supplant state or local General Fund money for any purpose, including back-filling state or local General Fund obligations.

(b) In addition to the provisions of subdivision (a), all moneys raised pursuant to the tax imposed by Section 30132.1, and all moneys raised by the resulting increase in the tax on tobacco products required by subdivision (b) of Section 30123, shall not supplant the following:

(1) Local funds used to secure state or federal matching funds for any children's health services, children's health, or medical assistance programs, including but not limited to the following: (A) Healthy Families, (B) Medi-Cal, whether full-scope or emergency or pregnancy-related care only, and (C) the Child Health and Disability Prevention Program; but not including funds generated by or expended from the California Children and Families First Trust Fund (Division 108 (commencing with Section 130100) of the Health and Safety Code) or from the

County Health Initiative Matching Fund (Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code);

(2) State funds used to secure federal matching funds for any children's health services, children's health, or medical assistance programs, including but not limited to the following:

(A) Healthy Families,

(B) Medi-Cal, whether full-scope or emergency or pregnancy-related care only, and

(C) The Child Health and Disability Prevention Program; or

(3) State or federal funds to continue or maintain the amount, duration, scope and structure of benefits that existed as of September 30, 2005 for any children's health services, children's health, or medical assistance programs, including but not limited to the following:

(A) Healthy Families,

(B) Medi-Cal, whether full-scope or emergency or pregnancy-related care only, and

(C) The Child Health and Disability Prevention Program.

(c) It is the intent of the people of the State of California that the Tobacco Tax Act of 2006 shall, in accordance with the purposes and intent of this Act, maximize, and not reduce, federal matching funds made available to the State for children's health coverage under Title XIX and/or Title XXI of the Social Security Act.

(d) No state or local government agency shall consider the revenue supporting emergency services to hospitals provided by this Act in its determination of the amount or rate of payment to hospitals on behalf of patients who are government-sponsored or the responsibility of a governmental agency or body.

§ 30132.6 Notwithstanding any other provision of law, money deposited in the Tobacco Tax of 2006 Trust Fund may 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, for any purpose other than those authorized by the Tobacco Tax Act of 2006.

§ 30132.7 Due to the necessity to rapidly and efficiently implement the mandates of the Tobacco Tax Act of 2006, any contract made pursuant to paragraphs (7) through (11) of subdivision (b), and paragraph (2) of subdivision (c) of Section 30132.3, shall not be subject to Part 2 (commencing with Section 10100) of the Public Contract Code for the first five full years after enactment.

§ 30132.8 At least two percent (2%) of the money appropriated to the Department of Health Services pursuant to paragraphs (1) through (4) and paragraph (6) of subdivision (b) of Section 30132.3, and paragraph (1) of subdivision (c) of Section 30132.3, shall be used solely for administration of the department's tobacco control programs.

§ 30132.9 Moneys in the Tobacco Tax of 2006 Trust Fund and any Account or Sub-Account therein, may be used to maximize federal matching funds, so long as all moneys are expended in a manner fully consistent with the Tobacco Tax Act of 2006.

§ 30132.10 To provide full public accountability concerning the uses to which moneys in the Tobacco Tax of 2006 Trust Fund are put, and to ensure full compliance with the Tobacco Tax Act of 2006:

(a) Beginning with the first full fiscal year after the adoption of the Tobacco Tax Act of 2006, and annually thereafter, the Department of Health Services shall prepare a report describing all programs that received Tobacco Tax of 2006 Trust Fund moneys in the previous fiscal year, and describing in detail the uses to which Fund moneys were put during the previous fiscal year. This report shall be made available to the public on the department's web site, no later than March 31.

(b) All programs and departments receiving moneys from the Tobacco Tax of 2006 Trust Fund are subject to audits by the Bureau of State Audits.

(c) No more than five percent (5%) of the funds appropriated to any Account or Sub-Account created by the Tobacco Tax Act of 2006 may be used for administration, unless a lower amount is specified elsewhere in this Act.

SECTION 4. Colorectal Cancer Prevention, Detection, and Treatment

Article 2.7 (commencing with Section 104195) is added to Chapter 2 of Part 1 of Division 103 of the Health and Safety Code, to read:

§ 104195 The Colorectal Cancer Prevention, Detection, and Treatment Program shall be established within the State Department of Health Services.

§ 104195.1 The program shall apply to both of the following groups:

(a) Uninsured and underinsured persons 50 years of age and older with incomes at or below two hundred percent (200%) of the federal poverty level.

(b) Uninsured and underinsured persons below 50 years of age who are at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the U.S. Preventive Services Task Force and who have incomes at or below two hundred percent (200%) of the federal poverty level.

§ 104195.2 Services provided under this Article shall include, but are not limited to, all of the following:

(a) Screening of men and women for colorectal cancer as an early detection health care measure, in accordance with the most recent cancer screening guidelines of the U.S. Preventive Services Task Force.

(b) After screening, medical referral of the screened person and services necessary for a definitive diagnosis.

(c) If a positive diagnosis is made, then assistance and advocacy shall be provided to help the person obtain necessary treatment.

(d) Necessary treatment in accordance with the most recent cancer treatment guidelines of the National Comprehensive Cancer Network.

(e) Outreach and health education activities to ensure that uninsured and underinsured persons are aware of, and appropriately utilize, the services provided by the program.

§ 104195.3 The department shall award one or more contracts to provide colorectal cancer screening and treatment through private or public nonprofit organizations, which may include, but shall not be limited to, community-based organizations, local health care providers, and the University of California medical centers.

SECTION 5. Heart Disease and Stroke Prevention Program

Section 104142 is added to Chapter 1 of Part 1 of Division 103 of the Health and Safety Code, to read:

§ 104142 The California Heart Disease and Stroke Prevention Program (CHDSP) is hereby created in the State Department of Health Services. The CHDSP program that is hereby created is consistent with the existing CHDSP program within the department and shall not be duplicated by another cardiovascular disease (CVD) program.

(a) The CHDSP program shall do, but is not limited to, all of the following:

(1) Conduct programs to prevent and reduce risk factors for CVD including, but not limited to, high blood pressure, as provided for in Section 104100, and high cholesterol.

(2) Design, implement, and support programs to improve disease treatment and management, including quality of care for CVD.

(3) Promote and support medical professional development for the prevention and treatment of CVD.

(4) Collect, analyze, and publish data on CVD, which may include the establishment of a heart disease and stroke registry to track the incidence and prevalence of CVD.

(5) Guide the development of public health policies, including linkages with appropriate state agencies, to improve health outcomes from CVD.

(6) Conduct a statewide public education campaign that focuses on the incidence, signs, symptoms, and risk factor reduction strategies for CVD.

(b) The department shall consider, as a priority, the recommendations of the Heart Disease and Stroke Prevention and Treatment Task Force, as provided for in Section 104141.

(c) The department may authorize CVD research, including pilot demonstration projects.

(d) Nothing in this section shall duplicate other programs in the department.

SECTION 6. Children's Health

Chapter 17 (commencing with Section 12693.99) is added to Part 6.2 of Division 2 of the Insurance Code, to read:

§ 12693.99(a) To ensure that every child in California is eligible for comprehensive, affordable health insurance and has access to needed health care, all children described in subdivision (b) shall be eligible for the California Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code (hereinafter "Healthy Families").

(b) All children under 19 years of age shall be eligible for the services and benefits provided under this Chapter, notwithstanding paragraph (4) of subdivision (a) of Section 12693.70 and Section 12693.73, if they meet all of the following:

(1) Are in families with countable household income up to and including 300 percent of the federal poverty level. In a family with annual or monthly household income greater than 300 percent of the federal poverty level, any income deduction that is applicable under Medi-Cal shall be applied in determining annual or monthly household income under this Section;

(2) Meet the state residency requirements of Healthy Families in place as of September 30, 2005, as set forth in paragraph (5) of subdivision (a) of Section 12693.70;

(3) Are in compliance with Sections 12693.71 and 12693.72; and

(4) Are not eligible for Healthy Families, or for full-scope Medi-Cal (Chapter 7 (commencing at Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) without a share of cost, under the eligibility rules in place as of September 30, 2005.

(c) The confidentiality and privacy protections set forth in Sections 10500 and 14100.2 of the Welfare and Institutions Code shall apply to all children seeking, applying for or enrolled in Healthy Families.

(d) Families of children enrolled in Healthy Families through this Chapter shall be required to contribute premiums equal to those required of families of children enrolled in Healthy Families not through this Chapter, subject to the following exceptions:

(1) Families of children up to and including 18 years of age who apply for or are enrolled in Healthy Families and whose countable household incomes are up to and including 100 percent of the federal poverty level shall not be required to contribute any premiums; families of children up to one year of age who apply for or are enrolled in Healthy Families and whose countable household incomes are up to and including 200 percent of the federal poverty level shall not be required to contribute any premiums; and families of children up to and including six years of age who apply for or are enrolled in Healthy Families and whose countable household incomes are up to and including 133 percent of the federal poverty level shall not be required to contribute any premiums.

(2) Families of children who are enrolled in Healthy Families whose countable household incomes are greater than 250 percent and up to and including 300 percent of the federal poverty level shall be required to contribute premiums at 150 percent of the premiums required for children who are enrolled in Healthy Families whose countable household incomes are greater than 200 percent and up to and including 250 percent of the federal poverty level. The same premium discounts available to children enrolled in Healthy Families whose families have countable incomes of 200 through 250 percent of the federal poverty level shall be available on the same terms to children enrolled in Healthy Families whose families' countable incomes are greater than 250 percent of the federal poverty level.

(e) Less restrictive Healthy Families eligibility requirements than those established at subdivision (b) may be established by the Legislature at any time before or after adoption of this Section. If the Legislature adopts less restrictive eligibility criteria for Healthy Families at any time, such a change shall supersede the eligibility requirements of this Section. Nothing in this Section shall preclude a child from eligibility for Medi-Cal or Healthy Families if less restrictive eligibility criteria are enacted. For purposes of this subdivision, requirements or criteria are considered to be "less restrictive" if, under such requirements or criteria, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

§ 12693.991(a) The Managed Risk Medical Insurance Board and the State Department of Health Services (hereinafter "administering agencies") shall continue to administer the Healthy Families and Medi-Cal programs, respectively, for all eligible children. The administering agencies shall coordinate their respective administrations of each program in a cost-effective, coordinated and seamless manner with respect to children seeking, applying for or enrolled in Medi-Cal or Healthy Families. Both administering agencies shall coordinate enrollment, renewal, eligibility, and outreach, and shall assign clear lines of responsibility for all associated agency activities with enforceable accountability. Implementation of duties and responsibilities that require the participation of both agencies shall be done jointly, as coordinated between them by agreement.

(b) The administering agencies, in consultation with the Healthy Kids Oversight and Accountability Commission, shall design and implement streamlined application, enrollment and retention procedures and mechanisms for all benefits available under Healthy Families and Medi-Cal. From the child's perspective there shall appear to be a single program, though the details are handled by two programs and administering agencies. The administering agencies shall implement strategies including at least the following to ensure that all children who are eligible for Healthy Families or Medi-Cal under the eligibility rules in place on September 30, 2005, and all children who are eligible for Healthy Families under this Chapter, receive health insurance:

(1) Simplify paperwork requirements for families to enroll their children and retain coverage as long as they remain eligible by requesting documentation and verifying information only to the extent required under federal law.

(2) Expedite and streamline enrollment by offering enrollment, which may be known as "express lane" or "gateway" enrollment, through entry points such as the National School Lunch

Program, the California Supplemental Special Nutrition Program for Women, Infants and Children, the Food Stamp Program, and the Child Health and Disability Prevention Program or similar programs; by utilizing the enrollment information provided by families to these other programs, with families' consent and ensuring confidentiality pursuant to subdivision (c) of Section 12693.99 for all children seeking, applying for, and enrolled in Healthy Families or Medi-Cal; and by implementing an electronic gateway system to process that enrollment.

(3) Develop a plan to ensure that eligible, enrolled children do not experience a gap in benefits and to ensure continuity of medical care for children when renewing or transferring between Medi-Cal and Healthy Families, or from a local children's health insurance program (hereinafter "local CHI"). The plan shall include simplifying renewal forms and renewal and transition processes.

(4) Facilitate outreach and education to current and potential beneficiaries, applicants, health care providers, and insurers.

(5) In coordination with the Healthy Kids Oversight and Accountability Commission, and while preserving confidentiality in accordance with subdivision (c) of Section 12693.99, undertake a pilot research demonstration project to test effective strategies, and gather data about the impact of specific efforts, to increase coverage for uninsured children in families with incomes above 300 percent of the federal poverty level; and recommend to the Legislature strategies for increasing coverage for this population based upon the pilot research demonstration project results.

(6) In coordination with the Healthy Kids Oversight and Accountability Commission, design and implement a process for ensuring a smooth transition for local CHI enrollees to Healthy Families. The transition shall provide that any child who applies for and is determined eligible for Healthy Families pursuant to this Chapter, and who is enrolled in a local CHI both as of enactment of this Chapter and as of his/her Healthy Families eligibility determination, shall be automatically rolled over into his/her existing local CHI health plan under Healthy Families, if the health plan is a participating plan in Healthy Families. For good cause or upon the child's next annual renewal, a child may switch plans or otherwise remain in his/her existing plan. Nothing in this paragraph is intended to delay immediate implementation of this Chapter, including eligibility for Healthy Families.

(7) Maximize federal matching funds available for eligible children's health insurance under Medi-Cal and Healthy Families and implement strategies that coordinate and integrate existing children's health insurance programs to maximize available federal and state matching funds, such as matching funds available for emergency or pregnancy-related Medi-Cal benefits, for all eligible children.

(8) Take any additional steps necessary to ensure that from a child's perspective, Medi-Cal and Healthy Families operate as a single program.

(c) The Healthy Kids Oversight and Accountability Commission is hereby established to guide the implementation and administration of this Chapter; advise the administering agencies on how best to provide affordable health insurance for all children; review financial audits of the

children's Medi-Cal and Healthy Families programs by the Bureau of State Audits; and identify inefficient practices or waste in the administration or operation of Healthy Families and Medi-Cal and direct anticipated savings back into providing health insurance for more children.

(1) The Commission shall consist of 15 members with expertise in children's health, health insurance and health insurance programs, and shall include representatives from the following categories:

(A) Consumers;

(B) Consumer advocates, including representatives of specific child populations;

(C) Health care providers, including physicians and public hospitals;

(D) Health plans, including local CHIs; and

(E) Other stakeholders, including but not limited to schools, business and organized labor, and county agencies.

(2) The Speaker of the Assembly, the Senate President Pro Tempore, and the Governor shall each appoint five commissioners such that each appoints one commissioner from each of the five categories.

(3) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(4) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(5) In carrying out its duties and responsibilities, the Commission may do all of the following:

(A) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the Commission shall be open to the public.

(B) Establish technical advisory committees such as a committee of parents and guardians.

(C) Advise the Governor and the Legislature regarding actions the state may take to improve access to, enrollment in, retention of, and use of health coverage for children and their families.

(D) Recommend strategies to increase the efficiency of Medi-Cal and Healthy Families, reduce paperwork requirements for benefit administration, and implement electronic gateways and other "express lanes" for increasing enrollment.

(E) Recommend strategies for transitioning children among and between local CHIs, Medi-Cal and Healthy Families.

(F) Recommend voluntary strategies with employers to maintain or increase employer-sponsored health coverage for employees' dependents under the age of 19 years.

(G) Provide guidance in the development of the pilot research demonstration project for pursuing affordable health insurance or assistance options for uninsured children whose families have incomes over 300 percent of the federal poverty level and, based on the results of the pilot research projects, recommend to the Legislature strategies for increasing coverage for this population.

(H) Study the adequacy of the provider network and seek broad participation from traditional and safety-net providers by recommending strategies to ensure adequate provider reimbursement rates.

(I) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted.

§ 12693.992(a) For the purposes specified in this Chapter and subject to Section 30132.5 of the Revenue and Taxation Code, funds appropriated from the California Healthy Kids Sub-Account established at paragraph (12) of subdivision (b) of Section 30132.3 of the Revenue and Taxation Code shall be used only for:

(1) The provision of children's health insurance, through Healthy Families, only for children defined in subdivision (b) of Section 12693.99; and

(2) Implementation of those measures contained in Section 12693.991.

(b) Funds expended or transferred from the California Healthy Kids Sub-Account shall supplement and not supplant the following:

(1) Local funds used to secure state or federal matching funds for any children's health services, children's health, or medical assistance programs, including but not limited to the following: (A) Healthy Families; (B) Medi-Cal, whether full-scope or emergency or pregnancy-related care only; and (C) the Child Health and Disability Prevention Program; but not including funds generated by or expended from the California Children and Families First Trust Fund (Division 108 (commencing at Section 130100) of the Health and Safety Code) or from the County Health Initiative Matching Fund (Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code).

(2) State funds used to secure federal matching funds for any children's health services, children's health, or medical assistance programs, including but not limited to the following:

(A) Healthy Families;

(B) Medi-Cal, whether full-scope or emergency or pregnancy-related care only; and

(C) The Child Health and Disability Prevention Program.

(3) State or federal funds to continue or maintain the amount, duration, scope and structure of benefits that existed as of September 30, 2005 for any children's health services, children's health, or medical assistance programs, including but not limited to the following:

(A) Healthy Families;

(B) Medi-Cal, whether full-scope or emergency or pregnancy-related care only; and

(C) The Child Health and Disability Prevention Program.

(c) The state may not increase a county's share of costs for children's health services unless the state includes adequate funding to fully compensate for such increased costs.

§ 12693.993(a) Nothing in this Chapter is intended to:

(1) Reduce or restrict any existing entitlement under Medi-Cal;

(2) Reduce or restrict the existing eligibility levels or the amount, duration, scope or structure of benefits in place as of September 30, 2005 under either Healthy Families or Medi-Cal;

(3) Create a new entitlement for children enrolled in Healthy Families;

(4) Preclude a child from eligibility for any other children's health insurance, medical service or medical assistance program, including but not limited to restricted Medi-Cal or Medi-Cal with a share of cost;

(5) Preclude a child from eligibility for Healthy Families or Medi-Cal if less restrictive eligibility criteria are enacted;

(6) Reduce or erode children's existing employer-sponsored health insurance coverage;

(7) Restrict any public appropriations or private contributions for the provision of children's health insurance through Medi-Cal or Healthy Families, such as federal financial match for state or county Medi-Cal funding; county, regional or local funding; private foundation grants, and family premium contributions;

(8) Prohibit eligibility for Medi-Cal or Healthy Families based on concurrent eligibility for a local CHI; nor

(9) Create or require creation of a new state department or agency.

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board may explore and utilize any options available under federal law to allow the use of charitable or other funding by private and public not-for-profit organizations as a match for federal funds for use in the provision of coverage consistent with the provisions of this Chapter.

SECTION 7. Community Clinics

Article 6 (commencing with Section 1246) is added to Chapter 1 of Division 2 of the Health and Safety Code, to read:

§ 1246(a) Funds in the Community Clinics Uninsured Sub-Account established at paragraph (3) of subdivision (c) of Section 30132.3 of the Revenue and Taxation Code shall be administered by the Department of Health Services solely for the purposes of this Section. The department shall allocate the funds for eligible non-profit clinic corporations providing vital health care services, including services related to smoking cessation programs to assist smokers to quit smoking, and educational efforts related to tobacco prevention, to the uninsured. The funds shall be allocated by the Department pursuant to the provisions of this Section.

(b) Annually, commencing August 1, 2007, the Department shall allocate to each eligible non-profit clinic corporation a percentage of the balance present in the Community Clinics Uninsured Sub-Account as of July 1 of the year the allocations are made based on the formula provided for in subdivision (c) and subject to subdivision (d).

(c) Funds in the Community Clinics Uninsured Sub-Account shall be allocated only to eligible non-profit clinic corporations. Funds in the Community Clinics Uninsured Sub-Account shall be allocated to eligible non-profit clinic corporations on a percentage basis based on the total number of uninsured patient encounters.

(1) For purposes of this Section, an "eligible non-profit clinic corporation" shall meet both of the following requirements:

(A) The corporation shall consist of non-profit free and community clinics licensed pursuant to subdivision (a) of Section 1204 or of clinics operated by a federally recognized Indian tribe or tribal organization and exempt from licensure pursuant to subdivision (c) of Section 1206.

(B) The corporation must provide at least 1,000 uninsured patient encounters based on data submitted to the Office of Statewide Health Planning and Development pursuant to the reporting procedures established under Section 1216 for the year the allocations are made.

(2) The total number of uninsured patient encounters shall be based on data submitted by each eligible non-profit clinic corporation to the Office of Statewide Health Planning and Development pursuant to the reporting procedures established under Section 1216. Beginning August 1, 2007 and every year thereafter, the allocations shall be made by the department based on data submitted by each eligible non-profit clinic corporation to the Office of Statewide Health Planning and Development by February 15 of the year the allocations are made.

(3) For purposes of this Section, except as otherwise provided in paragraph (4), an uninsured patient encounter shall be defined as an encounter for which the patient has no public or private third party coverage. An uninsured patient encounter shall also include encounters involving patients in programs operated by counties pursuant to Part 4.7 (commencing with Section 16900) and Part 5 (commencing with Section 17000) of Division 9 of the Welfare and

Institutions Code. An uninsured patient encounter must consist of a primary and preventive health care service, including tobacco cessation and prevention services, and specialty care services traditionally provided by comprehensive primary care providers.

(4) Each uninsured patient encounter shall count as one encounter, except that the encounters involving patients in programs operated pursuant to paragraph (1) of subdivision (aa) of Section 14132 and Division 24 (commencing with Section 24000) of the Welfare and Institutions Code, and pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code shall count as 0.15 encounter for purposes of determining the total number of uninsured patient encounters for each eligible non-profit clinic corporation.

(5) The Department shall compute each eligible non-profit clinic corporation's percentage of total uninsured patient encounters for all eligible non-profit clinic corporations. The Department shall then apply these percentages to the available funds in the Sub-Account to compute a preliminary allocation amount for each eligible non-profit clinic corporation. Final allocation amounts will be created pursuant to paragraph (6).

(6) Final allocation amounts shall be determined as follows:

(A) If the preliminary allocation for an eligible non-profit clinic corporation is equal to or less than twenty-five thousand dollars ($25,000), the allocation for that eligible non-profit corporation shall be twenty-five thousand dollars ($25,000).

(B) For all eligible non-profit clinic corporations with preliminary allocations of more than twenty-five thousand dollars ($25,000), the Department shall compute each such eligible non-profit clinic corporation's percentage of the total uninsured patient encounters and apply the percentage to the remaining funds available to determine the final allocation amount for each such eligible non-profit clinic corporation, subject to subparagraph (C).

(C) No eligible non-profit clinic corporation shall receive an allocation in excess of two percent (2%) of the total monies distributed to all eligible non-profit clinic corporations in that year. Allocations that are subject to the two percent (2%) limit shall be reallocated to those other eligible non-profit clinic corporations receiving allocations under subparagraph (B) utilizing the methodology in paragraphs (3) and (4), but provided that reallocations shall not make any final allocation surpass the two percent (2%) limit.

(d) The Department of Health Services shall be reimbursed from the Community Clinics Uninsured Sub-Account for the Department's actual cost of administration. The total amount available for reimbursement of the Department's administrative costs shall not exceed one percent (1%) of the monies credited to the Sub-Account during the fiscal year.

SECTION 8. Nursing Workforce Education Investment

Section 128224.5 of the Health and Safety Code is added to read:

§ 128224.5(a) The California Healthcare Workforce Policy Commission shall oversee the plan for and distribution of funds in the Nursing Workforce Education Sub-Account created by paragraph (6) of subdivision (c) of Section 30132.3 of the Revenue and Taxation Code. A state nursing contract program with accredited schools and programs that educate students seeking

degrees in nursing, including associate degree programs ("ADN"), bachelor of science degree programs ("BSN"), master's degree programs ("MSN"), programs for Advanced Practice Registered Nurses, and higher graduate nursing education programs ("DNSc/PhD"), shall be developed to create, expand and improve programs to educate students to become practicing registered nurses, nurses with advanced clinical skills, nurse managers, and faculty for schools of nursing. Priority shall be given to programs that increase the number and types of nursing student graduates and educators most likely to meet the state's most pressing needs for registered nurses.

(b) The California Healthcare Workforce Policy Commission shall recommend to the director the California Board of Registered Nursing ("BRN") -approved registered nurse education programs and California graduate nursing education programs (MSN, DNSc/Ph.D.) that shall be funded under subdivision (a) of this Section. For purposes of this Section the term "Advanced Practice Registered Nurse Programs" refers to programs that educate nurses with advanced clinical skills, including, but not limited to, nurse anesthetists, clinical nurse specialists, nurse practitioners, nurse midwives, and public health nurses.

Section 128225.5 of the Health and Safety Code is added to read:

§ 128225.5 The director shall utilize the funds appropriated to implement the recommendations of the California Healthcare Workforce Policy Commission pursuant to Section 128224.5; and to reimburse the office and the commission for all reasonable, actual, direct administrative costs incurred to implement this Section, not to exceed one percent (1%) of the amount deposited into the Nursing Workforce Education Sub-Account for the same period. The director shall utilize all funds appropriated to the extent reasonably possible. To the extent any funds appropriated are not utilized, or after being committed are returned or remain unspent for any reason, such funds shall remain in or shall be re-deposited into the Nursing Workforce Education Sub-Account for appropriation and use for the same purpose as provided in paragraphs (6)(A) or (6)(B) of subdivision (c) of Section 30132.3 of the Revenue and Taxation Code, as appropriate.

SECTION 9. Emergency and Trauma Hospital Services

Chapter 4.5 (commencing with Section 1797.300) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 4.5 HOSPITAL EMERGENCY SERVICES

Article 1. The Emergency and Trauma Hospital Services Sub-Account

§ 1797.300 To support the public's need for hospital emergency services, the department shall administer funds made available to hospitals for such services as provided by this Chapter.

§ 1797.301(a) The department shall calculate each eligible hospital's funding percentage to be used for the next calendar year based upon the information submitted by such hospital

pursuant to Section 1797.302 and notify each eligible hospital of its proposed funding percentage no later than June 15 of each calendar year.

(b) The department shall receive and review the accuracy and completeness of information submitted by eligible hospitals pursuant to Section 1797.302. The department shall develop a standard form to be utilized for reporting such information by eligible hospitals, but shall accept information from eligible hospitals that is not reported on such standard form. The department shall allow hospitals to report such information electronically no later than April 30, 2008.

(c) The department shall notify each hospital submitting the information specified under subdivision (a) of Section 1797.302 in writing through a communication delivered by no later than April 30 each year confirming the information it has from such hospital and of any apparent discrepancies in the accuracy, completeness, or legibility of information submitted by such hospital pursuant to Section 1797.302. Unless such written notice is timely delivered to an eligible hospital, the information it reports pursuant to Section 1797.302 shall be deemed to be complete and accurate, but shall be subject to audit under subdivision (f).

(d) A hospital that receives notice from the department that the information it reported was not accurate, complete, or legible shall have 30 days from the date the notice is received to provide the department with correct, complete and legible information. Such corrected or supplemental information shall be used by the department to make the calculation required by subdivision (a), but shall be subject to audit under subdivision (f). A hospital that does not provide sufficient legible information to establish that it qualifies as an eligible hospital or to allow the department to make the calculation required under subdivision (a) shall not be an eligible hospital.

(e) The department may enter into an agreement with the Office of Statewide Health Planning and Development or another state agency or private party to assist it in analyzing information reported by eligible hospitals and making the hospital funding allocation computations as provided under this Chapter.

(f) To ensure that the funds received by hospitals are utilized for the purpose specified in this Article, the department shall audit the use by eligible hospitals of any funds received pursuant to Section 1797.304, and the accuracy of data on emergency department patient encounters and other information any hospital reports under this Article, as follows: the department shall randomly select twenty percent (20%) of all eligible hospitals each year for audit of the information they submit. Additionally, the department may conduct a field audit of the use of funds or information submitted by any hospital. If the department determines upon audit that any funds received were improperly used, or that inaccurate data were reported by the eligible hospital resulted in an allocation of excess funds to the eligible hospital, the department shall recover any excess amounts allocated to, or any funds improperly used by, the eligible hospital. The department may impose a fine of not more than twenty-five percent (25%) of any funds received by the eligible hospital that were improperly used, or the department may impose a fine of not more than two times any amounts improperly used or received by the eligible hospital if it finds such amounts were the result of gross negligence or intentional misconduct in reporting data or improperly using allocated funds under this Article on the part of the hospital.

Any fines imposed by the department shall be stayed if appealed by the hospital pursuant to subdivision (g) until judgment by a court of final jurisdiction. In no event shall a hospital be subject to multiple penalties for both improperly using and receiving the same funds.

(g)(1) A licensed hospital owner shall have the right to appeal the imposition of any fine by the department, or a determination by the department that its hospital is not an eligible hospital, for any reason, or an alleged computational or typographical error by the department resulting in an incorrect allocation of funds to its hospital under Section 1797.304. A hospital shall not be entitled to be reclassified as an eligible hospital or to have an increase in funds received under this Chapter based upon subsequent corrections to its own final reporting of incorrect data used to determine funding allocations under this Article.

(2) Any such appeal shall be heard before an administrative law judge employed by the Office of Administrative Hearings. The hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The decision of the administrative law judge shall be in writing; shall include findings of fact and conclusions of law; shall be final; and shall be subject to appeal as provided by Section 11523 of the Government Code. The decision of the administrative law judge shall be made within 60 days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(3) The appeal rights of hospitals under this subdivision (g) shall not be interpreted to preclude any other legal or equitable relief that may be available.

(h) Any fines or other recoveries collected by the department shall be deposited in the Emergency and Trauma Hospital Services Sub-Account within the Tobacco Tax Fund for allocation to eligible hospitals in accordance with the provisions of Section 1797.304. Such funds shall not be used for administrative costs, and shall be supplemental to, and shall not supplant, any other funds available to be allocated from such Sub-Account to eligible hospitals.

(i) In the event it is determined, upon a final adjudicatory decision that is no longer subject to appeal, that a hospital has been incorrectly determined to not qualify as an eligible hospital, or was allocated an amount less than the amount to which it is entitled under Section 1797.304, the department shall, from the next allocation of funds to hospitals under Section 1797.304, allocate to such hospital the additional amount to which it is entitled, and reduce the allocation to all other eligible hospitals pro rata.

§ 1797.302(a) Each hospital seeking designation as an eligible hospital shall submit the following information to the department by no later than February 15 of each year, commencing the first February 15 following the operative date of this Act:

(1) The number of emergency department encounters that took place in the hospital's emergency department during the preceding calendar year;

(2) The total amount of charity care costs of the hospital for the preceding calendar year;

(3) The total amount of bad-debt costs of the hospital for the preceding calendar year;

(4) The total amount of county indigent program effort costs of the hospital for the preceding calendar year;

(5) If requested, a photocopy of the hospital's operating license from the State Department of Health Services or equivalent documentation establishing that it operates a licensed emergency department;

(6) A declaration of commitment to provide emergency services and training as required by subdivision (a) of Section 1797.303.

(b) Both pediatric and adult patients shall be included in the data submitted. The accuracy of the data shall be attested to in writing by an authorized senior hospital official. No other data or information shall be required by the department to be reported by eligible hospitals for purposes of this Chapter.

(c) Each hospital seeking status as an eligible hospital under this Chapter that receives a preponderance of its revenue from a single associated comprehensive group practice prepayment health care service plan shall report information required by this section for all patients, and not just for patients who are not enrolled in an associated health care service plan.

§ 1797.303(a) An eligible hospital shall, throughout each calendar quarter in which it receives an allocation pursuant to Section 1797.304:

(1) Maintain an operational emergency department available within its capabilities and licensure to provide emergency care and treatment, as required by law, to any pediatric or adult member of the public who has an emergency medical condition.

(2) Do all of the following:

(A) Participate in a minimum of two disaster-training exercises annually;

(B) Provide training and information as appropriate to the hospital's medical staff, nurses, technicians and administrative personnel regarding the identification, management, and reporting of emergency medical conditions and communicable diseases, as well as triage procedures in cases of mass casualties;

(C) Collaborate with state and local emergency medical services agencies and public health authorities in establishing communications procedures in preparation for and during a disaster situation; and

(D) Establish and maintain an emergency and disaster management plan. This plan shall include response preparations to care for victims of terrorist attacks and other disasters. The plan shall be made available by the hospital for public inspection.

(b) It is the policy of the state to encourage hospitals to work cooperatively to develop regional plans for assuring maximum availability of emergency services to all patients, and to share equitably in the provision of emergency services to uninsured and low income under-insured patients in achieving such maximum availability of emergency services.

(1) Each hospital receiving funds under this Chapter that operates a basic or comprehensive licensed emergency department may participate in the development of a regional or other local plan for equitably sharing responsibility for providing emergency services to uninsured and low-income underinsured patients arriving at the hospital via ambulance. Any such plan may be developed under the auspices of a hospital association or through other cooperative arrangements, and shall be submitted to the county or other local emergency services authority for approval and continuing oversight of implementation.

(2) Each hospital receiving funds under this Chapter may work cooperatively with one or more other hospitals to develop a plan for providing maximum coverage of specialty medical services. Any such plan may include such items as coordinated coverage of particular medical specialty services; alternate coverage of particular medical specialty services; and joint programs for the payment of coverage fees to physician specialists for providing on-call coverage of emergency services. Any such plan shall be submitted to and approved by the county or other local emergency services authority for approval and continuing oversight of implementation.

(3) To the extent that any hospital or hospitals work cooperatively in developing and implementing the plans for providing emergency services described in this Section, the people intend that such hospital or hospitals shall incur no liability under federal or state antitrust or other anti-competition laws prohibiting combinations in restraint of trade, including, without limitation, the provisions of Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code.

(c) Any funds received by an eligible hospital under this Article shall not be used in the determination of uncompensated costs for the purpose of the limitation on payment adjustments described in Section 1923(g) of the Social Security Act and any provision of state law which incorporates such limitation, to the extent consistent with federal law.

§ 1797.304(a) Funds deposited in the Emergency and Trauma Hospital Services Sub-Account, together with all interest and investment income earned thereon, shall be continuously appropriated without regard to fiscal years to and administered by the state Department of Health Services. The department shall allocate the funds solely to eligible hospitals as provided by this Article.

(b) Quarterly, commencing June 30 following the operative date of this Chapter, the department shall allocate to each eligible hospital a percentage of the balance of the Hospital Sub-Account equal to such hospital's funding percentage, as determined by the department pursuant to Section 1797.301, except as follows:

(1) The annual aggregate allocation to all hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan shall not exceed forty million dollars ($40,000,000.00) during any calendar year, and the department shall reduce the quarterly allocation to each such hospital pro rata, if and to the extent necessary, to contain the aggregate allocation to all such hospitals within any calendar year to a maximum of forty million dollars ($40,000,000.00). The maximum annual aggregate allocation shall be applied by the department in increments of no more than ten million dollars ($10,000,000.00) to each of the first three quarterly distributions of each calendar year, but no

specific portion of the limit on maximum annual aggregate distributions provided by this subsection shall apply to other quarterly distributions to such hospitals.

(2) The maximum aggregate annual allocation of forty million dollars ($40,000,000.00) to all hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan set forth in paragraph (1) above shall be adjusted upward or downward annually, together with corresponding changes in any quarterly limits, commencing on January 1, 2009, by the same percentage increase or decrease in the aggregate amount deposited in the Hospital Sub-Account for the immediate prior calendar year against the aggregate amount deposited in the Hospital Sub-Account during the 2007 calendar year. Any adjustment that increases or decreases the maximum aggregate annual allocation to such hospitals shall be applied only to the then current calendar year.

(3) After making the adjustment to the maximum aggregate annual allocation to hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan provided by paragraph (2) above, the department shall further adjust such maximum aggregate annual allocation by increasing or decreasing it by a percentage factor equal to the percentage increase or decrease in the aggregate funding percentage by all hospitals receiving a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan in the 2007 calendar year against the aggregate funding percentage of all hospitals associated with the same health care service plan for the most recent calendar year.

(4) After making the adjustments to the allocation of funds as provided by paragraphs (1) through (3) above, the department shall allocate any funds remaining in the Hospital Sub-Account to hospitals that do not receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan pro rata based upon their respective funding percentages.

(c) Prior to each allocation under subdivision (b), the actual costs of the department (including any costs to the department resulting from the charges under Section 11527 of the Government Code) for administering the provisions of this Chapter shall be reimbursed from the Hospital Sub-Account. The aggregate funds withdrawn for all administrative costs under this subdivision shall not exceed one half of one percent (0.5%) of the total amounts deposited in the Hospital Sub-Account (not including any fines collected under subdivision (h) of Section 1797.301) during the prior quarter.

(d) An eligible hospital shall use the funds received under this Section only to further the provision of emergency services by such means as payment for the unreimbursed cost of providing emergency services and improving or expanding emergency services, facilities, or equipment. Such funds may not be used to pay for more than the hospital's unreimbursed costs of providing emergency services, and no funds may be used to pay the hospital for providing emergency services where it receives payment for providing such services and has agreed to accept such payment as payment in full. No funds may be used for the compensation of hospital management executives, except for personnel who work full time in hospital emergency departments. No funds may be used for equipment or capital improvements not directly related to the improvement of hospital emergency department facilities or critical care units. An eligible

hospital owned by a public entity may use funds it receives under this Chapter to secure federal matching funds under the Medi-Cal program, or any other federal or state health program that includes coverage of emergency services and reduces the burden of providing uncompensated emergency services by hospitals and physicians.

(e)(1) A hospital may not utilize funds received under this Article to supplement payments physicians receive for services to patients enrolled in the Medicare or Medi-Cal programs, but may use such funds to provide payments to physicians for on-call coverage of emergency services to all patients, including those enrolled in the Medicare or Medi-Cal programs, as provided by subparagraph (2) below. Such payments to physicians for on-call coverage shall not be considered payments for services.

(2) A hospital, in its sole discretion, may utilize funds it receives under this Chapter to provide compensation to a physician that is fair and reasonable for providing on-call coverage of emergency services only if the governing board of the hospital makes the following findings:

(A) The amount or rate of payment is reasonable and necessary for the hospital to maintain coverage of medical services to care for patients entering the hospital through the emergency department, or patients who have emergent conditions requiring the services of on-call physicians while in the hospital; and

(B) The method and amount of compensation to any physician or physicians is in compliance with applicable law.

(3) The governing board of a hospital, in its sole discretion, prior to entering into an agreement to compensate one or more physicians for on-call coverage of emergency services may obtain the opinion of an independent financial analyst with expertise in the hospital industry that the proposed amount or rate of payment to compensate physicians under the proposed agreement is fair and reasonable under the circumstances. If a hospital governing board elects to obtain such an opinion, it shall notify the department in writing, and the department shall, within ten days of receiving the hospital's written request, provide the hospital with the names of three independent financial analysts (which may be individuals or firms) from a list of such independent financial analysts qualified to issue such an opinion it establishes and maintains. The hospital shall provide the list of the independent financial analysts it receives from the department to the Executive Committee of the hospital's organized medical staff, and the medical staff Executive Committee shall have fifteen (15) days to review the list and make a peremptory challenge of one of the independent financial analysts by notifying the hospital's governing board in writing. The hospital governing board may make a peremptory challenge to one of the independent financial analysts. If two of the three independent financial analysts are subject to a peremptory challenge, the hospital governing board may retain only the remaining independent financial analyst. If more than one independent financial analyst is not subject to a peremptory challenge, the hospital shall so notify the department, and the department shall select one of the remaining independent financial analysts by lottery. In such event, the hospital may retain only the independent financial analyst selected by lottery, unless the governing board of the hospital and the medical staff Executive Committee agree upon the retention by the hospital of one of the other independent financial analysts on the list of the three financial analysts

provided to the hospital by the department. The selected independent financial analyst may charge the hospital a reasonable fee to issue a written opinion to the hospital governing board as to whether the proposed amount or rate of payment is fair and reasonable under the circumstances. In the event such independent financial analyst opines that the proposed amount or rate of payment is not fair and reasonable, upon request, the independent financial analyst may describe a range of payment amounts and rates that are fair and reasonable, under the circumstances, for the hospital to pay various types of physicians for on-call coverage. The hospital may not pay an amount or rate for on-call coverage of emergency services by a physician that is higher than any amount or rate determined to be fair and reasonable by the opinion of such independent financial analyst, nor shall the hospital pay less than its highest written offer to the physician or physicians that is fair and reasonable.

(4) A hospital may compensate a physician for providing on-call emergency services coverage only through a written agreement.

(5) The requirements of this subdivision relate only to the use of funds eligible hospitals received under this Article, and do not apply to the use of other funds by hospitals to pay for on-call coverage of emergency services by physicians.

(f) Nothing in this Chapter shall be construed to prevent a hospital, in its sole discretion, from providing reasonable compensation to a physician for providing emergency physician staffing for the emergency department in a manner consistent with the Medical Practice Act, Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(g) The hospital governing board, in consultation with the hospital's medical staff, shall ensure the appropriate coverage of medical services within its capabilities to meet the emergency services needs of its patients as required by law.

§ 1797.305 The following definitions shall apply to terms utilized in this Chapter:

(a) "Bad-debt cost" means the aggregate amount of accounts and notes receivable accounted for during a calendar year by an eligible hospital as credit losses, using any method generally accepted for estimating such amounts on the date this Act became effective, based on patients' unwillingness to pay, and multiplied by the eligible hospital's cost-to-charges ratio.

(b) "County indigent program effort cost" means the amount of care during a calendar year by an eligible hospital, expressed in dollars and based upon the hospital's full established rates, provided to indigent patients for whom a county is responsible, whether the hospital is a county hospital or a non-county hospital providing services to indigent patients under arrangements with a county, multiplied by the eligible hospital's cost-to-charges ratio.

(c) "Charity care" means that portion of care provided by a hospital to a patient for which a third party payer is not responsible and the patient is unable to pay, and for which the hospital has no expectation of payment.

(d) "Charity-care cost" means amounts actually written off, using any method generally accepted for determining such amounts on the date this Act became effective, by an eligible

hospital during a calendar year for that portion of care provided to a patient for whom a third-party payer is not responsible and the patient is unable to pay, multiplied by the hospital's cost-to-charges ratio.

(e) "Charity care policy" means a policy adopted by the hospital establishing eligibility criteria for charity care services provided by the hospital.

(f) "Cost-to-charges ratio" means a ratio determined by dividing an eligible hospital's operating expenses less other operating revenue by gross patient revenue for its most recent reporting period.

(g) "Operating expenses" means the total expenses incurred for providing patient care by the hospital. Operating expenses include (without limitation) salaries and wages, employee benefits, professional fees, supplies, purchased services, depreciation, leases, interest and other expenses.

(h) "Other operating revenue" means revenue generated by health care operations from non-patient care services to patients and others.

(i) "Gross patient revenue" means the total charges at the hospital's full established rates for the provision of patient care services and includes charges related to hospital-based physician professional services.

(j) "Eligible hospital" or "hospital" means a hospital licensed to a public or private entity or person under subdivision (a) of Section 1250 of the Health and Safety Code, including without limitation, any hospital licensed to any county, city, hospital district, or the Regents of the University of California (but not including any hospital licensed to a department of the State of California, or to the federal government) which either operates an emergency department or is a children's hospital as defined in Section 10727 of the Welfare and Institutions Code.

(k) "Emergency department encounter" or "emergency department visit" means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the patient in an emergency department and exercises independent judgment in the care of the patient. An emergency department encounter or visit is counted for each patient of the emergency department, regardless of whether the patient is admitted as an inpatient or treated and released as an outpatient. An emergency department encounter or visit shall not be counted where the patient received triage services only.

(l) "Emergency services" or "hospital emergency services" means all services provided to patients in a hospital emergency department and all other patient services related to treatment of an emergent medical condition in any department or unit of a hospital, including, without limitation, any procedures necessary to avoid loss of life, serious disability, or severe pain until the patient has been stabilized and transferred to another health facility or discharged.

(m) "Office" means the Office of Statewide Health Planning and Development.

(n) "Department" means the state Department of Health Services.

(o) "Funding percentage" means the sum of (1) an eligible hospital's percentage of hospital emergency care (as defined in subdivision (s) below) multiplied by a factor of .50, added to (2) such hospital's percentage of effort (as defined in subdivision (p) below) multiplied by a factor of .50, the sum to be expressed as a percentage.

(p) "Hospital Sub-Account" or "Emergency and Trauma Hospital Services Sub-Account" means the Emergency and Trauma Hospital Services Sub-Account of the Tobacco Tax Fund established pursuant to paragraph 7 of subdivision (c) of Section 30132.3 of the Revenue and Taxation Code.

(q) "Tobacco Tax Fund" means the Tobacco Tax of 2006 Trust Fund established pursuant to Section 30132 of the Revenue and Taxation Code.

(r) "Percentage of effort" means the sum of an eligible hospital's total amount of charity care cost plus that hospital's total amount of bad-debt cost plus that hospital's county indigent program effort cost, as a percentage of the sum of the total amount of charity care cost plus the total amount of bad-debt cost plus the total county indigent program effort cost reported in final form to the department by all eligible hospitals for the same calendar year.

(s) "Percentage of hospital emergency care" means an eligible hospital's total emergency department encounters for the most recent calendar year for which such data has been reported to the department in final form, as a percentage of all emergency department encounters reported in final form by all eligible hospitals for the same calendar year. In the case of a children's hospital that does not operate an emergency department and provides emergency treatment to a patient under twenty-one years of age under arrangements with an emergency department of a hospital that is: (1) located within 1,000 yards of the children's hospital; and (2) is either (A) under common ownership or control with the children's hospital, or (B) has contracted with the children's hospital to provide emergency services to its patients under twenty-one years of age, the children's hospital providing emergency services to such patient shall receive credit for the emergency department encounter, and not the hospital operating the emergency department.

(t) "Unreimbursed cost of providing emergency service" means the difference between the hospital's cost of providing emergency services, determined by multiplying its gross patient charges for providing such services by its cost-to-charges ratio, and the amount it actually receives for providing such services, where the hospital has not agreed to accept the payment it receives as payment in full.

(u) "Physician" means a physician and surgeon licensed under the Medical Practice Act, Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

§ 1797.306 A hospital receiving funds under this Chapter shall maintain a written record of its use of all such funds, which shall be available to the department upon request, and available for inspection upon written request by the public. A hospital shall return to the department any funds it receives under this Chapter that it does not use for the purposes specified within one year of receipt or, in the case of a capital project, are not committed within two years of receipt by the governing board for a specific use. Any unused funds returned to the department shall be deposited in the Emergency and Trauma Hospital Services Sub-Account

within the Tobacco Tax of 2006 Trust Fund for allocation to eligible hospitals in accordance with the provisions of Section 1797.304.

§ 1797.307 The department may promulgate and adopt regulations to implement, interpret and make specific the provisions of this Article pursuant to the provisions of the Administrative Procedures Act as set forth in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The department shall have no authority to promulgate quasi-legislative rules, or to adopt any rule, guideline, criterion, manual, order, standard, policy, procedure or interpretation that is inconsistent with the provisions of this Chapter. This Section shall not be interpreted to allow the department to adopt regulations (as defined by Section 11342.600 of the Government Code) in contravention of Section 11340.5 of the Government Code.

§ 1797.308 No hospital may receive funds under this Chapter unless it complies with the provisions of Article 2 (commencing with Section 1797.309), relating to financial assistance to certain low-income patients.

Article 2. Hospital Charity Care and Financial Assistance Policies

§ 1797.309 For purposes of this Article the following definitions shall apply:

(a) "Allocation" means an allocation of funds received by a hospital under Article 1 (commencing with Section 1797.300) of this Chapter.

(b) "Discounted payment" means the payment amount after application of a discount from its full charges for services offered by a hospital to patients who have no or inadequate insurance and qualify under the hospital's discount payment policy.

(c) "Discount payment policy" means a policy adopted by the hospital establishing eligibility criteria for receiving services for a discounted payment.

(d) "Federal poverty level" means the most recent poverty guidelines periodically adopted by the federal Department of Health and Human Services for determining financial eligibility for participation in various programs based upon family size as applicable to California.

(e) "Hospital" means an "eligible hospital," as defined by subdivision (j) of Section 1797.305.

§ 1797.309.5 Each hospital shall comply with the provisions of this Article throughout each calendar year in which it receives an allocation. The requirements of this Article are applicable only to hospitals receiving an allocation , and shall not be construed to limit the ability of the legislature to enact charity care or discount payment policies applicable to all acute hospitals as a condition of licensure or participation in any other state program.

§ 1797.310(a) Each hospital shall maintain an understandable, written charity care policy and discount payment policy for low-income patients with no or inadequate insurance.

(b) Each hospital's charity care policy and discount payment policy shall clearly state eligibility criteria based upon the income and monetary assets of the patient, or consistent with the application of the federal poverty level, the patient's family. In determining such eligibility, a hospital may consider income and monetary assets of the patient, or the family of the patient. For purposes of such determination, monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's or a patient's family's monetary assets shall not be counted in determining eligibility; nor shall fifty percent (50%) of such assets over the first ten thousand dollars be counted in determining eligibility. The policy shall also state the process used by the hospital to determine whether a patient is eligible for charity care or discounted payment.

(c) Patients who are at or below three hundred fifty percent (350%) of the federal poverty level shall be eligible to apply for participation under each hospital's charity care policy or discount payment policy. However, rural hospitals, as defined by Section 124840, may establish eligibility levels for financial assistance and charity care at less than three hundred fifty percent (350%) of the federal poverty level as appropriate to maintain their financial and operational integrity.

(d) Absent any regulatory prohibition, each hospital shall limit expected payment for services it provides to any patient at or below three hundred fifty percent (350%) of the federal poverty level eligible under its discount payment policy to the greater of the amount of payment the hospital would receive for providing such services from Medicare or any other government-sponsored health program of health benefits in which the hospital participates. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

(e) A hospital shall use its best efforts to ensure all financial assistance policies are applied consistently.

(f) Any patient, or the patient's legal representative, seeking either charity care or discounted payment shall provide the hospital with information concerning health benefits coverage, financial status and other information that is reasonable and necessary for the hospital to make a determination regarding the patient's status relative to the hospital's charity care policy, discount payment policy, or eligibility for government-sponsored programs. For purposes of proving income, a patient or the patient's legal representative, must provide verification of the patient's or the patient's family's income. Reasonable and necessary information on monetary assets may include account numbers for all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. Hospitals may require waivers or releases from the patient, or the patient's family, authorizing the hospital to obtain account information from the financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their value.

(g) Eligibility for charity care and discounted payments may be determined at any time the hospital is in receipt of all the information needed to determine the patient's eligibility under its applicable policies.

(h) In determining a patient's eligibility for financial assistance, a hospital shall assist the patient in determining if he or she is eligible for government-sponsored programs.

§ 1797.311(a) Each hospital shall post notices regarding the availability of its discount payment policy and charity care policy. These notices shall be posted in visible locations throughout the hospital, including, but not limited to, patient admissions and registration, the billing office, the emergency department and other outpatient settings.

(b) Every posted notice regarding financial assistance policies shall contain brief instructions on how to apply for charity care or a discounted payment. Each notice shall include a contact telephone number that a patient or family member can call to obtain more information.

(c) A hospital shall train appropriate staff members about the hospital's discount payment policy. Training shall be provided to all staff members who directly interact with patients regarding their hospital bills.

(d) Each hospital shall make its charity care and discount payment policies available to appropriate community health and human services agencies and other organizations that assist low-income patients.

§ 1797.312(a) Each hospital shall have a written policy about when and under whose authority patient debt is advanced for collection, and shall use its best efforts to ensure that patient accounts are processed fairly and consistently.

(b) Each hospital shall establish a written policy defining standards and practices for the collection of debt, and shall obtain a written agreement from any agency that collects hospital receivables that it will adhere to the hospital's standards and scope of practices. In determining the amount of a debt a hospital may seek to recover from patients eligible under its charity care policy or discount payment policy, the hospital may consider only income and monetary assets as limited by subdivision (b) of Section 1797.310.

(c) At time of billing, each hospital shall provide to all low-income and uninsured patients, as the same are defined in policies adopted by the hospital regarding eligibility for charity care and discounted payment, the same information concerning services and charges provided to all other patients who receive care at the hospital.

(d) When sending a bill to a patient, each hospital shall include: (1) a statement that indicates that if the patient meets certain low-income requirements the patient may be eligible for a government-sponsored program or for financial assistance from the hospital; and (2) a statement that provides the patient with the name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's financial assistance policies for patients and how to apply for such assistance.

(e) For patients who have a completed application pending for either government-sponsored coverage or for eligibility under the hospital's own charity care or discount payment policies, a hospital shall not knowingly send that patient's bill to a collection agency prior to 120 days from time of initial billing, and without first having made more than one attempt to collect the bill, or while the completed application is being processed by a governmental agency or the hospital.

(f) If a patient qualifies for eligibility under the hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency if the hospital knows that doing so may negatively impact a patient's credit.

(g) The hospital or collection agency operating on behalf of the hospital shall not, in dealing with patients eligible under the hospital's charity care or discount payment policies, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills. This requirement does not preclude hospitals from pursuing reimbursement from third-party liability settlements or tortfeasors or other legally responsible parties.

(h) Any extended payment plans offered by a hospital to assist patients eligible under the hospital's charity care or discount payment policy, or any other policy adopted by the hospital for assisting low-income patients with no or inadequate insurance in settling past due outstanding hospital bills, shall be interest free.

§ 1797.313(a) Notwithstanding any other provision of law, the amounts paid by parties for services resulting from reduced or waived charges under a hospital's discount payment or charity care policy shall not constitute the hospital's uniform, published, prevailing, or customary charges, its usual fees to the general public, or its charges to non-Medi-Cal purchasers under comparable circumstances, and shall not be used to calculate a hospital's median non-Medicare or Medi-Cal charges, for purposes of any payment limit under the federal Medicare program, the Medi-Cal program or any other federal or state-financed health care program.

(b) Nothing in this Article shall be construed to prohibit a hospital from uniformly imposing charges from its established charge schedule or published rates, nor shall this Article preclude the recognition of a hospital's established charge schedule or published rates for purposes of applying any payment limit, interim payment amount, or other payment calculation based upon a hospital's rates or charges under the Medi-Cal, Medicare, worker's compensation, or other federal, state or local public program of health benefits.

(c) To the extent that any requirement of this Article results in a federal determination that a hospital's established charge schedule or published rates are not the hospital's customary or prevailing charges for services, the requirement in question shall be inoperative. The department shall seek federal guidance regarding modification to the requirement in question. All other requirements in this Article shall remain operative.

SECTION 10. Preservation of Existing Funding

Section 16950.2 of Article 3 of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code is added to read:

§16950.2(a) An amount, equal to the amount appropriated and allocated pursuant to Section 39.1 of Chapter 80 of the Statutes of 2005, twenty-four million eight hundred three thousand dollars ($24,803,000), shall be transferred and allocated pursuant to subdivision (b) from accounts within the Cigarette and Tobacco Products Surtax Fund (commencing with Section 30122 of the Revenue and Taxation Code) as follows:

(1) Twenty million two hundred twenty-seven thousand dollars ($20,227,000) from the Hospital Services Account.

(2) Four million five hundred seventy-six thousand dollars ($4,576,000) from the Physician Services Account.

(b) The funds specified in subdivision (a) shall be allocated proportionately as follows:

(1) Twenty-two million three hundred twenty-four thousand dollars ($22,324,000) shall be administered and allocated for distribution through the California Healthcare for Indigents Program (CHIP), Chapter 5 (commencing with Section 16940) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(2) Two million four hundred seventy-nine thousand dollars ($2,479,000) shall be administered and allocated through the Rural Health Services Program, Chapter 4 (commencing with Section 16930) of Part 4.7 of Division 9 of the Welfare and Institutions Code.

(c) This transfer shall be made on June 30 of the first fiscal year following adoption of this Act, and on June 30 of each fiscal year thereafter. Funds transferred are continuously appropriated without regard to fiscal years for the purposes so stated for each such account.

(d)(1) Funds allocated pursuant to this Section from the Physician Services Account and the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund shall be used only for reimbursement of physicians for losses incurred in providing uncompensated emergency services in general acute-care hospitals providing basic, comprehensive, or standby emergency services, as defined in Section 16953 of the Welfare and Institutions Code. Funds shall be transferred to the Physician Services Account in the county Emergency Medical Services Fund established pursuant to Sections 16951 and 16952 of the Welfare and Institutions Code, and shall be paid only to physicians who directly provide emergency medical services to patients, based on claims submitted or a subsequent reconciliation of claims. Payments shall be made as provided in Sections 16951 to 16959, inclusive, of the Welfare and Institutions Code, and payments shall be made on an equitable basis, without preference to any particular physician or group of physicians.

(2) If a county has an EMS Fund Advisory Committee that includes both emergency physicians and emergency department on-call back-up panel physicians, and if the committee unanimously approves, the administrator of the EMS Fund may create a special fee schedule and claims submission criteria for reimbursement for services rendered to uninsured trauma patients, provided that no more than fifteen percent (15%) of the tobacco tax revenues allocated to the county's EMS Fund is distributed through this special fee schedule, that all physicians who render trauma services are entitled to submit claims for reimbursement under this special fee schedule, and that no physician's claim may be reimbursed at greater than fifty percent (50%) of losses under this special fee schedule.

SECTION 11. Amendment

(a) Except as hereafter provided, this Act may only be amended by the electors pursuant to Article II, Section 10(c) of the California Constitution.

(b) Notwithstanding subdivision (a), the Legislature may amend Sections 8 and 9 of this Act to further its purposes by a statute passed in each house by roll-call vote entered in the journal, four-fifths of the membership concurring.

(c) Notwithstanding subdivisions (a) and (b), the Legislature may amend Article 2 (commencing with Section 1797.309) of Chapter 4.5 of the Health and Safety Code to further its purposes by a statute passed in each house by roll-call vote entered in the journal, two-thirds of the membership concurring.

(d) Notwithstanding subdivisions (a), (b), and (c), the Legislature may amend Sections 6 and 7 of this Act to further its purposes by a statute passed in each house by roll-call vote entered in the journal, a majority of the membership concurring, except that the Legislature may not amend subdivision (b) of Section 12693.992 of the Insurance Code added by Section 6 of this Act or subdivision (a) or subdivision (c)(1) of Section 1246 of the Health and Safety Code added by Section 7 of this Act.

SECTION 12. Statutory References

Unless otherwise stated, all references in this Act to existing statutes are to statutes as they existed on December 31, 2005.

SECTION 13. 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 14. Conflicting Measures

(a) This measure is intended to be comprehensive. It is the intent of the People that in the event that this measure and another initiative measure or measures relating to the same

subject shall 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.

(b) If this measure is approved by voters but superseded by law by any other conflicting ballot measure approved by the voters at the same election, and the conflicting ballot measure is later held invalid, this measure shall be self-executing and given full force of law.

SECTION 15. Conformity with State Constitution

Section 14 is added to Article XIIIB of the Constitution to read:

SEC. 14(a) "Appropriations subject to limitation" of each entity of government shall not include appropriations of revenue from the Tobacco Tax Act of 2006. No adjustment in the appropriations limit of any entity of government shall be required pursuant to Section 3 as a result of revenue being deposited in or appropriated from the Tobacco Tax of 2006 Trust Fund.

(b) The tax created by the Tobacco Tax Act of 2006 and the revenue derived therefrom shall not be considered General Fund revenues for the purposes of Section 8 of Article XVI.

(c) Distribution of moneys in the Tobacco Tax of 2006 Trust Fund or any of the Accounts or Sub-Accounts created therein, shall be made pursuant to the Tobacco Tax Act of 2006 notwithstanding any other provision of this Constitution.