AMENDED IN SENATE AUGUST 22, 2012

AMENDED IN SENATE AUGUST 21, 2012

AMENDED IN SENATE JUNE 25, 2012

california legislature—2011–12 regular session

ASSEMBLY BILL No. 1469

Introduced by Committee on Budget (Blumenfield (Chair), Alejo, Bonilla, Brownley, Buchanan, Butler, Cedillo, Chesbro, Dickinson, Feuer, Gordon, Huffman, Mitchell, Monning, and Swanson)

January 10, 2012

An act to amend Sections 1324.23, 1324.27, 1324.29, and 1324.30 of the Health and Safety Code, to amend Sections 12009, 12201, 12204, 12207, 12242, 12251, 12253, 12254, 12257, 12258, 12260, 12301, 12302, 12303, 12304, 12305, 12307, 12412, 12413, 12421, 12422, 12423, 12427, 12428, 12429, 12431, 12433, 12434, 12491, 12493, 12494, 12601, 12602, 12631, 12632, 12636, 12636.5, 12679, 12681, 12801, 12951, 12977, 12983, 12984, and 13108 of, and to add Section 12201.5 to, the Revenue and Taxation Code, to amend Sections 14126.022, 14126.027, 14126.033, 14126.036, and 14301.11 of, and to add Section 14126.028 to, the Welfare and Institutions Code, and to repeal Section 92 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, relating to public health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

legislative counsel's digest

AB 1469, as amended, Committee on Budget. Public health: Medi-Cal: skilled nursing facility and managed care plan charges.

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

Existing law requires the department to impose a uniform quality assurance fee on each skilled nursing facility, with certain exceptions, in accordance with a prescribed formula. The formula is based on the determination of the projected net revenues, as defined, of skilled nursing facilities. Under existing law, the charge will cease to be assessed after July 31, 2013, and these provisions will be repealed on January 1, 2014. Existing law, the Medi-Cal Long-Term Care Reimbursement Act, requires the department to implement a facility-specific reimbursement ratesetting system for certain skilled nursing facilities. Reimbursement rates for freestanding skilled nursing facilities are funded by a combination of federal funds and moneys collected pursuant to the skilled nursing uniform quality assurance fee. Existing law also establishes the Skilled Nursing Facility Quality and Accountability Special Fund in the State Treasury, which is a continuously appropriated fund that contains moneys from the assessment of specified administrative penalties and set asides of General Fund moneys, for the purposes of making quality and accountability payments. Existing law provides that this rate methodology shall cease to be implemented after July 31, 2013, and that these provisions shall be repealed on January 1, 2014.

This bill would modify the calculation of rates under the above-referenced rate methodology, and would extend the assessment of the charge, implementation of the rate methodology, and implementation of related provisions until July 31, 2015. By extending the period of time during which transfers are made to the Skilled Nursing Facility Quality and Accountability Special Fund, this bill would make an appropriation. This bill would also modify the amount of moneys to be deposited into the Skilled Nursing Facility Quality and Accountability Special Fund, by, among other things, requiring that specified set-asides under the rate methodology remain in the General Fund instead of transferring to the Skilled Nursing Facility Quality and Accountability Special Fund and increasing the amount of certain set-asides to be transferred to the fund. This bill would instead require that the quality and accountability payments be made beginning with the 2013–14 rate year.

(2) Existing federal Medicaid law requires nursing facilities, as defined, to perform an assessment of each resident's functional capacity that is based on a uniform minimum data set, as specified.

This bill would require nursing facilities, the State Department of Health Care Services, and the State Department of Public Health to perform various duties with respect to the federal government's nursing home quality initiative and this assessment.

(3) Under existing law, one of the methods by which Medi-Cal services are provided is through contracts with various types of managed care plans. Existing law imposes a tax at a specified rate on the gross premiums of an insurer, as defined, and, until July 1, 2012, on the total operating revenue, as specified, of a Medi-Cal managed care plan, as defined. Existing law exempts from that tax the total operating revenue of a Medi-Cal managed care plan, if specified events occur before July, 1, 2012. Existing law continuously appropriates the revenues derived from the tax on Medi-Cal managed care plans for specified purposes.

This bill would extend the imposition of the tax on the total operating revenue of Medi-Cal managed care plans until July 1, 2014, and would make other conforming changes. This bill would, beginning January 1, 2013, allocate the sum of $15 million dollars from the revenues derived after July 1, 2012, to the State Department of Health Care Services for the purpose of creating a performance-based incentive payment program for specified Medi-Cal managed care plans. This bill also would authorize the Controller to loan funds in the Children's Health and Human Services Special Fund to the General Fund, as provided, until July 1, 2014. By extending the imposition of a charge whose revenues are continuously appropriated, this bill would make an appropriation.

(4) Existing law requires, until July 1, 2012, every return required to be filed with the Insurance Commissioner pursuant to provisions governing taxes on the total operating revenue of Medi-Cal managed care plans to be signed by the insurer or the Medi-Cal managed care plan or an executive officer of the insurer or the plan and to be made under oath or contain a written declaration that is made under penalty of perjury.

This bill would instead apply this signature requirement until July 1, 2014. By expanding the crime of perjury, this bill would impose a state-mandated local program.

(5) Section 92 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011 provides that the act becomes inoperative if any of its provisions are amended or repealed.

This bill would repeal that provision and would provide that, notwithstanding Section 92 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, the provisions of Chapter 11 of the First Extraordinary Session of the Statutes of 2011 do not become inoperative upon the amendment or repeal of any provision of that chapter made by this bill.

(6) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

(7) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 1324.23 of the Health and Safety Code is amended to read:

1324.23. (a) The Director of Health Care Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but need not be limited to, any regulations necessary for any of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee not to exceed amounts reasonably necessary for purposes of this article.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(3) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to subdivision (b), and notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2015. It is the intent of the Legislature that the regulations adopted pursuant to subdivision (b) shall be adopted on or before July 31, 2015.

SEC. 2. Section 1324.27 of the Health and Safety Code is amended to read:

1324.27. (a) (1) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt facilities identified in subdivision (c) of Section 1324.20, including the submission of a request for waiver of broad-based requirement, waiver of uniform fee requirement, or both, pursuant to paragraphs (1) and (2) of subdivision (e) of Section 433.68 of Title 42 of the Code of Federal Regulations.

(2) The director may alter the methodology specified in this article, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval. The Director of Health Care Services may also add new categories of exempt facilities or apply a nonuniform fee to the skilled nursing facilities subject to the fee in order to meet requirements of federal law or regulations. The Director of Health Care Services may apply a zero fee to one or more exempt categories of facilities, if necessary to obtain federal approval.

(3) If after seeking federal approval, federal approval is not obtained, this article shall not be implemented.

(b) The department shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 1324.21 in order to assure that the aggregate quality assurance fee for any particular state fiscal year does not exceed 6 percent of the aggregate annual net revenue of facilities subject to the fee.

SEC. 3. Section 1324.29 of the Health and Safety Code is amended to read:

1324.29. (a) The quality assurance fee shall cease to be assessed after July 31, 2015.

(b) Notwithstanding subdivision (a) and Section 1324.30, the department's authority and obligation to collect all quality assurance fees and penalties, including interest, shall continue in effect and shall not cease until the date that all amounts are paid or recovered in full.

(c) This section shall remain operative until the date that all fees and penalties, including interest, have been recovered pursuant to subdivision (b), and as of that date is repealed.

SEC. 4. Section 1324.30 of the Health and Safety Code is amended to read:

1324.30. This article shall become inoperative after July 31, 2015, and, as of January 1, 2016, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. Section 12009 of the Revenue and Taxation Code is amended to read:

12009. (a) "Medi-Cal managed care plan" or "plan" means any individual, organization, or entity, other than an insurer as described in Section 12003 or a dental managed care plan as described in Section 14087.46 of the Welfare and Institutions Code, that enters into a contract with the State Department of Health Care Services pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089) of Chapter 7 of, or pursuant to Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8 of, Part 3 of Division 9 of the Welfare and Institutions Code.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 6. Section 12201 of the Revenue and Taxation Code, as amended by Section 2 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12201. (a) Every insurer and Medi-Cal managed care plan doing business in this state shall annually pay to the state a tax on the bases, at the rates, and subject to the deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

(b) Notwithstanding Section 13340 of the Government Code, the revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans are hereby continuously appropriated as follows:

(1) A percentage of the revenues derived from the imposition of the tax by this chapter on Medi-Cal managed care plans equal to the difference between 100 percent and the applicable federal medical assistance percentage (FMAP) to the department for purposes of the Medi-Cal program.

(2) After deducting the revenues appropriated pursuant to paragraph (1), any remaining revenue to the Managed Risk Medical Insurance Board for purposes of the Healthy Families Program.

(c) The Insurance Commissioner shall report the amount of revenue derived from the tax imposed on Medi-Cal managed care plans pursuant to this section to the California Health and Human Services Agency, the Joint Legislative Budget Committee, and the Department of Finance.

(d) Notwithstanding any other law, the Controller may use the funds in the Children's Health and Human Services Special Fund for cashflow loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code.

(e) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed. Any tax imposed by this section shall continue to be due and payable until the tax is paid.

SEC. 7. Section 12201 of the Revenue and Taxation Code, as amended by Section 3 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12201. (a) Every insurer doing business in this state shall annually pay to the state a tax on the bases, at the rates, and subject to the deductions from the tax hereinafter specified. For purposes of the tax imposed by this chapter, "insurer" shall be deemed to include a home protection company as defined in Section 12740 of the Insurance Code.

(b) This section shall become operative on July 1, 2014.

SEC. 8. Section 12201.5 is added to the Revenue and Taxation Code, to read:

12201.5. Notwithstanding Section 13340 of the Government Code, subdivision (b) of Section 12201, or any other law, beginning January 1, 2013, the sum of fifteen million dollars ($15,000,000) from the revenues derived after July 1, 2012, from the imposition of the tax by this chapter on Medi-Cal managed care plans is allocated to the State Department of Health Care Services for the purpose of creating a performance-based incentive payment program for Medi-Cal managed care plans subject to the following:

(a) Only Medi-Cal managed care plans in the two-plan model counties, county organized health systems, and geographic managed care pursuant to Article 2.7 (commencing with Section 14087.3), *Article 2.8 (commencing with Section 14087.5),* Article 2.81 (commencing with Section 14087.96), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code shall be eligible for this program.

(b) Payments to Medi-Cal managed care plans under this program shall be determined annually by the department based on a Medi-Cal managed care plan's performance on child-only Health Care Effectiveness Data and Information Set measures for all children enrolled in the plan under the Medi-Cal program.

(c) The revenues shall be allocated as follows:

(1) Eleven million dollars ($11,000,000) to two-plan model counties.

(2) Three million dollars ($3,000,000) to county organized health system counties.

(3) One million dollars ($1,000,000) to geographic managed care.

(d) The revenues shall be matched with federal financial participation to the extent that federal financial participation is available.

SEC. 9. Section 12204 of the Revenue and Taxation Code, as amended by Section 4 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12204. (a) The tax imposed on insurers by this chapter is in lieu of all other taxes and licenses, state, county, and municipal, upon those insurers and their property, except:

(1) Taxes upon their real estate.

(2) Any retaliatory exactions imposed by paragraph (3) of subdivision (f) of Section 28 of Article XIII of the Constitution.

(3) The tax on ocean marine insurance.

(4) Motor vehicle and other vehicle registration license fees and any other tax or license fee imposed by the state upon vehicles, motor vehicles or the operation thereof.

(5) That each corporate or other attorney-in-fact of a reciprocal or interinsurance exchange shall be subject to all taxes imposed upon corporations or others doing business in the state, other than taxes on income derived from its principal business as attorney-in-fact.

(b) This section shall not apply to any Medi-Cal managed care plan and to any tax imposed on that plan by this chapter.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 10. Section 12204 of the Revenue and Taxation Code, as amended by Section 5 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12204. (a) The tax imposed on insurers by this chapter is in lieu of all other taxes and licenses, state, county, and municipal, upon those insurers and their property, except:

(1) Taxes upon their real estate.

(2) Any retaliatory exactions imposed by paragraph (3) of subdivision (f) of Section 28 of Article XIII of the California Constitution.

(3) The tax on ocean marine insurance.

(4) Motor vehicle and other vehicle registration license fees and any other tax or license fee imposed by the state upon vehicles, motor vehicles or the operation thereof.

(5) That each corporate or other attorney-in-fact of a reciprocal or interinsurance exchange shall be subject to all taxes imposed upon corporations or others doing business in the state, other than taxes on income derived from its principal business as attorney-in-fact.

(b) This section shall become operative on July 1, 2014.

SEC. 11. Section 12207 of the Revenue and Taxation Code is amended to read:

12207. (a) Notwithstanding any other provision of this part, no credit shall be allowed under Section 12206, 12208, or 12209 against the tax imposed on Medi-Cal managed care plans pursuant to Section 12201.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 12. Section 12242 of the Revenue and Taxation Code is amended to read:

12242. This article shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 13. Section 12251 of the Revenue and Taxation Code, as amended by Section 8 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12251. (a) For the calendar year 1970, and each calendar year thereafter, insurers transacting insurance in this state and whose annual tax for the preceding calendar year was five thousand dollars ($5,000) or more shall make prepayments of the annual tax for the current calendar year imposed by Section 28 of Article XIII of the California Constitution and this part, provided that no prepayments shall be made with respect to the tax on ocean marine insurance underwriting profit or any retaliatory tax.

(b) Medi-Cal managed care plans shall make prepayments of the tax imposed by Section 12201 for the current calendar year, except that no prepayments shall be required prior to the effective date of the act adding this subdivision, and no penalties and interest shall be imposed pursuant to Section 12261 for not making those prepayments.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 14. Section 12251 of the Revenue and Taxation Code, as amended by Section 9 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12251. (a) For the calendar year 1970, and each calendar year thereafter, insurers transacting insurance in this state and whose annual tax for the preceding calendar year was five thousand dollars ($5,000) or more shall make prepayments of the annual tax for the current calendar year imposed by Section 28 of Article XIII of the California Constitution and this part, provided that no prepayments shall be made with respect to the tax on ocean marine insurance underwriting profit or any retaliatory tax.

(b) This section shall become operative on July 1, 2014.

SEC. 15. Section 12253 of the Revenue and Taxation Code, as amended by Section 10 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12253. (a) Each insurer and Medi-Cal managed care plan required to make prepayments shall remit them on or before each of the dates of April 1st, June 1st, September 1st, and December 1st of the current calendar year. Remittances for prepayments shall be made payable to the Controller and shall be delivered to the office of the commissioner, accompanied by a prepayment form prescribed by the commissioner.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 16. Section 12253 of the Revenue and Taxation Code, as amended by Section 11 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12253. (a) Each insurer required to make prepayments shall remit them on or before each of the dates of April 1st, June 1st, September 1st, and December 1st of the current calendar year. Remittances for prepayments shall be made payable to the Controller and shall be delivered to the office of the commissioner, accompanied by a prepayment form prescribed by the commissioner.

(b) This section shall become operative on July 1, 2014.

SEC. 17. Section 12254 of the Revenue and Taxation Code, as amended by Section 12 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12254. (a) (1) For each insurer, the amount of each prepayment shall be 25 percent of the amount of the annual insurance tax liability reported on the return of the insurer for the preceding calendar year.

(2) For each Medi-Cal managed care plan, the amount of each prepayment shall be 25 percent of the amount of tax the plan estimates as the amount of tax imposed by Section 12201 with respect to the plan.

(b) In establishing the prepayment amount of an insurer that has acquired the business of another insurer, the amount of tax liability of the acquiring insurer reported for the preceding calendar year shall be deemed to include the amount of tax liability of the acquired insurer reported for that year.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 18. Section 12254 of the Revenue and Taxation Code, as amended by Section 13 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12254. (a) The amount of each prepayment shall be 25 percent of the amount of the annual insurance tax liability reported on the return of the insurer for the preceding calendar year.

(b) In establishing the prepayment amount of an insurer that has acquired the business of another insurer, the amount of tax liability of the acquiring insurer reported for the preceding calendar year shall be deemed to include the amount of tax liability of the acquired insurer reported for that year.

(c) This section shall become operative on July 1, 2014.

SEC. 19. Section 12257 of the Revenue and Taxation Code, as amended by Section 14 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12257. (a) If the total amount of prepayments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of annual tax and, at the election of the insurer or Medi-Cal managed care plan, may be credited against the amounts due and payable for the first prepayment of the following year. Any amount of the overpayment not so credited shall be allowed as a credit or refund under Article 2 (commencing with Section 12977) of Chapter 7 of this part.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 20. Section 12257 of the Revenue and Taxation Code, as amended by Section 15 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12257. (a) If the total amount of prepayments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of annual tax and, at the election of the insurer, may be credited against the amounts due and payable for the first prepayment of the following year. Any amount of the overpayment not so credited shall be allowed as a credit or refund under Article 2 (commencing with Section 12977) of Chapter 7 of this part.

(b) This section shall become operative on July 1, 2014.

SEC. 21. Section 12258 of the Revenue and Taxation Code, as amended by Section 16 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12258. (a) Any insurer or Medi-Cal managed care plan that fails to pay any prepayment within the time required shall pay a penalty of 10 percent of the amount of the required prepayment, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the prepayment until the date of payment but not for any period after the due date of the annual tax. Assessments of prepayment deficiencies may be made in the manner provided by deficiency assessments of the annual tax.

(b) Notwithstanding any other law, the prepayment due on September 1, 2011, shall be due no later than 30 days after the effective date of this act for a Medi-Cal managed care plan as defined in subdivision (a) of Section 12009.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 22. Section 12258 of the Revenue and Taxation Code, as amended by Section 17 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12258. (a) Any insurer that fails to pay any prepayment within the time required shall pay a penalty of 10 percent of the amount of the required prepayment, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the prepayment until the date of payment but not for any period after the due date of the annual tax. Assessments of prepayment deficiencies may be made in the manner provided by deficiency assessments of the annual tax.

(b) This section shall become operative on July 1, 2014.

SEC. 23. Section 12260 of the Revenue and Taxation Code, as amended by Section 18 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12260. (a) Notwithstanding any other provision of this article, the commissioner may relieve an insurer or Medi-Cal managed care plan of its obligation to make prepayments where the insurer or Medi-Cal managed care plan establishes to the satisfaction of the commissioner that the insurer has ceased to transact insurance in this state or the Medi-Cal managed care plan has ceased to operate a plan in this state, or the insurer's or Medi-Cal managed care plan's annual tax for the current year will be less than five thousand dollars ($5,000).

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 24. Section 12260 of the Revenue and Taxation Code, as amended by Section 19 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12260. (a) Notwithstanding any other provision of this article, the commissioner may relieve an insurer of its obligation to make prepayments where the insurer establishes to the satisfaction of the commissioner that either the insurer has ceased to transact insurance in this state, or the insurer's annual tax for the current year will be less than five thousand dollars ($5,000).

(b) This section shall become operative on July 1, 2014.

SEC. 25. Section 12301 of the Revenue and Taxation Code, as amended by Section 20 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12301. (a) The taxes imposed upon insurers by Section 28 of Article XIII of the California Constitution and this part, except with respect to taxes on ocean marine insurance and retaliatory taxes, are due and payable annually on or before April 1st of the year following the calendar year in which the insurer engaged in the business of insurance or transacted insurance in this state. The taxes imposed with respect to ocean marine insurance are due and payable on or before June 15th of that year.

(b) With respect to Medi-Cal managed care plans, the taxes imposed by Section 12201 shall be due and payable on or before April 1st of the year following the calendar year in which the plan contracted with the State Department of Health Care Services as described in Section 12009.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed. However, any tax imposed by Section 12201 shall continue to be due and payable until the tax is paid.

SEC. 26. Section 12301 of the Revenue and Taxation Code, as amended by Section 21 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12301. (a) The taxes imposed upon insurers by Section 28 of Article XIII of the California Constitution and this part, except with respect to taxes on ocean marine insurance and retaliatory taxes, are due and payable annually on or before April 1st of the year following the calendar year in which the insurer engaged in the business of insurance or transacted insurance in this state. The taxes imposed with respect to ocean marine insurance are due and payable on or before June 15th of that year.

(b) This section shall become operative on July 1, 2014.

SEC. 27. Section 12302 of the Revenue and Taxation Code, as amended by Section 22 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12302. (a) On or before April 1st (or June 15th with respect to taxes on ocean marine insurance) every person that is subject to any tax imposed by Section 28 of Article XIII of the California Constitution or this part, in respect to the preceding calendar year shall file, in duplicate, a tax return with the commissioner in the form as the commissioner may prescribe. The return shall show that information pertaining to its insurance business, or in the case of a Medi-Cal managed care plan, pertaining to contracts for providing services as described in Section 12009, in this state as will reflect the basis of its tax as set forth in Chapter 2 (commencing with Section 12071) and Chapter 3 (commencing with Section 12201) of this part, the computation of the amount of tax for the period covered by the return, the total amount of any tax prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, and any other information as the commissioner may require to carry out the purposes of this part. Separate returns shall be filed with respect to the following kinds of insurance:

(1) Life insurance (or life insurance and disability insurance).

(2) Ocean marine insurance.

(3) Title insurance.

(4) Insurance other than life insurance (or life insurance and disability insurance), ocean marine insurance or title insurance.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 28. Section 12302 of the Revenue and Taxation Code, as amended by Section 23 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12302. (a) On or before April 1st (or June 15th with respect to taxes on ocean marine insurance) every person that is subject to any tax imposed by Section 28 of Article XIII of the California Constitution or this part, in respect to the preceding calendar year shall file, in duplicate, an insurance tax return with the commissioner in the form as the commissioner may prescribe. The return shall show that information pertaining to its insurance business in this state as will reflect the basis of its tax as set forth in Chapter 2 (commencing with Section 12071) and Chapter 3 (commencing with Section 12201) of this part, the computation of the amount of tax for the period covered by the return, the total amount of any tax prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, and any other information as the commissioner may require to carry out the purposes of this part. Separate returns shall be filed with respect to the following kinds of insurance:

(1) Life insurance (or life insurance and disability insurance).

(2) Ocean marine insurance.

(3) Title insurance.

(4) Insurance other than life insurance (or life insurance and disability insurance), ocean marine insurance or title insurance.

(b) This section shall become operative on July 1, 2014.

SEC. 29. Section 12303 of the Revenue and Taxation Code, as amended by Section 24 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12303. (a) Every return required by this article to be filed with the commissioner shall be signed by the insurer or Medi-Cal managed care plan or an executive officer of the insurer or plan and shall be made under oath or contain a written declaration that it is made under penalty of perjury. A return of a foreign insurer may be signed and verified by its manager residing within this state. A return of an alien insurer may be signed and verified by the United States manager of the insurer.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 30. Section 12303 of the Revenue and Taxation Code, as amended by Section 25 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12303. (a) Every return required by this article to be filed with the commissioner shall be signed by the insurer or an executive officer of the insurer and shall be made under oath or contain a written declaration that it is made under penalty of perjury. A return of a foreign insurer may be signed and verified by its manager residing within this state. A return of an alien insurer may be signed and verified by the United States manager of the insurer.

(b) This section shall become operative on July 1, 2014.

SEC. 31. Section 12304 of the Revenue and Taxation Code, as amended by Section 26 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12304. (a) Blank forms of returns shall be furnished by the commissioner on application, but failure to secure the form shall not relieve any insurer or Medi-Cal managed care plan from making or filing a timely return.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute,

that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 32. Section 12304 of the Revenue and Taxation Code, as amended by Section 27 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12304. (a) Blank forms of returns shall be furnished by the commissioner on application, but failure to secure the form shall not relieve any insurer from making or filing a timely return.

(b) This section shall become operative on July 1, 2014.

SEC. 33. Section 12305 of the Revenue and Taxation Code, as amended by Section 28 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12305. (a) The insurer or Medi-Cal managed care plan required to file a return shall deliver the return in duplicate, together with a remittance payable to the Controller, for the amount of tax computed and shown thereon, less any prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, to the office of the commissioner.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 34. Section 12305 of the Revenue and Taxation Code, as amended by Section 29 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12305. (a) The insurer required to file a return shall deliver the return in duplicate, together with a remittance payable to the Controller, for the amount of tax computed and shown thereon, less any prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, to the office of the commissioner.

(b) This section shall become operative on July 1, 2014.

SEC. 35. Section 12307 of the Revenue and Taxation Code, as amended by Section 30 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12307. (a) Any insurer or Medi-Cal managed care plan to which an extension is granted shall pay, in addition to the tax, interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from April 1st until the date of payment.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 36. Section 12307 of the Revenue and Taxation Code, as amended by Section 31 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12307. (a) Any insurer that is granted an extension shall pay, in addition to the tax, interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from April 1st until the date of payment.

(b) This section shall become operative on July 1, 2014.

SEC. 37. Section 12412 of the Revenue and Taxation Code, as amended by Section 32 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12412. (a) Upon receipt of the duplicate copy of the return of an insurer or Medi-Cal managed care plan the board shall initially assess the tax in accordance with the data as reported by the insurer or Medi-Cal managed care plan on the return.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 38. Section 12412 of the Revenue and Taxation Code, as amended by Section 33 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12412. (a) Upon receipt of the duplicate copy of the return of an insurer the board shall initially assess the tax in accordance with the data as reported by the insurer on the return.

(b) This section shall become operative on July 1, 2014.

SEC. 39. Section 12413 of the Revenue and Taxation Code, as amended by Section 34 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12413. (a) The board shall promptly transmit notice of its initial assessment to the commissioner and the Controller, and if the initial assessment differs from the amount computed by the insurer or Medi-Cal managed care plan, notice shall also be given to the insurer or Medi-Cal managed care plan.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute,

that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 40. Section 12413 of the Revenue and Taxation Code, as amended by Section 35 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12413. (a) The board shall promptly transmit notice of its initial assessment to the commissioner and the Controller, and if the initial assessment differs from the amount computed by the insurer, notice shall also be given to the insurer.

(b) This section shall become operative on July 1, 2014.

SEC. 41. Section 12421 of the Revenue and Taxation Code, as amended by Section 36 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12421. (a) As soon as practicable after an insurer's, surplus line broker's, or Medi-Cal managed care plan's return is filed, the commissioner shall examine it, together with any information within his or her possession or that may come into his or her possession, and he or she shall determine the correct amount of tax of the insurer, surplus line broker, or Medi-Cal managed care plan.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 42. Section 12421 of the Revenue and Taxation Code, as amended by Section 37 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12421. (a) As soon as practicable after an insurer's or surplus line broker's return is filed, the commissioner shall examine it, together with any information within his or her possession or that may come into his or her possession, and he or she shall determine the correct amount of tax of the insurer or surplus line broker.

(b) This section shall become operative on July 1, 2014.

SEC. 43. Section 12422 of the Revenue and Taxation Code, as amended by Section 38 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12422. (a) If the commissioner determines that the amount of tax disclosed by the insurer's tax return and assessed by the board is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(b) If the commissioner determines that the amount of tax disclosed by the surplus line broker's tax return is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(c) If the commissioner determines that the amount of tax disclosed by the Medi-Cal managed care plan's tax return is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(d) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 44. Section 12422 of the Revenue and Taxation Code, as amended by Section 39 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12422. (a) If the commissioner determines that the amount of tax disclosed by the insurer's tax return and assessed by the board is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(b) If the commissioner determines that the amount of tax disclosed by the surplus line broker's tax return is less than the amount of tax disclosed by his or her examination, he or she shall propose, in writing, to the board a deficiency assessment for the difference. The proposal shall set forth the basis for the deficiency assessment and the details of its computation.

(c) This section shall become operative on July 1, 2014.

SEC. 45. Section 12423 of the Revenue and Taxation Code, as amended by Section 40 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12423. (a) If an insurer, surplus line broker, or Medi-Cal managed care plan fails to file a return, the commissioner may require a return by mailing notice to the insurer, surplus line broker, or Medi-Cal managed care plan to file a return by a specified date or he or she may without requiring a return, or upon no return having been filed pursuant to the demand therefor, make an estimate of the amount of tax due for the calendar year or years in respect to which the insurer, surplus line broker, or Medi-Cal managed care plan failed to file the return. The estimate shall be made from any available information which is in the commissioner's possession or may come into his or her possession, and the commissioner shall propose, in writing, to the board a deficiency assessment for the amount of the estimated tax. The proposal shall set forth the basis of the estimate and the details of the computation of the tax.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 46. Section 12423 of the Revenue and Taxation Code, as amended by Section 41 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12423. (a) If an insurer or surplus line broker fails to file a return, the commissioner may require a return by mailing notice to the insurer or surplus line broker to file a return by a specified date or he or she may without requiring a return, or upon no return having been filed pursuant to the demand therefor, make an estimate of the amount of tax due for the calendar year or years in respect to which the insurer or surplus line broker failed to file the return. The estimate shall be made from any available information which is in the commissioner's possession or may come into his or her possession, and the commissioner shall propose, in writing, to the board a deficiency assessment for the amount of the estimated tax. The proposal shall set forth the basis of the estimate and the details of the computation of the tax.

(b) This section shall become operative on July 1, 2014.

SEC. 47. Section 12427 of the Revenue and Taxation Code, as amended by Section 42 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12427. (a) The board shall promptly notify the insurer, surplus line broker, or Medi-Cal managed care plan of a deficiency assessment made against the insurer, surplus line broker, or Medi-Cal managed care plan.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 48. Section 12427 of the Revenue and Taxation Code, as amended by Section 43 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12427. (a) The board shall promptly notify the insurer or surplus line broker of a deficiency assessment made against the insurer or surplus line broker.

(b) This section shall become operative on July 1, 2014.

SEC. 49. Section 12428 of the Revenue and Taxation Code, as amended by Section 44 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12428. (a) An insurer, surplus line broker, or Medi-Cal managed care plan against which a deficiency assessment is made under Section 12424 or 12425 may petition for redetermination of the deficiency assessment within 30 days after service upon the insurer, surplus line broker, or Medi-Cal managed care plan of the notice thereof, by filing with the board a written petition setting forth the grounds of objection to the deficiency assessment and the correction sought. At the time the petition is filed with the board, a copy of the petition shall be filed with the commissioner.

If a petition for redetermination is not filed within the period prescribed by this section, the deficiency assessment becomes final and due and payable at the expiration of that period.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 50. Section 12428 of the Revenue and Taxation Code, as amended by Section 45 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12428. (a) An insurer or surplus line broker against which a deficiency assessment is made under Section 12424 or 12425 may petition for redetermination of the deficiency assessment within 30 days after service upon the insurer or surplus line broker of the notice thereof, by filing with the board a written petition setting forth the grounds of objection to the deficiency assessment and the correction sought. At the time the petition is filed with the board, a copy of the petition shall be filed with the commissioner.

If a petition for redetermination is not filed within the period prescribed by this section, the deficiency assessment becomes final and due and payable at the expiration of that period.

(b) This section shall become operative on July 1, 2014.

SEC. 51. Section 12429 of the Revenue and Taxation Code, as amended by Section 46 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12429. (a) If a petition for redetermination of a deficiency assessment is filed within the time allowed under Section 12428, the board shall reconsider the deficiency assessment and, if the insurer, surplus line broker, or Medi-Cal managed care plan has so requested in the petition, shall grant an oral hearing for the presentation of evidence and argument before the board or its authorized representative. The board shall give the petitioner and the commissioner at least 20 days' notice of the time and place of hearing. The hearing may be continued from time to time as may be necessary.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 52. Section 12429 of the Revenue and Taxation Code, as amended by Section 47 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12429. (a) If a petition for redetermination of a deficiency assessment is filed within the time allowed under Section 12428, the board shall reconsider the deficiency assessment and, if the insurer or surplus line broker has so requested in the petition, shall grant an oral hearing for the presentation of evidence and argument before the board or its authorized representative. The board shall give the petitioner and the commissioner at least 20 days' notice of the time and place of hearing. The hearing may be continued from time to time as may be necessary.

(b) This section shall become operative on July 1, 2014.

SEC. 53. Section 12431 of the Revenue and Taxation Code, as amended by Section 48 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12431. (a) The order or decision of the board upon a petition for redetermination of a deficiency assessment becomes final 30 days after service on the insurer, surplus line broker, or Medi-Cal managed care plan of a notice thereof, and any resulting deficiency assessment is due and payable at the time the order or decision becomes final.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 54. Section 12431 of the Revenue and Taxation Code, as amended by Section 49 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12431. (a) The order or decision of the board upon a petition for redetermination of a deficiency assessment becomes final 30 days after service on the insurer or surplus line broker of a notice thereof, and any resulting deficiency assessment is due and payable at the time the order or decision becomes final.

(b) This section shall become operative on July 1, 2014.

SEC. 55. Section 12433 of the Revenue and Taxation Code, as amended by Section 50 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12433. (a) If before the expiration of the time prescribed in Section 12432 for giving of a notice of deficiency assessment the insurer, surplus line broker, or Medi-Cal managed care plan has consented in writing to the giving of the notice after that time, the notice may be given at any time prior to the expiration of the time agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 56. Section 12433 of the Revenue and Taxation Code, as amended by Section 51 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12433. (a) If before the expiration of the time prescribed in Section 12432 for giving of a notice of deficiency assessment the insurer or surplus line broker has consented in writing to the giving of the notice after that time, the notice may be given at any time prior to the expiration of the time agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

(b) This section shall become operative on July 1, 2014.

SEC. 57. Section 12434 of the Revenue and Taxation Code, as amended by Section 52 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12434. (a) Any notice required by this article shall be placed in a sealed envelope, with postage paid, addressed to the insurer, surplus line broker, or Medi-Cal managed care plan at its address as it appears in the records of the commissioner or the board. The giving of notice shall be deemed complete at the time of deposit of the notice in the United States Post Office, or a mailbox, subpost office, substation or mail chute or other facility regularly maintained or provided by the United States Postal Service, without extension of time for any reason. In lieu of mailing, a notice may be served personally by delivering to the person to be served and service shall be deemed complete at the time of the delivery. Personal service to a corporation may be made by delivery of a notice to any person designated in the Code of Civil Procedure to be served for the corporation with summons and complaint in a civil action.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 58. Section 12434 of the Revenue and Taxation Code, as amended by Section 53 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12434. (a) Any notice required by this article shall be placed in a sealed envelope, with postage paid, addressed to the insurer or surplus line broker at its address as it appears in the records of the commissioner or the board. The giving of notice shall be deemed complete at the time of deposit of the notice in the United States Post Office, or a mailbox, subpost office, substation or mail chute or other facility regularly maintained or provided by the United States Postal Service, without extension of time for any reason. In lieu of mailing, a notice may be served personally by delivering to the person to be served and service shall be deemed complete at the time of the delivery. Personal service to a corporation may be made by delivery of a notice to any person designated in the Code of Civil Procedure to be served for the corporation with summons and complaint in a civil action.

(b) This section shall become operative on July 1, 2014.

SEC. 59. Section 12491 of the Revenue and Taxation Code, as amended by Section 54 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12491. (a) Every tax levied upon an insurer under Article XIII of the California Constitution and this part is a lien upon all property and franchises of every kind and nature belonging to the insurer, and has the effect of a judgment against the insurer.

(b) (1) Every tax levied upon a surplus line broker under Part 7.5 (commencing with Section 13201) of Division 2 is a lien upon all property and franchises of every kind and nature belonging to the surplus line broker, and has the effect of a judgment against the surplus line broker.

(2) A lien levied pursuant to this subdivision shall not exceed the amount of unpaid tax collected by the surplus line broker.

(c) (1) Every tax levied upon a Medi-Cal managed care plan under Chapter 1 (commencing with Section 12001) is a lien upon all property and franchises of every kind and nature belonging to the Medi-Cal managed care plan, and has the effect of a judgment against the Medi-Cal managed care plan.

(2) A lien levied pursuant to this subdivision shall not exceed the amount of unpaid tax collected by the Medi-Cal managed care plan.

(d) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 60. Section 12491 of the Revenue and Taxation Code, as amended by Section 55 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12491. (a) Every tax levied upon an insurer under the provisions of Article XIII of the California Constitution and of this part is a lien upon all property and franchises of every kind and nature belonging to the insurer, and has the effect of a judgment against the insurer.

(b) (1) Every tax levied upon a surplus line broker under the provisions of Part 7.5 (commencing with Section 13201) of Division 2 is a lien upon all property and franchises of every kind and nature belonging to the surplus line broker, and has the effect of a judgment against the surplus line broker.

(2) A lien levied pursuant to this subdivision shall not exceed the amount of unpaid tax collected by the surplus line broker.

(c) This section shall become operative on July 1, 2014.

SEC. 61. Section 12493 of the Revenue and Taxation Code, as amended by Section 56 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12493. (a) Every lien has the effect of an execution duly levied against all property of a delinquent insurer, surplus line broker, or Medi-Cal managed care plan.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 62. Section 12493 of the Revenue and Taxation Code, as amended by Section 57 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12493. (a) Every lien has the effect of an execution duly levied against all property of a delinquent insurer or surplus line broker.

(b) This section shall become operative on July 1, 2014.

SEC. 63. Section 12494 of the Revenue and Taxation Code, as amended by Section 58 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12494. (a) No judgment is satisfied nor lien removed until either:

(1) The taxes, interest, penalties, and costs are paid.

(2) The insurer’s, surplus line broker’s, or Medi-Cal managed care plan’s property is sold for the payment thereof.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 64. Section 12494 of the Revenue and Taxation Code, as amended by Section 59 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12494. (a) No judgment is satisfied nor lien removed until either:

(1) The taxes, interest, penalties, and costs are paid.

(2) The insurer's or surplus line broker's property is sold for the payment thereof.

(b) This section shall become operative on July 1, 2014.

SEC. 65. Section 12601 of the Revenue and Taxation Code, as amended by Section 60 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12601. (a) Amounts of taxes, interest, and penalties not remitted to the commissioner with the original return of the insurer or Medi-Cal managed care plan shall be payable to the Controller.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 66. Section 12601 of the Revenue and Taxation Code, as amended by Section 61 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12601. (a) Amounts of taxes, interest, and penalties not remitted to the commissioner with the original return of the insurer shall be payable to the Controller.

(b) This section shall become operative on July 1, 2014.

SEC. 67. Section 12602 of the Revenue and Taxation Code, as amended by Section 62 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12602. (a) (1) On and after January 1, 1994, and before January 1, 1995, each insurer whose annual taxes exceed fifty thousand dollars ($50,000) shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. On and after January 1, 1995, each insurer whose annual taxes exceed twenty thousand dollars ($20,000) shall make payment by electronic funds transfer. The insurer shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(2) Each Medi-Cal managed care plan shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. The plan shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(b) Payment shall be deemed complete on the date the electronic funds transfer is initiated, if settlement to the state's demand account occurs on or before the banking day following the date the transfer is initiated. If settlement to the state's demand account does not occur on or before the banking day following the date the transfer is initiated, payment shall be deemed to occur on the date settlement occurs.

(c) (1) Any insurer or Medi-Cal managed care plan required to remit taxes by electronic funds transfer pursuant to this section that remits those taxes by means other than an appropriate electronic funds transfer, shall be assessed a penalty in an amount equal to 10 percent of the taxes due at the time of the payment.

(2) If the Department of Insurance finds that an insurer's or Medi-Cal managed care plan's failure to make payment by an appropriate electronic funds transfer in accordance with subdivision (a) is due to reasonable cause or circumstances beyond the insurer's or Medi-Cal managed care plan's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, that insurer or Medi-Cal managed care plan shall be relieved of the penalty provided in paragraph (1).

(3) Any insurer or Medi-Cal managed care plan seeking to be relieved of the penalty provided in paragraph (1) shall file with the Department of Insurance a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(d) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 68. Section 12602 of the Revenue and Taxation Code, as amended by Section 63 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12602. (a) On and after January 1, 1994, and before January 1, 1995, each insurer whose annual taxes exceed fifty thousand dollars ($50,000) shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. On and after January 1, 1995, each insurer whose annual taxes exceed twenty thousand dollars ($20,000) shall make payment by electronic funds transfer. The insurer shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(b) Payment shall be deemed complete on the date the electronic funds transfer is initiated, if settlement to the state's demand account occurs on or before the banking day following the date the transfer is initiated. If settlement to the state's demand account does not occur on or before the banking day following the date the transfer is initiated, payment shall be deemed to occur on the date settlement occurs.

(c) (1) Any insurer required to remit taxes by electronic funds transfer pursuant to this section that remits those taxes by means other than an appropriate electronic funds transfer, shall be assessed a penalty in an amount equal to 10 percent of the taxes due at the time of the payment.

(2) If the Department of Insurance finds that an insurer's failure to make payment by an appropriate electronic funds transfer in accordance with subdivision (a) is due to reasonable cause or circumstances beyond the insurer's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, that insurer shall be relieved of the penalty provided in paragraph (1).

(3) Any insurer seeking to be relieved of the penalty provided in paragraph (1) shall file with the Department of Insurance a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(d) This section shall become operative on July 1, 2014.

SEC. 69. Section 12631 of the Revenue and Taxation Code, as amended by Section 64 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12631. (a) Any insurer or Medi-Cal managed care plan that fails to pay any tax, except a tax determined as a deficiency assessment by the board under Article 3 (commencing with Section 12421) of Chapter 4, within the time required, shall pay a penalty of 10 percent of the amount of the tax in addition to the tax, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the tax until the date of payment.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 70. Section 12631 of the Revenue and Taxation Code, as amended by Section 65 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12631. (a) Any insurer that fails to pay any tax, except a tax determined as a deficiency assessment by the board under Article 3 (commencing with Section 12421) of Chapter 4, within the time required, shall pay a penalty of 10 percent of the amount of the tax in addition to the tax, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the tax until the date of payment.

(b) This section shall become operative on July 1, 2014.

SEC. 71. Section 12632 of the Revenue and Taxation Code, as amended by Section 66 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12632. (a) An insurer or Medi-Cal managed care plan that fails to pay any deficiency assessment when it becomes due and payable shall, in addition to the deficiency assessment, pay a penalty of 10 percent of the amount of the deficiency assessment, exclusive of interest and penalties. The amount of any deficiency assessment, exclusive of penalties, shall bear interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the date on which the amount, or any portion thereof, would have been payable if properly reported and assessed until the date of payment.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 72. Section 12632 of the Revenue and Taxation Code, as amended by Section 67 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12632. (a) An insurer that fails to pay any deficiency assessment when it becomes due and payable shall, in addition to the deficiency assessment, pay a penalty of 10 percent of the amount of the deficiency assessment, exclusive of interest and penalties. The amount of any deficiency assessment, exclusive of penalties, shall bear interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the date on which the amount, or any portion thereof, would have been payable if properly reported and assessed until the date of payment.

(b) This section shall become operative on July 1, 2014.

SEC. 73. Section 12636 of the Revenue and Taxation Code, as amended by Section 68 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12636. (a) If the board finds that an insurer's or Medi-Cal managed care plan's failure to make a timely return or payment is due to reasonable cause and to circumstances beyond the insurer's or Medi-Cal managed care plan's control, and which occurred despite the exercise of ordinary care and in the absence of willful neglect, the insurer or Medi-Cal managed care plan may be relieved of the penalty provided by Section 12258, 12282, 12287, 12631, 12632, or 12633.

(b) Any insurer or Medi-Cal managed care plan seeking to be relieved of the penalty shall file with the board a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 74. Section 12636 of the Revenue and Taxation Code, as amended by Section 69 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12636. (a) If the board finds that an insurer's failure to make a timely return or payment is due to reasonable cause and to circumstances beyond the insurer's control, and which occurred despite the exercise of ordinary care and in the absence of willful neglect, the insurer may be relieved of the penalty provided by Section 12258, 12282, 12287, 12631, 12632, or 12633.

(b) Any insurer seeking to be relieved of the penalty shall file with the board a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(c) This section shall become operative on July 1, 2014.

SEC. 75. Section 12636.5 of the Revenue and Taxation Code, as amended by Section 70 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12636.5. (a) Every payment on an insurer's, surplus line broker's, or Medi-Cal managed care plan's delinquent annual tax shall be applied as follows:

(1) First, to any interest due on the tax.

(2) Second, to any penalty imposed by this part.

(3) The balance, if any, to the tax itself.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 76. Section 12636.5 of the Revenue and Taxation Code, as amended by Section 71 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12636.5. (a) Every payment on an insurer's or surplus line broker's delinquent annual tax shall be applied as follows:

(1) First, to any interest due on the tax.

(2) Second, to any penalty imposed by this part.

(3) The balance, if any, to the tax itself.

(b) This section shall become operative on July 1, 2014.

SEC. 77. Section 12679 of the Revenue and Taxation Code, as amended by Section 72 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12679. (a) If an insurer's or Medi-Cal managed care plan's right to do business has been forfeited or its corporate powers suspended, service of summons may be made upon the persons designated by law to be served as agents or officers of the insurer or Medi-Cal managed care plan, and these persons are the agents of the insurer or Medi-Cal managed care plan for all purposes necessary in order to prosecute the action. In the case of corporations whose powers have been suspended, the persons constituting the board of directors may defend the action.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 78. Section 12679 of the Revenue and Taxation Code, as amended by Section 73 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12679. (a) If an insurer's right to do business has been forfeited or its corporate powers suspended, service of summons may be made upon the persons designated by law to be served as agents or officers of the insurer, and these persons are the agents of the insurer for all purposes necessary in order to prosecute the action. In the case of corporations whose powers have been suspended, the persons constituting the board of directors may defend the action.

(b) This section shall become operative on July 1, 2014.

SEC. 79. Section 12681 of the Revenue and Taxation Code, as amended by Section 74 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12681. (a) In the action, a certificate of the Controller or of the secretary of the board, showing unpaid taxes against an insurer or Medi-Cal managed care plan is prima facie evidence of:

(1) The assessment of the taxes.

(2) The delinquency.

(3) The amount of the taxes, interest, and penalties due and unpaid to the state.

(4) That the insurer or Medi-Cal managed care plan is indebted to the state in the amount of taxes, interest, and penalties appearing unpaid.

(5) That there has been compliance with all the requirements of law in relation to the assessment of the taxes.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 80. Section 12681 of the Revenue and Taxation Code, as amended by Section 75 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12681. (a) In the action, a certificate of the Controller or of the secretary of the board, showing unpaid taxes against an insurer is prima facie evidence of:

(1) The assessment of the taxes.

(2) The delinquency.

(3) The amount of the taxes, interest, and penalties due and unpaid to the state.

(4) That the insurer is indebted to the state in the amount of taxes, interest, and penalties appearing unpaid.

(5) That there has been compliance with all the requirements of law in relation to the assessment of the taxes.

(b) This section shall become operative on July 1, 2014.

SEC. 81. Section 12801 of the Revenue and Taxation Code, as amended by Section 76 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12801. (a) Annually, between December 10th and 15th, the Controller shall transmit to the commissioner a statement showing the names of all insurers and Medi-Cal managed care plans that failed to pay on or before December 10th the whole or any portion of the tax that became delinquent in the preceding June or which has been unpaid for more than 30 days from the date it became due and payable as a deficiency assessment under this part or the whole or any part of the interest or penalties due with respect to the tax. The statement shall show the amount of the tax, interest, and penalties due from each insurer or Medi-Cal managed care plan.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 82. Section 12801 of the Revenue and Taxation Code, as amended by Section 77 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12801. (a) Annually, between December 10th and 15th, the Controller shall transmit to the commissioner a statement showing the names of all insurers that failed to pay on or before December 10th the whole or any portion of the tax that became delinquent in the preceding June or which has been unpaid for more than 30 days from the date it became due and payable as a deficiency assessment under this part or the whole or any part of the interest or penalties due with respect to the tax. The statement shall show the amount of the tax, interest, and penalties due from each insurer.

(b) This section shall become operative on July 1, 2014.

SEC. 83. Section 12951 of the Revenue and Taxation Code, as amended by Section 78 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12951. (a) If any amount has been illegally assessed, the board shall set forth that fact in its records, certify the amount determined to be assessed in excess of the amount legally assessed and the insurer, surplus line broker, or Medi-Cal managed care plan against which the assessment was made, and authorize the cancellation of the amount upon the records of the Controller and the board. The board shall mail a notice to the insurer, surplus line broker, or Medi-Cal managed care plan of any cancellation authorized. Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 84. Section 12951 of the Revenue and Taxation Code, as amended by Section 79 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12951. (a) If any amount has been illegally assessed, the board shall set forth that fact in its records, certify the amount determined to be assessed in excess of the amount legally assessed and the insurer or surplus line broker against which the assessment was made, and authorize the cancellation of the amount upon the records of the Controller and the board. The board shall mail a notice to the insurer or surplus line broker of any cancellation authorized. Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

(b) This section shall become operative on July 1, 2014.

SEC. 85. Section 12977 of the Revenue and Taxation Code, as amended by Section 80 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12977. (a) If the board determines that any tax, interest, or penalty has been paid more than once or has been erroneously or illegally collected or computed, the board shall set forth that fact in its records of the board, certify the amount of the taxes, interest, or penalties collected in excess of what was legally due, and from whom they were collected or by whom paid, and certify the excess to the Controller for credit or refund.

(b) The Controller upon receipt of a certification for credit or refund shall credit the excess on any amounts then due and payable from the insurer, surplus line broker, or Medi-Cal managed care plan under this part and refund the balance.

(c) Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

(d) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 86. Section 12977 of the Revenue and Taxation Code, as amended by Section 81 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12977. (a) If the board determines that any tax, interest, or penalty has been paid more than once or has been erroneously or illegally collected or computed, the board shall set forth that fact in its records of the board, certify the amount of the taxes, interest, or penalties collected in excess of what was legally due, and from whom they were collected or by whom paid, and certify the excess to the Controller for credit or refund.

(b) The Controller upon receipt of a certification for credit or refund shall credit the excess on any amounts then due and payable from the insurer or surplus line broker under this part and refund the balance.

(c) Any proposed determination by the board pursuant to this section with respect to an amount in excess of fifty thousand dollars ($50,000) shall be available as a public record for at least 10 days prior to the effective date of that determination.

(d) This section shall become operative on July 1, 2014.

SEC. 87. Section 12983 of the Revenue and Taxation Code, as amended by Section 82 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12983. (a) Interest shall be allowed upon the amount of any overpayment of tax by an insurer or Medi-Cal managed care plan pursuant to this part at the modified adjusted rate per month established pursuant to Section 6591.5, from the first day of the monthly period following the period during which the overpayment was made. For purposes of this section, “monthly period” means the month commencing on the day after the due date of the payment through the same date as the due date in each successive month. In addition, a refund or credit shall be made of any interest imposed upon the claimant with respect to the amount being refunded or credited.

The interest shall be paid as follows:

(1) In the case of a refund, to the last day of the calendar month following the date upon which the claimant is notified in writing that a claim may be filed or the date upon which the claim is approved by the board, whichever date is the earlier.

(2) In the case of a credit, to the same date as that to which interest is computed on the tax or amount against which the credit is applied.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 88. Section 12983 of the Revenue and Taxation Code, as amended by Section 83 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12983. (a) Interest shall be allowed upon the amount of any overpayment of tax by an insurer pursuant to this part at the modified adjusted rate per month established pursuant to Section 6591.5, from the first day of the monthly period following the period during which the overpayment was made. For purposes of this section, "monthly period" means the month commencing on the day after the due date of the payment through the same date as the due date in each successive month. In addition, a refund or credit shall be made of any interest imposed upon the claimant with respect to the amount being refunded or credited.

The interest shall be paid as follows:

(1) In the case of a refund, to the last day of the calendar month following the date upon which the claimant is notified in writing that a claim may be filed or the date upon which the claim is approved by the board, whichever date is the earlier.

(2) In the case of a credit, to the same date as that to which interest is computed on the tax or amount against which the credit is applied.

(b) This section shall become operative on July 1, 2014.

SEC. 89. Section 12984 of the Revenue and Taxation Code, as amended by Section 84 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12984. (a) If the board determines that any overpayment has been made intentionally or made not incident to a bona fide and orderly discharge of a liability reasonably assumed by the insurer, surplus line broker, or Medi-Cal managed care plan to be imposed by law, no interest shall be allowed on the overpayment.

(b) If any insurer, surplus line broker, or Medi-Cal managed care plan which has filed a claim for refund requests the board to defer action on its claim, the board, as a condition to deferring action, may require the claimant to waive interest for the period during which the insurer, surplus line broker, or Medi-Cal managed care plan requests the board to defer action on the claim.

(c) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 90. Section 12984 of the Revenue and Taxation Code, as amended by Section 85 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

12984. (a) If the board determines that any overpayment has been made intentionally or made not incident to a bona fide and orderly discharge of a liability reasonably assumed by the insurer or surplus line broker to be imposed by law, no interest shall be allowed on the overpayment.

(b) If any insurer or surplus line broker which has filed a claim for refund requests the board to defer action on its claim, the board, as a condition to deferring action, may require the claimant to waive interest for the period during which the insurer or surplus line broker requests the board to defer action on the claim.

(c) This section shall become operative on July 1, 2014.

SEC. 91. Section 13108 of the Revenue and Taxation Code, as amended by Section 86 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

13108. (a) A judgment shall not be rendered in favor of the plaintiff when the action is brought by or in the name of an assignee of the insurer paying the tax, interest, or penalties, or by any person other than the insurer or Medi-Cal managed care plan that has paid the tax, interest, or penalties.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute,

that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 92. Section 13108 of the Revenue and Taxation Code, as amended by Section 87 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is amended to read:

13108. (a) A judgment shall not be rendered in favor of the plaintiff when the action is brought by or in the name of an assignee of the insurer paying the tax, interest, or penalties, or by any person other than the insurer that has paid the tax, interest, or penalties.

(b) This section shall become operative on July 1, 2014.

SEC. 93. Section 14126.022 of the Welfare and Institutions Code is amended to read:

14126.022. (a) (1) By August 1, 2011, the department shall develop the Skilled Nursing Facility Quality and Accountability Supplemental Payment System, subject to approval by the federal Centers for Medicare and Medicaid Services, and the availability of federal, state, or other funds.

(2) (A) The system shall be utilized to provide supplemental payments to skilled nursing facilities that improve the quality and accountability of care rendered to residents in skilled nursing facilities, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, and to penalize those facilities that do not meet measurable standards.

(B) A freestanding pediatric subacute care facility, as defined in Section 51215.8 of Title 22 of the California Code of Regulations, shall be exempt from the Skilled Nursing Facility Quality and Accountability Supplemental Payment System.

(3) The system shall be phased in, beginning with the 2010–11 rate year.

(4) The department may utilize the system to do all of the following:

(A) Assess overall facility quality of care and quality of care improvement, and assign quality and accountability payments to skilled nursing facilities pursuant to performance measures described in subdivision (i).

(B) Assign quality and accountability payments or penalties relating to quality of care, or direct care staffing levels, wages, and benefits, or both.

(C) Limit the reimbursement of legal fees incurred by skilled nursing facilities engaged in the defense of governmental legal actions filed against the facilities.

(D) Publish each facility's quality assessment and quality and accountability payments in a manner and form determined by the director, or his or her designee.

(E) Beginning with the 2011–12 fiscal year, establish a base year to collect performance measures described in subdivision (i).

(F) Beginning with the 2011–12 fiscal year, in coordination with the State Department of Public Health, publish the direct care staffing level data and the performance measures required pursuant to subdivision (i).

(b) (1) There is hereby created in the State Treasury, the Skilled Nursing Facility Quality and Accountability Special Fund. The fund shall contain moneys deposited pursuant to subdivisions (g) and (j) to (*l*), inclusive. Notwithstanding Section 16305.7 of the Government Code, the fund shall contain all interest and dividends earned on moneys in the fund.

(2) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated without regard to fiscal year to the department for making quality and accountability payments, in accordance with subdivision (m), to facilities that meet or exceed predefined measures as established by this section.

(3) Upon appropriation by the Legislature, moneys in the fund may also be used for any of the following purposes:

(A) To cover the administrative costs incurred by the State Department of Public Health for positions and contract funding required to implement this section.

(B) To cover the administrative costs incurred by the State Department of Health Care Services for positions and contract funding required to implement this section.

(C) To provide funding assistance for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(c) No appropriation associated with this bill is intended to implement the provisions of Section 1276.65 of the Health and Safety Code.

(d) (1) There is hereby appropriated for the 2010–11 fiscal year, one million nine hundred thousand dollars ($1,900,000) from the Skilled Nursing Facility Quality and Accountability Special Fund to the California Department of Aging for the Long-Term Care Ombudsman Program activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5. It is the intent of the Legislature for the one million nine hundred thousand dollars ($1,900,000) from the fund to be in addition to the four million one hundred sixty-eight thousand dollars ($4,168,000) proposed in the Governor's May Revision for the 2010–11 Budget. It is further the intent of the Legislature to increase this level of appropriation in subsequent years to provide support sufficient to carry out the mandates and activities pursuant to Chapter 11 (commencing with Section 9700) of Division 8.5.

(2) The department, in partnership with the California Department of Aging, shall seek approval from the federal Centers for Medicare and Medicaid Services to obtain federal Medicaid reimbursement for activities conducted by the Long-Term Care Ombudsman Program. The department shall report to the fiscal committees of the Legislature during budget hearings on progress being made and any unresolved issues during the 2011–12 budget deliberations.

(e) There is hereby created in the Special Deposit Fund established pursuant to Section 16370 of the Government Code, the Skilled Nursing Facility Minimum Staffing Penalty Account. The account shall contain all moneys deposited pursuant to subdivision (f).

(f) (1) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall use the direct care staffing level data it collects to determine whether a skilled nursing facility has met the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

(2) (A) Beginning with the 2010–11 fiscal year, the State Department of Public Health shall assess a skilled nursing facility, licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, an administrative penalty if the State Department of Public Health determines that the skilled nursing facility fails to meet the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code as follows:

(i) Fifteen thousand dollars ($15,000) if the facility fails to meet the requirements for 5 percent or more of the audited days up to 49 percent.

(ii) Thirty thousand dollars ($30,000) if the facility fails to meet the requirements for over 49 percent or more of the audited days.

(B) (i) If the skilled nursing facility does not dispute the determination or assessment, the penalties shall be paid in full by the licensee to the State Department of Public Health within 30 days of the facility's receipt of the notice of penalty and deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(ii) The State Department of Public Health may, upon written notification to the licensee, request that the department offset any moneys owed to the licensee by the Medi-Cal program or any other payment program administered by the department to recoup the penalty provided for in this section.

(C) (i) If a facility disputes the determination or assessment made pursuant to this paragraph, the facility shall, within 15 days of the facility's receipt of the determination and assessment, simultaneously submit a request for appeal to both the department and the State Department of Public Health. The request shall include a detailed statement describing the reason for appeal and include all supporting documents the facility will present at the hearing.

(ii) Within 10 days of the State Department of Public Health's receipt of the facility's request for appeal, the State Department of Public Health shall submit, to both the facility and the department, all supporting documents that will be presented at the hearing.

(D) The department shall hear a timely appeal and issue a decision as follows:

(i) The hearing shall commence within 60 days from the date of receipt by the department of the facility's timely request for appeal.

(ii) The department shall issue a decision within 120 days from the date of receipt by the department of the facility's timely request for appeal.

(iii) The decision of the department's hearing officer, when issued, shall be the final decision of the State Department of Public Health.

(E) The appeals process set forth in this paragraph shall be exempt from Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500), of Part 1 of Division

3 of Title 2 of the Government Code. The provisions of Section 100171 and 131071 of the Health and Safety Code shall not apply to appeals under this paragraph.

(F) If a hearing decision issued pursuant to subparagraph (D) is in favor of the State Department of Public Health, the skilled nursing facility shall pay the penalties to the State Department of Public Health within 30 days of the facility's receipt of the decision. The penalties collected shall be deposited into the Skilled Nursing Facility Minimum Staffing Penalty Account.

(G) The assessment of a penalty under this subdivision does not supplant the State Department of Public Health's investigation process or issuance of deficiencies or citations under Chapter 2.4 (commencing with Section 1417) of Division 2 of the Health and Safety Code.

(g) The State Department of Public Health shall transfer, on a monthly basis, all penalty payments collected pursuant to subdivision (f) into the Skilled Nursing Facility Quality and Accountability Special Fund.

(h) Nothing in this section shall impact the effectiveness or utilization of Section 1278.5 or 1432 of the Health and Safety Code relating to whistleblower protections, or Section 1420 of the Health and Safety Code relating to complaints.

(i) (1) Beginning in the 2010–11 fiscal year, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, shall establish and publish quality and accountability measures, benchmarks, and data submission deadlines by November 30, 2010.

(2) The methodology developed pursuant to this section shall include, but not be limited to, the following requirements and performance measures:

(A) Beginning in the 2011–12 fiscal year:

(i) Immunization rates.

(ii) Facility acquired pressure ulcer incidence.

(iii) The use of physical restraints.

(iv) Compliance with the nursing hours per patient per day requirements pursuant to Section 1276.5 of the Health and Safety Code.

(v) Resident and family satisfaction.

(vi) Direct care staff retention, if sufficient data is available.

(B) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, the department, in consultation with representatives from the long-term care industry, organized labor, and consumers, beginning in the 2013–14 rate year, shall incorporate additional measures into the system, including, but not limited to, quality and accountability measures required by federal health care reform that are identified by the federal Centers for Medicare and Medicaid Services.

(C) The department, in consultation with representatives from the long-term care industry, organized labor, and consumers, may incorporate additional performance measures, including, but not limited to, the following:

(i) Compliance with state policy associated with the United States Supreme Court decision in Olmstead v. L.C. ex rel. Zimring (1999) 527 U.S. 581.

(ii) Direct care staff retention, if not addressed in the 2012–13 rate year.

(iii) The use of chemical restraints.

(j) (1) Beginning with the 2010–11 rate year, and pursuant to subparagraph (B) of paragraph (5) of subdivision (a) of Section 14126.023, the department shall set aside savings achieved from setting the professional liability insurance cost category, including any insurance deductible costs paid by the facility, at the 75th percentile. From this amount, the department shall transfer the General Fund portion into the Skilled Nursing Facility Quality and Accountability Special Fund. A skilled nursing facility shall provide supplemental data on insurance deductible costs to facilitate this adjustment, in the format and by the deadlines determined by the department. If this data is not provided, a facility's insurance deductible costs will remain in the administrative costs category.

(2) Notwithstanding paragraph (1), for the 2012–13 rate year only, savings from capping the professional liability insurance cost category pursuant to paragraph (1) shall remain in the General Fund and shall not be transferred to the Skilled Nursing Facility Quality and Accountability Special Fund.

(k) Beginning with the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside the first 1 percent of the weighted average Medi-Cal reimbursement rate increase for the Skilled Nursing Facility Quality and Accountability Special Fund.

(*l*) If this act is extended beyond the dates on which it becomes inoperative and is repealed, in accordance with Section 14126.033, beginning with the 2014–15 rate year, in addition to the amount set aside pursuant to subdivision (k), if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the General Fund portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(m) (1) (A) Beginning with the 2013–14 rate year, the department shall pay a supplemental payment, by April 30, 2014, to skilled nursing facilities based on all of the criteria in subdivision (i), as published by the department, and according to performance measure benchmarks determined by the department in consultation with stakeholders.

(B) (i) The department may convene a diverse stakeholder group, including, but not limited to, representatives from consumer groups and organizations, labor, nursing home providers, advocacy organizations involved with the aging community, staff from the Legislature, and other interested parties, to discuss and analyze alternative mechanisms to implement the quality and accountability payments provided to nursing homes for reimbursement.

(ii) The department shall articulate in a report to the fiscal and appropriate policy committees of the Legislature the implementation of an alternative mechanism as described in clause (i) at least 90 days prior to any policy or budgetary changes, and seek subsequent legislation in order to enact the proposed changes.

(2) Skilled nursing facilities that do not submit required performance data by the department's specified data submission deadlines pursuant to subdivision (i) shall not be eligible to receive supplemental payments.

(3) Notwithstanding paragraph (1), if a facility appeals the performance measure of compliance with the nursing hours per patient per day requirements, pursuant to Section 1276.5 of the Health and Safety Code, to the State Department of Public Health, and it is unresolved by the department's published due date, the

department shall not use that performance measure when determining the facility's supplemental payment.

(4) Notwithstanding paragraph (1), if the department is unable to pay the supplemental payments by April 30, 2014, then on May 1, 2014, the department shall use the funds available in the Skilled Nursing Facility Quality and Accountability Special Fund as a result of savings identified in subdivisions (k) and (*l*), less the administrative costs required to implement subparagraphs (A) and (B) of paragraph (3) of subdivision (b), in addition to any Medicaid funds that are available as of December 31, 2013, to increase provider rates retroactively to August 1, 2013.

(n) The department shall seek necessary approvals from the federal Centers for Medicare and Medicaid Services to implement this section. The department shall implement this section only in a manner that is consistent with federal Medicaid law and regulations, and only to the extent that approval is obtained from the federal Centers for Medicare and Medicaid Services and federal financial participation is available.

(o) In implementing this section, the department and the State Department of Public Health may contract as necessary, with California's Medicare Quality Improvement Organization, or other entities deemed qualified by the department or the State Department of Public Health, not associated with a skilled nursing facility, to assist with development, collection, analysis, and reporting of the performance data pursuant to subdivision (i), and with demonstrated expertise in long-term care quality, data collection or analysis, and accountability performance measurement models pursuant to subdivision (i). This subdivision establishes an accelerated process for issuing any contract pursuant to this section. Any contract entered into pursuant to this subdivision shall be exempt from the requirements of the Public Contract Code, through December 31, 2013.

(p) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the following shall apply:

(1) The director shall implement this section, in whole or in part, by means of provider bulletins, or other similar instructions without taking regulatory action.

(2) The State Public Health Officer may implement this section by means of all facility letters, or other similar instructions without taking regulatory action.

(q) Notwithstanding paragraph (1) of subdivision (m), if a final judicial determination is made by any state or federal court that is not appealed, in any action by any party, or a final determination is made by the administrator of the federal Centers for Medicare and Medicaid Services, that any payments pursuant to subdivisions (a) and (m), are invalid, unlawful, or contrary to any provision of federal law or regulations, or of state law, these subdivisions shall become inoperative, and for the 2011–12 rate year, the rate increase provided under subparagraph (A) of paragraph (4) of subdivision (c) of Section 14126.033 shall be reduced by the amounts described in subdivision (j). For the 2013–14 rate year, and for each subsequent rate year, any rate increase shall be reduced by the amounts described in subdivisions (j) to (*l*), inclusive.

SEC. 94. Section 14126.027 of the Welfare and Institutions Code is amended to read:

14126.027. (a) (1) The Director of Health Care Services, or his or her designee, shall administer this article.

(2) The regulations and other similar instructions adopted pursuant to this article shall be developed in consultation with representatives of the long-term care industry, organized labor, seniors, and consumers.

(b) (1) The director may adopt regulations as are necessary to implement this article. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action.

(2) The regulations adopted pursuant to this section may include, but need not be limited to, any regulations necessary for any of the following purposes:

(A) The administration of this article, including the specific analytical process for the proper determination of long-term care rates.

(B) The development of any forms necessary to obtain required cost data and other information from facilities subject to the ratesetting methodology.

(C) To provide details, definitions, formulas, and other requirements.

(c) As an alternative to the adoption of regulations pursuant to subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article, in whole or in part, by means of a provider bulletin or other similar instructions, without taking regulatory action, provided that no such bulletin or other similar instructions shall remain in effect after July 31, 2015. It is the intent of the Legislature that regulations adopted pursuant to subdivision (b) shall be in place on or before July 31, 2015.

SEC. 95. Section 14126.028 is added to the ~~Health~~ *Welfare* and ~~Safety~~ *Institutions* Code, to read:

14126.028. (a) The Legislature finds and declares both of the following:

(1) Section Q of the Minimum Data Set, Version 3.0, developed as part of the federal government's nursing home quality initiative, uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and have the opportunity to receive long-term care services in the least restrictive setting possible.

(2) More community care services and support options and choices are now available to meet the care preferences and needs in the least restrictive setting possible.

(b) Nursing facilities shall either meet the residents' discharge planning and referral needs, or make referrals to a designated local contact agency (LCA) as determined by the State Department of Health Care Services. The LCA is responsible for contacting referred residents, and for providing information and counseling on available home- and community-based services. The LCA shall also either assist directly with transition services or make referrals to organizations that assist with transition services, as appropriate.

(c) It is the intent of the Legislature to ensure that nursing home residents who, during the Minimum Data Set, Version 3.0, Section Q assessment, express interest in the possibility of receiving care and services in the community are appropriately referred by nursing facilities to the LCA, as appropriate.

(d) The State Department of Health Care Services, in collaboration with the State Department of Public Health, shall, by April 1, 2013, provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Version 3.0, Section Q and nursing facilities referrals made to the LCA. This analysis shall also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

(e) The State Department of Public Health and the State Department of Health Care Services shall regularly, and at least quarterly, meet with representatives from the long-term care industry, organized labor, consumers, and consumer advocates to provide updates and receive input on the planning for, implementation of, and progress of the skilled nursing facility quality improvement program. To facilitate decisionmaking, the State Department of Public Health and the State Department of Health Care Services shall promptly convene this workgroup and provide ongoing guidance to reach tangible outcomes for implementation by no later than January 2013.

SEC. 96. Section 14126.033 of the Welfare and Institutions Code is amended to read:

14126.033. (a) The Legislature finds and declares all of the following:

(1) Costs within the Medi-Cal program continue to grow due to the rising cost of providing health care throughout the state and also due to increases in enrollment, which are more pronounced during difficult economic times.

(2) In order to minimize the need for drastically cutting enrollment standards or benefits during times of economic crisis, it is crucial to find areas within the program where reimbursement levels are higher than required under the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and can be reduced in accordance with federal law.

(3) The Medi-Cal program delivers its services and benefits to Medi-Cal beneficiaries through a wide variety of health care providers, some of which deliver care via managed care or other contract models while others do so through fee-for-service arrangements.

(4) The setting of rates within the Medi-Cal program is complex and is subject to close supervision by the United States Department of Health and Human Services.

(5) As the single state agency for Medicaid in California, the State Department of Health Care Services has unique expertise that can inform decisions that set or adjust reimbursement methodologies and levels consistent with the requirements of federal law.

(b) Therefore, it is the intent of the Legislature for the department to analyze and identify where reimbursement levels can be reduced consistent with the standard provided in Section 1902(a)(30)(A) of the federal Social Security Act and also consistent with federal and state law and policies, including any exemptions contained in the act that added this section, provided that the reductions in reimbursement shall not exceed 10 percent on an aggregate basis for all providers, services, and products.

(c) This article, including Section 14126.031, shall be funded as follows:

(1) General Fund moneys appropriated for purposes of this article pursuant to Section 6 of the act adding this section shall be used for increasing rates, except as provided in Section 14126.031, for freestanding skilled nursing facilities, and shall be consistent with the approved methodology required to be submitted to the federal Centers for Medicare and Medicaid Services pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(2) (A) Notwithstanding Section 14126.023, for the 2005–06 rate year, the maximum annual increase in the weighted average Medi-Cal rate required for purposes of this article shall not exceed 8 percent of the weighted average Medi-Cal reimbursement rate for the 2004–05 rate year as adjusted for the change in the cost to the facility to comply with the nursing facility quality assurance fee for the 2005–06 rate year, as required under subdivision (b) of Section 1324.21 of the Health and Safety Code, plus the total projected Medi-Cal cost to the facility of complying with new state or federal mandates.

(B) Beginning with the 2006–07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(C) Beginning with the 2007–08 rate year and continuing through the 2008–09 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not exceed 5.5 percent of the weighted average Medi-Cal reimbursement rate for the prior fiscal year, as adjusted for the projected cost of complying with new state or federal mandates.

(D) For the 2009–10 rate year, the weighted average Medi-Cal reimbursement rate required for purposes of this article shall not be increased with respect to the weighted average Medi-Cal reimbursement rate for the 2008–09 rate year, as adjusted for the projected cost of complying with new state or federal mandates.

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) is extended for the entire 2010–11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of this article shall not exceed 3.93 percent, or 3.14 percent, if the increase in the FMAP pursuant to ARRA is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the increase in the FMAP pursuant to ARRA is extended at a different rate, or for a different time period, the rate adjustment for facilities shall be adjusted accordingly.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2010–11 weighted average Medi-Cal reimbursement rate increase.

(C) If the maximum annual increase in the weighted average Medi-Cal rate is reduced pursuant to subparagraph (B), the department shall recalculate and publish the final maximum annual increase in the weighted average Medi-Cal reimbursement rate.

(4) (A) Subject to the following provisions, for the 2011–12 rate year, the increase in the Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall not exceed 2.4 percent of the rate on file that was applicable on May 31, 2011, plus the projected cost of complying with new state or federal mandates. The percentage increase shall be applied equally to each rate on file as of May 31, 2011.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2011–12 weighted average Medi-Cal reimbursement rate increase.

(C) The department may recalculate and publish the weighted average Medi-Cal reimbursement rate increase for the 2011–12 rate year if the difference in the projected quality assurance fee collections from the 2011–12 rate year, compared to the projected quality assurance fee collections for the 2010–11 rate year, would result in any additional General Fund expense to pay for the 2011–12 rate year weighted average reimbursement rate increase.

(5) To the extent that rates are projected to exceed the adjusted limits calculated pursuant to subparagraphs (A) to (D), inclusive, of paragraph (2) and, as applicable, paragraphs (3) and (4), the department shall adjust each skilled nursing facility's projected rate for the applicable rate year by an equal percentage.

(6) (A) (i) Notwithstanding any other provision of law, and except as provided in subparagraph (B), payments resulting from the application of paragraphs (3) and (4), the provisions of paragraph (5), and all other applicable adjustments and limits as required by this section, shall be reduced by 10 percent for dates of service on and after June 1, 2011, through July 31, 2012. This

is a one-time reduction evenly distributed across all facilities to ensure long-term stability of nursing homes serving the Medi-Cal population.

(ii) Notwithstanding any other provision of law, the director may adjust the percentage reductions specified in clause (i), as long as the resulting reductions, in the aggregate, total no more than 10 percent.

(iii) The adjustments authorized under this subparagraph shall be implemented only if the director determines that the payments resulting from the adjustments comply with paragraph (7).

(B) Payments to facilities owned or operated by the state shall be exempt from the payment reduction required by this paragraph.

(7) (A) Notwithstanding any other provision of this section, the payment reductions and adjustments required by paragraph (6) shall be implemented only if the director determines that the payments that result from the application of paragraph (6) will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(B) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the payments do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

(8) For managed care health plans that contract with the department pursuant to this chapter and Chapter 8 (commencing with Section 14200), except for contracts with the Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that these services are provided through any of those contracts, payments shall be reduced by the actuarial equivalent amount of the reduced provider reimbursements specified in paragraph (6) pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(9) (A) For the 2012–13 rate year, all of the following shall apply:

(i) The department shall determine the amounts of reduced payments for each skilled nursing facility, as defined in subdivision (c) of Section 1250 of the Health and Safety Code, resulting from the 10-percent reduction imposed pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, through July 31, 2012.

(ii) For claims adjudicated through October 1, 2012, each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code that is reimbursed under the Medi-Cal fee-for-service program, shall receive the total payments calculated by the department in clause (i), not later than December 31, 2012.

(iii) For managed care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, and to the extent that skilled nursing services are provided through any of those contracts, payments shall be adjusted by the actuarial equivalent amount of the reimbursements calculated in clause (i) pursuant to contract amendments or change orders effective on July 1, 2012, or thereafter.

(B) Notwithstanding subparagraph (A), beginning on August 1, 2012, through July 31, 2013, the department shall pay the facility specific Medi-Cal reimbursement rate that was on file and applicable to the specific skilled nursing facility on August 1, 2011, prior to and excluding any rate reduction implemented pursuant to clause (i) of subparagraph (A) of paragraph (6) for the period beginning on June 1, 2011, to July 31, 2012, inclusive, and adjusted for the projected costs of complying with new state or federal mandates. These rates are deemed to be sufficient to meet operating expenses.

(C) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (B) shall be adjusted by the department if the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the skilled nursing quality assurance fee pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code.

(D) Notwithstanding any other provision of law, beginning on January 1, 2013, Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code, which imposes a skilled nursing facility quality assurance fee, shall not be enforceable against any skilled nursing facility unless each skilled nursing facility is paid the rate provided for in subparagraphs (A) and (B). Any amount collected during the 2012–13 rate year by the department pursuant to Article 7.6 (commencing with Section 1324.20) of Chapter 2 of Division 2 of the Health and Safety Code shall be refunded to each facility not later than February 1, 2013.

(E) The provisions of this paragraph shall also be included as part of a state plan amendment implementing the 2011–12 and 2012–13 Medi-Cal reimbursement rates authorized under this article.

(10) (A) Subject to the following provisions, for the 2013–14 and 2014–15 rate years, the annual increase in the weighted average Medi-Cal reimbursement rate for the purpose of this article, for each skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code, shall be 3 percent for each rate year, respectively, plus the projected cost of complying with new state or federal mandates.

(B) (i) For the 2013–14 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside 1 percent of the increase in the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the nonfederal portion into the Skilled Nursing Facility Quality and Accountability Special Fund, to be used for the supplemental rate pool.

(ii) For the 2014–15 rate year, if there is a rate increase in the weighted average Medi-Cal reimbursement rate, the department shall set aside at least one-third of the weighted average Medi-Cal reimbursement rate increase, up to a maximum of 1 percent, from which the department shall transfer the nonfederal portion of this amount into the Skilled Nursing Facility Quality and Accountability Special Fund.

(C) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(11) The director shall seek any necessary federal approvals for the implementation of this section. This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of paragraph (6) shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

(d) The rate methodology shall cease to be implemented after July 31, 2015.

(e) (1) It is the intent of the Legislature that the implementation of this article result in individual access to appropriate long-term care services, quality resident care, decent wages and benefits for nursing home workers, a stable workforce, provider compliance with all applicable state and federal requirements, and administrative efficiency.

(2) Not later than December 1, 2006, the Bureau of State Audits shall conduct an accountability evaluation of the department's progress toward implementing a facility-specific reimbursement system, including a review of data to ensure that the new system is appropriately reimbursing facilities within specified cost categories and a review of the fiscal impact of the new system on the General Fund.

(3) Not later than January 1, 2007, to the extent information is available for the three years immediately preceding the implementation of this article, the department shall provide baseline information in a report to the Legislature on all of the following:

(A) The number and percent of freestanding skilled nursing facilities that complied with minimum staffing requirements.

(B) The staffing levels prior to the implementation of this article.

(C) The staffing retention rates prior to the implementation of this article.

(D) The numbers and percentage of freestanding skilled nursing facilities with findings of immediate jeopardy, substandard quality of care, or actual harm, as determined by the certification survey of each freestanding skilled nursing facility conducted prior to the implementation of this article.

(E) The number of freestanding skilled nursing facilities that received state citations and the number and class of citations issued during calendar year 2004.

(F) The average wage and benefits for employees prior to the implementation of this article.

(4) Not later than January 1, 2009, the department shall provide a report to the Legislature that does both of the following:

(A) Compares the information required in paragraph (2) to that same information two years after the implementation of this article.

(B) Reports on the extent to which residents who had expressed a preference to return to the community, as provided in Section 1418.81 of the Health and Safety Code, were able to return to the community.

(5) The department may contract for the reports required under this subdivision.

SEC. 97. Section 14126.036 of the Welfare and Institutions Code is amended to read:

14126.036. This article shall become inoperative on August 1, 2015, and as of January 1, 2016, is repealed, unless a later enacted statute that is enacted before January 1, 2016, deletes or extends that date.

SEC. 98. Section 14301.11 of the Welfare and Institutions Code is amended to read:

14301.11. (a) The department shall use funds attributable to the tax on Medi-Cal managed care plans imposed by Section 12201 of the Revenue and Taxation Code for the purpose specified in paragraph (1) of subdivision (b) of Section 12201 of the Revenue and Taxation Code.

(b) This section shall become inoperative on July 1, 2014, and, as of January 1, 2015, is repealed, unless a later enacted statute, that becomes operative on or before July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 99. Section 92 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, is repealed.

SEC. 100. Notwithstanding Section 92 of Chapter 11 of the First Extraordinary Session of the Statutes of 2011, the provisions of Chapter 11 of the First Extraordinary Session of the Statutes of

2011 shall not become inoperative upon the amendment or repeal of those provisions made by this act.

SEC. 101. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 102. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make statutory changes necessary for implementation of the Budget Act of 2012, it is necessary that this act take effect immediately.

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