2004

Emergency Medical Services. Funding. Telephone Surcharge.

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### PROP 67

**Emergency Medical Services. Funding.**

**Telephone Surcharge. Initiative Constitutional Amendment and Statute.**

**Summary**

Increases telephone surcharge and allocates other funds for emergency room physicians, hospital emergency rooms, community clinics, emergency personnel training/equipment, and 911 telephone system. Fiscal Impact: Increased state revenues of about $500 million annually to reimburse physicians and hospitals for uncompensated emergency medical services and other specified purposes. Continues $32 million in state funding for physicians and clinics for uncompensated medical care.

**What Your Vote Means**

**Yes**

A **YES** vote on this measure means: The state would impose a 3 percent emergency telephone surcharge, in addition to the existing surcharge, on bills for telephone services for calls made within the state. These revenues would be used to provide additional funds to reimburse physicians and hospitals for uncompensated emergency and trauma care and to fund other specified programs.

**Con**

Prop. 67 is a $540 million phone tax—a tax on talking. There's no cap on cell phone or business phone taxes. More than 1 million seniors will be affected. 90% of the money goes to large health care corporations and special interests—with no mandatory audits or financial controls.

**Arguments**

**For**

 FIREFIGHTERS, PARAMEDICS, DOCTORS, AND NURSES SAY: PROP. 67 will make sure emergency medical care is available when you and your family need it most. Emergency rooms are closing. Others are severely overcrowded. Paramedics, emergency room doctors, and nurses are overwhelmed. SAVE EMERGENCY CARE. SAVE LIVES. YES ON PROP. 67.

**Against**

No on 67—Californians to Stop the Phone Tax 916-930-0688 www.stophethphonetax.com

**For Additional Information**

Coalition to Preserve Emergency Care, sponsored by firefighters, paramedics, doctors, nurses, and healthcare providers—Yes on 67 191 Ridgeway Avenue Oakland, CA 94611 650-364-8495 info@saveemergencycare.org www.saveemergencycare.org

### PROP 68

**Non-Tribal Commercial Gambling Expansion.**

**Tribal Gaming Compact Amendments.**

**Revenues, Tax Exemptions. Initiative Constitutional Amendment and Statute.**

**Summary**

Authorizes tribal compact amendments. Unless tribes accept, authorizes casino gaming for sixteen non-tribal establishments. Percentage of gaming revenues fund government services. Fiscal Impact: Increased gambling revenues—potentially over $1 billion annually—primarily to local governments for additional specified services. Depending on outcome of tribal negotiations, potential loss of state revenues totaling hundreds of millions of dollars annually.

**What Your Vote Means**

**Yes**

A **YES** vote on this measure means: Slot machines would be authorized at 16 specific racetracks and card rooms, unless all Indian tribes with existing tribal-state gambling compacts agree to certain terms within 90 days. Under either scenario, local governments throughout the state would receive new gambling revenues, to be used primarily for additional child protective, police, and firefighting services.

**Con**

Beware: Their “fair share” claim is a scam. 68 lets its FUNDERS—RACETRACKS and CARD CLUBS—operate LAS VEGAS-SIZED CASINOS throughout California—NEAR FREEWAYS and 200 SCHOOLS. MORE TRAFFIC. MORE CRIME. ANOTHER BROKEN PROMISE TO INDIANS. Governor Schwarzenegger, firefighters, sheriffs, police, tribes, taxpayers, labor, educators say: “NO on 68!”

**Arguments**

**For**

Sheriff Lee Baca and Sheriff Lou Blanas A Fair Share for California 1717 1 Street Sacramento, CA 95814 916-551-2538 info@fairsareforcalifornia.org www.fairshareforcalifornia.org

**Against**

No on 68: Californians Against the Deceptive Gambling Proposition 11300 W. Olympic Blvd., Suite 840 Los Angeles, CA 90064 800-420-8202 info@stop68.com www.Stop68.com

**For Additional Information**

Sheriff Lee Baca and Sheriff Lou Blanas A Fair Share for California 1717 1 Street Sacramento, CA 95814 916-551-2538 info@fairsareforcalifornia.org www.fairshareforcalifornia.org

**Against**

No on 68: Californians Against the Deceptive Gambling Proposition 11300 W. Olympic Blvd., Suite 840 Los Angeles, CA 90064 800-420-8202 info@stop68.com www.Stop68.com

- Provides funding to physicians for uncompensated emergency care, hospitals for emergency services, community clinics for uncompensated care, emergency personnel training/equipment, and emergency telephone system improvements.
- Funded by addition of 3% to existing surcharge rate on telephone use within California, portions of tobacco taxes, and criminal and traffic penalties.
- Limits surcharge collected by residential telephone service providers to 50 cents per month. Monthly cap does not apply to cell phones or business lines.
- Excludes funding from government appropriations limitations, and telephone surcharge from Proposition 98’s school spending requirements.

Summary of Legislative Analyst’s Estimate of Net State and Local Government Fiscal Impact:
- Increased state revenues of about $500 million annually from an increased surcharge on telephone bills that would be used (1) to reimburse physicians and hospitals for uncompensated emergency medical care and (2) for other specified purposes. This amount would probably grow in future years.
- Continued funding of about $32 million annually in Proposition 99 tobacco tax funds to reimburse physicians and community clinics for uncompensated medical services.

ANALYSIS BY THE LEGISLATIVE ANALYST

BACKGROUND

Emergency Telephone Number Surcharge

Currently, telephone service customers in California pay a monthly surcharge that supports the state’s 911 emergency telephone number system. Under current law, the surcharge rate can be set up to 0.75 percent of a customer’s monthly bill for telephone services for calls made within the state. The surcharge applies to each separate telephone bill a customer may receive. The state has currently set the surcharge rate at 0.72 percent.

Revenues from the surcharge are deposited into the State Emergency Telephone Number Account (911 Account), which is available for expenditure upon appropriation by the Legislature. The revenues are used to reimburse government agencies and telephone companies for equipment and related costs associated with California’s 911 emergency telephone number system. Due to an increase in the number of cellular phone accounts, the 911 Account has maintained a reserve that has ranged from $15 million to $80 million in recent years. The revenue received from the surcharge in 2002–03 was $139 million. The Department of General Services and the Board of Equalization are responsible for administering the 911 Account.

Proposition 99

The Tobacco Tax and Health Protection Act (Proposition 99, enacted by the voters in 1988) assessed a $0.25 per pack tax on cigarette products that is allocated for specified purposes. In 2004–05, the state is projected to receive approximately $334 million in Proposition 99 revenues. Because the number of tobacco users is declining, this funding source has and will likely continue to decrease. Currently, the state utilizes Proposition 99 funding for a number of health-related purposes, including tobacco education and prevention efforts, tobacco-related disease research,
environmental protection and recreational resource programs, and health care services for low-income uninsured persons.

**Uncompensated Emergency Medical Care**

Under state and federal law, any person seeking emergency medical care must be provided that care regardless of his or her ability to pay. As a result, hospitals and physicians who provide emergency and trauma care are often not fully compensated for the care they provide. The amount spent today by physicians and hospitals on uncompensated emergency medical care is not known. Physicians and hospitals reported that, in 2000–01, their cost for this care was approximately $540 million. However, this estimate may be low because physicians and hospitals may have underreported the cost of the care that they provided.

Some of the cost of this uncompensated care is partly paid from various state and county government sources. For example, the state currently budgets about $32 million in Proposition 99 funds to help pay for uncompensated medical care provided by physicians and community clinics.

Also, under existing law, each county is allowed to establish a Maddy Emergency Medical Services Fund (Maddy Fund) made up of specified revenues from criminal fines and penalties. Counties may use up to 10 percent of these revenues for the cost of administering the fund. After these costs have been deducted, 58 percent of the remaining funds are to be used to reimburse physicians for uncompensated emergency and trauma care, 25 percent to reimburse hospitals for such care, and 17 percent for other emergency medical services such as regional poison control centers.

Even with these funds, hospitals and physicians generally are not compensated for all of the emergency and trauma care that they provide.

**PROPOSAL**

**New State Revenues**

This measure increases funding for the reimbursement of physicians and hospitals for uncompensated emergency medical care and other purposes. It does this by imposing an additional 3 percent emergency telephone surcharge, in addition to the existing surcharge, on bills for telephone services for calls made within the state. Long-distance services for calls to areas outside of California would not be affected by this measure. The surcharge paid by residential customers would generally be limited to 50 cents per month for each telephone bill they receive. The surcharge would not be imposed on low-income residential customers eligible for lifeline telephone services. However, the 50 cents per month limit would not apply for cellular telephone services or for commercial telephone lines. Revenues from the increased surcharge would be deposited into a new 911 Emergency and Trauma Care Fund established by the measure. Certain state agencies specified in the measure would be able to expend the funds without appropriation by the Legislature.

**Existing State and Local Funds**

In addition to providing the new revenues, this measure would affect the distribution of certain existing state and local funds for uncompensated medical care.

First, the proposition requires each county to establish a Maddy Fund and transfers a portion of fund revenues to the state for the reimbursement of each county’s emergency physicians. While the purpose of these funds would remain the same, this measure would generally shift the administration of the money from counties to the state. However, under this measure, a county could apply for and obtain permission from the state to administer certain accounts in its Maddy Fund.

In addition, this measure requires that the state continue to spend about $32 million per year in Proposition 99 funds to reimburse physicians and community clinics for uncompensated medical care.

**How the Funding Would Be Spent**

**New State Revenues.** Most of the additional revenues generated by this measure would be used to reimburse physicians and hospitals for uncompensated emergency and trauma care. The remaining portion of the funding would be used to improve the state’s emergency phone number system, to help train and equip “first responders” (such as firefighters and paramedics) for emergencies, and to support community clinics. Below
ANALYSIS BY THE LEGISLATIVE ANALYST (CONT.)

is a more detailed description of the funding distribution, the purpose of those funds, and how they would be administered. (The percentage of new funds distributed for each purpose is noted in parentheses.)

- **The 911 Account** funding (0.75 percent of the new revenues) would be used to make technological and service improvements to the basic emergency telephone number system. Under the measure, the Department of General Services would distribute the funds to state or local agencies.

- **Emergency and Trauma First Responders Account** funding (3.75 percent) would be allocated to the California Firefighter Joint Apprenticeship Training Program for training and related equipment for firefighters, paramedics, and other first responders. The Office of the State Fire Marshal would administer this funding.

- **Community Clinics Urgent Care Account** funding (5 percent) would be allocated to nonprofit clinics providing urgent care services to the uninsured. The Office of Statewide Health Planning and Development would administer this funding.

- **The Emergency and Trauma Physician Uninsured Account** funding (30.5 percent) would be used to reimburse claims filed by physicians who are not employed by hospitals and who provide uncompensated emergency services to patients. The Department of Health Services (DHS) would administer these funds.

- **The Emergency and Trauma Hospital Services Account** funding (60 percent) would reimburse hospitals for the cost of uncompensated emergency and trauma care. The funding would be administered by DHS.

**Existing State and Local Funds.** Additionally, the measure would establish the Emergency and Trauma Physician Unpaid Claims Account and the Emergency and Trauma Physician Uninsured Account would be administered by DHS, but a county could apply for and obtain permission to administer the funds allocated from these accounts within its jurisdiction. The Emergency and Trauma Physician Services Commission, consisting of ten emergency medical professionals, would be created in DHS to provide advice on all aspects of these accounts as well as to review and approve relevant forms, guidelines, regulations, and county applications to administer funds from these accounts.

**FISCAL EFFECTS**

**New State Revenues and Expenditures.** Based upon the expected number of telephone customers and accounting for the cap on residential charges, we estimate that the measure would raise about $500 million in additional annual revenues from the increased surcharge. This amount would probably grow in future years with increases in telephone users and the number of calls made within the state. State expenditures would grow in keeping with these new revenues. Figure 1 shows how the new funds would be distributed assuming increased revenues of $500 million annually.

**FIGURE 1**

<table>
<thead>
<tr>
<th>Account</th>
<th>Estimated Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>911 Account</td>
<td>$4</td>
</tr>
<tr>
<td>Emergency and Trauma First Responders Account</td>
<td>19</td>
</tr>
<tr>
<td>Community Clinics Urgent Care Account</td>
<td>25</td>
</tr>
<tr>
<td>Emergency and Trauma Physician Uninsured Account</td>
<td>153</td>
</tr>
<tr>
<td>Emergency and Trauma Hospital Services Account</td>
<td>300</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$500</strong></td>
</tr>
</tbody>
</table>

*Total may not sum to $500 million due to rounding.

**Impact on Existing State and Local Funds.** Based on the most recent data available, we estimate that this proposition would transfer about $32 million.
ANALYSIS BY THE LEGISLATIVE ANALYST (CONT.)

each year to the state from the county Maddy Funds to reimburse physicians for uncompensated emergency care.

The measure also requires that about $32 million per year in Proposition 99 funds continue to be provided to reimburse physicians and community clinics for uncompensated medical care. While this would provide fixed ongoing revenues for these purposes, it would also mean that future funding for other programs which now rely on Proposition 99 revenues, would have to be reduced or alternative sources of funding found as tobacco tax revenues decline.

State and Local Administrative Costs. This measure would result in increased onetime and ongoing state administrative expenditures of several million dollars. Generally, these costs would be paid by the additional revenues generated under this measure.

The measure would also result in minor administrative expenditures at the local level, that would be paid for by the revenues deposited into those accounts.
EMERGENCY MEDICAL SERVICES. FUNDING. TELEPHONE SURCHARGE.
INITIATIVE CONSTITUTIONAL AMENDMENT AND STATUTE.

ARGUMENT in Favor of Proposition 67

Firefighters, paramedics, doctors, and nurses agree that passage of Prop. 67 is essential to maintain emergency medical care in California.

Every day thousands of Californians are victims of heart attacks, strokes, car accidents, and other medical emergencies. For many, rapid response emergency treatment by a paramedic, doctor, or nurse is the difference between life and death.

YES on Prop. 67 will make sure that rapid response emergency medical care is available when you and your family need it most.

The Problem:

We are facing a crisis in emergency care. According to government reports, there are 64 fewer hospital emergency rooms and trauma centers available for patients in California than there were just a decade ago. Experts predict that many more emergency rooms and trauma centers will close. Children, families, and seniors will lose access to doctors, nurses, critical medical equipment, medicines, and essential emergency care.

If an emergency room closes near your home, place of work, or along the routes you drive, the time it takes for an ambulance to get you to a doctor could double, triple, or worse. In an emergency, every second is critical.

Emergency rooms throughout California are severely overcrowded. Patients face long lines and wait times. Firefighters, paramedics, doctors, and nurses are overwhelmed and lack the resources to provide quality lifesaving care that every patient deserves.

The Solution:

A YES vote on Prop. 67 will provide needed funds to help:

- Keep hospital emergency rooms, trauma centers, and health clinics open and operational
- Prevent long lines and wait times at local emergency rooms
- Attract and retain highly skilled physicians, nurses, and medical staff at our local emergency rooms and trauma centers
- Provide critical emergency medical equipment and technology
- Support local health clinics that treat non-emergency patients and preserve our emergency rooms for real emergencies
- Equip and train firefighters and paramedics who are often the first to respond and provide medical care in emergencies
- Upgrade our 911 emergency telephone system

Safeguards to ensure funds are properly spent:

Prop. 67 funds emergency medical care with a modest increase to the existing surcharge on telephone use for the 911 system. Prop. 67 caps the amount a phone company can bill residential telephone customers for the new surcharge at 50 cents per month. The new surcharge does not apply to out-of-state long distance calls, and senior citizens and others on basic lifeline phone rates are completely exempt from the additional cost.

For just pennies each month we can preserve emergency care for California’s children, families, and seniors. None of the money from Prop. 67 can be taken away by the Legislature to be used for other purposes.

You never know when you will need a paramedic, emergency room doctor, or nurse. YES on Prop. 67 will make sure that emergency medical care is available when you and your family need it most.

SAVE EMERGENCY CARE. SAVE LIVES.
Please join firefighters, paramedics, doctors, nurses, and patients in voting YES on Prop. 67.

For more information, visit www.saveemergencycare.org

Safeguards to ensure funds are properly spent:

- Upgrade our 911 emergency telephone system
- Attract and retain highly skilled physicians, nurses, and medical staff at our local emergency rooms and trauma centers
- Prevent long lines and wait times at local emergency rooms
- Attract and retain highly skilled physicians, nurses, and medical staff at our local emergency rooms and trauma centers

REBUTTAL to Argument in Favor of Proposition 67

Respected health care advocates, the Congress of California Seniors, the California Sheriffs’ Association, and the emergency care workers who run the 911 system all OPPOSE PROP. 67 because 90% of the funds go to large health care corporations and other special interests—which means:

- No new emergency rooms or trauma centers.
- No money to upgrade existing emergency rooms.
- No provisions to reduce emergency response times. LESS THAN 1% OF THE MONEY GOES TO THE 911 EMERGENCY SYSTEM.

Prop. 67 is a $540 MILLION PHONE TAX—another MISLEADING attempt to give taxpayer money to special interests. READ THE FINE PRINT—and see how misleading it is:

- Supporters claim it’s “a modest increase” in phone taxes—but it actually INCREASES YOUR PHONE TAXES BY 400%.
- Supporters claim that seniors are exempt, but more than 1 MILLION SENIOR CITIZENS will be affected.
- Supporters claim the tax rates are capped, but there are NO CAPS ON CELL PHONE OR SMALL BUSINESS PHONE TAXES.

Prop. 67 DOES NOT PROVIDE HEALTH INSURANCE to any of the millions of Californians who do not have any. It gives millions to health corporations, but DOES NOTHING TO REDUCE PRESCRIPTION DRUG COSTS OR HEALTH INSURANCE PREMIUMS.

And because there are NO MANDATORY AUDITS OR FINANCIAL CONTROLS, there’s potential for waste and fraud.

Prop. 67 won’t solve California’s health care problems, but it will RAISE YOUR PHONE TAXES BY 400%.

Say NO to the PHONE TAX. Vote NO on 67.

ANGELA MORA, Founder
Office of the Patient Advocate
ROBERT T. DOYLE, President
California State Sheriffs’ Association
DR. CHARLES J. SUPPLE, M.D.
EMERGENCY MEDICAL SERVICES. FUNDING. TELEPHONE SURCHARGE. INITIATIVE CONSTITUTIONAL AMENDMENT AND STATUTE.

ARGUMENT Against Proposition 67

Prop. 67 is really a phone tax—a $540 million tax increase that will likely increase in the future. If Prop. 67 passes, we will get higher taxes, but that’s only part of the story:
1) It’s a 400% tax increase that consumers would have to pay each year.
2) No cap on cell phone taxes—the more you talk, the more taxes you’ll pay.
3) No cap on small business phone taxes.
4) More than 1 million seniors, many of whom live on fixed incomes, will be affected by the phone tax.

LESS THAN 1% OF THE MONEY FROM PROP. 67 WILL GO TO THE 911 SYSTEM. This initiative is a scam. The California 911 emergency dispatchers who run the 911 system DON’T support Prop. 67.

THERE ARE NO ADEQUATE FINANCIAL CONTROLS OR AUDITS. Even though this is a massive half-billion dollar tax increase, it contains no mandatory financial audits to make sure the money is spent properly. In addition to the potential for waste and fraud, Prop. 67 will require millions of dollars per year in ongoing administrative costs that the state cannot afford.

THIS INITIATIVE IS MISLEADING. 96% of the money goes directly to special interest groups.

READ THE FINE PRINT, HERE’S WHAT YOU’LL FIND OUT:
1) This is really a $540 million phone tax increase;
2) No cap on cell phones;
3) No cap on small businesses;
4) More than 1 million seniors will be forced to pay higher taxes;
5) No mandatory financial audits;
6) California’s sheriffs and 911 emergency dispatchers oppose the measure because it is misleading and doesn’t do what it says it does.

Listen to what respected voices across California think about the phone tax:
- California’s 911 emergency dispatchers (CALNENA) oppose Prop. 67.
- The California Taxpayers’ Association and the Howard Jarvis Taxpayers Association oppose Prop. 67 because it’s a 400% ($540 million per year) phone tax increase.
- The California Chamber of Commerce says it will hurt our economy and drive businesses from our state.
- The California State Sheriffs’ Association opposes it because it will force seniors living on fixed incomes to pay higher taxes.
- The California State Sheriffs’ Association says Prop. 67 doesn’t do what it promises to do.

CALIFORNIA ALREADY HAS SOME OF THE HIGHEST TAXES IN THE COUNTRY. Just when our economy is starting to bounce back, this huge, half-billion dollar tax increase could harm businesses, hurt seniors, and gouge consumers—damaging our economy. WITH NO CAP ON CELL PHONES OR BUSINESSES, THE MORE YOU TALK, THE MORE TAXES YOU HAVE TO PAY.

VOTE NO ON THE PHONE TAX.

L.W. “CHIP” YARBOROUGH, President
The California Chapter of the National Emergency Number Association (CALNENA)
H.L. “HANK” LACAYO, President
Congress of California Seniors
LARRY MCCARTHY, President
California Taxpayers’ Association

FACT: Prop. 67 caps the surcharge a phone company can add to residential telephone bills at 50¢ per month—a maximum of $6 per year.

FACT: The cost to cell phone users is minimal—if you pay $30 a month, Prop. 67 will cost you 90¢.

FACT: Prop. 67 completely exempts senior citizens on basic life line phone service—they will not pay a dime.

FACT: Prop. 67 provides for audits to ensure funds are properly spent and prohibits the Legislature and phone companies from raiding these funds.

Voters have a clear choice: watch our emergency medical care system unravel OR vote YES ON PROP. 67 to ensure victims of heart attacks, strokes, car accidents, and other emergencies receive life-saving emergency care.

SAVE EMERGENCY CARE. SAVE LIVES. YES ON PROP. 67.

LOU STONE, Vice President
California Professional Firefighters
RAMON JOHNSON, M.D., Past Chair
California Emergency Medical Services Commission
PAUL KIVELA, M.D., President
California Chapter of the American College of Emergency Physicians

Arguments printed on this page are the opinions of the authors and have not been checked for accuracy by any official agency.
TEXT OF PROPOSED LAWS

Proposition 66 (cont.)

(f) A person who meets the requirements of subdivision (a) or (b) shall be entitled to representation by counsel under this section, and for the purposes of resentencing, trial, or retrial. The person may request appointment of counsel by sending a written request to the court.

(j) The case shall be heard by the judge who conducted the trial, or accepted the convicted person’s plea of guilty or nolo contendere, unless the presiding judge determines that judge is unavailable. Upon request of either party, the court may order, in the interest of justice, that the convicted person be present at the hearing of the motion.

(k) Notwithstanding any other provision of law, the right to resentencing pursuant to this act is absolute and shall not be waived. This prohibition applies to, but is not limited to, a waiver that is given as part of an agreement resulting in a plea of guilty or nolo contendere.

(l) Those qualifying individuals shall be remanded to court and re-sentenced within no less than 30 days, and no more than 180 days, of this act becoming effective, unless the qualifying individual personally waives this right during the 180-day time period.

(m) Nothing in this section shall be construed as limiting the grounds for a writ of habeas corpus, or as precluding any other remedy.

(a) Under no circumstances may the resentencing, trial, or retrial of any individual pursuant to this section result in a sentence that is longer than the current sentence.

(o) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provisions or application.

SEC. 12. Liberal Construction

This act is an exercise of the public power of the state for the protection of the health, safety, and welfare of the people of the State of California, and shall be liberally construed to effectuate these purposes.

Proposition 67

This initiative measure is submitted to the people in accordance with the provisions of Section 8 of Article II of the California Constitution. This initiative measure amends, repeals, and adds sections to the Health and Safety Code, the Revenue and Taxation Code and the Welfare and Institutions Code; therefore, existing provisions proposed to be deleted are printed in strikethrough type and new provisions proposed to be added are printed in italic type to indicate that they are new.

PROPOSED LAW

SECTION 1. Findings and Declaration of Purposes

(a) Access to hospital trauma and emergency medical services in California is in critical condition. The ability of hospitals and physicians to meet the demand for trauma and emergency services, including necessary follow-up hospital care to patients admitted through emergency rooms, is strained to the breaking point. The lack of adequate urgent care alternatives, particularly for those without insurance or the ability to pay for medical services, puts added stress on hospital emergency departments. Patients often wait for hours in overcrowded emergency rooms for treatment, and seriously injured patients are increasingly being diverted past the nearest hospitals.

(b) The 911 emergency telephone system serves as a lifeline for countless Californians each year. Californians deserve a high quality system that ensures that each emergency call is answered immediately.

(c) Firefighters and paramedics are the first on the scene to provide medical care to accident or disaster victims. The medical care they provide can mean the difference between life and death. They must be appropriately trained and equipped to respond to medical emergencies.

(d) Emergency physicians and on-call physician specialists provide hundreds of millions of dollars of uncompensated medical care annually. As a consequence, fewer doctors are available to provide emergency medical services.

(e) The operation of emergency departments and the provision of emergency and related services costs hospitals many hundreds of millions of dollars annually. These losses have contributed to the closure of 26 hospitals between 1995 and 2003 with a corresponding reduction in emergency care. Other hospitals are threatened with closure or reductions in emergency care. The people intend, by adopting this act, to allocate funds to all hospitals operating licensed emergency departments in the manner specified in order to support and augment hospital emergency services and to help prevent the further erosion of such services. Because all hospitals with emergency rooms have a legal obligation to provide emergency services, all hospitals operating emergency rooms should share state funds available under this act based upon their relative emergency department volume, uncompensated care, provision of charity care, and provision of care to county indigent patients, as specified.

(f) Community clinics are an important part of the emergency medical system and the continuum of emergency care. Community clinics provide services that prevent emergent conditions from developing; reduce unnecessary emergency room use; and also provide follow-up care for patients discharged from the emergency room. This keeps patients from unnecessarily using or returning to the emergency room. However, community clinics are financially threatened by the growing number of uninsured patients they must treat.

(g) Emergency medical care is a vital public service, similar to fire and police services, and is the back-bone of the health care safety net for our communities. By providing high-quality trauma and emergency care, lives will be saved and taxpayer costs for healthcare will be reduced.

(h) Currently the state funds the 911 emergency telephone system with a surcharge on telephone calls made within California. A small increase in the existing emergency telephone surcharge, no more than 50 cents per month for households, is appropriate to enhance the delivery of emergency medical care and to help offset the costs of uncompensated emergency medical care in California.

(i) The people of the State of California hereby enact the 911 Emergency and Trauma Care Act to create an ongoing fund to improve the 911 emergency telephone system; to improve the training and equipment of firefighters and paramedics; and to improve, and to preserve and expand access to, trauma and emergency medical care.

(j) The intent of this act is to provide additional funding for emergency medical services for the health and welfare of our residents. Further, existing funding, although inadequate, must be protected and maintained so that the intent of this act is realized.

SECTION 2. Supplemental Funding for Emergency and Trauma Services

SEC. 2.1. Section 41020.5 is added to the Revenue and Taxation Code, to read:

SEC. 13. Severability

The provisions of this act are severable. If any provision of this act, or the application thereof to any person or circumstance, is held invalid, that invalidity shall not affect any other provision or application of this act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SEC. 14. Conflicting Measures

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

SEC. 15. Effective Date

This act shall become effective immediately upon its approval by the voters.

SEC. 16. Self-Execution

This act shall be self-executing.

SEC. 17. Amendment

This act shall not be altered or amended except by one of the following:

(a) By statute passed in each house of the Legislature, by rollcall vote in the journal, with two-thirds of the membership and the Governor concurring, or

(b) By statute passed in each house of the Legislature, by rollcall vote entered in the journal, with a majority of the membership concurring, to be placed on the next general ballot, and with the majority of the electors concurring, or

(c) By statute that becomes effective when approved by a majority of the electors.
41020.5. (a) The surcharge imposed pursuant to Section 41020 shall be increased at a rate of 3 percent on amounts paid by every person in the state on intrastate telephone communication service of the charges made for such services. The increase in surcharge shall be paid by the service user and shall be billed and collected in the same manner as the surcharge imposed pursuant to Section 41020.

(b) Notwithstanding subdivision (a), the surcharge shall not be imposed on residential service users of lifetime telephone services pursuant to Article 8 (commencing with Section 871) of Chapter 4 of Part 1 of Division 1 of the Public Utilities Code.

(c) Notwithstanding subdivision (a), no service provider shall bill a surcharge to, or collect a surcharge from, a residential service user that exceeds 50 cents ($0.50) per month. For purposes of this section, the term “residential service user” does not include mobile telecommunication services.

SEC. 2. Section 41135 of the Revenue and Taxation Code is amended to read:

41135. All amounts required to be paid to the state under this part shall be paid to the board in the form of remittances payable to the State Board of Equalization of the State of California. The board shall, on a quarterly basis, transmit the payments to the State Treasurer to be deposited in the State Treasury to the credit of the State Emergency Telephone Number Account in the General Fund, which is hereby created and credited to the 911 Emergency and Trauma Care Fund and the following accounts within that fund, which are hereby created:

(a) To the State Emergency Telephone Number Account, all of the amounts collected pursuant to Section 41020.

(b) To the State Emergency Telephone Number Account, three-fourths of 1 percent of the amounts collected pursuant to Section 41020.5.

(c) To the Emergency and Trauma First Responders Account, three and-three-fourths percent of the amounts collected pursuant to Section 41020.5.

(d) To the Community Clinics Urgent Care Account, 5 percent of the amounts collected pursuant to Section 41020.5.

(e) To the Emergency and Trauma Physician Uninsured Account, 30 and one-half percent of the amounts collected pursuant to Section 41020.5.

(f) To the Emergency and Trauma Hospital Services Account, 60 percent of the amounts collected pursuant to Section 41020.5.

(g) There is hereby created in the fund the Emergency and Trauma Physician Unpaid Claims Account to receive funds pursuant to Section 1246. (a) There is hereby established the Community Clinics Urgent Care Account in the 911 Emergency and Trauma Care Fund. Funds in the Community Clinics Urgent Care Account shall be continuously appropriated to and administered by the Office of the State Fire Marshal. The Office of the State Fire Marshal shall allocate those funds solely to the California Firefighter Joint Apprenticeship Training Program, for training and related equipment for firefighters and pre-hospital emergency medical workers. The California Firefighter Joint Apprenticeship Training Program shall deliver the training as required by subdivision (c) of Section 8588.11 of the Government Code. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

SECTION 5. Administration of Community Clinics Urgent Care Account

SEC. 5.1. Article 6 (commencing with Section 1246) is added to Chapter 1 of Division 2 of the Health and Safety Code, to read:

Article 6. Administration of Community Clinics Urgent Care Account

1246. (a) There is hereby established the Community Clinics Urgent Care Account in the 911 Emergency and Trauma Care Fund. Funds in the Community Clinics Urgent Care Account shall be continuously appropriated to and administered by the Office of Statewide Health Planning and Development solely for the purposes of this section. The office shall allocate the funds for eligible nonprofit clinic corporations providing vital urgent care services to the uninsured. The funds shall be allocated by the office pursuant to the provisions of subdivisions (b) and (c). Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(b) Annually, commencing August 1, 2005, the office shall allocate to each eligible nonprofit clinic corporation a percentage of the balance present in the Community Clinics Urgent Care Account as of July 1 of the year the allocations are made and subject to subdivision (d), based on the formula provided for in subdivision (c).

(c) Funds in the Community Clinics Urgent Care Account shall be allocated only to eligible nonprofit clinic corporations. Funds in the Community Clinics Urgent Care Account shall be allocated to eligible nonprofit clinic corporations on a percentage basis based on the total number of uninsured patient encounters.

(1) For purposes of this section, an “eligible nonprofit clinic corporation” shall meet the following requirements:

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

(B) The corporation must provide at least 1,000 uninsured patient encounters based on data submitted to the office for the year the allocations are made.

(2) The total number of uninsured patient encounters shall be based on data submitted by each eligible nonprofit clinic corporation to the office pursuant to the reporting procedures established by the office under Section 1216 of the Health and Safety Code. Beginning August 1, 2005, and every year thereafter, the allocations shall be made by the office based on data submitted by each eligible nonprofit clinic corporation to the office by February 15 of the year the allocations are made.

(3) For purposes of this section, except as otherwise provided in paragraph (4), an uninsured patient encounter shall be defined as an encounter for which the patient has no public or private third party coverage. An uninsured patient encounter shall also include encounters involving patients in programs operated by counties pursuant to Part 2 of Division 1 of the Welfare and Institutions Code.

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

(5) The office shall compute each eligible nonprofit clinic corporation’s percentage of total uninsured patient encounters for all eligible nonprofit clinic corporations and shall apply the percentages to the available funds in the account to compute a preliminary allocation amount for each eligible nonprofit clinic corporation. If the preliminary allocation for an eligible nonprofit clinic corporation is equal to or less than twenty-five thousand dollars ($25,000), the allocation for that eligible nonprofit corporation shall be twenty-five thousand dollars ($25,000).
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(6) For the remaining eligible nonprofit clinic corporations, the office shall compute each remaining eligible nonprofit clinic corporation’s percentage of total uninsured patient encounters for the remaining eligible clinic corporations and shall apply the percentage to the remaining funds available to determine the allocation amount for each remaining eligible nonprofit clinic corporation, subject to paragraph (7).

(7) No eligible nonprofit clinic corporation shall receive an allocation in excess of 2 percent of the total moneys distributed to all eligible nonprofit clinic corporations in that year.

(d) The Office of Statewide Health Planning and Development shall be reimbursed from the Community Clinics Urgent Care Account for the office’s actual cost of administration. The total amount available for reimbursement of the office’s administrative costs shall not exceed 1 percent of the moneys credited to the account during the fiscal year.

SECTION 6. Administration of Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts

SEC. 6.1. Chapter 2.5 (commencing with Section 1797.98a) of Division 2.5 of the Health and Safety Code is repealed.

Chapter 2.5—The Mass Emergency Medical Services Fund

1797.98a. (a) The fund provided for in this chapter shall be known as the Mass Emergency Medical Services (EMS) Fund.

(b) Each county may establish an emergency medical services fund, upon adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this section. The fund shall be administered by the county elected or appointed to have the state administer its medically indigent services program. Another county which elects to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund, upon request. The amount of the reimbursement shall be determined by the state, as specified in this section.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the accounts of the fund reasonably to be expected by physicians and surgeons. Pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5), each administering agency may maintain a reserve of up to 10 percent of the amount in the accounts of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county, including the following:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided to all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic comprehensive emergency services up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of medical services and are consistent with the intent of this chapter.

(e) The source of the moneys in the fund shall be the assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98a for the administrative expenses of the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and not used to the next year pursuant to paragraph (1) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

1797.98b. (a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

(3) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted in the chapter.

(4) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon and hospital claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(b) The name of the physician and surgeon and hospital administration, or names of special physicians and surgeons and hospital administration, contracted to review claims payment methodologies.

(2) Upon request, shall make available to any member of the public the report required under subdivision (e).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a contemporaneous basis.

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon shall be reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon’s future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund.

(e) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who cannot afford to pay for those services and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, and where all of the following conditions have been met:

(1) The physician and surgeon has reviewed the patient or responsible third party, if any, claims, or source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received factual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(c) The physician and surgeon has stopped any current or previous efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.
(A) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(B) Notwithstanding any other provision of this chapter, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reimbursement level of reimbursement from the county's emergency medical services fund for reimbursable services.

(C) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the emergency medical services Physician and Surgeon Fee Schedule, published by the American Medical Association, or a similar reimbursement methodology.

(D) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide services, and for other emergency medical services purposes. The administering agency shall identify to physicians and surgeons for other emergency medical services purposes.

(E) The administering agency shall select the reimbursement methodology and shall establish procedures and time schedules for the submission, processing, and payment of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of money in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall establish procedures with reimbursement requests that are supported by records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy and completeness and reimbursement made that are not supported by records may be denied to, and recovered from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records shall be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician, and surgeon, or category of physician and surgeon and shall not engage in practice that creates a conflict of interest, or otherwise influences physician or surgeon selection, which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more or as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review methodology and payment. The requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations in lieu of the aforementioned methodologies.

(F) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered; the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date of the service rendered. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (A) where the medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(G) During normal working hours, the administering agency may inspect and examine the records of a hospital or physicians and surgeons, and issue necessary subpoenas to enforce this chapter. A provider who has knowingly submitted a false request for reimbursement shall be civilly liable.

(H) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(I) All payments from the fund pursuant to Section 1707.08c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, mobile and ambulance-based care.

(J) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

1. A basic or comprehensive emergency department of a licensed general acute care hospital.

2. A site that was approved by a county prior to January 1, 1990, as a mobile or receiving station for the treatment of emergency medical conditions.

3. A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

4. For the fiscal years 1991-92, and 1992-93, each fiscal year thereafter, a facility which contracted prior to January 1, 1991, with the Fair Plan Service to provide emergency medical services.

(K) Payments shall be made only for emergency services provided on the calendar day on which emergency medical services are first provided and on the immediately following calendar day, however, payments may not be made for services provided beyond a 48-hour period of continuous service to the patient.

(L) If the administering agency determines in good faith that the payee has an operational or financial relationship, the administering agency may not make an advance payment to a payee.

(M) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (G). The administering agency may adopt rules to avoid the duplication or overlap in the employee benefits of such entities.

(N) The administering agency shall compile a quarterly and year-end summary of reimbursement to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public and may charge a fee to recover the reasonable cost of duplication.

(O) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 2 (commencing with Section 1280) and Chapter 4 (commencing with Section 1285) of Part 7 of Title 1 of the Code of Civil Procedure, or to a local medical society, for resolution by neutral parties.

(P) Notwithstanding any other provision of this chapter, an emergency physician and surgeon or an emergency physician group, with a group billing arrangement, with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

1. The services are provided in a basic or comprehensive emergency department in a small and rural hospital as defined in Section 124840.

2. The physician and surgeon is not an employee of the hospital.

3. All provisions of Section 1707.08c are satisfied, except that pay-
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ment to the emergency physician and surgeon, or an emergency physician group, by a hospital, is a gross billing arrangement and shall not be interpreted to mean that payment for a patient is made by a combination of gross billings and a per diem amount.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital’s designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a “gross billing arrangement” is an arrangement whereby a hospital serves as the billing and collection agent for an emergency physician and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon group’s gross billings for all patients.

122.708b. (a) The money contained in the Emergency Medical Services Fund, other than money contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16953) of Chapter 1 of Part 1 of Division 2 of the Welfare and Institutions Code.

SEC. 6.2. Chapter 2.5 (commencing with Section 1797.98a) is added to Division 2.5 of the Health and Safety Code, to read:

CHAPTER 2.5. EMERGENCY AND TRAUMA PHYSICIAN SERVICES COMMISSION


1797.98a. (a) There is hereby created the Emergency and Trauma Physician Services Commission in the Department of Health Services.

(b) The commission shall consist of 10 members, appointed as follows:

(1) Three full-time physicians and surgeons who are board certified in emergency medicine and who are members of a professional medical association and are in a position to represent the interests of emergency physicians generally, appointed by the Governor of California; and

(2) Two full-time physicians and surgeons who provide on-call specialty services to hospital emergency departments and who are members of a professional medical association and are in a position to represent the interests of on-call physician specialists generally, appointed by the Governor of California; and

(3) One full-time physician and surgeon who is board certified in emergency medicine and who is a member of a professional medical association and is in a position to represent the interests of emergency physicians generally, appointed by the Senate Rules Committee; and

(4) One full-time physician and surgeon who provides on-call specialty services to hospital emergency departments and is a member of a professional medical association and is in a position to represent the interests of on-call physician specialists generally, appointed by the Senate Rules Committee; and

(5) One full-time physician and surgeon who is board certified in emergency medicine and who is a member of a professional medical association and is in a position to represent the interests of emergency physicians generally, appointed by the Speaker of the California State Assembly; and

(6) One full-time physician and surgeon who provides on-call specialty services to hospital emergency departments and who is a member of a professional medical association and is in a position to represent the interests of on-call physician specialists generally, appointed by the Speaker of the California State Assembly.

(c) The term of the members of the commission shall be three calendar years, commencing January 1 of the year of appointment, provided that the initial terms of the members shall be staggered.

(d) The members of the commission shall receive no compensation for their services to the commission, but shall be reimbursed for their actual and necessary travel and other expenses incurred in the discharge of their duties.

(e) The commission shall select a chairperson from its members, and shall meet at least quarterly on the call of the director, the chairperson, or two members of the commission.

(f) The commission shall advise the director on all aspects of the Emergency and Trauma Physician Services Accounts, including both the Emergency and Trauma Physician Unpaid Claims Account and the Emergency and Trauma Physician Uninsured Account.

(g) A majority of both the emergency physician members and the on-call physician specialist members shall constitute a quorum, and no recommendation or action will be effective in the absence of a majority vote of emergency physician members and a majority vote of on-call physician specialist members.

(h) The commission shall review and approve the forms, guidelines, and regulations implementing the Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts.

(i) The commission shall review and approve applications by counties to administer their own Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts.

(j) For each calendar quarter and at the end of each calendar year, the State Department of Health Services or, where applicable, the administering agency for each county shall report to the Legislature and the Emergency and Trauma Physician Services Commission on the implementation and status of the Maddy Emergency Medical Services Fund, Emergency and Trauma Physician Unpaid Claims Account and the Emergency and Trauma Physician Uninsured Account. These reports and the underlying data supporting these reports shall be publicly available. These reports shall, for the department and each county, include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments deposited into the Maddy Emergency Medical Services Fund (“fund”).

(2) The total amount of funds allocated to each county administering the account from the Emergency and Trauma Physician Unpaid Claims Account (“Unpaid Claims Account”).

(3) The total amount of funds allocated to each county administering the account from the Emergency and Trauma Physician Uninsured Account (“Uninsured Account”).

(4) The fund and account balances and the amount of moneys disbursed from the fund and accounts to physicians.

(5) For both the fund and accounts, the pattern and distribution of claims, including but not limited to the total number of claims submitted by physicians and surgeons in aggregate from each facility.

(6) For both the fund and accounts, the amount of moneys available to be disbursed to physicians, the dollar value of the total allowable claims submitted, and the percentage of such claims which were reimbursed.

(7) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(8) The actual administrative costs of the administering agency incurred in administering the program.

(k) (1) The State Board of Equalization shall, on a quarterly basis, report to the Legislature and the Emergency and Trauma Physician Services Commission and make publicly available, amounts required to be paid to the 911 Emergency and Trauma Care Fund pursuant to Section 41135 of the Revenue and Taxation Code and amounts credited to each of the accounts created within that fund.

(2) The administering agency, upon request, shall make available to any member of the public a listing of physicians and hospitals that have received reimbursement from the Unpaid Claims Account, the Insured Account and the Emergency and Trauma Hospital Services Account and the amount of the reimbursement they have received. This listing shall be compiled on a semi-annual basis.

(l) Each administering agency of an account under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in each county as to the availability of the accounts and the process by which to submit a claim against the accounts. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

(m) The department may issue forms, guidelines or regulations to implement this chapter pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code.

1797.98b. (a) For purposes of this chapter, the department shall be the administering agency unless delegated to a county pursuant to subdivision (c).

(b) The department shall be reimbursed from the state Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts for its actual costs of administration not to exceed 4 percent of the moneys credited to these accounts during the fiscal year, unless a different per-
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centage is approved by the Emergency and Trauma Physician Services Commission as necessary for the efficient administration of the accounts.
(c) The department may delegate to a county, upon application, the administration of its own County Emergency and Trauma Physician Uninsured and Unpaid Claims Accounts. The department shall establish terms and conditions for the delegation of a county to administer the accounts, which shall include, but not be limited to all of the following:
   (1) The County Board of Supervisors shall request, by resolution, to be the administering agency and shall have established accounts with the Maddy Emergency Medical Services Fund;
   (2) The resolution shall specify any delegation of this authority proposed by the County Board of Supervisors, and shall specify who will serve as the administering officer;
   (3) The county is of sufficient size to justify such delegation as cost effective;
   (4) The county has demonstrated its commitment to maintaining a stable and high quality emergency medical services system. An example of such commitment is a county’s augmentation of funding for emergency medical services;
   (5) The county will accept both paper and electronic claims;
   (6) Administration by the county is supported by local physician organizations;
   (7) The costs of administration will not exceed 4 percent of the money credited to these accounts during the fiscal year, or the amount authorized by the Emergency and Trauma Physician Services Commission as necessary for the efficient administration of the accounts;
   (8) The department may approve an application by a county for a period not more than three years. A county may thereafter reapply for delegation;
   (9) The department shall give great weight to the recommendations of the Emergency and Trauma Physician Services Commission during the application and review process and the commission shall have final authority to approve applications pursuant to subdivision (i) of Section 1797.98a.
   (d) If a county is delegated by the department to be the administering agency, claims for emergency medical services provided at facilities within that county may only be submitted to that county, and may not be submitted to the department.
   (e) If a county is delegated by the department to be the administering agency, the department shall do all of the following:
      (1) authorize a county to keep moneys deposited into that county’s Emergency and Trauma Physician Unpaid Claims Account for reimbursements pursuant to this chapter;
      (2) each calendar quarter, transfer to the County Emergency and Trauma Physician Services Unpaid Claims Account in that county funds deposited into the State Emergency and Trauma Physician Services Unpaid Claims Account pursuant to Sections 16950 and 16950.2 of the Welfare and Institutions Code and allocated to that county by the department based on the total population of that county to the total population of the state;
      (3) each calendar quarter, transfer funds from the State Emergency and Trauma Physician Uninsured Account to that county’s Emergency and Trauma Physician Uninsured Account, based on the total population of that county to the total population of the state, and
      (4) authorize the county to deduct its actual costs of administration not to exceed the amount authorized pursuant to paragraph (7) of subdivision (c).
1797.98c. (a) It is the intent of the people that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of claims submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency and Trauma Physicians Uninsured Claims Account and the Emergency and Trauma Physicians Uninsured Account on a quarterly basis to apply to the processing of claims submitted by physicians and surgeons. The administering agency may, as necessary, request records and documentation to support the claims requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Claims submitted and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit claims that are inaccurate or unsupported by records may be excluded from submitting future claims. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the supervision of that person, shall not be the administering officer.
   (b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the department may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.
   (c) During normal working hours, the administering agency may make any inspection and examination of a hospital’s or physician and surgeon’s books and records needed to carry out the provisions of this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.
   (d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.
   (e) All payments from the accounts to eligible physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.
   (f) All payments from the accounts shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:
       (1) A standby, basic, or comprehensive emergency department of a licensed general acute care hospital.
       (2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.
       (3) For the 1991–92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.
       (g) Reimbursement for emergency services rendered under this chapter shall be limited to emergency services provided on the calendar day on which emergency medical services are first provided and the immediately following two calendar days, however reimbursement for surgery for emergency services is permitted for up to seven calendar days if such surgery is necessary to stabilize the patient’s emergency medical condition and could not be performed during the first three calendar days due to the patient’s condition. Notwithstanding this subdivision, if it is necessary to transfer the patient to a facility that is further from the patient’s location, reimbursement shall be available for services provided at that facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.
   (h) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity named in subdivision (f). The commissioner shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the accounts. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to the arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Title 9 of Part 3 of the Code of Civil Procedure, or to a local medical
society for resolution by neutral parties.

1797.98d. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency and Trauma Physician Unpaid Claims Account, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.99b are satisfied for reimbursement from the Uninsured Claims Account, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Uninsured and Unpaid Claims Accounts is sought by the hospital, or the hospital’s designee, as the billing and collection agent for the emergency physician and surgeon or an emergency physician group.

For purposes of this section, a “gross billings arrangement” is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon’s or group’s gross billings for all patients.

Article 2. Emergency and Trauma Physician Unpaid Claims Account

1797.99a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) Each county shall establish a Maddy EMS Fund. Within the Maddy EMS Fund, each county shall establish a County Emergency and Trauma Physician Unpaid Claims Account and a County Emergency and Trauma Hospital Services Account. A county that has been designated as an administering agency pursuant to subdivision (c) of Section 1797.98b, shall also establish a county Emergency and Trauma Physician Uninsured Account for reimbursement from the state Emergency and Trauma Physician Uninsured Account pursuant to paragraph (3) of subdivision (e) of Section 1797.98b and Section 1797.99c.

(c) The source of the money in each Maddy EMS Fund shall be the amounts billed for services, which are provided in Section 76000 of the Government Code, and allocated pursuant to subdivision (d). Other money, which may be transferred from the state to accounts within the Maddy EMS Fund pursuant to this chapter, is not subject to allocation pursuant to subdivision (d).

(d) 58 percent of the money in the Maddy EMS Fund derived pursuant to subdivision (c) shall be deposited into the County Emergency and Trauma Physician Unpaid Claims Account. Each calendar quarter, the County Treasurer shall transfer the funds in the account to the State Treasurer for credit to the State Emergency and Trauma Physician Unpaid Claims Account created pursuant to subdivision (g) of Section 41135 of the Revenue and Taxation Code; 25 percent shall be deposited into the County Emergency and Trauma Hospital Services Account for distribution by the county to hospitals providing disproportionate trauma and emergency medical care services. The remaining money derived pursuant to subdivision (c) shall remain in each county and shall be used to reimburse the county for actual costs of administering emergency medical services pursuant to this chapter as determined by each county, including, but not limited to, the funding of regional poison control centers. All interest earned on moneys in each county’s account shall remain in the account for allocation pursuant to this chapter.

(e) Funds in the State Emergency and Trauma Physician Unpaid Claims Account shall be continuously appropriated to and administered by the State Department of Health Services. The department shall transfer funds, as necessary, to a county that has been delegated the role of administering agency pursuant to subdivision (c) of Section 1797.98b. Such funds shall be continuously appropriated and allocated and to by the county pursuant to this chapter. The administering agency shall allocate the funds solely for the reimbursement of physicians and surgeons providing uncompensated emergency services and care up to the time the patient is stabilized, except those physicians and surgeons employed by hospitals, pursuant to this chapter. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(f) Any physician and surgeon may be reimbursed from the Emergency and Trauma Physician Unpaid Claims Account up to 50 percent of the amount claimed pursuant to subdivision (g) of Section 1797.99b for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to subdivision (d) of Section 1797.99b. All funds remaining at the end of the fiscal year, in excess of any reserve held and rolled-over to the next year pursuant to subdivision (g), shall be distributed proportionally based on the dollar amount of claims paid to all physicians and surgeons who submitted qualifying claims during that year.

(g) Each administering agency may hold in reserve and roll-over to the following year up to 15 percent of the funds in the Emergency and Trauma Physician Unpaid Claims Account.

1797.99b. (a) Physicians and surgeons wishing to be reimbursed from the Emergency and Trauma Physician Unpaid Claims Account shall submit their claims for services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment. If the services were provided in a county in which the county is the administering agency, the physician and surgeon shall submit the claim to the county and may not submit a claim to the administering agency. The administering agency shall accept both paper and electronic claims. Claims shall conform to the CMS 1500 forms, or in whatever format is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims. Payments from the Emergency and Trauma Physician Services Uninsured Account shall not constitute payment for services.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon’s future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund.

(c) Reimbursement for claims submitted by any physician and surgeon shall be limited to services provided to a patient who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waived any future, collection efforts to obtain reimbursement from the patient, upon receipt of funds from the fund.

(5) The claim has been received by the administering agency within one year of the date of service.

(d) Notwithstanding any other restriction on reimbursement, the administering agency shall adopt a reimbursement methodology to establish a uniform reasonable level of reimbursement from the Unpaid Claims Account for reimbursable services using the Relative Value Scale System.

(e) Each hospital receiving payment from the Emergency and Trauma Physician Services Uninsured Account shall maintain a uniform reimbursement methodology that provides a uniform level of reimbursement and care up to the time the patient is stabilized, except those physicians and surgeons employed by hospitals, pursuant to this chapter. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(f) Any physician and surgeon may be reimbursed from the Emergency and Trauma Physician Unpaid Claims Account up to 50 percent of the amount claimed pursuant to subdivision (g) of Section 1797.99b for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to subdivision (d) of Section 1797.99b. All funds remaining at the end of the fiscal year, in excess of any reserve held and rolled-over to the next year pursuant to subdivision (g), shall be distributed proportionally based on the dollar amount of claims paid to all physicians and surgeons who submitted qualifying claims during that year.

(g) Each administering agency may hold in reserve and roll-over to the following year up to 15 percent of the funds in the Emergency and Trauma Physician Unpaid Claims Account.
Units (RVUs) established by the Resource Based Relative Value Scale (RBRVS). When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amount so paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly pro-rate, without preference, payments to each claimant at a level less than the maximum payment level. The administering agency, upon approval by the Emergency and Trauma Physician Services Commission, may adopt a different reimbursement methodology to promote equitable compensation to the physician community as a whole for uncompensated emergency services and care. For the purpose of submission and reimbursement of claims, the administering agency shall adopt and use the current version of the Physician’s Current Procedural Terminology, published by the American Medical Association, or whatever coding set is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims.

Article 3. Emergency and Trauma Physician Uninsured Account

1797.99c. (a) Funds in the State Emergency and Trauma Physician Uninsured Account shall be continuously appropriated to and administered by the State Department of Health Services. The department shall transfer funds, as necessary, to a county that has been delegated the role of administering agency pursuant to subdivision (c) of Section 1797.99b. Such funds shall be continuously appropriated and allocated to and by the county pursuant to this chapter. The administering agency shall allocate the funds solely for the reimbursement of physicians and surgeons providing uncompensated emergency services and care up to the time the patient is stabilized, except those physicians and surgeons employed by hospitals, pursuant to this chapter. Appropriations are made without regard to fiscal years and all interest earned in the account shall remain in the account for allocation pursuant to this section.

(b) Physicians and surgeons providing emergency services and care to an uninsured patient shall be entitled to receive reimbursement for services rendered to such patients, on a quarterly basis, from the account. For each such patient, a physician and surgeon shall bill the patient unless the physician and surgeon reasonably believes that the patient will not make payment. Physicians and surgeons shall submit a claim to the administering agency for reimbursement within one year of the day the services were rendered. If the services were provided in a county in which the county is the administering agency, the physician and surgeon shall submit the claim to that county and may not submit a claim to the department. The administering agency shall accept both paper and electronic claims. Claims shall conform to the CMS 1500 form, or in whatever format is mandated by the Health Insurance Portability and Accountability Act of 1996 for physician claims.

(c) For purposes of this chapter, the term “uninsured patient” means a patient that a physician and surgeon has determined after reasonable and prudent inquiry is without public or private third party health coverage and the amount which was received from the Uninsured Claims Account for each of these claims; and

(e) Within 30 days following the end of each calendar quarter, physicians and surgeons shall provide the administering agency with:

(1) a list of all claims for which reimbursement is received within one year of the date of service from any public or private third party that the physician and surgeon reasonably believes the patient is unwilling to pay, and multiplied by the eligible hospital’s cost to charges ratio.

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

(f) “Charity care cost” means amounts actually written off, using any method generally accepted for determining such amounts on the date the hospital became effective, based on a patient’s willingness to pay, and multiplied by the hospital’s cost to charges ratio.

(g) “Operating expenses” means the total direct expenses incurred for providing patient care by the hospital. Direct expenses include (without limitation) salaries and wages, employee benefits, professional fees, supplies, purchased services, and other expenses.

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

(i) “Eligible hospital” means a hospital licensed for providing patient care services and includes charges related to hospital-based physician professional services.

(j) “Eligible hospital” means a hospital licensed under Section 1250 of the Health and Safety Code that operates an Emergency Department or a children’s hospital as defined in Section 10727 of the Welfare and Institutions Code.

(k) “Emergency department” means, in a hospital licensed to provide emergency medical services, the location in which those services are delivered.
encounter or visit is counted for each patient of the emergency department, regardless of whether the patient is admitted as an inpatient or treated and released as an outpatient. An emergency department encounter or visit shall not be counted where a patient receives triage services only.

(k) “Emergency and disaster management plan” means a plan developed to provide appropriate response to emergencies and disasters, including preparedness activities, response activities, recovery activities, and mitigation activities.

(l) “Office” means the Office of Statewide Health Planning and Development.

(m) “Disaster” means a natural or man-made event that significantly: (1) disrupts the environment of care, such as damage to buildings and grounds due to severe wind storms, tornadoes, hurricanes, or earthquakes; (2) disrupts care and treatment due to: (A) loss of utilities including, but not limited to, power, water, and telephones, or (B) floods, civil disturbances, accidents or emergencies in the surrounding community; or (3) changes or increases demand for the organization’s services such as a terrorist attack, building collapse, or airplane crash in the organization’s community.

(n) “Department” means the State Department of Health Services.

(o) “Funding percentage” means the sum of (1) an eligible hospital’s percentage of hospital emergency care (as defined in subdivision (s) below) multiplied by a factor of .30, added to (2) such hospital’s percentage of effort (as defined in subdivision (r) below) multiplied by a factor of .20, from which to be expressed as a percentage.

(p) “Hospital Account” means the Emergency and Trauma Hospital Services Account of the 911 Fund established pursuant to subdivision (j) of Section 41135 of the Revenue and Taxation Code.

(q) “911 Fund” means the 911 Emergency and Trauma Care Fund established pursuant to Section 41135 of the Revenue and Taxation Code.

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

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

(t) “Joint Commission on Accreditation of Healthcare Organizations” means that certain independent, nonprofit organization that evaluates and accredits nearly 18,000 health care organizations and programs in the United States, including hospitals, home care agencies, nursing facilities, ambulatory care facilities, clinical laboratories, behavioral health care organizations, HMOs, and PPOs.

(u) “American Osteopathic Association” means that certain nonprofit national association representing osteopathic physicians which accredits hospitals, and whose accreditation of hospitals is accepted for participation in the federal Medicare program.

1797.99l. (a) The department shall calculate each eligible hospital’s funding percentage to be used for the next calendar year and notify each eligible hospital of its proposed funding percentage and that for all hospitals by no later than September 30 of each year.

(b) The department shall receive and review the accuracy and completeness of information submitted by eligible hospitals pursuant to Section 1797.99j. The department shall develop a standard form to be utilized for reporting such information by eligible hospitals, but shall accept information from eligible hospitals which is not reported on such standard form.

(c) The department shall notify each hospital submitting the information specified under subdivision (a) of Section 1797.99j in writing through a communication delivered by no later than April 30 of each year confirming the information it has from such hospital and of any apparent discrepancies in the accuracy, completeness, or legibility of information submitted by such eligible hospital pursuant to Section 1797.99j. Unless such written notice is timely delivered to an eligible hospital, the information it reports pursuant to Section 1797.99j shall be deemed to be complete and accurate, but it shall be subject to audit under subdivision (f).

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

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

(f) The department may conduct audits of the use by eligible hospitals of any funds received pursuant to Section 1797.99l, and the accuracy of emergency department patient encounters and other information reported by eligible hospitals. If the department determines upon audit that any funds received were improperly used, or that inaccurate data reported by the eligible hospital resulted in an allocation of excess funds to the eligible hospital, it shall recover any excess amounts allocated to, or any funds improperly used by, an eligible hospital. The department may impose a fine of not more than 25 percent of any funds received by the eligible hospital that were improperly used, or the department may impose a fine of not more than two times any amounts improperly used or received by an eligible hospital if it finds such amounts were the result of gross negligence or intentional misconduct in reporting data or improperly using allocated funds under this chapter.

(g) Any fines collected by the department shall be deposited in the Hospital Account within the 911 Fund for allocation to eligible hospitals in accordance with the provisions of Section 1797.99l. Such funds shall not be used for administrative costs, and shall be supplemental to, and shall not supplant, any other funds available to be allocated from such account to eligible hospitals.

(h) In the event it is determined upon a final adjudicatory decision that no longer subject to appeal that a hospital has been incorrectly determined to not qualify as an eligible hospital, or was allocated an amount less than the amount to which it is entitled under Section 1797.99l, the department shall, from the next allocation of
funds to hospitals under Section 1797.99l, allocate to such hospital the additional amount to which it is entitled, and reduce the allocation to all other eligible hospitals pro rata.

1797.99l. (a) Each hospital seeking designation as an eligible hospital shall submit the following information to the department by no later than March 15 of each year, commencing the first March 15 following the operative date of this act:
(1) The number of emergency department encounters taking place in its emergency department for the preceding calendar year;
(2) The total amount of charity care costs of the hospital for the preceding calendar year;
(3) The total amount of bad debt costs for the hospital for the preceding calendar year;
(4) The total amount of county indigent program effort cost for the hospital for the prior calendar year;
(5) A photocopy of its operating license from the State Department of Health Services or equivalent documentation establishing that it operates a licensed emergency department;
(6) A declaration of commitment to provide emergency services as required by paragraph (2) of subdivision (a) of Section 1797.99k.
(b) Both pediatric and adult patients shall be included in the data submitted. The accuracy of the data shall be attested to in writing by an authorized senior hospital official. No other data or information, other than identifying information, shall be required by the department to be reported by eligible hospitals.
(c) Each hospital which receives a preponderance of its revenue from a single associated comprehensive group practice prepayment health care service plan shall report information required by this section for all patients, and not just for patients who are not enrolled in an associated health care service plan.
1797.99k. An eligible hospital shall do all of the following throughout each calendar quarter in which it receives an allocation pursuant to Section 1797.99l:
(1) Maintain an operational emergency department available within its capabilities and licensure to provide emergency care and treatment, as required by law, to any pediatric or adult member of the public who has an emergency medical condition.
(2) On an annual basis, file with the department a declaration stating the hospital's commitment to provide emergency services to victims of any terrorist act or any other disaster, within its capability, and to assist both the state and county in meeting the needs of their residents with emergency medical conditions.
(3) Either be accredited to operate an emergency department by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, or do all of the following:
(A) Participate in a minimum of two disaster training exercises annually;
(B) Provide training and information as appropriate to the hospital's medical staff, nurses, technicians, and administrative personnel regarding the identification, management, and reporting of emergency medical conditions and communicable diseases, as well as triage procedures in cases of mass casualties; and
(C) Collaborate with state and local emergency medical services agencies and public health authorities in establishing communications procedures in preparation for and during a disaster situation.
(4) Establish or maintain an emergency and disaster management plan. This plan shall include response preparations to care for victims of terrorist attacks and other disasters. The plan shall be made available by the hospital for public inspection.
(5) Each hospital shall annually prepare and issue a written report summarizing its compliance with this section.
1797.99l. (a) Funds deposited in the Hospital Account, together with all interest and investment income earned thereon, shall be continuously appropriated without regard to fiscal years to and administered by the State Department of Health Services. The department shall allocate the funds solely to eligible hospitals as provided by this chapter.
(b) Quarterly, commencing June 30 following the operative date of this chapter, the department shall allocate to each eligible hospital a percentage of the balance of the Hospital Account equal to such hospital's funding percentage, as determined by the department pursuant to Section 1797.99l. Notwithstanding:
1. The annual aggregate allocation to all hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan shall not exceed twenty-five million dollars ($25,000,000) during any calendar year, and the department shall reduce the quarterly allocation to each such hospital pro rata, if and to the extent necessary, to contain the aggregate allocation to all such hospitals within any calendar year to a maximum of twenty-five million dollars ($25,000,000). Thereafter, the annual aggregate allocation shall be applied by the department in increments of six million two hundred and fifty thousand dollars ($6,250,000) to the first two quarterly distributions of each calendar year, but no specific portion of the limit on maximum annual aggregate distributions provided by this subsection shall apply to other quarterly distributions to such hospitals.
2. The maximum aggregate annual allocation of twenty-five million dollars ($25,000,000) to all hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan set forth in paragraph (1) above shall be adjusted upward or downward annually, together with corresponding changes in any quarterly limits, commencing on January 1, 2006, by the same percentage increase or decrease in the aggregate amount deposited in the Hospital Account for the immediate prior calendar year against the aggregate amount deposited in the Hospital Account during the 2004 calendar year. Any adjustment that increases or decreases the maximum aggregate annual allocation by increasing or decreasing it by a percentage factor equal to the percentage increase or decrease in the aggregate funding percentage by all hospitals receiving a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan in 2004 against the aggregate funding percentage of all hospitals associated with the same health care service plan for the most recent calendar year.
3. After making the adjustment to the maximum aggregate annual allocation to hospitals that receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan service plan provided by paragraph (2) above, the department shall further adjust such maximum aggregate annual allocation by increasing or decreasing it by a percentage factor equal to the percentage increase or decrease in the aggregate funding percentage by all hospitals receiving a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan in 2004 against the aggregate funding percentage of all hospitals associated with the same health care service plan for the most recent calendar year.
4. After making the adjustments to the allocation of funds as provided by paragraphs (1) through (3) above, the department shall allocate any funds remaining in the Hospital Account to hospitals which do not receive a preponderance of their revenue from the same associated comprehensive group practice prepayment health care service plan pro rata based upon their respective funding percentages.
(c) Prior to each allocation under subdivision (b), the actual costs of the department (including any costs to the department resulting from charges under Section 11527 of the Government Code) for administering the provisions of this chapter, and the percentage of costs incurred by the State Board of Equalization for its functions under Section 41135 of the Revenue and Taxation Code equal to the percentage of remittances it receives under such section which are deposited in the Hospital Account, shall be reimbursed from the Hospital Account. The aggregate funds withdrawn for all administrative costs under this subdivision shall not exceed 1 percent of the total amounts deposited in the Hospital Account (not including any fines collected under subdivision (h) of Section 1197.99l) during the prior quarter.
(d) An eligible hospital shall use the funds received under this section only to further the provision of hospital and medical services to emergency patients. A hospital may not utilize funds received under this chapter to compensate a physician and surgeon pursuant to a contractual agreement for medical services rendered to a patient that would cause total compensation to such physician and surgeon from all public and private sources, including the hospital, to exceed his or her billed charges.
1797.99f. The department may promulgate and adopt regulations to implement, interpret and make specific the provisions of this chapter pursuant to the provisions of the Administrative Procedures Act set forth in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The department shall have no authority to promulgate rules, or to adopt any rule, guideline, criterion, manual, order, standard, manual, policy, procedure or interpretation that is inconsistent with the provisions of this chapter. This section shall not be interpreted to allow the department to adopt regulations (as defined by Sections 11342.600 of the Government Code) in contravention of Section 11340.5 of the Government Code.

SECTION 8. Preservation of Existing Funding
SEC. 8.1. Section 16950 of the Welfare and Institutions Code is
amended to read:

16950. (a) Twelve and two-tenths percent, or that portion of the CHIP Account derived from the Physician Services Account in a fiscal year, of each county's allocation under Section 16941 shall be used for the support of or payment for uncompensated physician services.

(b) Up to 50 percent of the moneys provided pursuant to subdivision (a) may be used by counties to pay for new contracts, with an effective date no earlier than July 1989, with private physicians for provision of emergency, obstetric, and pediatric services in facilities which are not owned or operated by a county, and where access to those services has been severely restricted. The contracts may provide for partial or full reimbursement for physician services provided to patients who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

(c) At least 50 percent of the moneys provided pursuant to subdivision (a) shall be transferred to the county Physician Services Account established in accordance with Section 16952 and administered in accordance with Article 3.5 (commencing with Section 16951). Notwithstanding any other provision of this code, at least 50 percent of the moneys provided pursuant to subdivision (a) shall be credited to the State Emergency and Trauma Physician Unpaid Claims Account established pursuant to subdivision (g) of Section 41135 of the Revenue and Taxation Code and allocated for physician and surgeon reimbursement pursuant to Chapter 2.5 (commencing with Section 1797.99a) of Division 2.5 of the Health and Safety Code.

SEC. 8.2. Section 16950.2 is added to the Welfare and Institutions Code, to read:

16950.2. (a) An amount, equal to the amount appropriated and allocated pursuant to Section 76 of Chapter 230 of the Statutes of 2003 (twenty-four million eight hundred three thousand dollars ($24,803,000)), shall be transferred and credited to the State Emergency and Trauma Physician Unpaid Claims Account, created pursuant to subdivision (g) of Section 41135 of the Revenue and Taxation Code, to be used only for reimbursement of uncompensated emergency services and care as provided in Chapter 2.5 (commencing with Section 1797.99a) of Division 2.5 of the Health and Safety Code, from accounts within the Cigarette and Tobacco Products Surtax Fund established pursuant to Section 30122 of the Revenue and Taxation Code, as follows:

(1) Nine million fifteen thousand dollars ($9,015,000) from the Hospital Services Account within the Cigarette and Tobacco Products Surtax Fund;

(2) Two million three hundred eighty thousand dollars ($2,380,000) from the Physician Services Account within the Cigarette and Tobacco Products Surtax Fund.

(3) Thirteen million four hundred sixty thousand dollars ($13,460,000) from the Unallocated Account within the Cigarette and Tobacco Products Surtax Fund.

(b) This transfer shall be made on June 30 of the first fiscal year following adoption of this act, and on June 30 each fiscal year thereafter.

(c) Nothing in this section shall preclude the Legislature from making additional appropriations from any source for the benefit of the state account, created pursuant to subdivision (d) of Section 41135 of the Revenue and Taxation Code.

SEC. 8.4. Section 16951 of the Welfare and Institutions Code is repealed.

16951. As a condition of receiving funds pursuant to this chapter, each county shall establish an emergency medical services fund as authorized by counties to pay for services provided during the fiscal year of allocation due to patients who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

SEC. 8.5. Section 16952 of the Welfare and Institutions Code is repealed.

16952. (a) (1) Each county shall establish within its emergency medical services fund a Physician Services Account. Each county shall deposit in the Physician Services Account those funds appropriated by the Legislature for the purposes of the Physician Services Account of the fund.

(2) (A) Each county may encumber sufficient funds to reimburse physicians losses incurred during the fiscal year for which bills will not be received until after the fiscal year.

(B) Each county shall provide a reasonable basis for its estimate of the necessary amount encumbered.

(C) All funds which are encumbered for a fiscal year shall be expended or disencumbered prior to the submission of the report of expenses incurred pursuant to Sections 16980 and 16980.1

(b) Funds deposited in the Physician Services Account in the county emergency medical services fund shall be exempt from the percent age allocations set forth in subdivision (a) of Section 1707.8h. However, funds in the county Physician Services Account shall not be used to reimburse for physician services provided by physicians employed by county hospitals.

(c) The county physician services account shall be administered by each county, except that a county electing to have the state administer its medically indigent adult program as authorized by Section 16809, may also elect to have its county physician services account administered by the state in accordance with Section 16954.

(d) Costs of administering the account shall be reimbursed by the account, up to 10 percent of the amount of the account.

(e) For purposes of this article “administering agency” means the agency designated by the board of superintendents to administer the article or the department, in the case of those CMSP counties electing to have the state administer the article on their behalf.

(f) The county Physician Services Account shall be used to reimburse physicians for losses incurred for services provided during the fiscal year of allocation due to patients who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

(g) (1) Reimbursement for losses shall be limited to emergency services as defined in Section 16953, obstetric, and pediatric services as defined in Sections 16955.5 and 16957.5, respectively.

(2) It is the intent of this subdivision to allow reimbursement for all of the following:

(A) All inpatient and outpatient obstetric services which are medically necessary, as determined by the attending physician.

(B) All inpatient and outpatient pediatric services which are medically necessary, as determined by the attending physician.

(3) No physician shall be reimbursed for more than 50 percent of the losses submitted to the administering agency.

SEC. 8.6. Section 16953 of the Welfare and Institutions Code is repealed.

16953. (a) For purposes of this chapter “emergency services” means physician services in one of the following:

(A) A general acute care hospital which provides basic or comprehensive emergency services for emergency conditions.

(B) A site which was approved by a county prior to January 1, 1999, as a paramedic receiving station for the treatment of emergency conditions.
patients, for emergency medical conditions.

(3) Beginning in the 1991-92 fiscal year and each fiscal year thereafter, in a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services, for emergency medical conditions.

(4) A standing, emergency room in a hospital specified in Section 1281.10 of the Health and Safety Code, for emergency medical conditions.

(b) For purposes of this chapter, “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including external injury, so that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient’s health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction to any bodily organ or part.

(c) It is the intent of this section to allow reimbursement for all inpatient and outpatient services which are necessary for the treatment of an emergency medical condition as certified by the attending physician or other appropriate provider.

SEC. 8.7. Section 16953.1 of the Welfare and Institutions Code is repealed.

16953.1. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive a disproportionate share of the proceeds of a claim submitted to the county’s emergency medical services fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 16953 are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the physician services account in the county’s emergency medical services fund is sought by the hospital or the hospital’s designee, the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

(e) For purposes of this section, “gross billings arrangement” means an arrangement whereby a hospital, on the behalf of the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, pays the emergency physician and surgeon, or an emergency physician group, a percentage of the emergency physician and surgeon’s group’s gross billings for all patients.

SEC. 8.8. Section 16953.2 of the Welfare and Institutions Code is repealed.

16953.2. Nothing in this article shall prevent a physician from utilizing an agent who furnishes billing and collection services to the physician to submit claims or receive payment for claims.

SEC. 8.9. Section 16953.3 of the Welfare and Institutions Code is repealed.

16953.3. Notwithstanding any other restrictions on reimbursement, a county may adopt a fee schedule to establish a uniform, reasonable level of reimbursement from the physician services account for reimbursable services.

SEC. 8.10. Section 16955 of the Welfare and Institutions Code is repealed.

16955. Reimbursement for losses incurred by any physician shall be limited to services provided to a patient defined in subdivision (b) of Section 16953, and unless all of the following conditions have been met:

(a) The physician has incurred a loss of reimbursement from the physician services account for services rendered.

(b) The physician has billed for payment of services.

(c) Either of the following:

(1) A period of not less than three months has passed from the date the physician billed the patient or responsible third party, during which time the physician has made reasonable efforts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(2) The physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician.

(d) The physician has stopped any current, and waived any future, collection efforts to obtain reimbursement from the patient or responsible third party pursuant to a written agreement.

SEC. 8.11. Section 16955.1 of the Welfare and Institutions Code is repealed.

16955.1. This article shall not be applied or interpreted so as to prevent a physician from seeking payment from a patient or responsible third party payer, or arranging a repayment schedule for the costs of services rendered prior to receiving payment under this article.

SEC. 8.12. Section 16956 of the Welfare and Institutions Code is repealed.

16956. (a) The administering agency shall establish procedures and time schedules for submission and processing of reimbursement claims submitted by physicians in accordance with this chapter.

(b) Schedules for payment established in accordance with this section shall provide for disbursement of the funds available in the account periodically and at least annually to all physicians who have submitted claims containing accurate and complete data for payment by the dates established by the administering agency.

(c) Claims which are not supported by records may be denied by the administering agency, and any reimbursement paid in accordance with this chapter to any physician which is not supported by records shall be repaid to the administering agency, and shall be a claim against the physician.

(d) Any physician who submits any claim for reimbursement under this chapter which is inaccurate or which is not supported by records may be excluded from reimbursement of future claims under this chapter.

(e) A listing of patient names shall accompany a physician’s claim, and those names shall be given full confidentiality protections by the administering agency.

SEC. 8.13. Section 16957 of the Welfare and Institutions Code is repealed.

16957. Any physician who submits any claim in accordance with this chapter shall keep and maintain records of the services rendered, the payments which have been rendered, and any additional information the administering agency may require, for a period of three years after the services were provided.


16958. If, after receiving payment from the account a physician is reimbursed by a patient or a responsible third party, the physician shall do one of the following:

(a) Notify the administering agency and the administering agency shall reduce the physician’s future payment of claims from the account.

(b) Notify the administering agency and the physician shall reduce the physician’s future payment of claims from the account.

(c) If the account is an amount equal to the amount collected from the patient or third party payer, but not more than the amount of reimbursement received from the account.

(d) Notify the administering agency of the payment and reimburse the physician an amount equal to the amount collected from the patient or third party payer, but not more than the amount of reimbursement received from the account.

SEC. 8.15. Section 16959 of the Welfare and Institutions Code is repealed.

16959. The money contained in a Physician Services Account within an Emergency Medical Services Fund shall not be subject to Chapter 2.5 (commencing with Section 1797.98a) of Division 2.5 of the Health and Safety Code.

SECTION 9. New Funds Not to Supplant Existing Funds

Funds allocated and appropriated pursuant to this act shall be used to supplement existing levels of federal, state and local funding and not to supplant existing levels of funding.

SECTION 10. Amendment

This act may only be amended by the Legislature to further its pur-
poses by a statute passed in each house by rollock vote entered in the
journal, four-fifths of the membership concurring.

SECTION 11. Operative Date
This act shall become effective immediately upon its adoption by the
people, however it shall not become operative until January 1 in the year
following its adoption.

SECTION 12. Severability
If any provision of this act, or part thereof, is for any reason held to
be invalid or unconstitutional, the remaining provisions shall not be
affected, but shall remain in full force and effect, and to this end the pro-
visions of this act are severable. In addition, the provisions of this act
are intended to be in addition to and not in conflict with any other ini-
tiative measure that may be adopted by the people at the same election,
and the provisions of this act shall be interpreted and construed so as to
avoid conflicts with any such measure whenever possible. In the event
the distribution of funds from any of the accounts established by subdi-
vision (c), (d), (e), (f), or (g) of Section 41135 of the Revenue and Taxation Code is permanently enjoined or invalidated by final judicial

In addition to paying substantial taxes, the owners of gambling
establishments and horse racing tracks authorized to operate gaming
device, would have to be licensed by the California Gambling Control
Commission under the Gambling Control Act, which requires that they be
persons of good character, honesty, and integrity, and persons whose prior
activities, reputation and associations entitle them to receive a license
from the state.

Proposition 67 (cont.)

SECTION 13. Conformity with State Constitution
SEC. 13.1. Section 14 is added to Article XIII B of the California
Constitution, to read:
SEC. 14. “Appropriations subject to limitation” of each entity
of government shall not include appropriations of revenue from the
911 Emergency and Trauma Care Fund created by the 911 Emergency
and Trauma Care Act. No adjustment in the appropriations limit of any
entity of government shall be required pursuant to Section 3 as a result
of revenue being deposited in or appropriated from the 911 Emergency
and Trauma Care Fund. The surcharge created by the 911 Emergency
and Trauma Care Act shall not be considered General Fund revenues
for the purposes of Sections 8 and 8.5 of Article XVI.

PROPOSED LAW
THE GAMING REVENUE ACT OF 2004
SECTION 1. Title.
This act shall be known as and may be cited as the “Gaming Revenue
Act of 2004.” This act may also be cited as the “Gaming Revenue Act”
or the “act.”

SEC. 2. Findings and Purpose.
The people of the State of California hereby make the following
findings and declare that their purpose in enacting this act is as follows:
(a) California now faces an unprecedented budget deficit of billions
of dollars that particularly threatens funding for education, police
protection, and fire safety. As a result of California’s budget crisis, the state
needs to find new ways to generate revenues without raising taxes. In
March 2000, Proposition 1A was enacted, which triggered an unpreced-
ented expansion of Indian casino gaming, gave Indian tribes a monop-
opoly on casino gaming, and has led to billions of dollars in profits for
Indians and local governments, but little or no taxes to the state. Moreover,
local governments and communities have not been adequately protected, the state
does not have sufficient regulation and oversight of tribal casino gam-
ing, and tribal casinos have not complied with state laws applicable
to other businesses and designed to protect California citizens, such as
laws regarding the environment and political contributions. Gaming
establishments have failed to fully fund a trust fund to promote the welfare
of Indian tribes that do not operate large casinos. Some Indian tribes have
attempted to acquire land far away from their reservations or tradi-
tional lands to be used as casinos and not for use as traditional reserv-
atons. Tribes have expended over one hundred twenty million dollars
($120,000,000) in political contributions but have refused to comply
with disclosure requirements.
(b) California should require that all Indian gaming tribes voluntari-
ely share some of their gaming profits with the state that can be used
to support public education, and local police and fire services, and
address other problems associated with tribal casino gaming, and in the
event all Indian gaming tribes do not do so, California should grant
gaming rights to other persons who will share substantial revenue with the
state that can be used to support public education and local police and
fire services.
(c) The Governor should be authorized to negotiate amendments to all
existing compacts with Indian tribes to allow these Indian tribes to con-
tinue to have the exclusive right to operate gaming devices in the State of
California if the Indian tribes agree to pay 25 percent of their winnings
from such devices to a gaming revenue trust fund and agree to comply with
state laws, including laws governing environmental protection, gaming
regulation, and campaign contributions and their public disclosure.

Proposition 68

This initiative measure is submitted to the people of California in
accordance with the provisions of Section 8 of Article II of the California
Constitution.

This initiative measure amends provisions of, and adds sections to,
the California Constitution and the Business and Professions Code and
the Government Code; therefore, existing provisions proposed to be
deleted are printed in italic type and new provisions proposed to be
added are printed in italic type to indicate that they are new.

SECTION 1. Title.
This act shall be known as and may be cited as the “Gaming Revenue
Act of 2004.”

SEC. 2. Findings and Purpose.
The people of the State of California hereby make the following
findings and declare that their purpose in enacting this act is as follows:
(a) California now faces an unprecedented budget deficit of billions
of dollars that particularly threatens funding for education, police
protection, and fire safety. As a result of California’s budget crisis, the state
needs to find new ways to generate revenues without raising taxes. In
March 2000, Proposition 1A was enacted, which triggered an unprece-
anted expansion of Indian casino gaming, gave Indian tribes a monop-
opoly on casino gaming, and has led to billions of dollars in profits for
Indians and local governments, but little or no taxes to the state. Moreover,
local governments and communities have not been adequately protected, the state
does not have sufficient regulation and oversight of tribal casino gam-
ing, and tribal casinos have not complied with state laws applicable
to other businesses and designed to protect California citizens, such as
laws regarding the environment and political contributions. Gaming
establishments have failed to fully fund a trust fund to promote the welfare
of Indian tribes that do not operate large casinos. Some Indian tribes have
attempted to acquire land far away from their reservations or tradi-
tional lands to be used as casinos and not for use as traditional reserv-
atons. Tribes have expended over one hundred twenty million dollars
($120,000,000) in political contributions but have refused to comply
with disclosure requirements.
(b) California should require that all Indian gaming tribes voluntari-
ely share some of their gaming profits with the state that can be used
to support public education, and local police and fire services, and
address other problems associated with tribal casino gaming, and in the
event all Indian gaming tribes do not do so, California should grant
gaming rights to other persons who will share substantial revenue with the
state that can be used to support public education and local police and
fire services.
(c) The Governor should be authorized to negotiate amendments to all
existing compacts with Indian tribes to allow these Indian tribes to con-
tinue to have the exclusive right to operate gaming devices in the State of
California if the Indian tribes agree to pay 25 percent of their winnings
from such devices to a gaming revenue trust fund and agree to comply with
state laws, including laws governing environmental protection, gaming
regulation, and campaign contributions and their public disclosure.

(d) In the event all Indian tribes with existing compacts do not agree
to these terms, five existing horse racing tracks and 11 existing
gambling establishments, where forms of legal gambling and wagering
already occur, should have the right to operate a limited number of gam-
ing devices, provided they pay 33 percent of their winnings from the
operation of such gaming devices to cities, counties, and a gaming rev-
ue trust fund to be used for education, and police and fire services,
and provided they comply with strict legal requirements on the opera-
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